ISSN: 2230-9926

Available online at http://www.journalijdr.com

IJDR

International Journal of Development Research
Vol. 13, Issue, 05, pp. 62837-62843, May, 2023
https://doi.org/10.37118/ijdr.26786.05.2023

RESEARCH ARTICLE **OPEN ACCESS**

SOCIAL AND NON-SOCIAL FACTORS INFLUENCING ACCESS TO HEALTHCARE IN EKITI AND KOGI STATES OF NIGERIA

C. T. Oluwadare[1], K. E. Igbekoyi[1], O. A. Ijabadeniy[2] and A. A. Olurunfemi[1]

[1]Department of Sociology, Ekiti State University, Ado-Ekiti, Ekiti State
[2]Department of Sociology, AfeBabalola University, Ado-Ekiti, Ekiti State

ARTICLE INFO

Article History:
Received 25th March, 2023
Received in revised form
03rd April, 2023
Accepted 28th April, 2023
Published online 30th May, 2023

KeyWords:
Access, Availability, Healthcare,
Non-social Factors and Social Factors.

****Corresponding author:***
C. T. Oluwadare,

ABSTRACT

This study examined social and non-social factors affecting healthcare access in Ekiti and Kogi States of Nigeria. These two States represent a cultural plurality of Nigeria. Ekiti State is homogeneously Yoruba while Kogi State is heterogeneous home to at least five ethnic groups. The study adopts a descriptive research design using a quantitative method to conduct a comparative study between Ekiti and Kogi States. The study population involves all adults 18 years and above who are aware to engage in health-seekingbehaviour. The sample size for this study is eight hundred and fifty-six (856) respondents. Multi-stage sampling techniques were adopted in selecting the respondents for the study. Analysis was done using a special package social sciences (SPSS version 21) and it is presented in frequency percentage. Findings show that Kogi State has more female respondents. While Ekiti State has more respondents having above secondary school education. Kogi State also has more respondents with diverse ethnic identities and engaged in self-employed occupations. About 30% of Kogi State respondents were either widowed or divorced. Income level did not show a significant difference. Analysis of social factors of healthcare access indicated that level of education, ethnic identity, type of education, marital status and religion had a significant influence on access to healthcare. Findings on the social factors showa more significant influence in Ekiti State than Kogi State. Also, waiting time, health personnel shortage and frequent strikes were the most significant non-social factors of healthcare access in Ekiti State. In Kogi State, availability of health facilities, personnel shortage and waiting time were the most significant non-social factors of healthcare access. It was concluded that educational status and quality of health personnel are significant predictors of healthcare access. In Kogi State, the physical availability of health facilities is equally a unique non-social factor. As a result, the study recommends that Government should establish additional modern healthcare institutions to make healthcare accessibility easier for the users, and Professional staff should be recruited to various healthcare institutions to avoid patient delay and poor service delivery.

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Citation: ***C. T. Oluwadare; A. A. Olorunfemi; and K. E. Igbekoyi. 2023.*** "Social and non-social factors influencing access to healthcare in ekiti and kogi states of nigeria". *International Journal of Development Research*, 13, (05), 62837-62843.

INTRODUCTION

Achieving access to healthcare services as envisaged by Dawkins, Renwick, Ensor, Shinkins, David and Mead (2021) is an intentionally recognized worldview and aim, which was reinforced by the Universal Healthcare Movement and Sustainable Development Goals (SDGs). Nevertheless, inequalities in the healthcare sector persist among people due to differences in both social and non-social factors. It is on this note that this study intends to examine the social and non-social factors that influence access to healthcare services in Ekiti and Kogi State, Nigeria. Access to healthcare services is a fundamental human right and central to the performance of the healthcare system as posited by Dassah, Aldersay, McColl and Davison (2018).

Ideally, access to healthcare services reflects a need for care, but that is not the case for several social and non-social factors. This is not far-fetched as numerous factors affect access to healthcare services. Access to healthcare is having timely use of personnel and facilities to achieve the best possible health outcome. However, several social and non-social factors have posed a barrier to achieve its objective. According to NCHS (2018), access requires gaining entry as far as it enables patients and physicians to prevent illness, control diseases or manage chronic conditions which could avoid exacerbation or complication of health conditions.

