

Accessibility of Public Healthcare Facilities and Their Distribution in Benin City, Edo State

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ABSTRACT

Access to quality health services determines human health and well-being, especially in this pandemic era. The objective of the study is to examine the factors that affect the utilization and accessibility of public healthcare services within selected local government areas in Benin City. The study adopted the use of 400 questionnaires, which were administered to respondents within the study area. ArcGIS 10 was used to depict health facility disparities within the city, while Pearson's Product Moment Correlation was used to test healthcare utilization. The results indicate that public healthcare facilities are clustered in distribution, having a 0.28 nearest neighbour ratio. The public healthcare facilities are accessible and there are no shortages of healthcare within the study area. Socio-demographic variables such as gender, age, marital status, education, and employment at a were positively related to healthcare accessibility. Approximately 73% of patronage and the type of public healthcare facility influence facility utilization in the study area. Factors influencing accessibility and utilization of healthcare facilities are means of transportation, travel distance, and challenges within healthcare facilities. The quality of services at 48% improves healthcare utilization. This study recommends that health care facilities need to be maintained to encourage more patronage and better service delivery that includes a policy framework for the regular maintenance and provision of necessary equipment and infrastructure that would encourage accessibility and utilization of public healthcare facilities.

Keywords: Accessibility, utilization, public health facility, determinants, healthcare service

1.0. Introduction

Access to healthcare services is one of the necessities of a modern human community. According to the World Health Organization (WHO, 2019) "health is complete physical, mental and social well-being, not merely the absence of diseases or infirmity". Humans' socioeconomic and productive lives are reliant on good health, and its absence leads to poor human health, socioeconomic hardships for families, and even death (Omonona *et al.*, 2015). Child development, family well-being, and wealth creation are subject to the health status of adults (Asenso *et al.*, 2011). Man's health is perceived as most vital because all economic activities are performed by a man (Olugbamila and Adeyinka, 2017). The various processes in accessing health care include health care quality, location, various health care needs, ease of paying for treatment, and willingness to seek treatment (Peter *et al.*, 2008).

The ease of accessing a location by a user is termed geographical accessibility (McGrail and Humphrey, 2014). Wang *et al.* (2016) state that accessibility links places of demand and supply; available transportation means; and other travel hinderances in getting there. Several methods are used to measure spatial accessibility: provider-to-population ratio, kernel density, network analysis, cost distance analysis, gravity model, and Euclidean distance (Ouma *et al.*, 2021). The spatial separation-based model is another method that is dependent on infrastructures such as healthcare facilities, as an input and it is applicable in areas where information on transportation routes is unavailable (Parvin *et al.*, 2021). The

cumulative opportunity method applies the desired minimum travel time (isochrones) and takes into cognizance the land use pattern and inherent landscape limitations (Geurs *et al.*, 2004).

Healthcare is the prevention, early or late diagnosis, and treatment of all types of diseases, including physical and mental health challenges, leading to the overall wellness of the human body (Oyibocho *et al.*, 2014). To improve the human body, there is a need for hospital equipment, drugs, vaccines, available clean water, electricity supply, proper records, hospital ambulances, and all medical personnel to make it attainable (Ubochi *et al.*, 2019). A patient's first level of healthcare is primary health care, and it is the initial element of the care continuum across communities (WHO, 2020). This health care is the least expensive outpatient consultation, where the patients have not been hospitalized. Severe and complicated health care challenges require a secondary level of care. Here, specialized health care facilities, known as second-tier hospitals/clinics, having healthcare specialists. The next level of health is tertiary healthcare, which provides referral functions for more complex cases from secondary healthcare facilities. Tertiary healthcare serves as the third tier of the healthcare system. In the public sector, these healthcare services are meant to be delivered across three tiers. In Nigeria, these three tiers of health care (primary, secondary, and tertiary) fall under the responsibility of the three tiers of government (Federal, State, and Local government) in the country.

