

**DETERMINANTS OF PRIMARY HEALTH CARE SERVICE UPTAKE AMONG
TRADERS IN NEW BENIN MARKET, BENIN CITY, EDO STATE**

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FACULTY OF EDUCATION UNIVERSITY OF BENIN, BENIN CITY**

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**A RESEARCH PROJECT SUBMITTED TO THE DEPARTMENT OF HEALTH,
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CERTIFICATION

We, the undersigned, hereby certify that this project was carried out by **Faith IGBINIGIE**, with matriculation number **EDU2112061**, in partial fulfilment of the requirements for the award of the Bachelor of Science (B.Sc. Ed) in Health Education at the University of Benin.

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Date

DEDICATION

This research work is dedicated to God Almighty, whose boundless love, grace, and mercy sustained the researcher throughout her academic journey and enabled her to successfully complete her bachelor's degree programme.

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The researcher is profoundly grateful to God Almighty, her Creator, for His love, divine guidance, strength, and grace, all of which made it possible for her to complete this project and her academic programme at the University of Benin.

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ABSTRACT

This study examined the determinants of primary health care (PHC) service uptake among traders operating in New Benin Market. In pursuit of this objective, four research questions were formulated and relevant literature on primary health care services was comprehensively reviewed.

A descriptive research design was employed, with a target population of 4,320 market traders drawn from New Benin Market in Oredo Local Government Area of Edo State. Using simple random sampling, 216 traders were selected to serve as the study sample. Data were gathered through a structured close-ended questionnaire consisting of 20 items, which was validated by the project supervisor and two additional experts in the Department of Health, Safety and Environmental Education. Reliability was established via the test-retest method. The 216 administered questionnaires were returned in full, and the collected data were analyzed using frequency counts, percentages, means, and standard deviations.

Findings indicated that economic constraints, limited awareness, proximity to health facilities, and religious orientation significantly influence PHC service uptake. Notwithstanding these challenges, traders in New Benin Market were found to exhibit a relatively high rate of PHC utilization, especially for minor ailments, routine medical examinations, and immunizations. The study recommends that government and relevant health authorities extend financial assistance to lower the cost burden of PHC services; that public health bodies mount regular awareness and health promotion campaigns to inform traders of the availability and advantages of PHC services; and that additional PHC facilities be established in closer proximity to major trading centres and densely populated market zones.

CHAPTER ONE

INTRODUCTION

Background to the Study

Primary health care (PHC) services occupy a central position in the attainment of equitable health outcomes, given their role in providing foundational healthcare to individuals and communities, particularly those engaged in informal economic activities such as market trading. The World Health Organization (WHO, 1946) defines health as a condition of total physical, mental, and social well-being, rather than merely the absence of illness or infirmity. This definition implies the capacity to adapt to and manage the full range of physical, mental, and social challenges encountered throughout life (Smith et al., 2020). Efforts to prevent and treat health problems and to advance sound health systems for humanity have long been undertaken by healthcare practitioners (WHO, 2015).

PHC gained its first formal global recognition in 1978 as an essential instrument for achieving health equity worldwide and for managing principal community health challenges through preventive, promotive, curative, and rehabilitative services (WHO, 1978). It constitutes the initial point of contact between individuals, families, communities, and the national health system (WHO, 1978). By 2008, the WHO had reinforced PHC's status as the gold standard for comprehensive health service delivery at both global and national levels, emphasizing the imperative of a people-centred approach (WHO, 2008).

Following the United Nations' (UN) renewed commitment to health and well-being for all in 2015, PHC gained renewed prominence as an effective, efficient, and equitable pathway to health enhancement, thereby becoming a cornerstone strategy for achieving Universal Health Coverage (UHC) (WHO, 2018). Sustainable Development Goal (SDG) 3 addresses all major health priorities, seeking to ensure healthy lives and promote well-being for all by 2030 (UN, 2017). PHC continues to be acknowledged globally as a vital mechanism for attaining health-related SDGs and UHC (Puras, 2016). As discussions around UHC gather momentum, the considerable contribution of PHC to health and health systems in Low and Middle Income Countries (LMICs) has been widely recognised (Kruk, Rockers, & Van, 2010).

Within Nigeria, successive national health policies have identified PHC as a foundational principle and strategy for national health development (Federal Ministry of Health [FMOH], 2022). Since PHC was adopted as the cornerstone of Nigeria's health system, it has undergone a series of transformations aimed at expanding access to and use of basic health services (Aigbiremolen, Alenoghena, Eboreime, & Abejegah, 2014). PHC implementation in Nigeria is carried out through services provided at primary health facilities and health posts across the country, encompassing health education on prevailing diseases, maternal and child health services including family planning, immunization against major infectious diseases, and treatment of minor ailments. Despite repeated government efforts to reposition and revitalize PHC, numerous constraints have impeded its implementation, undermining UHC goals, with low PHC utilization being a

central concern (Aigbiremolen et al., 2014). The preference for alternative care sources, including patent medicine vendors, traditional healers, and private or public secondary and tertiary facilities over designated PHC facilities has been documented in several parts of Nigeria (Nwankwo, Udeobasi, Osakwe, & Okafor, 2017).

In any well-functioning healthcare system, PHC centres serve as the first resort for health-seeking individuals in both urban and rural settings. However, utilization patterns are shaped by a variety of socio-economic, political, religious, educational, and cultural factors, all of which similarly affect traders across diverse communities (Robert et al., 2018). Among the most prominent determinants for traders is their economic situation. Operating within informal economies and often earning inconsistent incomes, many traders find the financial cost of healthcare prohibitive, even when PHC services are designed to be low-cost or free. Indirect costs such as transport fees, foregone earnings, and out-of-pocket expenditures on medications further compound these barriers. Traders reliant on daily wages frequently delay or forgo treatment, prioritizing economic survival, which results in late or insufficient medical intervention (Mugisha & Maina, 2019).

Time constraints arising from the nature of trading also limit healthcare access. Traders in market settings typically work long and irregular hours, making it difficult to visit health facilities that operate during standard business hours. Since missing a workday directly translates to income loss, traders are deterred from seeking preventive

care such as health screenings or routine check-ups, leading to delayed detection of illnesses (Gupta, Sabarwal, & Tyagi, 2019). A Nigerian study found that many traders visit health facilities only when their conditions have worsened significantly, placing added strain on the health system (Smith et al., 2020).

