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Healthcare Services and Rural Development in Nigeria

[1]Bukie, Fidelis Bukie; [2]Evaristus Akpanke Ushie; [3]Eni, Joseph S.; & [4]Lekam, Blessing

[1]Department of Social Work, University of Calabar, Cross River State, Nigeria
[2,3&4] Department of Sociology, University of Calabar, Cross River State, Nigeria

Abstract

The study examined the relationship between healthcare services and rural development in Nigeria. Primary data were collected using structured questionnaire and IDI guide to reach 440 rural dwellers in Bakassi Local Government Area, Cross River State, Nigeria. Percentage, Chi-square were used in analysing the data the quantitative data while content analysis was used to analyse the qualitative data. The result showed that, strong relationship between healthcare services and rural development in Nigeria. The study recommended among other things that While there is a strong desire to equip existing health care provisions with human resources, medical equipment, and supplies, new ones should be made available to communities that lack health centres. This is to promote proximity, enhance easy accessibility, and encourage regular hospital consultation.

Keywords*: Healthcare facilities, cross-sectional, socio-economic development, Job Performance, sustainable development, empowerment opportunities, and rural area, Nigeria*

Introduction

Health care services are regarded to be of utmost significance, and individuals, belonging to all age groups and backgrounds need these services (Jaysawal, 2015; Okon, 2018). It is against this background that government in all countries, regardless of their level of economic development, struggle to achieve health equity and to meet the health needs of their populations, especially vulnerable and disadvantaged groups. One of their most complex challenges is ensuring people living in rural and remote locations have access to quality health services. This is because good healthy is a fundamental requirement for living a socially and economically productive life. Healthcare access and utilization are of major interest to rural development, because they are vital elements of well-being and components of human capital (Aghion et al., 2010). In rural areas, where physical jobs tend to be more abundant, healthcare access and utilization stand to be more important than education in determining labour productivity. Health care is not demanded for itself but for the advantages that can be derived from being healthy.

Nigeria has one of the worst health indices in the world with a health system that is grossly under-funded with a per capita expenditure of US $9.44 (World Bank, 2010; Okpa, *et al*, 2021). Many low-income countries, Nigeria inclusive, have not been able to meet the basic healthcare needs of their people, especially those in the rural areas. In Nigeria, there has been a growing recognition of the challenge of rural people's health issues and the need for it to be addressed (Hamid et al., 2005; Okpa & Ekong, 2017). Healthcare services is critical to good health, yet rural residents face a variety of access barriers. There is a huge shortage of qualified practitioners in the rural areas. Accessing health care in rural areas is confounded by problems such as insufficient health infrastructure, the presence of chronic diseases and disabilities, socioeconomic and physical barriers (Ricketts, 2009; Ebingha, *et al*, 2019). All these barriers put together limit the ability of rural dwellers to obtain and access the type of healthcare they need. In order for rural residents to have sufficient access, necessary and appropriate healthcare services must be available and obtainable in a timely manner. This to a large extent will guarantee rural development (Peter *et al*, 2020). This paper is interested in answering the question, what is the

relationship between healthcare services and rural development in Nigeria with Bakassi LGA as the unit of analysis.

Methods

This study adopted cross-sectional survey research design in studying the relevance of healthcare services and rural development in Nigeria. Ethical approval was obtained from the University of Calabar Ethical Committee before commencement of the study. Informed consent was obtained from all participants. The study purposively selected rural communities from Bakassi local government area in Cross River state Nigeria. The Local Government Area was created in 1996 from Akpabuyo Local Government Area. It had 10 traditional council wards (Abana, Akpa Nkanya, Akwa , Ambai Ekpa, Amoto, Archibong, Atai Ema, Efut Inwang, Ekpot Abia and Odiong) until 2002 when International Court of Justice (ICJ) judgment ceded Bakassi to the Republic of Cameroon. The judgment ceded in entirety the aforementioned traditional wards of former Bakassi to Camaroon. But in order not to lose one Local Government Area out of the 774 Local Government Areas in Nigeria, it became imperative that Cross River State Government invoked section 8 (4) of 1999 Constitution of Nigeria and enacted Cross River State Law No. 7 of 2007 which carved the three former wards of Akpabuyo (Ikang North, Ikang Central and Ikang South) to become the new Bakassi. This gave rise to Bakassi now having 10 numerical wards 1-10 instead of the former traditional named wards. The inhabitants are agrarian communities with predominant subsistence agricultural practices. Their markets are the major pull factors that attract people from far and near to trade in mainly food items and other domestic consumables at home.