Due to a deficiency in the distribution and planning of hospitals across the country, public and private health facilities have been given due attention to reducing the gap in Nigeria's hospital infrastructure (Agaja, 2012). With global recognition of Nigeria as one of the great nations in Africa, its healthcare status is poor (Welcome, 2011). Although there are global and national reforms and policies to address the dilemma in the healthcare system, Nigeria's local and state government areas are yet to achieve much in their implementation (National Health Policy, 2016). Owoola (2002) in Adeyinka and Olugbamila, (2016) affirm that the country has a high population to facilities ratio due to negligence in the distribution of healthcare facilities.

Barriers to seeking healthcare services include high hospital bills, and lack of health insurance and services, amongst others. Several factors like aging, and availability of healthcare services affect the utilization of health facilities where they are located (Bernstein *et al.*, 2003). One of the fundamental human rights is access to good health services/care. Even more evident is the strain on health care provision during the coronavirus pandemic on the populace's health needs (Cohut, 2020). The government directive putting a ban on mass gatherings, several hospitals and centers restricted services to only severe cases deemed emergencies, and other needs of patients were denied. Hence, it has become more difficult than usual to access care for non-emergency cases (Adeboyejo, 2020).

Health care policies in Nigeria have been only partially implemented with the country's health system, which is a mixture of unorthodox and orthodox medicine, optimising resources, leading to failure in achieving the millennium development goals for health care. Accessibility and utilization of healthcare facilities across any region are very important. The distribution of healthcare facilities across regions is therefore very vital since it determines the level of health of the population in general. The clustering of such facilities can create the problem of accessibility, and to overcome this, even the distribution of such important amenities should be encouraged. Fadahunsi *et al.* (2017) note that the location of healthcare facilities does not always correspond to the needs of population in most states in Nigeria, and this has resulted in poor health care delivery. Disparities in the distribution and accessibility of healthcare facilities have resulted in variations in health outcomes between regions. The third Sustainable Development Goal (SDG) is to ensure healthy lives and promote well-being for all ages (WHO, 2022). It is imperative that inequality in healthcare needs, especially the ease of accessing such facilities, be addressed in a bid to achieve the third Sustainable Development Goal.

Conversely, many peripheral public healthcare facilities are not being patronized due to poor accessibility, poor service provision, and rivalry by healthcare providers, amongst others. In a variety of ways, there are positive and negative consequences to utilizing available facilities such as affordability, service cost, service delivery, cultural ethnicity, travel cost, distance, state of the road, infrastructure, and service providers (staffing). The presence and quality of staff and staff attitude to patients, lack of drugs and perceived high hospital bills, place of residence, and maternal education are challenges hindering health care utilization in hospitals/centers across demographics (Adeyemo, 2005; Anderson *et al.*, 2007; Babalola *et al.*, 2009; Salome *et al.*, 2009; Nteta *et al.*, 2010; John-Abebe and

Osirike, 2015). The study seek to *examine the factors that affect the utilization and accessibility of public healthcare services within selected local government areas in Benin City.*

2.0. Methodology

2.1. Study Area

The administrative capital of Edo State, Nigeria is Benin City. The city is geographically located in the southern part of Edo State between latitude 6° 16' to 6° 33' N of the Equator and longitude 5° 31' to 5° 45' E of the Greenwich Meridian. The city encompasses three local government areas, namely: Oredo, Egor, and Ikpoba-okha. Overall, the city's territorial coverage is roughly 1,318km² with 166km² and 78 meters above sea level (Ekhaese *et al.*, 2014). Due to the rapid urban expansion, the metropolis is now made up of five local government areas, with Ovia North East and Uhumwonde. The city has an equatorial climatic belt (Af Koppens climatic classification), with an annual rainfall of above 2000mm, a temperature of 28°C and relative humidity of 80% (Odjugo, 2012).

The Benin region exhibits nodal links with connecting routes to the west through the Benin-Lagos Road, and to the east by the Benin-Asaba Road. In the south of the region is the Benin-Warri Road, and to the north is the Benin-Auchi Road. The road network is spanned by six trunk roads (golden corridors) which originate from the king's square axis in a concentric and sectorial pattern. They are Airport Road, Akpakpava Road, Mission Road, Sapele Road, Sokponba Road, and Oba Market Road (see Figure 1).