Statement of the Problem: In the past, several studies have focused on access to healthcare service which include both social and no-social factors such as education, economic stability, community safety and availability of adequate housing and healthful food, has

shown that they correlate with healthier population (Dassah et al, 2018). The availability of newer and improved healthcare facilities does not mean that they are equally available to all persons in Nigeria (NCHS, 2018).According to World Health Organization (2018), access to healthcare service is determined by a person's individual characteristics such as behaviors, physical environment and socioeconomic status. However, the prevalence of these conditions differs by sex, age, ethnicity, employment status, and among other factors. According to World Health Organization (2018) at least half of the world's population lack access to essential health services. The table below shows the level of access to health care services in different countries.

Table 1. Indicators of level of access to health care services in various countries

Measuring Access in term of:	India	Nigeria	South Africa	United Kingdom	USA
Budgetary allocation on health	3.6	3.6	8.1	9.5	17.1
Density of doctors	7.8	3.8	9.1	28.1	25.9
Density of nurses	21.1	14.5	35.2	82.9	85.5
Life Expectancy	68.8	55.2	63.6	81.4	78.6
Maternal mortality rate	174	814	138	9	14
Under 5 mortality rate	39	100	37	4	7
Universal health coverage	56%	39%	67%	80%	80%

Source: World Health Statistics (2018)

At the global level, using the level of universal health coverage, not all individuals in the world have access to health care services. In developed countries like United State of America and United Kingdom, 20% of the population does not have access to health care services. However, this is better compared to Nigeria where a large percentage (60%) of the population depending on out-of-pocket payment in accessing health care services as averred in the work of *Oyekale* (2017). Within the sub Saharan Africa, South Africa have a better health coverage than Nigeria. The life expectancy at birth for Nigerians is also one of the lowest in the world compared to other African countries. Access to healthcare services in Nigeria worrisome and Nigeria is among the greatest burden bearers of diseases morbidity and mortalities in the world. Malaria, Tuberculosis (TB), Human Immunodeficiency Virus (HIV) and malnutrition which have disappeared or reduced in many countries are still among the active sources of death in the country. Despite the successes achieved in the last decade in many countries, malaria remains a major public health problem in Nigeria with the greatest toll on under-five children and pregnant women. According to the Nigeria Malaria Indicator Survey (2015), malaria accounts for 60% of outpatient visits and 30% of admissions in the hospitals. It causes up to 11% of maternal mortalities, 25% of infant mortalities and 30% of under-five mortalities. It also records 110 million clinically diagnosed cases and estimated 300,000 malaria-related childhood deaths yearly. Nigeria is also counted among the 14 high burden countries for TB and HIV, seventh among 30 high TB countries worldwide and second in Africa. According to Kanabus (2018), about 407,000 people in Nigeria get TB every year. The problem is further compounded with the presence of HIV. It is estimated that 63,000 HIV positive cases get TB each year and an estimated 115,00 HIV negative people die from TB. These are clear indications of poor access to health care in Nigeria and the situation is worsening considering the low expenditure on health.

It is important to know that over 90% of Nigerian households in 2021 reported being able to access necessary maternal and pregnancy healthcare when needed. Also, 22% claimed that they were unable to gain vaccination services. In fact, vaccinations were the medical service harder to access in Nigeria. Nevertheless, over 85% of adults and 88% of children were medically taken care of when needed as reported by *Sasu*(2022). The World Health Organization (WHO) target for doctor to population ratio is one per 600 (WHO, 2015). In Nigeria, there are 3.8 doctors to 10,000 population based on World Health Statistics (2018). This reduces the level of access to medical personnel and often results in prolonged waiting hours. *Salawu, Fawole and Diaro,*(2016) stressed that about 237,000 medical doctors are needed to meet the World Health Organization standard and meet the SDG No 3 goal in Nigeria. Despite the fact that malaria and chronic disease are the major cause of morbidity and mortality in Nigeria, the high cost of medication is a challenge in accessing healthcare services considering that most Nigerians leave below the poverty line

Theoretical Framework

Penchansky and Thomas Theory of Access: Penchansky and Thomas developed the theory in 1981. The theory of access according to Penchansky and Thomas is the degree of fit between the consumer and the service, which that is, the better the fit, the better the access (Saurman, 2015).

