Revista Bioetica
ISSN – 1983-8042, Vol 14, Issue 03, 306-314

The Impact of Poverty on Accessing Health Facilities in Makarfi, Kudan, and Ikara Local Governments, Kaduna State, Nigeria

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DOI: https://doi.org/10.5281/zenodo.22300512
Received: 15-08-2026 **Accepted: 25-08-2026** **Published: 04-09-2026**

ABSTRACT
A lot of societies in Nigeria are saddled with many social challenges that undermined struggles in the process of societal development in Nigeria. The part of Northern Nigeria, poverty and deseases are common challenges that attacked against many people in Northern societies which had attracted less concerns over the years. This Survey analyzed the situation and how poverty lead to diseases and ill-health in Northern part. Poverty is the engine causes of deteriorated health; on the other hand, sufficient money and education ensure good healthy for every societies. The methods applied for data retrieve was derived from primary sources showing the relationship between poverty and health facilities in three (3) local governments. Relevant data drown from Primary and Secondary sources were analyzed using percentages and Chi- Square on purely poverty and health facilities. A lot of the low income earners either do not or not at all use the very fewer health care centers provided in the various localities across the Northern part due to inability to pay the medical bills. Generally, Poverty has a major significant influence on prevalent diseases in the northern societies which comprised diseases like malaria, whooping cough, skin and diarrheal diseases, measles, tuberculosis, sexually transmitted diseases, Buruli ulcer, typhoid, cholera, and intestinal disorder. It come to noticed that many strategies or recommendations were applied towards tackling poverty and health facilities challenges in Northern regime in order to focus on providing equipment for the less privilege people and those with adequate and daily income in northern part.
Key Words: Impact of Poverty, Accessing Health Facilities, Makarfi, Kudan, and Ikara LGAS, Kaduna State, Nigeria.

I. INTRODUCTION

Global Development Indices 2008, CD-ROM. Said the data on poverty is highly controversial, it is confirmed by the data provided by the United States Central Intelligence Agency's World Fact book (henceforth CIA Fact book), which explained that 70 percent of the Nigerian people lived below the poverty line in 2007. However, according to the World Bank's World Development Indices 2008, Nigeria's experienced undernourished is with about 10 percent of the total population over the last decade had 70 percent of the people living below the poverty line, the prevalence of undernourished in Africa is going to be around 30 percent over the last decade. It is cleared to see even with rich natural resources, the situation of poverty in Nigeria is every high. According to the data on Nigeria's poverty many years remain scattered, there is a lot of evidences that shows Nigeria's poverty has actually increased over time. Nigeria

also ranked third in the world with majority of people living with HIV/AIDS and has the third highest death rate as a result of diseases (CIA Fact book).

Nigeria's infant's mortality rate has been estimated as of now 99 per 1000 births, which indicated that Nigeria became the thirteenth (13) highest infant's mortality rate all over the world. The infant's mortality of children under the age of five (5) was 189 per 1000 births in 2007. These high mortality rates are mostly due to mothers not having enough money to take care of their children. Many mothers are also ignorant of some preventive measures such as immunizations and vaccines. The immunization rate against diphtheria, pertussis and tetanus (DPT) for children between 12-23 months was about 54 percent in 2007. Children in Nigeria die as a results diseases such malaria, diarrhea, tuberculosis, cardiovascular diseases. All of these are social diseases preventable and curable, but as a results of sufficient health care equipment and lack of fund many children lost their life. Some children cannot get portable water and sanitary conditions which mostly causes diseases in children.

In Sub-Saharan Africa countries, Nigeria has better off in the aspect of economic and social but worse in aspect most cases. In some selected economic and social data the average Nigerian is slightly poor in terms of GDP and per capita income than the average person in some Sub-Saharan Africa countries. However, the life expectancy of an average Nigerian at birth has been estimated to be as low as 47 years, which is again slightly lower than some of Sub-Saharan Africa countries (51 years). In Nigeria the immunization rates for b DPT and measles were relatively low compared to Sub-Saharan Africa countries which rates is 72 percent in DPT and 71 percent in measles, while Nigeria's immunization rates are still at 54 percent and 62 percent respectively. The DPT and measles according to the Encyclopedia, Nigerians GDP and per capital has declined from $1,200 in 1981 to $300 in 2000.

