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HEALTH INEQUALITY AND SUSTAINABLE DEVELOPMENT IN RURAL COMMUNITIES OF ONDO STATE

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Abstract

Rural communities play a vital role in the development of any nation, contributing both economically and politically to the developmental process. These areas provide a significant portion of food products and a substantial number of votes. Given this importance, rural residents should have access to quality healthcare comparable to what is available in urban settings to support these developmental activities. However, in Ondo State, rural communities have not been receiving effective and efficient healthcare services. Most health facilities are absent in these areas, with the few available ones concentrated in urban centers, leading to inequality in access to healthcare and resulting in health challenges for rural populations. This study examines the extent of health service delivery in rural communities and the challenges related to equal access to health services between urban and rural residents. Data were collected using questionnaires and interviews. The findings are expected to bridge the gap in healthcare access and quality between rural and urban communities, thereby improving healthcare delivery in Ondo State's rural areas. Additionally, the study aims to assist the government and other stakeholders in formulating, adopting, and implementing health policies, particularly for rural areas.

Keywords: Development; Health; Inequality; Ondo State; Service Delivery.

Introduction

The significance of rural communities in the developmental process of any nation cannot be overemphasized. In Nigeria, these communities hold immense value due to their numerous contributions. Rural areas are the backbone of the country's agriculture, providing a substantial portion of food products and raw materials for industries. Additionally, they contribute a significant percentage of votes during elections, underscoring their political importance. Given these robust contributions, it is only logical that rural residents should have access to basic facilities, particularly healthcare, comparable to that available in urban areas. This access is crucial for sustaining these

developmental activities because healthier populations are more productive. As Adebayo (2022) aptly states, health is a fundamental indicator of development, and no society can progress if its population's health is poor. Similarly, Lawanson and Opeloyeru (2016) describe access to healthcare services as essential for both urban and rural populations, highlighting that healthcare accessibility largely determines the wellness of the people.

In Nigeria, healthcare delivery systems are provided by both public and private institutions. The three levels of government—federal, state, and local—are heavily involved in healthcare provision, alongside private individuals and organizations. Despite these efforts, rural areas remain inadequately covered in terms of health services. This lack of coverage makes accessing health facilities difficult for rural residents, thereby creating a widening gap and inequality in healthcare access and delivery between urban and rural dwellers, particularly in Owo Local Government of Ondo State.

Several attempts have been made by successive governments to ensure equal access to health facilities for both urban and rural areas. These efforts include the creation of the Basic Health Services Program (BHSS), the introduction of the Rural Health Scheme, and the establishment of Primary Health Care (PHC). Despite being well-funded and carefully implemented, these programs have not significantly improved accessibility for rural areas. The persistent accessibility gap between urban and rural dwellers raises critical questions: What is responsible for the widening gap between rural and urban communities in terms of access to health facilities? Why are rural health programs and schemes not achieving their objectives? How can this inequality be addressed? These questions will be explored in the course of this study.

The study aims to raise awareness about vulnerable rural communities that are deprived of quality healthcare services and provide information to the government, policymakers, and development partners on the need to formulate quality and equity-oriented health policies and programs. The paper is divided into five sections. Section one is the introduction, which includes the background, the problem, and the objectives of the study. Section two reviews relevant literature and discusses the theoretical framework. Section three analyzes the methodology employed to source the needed data. Section four presents data and discusses findings. Section five concludes and makes viable recommendations.

Objectives of the Study

i. To compare and determine the level of health care facilities between the rural and urban communities in Owo Local Government.
ii. To identify inequalities in access to health services between the rural and urban communities in Owo Local Government.
iii. To interrogate factors responsible for inequalities in access to health services between the rural and urban communities in Owo Local Government.
iv. To provide possible methods of tackling health inequalities between rural and urban communities in Owo Local Government.

Research Questions

i. What is the level of health facilities in the rural and urban communities of Owo Local Government?
ii. Are there differences in access to health services between rural and urban communities in Owo Local Government?
iii. What are the factors responsible for inequalities in access to health services between the rural and urban communities in Owo Local Government?
iv. How can health inequalities between rural and urban communities in Owo Local Government be tackled?

