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Healthcare Access and Health Seeking Behaviors among Households in Katsina State, North-Western, Nigeria

Nasiru Lawal

Director, Planning Research and Statistics,
Katsina State Contributory Healthcare Management Agency, Nigeria

Mohammad Tukur Safana

Director General, Katsina State Contributory Healthcare Management Agency, Nigeria

Hassan Abdulsamad

Director Program, Katsina State Contributory Healthcare Management Agency, Nigeria

Mukhtar Bature

Director, Quality and Standard Assurance,
Katsina State Contributory Healthcare Management Agency, Nigeria

Sani Daninna Kankia

Director, Finance and Account,
Katsina State Contributory Healthcare Management Agency, Nigeria

Hamza Mohammad Goya

Director, Admin and Supply,
Katsina State Contributory Healthcare Management Agency, Nigeria

Shamsudden Yahaya

Executive Secretary, State Primary Healthcare Agency,
Katsina State Primary Healthcare Agency, Katsina, Nigeria

Abstract:

Achieving Universal Health Coverage (UHC) is one of the targets set by nations of the world when adopting the Sustainable Development Goals in 2015. The law establishing Katsina State Contributory Healthcare Management Agency (KTSCHMA) was signed on 27th December 2018 as Law No. 10 of 2018. The agency carried out the Household Baseline Assessment Survey to implement the Scheme across the state. This aimed at determining the households, access to healthcare services, and health-seeking behaviors among households' in Katsina State. It is a descriptive cross-sectional design study carried out across the state. In January 2020, 416 households were surveyed using multi-stage sampling techniques. The result shows that the majority (88.5%) of households have male heads, with (56.1%) having no formal education. Most (46.6%) household heads are self-employed, and only 9.6% of household heads are working in the public sector. The average household is made up of 6 members. The majority (95.2%) of residents visit healthcare facilities when ill, and only about 63.9% visit government health facilities as their first point of call for treatment, with fewer (15.2%) visiting chemists and pharmacists, usually without a prescription from a doctor. Access to healthcare facilities is also very high, with about 83.6% of residents living within 30 minutes of a healthcare facility. Full implementation of the scheme will improve healthcare coverage and utilization among residents of Katsina State.

Keywords: Healthcare access, health seeking behaviors

1. Introduction

Access to health care is concerned with the relationship between the need, provision, and utilization of health services. Aday and Anderson (1981) suggest that access describes the potential and actual entry of a given individual or population group into the health care delivery system. This notion of access involves different aspects of the relationship between the service providers and clients, which determine patterns of utilization. The concept of access is centered on the processes determining entry into the health care system. The term 'access' is commonly used in two ways:

- Having access denotes the theoretical potential to utilize a service if required. To have access to a service means that the service required exists, is available, and that there are systems in place that would allow service utilization following contact with the health care service.
- Gaining access alludes to the actual procedure of admission into the processes of utilizing the service. Here, if access has been gained, it means that the service has been utilized.

This definition denotes entry to, or utilization of, health care services. Access has sometimes been identified as one

of the dimensions of quality of care (Maxwell, 1984), but access is itself a multi-faceted concept. Pechansky and Thomas (1981) suggested that the concept of access described the 'degree of fit' between clients and the health system.

Health seeking behavior is preceded by a decision-making process that is further governed by individuals and/or household behavior, community norms, expectations, provider-related characteristics, and behavior (Ihaji, 2014). Health or care seeking behavior has been defined as any action undertaken by individuals who perceive themselves to have a health problem or to be ill to find an appropriate remedy. For this reason, the nature of care seeking is not homogenous depending on cognitive and non-cognitive factors that call for a contextual analysis of care seeking behavior. Context may be a factor of cognition or awareness, socio-cultural as well as economic factors (Kakkar, 2013). The Health Belief Model (HBM) proposes that whether a person performs a particular health behavior is influenced by two major factors: The degree to which the disease (negative outcome) is perceived by the person as threatening and the degree to which the health behavior is believed to be effective in reducing the risk of a negative health outcome.

- The first factor, i.e., perceived threat, is determined by whether someone believes he or she is susceptible to (that is, likely to get) the disease and how severe that person believes it would be if it developed.
- The second factor, i.e., perceived effectiveness of the preventive behavior, takes into account not only whether the person thinks the behavior is useful but also how costly (in terms of money, time, and effort) it is to carry out the preventive behavior.