Beyond economic and time-related barriers, traders' knowledge and perceptions of PHC services are also critical to their health-seeking behaviour. In low-resource settings, awareness of the services available at PHC centres can be limited, especially where health education campaigns do not adequately reach informal workers. Without adequate health literacy, traders may not appreciate the value of preventive care and routine check-ups, contributing to underutilization (Ajayi & Ross, 2017). Negative perceptions of service quality including dissatisfaction with waiting times, inadequate services, medication shortages, and perceived poor staff attitudes erode trust in the healthcare system, driving traders to seek alternative care from private clinics, traditional healers, or through self-medication (Mukherjee & Basu, 2019). Such alternatives are often more expensive or less effective, deepening health inequalities (Chuma, Maina, & Ataguba, 2019).

Cultural and social dynamics further shape traders' healthcare choices. Health-seeking behaviours are frequently rooted in traditional beliefs and practices that may either support or obstruct the use of formal health services. In several societies, traders favour traditional medicine, viewing it as more accessible or effective. For instance, in

many African and Asian contexts, herbal remedies or spiritual healing are first-line responses before formal medical care is sought (Ajayi & Ross, 2017). Gender norms also play a role: expectations of masculinity may deter male traders from seeking early care, while female traders may encounter barriers tied to household duties, social expectations, or limited decision-making autonomy (Mukherjee & Basu, 2019).

Systemic healthcare challenges similarly discourage traders from utilizing PHC services. In many low-income countries, PHC facilities suffer from underfunding and understaffing, resulting in inadequate service provision, long queues, poor infrastructure, and essential drug shortages (Chuma et al., 2019). When health facilities fail to address the specific occupational health risks of traders such as respiratory conditions arising from exposure to unsanitary market environments their relevance to this population is further diminished (Bourne, 2017). Healthcare financing systems in many developing countries are also not designed to serve the informal sector, with health insurance schemes predominantly targeting formal-sector employees, leaving traders without adequate financial protection. This absence of coverage places the full cost burden on traders, discouraging timely utilization (Mugisha & Maina, 2019). The lack of health policies tailored to informal workers further marginalises this group (Assefa, Hill, Taye, & Van, 2021).

Understanding the determinants of PHC uptake among traders is therefore essential for addressing health disparities, given this group's underrepresentation in

formal health systems (Bourne, 2017; Smith et al., 2020). Country-level interventions should be grounded not only in global evidence but also in locally derived, context-specific research (WHO/UNICEF, 2018). Such understanding can guide policy development aimed at increasing PHC utilization at the community level, thereby advancing UHC and improving health outcomes among vulnerable populations (WHO, 2015).

Statement of Problem

Access to and use of primary health care (PHC) services is pivotal to achieving equitable health outcomes, especially among economically vulnerable groups such as informal-sector traders. Despite the existence of PHC infrastructure, available evidence suggests that traders frequently underutilize these services, with consequent poor health outcomes, delayed diagnoses, and increased preventable disease burden. For example, a sub-Saharan Africa study established that 50% of informal workers, including traders, cited financial hardship as the principal barrier to healthcare access (BMC Public Health, 2020). Similarly, research in Nigeria found that 67% of informal workers, traders included, opted for private healthcare over PHC services owing to perceptions of superior quality (Global Health Action, 2019).

Contributing factors to this underutilization include economic constraints, time pressures stemming from long working hours, limited awareness of available services, cultural beliefs, and systemic healthcare challenges. Traders also frequently face high

out-of-pocket costs, lack of health insurance coverage, and unfavourable perceptions of PHC quality, all of which discourage timely health-seeking. The underutilization of PHC among traders has broader public health implications, as it increases the burden on secondary and tertiary healthcare systems and contributes to preventable morbidity and mortality. This problem underscores the need for targeted interventions and policies that specifically address the challenges traders face in accessing PHC services. Accordingly, this study sought to investigate the determinants of PHC service uptake among traders in New Benin Market, Oredo LGA, Edo State.

Research Questions

The following research questions were raised guided the study:

1. What are the determinants of primary health care service uptake among traders in New Benin Market?
2. Does financial status influence the utilization of PHC services among traders in New Benin Market?
3. Does religion influence the utilization of PHC services among traders in New Benin Market?
4. To what extent do traders in New Benin Market utilize PHC services?

Purpose of the Study

The primary aim of this study was to investigate the determinants of PHC service uptake among traders in New Benin Market. Specifically, the study sought to:

1. Examine whether financial factors influence PHC service utilization among traders in New Benin Market
2. Determine whether religious beliefs influence PHC service utilization among traders in New Benin Market
3. Examine the extent to which traders in New Benin Market utilize PHC services.

Significance of the Study

This study on the determinants of PHC service uptake among traders in New Benin Market holds significant relevance across several critical areas. Traders in the informal economy encounter distinctive barriers to essential health services, and a thorough understanding of these barriers can yield valuable insights for policymakers, healthcare providers, and stakeholders committed to improving health access for vulnerable groups. For health planners, the study offers specific knowledge about the challenges traders face, enabling tailored interventions. For instance, understanding that irregular working hours reduce PHC access could support the introduction of extended clinic hours or mobile health units, thereby enhancing service accessibility.

The study also has the potential to shape health policy by making a case for including informal-sector workers in health insurance programmes and developing

measures to reduce financial barriers to care. It can likewise inform public health education campaigns tailored to traders, promoting awareness of preventive health services and a culture of routine medical check-ups. Furthermore, the research provides a foundational basis for future investigations into the cultural, regional, and contextual factors shaping healthcare-seeking behaviour among traders. As such, it serves as a bridge between identifying current gaps, implementing effective solutions, and sustaining scholarly inquiry to refine health systems.

Scope and Delimitation of the Study

This study focused on evaluating the determinants of primary health care service uptake among traders in New Benin Market, with specific attention to PHC utilization patterns among this population. The study was delimited to traders operating in New Benin Market, Benin City, Edo State.

Definition of Terms

Health: A condition of complete physical, mental, and social well-being in an individual.

Utilization: The degree to which traders in New Benin Market access and make use of available primary health care services.

Primary Health Care: A community-based health service approach that provides accessible care, with emphasis on health promotion, disease prevention, treatment, rehabilitation, and palliative care.

Traders: Individuals engaged in the buying and selling of goods and services within New Benin Market.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

This chapter presents a review of literature relevant to the study, organised under the following sub-headings: Concept of Primary Health Care (PHC) Services;

- Theoretical Framework
- Utilization of Health Care Services
- Factors Affecting PHC Utilization
- Perceptions of PHC Quality and Service Delivery
- Barriers to PHC Utilization
- Role of Government Policies and Interventions on PHC Utilization in Nigeria
- Strategies for Improving PHC Utilization among Traders
- Summary of Reviewed Literature.