The language spoken is Efik and English with a mixture of other ethnic languages in Nigeria such as Hausa, Yorubas, Nupe, Tiv and Igbo. The population for this study was all drawn from all the communities that made up Bakassi local government area, the study population comprises of persons who have stayed at least one year in the study areas. Data were collected from participants with the use of questionnaire in the communities selected for the study, which are Ikang North, Ikang Central and Ikang South. The respondents were required to tick their level of agreement for each statement. The instrument was validated by senior lecturers in the department of Sociology and two from educational measurement research and evaluation, from the University of Calabar. The reliability instrument was established using test re-test method. The reliability index ranged 0.83. This was selected using purposive sampling method to cut across and represent diverse qualities of the demographics of the communities. Four hundred and twenty questionnaires were gotten back from the study area out of four hundred and forty-four that was randomly distributed in selected areas. The data collected were analysed using descriptive and inferential statistics. Frequency count and percentage were used to analyse the demographic data and personal information of the respondents. Likert scale was developed and used to scale responses from respondents on the objective of the study. All the analyses were done using SPSS 21 version. The consent of community leaders was sought before carrying out the exercise and so respondents were not coerced, they accepted to respond to the questionnaire, prior to the administration of the questionnaire the respondents were made to understand that they are free to discontinue with the study at will. The views of the respondents were treated with confidentiality.

Results

The results presented in Table 1 showed that 234 (55.7%) were males while 186 (44.3%) were females. With regards to age, 131 (31.2%) were aged between 28-37 years, 120 (28.6%) were aged between 38-47 years and 75 (17.8%) were aged between 48-57 years. In terms of marital status, 245 (58.3%) were single and 151 (36.0%) were married. With regards to religion, 396 (94.3%) were Christians, 2 (0.5%) were Islam and 22 (5.2%) traditional religion. For educational status, 120 (28.6%) respondents had primary education. 166 (39.5%) had secondary education

and 48 (11.4%) had tertiary education. In terms of occupational status, 101 (24.0%) were farmers, 148 (35.2%) were traders/businessmen or women, 54 (12.8%) were civil servant and 78 (18.6%) were unemployed. With regards to monthly income, 201 (47.8%) earned less thanN20, 000, 152 (36.2%) earned between N20,000-N50,000 and 67 (16.0%) earned from N51,000 and above.

Health care services and socio-economic well-being rural development

The results in Table 1 showed that l66 (39.5%) respondents acknowledged that there are existing health care facilities in their communities while 254 (60.5%) respondents indicated that such facilities do not exist in their communities. Again, 120 (72.3%) respondents indicated that the available health facilities were completed, 46 (27.7%) respondents indicated that the available health facilities were on going, while no respondents indicated that no health facility project was abandoned. With regards to the type of implementing organization or partners involved in executing health care services, 148 (89.1%) indicated that most healthcare services were provided by the government and 18 (10.9%) respondents indicated that the healthcare services were provided by the benefitting communities. Out of 420 respondents, 140 (33.3%) admitted that the provision of healthcare services has improved the rural development, while 280 (66.7%) indicated otherwise.

TABLE 1: Healthcare provision and rural development

Variables	Number of respondents	Percentage
Existence of health care provision in communities		
Exist	166	39.5
Do not exist	254	60.5
Total	420	100
Nature of health care provision in communities		
Completed	120	72.3
Abandoned	0	0.0
On-going	46	27.7
Total	166	100
Type of organization or partners involved in executing health care provision		
Government	148	89.1
Benefitting community	18	10.9
Non-governmental organization	0	0.0
Do not know	0	0.0
Total	166	100
Provision of health care infrastructure has improved the socioeconomic wellbeing of the people		
Has improved	140	33.3
Has not improved	280	66.7
Total	420	100

Source: Fieldwork

As presented in Table 2, the provision of health care and rural development as indicated by respondents mostly include; 140 (100%) treatment of diseases, 126 (90.0%) prompt access to health information, 120 (85.7%) increased employment opportunities for community members as health worker and auxiliary staff, 102 (72/8%) Improvement in maternal and child health outcome, 100 (71.4%) increase household income generation for employed community members, 90 (643%) increased access to affordable health care and 70 (50.0%) increase household income generation for employed community members.