They conceptualized access into five specific dimensions to describe the fit between the patient and the healthcare system. These dimensions include; availability, accessibility, accommodation, affordability and acceptability. These dimension of access are independent yet interconnected and each is important to assess the achievement of access (Levesque, Harris,and Russell, 2013). According to Saurman (2015), awareness is another dimension of access to modified Penchansky and Thomas's Theory of access. Awareness is integral to access. This relates to the knowledge on the facilities available at the health care centre through information technology. This will aid to develop, implement or evaluate healthcare services and access. These dimensions are independent yet interconnected and each is important to assess the achievement of access. Penchansky and Thomas theory of access believe that for individual to access health care services the individual must be aware that the facility exists in the area. The accessibility in term of location will also be a determinant factor. The location must be within reasonable proximity to the consumer in term of distance and time. An available service has sufficient facilities and resources to meet the volume and needs of the consumers and community. These includes availability of medical personnel, drugs and even building. The corresponding attitude of the provider and the user regarding the nature of services rendered, social or cultural concern will determine if the services are acceptable to the people. For example, a female patient who is willing to see a female doctor will determine if a service has been acceptable or not. The cost of service render to provider, expenses on transportation and medicine will determine if service is affordable or not. The relationship between the health staffs and patient, the organizational structural, working hours, waiting time and facility structure are determinants of whether the health care service is adequate. The knowledge to the importance of accessing health facilities by health provider and the understanding of this importance by individual either the family or community level will influence the access to health care services.

METHODOLOGY

The study adopted a descriptive research design using a quantitative method to conduct a comparative study between Ekiti and Kogi States. This provided answers to research questions that are associated with the research problem. The study was conducted in two States in Nigeria namely Ekiti State and Kogi State. the study population involves all adults 18 years and above that have the consciousness to engage in health-seekingbehaviour. The sample size for this study is eight hundred and fifty-six (856) respondents. Multistage sampling techniques were adopted in selecting the respondents for the study. The first stage was a purposive selection of

the three senatorial districts in each State (for Ekiti State: Ekiti Central, Ekiti Southwest and Ekiti North, and for Kogi State: Kogi Central, Kogi East, and Kogi West). The second stage employed simple random sampling techniques in which three (3) Local Government Areas LGAs were selected from each senatorial district in both Ekiti and Kogi States. For Ekiti State, the LGAs include; Ado-Ekiti, Ilejemeje, and Ekiti East LGAs. While for Kogi State, the LGAs were Adavi, Ofu, and Lokoja LGAs. The last stage adopted a stratified sampling method, as each LGAs were stratified into the urban and rural setting in order to compare the level of access to healthcare service.Also, the sample size for the study was determined using the 'table of sample size' developed by Gill (2010), in which 1320 were selected. However, 65% of respondentswere selected from the total sampled frame thereby resulting in856 sampled size.Eight hundred and fifty-six (856) copies of questionnaires were used to gather data from the field. Analysis was done using a special package social sciences (SPSS version 21) and it is presented in frequency percentage.

RESULTS

Background Information about the Survey Respondents

Table 1. Social Characteristics of the respondents

	Ekiti State (N=418)		Kogi State (N=430)	
Age	Frequency	Percentage %	Frequency	Percentage%
Less than 20	51	12.2	37	8.6
21-30	141	33.7	149	34.7
31-40	54	12.9	150	34.9
41-50	129	30.9	56	13.0
51 Above	43	10.3	38	8.8
Sex				
Male	227	54.3	156	36.3
Female	191	45.7	274	63.7
Marital Status				
Single	169	40.4	117	27.2
Married	241	57.7	186	43.3
Widowed	-	-	73	17.0
Divorced	8	1.9	54	12.5
Educational Background				
Koranic School	23	5.5	22	5.1
Primary Education	15	3.6	58	13.5
Secondary Education	131	31.3	191	44.4
Tertiary Education	232	55.5	119	27.7
Ethnic Group				
Yoruba	239	57.2	95	22.1
Igala	17	4.1	131	30.5
Ebira	46	11.0	118	27.4
Hausa	26	6.2	21	4.9
Fulani	-	-	6	1.4
Bassa	-	-	27	6.3
Ibo	90	21.5	32	7.4
Occupation				
Schooling	100	43.1	52	12.1
Public Servant	193	34.2	108	25.1
Trading	57	13.6	206	47.9
Artisan	68	9.1	64	14.9
Religion				
Christian	309	73.9	206	47.9
Islam	109	26.1	207	48.1
Traditional	-	-	17	4.0
Monthly Income				
Below 30,000	180	43.1	188	43.7
31,000-70,000	159	38.0	141	32.8
71,000 Above	79	18.9	101	23.5

Source: Field Survey, (2020)