Concept of Primary Health Care Services

Primary Health Care (PHC) is a foundational pillar of health systems globally, designed to address the core health needs of individuals and communities in a comprehensive, equitable, and cost-efficient manner. The concept was formally introduced through the 1978 Alma-Ata Declaration, which stressed the need for universal access to essential health services through community-centred, preventive, and socially

integrated approaches (WHO, 1978). Since then, PHC has been broadly recognised as a key strategy for advancing health equity and improving health outcomes, particularly in resource-limited settings. PHC is widely regarded as the first tier of contact between individuals and the health system, providing accessible, affordable, and wide-ranging services that address most health needs across the lifespan. The WHO characterises PHC as a whole-of-society health approach that targets the highest attainable level of health and well-being through a focus on people's needs and preferences, intervening as early as possible along the care continuum (WHO, 2021). PHC transcends clinical services to address the broader health determinants including education, housing, sanitation, and nutrition, in recognition that health outcomes are deeply intertwined with socio-economic conditions.

Historical Evolution of PHC

PHC is an essential component of contemporary health systems, with its development shaped by evolving social, economic, and political dynamics. Its history reflects global efforts to ensure equitable health access for all people, culminating in pivotal policy milestones and implementation shifts over several decades. The roots of PHC trace back to the late 19th and early 20th centuries, a period marked by rapid industrialisation and urbanisation that brought overcrowded cities, deteriorating living conditions, and rampant infectious diseases. Early health reform movements emphasised

preventive measures, sanitation, vaccination, and health education which formed the initial building blocks of public health and, later, PHC.

One notable early model was the Chinese 'barefoot doctors' initiative of the 1930s and 1940s, which deployed community paramedics in rural areas to deliver basic healthcare, health education, and integrate traditional with modern medicine (Chen et al., 2010). This highlighted the value of decentralized care and community involvement in health management. Similarly, mid-20th century health interventions in colonial territories demonstrated the importance of primary-level care, though missionary hospitals and clinics focused on maternal and child health, infectious disease management, and community education often operated in a fragmented manner without integration into broader health systems (Cueto, 2004).

The formalization of PHC as a global health strategy accelerated after World War II, as the WHO and the UN sought to address mounting global health disparities. Early WHO programmes concentrated on eliminating infectious diseases and supporting countries in building health systems (WHO, 2008). Through the 1950s and 1960s, various countries launched primary health initiatives: India's community health worker programmes targeted rural health, while Cuba's revolutionary administration built a robust PHC network grounded in prevention and universal access (Keck & Reed, 2012). The 1970s brought growing dissatisfaction with hospital-centric, disease-focused health

systems, particularly in LMICs, which neglected rural and marginalized populations, ultimately prompting the conceptualization of PHC (Magnussen, Ehiri, & Jolly, 2004).

The Alma-Ata Declaration and the Birth of PHC

The most significant milestone in the history of PHC was the 1978 International Conference on Primary Health Care held in Alma-Ata, Kazakhstan, convened by the WHO and UNICEF with representatives from 134 countries, NGOs, and global health experts. The resulting Alma-Ata Declaration defined PHC as essential health care that is practically sound, scientifically based, socially acceptable, universally accessible to communities at affordable cost, and sustained across all stages of national development (WHO, 1978). The declaration advanced several core principles: health as a universal human right; equity in health service provision; active community participation in planning and delivering health services; and inter-sectoral collaboration, recognizing that health is influenced by factors such as education, agriculture, and housing. The declaration set the ambitious target of achieving 'Health for All' by the year 2000, positioning PHC as the centrepiece of global health policy.

Selective vs. Comprehensive PHC and the Decline and Revival of PHC

Debates following the Alma-Ata Conference centred on the feasibility of comprehensive PHC implementation given resource constraints in LMICs, leading to the

emergence of Selective Primary Health Care (SPHC) in the early 1980s, which prioritized specific, cost-effective interventions such as immunizations, oral rehydration therapy, and family planning (Walsh & Warren, 1979). While SPHC recorded notable successes, particularly in expanding childhood immunization, critics argued it reduced PHC to narrow vertical programmes, undermining its potential to address the root causes of poor health (Cueto, 2004). The 1980s and 1990s then saw reduced global commitment to PHC as economic crises led to cuts in public health spending, with many countries pivoting towards privatized healthcare, further deepening health inequities (Savedoff, 2007). In 2008, the WHO published 'Primary Health Care: Now More Than Ever', calling for a renewed focus through people-centred care, stronger health systems, and inter-sectoral action in pursuit of UHC (WHO, 2008).

PHC in the 21st Century

The 21st century has witnessed a resurgence of interest in PHC, driven by global priorities such as UHC and the SDGs. PHC is now acknowledged as a critical UHC strategy, ensuring that all people access essential health services without financial hardship (Kruk et al., 2018). Technological innovations such as telemedicine and electronic health records have expanded PHC's reach to underserved populations. Community-based models including Brazil's Family Health Strategy and Ethiopia's Health Extension Programme, have demonstrated PHC's effectiveness in improving health outcomes and reducing disparities (Macinko et al., 2006; Assefa et al., 2019). The

trajectory of PHC reflects a deepening understanding of health as a human right and the importance of equitable, community-grounded health systems in achieving universal well-being.

Scope and Objectives of Primary Health Care

PHC constitutes a comprehensive, people-centred approach that forms the backbone of health systems globally. Anchored in principles of equity and accessibility, PHC is designed to address the majority of an individual's health needs over the life course, encompassing a broad spectrum of services from immediate care to disease prevention, health promotion, and tackling the broader determinants of health. The scope of PHC covers the continuum of preventive, promotive, curative, rehabilitative, and palliative care for individuals and communities, with an integrated approach ensuring that healthcare is coherent and well-coordinated across levels of care (WHO, 2021). PHC also emphasizes community-oriented and culturally sensitive service delivery, tailoring interventions to community needs and contexts with active community involvement in planning and implementation (Macinko & Starfield, 2002). Among PHC's primary functions is disease prevention through health education, immunisation, and early intervention including vaccination campaigns and hygiene and nutrition awareness (Perry et al., 2014). PHC also serves as the first point of contact for care-seeking individuals,

striving to eliminate access barriers such as geographical distance, high costs, and social exclusion (Bitton et al., 2017), while its scope extends into inter-sectoral domains recognising that social determinants like education, housing, and sanitation profoundly influence health outcomes (WHO, 2008).

The objectives of PHC align with its core values of equity, accessibility, and community participation, and include: equitable access to health services regardless of socio-economic status, gender, or geography (Kruk et al., 2018); health promotion through education and early intervention (Perry et al., 2014); strengthening health systems through service integration and workforce capacity building (Bitton et al., 2017); empowering communities to participate actively in their own health (WHO, 1978); advancing UHC through affordable, accessible care (Kruk et al., 2018); addressing social determinants of health through multi-sectoral action (Magnussen et al., 2004); and ensuring continuity of care through stable patient-provider relationships (Starfield et al., 2005). These objectives collectively position PHC as an indispensable strategy for tackling modern health challenges, including the rising burden of non-communicable diseases, ageing populations, and global health emergencies such as the COVID-19 pandemic.