Scope of the Study

The scope of the study was limited to health inequality in Owo Local Government, Ondo State. Specifically, the study covered the period from 2009 to 2023, focusing on accessibility to health facilities and differences in accessibility between rural and urban communities in Owo. It encompassed the administrations of Olusegun Mimiko (eight years) and Oluwarotimi Akeredolu (seven years of his eight-year tenure). This period is significant as it covers recent democratic regimes in the state. However, during the study, some pieces of information outside the defined scope were also utilized.

Review of Relevant Literature

This section concentrates on the review of existing literature on health services and inequalities to gain a deeper understanding of what scholars, authors, and practitioners have said about the subject and to identify and fill existing gaps in the literature. Health inequalities are defined as policy problems with clear targets that assume it is possible to narrow gaps in health outcomes through policy action rather than fundamental social or economic change (Jonathan, Tim, David & Gerald, 2015). They are perceived as the disproportionate disease burden or behavioral risk factors experienced by subgroups of the population (Sara, Marian, Caryn & Thomas, 2012).

Williams, Buck, Babalola, and Maguire (2022) describe health inequalities as differences in people's health status. These differences can also refer to variations in the care people receive and their opportunities to lead healthy lives. They argue that inequalities can manifest in differences in health status, access to care, quality and experience of care, behavioral risks to health, and broader determinants of health. Various factors can contribute to health inequalities, including socio-economic status, geography, specific characteristics, and exclusion of certain social groups.

Lawanson and Opeloyeru (2016) describe accessibility to healthcare services as a crucial parameter for determining how health services are utilized in developing countries. They argue that greater access to health services leads to better health conditions and status, while the absence, inadequacy, or underutilization of health facilities can lead to inequality and health challenges.

Ghosh (2014) advocates for an egalitarian approach in distributing health infrastructure by the government. He argues that a government-financed system should provide equal access opportunities for those in equal need, regardless of their ability to pay. Ghosh calls for horizontal equity in health services provision, where individuals with equal medical needs receive similar services irrespective of their income, wealth, or socio-economic status. While this approach can address disparities in health service delivery, it may not be sustainable unless health services are provided free of charge. The government may not be ready to make healthcare services free for all at all levels, especially given meager resources in developing countries. Thus, accessibility and affordability are crucial in addressing health inequality, as noted by Williams et al. (2022). They emphasize that access to health services must include primary and secondary healthcare, preventive interventions, and other social services. Inequitable access can result in particular groups receiving less care relative to their needs, leading to poor health outcomes and status.

Phaae (2023) argues that unaddressed health disparities can threaten the prosperity and sustainable development of entire communities. Inequalities can occur between ethnic groups, income groups, and regions of a nation. Enabulele (2024) views health inequalities as a serious challenge requiring pragmatic efforts from individuals, organizations, and governments. He notes that rural communities in Nigeria face significant health inequalities compared to urban areas, where healthcare services are more accessible and better resourced. He argues that inequalities in healthcare delivery are also a feature of urban health services and result from disparities in income and economic status. Enabulele attributes health inequality in Nigeria to brain drain, which has left many health institutions inadequately staffed. He insists that addressing brain drain is essential to tackling health inequalities.

Abu (2024) blames low public health expenditure for health inequalities in Nigeria. He points out that in 2020, 82.7% of the health budget was allocated for salaries and office operations, while only 10.9% was allocated for repairs, construction of health facilities, provision of drugs, and medical equipment. This low budget forces individuals to pay high costs for health services, creating disparities in healthcare quality and widening the gap between the rich and the poor. Abu compares Nigeria's health expenditure with other African nations and finds that countries like Angola, Botswana, South Africa, and Gabon allocate a higher percentage of their budgets to health. This disparity highlights the inadequacies in Nigeria's health sector.