Table 1 above shows the demographic characteristics of respondents that took part in the study. In respect to the age bracket of respondents, in Ekiti State, it shows that 12.2% were less than 20 years, about 34% were between 21-30 years, about 13% of the respondents falls between 31-40, about 31% were between 41-50 and 10.3% were 51 years and above. While in Kogi State, about 9% were less than 20 years, about 35% of respondents were between 21-30 and 31-40 years, 13.0% claimed between 41-50 years, and about 9% were 51 years and above. What this implies is that there were more adults and active respondents in the study. The gender disparity was also revealed in Table 1. For Ekiti State, there was more males with 54.3% respondents as against female with about 45.7%. While, for Kogi State, there were more females with a large proportion of respondents as against one-quarter of the male respondents. In other words, the implication of these results shows that both males and females can or do make use of healthcare facilities. In the same table 1, the marital status of respondents was illustrated. In regard to Ekiti State, more than half of the total respondents were married while 40.4% were single and 1.9% were divorced. While Kogi State stated that 43.3% were married, 27.2% were single, 17.0% were widowed, and 12.5% were divorced. That is, the majority of the respondents both in Ekiti and Kogi State were married. In Table 1 also, the educational background of respondents was sorted out. In the case of Ekiti State, more than half of the total respondents have tertiary education followed by 31.3% of respondents with secondary education. While in the case of Kogi State, the majority of the respondents had secondary education followed by 27.7% of respondents who have tertiary education. This is to say that level of educational attainment in tertiary institutions is high in Ekiti than in Kogi State. The ethnic group of respondents was shown in Table 1.

Social factors influencing Access to Healthcare

Table 2. Relationship between Social factors and Access to Health Care Services

	Ekiti State					Kogi State				
Age	Yes	No	Total	%	X_2/P-v	Yes	No	Total	%	X_2/P-v
Less than 20	51 (100%)	0	51	*12.2*	χ^2=4.082	33 (89%)	4 (11%)	37	*8.6*	χ^2=9.447
21-30	140 (99.2%)	1 (0.7%)	141	33.7	Pv=.770	141 (94.6%)	8 (5.3%)	149	34.7	Pv=.150
31-40	54 (100%)	0	54	12.9		146 (97.3%)	6 (4%)	150	34.9	
41-50	128 (99.2%)	1 (0.7%)	129	30.9		49 (87.5%)	7 (12.5%)	56	13.0	
51 Above	43 (100%)	0	43	10.3		34 (89.4%)	4 (10.5%)	38	8.8	
Total	416	2	418			401	29	430		
Sex										
Male	218 (96%)	9 (3.9%)	227	54.3	χ^2=0.540	154 (98.7%)	2 (1.3)	156	*36.3*	χ^2=5.551
Female	184 (96.3%)	7 (3.7)	191	27.4	Pv=.462	261 (95.2%)	13 (4.7)	274	63.7	Pv=.136
Total	402	16	418			415	15	430		
Educational Background										
Koranic School	14 (60.8%)	9 (39.1%)	23	*5.5*	χ^2=34.653	15 (68.1%)	7 (31.8%)	22	*5.1*	χ^2=6.805
Primary Education	14 (93.3%)	1 (6.7%)	15	3.6	Pv=.000	57 (98.2%)	1 (1.7%)	58	13.5	Pv=.006
Secondary Education	121 (92.3%)	10 (7.6%)	131	31.3		179 (93.7%)	12 (6.3%)	191	44.4	
Tertiary Education	148 (63.7%)	84 (36.2%)	232	55.5		69 (58%)	50 (42%)	119	27.7	
Total	314	104	418			360	70	430		
Ethnic Group										
Yoruba	233 (97.4%)	6 (2.5%)	239	*57.2*	χ^2=2.408	90 (94.7%)	5 (5.3%)	95	*22.1*	χ^2=2.192
Igala	16 (94.1)	1 (5.9%)	17	4.1	Pv=.932	127 (96.6)	4 (3.1%)	131	30.5	Pv=.996
Ebira	42 (91%)	4 (8.7%)	46	11.0		111 (94.1%)	7 (5.9%)	118	27.4	
Hausa	23 (88.4)	3 (11.5)	26	6.2		21 (100%)	0	21	4.9	
Fulani	-	0	-			6 (100%)	0	6	1.4	
Bassa	-	0	-			27 (100%)	0	27	6.3	
Ibo	89 (98.8)	1 (1.1%)	90	21.5		32 (100%)	0	32	7.4	
Total	403	15	418			414	16	430		
Occupation										
Student	96 (96%)	4 (4%)	100	*43.1*	χ^2=26.388	51 (98%)	1 (2%)	52	*12.1*	χ^2=21.861
Public Servant	182 (94.3%)	11 (5.7%)	193	34.2	Pv=.000	106 (98%)	2 (2%)	108	25.1	Pv=.000
Trading	56 (98.2%)	1 (1.8%)	57	13.6		204 (99%)	2 (1%)	206	47.9	
Artisan	59 (86.7%)	9 (13.2%)	68	9.1		61 (95.3%)	1 (1.6%)	64	14.9	
Total	393	25	418			424	6	430		
Religion										
Christian	292 (94.5%)	17 (5.5%)	309	*73.9*	χ^2=13.538	197 ()	9 ()	206	*47.9*	χ^2=3.094
Islam	96 (88.1%)	13 (11.9)	109	26.1	Pv=.064	205 (99%)	2 (1%)	207	48.1	Pv=.047
Traditional	-		-			17 (100%)	0	17	4.0	
Total	388	30	418			419	11	430		
Marital Status										
Single	163 (96.4)	6 (3.6%)	169	*40.4*	χ^2=18.574	115 (98.3%)	2 (1.7%)	117	*27.2*	χ^2=0.290
Married	234 (97.1%)	7 (2.9%)	241	57.7	Pv=.017	178 (95.7%)	8 (4.3%)	186	43.3	Pv=.784
Widowed	0	0	-			69 (94.5%)	4 (5.5%)	73	17.0	
Divorced	6 (75%)	2 (25%)	8	1.9		52 (96.3%)	2 (3.7%)	54	12.5	
Total	403	15	418			414	16	430		
Monthly Income										
Below 30,000	177 (98.3%)	3 (1.7%)	180	*43.1*	χ^2=29.315	182 (96.8%)	6 (3.2%)	188	43.7	χ^2=26.324
31,000-70,000	153 (96.2%)	6 (3.8%)	159	38.0	Pv=.000	132 (94.6%)	9 (6.4%)	141	32.8	Pv=.000
71,000 Above	78 (98.7%)	1 (1.3%)	79	18.9		95 (94.1)	6 (5.9%)	101	23.5	
Total	408	10	418			409	21	430		