Hypothesis generated by the HBM has been generally supported by research. When health messages demonstrate to people that there is a real threat to their health and also convince them that a particular behavior can reduce their risk, the likelihood of behavior change is greatly increased.

Many countries are already making progress toward UHC. All countries can take action to move more rapidly towards it or to maintain the gains they have already made. In countries where health services have traditionally been accessible and affordable, governments are finding it increasingly difficult to respond to the ever-growing health needs of the populations and the increasing costs of health services. Moving towards UHC requires strengthening health systems in all countries. Robust financing structures are necessary. When people have to pay most of the cost for health services out of their own pockets, the poor are often unable to obtain many of the services they need, and even the rich may be exposed to financial hardship in the event of severe or long-term illness. Pooling funds from compulsory funding sources (such as mandatory insurance contributions) can spread the financial risks of illness across a population. In view of the above, the Katsina State government has signed into law establishing Katsina State Contributory Healthcare Management Agency (KTSCHMA) on 27th December 2018. In order to appropriately design and successfully implement the health Contributory Scheme in the State, KTSCHMA conducted a Household Baseline Assessment Survey to implement the Katsina State Contributory Healthcare Scheme. This is in line with the World Health Organization (WHO) requirement for setting up a health Contributory Scheme towards achieving UHC, which includes the availability of a functional health system that meets priority health needs and affordability of the scheme by target beneficiaries, amongst others. The findings from the baseline assessment inform steps to be taken in designing various aspects of the scheme, including designing cost and benefit packages and reviewing operational guidelines.

Many low-income countries, Nigeria inclusive, have not been able to meet the basic healthcare needs of their people, especially those in rural areas. In Nigeria, there has been a growing recognition of the challenge of rural people's health issues and the need for them to be addressed (Hamid et al., 2005). There is a huge shortage of qualified practitioners in rural areas. Accessing health care in rural areas is confounded by problems such as insufficient health infrastructure, the presence of chronic diseases and disabilities, and socio-economic and physical barriers (Ricketts, 2009). Over the years, Katsina State healthcare services and facilities have not achieved all its objectives of ensuring that everybody has access to adequate healthcare services at affordable costs. This study will extend prior literature such as: Sanusi and Awe (2009), who studied the level of awareness of National Health Insurance Scheme (NHIS) by healthcare consumers in the southwest of Nigeria using chi-square and descriptive statistics. Ibiwoye and Adeleke (2009) examined the extent to which the income of household heads, occupation of household heads, sex of household heads, age group, marital status, and family size plays an explanatory role in the slow pace of usage of healthcare service in Lagos State; while Olugbenga-Bello and Adebimpe (2010) examined the knowledge and attitude of civil servants in Osun State towards its healthcare usage. However, this research work fills the huge knowledge gap by examining the access and utilization of healthcare services among households in Katsina State.

2. Literature Review

More than four decades ago, Grossman (1972) developed a theory showing that health stock is a capital that produces healthy days, which are used in the production process. Aside from enhancing productivity, Grossman also showed that improved health status promotes well-being as it is a source of enjoyment and happiness for households and individuals. These theoretical benefits of improved health status have been supported by empirical evidence that shows the relationship between better health status and enhanced productivity and well-being. Tompa's (2002) review of evidence from developed and developing countries over a period of more than 200 years showed that improved physical and mental capacities among workers increased productivity levels. Other studies found similar results (Boles et al., 2004; Mitchell et al., 2013; Boman & Isiaka, 2015). Besides the link at the micro level, analysis at the macro level showed that better health status was positively associated with economic growth (Bloom & Canning, 2005; Mehmood et al., 2014; Oni, 2014). Another string of evidence linked better health status to poverty reduction (Carrin & Politi, 1996; Peters et al., 2008).