Chanya (2007) observes that inadequate health facilities in rural communities complicate access to health services. He argues that health inequalities between rural and urban communities result from a lack of basic drugs and required personnel. Ajetomobi (2020) similarly notes that qualified medical personnel are rarely available in rural health centers because they prefer to work and live in urban areas where basic needs are more accessible. This creates disparities in health service delivery between rural and urban dwellers. Ajetomobi suggests that rural communities should be given more attention by providing necessary facilities and infrastructure to attract medical personnel, enabling rural dwellers to access quality healthcare.

Adewole (2019) traces health inequalities to poor funding, echoing Abu's (2024) observations. He argues that the poor performance of the Primary Health Care System at the grassroots level is due to the government's failure to adequately fund health-related activities. Studies have shown that a larger percentage of urban children receive immunizations compared to rural children, reflecting unequal access to healthcare services (Ajetomobi, 2020).

Affordability is a significant constraint to equal access to health services. Mike (2020) observes that many rural residents find it difficult to pay user charges, often resorting to alternative medicine during health challenges. The high cost of services is a major factor contributing to health inequality in Nigeria, particularly in Ondo State.

Governance theory serves as the theoretical framework for this study, as it revolves around the provision and delivery of essential services at the grassroots level. Governance theory emphasizes the need to promote economic development through necessary interventions by relevant entities to secure security, protection, basic amenities, and sustainability (Harpet, 2011). Good governance is based on principles of accountability, responsiveness, effectiveness, transparency, efficiency, and equitable distribution of resources (World Bank, 2004). Effective service delivery depends on adherence to these principles, and their absence or inadequate application can lead to biases and inequalities. Fundamentally, good governance involves respect for the rules and norms of economic and social interaction, ensuring equal distribution and access to economic provisions and facilities by all citizens (Ogbuagu, Ubi & Effiom, 2014). This theory is relevant to this study as it enhances the state's capacity to deliver on its economic and social welfare mandate, which includes eradicating diseases and poverty through accessible and effective healthcare delivery systems at the grassroots level.

Research Methodology

To achieve the objectives of this study, both primary and secondary data collection methods were employed. Additionally, a sample survey was conducted to enhance the data-gathering process. Simple random and purposive sampling techniques were used to select communities and respondents, while questionnaires and interviews were utilized to gather the required information. The data collected were analyzed using frequency counts, percentages, and narrative reports.

The study was conducted in Owo Local Government Area of Ondo State. Six communities were purposively selected for this research, comprising three rural communities (Isuada, Emure-Ile, Iyere) and three urban communities (Ehin-Ogbe, Ijebu-Owo, Oke-Oja). These communities were chosen due to their relatively large populations, the presence of health facilities, and their locations in both rural and urban parts of the local government area, which allows for a comprehensive investigation of

health service delivery. This selection aimed to provide relevant and valid results regarding healthcare accessibility and quality.

Sampling Techniques and Data Collection

The sample frame for this study included a diverse group of participants such as public and civil servants, traders, traditional rulers, opinion and community leaders, health practitioners, farmers, artisans, civil society groups, politicians, and community-based organizations. These groups were chosen because they represent the end-users of healthcare services, stakeholders in their communities, and providers of healthcare services. Their varied perspectives and experiences offer a holistic view of healthcare delivery in the selected communities. The groups were randomly and purposively selected to ensure that the unit of observation was the group, rather than individual members, to capture a broader range of opinions and experiences.

Sample Size and Data Collection Instruments

The sample size for this study was 300 respondents. Questionnaires were administered to these 300 respondents from the various groups identified in the sample frame, and 286 completed questionnaires were retrieved, representing a high response rate. The questionnaire was designed to elicit detailed information about healthcare accessibility, quality, and inequalities in the selected communities. Additionally, oral interviews were conducted with some members of the selected groups in the sampled areas to complement the responses obtained from the questionnaires. This mixed-methods approach ensured a more robust and comprehensive understanding of the issues under investigation.

Data Analysis

The data collected from the questionnaires and interviews were analyzed using both quantitative and qualitative methods. Frequency counts and percentages were employed to quantify the responses, providing a clear statistical overview of the data. Narrative reports were used to analyze and present qualitative data, offering deeper insights into the participants' perspectives and experiences. This combination of quantitative and qualitative analysis enabled the researchers to draw well-rounded conclusions and make informed recommendations based on the study's findings.