Source: Field Survey, (2020)

With respect to Ekiti State, 73.9% were Christian While 26.1% were Islam. In the case of Kogi State, 48.1% were Islam, 47.9% were Christian, and 4.0% were traditional worshippers. What this invariably implies is that an overwhelming percentage of respondents in Ekiti State were Christians while the majority in Kogi State were Islamic worshippers with little difference from the Christians. The monthly income of respondents was stated in Table 1. For Ekiti State, 43.1% earned below 30,000. While, 38.0% earned between 31,000-70,000, and 18.9% earned 71,000 and above. while in the case of Kogi State, 43.7% earned below 30,000, 32.8% earned 31,000-70,000, and 23.5% earned 71,000 and above. However, the implication of these results shows that the majority of the respondents both from Ekiti and Kogi State earned below 30,000, and this can have an effect in accessing healthcare facilities in the States. Data from Table 2 is analyzed using chi-square to check the relationship between the social factors and access to healthcare services in Ekiti and Kogi States. To test these hypotheses, social factors such as age, gender, marital status, educational background, ethnic group, occupation, religion, and monthly income were used to measure access to healthcare services in terms of acceptability. FromTable (2), the influence of age and access to healthcare services was shown.

It was revealed that there was no significant relationship between the age of the respondents and access to health care services in both Ekiti State (P=0.770) and Kogi State (P=0.150). As a result, what this implied is that age has no influence on the access to health care services in Ekiti and Kogi States as any age bracket can and should have access to health care services. Considering gender relationship with access to health care service, it was also revealed that there was no significant relationship between the gender of the respondents and access to health care service in Ekiti State (P=0.462) and in Kogi State (P=0.136). This was proven that gender has no influence on access to healthcare services in Ekiti and Kogi State. The marital status relationship and access to health care serviceshow that there is a significant relationship between the marital status of respondents and access to health care services in Ekiti State (P=0.017) while there is no significant relationship between marital status and access to health care service in Kogi State (P=0.784). Therefore, marital status is more effective in accessing health care services in Ekiti State than in Kogi State. With respect to the relationship between education qualification and access to health care service, there is a significant relationship between the educational background of the respondents and access to health care service in Ekiti State (P=0.000) and also in

Kogi State (P=0.006). Although, it was shown that education has much more influence on the accessibility of health care in Ekiti State than Kogi State. The relationship between the ethnic group and access to health care service, there is no significant relationship between ethnic group and access to health care service Ekiti State (P=0.093) as well as Kogi State (P=0.996). This implied that ethnic group has no influence on access to healthcare service in Ekiti and Kogi States. From the occupation relationship and access to health care services, there is a significant relationship between the occupation of the respondents and access to health care services in both States (P=0.000). This implied that occupation determines the affordability of healthcare services as it's found significant in Ekiti and Kogi States. On the part of religion and access to health care service, there is no significant relationship between the religion of the respondents and access to health care service in Ekiti State (P=0.064) while there is a relationship between the two variables in Kogi State (P=0.047). This implied that religion is more effective in accessing health care services in Kogi than Ekiti States. From the monthly income relationship and access to health care service, it was found that there is a significant relationship between the monthly income of the respondents and access to health care service in both states (P=0.000).