Moreover, the standard of living has declined in Nigerian, but it has improved gradually for better off. It has been indicated that the number of people below poverty line has been on the rising in Sub-Saharan African countries, those with 45 percent of the population living below the international poverty line of $1 per day. The region also has the highest level of intra-regional poverty as half of its population was classified poor (see the Organization of the Islamic Conference (OIC), Statistical, Economic and Social Research and Training Centre for Islamic Countries (SESRTCIC). World Bank (2008). Poverty is a complex and determinants of health caused by multiple factors that can affect generations as well as families. Started at birth and persist throughout an individual's life, and poverty itself is a disease.

Features of Poverty among male and female headed households in the research setting which comprised of Makarfi, Ikara, and Kudan respectively

Male groups	Female groups
• Having no job or vocation training • Having no good accommodations • Inability to get balance diets to eat • Inability to provide basic needs for children. eg education and clothe • Inability to pay medical bills when sick • Having no support when in a misery situation • Lack of skills work. • Inability to provide decent life for the family members • Lack of fund to buy farm inputs • Lack of access to basic social amenities.	• Not having nutritious food to eat • Living in unhygienic house condition • Having no access to education for one's children. • Not having better job to do for survival • Inability train self and her children decently in life • Having a deteriorated health condition (ill-health) • Poverty affects the whole of life • A condition of being self-inferiority • Having helpless husband

Source: (World Health Organization 2000-2009)

Significant of the Study

The important of this research is to contribute to the existing knowledge globally and also to breach the gap between poverty and access to health facilities in the Makarfi, Kudan, and Ikara Local Governments, if government use the research for policy making in order to improve the quality of people in the study area.

Method of Data Collection

Both the primary and secondary sources of data were used (Cross sectional Survey Research) was used for the research. The primary information was elicited from selected respondents living in the rural areas about their health, access to health care services and their socio-economic status in terms of income and level of knowledge about some specific health issues.

Analytical Techniques

- Descriptive statistics (frequencies, percentages) to summarize categorical responses.
- Pearson chi-square (χ^2) tests of independence to examine relationship between categorical variables, primarily Perceived facility quality and specific service-delivery indicators.

Healthcare Access, Quality, and Resource Availability

Access to quality healthcare is one of the prerequisite for translating households and community health knowledge to improved health outcomes. This aspect examines the physical, financial, qualitative, and infrastructural dimensions of healthcare access experienced by the surveyed population revealing a multi-layered barrier structured that systematically prevents timely and effectively medical interventions.

Healthcare Utilization and Distance Barriers

The overwhelming majority of respondents 89.5 %, disclosed that visiting a health facility when ill-health, demonstrate that healthcare-seeking behavior is widely oriented within the communities. However, the facility type access revealed a reasonable concentration at the primary health care: 62.3% visit primary healthcare centers, 18.5% utilized secondary hospitals, and only 9.5% visit tertiary institutions. This utilization pattern is appropriate in principle but became problematic when, as documented subsequently, even primary facilities are highly under-resourced.

Distribution of Health Facility Types Utilized

Category	Frequency	Percent (%)	Valid %	Cumulative %
Primary Healthcare Centre	249	62.3%	62.3%	62.3%
Secondary Hospital	74	18.5%	18.5%	80.8%
Tertiary Hospital	38	9.5%	9.5%	90.3%
Dispensary	35	8.8%	8.8%	99%
None	4	1%	1%	100%
Total	400	100%	100%	—%

Source: Field Survey, 2025.

The physical utilization of health care facilities constitutes a meaningful barrier for a larger proportion of respondents. While 35.5% described their nearest facility as "nearby," the majority 37.8%, must trek by foot to access health Centre, and 26.5% classified the facility as "far away." In the context of severe illness, these physical barriers translate directly into delayed seeking care, which for diseases such as malaria, cholera, and acute diarrhea can easily escalate into preventable mortality.

Distribution of Distance to Health Facility

Category	Frequency	Percent (%)	Valid %	Cumulative %
Nearby	142	35.5%	35.5%	35.5%
Trek	151	37.8%	37.8%	73.3%
Far away	106	26.5%	26.5%	99.8%
Others	1	0.3%	0.3%	100%
Total	400	100%	100%	—%

Source: Field Survey, 2025.