Study Area and Participant Selection

The six communities selected for this study were chosen for their unique characteristics and the availability of health facilities. The rural communities (Isuada, Emure-Ile, Iyere) and urban communities (Ehin-Ogbe, Ijebu-Owo, Oke-Oja) provided a balanced perspective on healthcare delivery across different settings. The selection criteria ensured that the study captured the diversity of healthcare experiences and challenges faced by residents in both rural and urban areas.

Table 1 – Administration of Questionnaires in the Six Communities

S/N	Communities	No of questionnaires distributed	No of questionnaires retrieved	Total Retrieved
1.	Emure-Ile	44	40	40
2.	Isuada	42	41	41
3.	Iyere	44	42	42
4.	Ehin-Ogbe	55	54	54
5.	Oke-Oja	60	56	56
6.	Ijebu-Owo	55	53	53
	Total	**300**	**286**	**286**

Source: Field Work, 2024

Table 2 – Selection of Interview participants in the Six Communities

S/N	Communities	No of questionnaires distributed	No of questionnaires retrieved
1.	Emure-Ile	5	5
2.	Isuada	5	5
3.	Iyere	5	5
4.	Ehin-Ogbe	5	5
5.	Oke-Oja	5	5
6.	Ijebu-Owo	5	5
	Total	**30**	**30**

Source: Field work, 2024

Data Presentation and Analysis

Table 3: Demographic Information of the Respondents

Characteristics	**Responses**	
Age	**Frequency (F)**	**Percentage (%)**
18 – 20	38	13.2
21 – 29	58	20.2
30 – 39	102	35.7
40 and above	88	30.8
Occupation		
Public Service	52	18.1
Private Service	54	18.9
Self-Employed	100	35
Unemployed	80	28
Education		
Primary	28	9.8
Secondary	136	47.5
Tertiary	122	42.7
Sex		
Male	152	53.1
Female	134	46.9
Income		
High	36	12.6
Low	186	65.1
Medium	64	22.3
Marital Status		
Married	254	88.9
Single	32	11.1

Source: Field work, 2024

From the table, it is observed that respondents within the age ranges of 30-39 and 40 and above constitute 35.7% and 30.8%, respectively. This shows that 65.5% of the respondents fall within an active, mature, and older age group, who are likely to visit or use health facilities intermittently. Therefore, this indicates that an adequate number of respondents can provide valid and reliable information on health issues.

Additionally, the table indicates that 18.1% of the respondents were public servants, 18.9% were in private practice, 35% were self-employed, and 28% were unemployed. This shows that a larger percentage of the respondents were not employed by the government, which might lead to more unbiased responses. The table also indicates that 90.2% of the respondents had formal education. This suggests that a large percentage of the respondents were literate and could conveniently respond to questions.

The sex distribution in the table shows 53.1% male and 46.9% female respondents, implying that both genders were adequately represented in the study. The income level of the respondents, as demonstrated in the table, shows that 65.1% were low-income earners, which implies that the majority of the respondents were poor in terms of earnings. The table also indicates that a large percentage, 88.9%, of the respondents were married. This suggests that a significant portion of the respondents were mature individuals with independent minds, capable of addressing logical questions without fear of intimidation.

Table 4: Responses, Frequencies and Percentages of the Respondents from Rural Communities (123) and Urban Communities (163)