TABLE 2: Health care provision and rural development

Variables	Yes (%)	No (%)	Total (%)
Increased access to affordable health care	90(64.3)	50(35.7)	140(100)
Increased employment opportunities for community members as health worker and auxiliary staff	120(85.7)	20(14.3)	140(100)
Prompt access to health information	126(90.0)	14(10.0)	140(100)
Treatment of diseases	140(100)	0(0.0)	140(100)
Increase household income generation for employed community members	70(50.0)	70(50.0)	140(100)
Increase household income generation for employed community members	100(71.4)	40(28.6)	140(100)
Improvement in maternal and child health outcome	102(728)	38(27.2)	140(100)

Source; Fieldwork

Health care provision and rural development

Participants in all eight communities where IDI was conducted acknowledged the availability and accessibility of healthcare services. However, some participants complained about the distance they had to travel to other communities to access quality healthcare and, as a result, requested a health centre to be built in their community for close proximity. According to a 27 years old female participant:

We have a health centre here where we go to complain about our health problems, and the health workers there will give us drugs. Sometimes, we deliver our babies there.

Another participant acknowledged the existence of a facility in their community. The summary of 34 years old participant is reported below:

> *Here we have one small health centre that we managed to build by ourselves. When my wife wanted to deliver, I had to take her to a far away health centre for good care, and the distance was too far.*

The affordability of health care services in community health centres depends on the type of health problems presented at the health facilities. Some respondents reported that in situations where the services needed are not available or are beyond the capacity of the health centres, clients are referred to the secondary or tertiary level of health care for appropriate treatment. However, health services are affordable from a general perspective. According to a 28 years old woman: “Health workers are trying here; they give us drugs and treat us well when we go there”.

Another woman participant stated that;

> *We do not have any good health centres in this place. Sometimes, when we need to go for treatment, we drive a long distance before we see a good health center. So, the government should build a health centre for us because we are suffering*.

Most participants have confirmed that the availability of well-equipped health facilities has brought enormous benefits to their health, such as treatment of diseases, childbirth, health education, improved hygiene practices, employment opportunities for community members as

adhoc or permanent staff, and immunisation of children. Despite these benefits, certain challenges were also highlighted, such as the long distance to health facilities, the attitude of health workers, the cost of drugs, the unavailability of drugs, and the unavailability of health workers when needed. A 31 years old woman opined that:

> *It is a good thing we have a health centre in this community, at least to treat our children when they are sick, but the thing is that the drugs are too costly; sometimes the drugs are not there*.

Another woman stated that:

> *To me, our health services are cheap and something one can afford, though it depends on the type of problem you are complaining about to the health worker. It is just that we want our health workers to always be available.*

A woman participant opined that:

> *The establishment of health centres has greatly aided in the collection of drugs to treat our illnesses. The health workers teach us many things, like family planning methods and other things.*

Discussion of findings

Healthcare services and rural development

The result of the third hypothesis showed that there was a significant association between healthcare provision and socio-economic wellbeing. Out of 420 study participants, only one-third of the respondents (33.3%) confirmed that the provision of health care facilities has improved their socio-economic wellbeing in terms of treatment of disease, increased employment opportunities for community members as health workers or auxiliary staff, prompt access to health information, and increased household income for employed community members, as well as other healthy individuals in their activities. This means that 66.7% of the respondents lack access to quality and affordable basic health care services. This finding is consistent with the findings of Bloom et al. (2008), who stated that human capital development and increased household income are directly related to one's health status. This implies that optimal human capital development cannot be attained if the health status of the population is still poor.

