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Patient-Level and Health-System Determinants of Effective Healthcare Service Utilisation in Nigeria: A Narrative Review

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Abstract:

Effective healthcare service delivery and its utilisation remain central to the pursuit of universal health coverage in Nigeria, yet a substantial gap persists between the availability of services and their actual use by patients. This review synthesises evidence on the determinants of effective healthcare service utilisation among patients in Nigeria, with particular attention to South-West Nigeria. A narrative review approach was adopted, guided by established methodological frameworks for non-systematic reviews and appraised against the Scale for the Assessment of Narrative Review Articles (SANRA). Peer-reviewed studies, theoretical literature, and policy documents were purposively identified from bibliographic databases and organised thematically around patient-level, sociocultural, and health-system determinants. Findings were interpreted through the Health Belief Model and Andersen's Behavioural Model of Health Services Use. Utilisation is shaped by an interacting set of factors operating at individual, community, and system levels. Patient knowledge and health literacy, perceptions of service quality, and attitudes toward formal care influence health-seeking decisions but are insufficient on their own. Sociocultural beliefs, trust in traditional medicine, financial hardship from out-of-pocket payments, geographical distance, workforce shortages, and perceived poor service quality operate as persistent barriers, while health insurance, community engagement, culturally responsive health education, and improved provider communication function as facilitators. Effective utilisation in Nigeria is best understood as a product of the alignment between patient predisposition, enabling resources, and the responsiveness of the health system. Interventions that integrate demand-side health education with supply-side improvements in affordability, proximity, and quality are most likely to convert access into use.

Keywords: healthcare utilization, health-seeking behavior, access to care, Health Belief Model, Andersen's Behavioural Model, Nigeria,

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1. Introduction

Population health and the global aspiration of universal health coverage are built upon timely and effective access to and utilization of health care services. However, in Nigeria, even in the presence of a multi-tiered health system (primary, secondary and tertiary), patients do not necessarily use the available services at the right time, level and frequency. Many patients may present late, self-refer to secondary or tertiary care providers or seek informal or traditional providers, despite the presence of the services they are seeking (Koce et al., 2019, 2020). Identifying the reasons why availability and utilisation of HSS are not the same is a key to any meaningful attempt to build up the health system.

Utilisation of services is a multidimensional behaviour that is more than the mere physical availability of services. It is shaped by knowledge, perception and attitudes patients possess when making health decisions, sociocultural factors of where patients make health decisions, and structural factors in the health system that includes the affordability, distance, workforce distribution, and perceived quality of care (Amedari & Ejidike, 2021; Levesque et al., 2013). High out-of-pocket payments, unequal geographical access to facilities and staff, and significant parallel care-seeking routes away from the formal health care system, compounded by the Nigerian context and especially in South-West states like Ogun, are additional factors that affect these determinants (Aboaba et al., 2023; Akeju et al., 2016).

While there is a significant number of empirical studies that have looked into the individual determinants of utilisation in Nigeria, the evidence has been scattered across disciplines, study designs and geographical contexts. Studies of individuals tend to focus on one factor without placing it in an explanatory context, such as knowledge, cost, distance or culture. It is therefore worthwhile to bring these threads together, using a method that synthesizes the findings, uses a framework of well-known behaviour theory to interpret the findings, and reveals where the mass of evidence is and where the significant gaps are.

This review aims to further three goals. For one, it expounds the core tenets of good healthcare service delivery and utilisation applicable to the Nigerian context. Second, it combines patient-level, sociocultural and health-system factors of utilisation found in the Nigerian literature and in similar studies from other parts of the world and attempts to explain these using the Health Belief Model (HBM) and Andersen's Behavioural Model of Health Services Use. Thirdly, it highlights policy and practice implications and proposes future research priorities. The review takes a different approach to positioning supply-side and demand-side determinants: not as opposed, but as complementary parts of the same utilisation pathway.

2. Methodological Approach

This is a narrative (non-systematic) review paper. The narrative review is a well-established type of knowledge synthesis that has strengths in its ability to interpret and integrate multiple, diverse bodies of evidence, to accommodate a variety of study designs, and to develop a coherent 'big picture' conceptual account of a broad topic that cannot easily be captured by a narrowly scoped systematic review (Ferrari, 2015; Greenhalgh et al., 2018; Sukhera, 2022a). The approach has been chosen carefully because the factors influencing the uptake of healthcare in Nigeria could be quantitative surveys, qualitative studies, theories, and grey literature policy documents, and the purpose of the review is to provide interpretive integration and not to calculate a single pooled effect.