Financial Barriers and Coping Mechanisms

The financial barrier data constituted one of the most consequential outcomes in this entire research. Table revealed that 80.5% of respondents faced clear financial difficulties when attempting to access health facility. This near-universal economic exclusion from medical care in a population where over half had tertiary qualifications powerfully shows that poverty and health in this region is a structured phenomenon, not merely a product of individual choices or inadequate education. With disposable income consumed by food insecurity and basic livelihood in life, healthcare expenditures became an unaffordable luxury for the majority population.

Distribution of Financial Barriers to Healthcare Access

Category	Frequency	Percent (%)	Valid %	Cumulative %
Face financial problems — Yes	322	80.5%	80.5%	80.5%
No financial problems	78	19.5%	19.5%	100%
Total	400	100%	100%	—%

Source: Field Survey, 2025.

When respondents do manage to source funds for healthcare, the dominant coping mechanism is community support (47.3%), followed closely by loans (41.2%), with a small minority resorting to begging (5.0%) and other means (6.4%). The reliance on informal community solidarity networks as the primary healthcare financing mechanism reveals a significant gap in formal social protection systems — a gap that exposes communities to acute vulnerability in periods of widespread or concurrent illness.

Distribution of Methods Used to Source Healthcare Funds

Category	Frequency	Percent (%)	Valid %	Cumulative %
Community Support	169	42.3%	47.3%	47.3%
Loans	147	36.8%	41.2%	88.5%
Others	23	5.8%	6.4%	94.9%
Begging	18	4.5%	5%	100%
Total (Valid)	357	89.3%	100%	—%

Source: Field Survey, 2025.

Facility Quality, Staffing, and Infrastructure

Despite the structural challenges documented above, respondents offer a surprisingly moderate assessment of healthcare quality: 68.0% rate local facilities as "good" and 13.8% as "very good". This perceptual generosity may reflect low baseline expectations and limited comparative experience with higher-quality facilities, rather than objectively adequate provision. The dissonance between this quality rating and the objective deficits documented elsewhere in this section underscores the importance of objective facility assessment alongside subjective community perception surveys.

The most critical objective deficit is captured in Table 62.8% of respondents' state that local health facilities are not adequately equipped or staffed. This institutional insufficiency is compounded by a pharmaceutical supply chain breakdown: 57.0% of respondents report regular shortages of essential medicines at their local facilities. Together, these findings paint a picture of facilities that are physically present but operationally hollow a scenario in which the mere existence of a building does not translate into functional healthcare delivery.

Distribution: Are Health Facilities Adequately Equipped and Staffed?

Category	Frequency	Percent (%)	Valid %	Cumulative %
No Inadequately equipped/staffed	251	62.8%	62.8%	62.8%
Yes Adequately equipped/staffed	149	37.3%	37.3%	100%
Total	400	100%	100%	—%

Source: Field Survey, 2025.

Distribution: Are There Shortages of Essential Medicines?

Category	Frequency	Percent (%)	Valid %	Cumulative %
Yes Medicine shortages reported	228	57%	57%	57%
No Medicines generally available	172	43%	43%	100%
Total	400	100%	100%	—%

Source: Field Survey, 2025.

Power Infrastructure in Health Facilities

One rare positive finding in this dataset concerns energy supply in healthcare centers. As indicated in Table, solar power has emerged as the dominant energy source, utilized by 58.8% of facilities. This represents a pragmatic adaptation to the unreliability of the national electricity grid, which serves as the primary sources for only 30.3% of healthcare centers. Generators supplement supply for 9.8%. The consequence of this solar transition is significant: Table revealed that 57.3% of respondents reported 24-hour power availability in their local health centers an outcome that enables vaccine refrigeration, nighttime emergency services, and the operation of essential diagnostics equipment. However, 38.6% of healthcare centers still experienced severe power rationing, representing an ongoing threat to patients care quality.

Distribution of Primary Power Sources in Health Facilities

Category	Frequency	Percent (%)	Valid %	Cumulative %
Solar	235	58.8%	58.8%	58.8%
National Power Grid	121	30.3%	30.3%	89%
Generator	39	9.8%	9.8%	98.8%
Others	5	1.3%	1.3%	100%
Total	400	100%	100%	—%

Source: Field Survey, 2025.