2.2. Methods

Benin City can boast of a reasonable number (445) of healthcare facilities. It enjoys a large presence of primary healthcare facilities in Edo State. There are 148 pubic primary healthcare centers (PHCs) and 223 private primary healthcare centers in the study area; 9 public secondary hospitals and 3 public tertiary hospitals (Federal Ministry of Health, 2021).

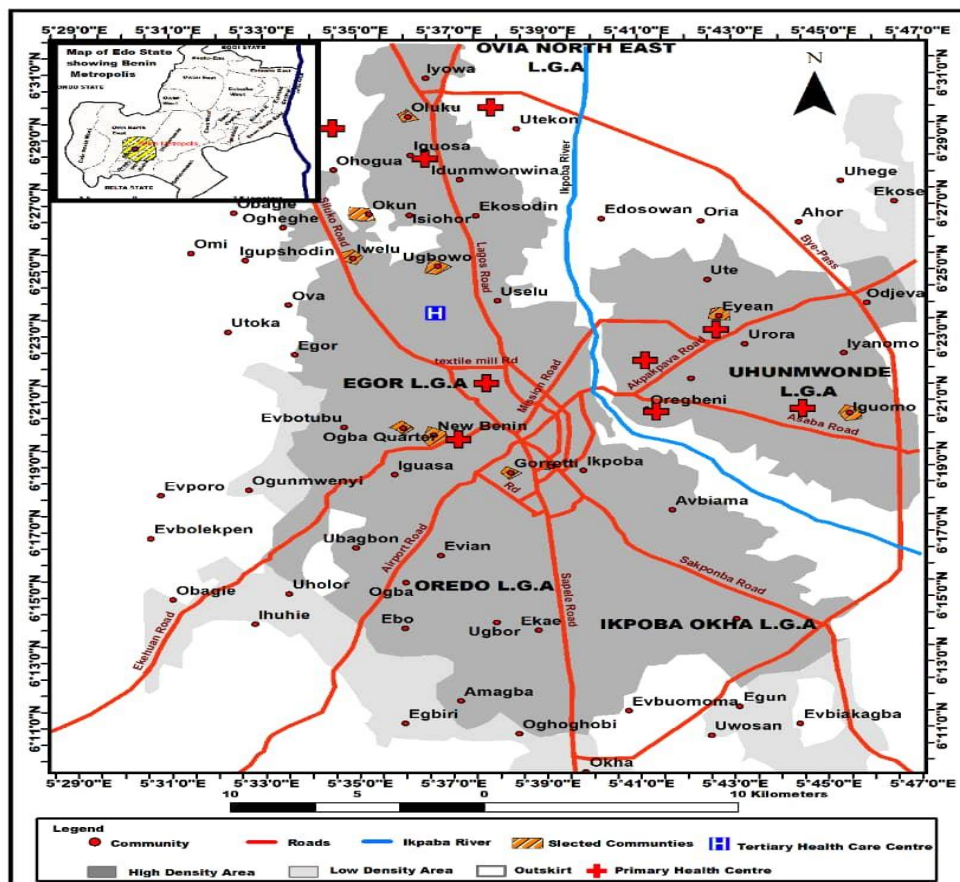


Figure 1: Public Health Care Facilities in Benin Metropolis

Table 1: Total number of private and public health care facilities in Benin City

Types of Health Facilities	Egor	Ikpoba-Okha	Oredo	Ovia North East	Uhunmwonde	Total
Public Tertiary	3	-	-	-	-	3
Private Tertiary	-	-	3	1	-	4
Public Secondary	-	1	5	2	1	9
Private Secondary	12	11	35	-	-	58
Public Primary	12	32	22	42	40	148
Private Primary	53	85	83	-	2	223
Total	80	129	148	45	43	445

Source: Federal Ministry of Health (2021)

The study area population (Egor, Oredo, Ikpoba-Okha, Uhumwonde, and Ovia North-East) were projected to be 1,109,540 people in 2020 based on a calculation with a growth rate of 2.7% from 2006 census figures (NPC, 2010). The age group of respondents for this study is 15 and above. The study area is centered on two communities from each local government sampled. Every first street in that community will be systematically selected along with the next adjoining street. A total of 400 questionnaires were administered according to population and residential household size. The questionnaires was administered on both sides of the street and on every 1st, 3rd, and 5th building was selected from each street.

