



## Perception and Utilization of Primary Health Care Services in a Semi-Urban Community in South-Western Nigeria

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### KEYWORDS

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### ABSTRACT

**Objective:** The health status of most people living in developing countries of the world remains poor. Linked to this are some factors, of which low utilization of PHC facilities remain a major issue. This study therefore aimed to determine the utilization of PHC services in a sub-urban community in a developing country in West Africa.

**Design:** The study was a descriptive cross sectional study conducted in Olorunda Local Government Area of Osun State, Nigeria. A multistage sampling technique was used to recruit adults above the age of 18 years, normally resident in the community. Three hundred and ninety five individuals were involved in this community-based study. Interview was conducted using semi-structured pre-tested questionnaire to obtain relevant information.

**Result:** Most (71.7%) of respondents were aware of PHC facilities in their communities and the most frequently mentioned health service provided was the immunization service. Three quarters of respondents felt that PHC services were accessible while over half (57.2%) felt it could address the disease burden in the community. Only 44.1% of them had ever-utilized any PHC health facility within the district. Respondents' age, sex, marital status, educational level and occupation are all significantly related to utilization status.

**Conclusion:** The study demonstrates high awareness level of the PHC system in the population studied; however, utilization of the facilities is still very low. We hereby recommend that managers of this health institution put in place programs and schemes that will facilitate more effective service delivery especially in relation to the workers in this health sector. In addition, orientation programs lauding the benefits of the PHC facilities to correct wrong opinions about PHC among local communities and creation of good access routes that link primary health centers to the communities should be on the priority list of the managers of PHC to enhance utilization of services.

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### INTRODUCTION

Preceding the Alma-Ata Conference declaration (with respect to Primary Health Care) was the decision by the World Health Assembly (WHA) to make health available to all peoples globally by the year 2000.<sup>1</sup> Primary Health Care (PHC), which is essential health care made available to all people where they live, work and play, needs substantial community involvement for its success.<sup>1,2,3</sup>

The perception of the community about health programs and their involvement in organizing for health services, affect their level of participation and utilization of related health facilities; that is, when members of the community view health programs positively they are then likely to have a good attitude to such programs and participate actively in it.<sup>3</sup> Majority of people residing in most developing countries of the world, Africa inclusive, have a poor understanding of their national health systems and programs and therefore do not put the health facilities into proper

and optimal use.<sup>4</sup> In Nigeria, despite the launching of PHC Services since 1986,<sup>2,5</sup> the rate of utilization of health services have remained low, contributing to poor health status of its people, for example, an evaluation of infant health services in Nigeria reveal that in the last decade, there has been an increase in infant mortality (IMR) for which values had deteriorated from an estimated 83 per 1000 in 1990, to about 118 per 1000 in the year 2003.<sup>6</sup>

The poor perception and utilization of PHC programs in developing countries is linked to weak management and poor adherence to the basic principles of PHC. For PHC programs to succeed, it is required that functional district health committees be put in place and that all sectors relevant to provision of health care services e.g. agriculture, education and information, be fully involved in its planning and implementation processes and evaluation.<sup>2,7,8</sup>

In Nigeria, though majority of PHC health districts claim to have health committees in place, these are most times non-functional and in a significant proportion of districts, the committees have not been constituted.<sup>7</sup>

The mere provision of health facilities does not necessarily imply increased or improved utilization of health services by communities; major factors that influence health facility use include distance to facilities, cost of services, cultural beliefs of the community, educational status of the individual, nature of illness and quality of the health services available.<sup>9</sup> Since one of the major objectives of PHC in developing countries is to improve the health status of individuals and the community through health promotion and increased utilization of preventive, curative and rehabilitative health services, the question of perception and utilization of individuals and the community with respect to PHC service is of considerable interest to health policy makers.<sup>8,10</sup> An improved understanding of factors influencing PHC services utilization in sub-Saharan Africa will therefore assist policy makers in the design of health programs that are acceptable and beneficial to individuals and members of the community.

