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EFFECT OF POVERTY ON HEALTHCARE ACCESSIBILITY AMONG PREGNANT WOMEN: A STUDY OF JINO COMMUNITY OF BATAGARAWA LOCAL GOVERNMENT AREA, KATSINA STATE, NIGERIA

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ABSTRACT: This paper investigated the effect of poverty on healthcare accessibility among pregnant women in Batagarawa Local Government area, Katsina state. The Objectives of the study include assessing the correlation between poverty and healthcare availability, identifying barriers to accessibility to healthcare services, and understanding health outcomes in impoverished regions. The paper adopted a triangulation method of data collection that elicits information from primary sources. A total of 45 questionnaires were administered to generate qualitative data which were analysed using tables and simple percentages. In-depth interviews were also conducted with two residents, two healthcare providers and three community leaders. The vicious circle of poverty theory was used to guide the study. The findings revealed the effect of poverty on healthcare accessibility among pregnant women. Recommendations emphasized the necessity of targeted interventions, improved infrastructure, and community engagement to enhance healthcare accessibility in rural areas, mitigating the adverse effects of poverty on overall health outcomes.

Keywords: Accessibility, Effect, Healthcare, Katsina State, Pregnant Women, Poverty

INTRODUCTION

There is a debate among academics, policymakers, elites and professionals on accessibility to healthcare in low-income nations (Trani et al., 2011). The need for the link between poverty and poor health has long been acknowledged by the scientific community. Social scientists have concentrated their efforts on investigating the link between socioeconomic status and health conditions such as mortality, morbidity as well as nutrition. This has encouraged a focus on individual capabilities and conceptualization of poverty. The causes of poverty in rural regions vary and can be determined by other variables such as culture, gender, climate and government policies (Khan, 2001).

Rural poverty constitutes almost 63% of world poverty, and it is estimated that over half of the rural population in sub-Saharan Africa lives in absolute poverty (Avery, 2016; Rowson, 2011). With regard to Nigeria, the National Bureau of Statistics (2020) estimates that more than 82 million Nigerians are poor and 52% reside in rural regions. It is important to note, however, that if poverty was measured in terms other than economic poverty, the estimate of poverty incidence in Sub-Saharan Africa would decrease (Sahn and Stifel, 2012). Adults' health has an impact on their capacity to work, which in turn impacts household well-being, including the development of children (Asenso-Okyere et al., 2011).

The quality of treatment, geographical accessibility, availability of the correct type of care for individuals in need, financial accessibility, and acceptance of services are all factors in gaining access to healthcare services (Peters et al., 2008). The underutilization of public health services in underdeveloped nations has been a worldwide issue (Zwi, 2001). Poverty may also be linked to a lack of access to adequate health care and services in developing nations, notably in sub-Saharan Africa. With a per capita expenditure of US$ 9.44, Nigeria's health system is ineffective and badly underfunded (World Bank, 2010).

Nigeria continues to have one of the poorest health indices in the world, accounting for 10% of all maternal fatalities worldwide. Medical physicians, according to research, have a high incidence of absence (approximately 40%), particularly in rural locations (Hamid et al., 2005). Geographic factors such as population density, remoteness, and a lack of services all have an impact on healthcare delivery in rural areas, and these are the typical travel problems that rural residents face (Chipp et al., 2010; Regan and Wong 2009). According to Brem et al. (2006), distance is a negative impact on healthcare services for patients in rural locations compared to those in metropolitan areas. According to Chipp et al. (2010), rural residents lack access to medical specialists and consultants such as oncologists, psychiatrists, and cardiologists. According to Nwabu (2008), a home's poor status restricts the types of healthcare, health-enhancing, and no health items that members of the household may consume, and people are presumed to pick up their healthcare services. Rural development is interested in healthcare availability and usage because they are important aspects of well-being and components of human capital (Aghion et al., 2010). In rural locations, where physical occupations are more plentiful, access to and use of healthcare are likely to be more essential than education in influencing labour productivity. This study investigated the profound impact of poverty on healthcare accessibility within the Jino Community Batagarawa Local Government, an area of Katsina State.

Conceptual clarification

Accessibility

Accessibility is ensuring the ability of everyone, regardless of disability status, to have access, use, and benefit from their environment. This means making sure that people with disabilities have access to the physical environment, transportation, information and communications and to other facilities and services that are open or provided to the public, on an equal basis to others. Accessibility means having the necessary conditions to reduce or eliminate the barriers that hinder the full and effective participation of people with disabilities on an equal basis with others.