Table 2: Household Questionnaire Distribution

S/N	Local Government Areas	Communities	No. of Questionnaire
1.	Oredo	Ogbe quarters and New Benin	103
2.	Ikpoba-okha	Gorretti and St. Saviour	110
3.	Egor	Uwelu and Ugbowo	99
4.	Ovia North-East	Oluku and Okhun	52
5.	Uhumwonde	Iguomo and Eyaen	36
	Total		400

2.3 Data Analysis

The study employed a quantitative method for data analysis. Data was collected from a household questionnaire and analysed using SPSS 16. Data analysis was conducted through descriptive statistics such as percentages, frequency tables from respondents' information. The distribution of health care facilities was carried out using the Nearest Neighbour index model in the ArcGIS 10.1 environment. The correlation was done using Pearson's (r) and it showed the relationship between certain determinants and the utilization of government-owned public health facilities.

3.0. Results and Discussion

3.1. Characteristics of Respondents

Table 3: Socio-Demographic Characteristics of Respondents

Social Demographic Characteristics of Respondents	Egor	Ikpoba - Okha	Oredo	Ovia North East	Uhunmwonde	Total	Percentage (%)	P-value
Sex								
Female	61	83	81	47	28	300	75	0.000
Male	42	27	18	5	8	100	25	
Age								
15-30	25	44	42	28	12	151	38	0.000
31-45	39	51	46	20	21	177	44	
46-60	30	11	10	3	2	56	14	

61-75	9	2	0	1	1	13	3	
Above 75	0	2	1	0	0	3	1	
Marital Status								
Single	19	30	31	16	7	103	26	
Married	76	76	66	35	28	281	70	0.000
Widowed/Others	8	4	2	1	1	16	04	
Education Status								
No Formal Education	16	6	5	0	1	28	7	
Primary	22	9	11	4	4	50	13	0.000
Secondary	39	59	60	30	23	211	53	
Tertiary	26	36	23	18	8	111	27	
Religion								
Christian	98	105	98	48	35	384	96	
Muslim	2	3	1	3	1	10	2.5	0.114
Traditional	2	1	0	1	0	4	1	
Others	1	1	0	0	0	2	0.5	
Occupation								
Farmers	14	11	4	1	1	31	8	
Business Person	53	78	68	42	28	269	67	
Industrial worker	4	2	3	5	1	15	4	0.034
Public Servant	15	5	9	2	2	33	8	
Others	17	14	15	2	4	52	13	
Monthly Income								
Less than ₦30,000	47	58	58	27	17	207	52	
30,000- 50,000	49	38	31	20	15	153	38	
51,000- 70,000	3	4	4	3	3	17	4.25	0.065
71,000-90,000	1	5	5	0	0	11	2.75	
91,000- 110,000	3	5	1	2	0	11	2.75	
Above ₦110,000	0	0	0	0	1	1	0.25	

*Significant at 0.05 and 0.01 level.

Table 3 presents the socio demographic characteristics of respondents across the study area. A higher percentage of respondents, at 75% are females, with the highest proportion (27%) of all females recorded in Ikpoba-Okha. Uhumwonde and Oredo local government areas have the highest percentage of females as affirmed by 90% and 81.8% of their respective sampled populations. Egor local government area records the highest number of male respondents in the study area, with 42% of the total male respondents across the study area. The results show that Ikpoba-Okha (83) recorded the highest number of female respondents while Uhumwonde (28) recorded the lowest, indicating 45% and 12% of the female respondents, respectively. Health care accessibility and utilization of public healthcare in Benin City indicate that there are more females than males utilizing public healthcare facilities.