Non-social factors Influencing Access to Healthcare

Table 3. Regression Statistics of Non-Social Factors and Access to Health Care Service in the two states

Model (Ekiti)	R	R^2	Adj R^2	B	Std Error	T value	P Value	Rank
	0.402	0.162	0.155					
Waiting Time				.165	.078	2.831	.010	5th
Frequent Strike				.248	.014	3.369	.001	4th
Distance Challenges				.285	.023	3.689	.000	2nd
Health Facilities				.291	.021	8.948	.000	1st
Personnel Shortage				.221	.035	3.484	.001	3rd
Constant				1.127	.133	8.497	.000	
Model (Kogi)	R	R^2	Adj R^2	B	Std Error	T value	P Value	Rank
	0.204	0.050	0.038					
Waiting Time				.241	.116	2.213	.050	5th
Frequent Strike				789	.252	3.136	.002	1st
Distance				560	.193	2.895	.004	2nd
Health Facilities				224	.231	2.537	.031	4th
Personnel Shortage				396	.128	2.751	.003	3rd
Constant				1.582	.274	3.496	.000	

Source: Field Survey, (2020)

In the case of Ekiti State, Table (3) shows the unstandardized β co-efficient of prolonged waiting time gives a positive value of 0.165 with t= 2.831 and (P= 0.010 < 0.05). This result showed that prolonged waiting time has a positive effect on healthcare facilities. This means that respondents' reason for health care service is influenced by prolonged waiting time. The unstandardized β co-efficient of frequent strikes gives a positive value of 0.248 with t= 3.369 and (P= 0.001< 0.05). This result showed that frequent strike has a positive significant effect on healthcare facilities, therefore, it was found significant. The unstandardized β co-efficient of distance gives a positive value of 0.285 with t= 3.689 and (P= 0.000< 0.05). The unstandardized β co-efficient of health care facilities gives a positive value of 0.291 with t= 8.948 and (P= 0.000 < 0.05). This result showed that healthcare facilities have a positive significant effect on healthcare service, therefore, it was found significant. This means that respondents' reason for health care service is positively influenced by health care facilities. The unstandardized β co-efficient of personnel shortage gives a positive value of 0.221 with t= 3.484 and (P= 0.001< 0.05). This result showed that personnel shortage has a positive significant effect on health care service, therefore, it was found significant. In view of the above, it is visible that accessibility of health care service constructs (waiting time, frequent strikes, distance, health facilities and personnel shortage) positively influences health care service in Ekiti State. This implied that non-social factors have a more significant influence on access to health care services in Ekiti State. Table 3statesthe report for Kogi State. the unstandardized β co-efficient of prolonged waiting time gives a positive value of 0.241 with t= 2.213 and (P= 0.050 < 0.05). This result showed that prolonged waiting time has a positive effect on healthcare facilities.

The unstandardized β co-efficient of frequent strikes gives a positive value of 0.789 with t= 3.136 and (P= 0.002< 0.05). This result showed that frequent strike has a positive significant effect on healthcare facilities, therefore, it was found significant. The unstandardized β co-efficient of distance gives a positive value of 0.560 with t= 2.895 and (P= 0.004 < 0.05). This result showed that distance has a positive significant effect on health care service, therefore, it was found significant. The unstandardized β co-efficient of health care facilities gives a positive value of 0.224 with t= 2.531 and (P= 0.031 < 0.05). This result showed that healthcare facilities have a positive significant effect on healthcare service, therefore, it was found significant. The unstandardized β co-efficient of personnel shortage gives a positive value of 0.396 with t= 2.751 and (P= 0.003< 0.05). This result showed that personnel shortage has a positive significant effect on health care service, therefore, it was found significant. In view of the above, it is visible that accessibility of health care service in Kogi State constructs (waiting time, frequent strikes, distance, health facilities and personnel shortage) positively influences health care service in Ekiti State. This implied that non-social factors have a more significant influence on access to health care services in Kogi State.