The review was organised based on the widely cited guidance for writing rigorous narrative reviews (Ferrari, 2015; Green et al., 2006; Gregory & Denniss, 2018; Sukhera, 2022b; Baethge et al., 2019), and self-appraised against the six domains of the Scale for the Assessment of

Narrative Review Articles (SANRA): justification of importance, statement of aims, description of the literature search, appropriate referencing, presentation of the level of evidence, and clarity of reasoning and data (Baethge et al., 2019). These domains were used to give the organizing logic to the manuscript and are briefed in Table 1.

Literature was hand searched in the reference list of relevant articles and keywords were searched in the following online databases: PubMed, Scopus, Google Scholar and African Journals Online. In addition to the concepts of "healthcare utilisation", "health seeking behaviour", "access to care", "service delivery" and "quality of care", concepts of "Nigeria" and South-West Nigerian states were also used as search terms. The emphasis was on peer-reviewed studies done in Nigeria and sub-Saharan Africa or on theoretical and conceptual texts of international importance which informed the interpretation of the studies. No exhaustive protocol was used to select sources as they were chosen for their relevance to the objectives of the review, methodological soundness, and context for the application. The selection of sources for this narrative review was not determined by a predetermined exhaustive protocol but instead was based on their relevance to the objectives of the review, methodological soundness, and context for application.

Like the guidance for narrative reviews to always be reflexive about what they don't consider, it is noted that purposive identification of literature is subject to the possibility of selection bias and that the synthesis is not reproducible as in a systematic review (Sukhera, 2022a). The transparent structure is adopted here, and these features are mitigated, but not eradicated, by this structure which is guided by a framework. This synthesis is therefore interpretive and integrative, to help to organise current understanding and encourage further enquiry, not to give a final quantitative account.

Table 1

Correspondence between SANRA quality domains and this review

SANRA domain (Baethge et al., 2019)	How it was addressed in this review
Importance of the topic	Framed by the persistent gap between service availability and utilisation in Nigeria
Aims of the review	Three explicit objectives stated in the Introduction
Literature search	Purposive multi-database search with defined concepts and priority to Nigerian evidence
Referencing	Claims linked to peer-reviewed and foundational sources in APA style
Level of evidence	Study designs distinguished; theoretical and empirical sources treated separately
Reasoning and data	Findings interpreted through HBM and Andersen's Behavioural Model

Note. SANRA = Scale for the Assessment of Narrative Review Articles; HBM = Health Belief Model.

3. Conceptual Foundations

3.1 Effective healthcare service delivery

Effective service delivery is the ability to deliver safe, timely, person-centred, equitable and efficient health services that achieve expected health outcomes. It is not just about the physical environment, but also the people, processes and technology that all contribute to the patient experience (World Health Organization, 2010). However, effectiveness is strongly

linked with the coordination between tiers, which is often a problem in Nigeria as weak referral linkages mean patients do not seek primary care services but instead go to secondary or tertiary care (Koce et al., 2020). This result is not just a function of individual facilities but depends on the system's ability to help guide patients to the appropriate level of care at the appropriate time.

3.2 Healthcare service utilisation and access

Healthcare utilisation is the actual use of healthcare services by population and individuals, separate from the concept of access, which is the opportunity to utilise services. Access is best seen as a multidimensional phenomenon including approachability, acceptability, availability and affordability of services in the supply side, and the ability of the populations to perceive, seek, reach, pay for and engage in care in the demand side (Levesque et al., 2013). This interface framing is especially important for Nigeria as it sheds light into the reason why availability is not necessarily usage when affordability or acceptability is not ensured. Utilisation, however, is an observable behavioural outcome which only occurs when there is alignment between supply-side opportunities and demand-side abilities (Peters et al, 2008).

4. Theoretical Framework

4.1 The Health Belief Model

The Health Belief Model (HBM) is one of the many models that have been widely used to explain and predict health-seeking behaviour. It has been developed in an attempt to explain why people do not engage in preventive programmes and assumes that the decision to act for health is primarily influenced by individuals' attitudes and beliefs, and not by objective reality (Rosenstock, 1974). The key constructs of its framework, the perceived threat (perceived susceptibility and perceived severity), the perceived benefits compared to perceived barriers, cues to action, and self-efficacy, provide a parsimonious explanation of why patients take or do not take action to seek or avoid care (Champion & Skinner, 2008; Janz & Becker, 1984).