The age of respondents showed that respondents with the ages of 31–45 years, has the highest proportion at 44.3% in the study area, followed by the age-groups of 15–30 years, which has about 38%. The age-groups 61–75 and above 75 years old recorded 3.3% and less than 1% respectively, in the study area. Generally, it can be inferred that a large number of respondents are younger than 46 years old in Benin City. This study shows that 82% of respondents were between the ages of 15–45 years old. Olugbamila and Adeyinka, (2017) states that young adults utilise healthcare facilities than other age groups.

The marital status of respondents indicates that 70% of the population are married, 26% are single while 4% of the population are widowed or divorced. In Egor and Ikpoba-Okha local government areas, 54% of respondents are married couples. Egor local government area also has the highest number of respondents (50%) who are widowed, divorced or separated. Over 80% of respondents have either secondary or tertiary qualifications, with 53% and 27% showed to have a secondary and tertiary education. The study area has a high number of people who have a basic education. Grossman and Kaestmer (2000) affirm that education plays a positive role in having good health. There are more Christians (96.0%) than any other religion within the study area.

The major occupation are businessmen and women (67.3%), while 16% are farmers and public servants. The majority of the populace are small and medium-scale private business owners. The highest monthly income of (₦30,000–₦50,000) is found in Egor, Oredo, and Ikpoba-Okha local government areas. The

study area is made up of low-income earners, as deduced from the 52% of workers who earn less than ₦30,000. The majority of low-income earners are self-employed and have at least a secondary education. The implication of this is that the majority of respondents can only afford to utilize public healthcare facilities. This concurs with Olugbamila and Adeyinka (2017) findings that human health is vital to economic activity. The analysis revealed that five (5) out of the eight (8) characteristics are linked to health services accessibility and utilization. The socio-demographic variables (gender, age, marital status, education, and employment) were statistically significant at a *p-value* of 0.000. Occupation is slightly more significant at a *p-value* < 0.05 than income and religion.

3.2. Factors Responsible for Disparity in Public Healthcare Distribution

Spatially, the distribution of public healthcare facilities was analysed following an examination of the Benin metropolis, indicating the location of public healthcare facilities. This analysis was carried out using the nearest neighbour statistical model in the ArcGIS 10.1 environment. The results are shown below.