DISCUSSION

The study shows that there were more adults and active respondents in the study. Also revealing from the study is that both males and females can or do make use of healthcare facilities. Findings from the study revealed the majority of the respondents both in Ekiti (57.7%) and Kogi States (43.3%) were married. Also revealing from the study is the level of educational attainment at tertiary institutions. It shows that Ekiti State with 55.5% higher than Kogi State with 27.7%. The study revealed that the majority of the respondents include the Yoruba in Ekiti State and the Igala in Kogi State. the implication here is that the States is dominated by the speaking Ethnic group. Findings from the study show that the majority of the respondents were students (Ekiti State) and traders (Kogi State). Revealing from the study is that an overwhelming percentage of respondents in Ekiti State were Christians whilethe majority in Kogi State were Islamic worshippers with little difference from the Christians. The study shows that the majority of the respondents both from Ekiti and Kogi State earned below 30,000, and this can have an effect in accessing healthcare facilities in the States. Data from the study revealed that there was no significant relationship between the age of the respondents and access to healthcareservices in both Ekiti State (P=0.770) and Kogi State (P=0.150). Although, access to modern health care is closely related to child survival, a number of barriers prevent many people from access. Consequently, poor access to healthcare services presents a daunting challenge to the attainment of the Millennium Development Goals (MDG) in many countries (*Adedini, Odimegwu, Bamiwuye, Fadeyibi,and Wet,* 2017). The findings from the study show that there was no significant

relationship between the gender of the respondents and access to healthcareservices in Ekiti State (P=0.462) and in Kogi State (P=0.136). This is because there is no gender barrier in accessing healthcare services. This is because there is no gender barrier in accessing healthcare services. However, it was believed that females have higher access to healthcare services than the male. This is because the female that is in their reproductive stage receive healthcare due to childbearing. Several studies have shown that women make more visits and receive more diagnostic, screening, diet, nutrition, counselling and sexual health services. While men generally have high rates of visits to healthcare due to obesity and cardiovascular problems as envisaged by Kalseth and Halvorsen (2020). Nonetheless,NCHS's (2018) view contradicted this finding by stating that sexual inequalities exist in every sphere of societies, as women are discriminated especially in politics, inheritance, and among others. Women have limited access to assets and services such as education and health care, resulting in their being socio-economically dependent on men.

The study also revealed that there is a significant relationship between the marital status of respondents and access to health care service in Ekiti State (P=0.017) while there is no significant relationship between marital status and access to health care service in Kogi State (P=0.784). There is a growing body of research regarding the influence of education on access to healthcare. Even in developed nations, it has been observed that those with lower educational attainment suffer from accessing healthcare compared to those with higher educational status (Raghupathi and Raghupathi, 2020). It is on this note that findings from the study show that there is a significant relationship between the educational background of the respondents and access to health care services in Ekiti State (P=0.000) and also in Kogi State (P=0.006). Although, it was shown that education has much more influence on the accessibility of health care in Ekiti State than Kogi State. Therefore, the finding implied that educational background significantly influences the choice of accessing healthcareservices in Ekiti and Kogi State. These findings collaborate with the study carried out by Mekonnen and Worku (2017) thataccess to modern healthcare services increases with educational attainment. Also, ethnic disparity is found in many places, especially in Nigeria. Ethnic segregation is a key mechanism through which nepotism or tribalism produces and perpetrates social disadvantages (Kalseth and Halvorsen, 2020). Revealing from the study shows that there is no significant relationship between ethnic group and access to health care service Ekiti State (P=0.093) as well as Kogi State (P=0.996). The findings, it revealed that there is a significant relationship between the occupation of the respondents and access to health care services in both States (P=0.000). This implied that occupation determines the affordability of health care services as it's found significant in Ekiti and Kogi States.