Healthcare

The term healthcare services or medical care refers to any service offered to patients by healthcare providers for example, an individual or an entity operating under the leadership of a healthcare professional who perform the functions of diagnosis, prevention, or treatment of a disease or impairment inter alia assessing the human beings healthcare (Sosic, et al., 2008).

Problem statement

The effect of poverty on healthcare accessibility among pregnant women is a vital issue impacting maternal morbidity, maternal mortality, and child health. Pregnant women living in poverty face numerous challenges in accessing necessary prenatal and postnatal care. These barriers include financial constraints, lack of transportation, inadequate health insurance, and limited availability of healthcare facilities in low-income communities. Consequently, these women are at a higher risk of experiencing complications during pregnancy and childbirth, leading to adverse health outcomes for both the mother and the child. Hence again, lack of awareness, dilapidated healthcare buildings, unqualified staff, and ineffective medicine contribute to complications during pregnancy. Such as eclampsia, preeclampsia, infection, bleeding, and anaemia. Understanding and addressing these barriers is essential to improving healthcare accessibility and ensuring better health outcomes for pregnant women living in destitute conditions.

LITERATURE REVIEW

This section of the paper examines relevant literature regarding the effect of poverty on healthcare accessibility among pregnant women.

Effect of Poverty

According to Obadan (1997), poverty has a wide range of characteristics, including a lack of purchasing power, exposure to risk, malnutrition, a high mortality rate, a short life expectancy, a lack of access to social and economic services, etc. Poverty manifests itself in a variety of ways, including hunger, malnutrition, poor health, restricted or no access to education and other basic services, an increase in morbidity and mortality from illness, homelessness, an inadequate, unsafe, and degraded environment, and social exclusion and discrimination (Shaba, Obansa, Magaji & Yelwa, 2018).

Causes and Consequences of Poverty

Yahie (1993) confirmed in his study that the factors that cause poverty include: (a) structural causes, which are more long-term and depend on a variety of exogenous factors, such as limited resources, a lack of skills, geographic disadvantage, and other factors that are inherent in the social and political set-up; and (b) transitional causes, which are prima facie causes of poverty.

According to Yahie (1993), the causes of poverty are (a) structural causes, which are more long-lasting and dependent on a variety of exogenous factors, including a lack of resources, a lack of skills, geographic disadvantage, and other factors that are inherent in the social and political structure; and (b) transitional causes, which are primarily caused by structural adjustment reforms and changes in domestic economic policies and may cause price changes and unemployment. Obadan (1997) names a number of elements as the root causes of poverty, including a lack of access to markets, a lack of physical resources, a lack of employment opportunities, the depletion of natural resources, a lack of influence over the creation of development initiatives, and a lack of access to assistance for those who are marginalized.

De Haan (2000) noted that social exclusion on a broad scale may also contribute to poverty. The multidimensional poverty index and the UNDP's human development index list education as one of the main determinants of human development. The relationship between poverty and illiteracy is strong, and it appears to be both a cause and an effect of poor people, feeding the cycle of poverty (Kambon & Busby, 2000).

Theoretical framework

This theory was first introduced by Nurkse (1953). This theory explains the situation of poor families in which the head of household (HOH) is unable to meet the basic needs of the household such as food, clothing, shelter housing, education, and many others (Bass, 2011). Poverty will continue to be inherited by future generations if the earlier HOH is still unable to meet all the basic needs. Nurkse (1953) described his theory as follows a source of income in developing countries that has not yet fully developed will cause the whole household to the same poverty.

According to the vicious cycle of state demand, low income will cause low purchasing power among poor people as a result of equally low productivity. Thus, this chain will indirectly reduce their ability to save and invest. On the supply side, low income will also result in low saving power capacity. This is everywhere. The previous structure of society regarded farmers, teachers, ranchers and others at a lower level before the level of slave. Currently farmers, ranchers and others are more advanced within the middle-class community. Those who are perceived as poor are now homeless people, the group who make their own choices for their lives.

The vicious circle of poverty in Nigeria is intricately tied to health insecurity, forming a complex interplay that perpetuates socioeconomic challenges. Widespread poverty limits access to quality healthcare, as individuals struggle to afford essential services. Moreover, pervasive health insecurity, marked by a disease and inadequate medical infrastructure, hinders workforce productivity and economic development. This symbiotic relationship deepens poverty, creating a cycle where the impoverished struggle with compromised health and compromised health reinforce poverty. Breaking this cycle necessitates integrated strategies addressing healthcare accessibility, poverty alleviation, and overall socioeconomic development.