Theoretical Framework

The theoretical framework underpinning this study provides the conceptual foundation for understanding the dynamics that shape traders' utilization of primary

health care services. As a distinct occupational group, traders face unique challenges rooted in their economic activities, time constraints, and specific social determinants of health. This framework draws on multiple theories and models — the Health Belief Model, Andersen's Behavioural Model, the Social Ecological Model, and the Theory of Planned Behaviour — to explain the interplay of individual, societal, and systemic factors that influence health-seeking behaviour.

1. Health Belief Model (HBM)

The Health Belief Model (HBM) provides a robust foundation for understanding health-related decision-making, positing that health-seeking behaviour is determined by individuals' perceptions of risk and disease severity, as well as their assessment of the benefits and obstacles to taking preventive action. For traders largely preoccupied with income generation, these perceptions carry significant weight. Perceived Susceptibility refers to a trader's personal assessment of their risk of developing a health condition, which may be linked to occupational hazards such as market pollution or irregular eating habits; if traders perceive themselves as unlikely to fall ill, they may not prioritise PHC services. Perceived Severity relates to how seriously traders weigh the health and economic consequences of illness- chronic conditions may be overlooked until they manifest as severe complications, resulting in delayed PHC utilization. Perceived Benefits involve traders' evaluation of the practical and intangible advantages of PHC

services; recognizing that early detection sustains productivity and reduces long-term costs may motivate greater engagement. Perceived Barriers such as service costs, long waiting times, distance to facilities, and skepticism about care quality can discourage utilization, prompting self-medication or reliance on informal care. Cues to Action such as health campaigns, peer influence, or visible illness symptoms may trigger care-seeking, and Self-Efficacy, confidence in managing one's health while meeting work demands increases the likelihood of PHC engagement.

2. Andersen's Behavioural Model of Health Services Use

Andersen's Behavioural Model explores how predisposing, enabling, and need-based factors shape health service utilization, making it highly relevant to understanding PHC access among traders. Predisposing factors encompass demographic characteristics (age, gender, marital status) and social variables (education level, health beliefs); for instance, younger or less-educated traders may have limited awareness of preventive care. Enabling factors include income, transportation access, and proximity to health facilities, traders with limited finances or located far from PHC centres may find services less accessible. Need factors are the actual and perceived health requirements that prompt care-seeking; work-related injuries or chronic conditions may lead traders to seek PHC services, but the perception of being 'not sick enough' may delay care.

3. Social Ecological Model (SEM)

The Social Ecological Model captures layered influences on health behaviour, spanning individual to policy levels, providing a nuanced understanding of PHC utilization among traders. At the individual level, personal health literacy, income, and attitudes towards health services are critical. At the interpersonal level, family members and trading peers who share positive PHC experiences can motivate care-seeking. At the community level, local market conditions, availability of health facilities, and community health programmes directly affect access. At the organizational level, PHC facility policies such as operating hours, staff conduct, and drug availability influence patient experience and return visits. At the policy level, broader interventions such as PHC subsidies, awareness campaigns, and trader-friendly health insurance schemes can address systemic barriers.

4. Theory of Planned Behaviour (TPB)

The Theory of Planned Behaviour posits that behavioural intention is the primary predictor of action and is shaped by three components. Attitudes formed through past experiences and perceived effectiveness of PHC services determine traders' likelihood of seeking care; positive service encounters foster favourable attitudes. Subjective norms, including social pressures and cultural expectations within trading communities, may either encourage or discourage PHC utilization, as stigma or fear of business disruption can serve as deterrents. Perceived Behavioural Control refers to the degree to which traders believe they can overcome practical obstacles such as time constraints or costs —

also influences utilization; those with greater schedule flexibility or access to affordable care are more likely to seek services. This integrated framework provides a comprehensive lens for analyzing PHC utilization among traders, highlighting key areas for intervention to enhance access and uptake.

Utilization of Health Care Services

Health care utilization denotes the process by which individuals access and engage with health services for the prevention, diagnosis, treatment, and management of diseases and other health conditions. It is a critical element of health system performance, shaped by a broad array of individual, community, and systemic factors. Optimal health care utilization translates to improved health outcomes, a reduced disease burden, and enhanced quality of life. The WHO acknowledges that gaps in health care utilization, particularly in LMICs, contribute to preventable mortality and morbidity (WHO, 2018). Utilization encompasses both preventive services (immunizations, screenings, and health education) and curative care, with studies showing that regular preventive care significantly lowers the risk of chronic disease and facilitates early diagnosis (Marmot et al., 2012).

Global utilization trends vary widely by income level, region, and health system characteristics. Roughly 80% of adults in the United States report undergoing routine health check-ups annually, compared to fewer than 30% in parts of sub-Saharan Africa (OECD, 2017; WHO, 2018). In LMICs, utilization of preventive services is considerably

lower: only 20% of women in Ghana accessed antenatal care during the first trimester (Ganle et al., 2015), while India's immunization coverage in many states falls below 70% due to accessibility and awareness gaps (Singh et al., 2019). Research consistently highlights the role of individual and contextual factors in shaping utilization patterns. The WHO (2018) identified underutilization in LMICs as a leading cause of preventable mortality, with rural and marginalized populations most severely affected. Onwujekwe et al. (2014) demonstrated in Nigeria that wealthier individuals were approximately 2.3 times more likely to access health facilities than their low-income counterparts, while Hailemeskel et al. (2019) found in Ethiopia that more educated individuals were more likely to use PHC services, attributing this to improved health literacy and awareness.

Factors Affecting PHC Utilization

Despite its importance, PHC utilization varies significantly across regions and populations. Individual-level factors such as age and gender are key determinants, women consistently demonstrate higher utilization rates than men, largely due to reproductive health needs (Onah et al., 2014), while older adults often face reduced utilization due to mobility limitations. Education enhances health literacy and care-seeking; Hailemeskel et al. (2019) found in Ethiopia that secondary-educated individuals were 2.3 times more likely to use PHC services. Perceived need also drives utilization, though those with asymptomatic chronic conditions may underestimate their need for care (Andersen, 1995).