Since health as a phenomenon directly affects the whole system of the human body and indirectly affects human social and welfare, Hence, the provision of well-equipped health care facilities with quality and cost-effective services is indispensable in communities for the improvement of the health status of community members (Omang, *et al,* 2020, Okpa, *et al*, 2021). Nonetheless, the challenges confronting community members are the distance they travel to access health care in the study area. This was the major factor facing communities without reliable health care centers. The major challenges confronting rural dwellers accessing health care in communities with a comprehensive health centre were the cost of drugs, the unavailability of prescribed drugs, and the unavailability of health care workers when clients needed them. Hence, in order to address the aforementioned challenges, the government should be involved in the provision of health care infrastructure in every community and equip them with manpower, drugs, and medical equipment to enable access to basic health care among rural dwellers.

Conclusion and recommendations

A viable health sector is a major component of a community's infrastructure, that can guarantee rural development. To achieve sustainable development and attract new firms to provide jobs and economic growth in rural areas there is need to strengthen the existing health system in rural areas. Rural health is a key component of a high-performing health system. This is true not only because rural regions host around 70% of the population but also because inequalities in provision are more likely to happen in rural places (OECD, 2020). Rural residents have shorter life spans, less healthy lifestyles and overall, live in worse health states due to a higher incidence of chronic disease. They also face a wide range of threats to health status and health performance challenges including increased poverty and unemployment. The provision of quality health services in rural areas is not only challenged by a larger share of ageing populations but also by poor social determinants of health, barriers to system access and issues finding and retaining qualified medical personnel. Rural healthcare facilities also face financial pressure from low economies of scope and scale, making the balance between access and efficiency particularly difficult. While there is a strong desire to equip existing health care provisions with human resources, medical equipment, and supplies, new ones should be made available to communities that lack health centers. This is to promote close proximity, enhance easy accessibility, and encourage regular hospital consultation.

References

Aghion P, Peter H, Fabrice M (2010). The Relationship Between Health and Growth: When Lucas Meets Nelson-Phelps. National Bureau Econ. Res. (NBER) Working Paper No. 15813.

Bloom. D. E. & Canning, D. (2008): Population Health and Economic Growth. The International Bank for Reconstruction and Development / The World Bank On behalf of the Commission on Growth and Development. WORKING PAPER NO. 24

Ebingha, E. E., Eni, J. S., & Okpa, J.T. (2019). Population growth and socio-economic development of Cross River State, Nigeria. European Journal of Economic and Financial Research 3(3), 20-35

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

Jaysawal, N. (2015). Rural Health System in India: A Review. *International Journal of Social Work and Human Services Practice*, 3(1), 29-37.

OECD (2020), Realising the Potential of Primary Health Care, OECD Health Policy Studies, OECD Publishing, Paris, https://dx.doi.org/10.1787/a92adee4-en.

Okon, R. B. (2018). Infrastructural provision and socio-economic wellbeing of the people of Bakassi Local Government Area of Cross River State, Nigeria. A Master's Degree Thesis Carried out in the Department of Sociology, Faculty of Social Sciences University of Calabar, Calabar, Nigeria

Okpa, J. T. & Ekong, I. D. (2017). Global and National Terrorism: Implications for Sustainable Development in Nigeria IOSR Journal Of Humanities And Social Science (IOSR-JHSS) 22 (11), 49-56

Okpa, J. T., Ajah, B. O., Igbe, J. E. (2021). Rising Trend of Phishing Attacks on Corporate organisations in Cross River State, Nigeria. International Journal of Cyber Criminology, 14, 460–478

Okpa, J. T., Ilupeju, A. A. & Eshiotse, E. (2020). Cybercrime and Socio-economic Development of Corporate Organisations in Cross River State, Nigeria. Asian Journal of Scientific research 13 205-213

Omang, T. A., Okpa, J. T., Okoi, O. N., Iniama, J. (2020). Women Barriers and Empowerment Opportunities in The Nigerian Context. Pertanika Journal of Social Sciences and Humanities. 28 (4), 3167 – 3186

Omonona, B. T., Adebisola, O. A., & Adeniji, A. O. (2015). Health-care access and utilization among rural households in Nigeria. *Journal of Development and Agricultural Economics* 7(5), 195-203

Peter, E. O., Okpa, J. T., & Okoi, O. N. (2020). Educational Support Services and Teachers' Job Performance in Secondary Schools in Akwa Ibom State, Nigeria. Journal of Educational System 4(1), 22-29

Ricketts TC (2009). *Rural health in the United States*. New York: Oxford University Press.