Research Questions	**Responses**							
	Rural Communities				**Urban Communities**			
	F Yes	F No	% Yes	% No	F Yes	F No	% Yes	% No
Are you a permanent resident of your community?	118	5	96	4.0	150	13	92.0	8.0
Do you have health centre in your community?	123	-	100	-	150	-	100	-
Are there adequate drugs and facilities in the health centre?	4	119	3.2	96.8	75	88	46.0	54.0
Are there adequate number of Health workers in your health centre?	23	100	18.7	83.3	105	58	64.4	35.6
Do you often visit the Health Centre in your community during illness?	55	68	44.8	55.2	126	37	77.3	22.7
Do you enjoy the services of the Health Centre in your community?	26	97	21.1	78.9	50	113	30.7	69.3
Are there private clinics apart from government health centre in your community?	3	120	2.4	97.6	162	1	99.3	0.7
Are the available drugs in the health centre affordable by you?	13	110	10.6	89.4	80	83	49.1	50.9
Do you have general hospital or specialist hospital or medical centre in your community?	-	123	-	100	163	-	100	-
Are there adequate health personnel in these hospitals?	-	-	-	-	152	11	93.8	6.8
Do you have access to these hospitals?	-	-	-	-	163	-	100	-
Each time you visit the health centre, do you always meet the workers on duty?	3	120	2.4	97.6	152	11	93.2	6.8
Do you prefer herbs to orthodox drugs to treat your ailment?	98	25	79.7	20.3	50	113	30.7	69.3

Source: Field work, 2024

The table above shows that a larger percentage of respondents from both rural and urban communities were permanent residents familiar with their environment, with 96% in rural communities and 92% in urban communities. Additionally, 100% of respondents in both communities claimed they have health centers in their areas.

From the table, a larger percentage (96.8%) of respondents from rural communities claimed that drugs and other facilities were not adequately available in their health centers, while 46% of respondents from urban communities agreed that drugs and other facilities were adequately available. The table

also shows that health workers were in short supply in rural areas, while urban communities enjoy a more adequate number of health workers. It is observed that health institutions are concentrated in urban communities, leaving rural communities with just one health center to serve the whole population. Furthermore, the table shows that most people in rural communities rarely visit health centers compared to those in urban areas, with 55.2% from rural areas claiming not to visit regularly, while 77.3% from urban centers agreed to visit regularly.

It is observed that rural people could not afford the available drugs in health centers due to their low income and earnings compared to those in urban communities. The table also shows that other health facilities, such as General Hospitals, Specialist Hospitals, Medical Centers, and Clinics owned by the government and private individuals, were also located in urban communities to the detriment of rural communities. It is observed that these other health institutions, aside from health centers, had adequate health workers and modern facilities, as 93.2% from urban communities agreed. Urban residents had access to these health institutions, as 100% of the respondents confirmed.

The table also shows that 97.6% from rural communities claimed that health workers were not punctual or regular at work, while 93.2% from urban communities agreed that health workers were punctual and regular. Additionally, a large number of respondents (97.7%) from rural communities preferred using herbs for treating ailments over orthodox medicine.

From the interviews conducted, a question was raised about differences in access to health services between rural and urban communities. Respondents agreed that access to health services in rural communities could not be compared to that in urban communities. According to the respondents, rural people do not have the option of visiting many hospitals or clinics except primary or comprehensive health centers, which cannot be compared to the larger hospitals in urban areas, both private and government-owned. One respondent noted that sometimes, before a sick person could be rushed to urban communities for better treatment, the situation would have worsened. Many respondents argued that rural people did not have enough money to access good hospitals. One respondent even mentioned that rural residents often preferred taking herbs or concoctions over going to hospitals for proper medical attention. All these behaviors create differences between rural and urban people in accessing health facilities.

Another question raised was about the factors responsible for inequalities in access to health services between rural and urban communities. A large number of respondents identified the inadequate number of health centers and hospitals in rural areas, the shortage of medical personnel and health workers, the low income of rural residents, the absence of basic drugs and essential medicines in basic and comprehensive health centers, and the reliance on herbs and concoctions.

Discussion of Findings

The findings from the study revealed a significant disparity in the availability and quality of health facilities between urban and rural areas in Owo Local Government Area of Ondo State. Health facilities and healthcare outfits are predominantly concentrated in urban communities, leaving rural communities with only basic and comprehensive health centers that often lack adequate drugs and health workers. This disparity underscores the existing inequalities in access to health services between rural and urban communities.

The study highlighted that the number of health facilities in urban areas far surpasses those in rural areas. Urban communities benefit from a wide range of healthcare services provided by General Hospitals, Specialist Hospitals, and Medical Centers. In contrast, rural communities are primarily served by Primary Health Care (PHC) centers, which focus on basic health and maternity services. This skewed distribution of health facilities indicates a discriminatory health policy that does not support equality and equity in healthcare provision.