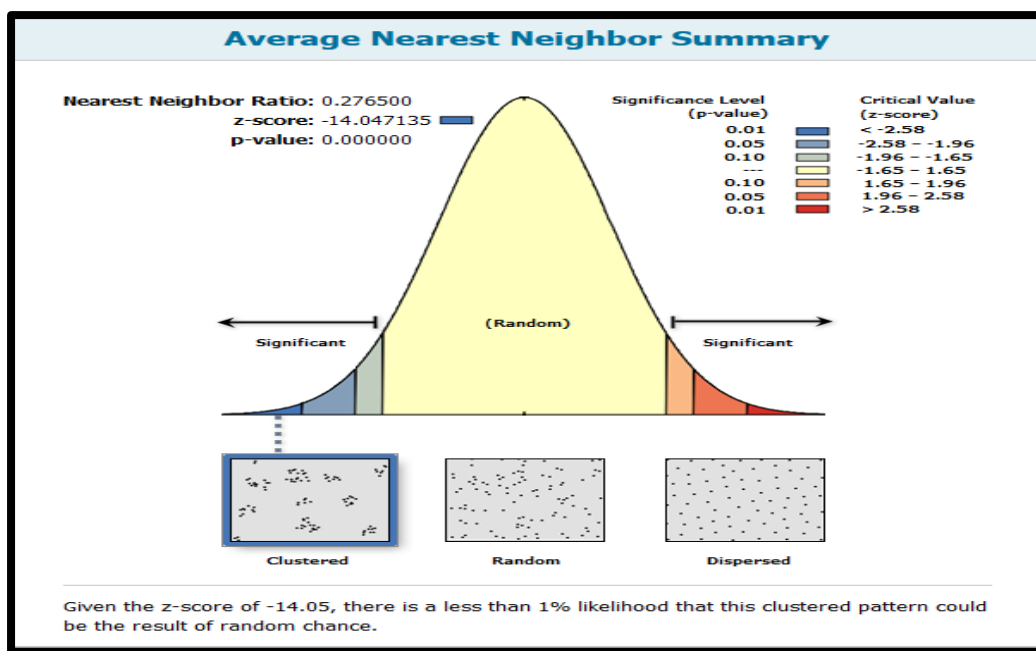


Figure 2: Nearest Neighbour Index

Figure 2 shows the public healthcare facilities with the nearest neighbour ratio of 0.28, indicating a clustered pattern in public healthcare distribution. There is a less than one percent (1%) chance that the city’s clustered pattern of facilities is due to random chance. It could also be inferred that the location of these public healthcare facilities could have been informed by the developmental pattern of the city.

Table 4: Factors that Affect Utilization and Accessibility of Public Healthcare Facilities

Factors influencing accessibility and utilization of public health facilities	Egor	Ikpoba-Okha	Oredo	Ovia North East	Uhunmwonde	Total	Percentage	P-value
Accessibility of Health Facilities								
Highly Accessible	30	40	33	21	4	128	32	0.001
Easily Accessible	60	64	49	21	25	219	54.75	
Poorly Accessible	13	6	17	9	6	51	12.75	
Not Accessible	0	0	0	1	1	2	0.5	
Travel Time								
Less than 30 Minutes	82	59	33	34	25	233	58	0.332
30–60 Minutes	21	37	25	17	11	111	28	
More than 60 Minutes	0	14	41	1	0	56	14	

Means of Transportation								
Foot	58	36	43	20	15	163	41	
Motorcycle/Tricycle	1	17	2	6	6	32	8	0.002
Public Vehicles	39	57	48	22	13	179	45	
Private Vehicles	8	6	6	4	2	26	6	
Religious Influence on Patronage								
Yes	7	7	1	1	3	19	5	0.602
No	96	103	98	51	33	381	95	
Patronage Level of Healthcare Facilities								
Weekly	1	6	1	3	3	14	3	
Monthly	39	31	23	7	12	112	28	0.169
Yearly	18	19	17	6	6	66	17	
On Recommendation	11	15	23	10	14	73	18	
On Appointment	34	39	35	26	1	135	34	
Cost of Health Services								
Affordable	44	75	61	23	20	223	56	
Cheap	28	16	18	14	9	85	21	0.093
Expensive	31	19	20	12	7	89	22	
Free	0	0	0	3	0	3	1	
Travel Distance								
Below 100 Meters	83	59	30	33	27	232	58	
101–150 Meters	18	27	60	13	8	126	31	0.038
151-200 Meters	1	10	3	5	0	19	5	
Above 200 Meters	1	14	6	1	1	23	6	
Challenges within Health Facilities								
Distance	11	19	3	9	3	45	11	
Cost of Health Services	25	20	17	8	4	74	19	
Waiting Hours	20	29	40	14	8	111	28	0.003
Inadequate Health Personnel	18	12	9	6	4	49	12	
Others	29	30	30	15	17	121	30	
Type of Facility Patronized								
Primary	48	54	25	29	22	178	45	
Secondary	24	41	62	10	10	147	37	0.042
Tertiary	31	15	12	13	4	75	18	

*Significant at 0.05 level.

Table 4 shows the perception of respondents towards the accessibility of public healthcare facilities across the five local government areas. Generally, 54.8% of respondents stated that healthcare facilities are easily accessible, with a further 32.0% indicating that they are very accessible. Cumulatively, 86.8% of respondents agreed that public health care facilities in Benin City are easy to access. The travel time of healthcare facilities from respondents' places of residence (58%) reports that health facilities in their location are less than 30 minutes from their place of residence. Spatially, 41% of respondents that access health facilities between 1-2 hours are found in Oredo Local Government Area. This implies that health facilities are located in residential areas for ease of access, and Oredo local government area records the highest number of tertiary and secondary health facilities in the study area (FMOH, 2021).