The HBM is applicable to Nigeria, revealing several patterns observed. Late presentation can be due to patients not perceiving themselves as being vulnerable to a condition or not recognising the extent that it may have impacted upon them. The cost and distance to care, fear of diagnosis, and previous negative experiences are common fears that are perceived as outweighing benefits, thereby tipping the cost–benefit ratio against formal care. Patient symptoms, provider suggestions and health education initiatives may trigger healthcare-seeking; patient self-efficacy is a key factor in whether they are capable of navigating the health system. The model's main weakness is that it focuses on individual factors while neglecting the structural and sociocultural factors which are highlighted in the Nigerian context.

4.2 Andersen's Behavioural Model of Health Services Use

The Andersen's Behavioural Model extends the HBM by adding a set of determinants that are part of a larger system in which individual behaviour exists. The model has been further developed to list the predictors of utilization within three categories: predisposing characteristics (demographic characteristics, social structure and health beliefs); enabling resources (income, health insurance, services available, and access to services); and need (both perceived need and professionally assessed need) (Andersen, 1995; Andersen & Newman, 1973). Utilisation is considered to be a function of these domains, and the model also acknowledges that willingness to use the health system depends on health system responsiveness and policies (Aday & Andersen, 1974).

In contrast, Andersen's model is useful as a scaffold for Nigeria since it allows for those factors that enable a person to seek help – insurance coverage, out-of-pocket costs, distance

from service, and availability of labour – that are present in the empirical literature but not in the HBM. Together, from the two models, utilisation occurs when there is a match between perceived threat and perceived benefit (HBM) and adequate predisposing orientation, enabling resources, and evaluated need (Andersen). This integrated reading prepares for the thematic synthesis that follows, which links patient-level determinants with predisposing and perceptual factors, and sociocultural and health-system determinants with enabling resources and the responsiveness of the health system.

5. Patient-Level Determinants of Utilisation

5.1 Knowledge and health literacy

Knowledge is a regular but partial determinant of utilisation. Empowerment to access health care services, preventive services like immunisation and screening, and adherence to treatment is linked with greater knowledge about health in Nigeria and low- and middle-income countries generally (Akute et al., 2024). However, a common result is awareness but low usage levels: although respondents may be aware of the services, their actual usage is relatively low, which suggests that knowing is not enough to promote behaviour (Amedari & Ejidike, 2021). When knowledge is high and there are infrastructural, financial and geographical limitations that still stand in the way, utilisation slows down and by itself, health literacy fails to impact on behaviour, confirming that the conditions for utilisation must be put in place in order for knowledge to be effective.

This relationship is shaped and influenced by the source and quality of the information regarding health. Quality information from trusted sources and structured health programmes encourages safe use of health services, while asking for information from unknown sources or unofficial health programmes can lead to the spread of misinformation and unsafe health-seeking. Education acts as an important moderator with people with higher educational levels more easily developing health literacy and navigating the system well, resulting in socially patterned differences in system navigation. These observations place health education in the context of the need for an enabling strategy rather than being a 'one-off' intervention.

5.2 Perception of service quality

Patients' perceptions of the quality of the service provided, which are influenced by factors such as waiting times, attitudes of providers, availability of medicines and equipment, the cleanliness of the service and communication between the provider and the patient, can have great impact on whether services are used or not. Negative experiences – whether based on personal or community reputation – can lead to dissatisfaction and distrust, which discourages further use and can make patients seek out facilities that they think provide better care, even when they're closer (Koce et al., 2020). The poor quality of primary health care services in Nigeria is reported to be a contributing factor to self-referral to secondary and tertiary health care facilities which leads to congestion in the secondary and tertiary levels, and inefficiency in the health system (Koce et al., 2019).

Quality is a demand-side determinant as well as a supply-side determinant because it is a point of reference for the patient against which the worthiness of a health care seek is measured. With the increasing importance of objective quality, there is a need to go beyond that and tackle the perception of quality and trust of the user by communicating and engaging with the community.

5.3 Attitudes and health-seeking behaviour

Formal health care attitudes influence the conversion of knowledge and perception to action. Positive attitudes (confidence in the effectiveness of orthodox care and positive orientation

towards providers) are correlated with prompt and appropriate utilisation, while ambivalent or negative attitudes would lead to a delay in utilisation or to self-medication or using alternative providers. Attitudes are not just created out of nowhere; they are shaped by other prior experiences of care, the respectfulness and competence of providers and, of course, the norms of the community. Attitudes have been found to be a determinant of the need for care as well as the selection of the level of facility in several Nigerian studies, which adds an element of behavioural pathway to the HBM in which perceived benefits and barriers interact to determine behaviour (Champion & Skinner, 2008).