Socio-economic factors are equally influential. Out-of-pocket expenses significantly deter care-seeking in LMICs, in India, low-income households were 40% less likely to visit PHC centres due to consultation and transport fees (Ghosh, 2014). Traders and daily wage earners frequently prioritize income over health (Abuya et al., 2015), while health insurance coverage has been shown to increase PHC visits significantly, as demonstrated by Rwanda's community-based insurance schemes (Shimeles, 2010). Geographical barriers, particularly distance to facilities and poor transport infrastructure, are critical, with studies in Tanzania and India showing that individuals residing more than 5 km from a PHC facility were 30% less likely to seek care (Kruk et al., 2009; Chokshi et al., 2016). Seasonal factors such as flooding can further isolate communities (Akinyemi et al., 2019).

Cultural and social factors profoundly shape health-seeking behaviours. Traditional medicine often competes with modern PHC, and in northern Nigeria, 60% of women preferred traditional birth attendants (Adamu & Salihu, 2002). Gender norms in patriarchal societies restrict women's healthcare access, and in Afghanistan, women required spousal permission to visit PHC facilities (Jewkes et al., 2020). Systemic and policy factors — including quality of care, availability of services, operating hours, and health policy frameworks, also significantly impact utilization. Dissatisfaction with staff conduct, waiting times, and medicine availability reduces patient trust and repeat visits (Kruk et al., 2009), while essential drug stock outs can deter 40% of patients from using PHC facilities (Kiwanuka et al., 2008). Well-designed health policies such as UHC

initiatives and PHC subsidies can substantially increase utilization, as demonstrated in Rwanda (Shimeles, 2010).

Perceptions of PHC Quality and Service Delivery

Perceptions of quality in PHC service delivery play a decisive role in determining utilization and overall health system effectiveness. These perceptions are shaped by multiple dimensions of care including the technical competence of providers, interpersonal dynamics, physical infrastructure, and service accessibility, and directly influence health-seeking behaviour, treatment adherence, and trust in health systems. Technical competence is a key dimension; patients associate high-quality care with skilled providers, and where competence is questioned, patients may avoid local PHC centres in favour of higher-level or alternative facilities, even at greater cost (Kruk et al., 2009). Interpersonal relationships are equally important; respectful, empathetic, and communicative provider conduct encourages patients to return and adhere to treatment even when other aspects of care are suboptimal (Kiwanuka et al., 2008). Physical conditions of facilities also affect perceived quality, poorly maintained buildings and outdated equipment discourage utilization (Kruk et al., 2008), and accessibility and convenience further shape perceptions, as patients value short waiting times and hours aligned with their schedules (Abuya et al., 2015).

Socio-demographic characteristics, cultural norms, past care experiences, and peer recommendations all further shape quality perceptions. Younger and more educated

individuals tend to hold higher expectations, while facilities that align services with local customs are more positively evaluated (Adamu & Salihu, 2002). Positive experiences build trust and encourage return visits, while negative ones deter future use (Bleich et al., 2009), and word-of-mouth from peers can boost service uptake (Ganle et al., 2015). Positive quality perceptions enhance uptake of preventive services (Singh et al., 2019) and promote treatment adherence (Desta et al., 2020), while negative perceptions lead to bypassing of PHC in favour of more expensive tertiary care (Kruk et al., 2009). Strategies for improving perceptions include provider training in clinical and communication skills (Bitton et al., 2019), infrastructure investment (Banteyerga, 2011), community engagement in service planning (Shimeles, 2010), and systematic patient feedback mechanisms (Abuya et al., 2015).

Barriers to the Utilization of Primary Health Care Services

Despite the global emphasis on UHC, numerous barriers continue to impede access to and uptake of PHC services, particularly in LMICs. Financial constraints rank among the most significant barriers, direct costs such as consultation fees and medication expenses, combined with indirect costs such as transport and income loss, deter individuals from seeking care (Kruk et al., 2009). Even in subsidized settings, hidden costs such as transport and informal payments can remain prohibitive for vulnerable populations (Abuya et al., 2015). Geographical barriers, particularly physical distance and inadequate transport infrastructure, are critical especially in rural and remote areas; in

Uganda, patients living more than 5 km from a PHC facility were considerably less likely to seek care (Kiwanuka et al., 2008), with seasonal obstacles such as flooded roads further isolating communities (Hailemeskel et al., 2019).

Cultural and social barriers are equally significant. Deep-rooted traditional beliefs and gender norms profoundly influence care-seeking, in northern Nigeria, reliance on traditional birth attendants reduced formal antenatal service utilization (Adamu & Salihu, 2002), while in Afghanistan, women required male permission to access healthcare (Jewkes et al., 2020). Social stigma around conditions such as STIs and mental health disorders also deters individuals from PHC facilities (Ganle et al., 2015). Systemic and institutional barriers, including understaffing, essential medicine stockouts, inadequate equipment, and long queues, contribute to patient dissatisfaction, while perceived provider incompetence and lack of empathy further reduce utilization (Desta et al., 2020). Educational and awareness barriers, including low health literacy and misconceptions about health interventions, prevent individuals from knowing when and where to seek care (Singh et al., 2019). Psychological barriers such as fear and distrust stemming from past negative experiences (Bleich et al., 2009), and policy and governance barriers including weak governance structures and insufficient PHC funding (Banteyerga, 2011), complete the complex landscape of obstacles. Addressing these multifaceted barriers requires comprehensive strategies encompassing infrastructure investment, community engagement, health education, and policy reform.

The Role of Government and Policy Interventions in PHC Utilization in Nigeria

The Nigerian government plays a pivotal role in shaping the PHC landscape through policy formulation, financing, and infrastructure development. As a signatory to the Alma-Ata Declaration and the SDGs, Nigeria has consistently prioritized PHC in its national health frameworks, though implementation challenges, including inadequate funding, weak infrastructure, and systemic inefficiencies, have tempered the impact of these interventions. Nigeria has introduced several policies to strengthen PHC, most notably through the National Primary Health Care Development Agency (NPHCDA), established in 1992 to coordinate PHC delivery and improve access to immunization, maternal and child health, disease prevention, and health education. The revised National Health Policy of 2016 emphasizes UHC through an enhanced PHC system, with commitment to accessible, affordable, and high-quality community-level services (FMOH, 2016). However, inadequate funding and governance gaps have limited its impact.