The main objective of this study is therefore to determine the awareness, perception and utilization of PHC services by people living in an urban community of a developing country in sub-Saharan Africa.

## METHODOLOGY

**Study location:** The study was conducted in Olorunda Local Government Area (LGA) located in Osogbo, the capital of Osun State, Nigeria. Olorunda LGA with an estimated human population of about 126,587 is urbanized with fairly developed social infrastructure e.g. primary, secondary and tertiary educational and health facilities; most parts of the town have regular potable water and electricity supply. As at the time of conducting the study the population of adults residing in Olorunda LGA was estimated at 69,622.

**Study Population:** Any adult who has lived in the LGA in the last five years could be selected for the study. Olorunda LGA is inhabited mainly by the Yoruba speaking people of south-western Nigeria and predominantly Muslims. Majority of the people living in this community are traders, artisans, farmers, civil servants and commercial transporters. The study location has 11 health districts from which the participants in the study were drawn.

**Study Design:** A cross-sectional study of all adults who have resided within the LGA for at least five years.

**Sample size determination and sampling techniques.** A minimum sample size of 385 was obtained using sample size calculation formula for a single proportion in a population greater than 10,000.<sup>11</sup> The multistage sampling technique was used in recruiting participants for the study. In the first stage, five districts were randomly selected from the 11 health districts making up the LGA and in the second stage, two enumeration areas (EAs) were also randomly selected from each of the selected health districts; therefore 10 enumeration areas were selected in all. In the third stage, a street was randomly selected from each of the previously chosen EAs and all available eligible adults were interviewed in selected houses, with the aid of a semi-structured questionnaire.

**Data Collection Instruments:** A semi structured pre-tested questionnaire was used in collecting om the

information from the respondents. The questionnaire elicited information about participant's socio-demographic status, awareness, perception and utilization of primary health care facilities in their district. The interviews conducted by trained interviewers spanned a period of 4 weeks.

**Data Analysis:** Information collected through the survey was edited for errors, entered into a micro-computer and analyzed using the Statistical Package for Social Sciences (SPSS) version 11.0. The Chi-square test was used to test for significance of associations between categorical variables at 5% level of significance.

## RESULTS

**Socio-Demographic Characteristics:** A total of 395 adult respondents were interviewed between January and March. Majority (72.9%) of these respondents were below 50 years of age with a mean age of  $42.3 \pm 7.1$  years. Two hundred and thirteen (53.9%) respondents were male, while 46.1% were female giving a male to female (M: F) ratio of 1.2:1. Majority (77.0%) of the respondents were married while 22.3% were single. Two hundred and twenty three (56.5%) respondents claimed having tertiary education while 84 (21.3%) and 14 (3.5%) claimed to have secondary and primary education respectively; seventy four (18.3%) respondents had no formal education (NFE). Most of the respondents were artisans (41.5%), civil servants (20.5%) and traders (16.5%); farmers (9.6%), students (9.6%) and highly skilled professionals (1.0%) were in the minority. A little over half (51.9%) of the respondents were Muslims while Christians constituted 46.8% of the study population. While most (80.0%) of the respondents were of the Yoruba ethnic stock, Ibos, Hausas and others minority ethnic groups constituted 12.2%, 4.1% and 3.3% respectively.

Over two-thirds (69.87%) of respondents stated that their houses were within 5km of the PHC facility, while 74 (18.7%) and 35 (8.9%) respondents stated that they either lived farther than 5km or had no idea of the distance of the

health facility. With regards to transportation costs, most (86.8%) respondents stated that they needed to spend about N100.00 (₦ 0.50) to transport themselves, to and from the nearest PHC Center ; only 52 (13.2%) respondents needed more than this to transport themselves. **(Table 1)**

**Awareness of PHC services:** Majority (71.1%) respondents were aware of the existence of a PHC facility within their health districts. The most common health services provided which respondents were aware of are immunization services (78.2%), health education (74.7%), treatment of common ailments (72.9%) and antenatal care (69.9%); others were dental care (61.8%), family planning (65.8%), essential drugs (61.8%) and growth monitoring (60.8%) **(Table 2)**

### Perception of PHC services:

**Accessibility-** Most (75.7%) participants believed that PHC facilities were readily accessible. An evaluation of accessibility among respondents revealed that 55.7% respondents felt that the PHC services were readily accessible, while 20.0% and 24.3% respectively felt that PHC services were either fairly or difficult to access.