6. Sociocultural Determinants

In the context of Nigeria, some of the most distinctive factors affecting utilisation are the socio-cultural factors. The traditional understanding of sickness and healing capabilities provides strong support for a parallel domain of care where traditional healers, birth attendants, spiritual providers and patent medicine vendors are often first contacts. A qualitative study in Ogun State, Nigeria, revealed that women sought care from multiple providers, favouring the traditional ones who had established trust and long-standing relationships with them, and shared physical and cultural spaces and community identity (Akeju et al., 2016). The preferences can be important as a delaying or replacement for formal care, having significant impact in time sensitive situations like obstetric emergencies.

Utilisation is also influenced by cultural norms and stigma towards certain conditions. Issues such as mental illness and some reproductive and infectious diseases are often not presented to the early days of the illness due to stigma. Gendered decision-making structures also play a mediating role in access, where the power of male partners and family elders can shape access to care for women and children, including when and where. The dynamics are similar to the predisposing portion of Andersen's model, as well as the belief constructs of the HBM, which has examined the link between social meaning and real use. These dynamics are consistent with the predisposing part of Andersen's model and the belief constructs of the HBM, which has explored the relationship between social meaning and real use.

The policy implication is that traditional systems should not be replaced but rather should be involved. Health education that is culturally responsive, community mobilisation, and positive engagements with trusted community members and traditional providers are more likely to impact on care-seeking than health education that rejects or disregards locally held beliefs. The interventions that are in line with the community values have the highest probability of achieving the conversion of cultural trust to appropriate utilisation.

7. Health-System and Structural Determinants

7.1 Financial barriers

One of the common reasons for non-utilization in Nigeria is financial constraint. Out-of-pocket payment continues to be the major source of expenditure on health, with a disproportionate burden on households, sometimes devastating (Amedari & Ejidike, 2021). The fees for consultations, prescriptions and diagnostics are a disincentive to seeking treatment, especially for the poor, and in addition to preventing uptake, they also prevent sustained treatment as people fail to keep up with their medicines costs. The evidence is consistent and shows that coverage is directly linked to utilisation, suggesting that financial protection, via health insurance and targeted subsidies, is a key instrument to improve the use of health services and that expanding prepayment mechanisms is a key driver towards obtaining such financial protection.

7.2 Geographical access and infrastructure

The use of services is limited by geographical barriers particularly in rural and underserved areas. The inequitable distribution of facilities, poor road infrastructure, and limited transportation access pose challenges to accessing care, and drive down the use of services when it is most needed (Aboaba et al, 2023). These findings are corroborated by the findings of the studies conducted on the rural households in Ogun State where it was observed that the availability and ease of access of transport and the perceived quality of available facilities have a significant influence on the choice of services used by the rural households. Financial barriers also act as a factor of distance, as travel will also cause lost income costs and direct expense, further reducing the motivation to seek timely care

7.3 Workforce and service quality

There is a structural determinant of the health workforce, with direct behavioural consequences, which is the shortage and maldistribution of the health workforce. Underserviced rural populations in relation to skilled people are associated with high waiting time, high workload for staff and high pressure on quality of care, which lead to low use. Whenever facilities are seen as lacking the necessary medicines, equipment and staff (courteous and competent), patients make rational decisions to postpone the use of the facility or to avoid using the nearest facility (Koce et al., 2019, 2020). Lack of coordination between levels and lack of fragmentation have an impact on efficiency and trust in the referral system. These supply-side factors align very closely with the enabling and system-responsiveness factors of Andersen's model, further supporting the notion that demand-side measures alone will fail if supply-side measures are not undertaken as well (Andersen 1995).

8. Facilitators and Enabling Strategies

In addition to the barriers, a list of facilitators (enabling conditions that support and maintain utilisation) has been identified in the literature. Financial protection such as community-based and state health insurance schemes helps mitigate financial deterrence of out-of-pocket payment and enhance initial contact and continuity of care (Amedari & Ejidike, 2021). Increasing facility coverage and geographical access, in addition to investment in transport and road infrastructure, overcomes distance barriers, and equitable distribution and retention of the health workforce ensures availability and perceived quality of care in less accessible areas.

All the same, a demand side facilitator is crucial. Culturally responsive health education educates the public, corrects misperceptions of susceptibility and severity, and enhances self-efficacy, directly activating cues-to-action and perceived-benefit constructs of the HBM. Engaging communities through trusted local figures creates acceptability and trust, which is important to understand sociocultural determinants of care seeking. Better provider communication and patient-centred practice add to patient satisfaction and redefine the beliefs that drive the use of services. Importantly, the evidence is that these facilitators work best when delivered together: health education with financial protection and better proximity and quality results in bigger and longer lasting gains in utilisation than when offered individually (Levesque et al., 2013; Nwokoro et al., 2022).