These findings supported is supported by the National Academy of Sciences (2018) supported that well-paying work provides the individual with the financial means to access healthcare services. That is, access to healthcare is tied to the affordability of the patient's level of income. Also revealing is that there is no significant relationship between the religion of the respondents and access to health care service in Ekiti State (P=0.064) while there is a relationship between the two variables in Kogi State (P=0.047). This implied that religion is more effective in accessing health care services in Kogi than in Ekiti States. This is said to be true as the preference for traditional medicine was an important barrier to accessing effective healthcare. This, however, reflects cultural differences and the acceptance of medical pluralism as stated by Dawkins et al (2021). Low income or lack of access to money has been shown to be the most common barrier to accessing healthcare services. Therefore, the affordability of healthcare services is critical to patients. More so, health providers have noted that the provision of low-cost or free healthcare services will ensure equitable access (National Academy of Science, 2018). Findings show that there is a significant relationship between the monthly income of the respondents and access to healthcare services in both states (P=0.000). These findings also supported the finding of *Alawode and Lawal*(2018) that richer people have better access to healthcare services because they can afford goods and services, and medical care facilities. Based on the result from Ekiti and Kogi States, it was found in the model summary (regression coefficients) that there is a moderate relationship between non-social factors and healthcare services in Ekiti and similarly Kogi States. However, based on the coefficient values, Ekiti State is found to be more effective due to the higher value than Kogi State. This implied that non-social factor significantly influences access to health care services in Ekiti State more than Kogi State. Furthermore, it was found that based on the ranking of the T-values health facilities, distance and personnel shortage among other non-social factors influences access to health care services most in Ekiti State while in Kogi State, frequent strike, distance and personnel shortage influences health care service most. Therefore, health care facilities influence most in Ekiti State while strike action influences most in Kogi State thus implying that non-social factors significantly influence access to health care service in both states but are more effective in Ekiti State as revealed by the regression analysis. To test this hypothesis, five variables (waiting time, frequent strikes, distance, health facilities and personnel shortage in Ekiti State) were used to measure the accessibility of health care services which were subjected to regression analysis. From Table 3, the R (Regression Coefficient) gives a positive value of 0.402; this indicates that accessibility of healthcare services has a moderate effect on healthcare facilities. The R^2 is a portion of the total variation in the dependent variable that is explained by the variation in the independent variables. From the results obtained, R^2 is equal to 0.162, this implies that accessibility of health care service bought about a 16.2% variance in healthcare facilities, this is further proven by the adjusted R^2 that shows the goodness of fit of the model which gives a value of 0.155, implying that when all errors are corrected and adjustments are made the model can only account for 15.5% of accessibility of health care service in the surveyed local government area.

To test this hypothesis, seven variables (waiting time, frequent strikes, distance, health facilities and personnel shortage in Kogi State) were used to measure the accessibility of health care services which were subjected to regression analysis. From Table 4.20, the R (Regression Coefficient) gives a positive value of 0.224; this indicates that accessibility of healthcareservices has a moderate effect on healthcare facilities. The R^2 is a portion of the total variation in the dependent variable that is explained by the variation in the independent variables. From the results obtained, R^2 is equal to 0.050, this implies that accessibility of healthcare service bought about a 5.0% variance in healthcare facilities, this is further proven by the adjusted R^2 that shows the goodness of fit of the model which gives a value of 0.038, implying that when all errors are corrected and adjustments are made the model can only account for 3.8% of accessibility of health care service in Kogi State. These findings from the two States corroborate the study conducted by Dassah et al (2018). With respect to waiting time, the time frame that can be provided to patients is an important determinant of healthcare access. They further stressed that waiting time can take over half a day on average. Also, with respect to distance, it is noted that the proximity of patients to healthcare facilities is a major concern, as it was reported most healthcare facilities were located in urban areas. Thus, patients especially in the rural areas or new sites had to travel long distances to reach the healthcare centers. Lack of health infrastructure like drugstores, or limited supply of drugs, medical equipment and laboratories as well as limited healthcare centres hinder health access as averred by Dassah et al (2018). With regard to human resources, the healthcare service is hampered by the lack of healthcare personnel. The limited number of healthcare personnel was however attributed to the difficulties in recruiting healthcare personnel due to low salaries, hence, the consistent industrial strike actions. With respect to frequent strike, a study conducted by Oleribe, Udofia, Oladipo, Ishola and Taylor-Robinson (2018) affirmed this study by stressing that the healthcare services in Nigeria has suffered greatly from consistent and persistent industrial actions over the years, and this has resulted in multiple avoidable mortalities and morbidities in Nigeria as patients were unable to access the healthcare service during the strike action.

Conclusion and Recommendations: This study examined social factors influencing access to health care services in Ekiti and Kogi States, Nigeria. Eighth hundred and forty-eight (848) questionnaires were returned and analyzed which represented approximately 99% of the sample size of this study. Data collected were analyzed through the adoption of frequency tables, chi-square and regression (Statistical Package for Social Sciences) at a 5% level of significance. Based on the findings, social demographic and social factors are analyzed through frequency tables, chi-square and regression. However, it was found that only educational background, occupation, marital status and income significantly influence access to healthcare services while age, gender, ethnic group and religion do not determine the accessibility of health care services in Ekiti and Kogi States. The study concluded that accessibility of health care services is positive and significant in Ekiti and Kogi States, Nigeria. The study, therefore, recommends that; Government should establish additional modern healthcare institutions to make healthcare accessibility easier for the users, and Professional staff should be recruited to various healthcareinstitutions to avoid patient delay and poor service delivery.

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