2.1. Theoretical Framework for Access to Health Care

While measuring access to health care is essential, one of this study's objectives was establishing the determinants of such access. As a starting point, the relevant theories were reviewed. The key frameworks formulated to analyze the factors that determine access to health care are those of Aday and Andersen (1974), Penchansky & Thomas (1981), and Peters-Garg-Bloom-Walker-BriegerRahman (2008), evaluation of the need to use health care. This is the most popular model in studying the utilization of health care by different population groups (Andersen, 1995). It is built on the Donabedian assumption, which suggests that the proof of access is the use of services (Ricketts & Goldsmith, 2005). The model analyses access throughout the use of health care services, the process of interaction between suppliers (the health care system) and clients (the population at risk), and the outcomes resulting from the utilization of health care and satisfaction of clients (Figure 1).

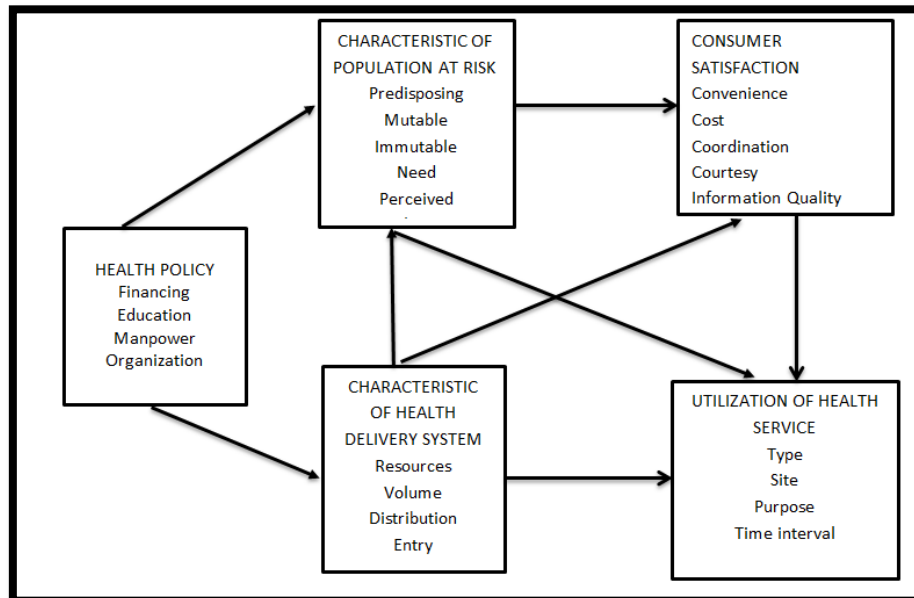


Figure 1: Aday and Andersen Framework

A critical analysis of the model proposed by Andersen & Newman (1973) shows that, while describing the factors that determine access to health care, it integrates more of the supply-side factors, with income being the only factor on the demand side. It is also worth noting that all these models use facility utilization as a proxy for access to health care and can thus be considered models that predict utilization rather than access to health care. Aday and Andersen (1974) developed the behavioral model of health services to explain access to health care. The model assumes that the predisposing characteristics of the population seeking health care and enabling resources in the environment are combined with perceived or professional.

2.2. Access to Healthcare: Dimensions Used and Measurement

Dimensions used in the literature on health access reviewed in the previous chapter have noticed that the concept of access to health care is complex. As the first step in analyzing the determinants of access, a discussion is presented on how these determinants were conceptualized and measured. This study follows the demand perspective of Peters et al.'s (2008) framework and focuses only on two dimensions of access, namely:

- Financial access (price of care, income), and
- Geographical access (distance to facility)

These two dimensions were selected because they are considered to include more objective factors that influence the demand side of access to health care that can be measured and are relevant to policymaking.

2.3. Distance to the Healthcare Facilities

Good roads are essential for people to get health facilities, for easy distribution of medicines and other items to health care services, for timely transfers in case of emergency, and for better supervision of health workers. Remote health centers mean that more time and money are spent on travel-related expenditures, all of which act as obstacles to gaining care, especially for the poor (Peters et al, 2008). While the study from Adesiji & Komolafe (2012) argues that long distances entail a higher cost of transport, it specifies that costs include hiring a vehicle and driver, fuel expenses, and the opportunity costs of the person accompanying the patient at the micro level surveys.