**Adequacy-** Two hundred and eighty-six (72.4%) respondents believed that PHC facilities had adequate facilities to attend to the health problems of the community while 109 (27.6%) felt otherwise.

**Distance-** Two hundred and sixty six (67.4%) respondents felt that the PHC facility is not far from their homes, while 69 (17.5%) and 100 (25.3%) respondents felt it was either too far or could not comment on the distance of the PHC facility.

**Competence-** while 26.6% of the respondents felt that PHC workers had adequate technical skills, 57.7% and 15.7% of them respectively felt that they were of average standard or incapable. **(Table 3)**

### Utilization (use) of PHC Services and

### Utilization (use) of PHC Services and demographic profile of respondents:

One hundred and Seventy-four (44.1%) respondents had ever-utilized PHC facilities within their health district. The most frequently demanded health services were immunization, maternal and child health including family planning, health education and treatment of common ailments with 55.4%, 57.5% 60.4% and 75.2% of respondents respectively reporting use. Of respondents who had ever-used PHC services, 138 (79.3%) were satisfied with the quality of services rendered while 36 (21.7%) felt that the services rendered were of poor quality. Ever-use of PHC facilities was significantly associated with age, sex, marital status, educational qualification and socio-economic status ( $P < 0.05$ ) in each case. A significantly higher proportion of users were found among respondents that were above 50 years of age, married, female, with low or no

educational qualifications and of low socio-economic status. (Table 4)

### Reasons for non-utilization:

Of the 221 (55.9%) non-utilizers of PHC facilities, the major reasons cited for non-utilization were perception of poor quality of service provided by PHC workers (61.5%), far distance from PHC facilities (26.7%) and poor understanding of the PHC system (50.7%); other reasons were lack of cultural access (55.2%) and long waiting times (14.9%). Only 2 (0.9%) respondents felt that cost was a factor against the use of PHC service. (Table 5)

**Table 1: Socio-demographic Characteristics of Respondents (n = 395)**

| Variable                  | Frequency | %    |
|---------------------------|-----------|------|
| <b>Age (yrs.):</b>        |           |      |
| <30yrs.                   | 87        | 22.0 |
| 31-40yrs.                 | 101       | 25.6 |
| 41-50yrs.                 | 107       | 27.1 |
| >50yrs.                   | 100       | 25.3 |
| <b>Sex:</b>               |           |      |
| Male                      | 213       | 53.9 |
| Female                    | 182       | 46.1 |
| <b>Type of marriage:</b>  |           |      |
| Monogamous                | 205       | 66.6 |
| Polygamous                | 102       | 33.4 |
| <b>Marital Status:</b>    |           |      |
| Single                    | 88        | 22.3 |
| Married                   | 307       | 77.0 |
| Others                    | 3         | 0.7  |
| <b>Educational Level:</b> |           |      |
| No Formal Education       | 74        | 18.7 |
| Primary                   | 14        | 3.5  |
| Secondary                 | 84        | 21.3 |
| Tertiary                  | 223       | 56.5 |
| <b>Occupation:</b>        |           |      |
| Professional              | 4         | 1.1  |
| Trader                    | 65        | 16.5 |
| Civil Servant             | 85        | 21.6 |
| Artisan                   | 164       | 41.6 |
| Farmer                    | 38        | 9.6  |
| Student                   | 38        | 9.6  |
| <b>Religion:</b>          |           |      |
| Christianity              | 185       | 46.8 |
| Islam                     | 205       | 51.9 |
| Others                    | 5         | 1.3  |