The Basic Health Care Provision Fund (BHCPF), established under the National Health Act of 2014, allocates 1% of the Consolidated Revenue Fund to PHC services, with a focus on subsidizing care for vulnerable populations. Research indicates that the BHCPF has improved essential drug availability in PHC facilities, particularly in rural areas (Oyibocha et al., 2021), though fund disbursement delays and transparency concerns limit its full impact. The National Health Insurance Scheme (NHIS), intended to

reduce financial barriers, remains limited in scope with only approximately 5% of Nigerians enrolled; expansion to informal-sector workers is critical (Ekpenyong et al., 2020). Initiatives such as the Midwives Service Scheme (MSS) have increased skilled birth attendance and reduced maternal mortality in underserved areas (Abimbola et al., 2012), while the PHC Under One Roof (PHCUOR) strategy seeks to address infrastructure deficits through integrated management and efficient resource allocation (FMOH, 2018). Nigeria's National Immunization Programme has significantly improved vaccination coverage, though persistent gaps driven by cultural resistance and logistical obstacles underscore the need for sustained community engagement. Community health workers (CHWs) play a crucial role in hard-to-reach areas, and public-private partnerships such as the CHAI collaboration have increased availability of life-saving commodities, though more structured frameworks are needed for sustainability and equity (Okafor et al., 2020). Significant implementation challenges persist, including mismanagement of health funds, policy discontinuity from frequent government changes, and weak monitoring and evaluation systems.

Strategies for Improving PHC Utilization among Traders

Traders form a vital segment of the workforce, particularly in developing economies, yet face unique barriers to PHC access due to irregular schedules, mobility, and economic constraints. Addressing these barriers calls for targeted, multi-faceted strategies. Raising traders' awareness through health education campaigns and mobile

health education units in market settings has demonstrated effectiveness; targeted campaigns in Kenya significantly increased HIV testing uptake among market vendors (Odhiambo et al., 2020), and similar approaches can be adapted for broader PHC services. Flexible service delivery models such as extending clinic hours, offering weekend services, or deploying mobile health units to market areas, can significantly reduce access barriers; in India, mobile health units increased maternal and child health service utilization in remote areas (Banerjee et al., 2018).

Financial incentives and health insurance mechanisms are also vital. Community-based health insurance schemes reduced out-of-pocket expenses and increased PHC visits in Rwanda (Shimeles, 2010), while voucher schemes for targeted services have demonstrated success in Bangladesh (Sarker et al., 2018). Integrating occupational health services into PHC such as addressing work-related conditions such as musculoskeletal disorders and respiratory problems can attract traders to healthcare facilities, as demonstrated in South Africa (van Rensburg et al., 2019). Collaboration with trade unions and market associations, powerful conduits for health promotion, improved awareness and uptake of HIV prevention services in Ghana (Agyei-Mensah & de-Graft Aikins, 2010). Digital health solutions such as mobile apps, telemedicine, and SMS-based health reminders have increased immunization rates and antenatal care attendance in Nigeria (Kazi et al., 2017). Culturally appropriate care delivery, involving community leaders and training health workers in cultural competence, increases trust and PHC participation (Katamba et al., 2015). Strengthening referral systems with financial

support for referred cases and improving continuity of care are also essential (Banteyerga, 2011), as is ongoing monitoring and evaluation to assess effectiveness and guide policy adjustments (Sarker et al., 2018). Ultimately, sustained government commitment and multi-stakeholder engagement are essential for long-term success and equitable PHC access for traders.

Summary of Reviewed Literature

Primary Health Care serves as the backbone of health systems worldwide, emphasizing accessible, equitable, and community-focused services. Since its introduction at the 1978 Alma-Ata Declaration, PHC has provided comprehensive care through prevention, promotion, treatment, and rehabilitation, while addressing broader social determinants of health such as education and sanitation. It is pivotal to achieving Universal Health Coverage and the Sustainable Development Goals. Theoretical models guiding the analysis of PHC utilization includes the Health Belief Model, Andersen's Behavioural Model, and the Social Ecological Model which collectively illuminate why individuals choose to engage with or avoid PHC services. Factors shaping utilization include individual characteristics, socio-economic constraints, geographical barriers, cultural beliefs, and systemic inadequacies such as staff shortages and poor service quality, while perceptions of care quality shaped by provider competence, interpersonal interactions, and facility conditions also significantly affect uptake.

Barriers to PHC utilization include financial costs, physical distance, cultural preferences for traditional medicine, and systemic inefficiencies such as essential drug shortages and long waiting times. Women in particular face gender-based constraints including limited healthcare decision-making autonomy. Nigerian government policies such as the National Health Policy and the BHCPF aim to improve PHC access through financial subsidies, workforce development, and infrastructure expansion, with community health programmes and public-private partnerships also playing an important role. To improve PHC utilization among traders, evidence-based strategies include health education campaigns, flexible service delivery models, targeted financial schemes, and integration of occupational health services. Collaboration with market associations, digital health innovations, and culturally responsive approaches further strengthen accessibility and trust. Overall, addressing the systemic, cultural, and economic barriers to PHC utilization is fundamental to improving health outcomes and achieving equitable care for all.

CHAPTER THREE

METHODOLOGY

This chapter describes the methods and procedures employed in the study under the following sub-headings:

- Design of the Study
- Population of the Study
- Sample and Sampling Technique
- Research Instrument
- Validity of the Instrument
- Reliability of the Instrument
- Method of Data Collection
- Method of Data Analysis.

Design of the Study

A descriptive survey research design was adopted for this study. According to Jackson (2009), this approach involves collecting data from participants through interviews or questionnaires, allowing the researcher to describe and interpret the responses obtained. It was deemed appropriate because it enables the investigation of a

phenomenon across a defined population, thereby facilitating a comprehensive examination of the study subject.

Population of the Study

The target population comprised 4,320 market traders operating within New Benin Market in Oredo Local Government Area (LGA) of Edo State.

Sample and Sampling Technique

A sample of 216 market traders was selected for this study. Simple random sampling was employed to draw the sample, representing 5% of the total study population. This technique was chosen because it gives every member of the population equal opportunity of being selected, is free from bias, and ensures that the sample is a true and representative subset of the target population.

Research Instrument

Data were collected using a structured close-ended questionnaire. The instrument comprised of two sections: Section A sought demographic information from respondents, including age, sex, gender, and academic level; Section B consisted of 20 items addressing the research questions of the study.

Validity of the Instrument

Content validity of the questionnaire was ensured through review by the researcher's supervisor and two other experts within the Department of Health, Safety and Environmental Education, Faculty of Education, University of Benin. Their observations, comments, and corrections were incorporated in drafting the final version of the instrument.

Reliability of the Instrument

The test-retest method was employed to establish instrument reliability. The constructed questionnaire was administered twice, at a two-week interval, to a group of 20 individuals outside the study population. The scores from both administrations were correlated, and a reliability coefficient of 0.8 was set as the threshold for the instrument to be considered reliable.

Method of Data Collection

Copies of the questionnaire were distributed to respondents by the researcher, supported by trained research assistants. Questionnaires were collected immediately upon completion to ensure a 100% response rate and return.