3. Methodology

This study was carried out in Katsina State, Northwest Nigeria. The State was created on 23rd September 1987, and now it has 34 Local Government Areas and 361 political wards, with a population of 8,536,138.00 (NPC, 2006). Katsina is located on latitude 12° 59' N and longitude 7° 36' E. The main town is situated about 400 kilometers east of Sokoto, 160 kilometers northwest of Kano, 300 kilometers north of Kaduna, 460 kilometers north of Abuja Federal capital,

and about 90 kilometers southeast of Maradi in Niger Republic. It covers an area of about 24,192sqkm (9341 sq. miles). Agricultural products such as maize, guinea corn, and millet are widely grown all over the state, mainly for subsistence use. In contrast, other products, such as groundnuts, cotton, and hides, are produced commercially. Primary data employed in this study were obtained with the aid of well-structured questionnaires. A multi-stage sampling technique was employed in the selection of respondents. The first stage involved selecting 50% of LGAs among the 34 LGAs across the three senatorial zones, using a simple random sampling technique by balloting. The second stage involved selecting wards from each LGA, using simple random sampling by balloting. This gives 90 wards out of 361 wards within the state. The frame of Enumeration Areas (EAs) demarcated by the National Bureau of Statistics for the National Agricultural Sample Census 2014 was adopted. A line list of the enumeration areas in each ward (locality) was generated and served as a household to visit for data collection. The third stage involved the selection of 416 households using Systematic sampling to select the households to be interviewed from the selected wards. Descriptive statistics such as frequencies, means, percentages, and standard deviation were used to describe the sources and uses of healthcare facilities in relation to socio-economic characteristics and the level of utilization of healthcare services.

4. Results

4.1. Household Demography

Background Characteristics	Frequency (n=416)	Percentage (%)
Age		
10-24	14	3.4
30-39	95	22.8
40-59	181	43.5
>60	126	30.3
Mean age 47		
Sex		
Male	368	88.5
Female	48	11.5
Religion		
Islam	414	99.5
Christian	2	0.5
Ethnic Group		
Hausa	354	85.1
Fulani	57	13.7
Others	5	1.2
Marital Status		
Married	394	94.7
Widow/Others	22	5.3
Level of Education		
Primary	68	16.3
Secondary	58	13.9
Tertiary education	57	13.7
Qur'anic	233	56.1
Occupation		
Business	135	32.5
Farming	194	46.6
Civil Servant	40	9.6
Retiree	10	2.4
Unemployed	37	8.9
Number of Children		
Total	2843	
Average	7	
Less than 7 members	204	49.0
More than 7 members	212	51.0

Table 1: Socio-Demographic Characteristics of Respondents

Source: Field Survey 2020

Of the 427 questionnaires administered, 416 were adequately completed and found suitable for analysis, giving a response rate of 97.4%. The age distribution of respondents ranged from 40 to 59 years (Middle age adults), while the mean age of household heads interviewed was 47.88 ± 15.90 . A larger proportion of household heads were males. They accounted for 368 (88.5%) out of 416 respondents. The majority (384; 85.1%) of the household respondents were Hausa, with 394 (94.7%) of them married. Almost half (233; 56%) of household heads that responded to the questionnaires had

no formal education. The majority (233; 56.1%) had attended Quranic school, while others attended primary, secondary, and tertiary institutions (16.3%, 13.9%, and 13.7%), respectively. The main occupation of the respondents was farming 194(46.6%). This is followed by business 135(32.5%) and civil service job 40(9.6%). Only a small proportion (37, 8.9%) does not earn a living. Several household members varied greatly among the respondents. Those with household sizes ranging between one and six are 204 (49.0%). Those with a household size of more than six are 212 (51.0%).

4.2. Access to Health Services

Variable	Frequency % (n=416)	
Time taken to reach the nearest health facility		
Short time (<30min)	348	83.6
Medium (30-120min)	58	13.9
Long time (>2 hours)	10	2.5
Time taken to see a healthcare provider		
Short time (<30min)	250	60.1
Medium (30-120min)	125	30.0
Long time (>2 hours)	41	9.9
Do you have to pay money to get to the nearest facility		
Yes	272	65.4
No	144	34.6
Amount Spend to get to the nearest health facility and come back home.	n=272	
100-200 Naira	180	66.2
200-400 Naira	51	18.8
400-600 Naira	24	8.8
>1000	17	6.3
Means of transportation to health facility among those that pay out of pocket		
Motorcycles	215	79.0
Car	57	21.0
Means of transportation to health facility among those that did not pay out of pocket	(n=144)	
Foot	136	94.4
Bicycle	8	5.6