9. Integrated Synthesis

Overall, the evidence indicates that effective utilisation in Nigeria is a result of the confluence of demand side predispositions and enabling supply-side conditions. The predisposing and belief-based determinants, as emphasized by the HBM, are patient knowledge, perceptions and attitudes, which form the motivation to seek care. Whether or not that motivation is acted upon depends on enabling resources like affordability, proximity, insurance and

available competent workforce, which are the areas highlighted by Andersen's model. Patients' or professionals' perception or evaluation of the need initiates the process. The use of these elements is located at the intersection of these elements and is weak when one of these elements is missing (Andersen, 1995; Champion & Skinner, 2008).

This integrated perspective resolves the seeming paradox of high knowledge, but low use. Cost, distance, cultural preference, or distrust of quality may be the intervening factors if the patient feels susceptible, perceives the benefit of care, but is not attending. Well-resourced and close services, on the other hand, will underutilised by patients who don't feel they need it or have negative attitudes. The cost-effective implication is policy needs to address both sides at once: improving health literacy and trust and increasing financial protection, geographical coverage, and service quality. A single lever solution (either educational or infrastructural) is unlikely to be effective.

Table 2 summarises the main determinants and their direction of influence and where they are, in theory, located on the map, and offers a brief overview of the synthesis of the review.

Table 2

Summary of determinants of healthcare service utilisation in Nigeria

Determinant	Typical effect on utilisation	Theoretical location
Knowledge and health literacy	Enabling; necessary but not sufficient	HBM perceptions; Andersen predisposing
Perceived service quality	Barrier when negative; drives bypassing	HBM perceived barriers
Attitudes to formal care	Enabling when favourable	HBM perceived benefits
Sociocultural beliefs and trust	Barrier when care sought informally	Andersen predisposing; HBM beliefs
Out-of-pocket cost	Strong barrier; reduces continuity	Andersen enabling
Geographical distance	Barrier, especially rural areas	Andersen enabling
Workforce availability	Barrier when scarce or maldistributed	Andersen enabling; system responsiveness
Health insurance and subsidies	Facilitator; improves access and continuity	Andersen enabling
Health education and engagement	Facilitator; activates care-seeking	HBM cues to action, self-efficacy

Note. HBM = Health Belief Model; Andersen = Andersen's Behavioural Model of Health Services Use.

10. Gaps and Directions for Future Research

There are several gaps arising from this synthesis. First, much of the Nigerian evidence is cross sectional and single factor design, which makes it difficult to make causal inferences and difficult to model the interaction of the determinants. Long-term and multi-methods studies which track usage over time and from the demand-supply interface would make significant contributions to knowledge. Secondly, the evidence is not geographically consistent, with some states and rural populations underrepresented, and a need for facility-based studies that also draw on patient and provider and system-level data, particularly in South-West Nigeria, which would benefit from this. Third, few studies explicitly test integrated theoretical models and the interaction between HBM and Andersen constructs is only inferred and not demonstrated.

In future, it is important that theory-driven, multilevel designs be used, which simultaneously measure predisposing, enabling, and need factors; that the comparative effectiveness of combined demand- and supply-side interventions be assessed; and that the perspectives of the role of traditional and informal providers of care, which although significant, remain poorly studied, be included in the pathway of care-seeking. High-quality culturally tailored health education and financial-protection and quality-improvement initiatives, coupled with intervention research that rigorously tests these interventions and their effects, would yield the evidence for action that policy makers need.

11. Conclusion

A complex mix of patient-level, sociocultural and health system determinants influence the ability of patients to access healthcare services in Nigeria, not a single one. Knowledge, perception and attitude create disposition to seek care while affordability, proximity, quality and cultural acceptability are factors that determine the behavioural expression of this disposition. The evidence suggests that utilisation takes place when patient motivation and enabling conditions of the system are present and that these are lacking when utilisation is found to be low or non-existent, as interpreted through the Health Belief Model and Andersen's Behavioural Model.

The key take-home messages for policy and practice are the need to act in an integrated fashion. Health education, community outreach and trust-building initiatives should be combined with supply-side efforts with regard to financial protection, geographic coverage, distribution of the workforce and quality of services. In south-west Nigeria and similar places, this alignment will be crucial for making the availability of services into their actual utilization. Enhancing it is a realistic and evidence-based way to better use it and towards the ultimate aim of universal health coverage, all the while making it more equitable in use.

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