Method of Data Analysis

The collected data were analyzed using descriptive statistical methods, including simple percentages, frequency distributions, and tabulation. Data presented in tables were

subsequently analyzed and interpreted to facilitate clarity in understanding the figures and percentages.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS, AND INTERPRETATION

This chapter presents, analyses, and interprets the findings based on data collected from respondents in relation to the research questions guiding the study.

Research Question 1: What are the determinants of primary health care service uptake among traders in New Benin Market?

Table 1: Descriptive Statistics on Determinants of PHC Service Uptake

S/N	ITEMS	SA (%)	A (%)	D (%)	SD (%)	MEAN	S.D	DECISION
1	I do not access PHC services due to financial constraints	190 (88%)	26 (12%)	0 (0%)	0 (0%)	3.88	.326	Accepted
2	My beliefs and culture affect my utilization of PHC services	6 (2%)	34 (16%)	100 (46%)	76 (35%)	1.85	.726	Rejected
3	I do not utilize PHC services because I am unaware of them	98 (45%)	102 (47%)	16 (8%)	0 (0%)	3.38	.621	Accepted
4	Distance to the health centre is a barrier to PHC utilization	205 (94%)	11 (6%)	0 (0%)	0 (0%)	3.95	.220	Accepted
5	I do not utilize PHC services because my religion is against it	0 (0%)	10 (5%)	46 (21%)	160 (74%)	1.31	.553	Rejected

Source: Field Survey, 2026

Table 1 presents the descriptive statistics on the determinants of PHC service uptake among traders in New Benin Market. The data indicate that the majority of respondents agreed that financial constraints prevent them from accessing PHC services (mean = 3.88). The statement relating to cultural and belief-based barriers to PHC utilization was rejected (mean = 1.85), while awareness and educational limitations were

accepted as a barrier (mean = 3.38), as was geographical distance to health facilities (mean = 3.95). The statement suggesting religion as a barrier to PHC use was rejected (mean = 1.31). Based on these findings, it can be concluded that the principal determinants of PHC utilization among traders in New Benin Market are financial constraints, limited awareness, and geographical distance to PHC centres.

Research Question 2: Does financial status influence the utilization of PHC services among traders in New Benin Market?

Table 2: Influence of Financial Factors on PHC Service Utilization

S/N	ITEMS	SA (%)	A (%)	D (%)	SD (%)	MEAN	S.D	DECISION
1	The cost of PHC services significantly affects my decision to seek medical care	191 (88%)	25 (12%)	0 (0%)	0 (0%)	3.88	.320	Accepted
2	High consultation fees at PHC centres discourage me from using their services	201 (93%)	15 (7%)	0 (0%)	0 (0%)	3.93	.254	Accepted
3	I am more likely to visit a PHC facility when services are affordable	102 (47%)	98 (45%)	16 (8%)	0 (0%)	3.40	.624	Accepted
4	The cost of medications at PHC facilities does not affect my decision to use their services	205 (95%)	11 (5%)	0 (0%)	0 (0%)	3.95	.220	Accepted
5	Financial constraints have no influence on my ability to utilize PHC services	0 (0%)	10 (5%)	46 (21%)	160 (74%)	1.31	.553	Rejected

Source: Field Survey, 2026

Table 2 presents findings on the influence of financial factors on PHC utilization. Respondents widely accepted that service costs significantly affect their decision to seek care (mean = 3.88), that high consultation fees discourage PHC use (mean = 3.93), and

that affordability increases the likelihood of PHC facility visits (mean = 3.40). Medication pricing was also identified as a significant determinant (mean = 3.95), while the claim that financial constraints have no influence on utilization was rejected (mean = 1.31). These findings confirm that financial factors are a significant determinant of PHC service utilization among traders in New Benin Market.

Research Question 3: Does religion influence the utilization of PHC services among traders in New Benin Market?

Table 3: Influence of Religion on PHC Service Utilization

S/N	ITEMS	SA (%)	A (%)	D (%)	SD (%)	MEAN	S.D	DECISION
1	My religious beliefs influence my decision to seek care at PHC facilities	0 (0%)	25 (11%)	125 (58%)	66 (30%)	1.81	.622	Rejected
2	I prefer PHC services that align with my religious values and practices	202 (69%)	14 (27%)	0 (0%)	0 (0%)	3.93	.247	Accepted
3	I trust PHC providers who respect and understand my religious beliefs	201 (93%)	15 (7%)	0 (0%)	0 (0%)	3.93	.255	Accepted
4	I seek medical care regardless of whether it aligns with my religious views	0 (0%)	0 (0%)	190 (88%)	26 (12%)	1.88	.326	Rejected
5	I prioritise health care needs over religious concerns when choosing PHC services	215 (99%)	1 (1%)	0 (0%)	0 (0%)	3.99	.068	Accepted

Source: Field Survey, 2026

Table 3 presents the influence of religion on PHC utilization among traders. Respondents rejected the notion that religious beliefs directly determine PHC facility visits (mean = 1.81) and that they seek care regardless of religious alignment (mean =

1.88). However, they accepted that they prefer services aligned with their religious values (mean = 3.93), trust providers who respect their beliefs (mean = 3.93), and prioritize health needs over religious concerns (mean = 3.99). With a cluster mean of 3.11, the findings indicate that religion does exert a measure of influence on PHC utilization among traders, though primarily in terms of preferences for religiously sensitive care rather than outright avoidance.

Research Question 4: To what extent do traders in New Benin Market utilize PHC services?

Table 4: Level of PHC Service Utilization among Traders in New Benin Market

S/N	ITEMS	ALWAYS (%)	SOMETIMES (%)	NEVER (%)	TOTAL (%)
1	How often do you visit a PHC facility when you feel unwell?	160 (74%)	50 (23%)	06 (3%)	216 (100%)
2	How often do you rely on PHC services for routine health check-ups?	90 (42%)	110 (51%)	16 (7%)	216 (100%)
3	How often do you seek treatment at PHC centres for minor illnesses or injuries?	180 (83%)	16 (7%)	20 (10%)	216 (100%)
4	How frequently do you use PHC services for immunizations or vaccinations?	205 (95%)	11 (5%)	0 (0%)	216 (100%)
5	How often do you utilize PHC services for preventive health education or counselling?	9 (4%)	201 (93%)	6 (3%)	216 (100%)

Source: Field Survey, 2026

Table 4 reveals that 74% of respondents always visit a PHC facility when unwell; 51% sometimes rely on PHC for routine check-ups; 83% always seek treatment at PHC centres for minor ailments or injuries; 95% always use PHC services for immunizations

or vaccinations; and 93% sometimes utilize PHC for preventive health education or counselling. These results collectively indicate that traders in New Benin Market maintain a high overall rate of PHC service utilization.