METHODOLOGY

Study Area

Jino is a community in Batagarawa Local Government Area of Katsina State and is four kilometres away from the state capital. The target population of this study is fifty (50). The predominant occupation in the area farming and is a Hausa community.

Sampling Technique and Sample Size

A random sampling technique was used to select the respondents in the area. A sample size of forty-five respondents was considered the size of the target population.

Method of Data Collection

Interviews and questionnaires were utilized for data collection in the study. Forty questionnaires were used to elicit the required information from the respondents. Furthermore, five participants were interviewed to furnish the needed information. The questionnaires contained both open-ended and close-ended questions, while the qualitative data were collected via in-depth interviews.

Research design

This study used a survey design with a methodological triangulation approach (quantitative and qualitative) to collect data from respondents. The quantitative data were collected through questionnaires administered to the sample respondents of Jino Community. The qualitative data were obtained through in-depth interviews (IDIs) with five (5) community members.

Data Analysis

The data gathered from the interviews as well as the questionnaires were analysed accordingly as follows:

Table 1: In which way does poverty affect pregnant women in the Jino Community?

Response	Frequency	Percentage
Malnutrition	17	37.8
Inability to access healthcare services	20	44.5
Lack of economic empowerment	8	17.8
Total	45	100

Source: Field Work (2024)

A total of seventeen respondents said that, a lack of nutrition had a negative impact on pregnant women in the Jino Community, twenty said that they were unable to access healthcare services, while, eight of them affirmed that a lack of empowerment was a factor associated with the effect of poverty on pregnant women in the area. This means that the inability to access healthcare services and lack of nutrition are the dominant factors of poverty that affect pregnant women in Jino the Community. According to an interviewee who described how poverty affects pregnant women:

> Poverty can derail any kind of suffering for any person, so long as one remains in poverty, and may live in a destitute living condition. In addition, health issues in this country have become marketized, if one is rich and can have the best healthcare services including all his or household members, those who remain in poverty will receive the poorest kind of health treatment (IDI, religious cleric).

Table 2: The Jino community has adequate primary healthcare facilities

Response	Frequency	Percentage
Strongly agree	18	40
Agree	15	33.4
Undecided	7	15.6
Disagree	2	4.5
Strongly disagree	3	6.7
Total	45	100

Source: Field Work (2024)

The above table shows that about 33 of the respondents (73.4) percent strongly agreed and agreed that the Jino Community has a primary healthcare facility, while, seven of were undecided and five strongly disagreed. This means that the Jino Community has primary healthcare facilities. During an interviewee conducted with a participant:

> I can't say anything about that, because it is out of imagination. The whole community has only one primary healthcare facility, and the staff are not well trained. The most disturbing thing is that, the premise is not hygienic one can contact with multiple infections, (district head).

Table 3: Does Jino have enough healthcare professionals?

Yes	5	11.1
No	40	88.9
Total	45	100

Source: Field Work (2024)

Five respondents (11.1%) answered ''Yes'' while 40 respondents (88.9%) said 'No". This indicates that Jino does not have enough healthcare personnel.

During an interviewee session, the participants said:

> It is unfortunate that the staff working in the community are unqualified to the very sense of humility. You can differentiate between staff and patients. The way their staff are addressing very poor. One can say that those people who have not attended primary school talk less about higher institutions, (IDI, Women's Leader).

Table 4: Drugs are available and adequate and healthcare facilities in the Jino Community

Response	Frequency	Percentage
Strongly agree	5	11.11
Agree	5	11.11
Undecided	5	11.11
Disagree	15	33.33
Strongly disagree	15	33.33
Total	45	100

Source: Field Work (2024)

The above table shows that fifteen respondents are strongly agreed, five strongly agreed, and five undecideds, while thirty respondents are strongly disagreed. This implies that the Jino Community does not have adequate or effective drugs or primary healthcare facilities. During an interview session held with a participant, he stated:

> The medicine provided for the clinic is pure and qualitative and the medicine is registered and has a number of NAFDACs; however, it is inadequate to serve the number that visit the clinic on a daily basis, which is the challenge we face on this issue of drugs supply, (IDI, pharmacy).

DISCUSSION OF THE MAJOR FINDINGS

The findings revealed that there is a stark disparity in healthcare access between the rich and the impoverished families in the community. Moreover, there is a dearth of health facilities in the community to meet the demands and aspirations of the community. The study further revealed that Jino community does not have enough healthcare personnel. The drugs are scarce.

Conclusion

The paper concluded that poverty impacted negatively on maternal and child development The paper also, pinpointed that government, stakeholders, and nongovernmental organizations should take urgent measures to address the problem of poverty and health-related problems in the community to minimize the level of morbidity and mortality among pregnant women in the community.