Distribution of Power Constancy in Health Facilities

Category	Frequency	Percent (%)	Valid %	Cumulative %
24 hours	229	57.3%	57.3%	57.3%
1–2 hours per day	87	21.8%	21.8%	79%
3–4 hours per day	67	16.8%	16.8%	95.8%
Others	17	4.3%	4.3%	100%
Total	400	100%	100%	—%

Source: Field Survey, 2025.

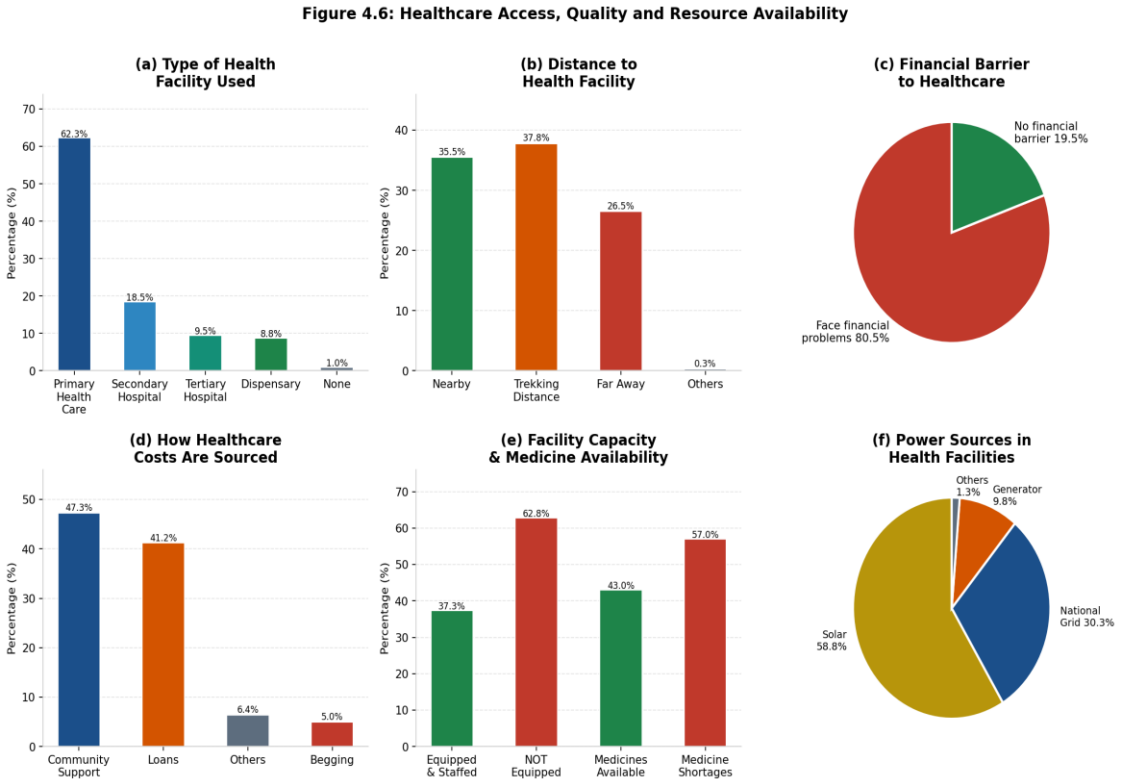

Figure 4.6. Healthcare Access, Quality and Resource Availability: Facility Types, Distance, Financial Barriers, Funding Sources, Capacity Deficits, and Power Infrastructures (N = 400). Source: Field Survey, 2025-2026

II. CONCLUSION

It has been confirmed that poverty is the dominant determinants of health outcomes in the research area. The empirical findings align closely with theoretical and empirical literatures, demonstrating that:

- Poverty manifested as nutritional deprivation, inadequate sanitary, environmental exposure, limited healthcare access, and poor housing conditions.
- The healthcare centers were under-resources, overstretched, and unable to adequately address societal needs.
- Disease burden was higher because of environmental risks coincided with weak healthcare system capacity.
- Financial barriers prevent healthcare access on time, prolonging illness and increasing poverty situation.
- Societal perceptions reflected deep mistrust in government, shaping health seeking behaviors.

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