Discussion of Findings

This study investigated the determinants of PHC service uptake among traders in New Benin Market. Based on the analysis of collected data, financial constraints, limited awareness, and geographic distance to PHC facilities were identified as the primary influencing factors. This finding is consistent with Onwujekwe et al. (2010), who similarly reported that financial barriers, information deficits, and distance significantly affect healthcare utilization in Nigeria. Adamu and Salihu (2019) equally noted that insufficient knowledge of available services is a critical barrier to utilization among market traders. The finding that financial factors significantly influence PHC utilization aligns with Okafor and Orji (2014), who highlighted financial barriers as a primary reason for low healthcare utilization among low-income groups, and with Onwujekwe et al. (2010), who noted that healthcare costs are major impediments to PHC access in Nigeria. Religion was also found to influence PHC utilization, consistent with Agunbiade and Ogunleye (2017), who established that religious beliefs shape health-seeking behaviour. Finally, the finding that traders in New Benin Market have a high PHC utilization rate is in line with Eze et al. (2018), who observed that urban traders

frequently access healthcare services for preventive purposes, attributing this to greater awareness and proximity to health facilities.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

This chapter presents the summary of the study, its conclusions, recommendations, and suggestions for further research.

Summary

This study was undertaken to investigate the determinants of primary health care service uptake among traders in New Benin Market. Four research questions were formulated to guide the study, and a comprehensive review of related literature on primary health care was conducted. A descriptive research design was employed, with a target population of 4,320 market traders in New Benin Market, Oredo LGA, Edo State. A total of 216 traders were drawn via simple random sampling, representing 5% of the population. Data were collected using a structured close-ended questionnaire consisting of 20 items, validated by the project supervisor and two other departmental experts. Reliability was established through the test-retest method. All 216 questionnaires were returned and analyzed using frequency counts, percentages, means, and standard deviations.

Findings

Based on data collected and analyzed, the following findings emerged:

1. The key determinants of PHC service uptake among traders in New Benin Market are financial constraints, limited awareness, and geographical distance to PHC facilities.
2. Financial factors significantly influence PHC service utilization among traders in New Benin Market.
3. Religion influences PHC service utilization among traders in New Benin Market.
4. Traders in New Benin Market demonstrate a high overall rate of PHC service utilization.

Conclusion

Based on the findings, the study concludes that financial constraints, limited awareness, geographic distance to health facilities, and religious orientation significantly influence PHC service utilization among traders in New Benin Market. Among these, financial barriers emerged as the primary deterrent, with high service and medication costs widely cited. Religious beliefs were also found to shape health-seeking behaviour, though traders generally prioritize health needs over religious concerns. Notably, despite these challenges, traders in New Benin Market demonstrate a high rate of PHC utilization particularly for minor illnesses, routine examinations, and immunizations, suggesting that reducing barriers could yield even greater uptake.

Recommendations

Based on the findings, the following recommendations are made:

- Governments and relevant health authorities should implement financial support programmes and subsidies to lower the cost burden of PHC services for traders and informal-sector workers.
- Public health stakeholders should organize regular awareness and health promotion campaigns tailored to traders, educating them on the availability and benefits of PHC services and dispelling misconceptions about preventive health practices.
- PHC providers should be trained in cultural competence and religious sensitivity, and health facilities should engage religious and community leaders to advocate for health-seeking behaviours consistent with community values.
- More PHC centres should be established in closer proximity to major trading hubs and densely populated market areas, and mobile healthcare units should be periodically deployed to deliver services directly within market environments.

Suggestions for Further Study

1. Knowledge and Attitudes of Traders towards PHC Services among Traders in New Benin Market.
2. Impact of Public Health Education on PHC Service Utilization among Traders in New Benin Market.
3. Barriers to Effective Utilization of Primary Health Care Services among Traders in New Benin Market.

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APPENDIX

QUESTIONNAIRE

**DEPARTMENT OF HEALTH, SAFETY AND ENVIRONMENTAL EDUCATION
FACULTY OF EDUCATION, UNIVERSITY OF BENIN,
BENIN CITY, EDO STATE.**

RESEARCH QUESTIONNAIRE

Dear Respondent,

The researcher is a student of the above-named institution, conducting a study on 'Determinants of Primary Health Care Service Uptake among Traders in New Benin Market, Oredo LGA, Edo State'. You are kindly requested to complete this questionnaire. All information provided will be used solely for research purposes and treated with strict confidentiality.

SECTION A: Demographic Data

Gender: Male [] Female []

Age: 20–24 [] 25–30 [] 30 years and above []

Marital Status: Single [] Married [] Divorced []

Religion: Christian [] Muslim [] Others []

SECTION B

Please tick as appropriate (✓)

NOTE: SA = Strongly Agree A = Agree D = Disagree SD = Strongly Disagree

Research Question 1: What are the determinants of primary health care service uptake among traders in New Benin Market?

S/N	ITEMS	SA	A	D	SD
1.	I do not access PHC services due to financial constraints				
2.	My beliefs and culture affect my utilization of PHC services				
3.	I do not utilize PHC services because I am unaware of them				
4.	Distance to the health centre is a barrier to PHC utilization				
5.	I do not utilize PHC services because my religion is against it				

Research Question 2: Does financial status influence the utilization of PHC services among traders in New Benin Market?

S/N	ITEMS	SA	A	D	SD
6.	The cost of PHC services significantly affects my decision to seek medical care				
7.	High consultation fees at PHC centres discourage me from using their services				
8.	I am more likely to visit a PHC facility when services are affordable				
9.	The price of medications at PHC facilities does not affect my decision to use their services				
10.	Financial constraints have no influence on my ability to utilize PHC services				

Research Question 3: Does religion influence the utilization of PHC services among traders in New Benin Market?

S/N	ITEMS	SA	A	D	SD
11.	My religious beliefs influence my decision to seek care at PHC facilities				
12.	I prefer PHC services that align with my religious values and practices				
13.	I trust PHC providers who respect and understand my religious beliefs				
14.	I seek medical care regardless of whether it aligns with my religious views				
15.	I prioritize health care needs over religious concerns when choosing PHC services				

Research Question 4: To what extent do traders in New Benin Market utilize PHC services?

S/N	ITEMS	Always	Sometimes	Never
16.	How often do you visit a PHC facility when you feel unwell?			
17.	How often do you rely on PHC services for routine health check-ups?			
18.	How often do you seek treatment at PHC centres for minor illnesses or injuries?			
19.	How frequently do you use PHC services for immunizations or vaccinations?			
20.	How often do you utilize PHC services for preventive health education or counselling?			