Recommendations

Based on the findings the study recommends the following:

1. There is a need for poverty alleviation programmes in the community to empower the entire community with particular reference to women.
2. The government and other stakeholders should embark on massive community enlightenment campaigns in relation to poverty and health issues.
3. The paper emphasized the need for collaborated intervention, improved infrastructure, and community engagement to enhance healthcare accessibility in rural areas, mitigating the adverse effects of poverty on overall health outcomes.
4. The government should employ health workers in communities with good payrolls and housing estates, which can minimize the level of difficulties faced by pregnant women during delivery.
5. The State Ministry of Health should provide adequate and free drugs in the community.

REFERENCES

Aghion, P., Howitt, P., & Murtin, F. (2010). The relationship between health and growth: When Lucas meets Nelson Phelps (No. w15813). National Bureau of Economic Research.

Asenso Okyere, K., Asante, F. A., Tarekegn, J., & Andam, K. S. (2011). A review of the economic impact of malaria in agricultural development. *Agricultural Economics, 42*(3), 293-304.

Avery, K. (2016). *The least developing countries: Closing the technological gap*.

Brems, C., Johnson, M. E., Warner, T. D., & Roberts, L. W. (2006). Barriers to healthcare as reported by rural and urban interprofessional providers. *Journal of Interprofessional Care, 20*(2), 105-118.

Chipp, C., Dewane, S., Brems, C., Johnson, M. E., Warner, T. D., & Roberts, L. W. (2011). "If only someone had told me…" lessons from rural providers. *The Journal of Rural Health, 27*(1), 122-130.

De Haan, A. (2000). Social exclusion: Towards a holistic understanding of deprivation. In G. Koherdorfer Lucius & B. Pleskovic (Eds.), *Inclusion justice and poverty reduction* (Villa Bosig Workshop Series, 1999). German Foundation of International Development, Berlin.

Hamid, S. A., Sadique, Z., Ahmed, S., & Molla, A. A. (2005). Determinants of choice of healthcare providers: Evidence from selected rural areas of Bangladesh. *Pak. J. Soc. Sci., 3*(3), 437-444.

Khan, M. M. H. (2001). *Rural poverty in developing countries: Implications for public policy*. International Monetary Fund.

Kambon, A., & Busby, L. (2000). Education and its implication on poverty: Equity or exclusion. UNESCO.

Krishna, A. (2007). Poverty and health: Defeating poverty by going to the roots. *Development, 50*(2), 63-69.

LE Bass. (2011). Family structure and child health outcomes in the United States. *Sociological Inquiry, 81*(4), 527-548.

Nurkse, R. (1953). *Problems of capital formation in underdeveloped countries*. Oxford University Press.

Obadan, M. (1997). Analytical framework for poverty reduction: Issues of economic growth versus other strategies. In *Proceedings of the Nigerian Economic Society Annual Conference on Poverty Alleviation in Nigeria 1997* (pp. 1-18). Nigerian Economic Society.

Peters, D. H., Garg, A., Bloom, G., Walker, D. G., Brieger, W. R., & Hafizur Rahman, M. (2008). Poverty and access to health care in developing countries. *Annals of the New York Academy of Sciences, 1136*(1), 161-171.

Rowson, M. (2011). Poverty and health. *Student British Medical Journal, 9*, 1-3.

Sahn, E. D., & Stifel, D. C. (2012). Progress towards the Millennium Development Goals in Africa. Cornell University.

Sheba, N. Y., Obansa, S. A. J., Magaji, S., & Yelwa, M. (2013). Analysis of the relationship between income inequality and poverty prevalence in selected north central states of Nigeria. *Applied Economics and Finance, 5*(3), 22-33.

Sosic, Z., Zvonko, V., Donev, D., & Doncho, M. (2008). Community health course at school of public health Andrija Stamper, School of Medicine University of Zagreb. *INTED 2008 Proceedings*, 5585-5595.

Trani, J. F., Browne, J., Kett, M., Bah, O., Morlai, T., Bailey, N., & Groce, N. (2011). Access to health care, reproductive.

World Bank. (2008). *Nigeria demographic and health survey*. Retrieved from http://www.microdata.worldbank.org/index.php/catalog/1459/

Yahie, A. M. (1993). The design and management of poverty alleviation projects in Africa: Evolving guidelines based on experience. World Bank EDI Human Resources Division.

Zwi, A. B. (2001). Private health care in developing countries. *British Medical Journal, 323*, 464–466.