Public transport (45%) serves as the common means of transportation for accessing healthcare facilities, while 41% access the healthcare facilities on foot. The result shows a high dependency on public transportation and that public healthcare facilities are located close to residential areas. The respondents (95%) affirm that religion does not influence their patronage of healthcare facilities in Benin Metropolis. Most respondents (34%) stated that they patronize health facilities on scheduled appointment days, and 28% patronize health facilities monthly. In Egor local government area, 38% of respondents visit healthcare facilities monthly, and 50% in Ovia North-East visit health facilities on

appointment days. It can be inferred that most people visit health care facilities only when they have a scheduled appointment.

56% of respondents affirmed that the cost of health services in public health facilities is affordable. This was found to be the general perception across all local government areas in the study area. It can be implied from the above that the services rendered by health care providers in the city are mostly affordable for residents in the study area. Frost and Reich (2008) affirmed that affordability is a prerequisite for ensuring access to healthcare services. Onokerhoraye (2000) reports that the inability of people to afford healthcare services is responsible for pushing the masses to patronize traditional healers. The distance to healthcare facilities for 58% of respondents is below 100 meters, and this concurs that healthcare facilities are located in residential areas for easy access. John-Abebe and Osirike (2015) observe that place of residence and distance influence maternal and child health care utilization. The result of this study also shows that 30% of respondents affirm that lack of equipment, bad and broken hospital equipment, poor services, and other factors are some of the challenges in utilizing public health care facilities.

Some of the challenges of using healthcare facilities are the waiting hours in healthcare facilities, which is 27.8% of respondents. This is followed by the cost of healthcare at 18.5%. This study indicates that the time spent by patients in healthcare facilities before they are attended to is a tough challenge for residents, and it could be a pointer to the shortage of staff in these healthcare facilities. Shaikh *et al.* (2004) noted that healthcare cost is a determinant in healthcare facility utilization. As noted by Anderson *et al.*, (2007), the presence of competent staff and their attitude to patients affects the utilization of healthcare services provided. Lu *et al.* (2010) affirm that the insufficient number of healthcare infrastructures/ personnel and the inability to pay hospital bills amongst others are factors affecting the people patronizing healthcare services. A majority (45%) of respondents stated that they patronize primary healthcare facilities with 37% observed to patronize secondary healthcare facilities, while the percentage of respondents who patronize tertiary healthcare facilities in Benin City is represented by 18%. This study confirms that primary healthcare facilities in the city have the highest patronage. This could be a result of primary healthcare facilities (PHCs) being closer to their places of residence. Primary health care facilities meet child and maternal health care needs. According to Duong *et al.* (2004), preference is given to facilities that are 20 minutes away from places of residence in the patronage of healthcare facilities, and Geur *et al.* (2004) state the importance of minimum travel time. This study reports that healthcare facilities that are closer to residential areas receive more patronage. This was also affirmed by the majority of respondents, who stated that public healthcare facilities are located in residential areas and are easily accessible. In terms of accessibility, it was discovered that the distance between places of residence and public healthcare facilities is not a significant barrier. Most healthcare facilities are less than 30 minutes away from residential areas. Challenges encountered in utilizing health facilities were found to be lacking and sometimes non-functional service delivery, and this has hampered utilization. Waiting hours were also identified as a major barrier to healthcare utilization in the city.

The majority of respondents found healthcare service quality in public healthcare facilities to be satisfactory. However, the attitude of health workers in some healthcare facilities was found to be unpleasant. Staffing was also cited as a problem influencing adequate service delivery in public healthcare facilities. Many public healthcare facilities in the city lack adequate infrastructure for efficient service delivery. The number of bed spaces in these facilities, alongside other key healthcare equipment, was found to be inadequate. Many public healthcare facilities, particularly PHCs, are in desperate need of physical and environmental upgrades and maintenance. Five variables (access to health care, means of transport, challenges of health care, travel distance, and type of facility) are related to accessibility at a 0.05 level of significance.