The findings revealed multiple factors contributing to the inequalities in access to health services between rural and urban communities. These factors include the number of existing health facilities, the availability of medical and health workers, the availability of drugs and basic medicines, income levels, and attitudinal dispositions towards healthcare. Interviews with respondents indicated that different policies for health provision and delivery are applied to different communities, with rural areas receiving minimal benefits from PHC services. This policy arrangement limits the accessibility of rural dwellers to modern and comprehensive health facilities, thereby perpetuating health inequality.

Further findings showed that 99% of private health service organizations in the local government are located in urban areas, leaving rural areas with only 1%. This stark disparity is a clear indication of the health inequality between rural and urban communities. The concentration of private health services in urban areas leaves rural residents with limited options for healthcare, exacerbating the inequality.

The study observed that the shortage of health workers significantly affects the access to healthcare services in rural communities. The unattractiveness of rural areas, due to the lack of social amenities such as good roads, potable water, electricity, consumables, good schools, and adequate accommodation, discourages health workers from residing and working in these areas. This lack of social infrastructure creates barriers to healthcare access and contributes to the health inequalities between rural and urban communities.

It was also found that health workers in rural communities are often not punctual or regular at work, which is attributed to the challenges related to social amenities. The current economic situation has exacerbated this issue, with health workers struggling to afford transportation costs due to increased fuel prices. The hike in transportation fares without a corresponding increase in salaries negatively impacts the delivery of health services in rural areas.

The findings revealed that rural residents often rely more on herbs and traditional concoctions for treating ailments and infections, rather than using orthodox medicine. This reliance on traditional remedies is partly due to deeply ingrained cultural beliefs, which negatively influence the utilization of available healthcare resources in rural communities. Some rural residents deliberately avoid health centers, preferring traditional treatments, which further reduces their access to modern healthcare services.

The study's findings clearly indicate significant health inequalities between rural and urban communities in Owo Local Government Area. The disparities in the distribution of health facilities, the availability of healthcare workers, and the utilization of healthcare services highlight the urgent need for policies that promote equitable healthcare access.

Conclusion and Recommendations

The analysis has revealed significant healthcare inequalities affecting rural communities, particularly in Owo Local Government. Despite the rural communities' contributions to economic and national development, they have been consistently disadvantaged in terms of access to healthcare services compared to urban communities. To make rural communities more productive and active participants in the development process, it is essential to address these healthcare inequalities and eliminate health-related challenges and obstacles hindering rural economic activities. Based on the findings, the following recommendations are proposed:

Revise Health Distributive Policies: Current health distributive policies need to be revisited to favor rural communities. The Primary Health Care (PHC) model, as it is currently designed, is inadequate for addressing the comprehensive healthcare needs of grassroots communities. Establishing general, specialist hospitals and medical centers in rural areas is necessary to reduce the healthcare inequalities these communities face.

Subsidize Healthcare Delivery: The government should subsidize healthcare services at the grassroots level to make them more affordable for rural residents. Ensuring that rural and urban populations have equal access to health services is critical for bridging the healthcare gap.

Equitable Distribution of Health Resources: There must be equity in the distribution of drugs and other health infrastructures between rural and urban communities. Removing unnecessary disparities in the provision of medical facilities will promote equal treatment in terms of supplies, procurements, and health services.

Improve Socio-Economic Conditions: Enhancing the socio-economic conditions of rural dwellers is crucial. Providing the necessary social amenities can improve income and earnings and make rural communities more attractive to health workers. This improvement will reduce income disparities between rural and urban residents, thereby addressing health inequalities.

Promote Orthodox Medicine: There should be increased orientation and campaigns to encourage rural people to embrace orthodox medicine. Raising awareness about the benefits of visiting and utilizing available health facilities can improve healthcare utilization in rural communities.

By implementing these recommendations, healthcare access and quality in rural areas can be significantly improved, reducing the inequalities between rural and urban communities and contributing to the overall development of the region.

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