**Table 2:**  
**Respondents awareness of some PHC service components (n= 395)**

| <b>PHC Services</b>          | <b>Aware (%)</b> | <b>Not Aware (%)</b> |
|------------------------------|------------------|----------------------|
| Immunization                 | 309 (78.2%)      | 86 (21.8)            |
| Treatment of common Diseases | 288 (72.9)       | 107 (27.1)           |
| Health Education             | 295 (74.7)       | 100 (25.3)           |
| Dental Care                  | 244 (61.8)       | 151 (38.2)           |
| Antenatal Care               | 272 (68.9)       | 123 (31.1)           |
| Family Planning              | 260 (65.8)       | 135 (34.2)           |
| Essential Drugs              | 244 (61.8)       | 151 (38.2)           |
| Growth Monitoring            | 240 (60.8)       | 155 (39.2)           |

**Table 3:**  
**Perception of PHC Services by respondents (n = 395)**

| <b>Perception</b>                   | <b>Frequency</b> | <b>%</b> |
|-------------------------------------|------------------|----------|
| <b>Accessibility:</b>               |                  |          |
| Very Accessible                     | 220              | 55.7     |
| Just Accessible                     | 79               | 20.0     |
| Difficult to Access                 | 2                | 0.1      |
| Not Accessible                      | 94               | 24.2     |
| <b>Adequacy of Service:</b>         |                  |          |
| Adequate                            | 286              | 72.4     |
| Inadequate                          | 109              | 27.6     |
| <b>Quality of Service Provided:</b> |                  |          |
| Satisfactory                        | 138              | 34.9     |
| Fair                                | 56               | 14.2     |
| Not Satisfactory                    | 201              | 50.9     |
| <b>Competence of Health-Worker:</b> |                  |          |
| Above Average                       | 105              | 26.6     |
| Average                             | 228              | 57.7     |
| Below Average                       | 62               | 15.7     |

**Table 4: Socio-demographic characteristics of respondents as related to Utilization of PHC services status (N=394)**

| <b>Socio-demographic Characteristics</b> | <b>Ever-Used (%)</b> | <b>Never-Used (%)</b> | <b>Total (%)</b> | <b>X<sup>2</sup></b> | <b>P-value</b> |
|--|----------------------|-----------------------|------------------|----------------------|----------------|
| <b>Age (yrs.):</b>                       |                      |                       |                  |                      |                |
| 18-30                                    | 31 (17.7)            | 56(25.7)              | 87(22.1)         | 12.15                | 0.02           |
| 31-40                                    | 36 (20.6)            | 65(29.9)              | 101(25.6)        |                      |                |
| 41-50                                    | 53 (30.3)            | 54(24.8)              | 107(27.2)        |                      |                |
| above 50yrs.                             | 55 (31.4)            | 44(19.6)              | 99(25.1)         |                      |                |
| <b>Sex:</b>                              |                      |                       |                  |                      |                |
| Male                                     | 83 (47.0)            | 130(59.8)             | 213(53.9)        | 5.85                 | 0.02           |
| Female                                   | 93 (53.0)            | 89(40.2)              | 182(40.1)        |                      |                |
| <b>Marital Status:</b>                   |                      |                       |                  |                      |                |
| Ever Married                             | 152 (85.5)           | 151(69.5)             | 304(77.2)        | 21.88                | <0.001         |
| Single                                   | 24 (14.5)            | 66(30.5)              | 90(22.8)         |                      |                |
| <b>Educational Level:</b>                |                      |                       |                  |                      |                |
| No formal Education/Primary              | 78 (44.5)            | 10(4.6)               | 88(20.2)         | 113.53               | <0.001         |
| Secondary                                | 46 (26.2)            | 38(17.5)              | 84(21.3)         |                      |                |
| Tertiary                                 | 52 (29.3)            | 171(77.9)             | 223(56.5)        |                      |                |
| <b>Occupation:</b>                       |                      |                       |                  |                      |                |
| Trader                                   | 48 (29.0)            | 17(7.8)               | 65(16.5)         | 64.20                | <0.001         |
| Civil Servant                            | 21 (11.9)            | 64(29.4)              | 85(21.6)         |                      |                |
| Student                                  | 9 (5.1)              | 29(13.3)              | 38(9.6)          |                      |                |
| Farmer                                   | 30 (17.1)            | 8(3.7)                | 38(9.6)          |                      |                |
| Artisan                                  | 65 (36.9)            | 99(45.8)              | 164(41.6)        |                      |                |
| No Response                              |                      |                       | 5(1.0)           |                      |                |
| <b>Total</b>                             | <b>176 (44.6)</b>    | <b>219(55.4)</b>      | <b>395 (100)</b> |                      |                |