Using Pearson’s product-moment correlation, the null hypothesis was analysed to indicate that there is no significant relationship ($p>0.05$) between the quality of public healthcare services and utilization.

Table 5: Descriptive Statistics of the Correlation Between Quality of Public Healthcare Services and Utilization

	Mean	Standard Deviation	N
Quality of public healthcare services	1.82	.589	400
Type of public healthcare facilities	1.75	.761	400
Patronage level of facility	3.50	1.305	400
Satisfaction level of health services rendered	1.11	.313	400

Table 5 presents the descriptive statistics of the correlation between the quality of public healthcare services and utilization. The mean and standard deviation for each variable are given, with quality of public healthcare facilities as (M = 1.82, SD = 0.589); type of public healthcare patronized at (M = 1.75, SD = 0.761); frequency of facility patronized (M = 3.50, SD = 1.305); and perception of the level of satisfaction of healthcare services (M = 1.11, SD = 0.313). The correlation coefficient is shown in Table 6 below.

Table 6: Correlations between the quality of public healthcare services and utilization

		Quality of public healthcare services	Type of public healthcare facilities patronize	Patronage level of facility	Satisfaction level of health services rendered
Quality of public healthcare services	Pearson	1	-.015	.009	.486**
	Correlation				
	Sig. (2-tailed)		.759	.862	.000
	N	400	400	400	400
Type of public healthcare facilities patronize	Pearson	-.015	1	.255**	.032
	Correlation				
	Sig. (2-tailed)	.759		.000	.529
	N	400	400	400	400
Patronage level of facility	Pearson	.009	.255**	1	.036
	Correlation				
	Sig. (2-tailed)	.862	.000		.472
	N	400	400	400	400
Satisfaction level of health services rendered	Pearson	.486**	.032	.036	1
	Correlation				
	Sig. (2-tailed)	.000	.529	.472	
	N	400	400	400	400

****.** Correlation is significant at the 0.01 level (2-tailed).

The use of healthcare facilities was discovered to be strongly related to the quality of public healthcare service ($r = 0.4$), $p = 0.001$. This finding indicates that the quality of services rendered in a healthcare facility has a strong influence on people's utilization of these facilities. The quality of service ($r^2 = 0.48$) Indicates that the quality of services has improved utilization by 48%. Conclusively, the alternative hypothesis is accepted: there is a significant and direct relationship between the quality of healthcare services and utilization. The implication of this is that people are more willing to utilize facilities where quality services are rendered. The patronage level is related to the type of public health facilities utilized at 25%.

4.0. Conclusions

Public health care facilities are clustered and accessible to the residents of Benin Metropolis. This makes it easy for people to access healthcare facilities. However, the majority of these facilities are in dire need of rehabilitation and maintenance to improve the quality of service rendered. The government of the study area should put in place measures that would improve the socio-economic status of the population, ensuring that healthcare facilities are built with adequate infrastructure, equipment, and personnel to render efficient and effective health care services. The government should ensure that roads leading to public healthcare facilities are always in good condition and properly maintained. This would enhance access to healthcare services, especially in cases of emergencies. Healthcare facilities should be fully functional and provide quality services.

To cut-down waiting hours of patients, it is expedient for the government and management of public healthcare facilities to employ more staff and adopt the usage of modern technology in service delivery. Staff should also be trained regularly and treat patients with the utmost respect in their discharge of duties. Hospital/Centre management should ensure that the physical and environmental condition of public healthcare facilities are to standard. Government should establish healthcare policies for effective

and efficient service delivery to encourage accessibility and utilization of public healthcare facilities in Benin City. It is of utmost importance that the government and stakeholders ensure that public healthcare facilities in the country are fully utilized.

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