Table 2: Access to Healthcare Services among Respondents
Source: Field Survey 2020

To achieve universal health coverage, there must be functional health facilities close enough to households to ensure that distance does not become a barrier. Findings from the baseline assessment show that 83.7% of households in Katsina State live in places from where they can reach their nearest health facilities in only 30 minutes. Regarding the time taken to see a healthcare provider, 250 (60.1%) respondents reported that it took less than 30 minutes to reach a healthcare provider. With regard to expenditure spent to travel to health facility, the majority (272; 65.4%) of the respondents spent money to get to the nearest facility, and 180 (66.2%) respondents reported 100-200 Naira as the spending limit, while 51 (18.8) respondents spent 200-400 Naira only. Regarding the commonest means of transportation among respondents, 215 (79%) of them traveled by motorcycle, and 136(94.4%) of them did not spend money and traveled via foot to the health facility.

4.3. Health Seeking Behaviors

Variable	Frequency % (n=416)	
	Yes	No
Respond		
Attempt to treat illness when sick	396(95.2)	20(4.8)
Facility-based Health Care	253(63.9)	
Non-Facility-based Healthcare	143(36.1)	
Days of commencing treatment after the onset of symptom (n=396)		
	Frequency	Percentage
The same day/onset of early symptom	258	62.0
The next day	96	23.1
3-7 days	36	8.7
>7 days	2	0.5
When I get money	4	1.0
First point of call for treatment		

Government Hospital, GH, PHCs,	245	61.9
Chemist/pharmacy	60	15.2
Chemist/pharmacy with prescription	53	13.4
Self-medication	23	5.8
Private hospital	8	2.0
Traditional healers	6	1.5
Religious healers	1	0.2
Variable	Frequency % (n=416)	
The main consideration for deciding where to seek healthcare services		
Quality of care	204	51.5
Affordability	92	23.2
Proximity to a place of residence	42	10.6
Attitude of staffs	22	5.6
Timeliness	18	4.5
Physical environment of the facility	11	2.8
Privacy	7	1.8

*Table 3: Health Seeking Behavior among Household
Source: Field Survey 2020*

Table 3 above highlights how residents of Katsina State engaged with the available health services and the factors influencing the choice of where to seek care. The survey showed that most Katsina residents (95.2%) visit a healthcare provider at some point during an illness to seek care for 62% at early symptoms of the illness. About 63.9% of households seek facility-based healthcare services during health events. Visits to the government hospital or clinic 245(61.9%) were the most common source of healthcare. This was followed by visits to the chemist 60(15.2%), self-medication 23(5.8%), private clinic 8(2%) and traditional healers 6(1.5%). Almost half (51.5%) of respondents considered the quality of care (good service delivery) the most important factor affecting HSB. This was followed by affordability (23.2%), proximity (10.6%), the attitude of healthcare workers (prompt attention) (5.6%)

5. Conclusion and Recommendations

5.1. Conclusion

- The finding from the surveyed households shows that the majority of the household has more than six members (dependents).
- The majority of the household heads utilized government health facilities as the first point of call for treatment during health events. They do not necessarily do, so the quality of care received in the facility influences this, as reported by most respondents.
- Geographic access to health facilities was high, with about eighty-four percent of the population living in places only 30 minutes walking distance away from a health facility.

5.2. Recommendations

- Extra household members in households with more than 6 members should be considered for inclusion in the scheme so that no household member/individual is excluded from the scheme. There is a need for the Agency to continue sensitization to a resident of Katsina because there are more programs in the scheme that can cover other members of the household.
- There is a need for more effort from the Agency for quality assurance and monitoring & evaluation exercises to maintain a high standard of quality care and accurate data submission to the Agency for effective implementation of the scheme.
- There is a need for the Agency to collaborate with National Health Insurance Scheme (NHIS), Hospital Service Management Board, and State Primary Healthcare Agency to facilitate accreditation or to establish more health facilities to cover the remaining 16.4% population to have easy access to healthcare services to achieve full universal health coverage.

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