**Table 5**  
**Reasons for non-utilization of PHC Service (Multiple Responses)**

| Reasons                    | Frequency | %    |
|----------------------------|-----------|------|
| Poor Attitude of H/Workers | 136       | 61.5 |
| Poor opinion of PHC System | 112       | 50.7 |
| Cost                       | 2         | 0.9  |
| Far from House (distance)  | 59        | 26.7 |
| Long Waiting Time          | 33        | 14.9 |

## DISCUSSION

### Demographic Profile:

Majority of the respondents (74.2%) were found between 21 and 50 years of age: their mean age was 42.3 years. The mean age of respondents appear higher than the national mean age of the Nigerian population which is 17 years<sup>6</sup> being that only adults were involved in the study, however, the sex distribution, female to male ratio of 1:1.2 in the study is similar to the national figure of 1.01:1.<sup>6</sup> Also, most (81.3%) respondents were literate and at least 56.5% of them have tertiary education. In south-western zone of Nigeria, the literacy rates among adult women and men were estimated at 48.2% and 72.5% respectively according to the 2003 NDHS;<sup>6</sup> the literacy rate in south-west Nigeria is higher than other zones except in the south-east region. Occupationally, considerable proportions of the respondents were artisans, traders and civil servants while other groups like farmers and students were in the minority. The occupational distribution is not strange considering the fact that with the downturn in the economy of the country, majority of the productive sector of the population have to be self-employed.

Though two hundred and eighty one (71.7%) respondents were aware of the existence of PHC facilities within their districts, there were varied trend of awareness with specific PHC components e.g. awareness about immunization services was very high (78.2%) compared to other PHC

components and this is probably attributable to the current immunization campaigns (NIDs) to eradicate polio in Nigeria which had commenced since the last decade.<sup>12</sup> A more recent immunization campaign is the Immunization Plus Days (IPDS). However, awareness of other PHC components were also fairly high and this is consistent with the position of PHC within the National health system (NHS).<sup>2,5</sup> In Nigeria the PHC level is the first point of formal contact by individuals with the national health system and is recognized by the national health policy<sup>5</sup> as the cornerstone and bed rock for the provision of mainly preventive and promotive health services. The PHC level is fully decentralized and is run by the Local Government Authorities (LGAs). It is the level at which most health problems are addressed. There is a general notion that the facilities in place at this level of health care is not adequate, though, supported by the referral levels i.e. the secondary and tertiary levels organized by the state and federal governments respectively.

Two hundred and ninety nine (75.7%) respondents felt that PHC services were accessible and of this population, 220 (73.6%) felt that the services were very accessible. Respondents perception of accessibility is probably linked to the short traveling distance to access the facility; some 276 (69.9%) of the studied population stated that the health facility was not far from their residences. In Nigeria, one of the fundamental principles of PHC is accessibility<sup>2,3,5</sup> and in furtherance of this, the national health policy stipulates that all

Nigerians should have access to quality health services not more than 1km from their residences.<sup>7,13</sup> Recent estimates suggests that about (75%) of health districts in Nigeria have a primary facility.<sup>9,13</sup> Even though 286(72.4%) and 333(84.3%) respondents believed that a functional PHC services could adequately address the prevailing health problems in the community and that health workers were competent respectively, only 176 (44.6%) of them had ever utilized a PH-center. The low rate of PHC facility utilization in this study is consistent with observations from studies conducted in other parts of sub-Saharan Africa and the developing world.<sup>10,14,15</sup>

For example in India, PH centers were woefully underutilized because they failed to provide clients with the desired amount of quality services, because of inconvenient locations and long waiting times.<sup>14</sup> In Nigeria, a study of mothers revealed that factors causing non use of PHC facilities included high cost of drugs and service charges, easy access to traditional healers and difficulty in finding transportation.<sup>15</sup> Ample evidence confirms that because of the gross underutilization of effective health care in developing countries, there exist unrealized health gains. For example child deaths could be cut by 63% worldwide if coverage rates of effective prevention and treatment interventions were to increase from current levels to 99%. A multitude of factors are responsible for the missed opportunities to realize major gains in population health. On the demand side, cultural and educational factors may obscure the recognition of illness and the potential benefits from health care, while economic constraints may suppress utilization, even if benefits are recognized. On the supply side, appropriate interventions may not be provided at all, perhaps due to a lack of resources. Where health care is available, the quality is often severely deficient, leaving its effectiveness well short of potential efficacy. One review concludes that, despite the claimed efficacy of primary health care interventions, the evidence is mixed on whether primary care clinics have any impact on population health. This discouraging conclusion is attributed to the poor quality of public primary health care in many parts of the developing

world.<sup>16</sup>

About 79% of respondents that had ever utilized a PH center felt that services were satisfactory. The high level of satisfaction may be linked with the fact that most of the PHC facility users were of lower social class. In Saudi -Arabia,<sup>17</sup> consumer satisfaction with PHC services was significantly higher among people with lower socio-economic status i.e. unskilled laborers. In a survey of women in four developing counties, respondents preferred hospital to PHC centers because they felt that doctors in the hospital were better trained, and that these facilities had superior equipment and technologies to investigate and find solutions to their health problems.<sup>18</sup>

In this study, reasons respondents gave for non-utilization of PHC facilities include: poor attitudes of health workers, difficulties in physical access; having an overall poor opinion of the PHC system also contributed to non-utilization. In Indian rural Orissa,<sup>14</sup> key factors guiding pattern of utilization were reputation of the service providers and accessibility; among the inhabitants of the village, local health provision through assistant nurse, midwives and male health workers were perceived to be of poor quality and even when a sub-centre was located in the village, utilization of the health facility did not improve. In Saudi Arabia,<sup>17</sup> consumers satisfaction ratings for the health facility was lowest for receptionists and the overall average satisfaction with services provided was 2.45 points out of a maximum 5 points.

Majority of respondents that did not use PHC services in this study were oftentimes, men, single and of higher educational and social class. Those that used it more often were women, married, farmers, traders, artisans, older people and people of lower educational and social status. This picture is consistent with studies conducted locally<sup>15</sup> and in other parts of the developing world too.<sup>14,17</sup>



## CONCLUSION

In conclusion, though respondents could be viewed to have a high level of awareness of district primary health care facilities, yet their rates of utilization of the facilities are very low. Major reasons for non-utilization of the primary health facility could be adduced to the perception of poor quality of services provided by PHC workers, lack of access and poor understanding of the PHC system.

It is hereby suggested in the interest of improved quality service delivery at PHC centres, that managers and administrators of these facilities should begin to pay more attention to service providers at this level of health care delivery. We recommend a holistic approach that will facilitate effective service delivery, this may include a general upgrading of the PHC facilities, regular in-service training for worker to update skill and of course priority attention should be paid to workers welfare. Existing road networks that leads to these centers, which are in bad conditions especially in rural areas, should be well re-constructed and new ones opened up to facilitate easy access. Orientation programs directed at promoting the strength and benefits of primary health care in local communities should be put in place to correct possible erroneous opinions on this health institution.

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