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INFORMAL MICROFINANCE AND PRIMARY HEALTH CARE IN
EKITI LGA, KWARA STATE

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Abstract: Microfinance provides a promising platform to expand health access and coverage for rural poor that are mostly farmers and urban poor who are in the informal sector of the economy through organized groups. Health in rural area is accessed through primary health and community care which is the most visible and commonly used part of the health system. Using a multi regression analysis, this study examines the impact of informal microfinance on primary healthcare. The study shows that there is positive relationship between informal microfinance and primary healthcare.

INTRODUCTION

Out-of-pocket health expenditure usually increases poverty for rural and urban dwellers. One of the important contributors to the common goal of ending world poverty and diseases is microfinance. Microfinance provides a promising platform to expand health access and coverage for rural poor that are mostly farmers and urban poor who are in the informal sector of the economy through organized groups. Microfinance most especially the informal microfinance increased people access to saving that enables the household to put aside precautionary funds, which they can use in times of death and illness. This saving also provides credit to clients that suffer from prolonged related illness/diseases. Thus such savings served as an insurance cover against liability of loaness in cases of prolonged diseases like malaria fever, blindness and permanent disability. However, the best microfinance programmes can be undermined by the illness of borrowers or their family members, since microfinance provide services that safeguard family health, protect clients and their families from the shock of major health expenses. This is especially true for every poor and rural community where people are exposed to more health risks and have few options for health care. (see Substad and Cheu 1996; Goodland, Onumah and Amadi 1999; Manje, 2000; Saha and Metcalfe, 2011).

Primary health and community care is the most visible and commonly used part of the health system in rural areas. For instance, rural people with mental illness, chronic disease, post acute needs, alcohol and drug problems and younger people with physical and intellectual disabilities have variable access to publicly funded primary health and community care services across jurisdictions. This leads to fewer low birth weight infants; lower infant mortality, especially post-neonatal; few years of life lost due to suicide; few years of life lost due to all expect external causes; and higher life expectancy at all ages except at age 80. Primary health care allows for earlier detection of cancers such as colorectal cancer, breast cancer, uterine/cervical cancer, and melanoma. Primary health care involves four core principles of effective health systems, namely: universal coverage; enhanced patient-centered primary care services; strengthened community-centered public health policies; and effective health system leadership. Thus, the philosophy of

primary health care service includes a holistic understanding of health; recognition of multiple determinants of health; community control over health services; health promotion and disease prevention; equity in health care; research-based methods; accessible, acceptable, and affordable technology. (see Starfield, 2002; Swerissen, 2004; Starfield 2008; WHO, 2008; UNSW, 2010).

In Bolivia, microfinance institutions offer financial products and other services that improve access to actual healthcare services and medicines. For instance, women have regular access to regular check-ups to prevent problems or diagnose them early. If treatment is needed, such women access health loans, health savings or linkages to pay for the service through their microfinance institutions. Besides, microfinance provides a platform for extending health coverage through India's national health insurance programs, by increasing access to health services through awareness generation, creating linkages with health providers, and provision of financing mechanisms such as health loans or health savings plans that can support or supplement health insurance programs. Thus, countries with health care that is organized around tenet of primary health care produce a higher level of health outcomes that includes reduction in total mortality rate, heart disease mortality rates, and infant mortality (See Swerissen, 2004; Starfield, Shi and Micinko, 2005; Starfield, 2008; Rivo, 2008).

In Nigeria, the health sector is principally financed by the government. But the government is faced with various challenges – a stagnant mono-cultural economy that depends on crude oil as a single export commodity; rapid population growth, political instability; non-existence rural workforce policies and strategies; inadequate number of health staff with skills appropriate to the health priorities of rural areas; poor maintenance of equipment; diminishing confidence in public sector health facilities, etc, as well as the spartan living conditions in rural areas. All these made health care services inaccessible to the rural people. This assertion concord with World Health Organization (WHO)'s World Health Report 2006 observation of an unmet health needs in rural and remote regions of Nigeria. (see Adesina, 2009; Awofeso, 2010; Ijaiya, *et al*, 2008; Ijaiya, *et al*, 2009; WHO, 2008; UNDP, 2009; UNDP, 2007).

Thus, an alternative source of health financing is inevitable. Informal microfinance, because of its proximity and other characteristics, provides a platform to expand health access to the rural poor through the provision of credit that offers opportunities to travel and procure medicals to meet the rural dwellers health challenges. Besides, adding health to microfinance can improve health and financial security of clients which holds a great potential for improving the overall health of microfinance institutions. Thus the role of informal microfinance in primary health care services in Ekiti LGA of Kwara State.

The rest of the paper is structured as follows. The next section examines the study area, materials and methods. Section three presents and discusses the results. The recommendations and conclusion are presented in the last section.

STUDY AREA, MATERIALS AND METHODS

Study Area

Ekiti Local Government Area was carved out from the present Irepodun Local Government Area in 1991 by Ibrahim Babangida administration to bring government nearer to the people. The Local Government Area was further split into Ekiti and Oke-Ero Local Government Areas. The present Ekiti Local Government Area has a land mass of about 747 square kilometers, with a population of 54,399 people according to 2006 population census (FGN Official Gazette, 2009). The Local Government Area is located on latitude $7^{\circ} 45'$ North, and Latitude $7^{\circ} 45'$ in its Southern part. It also lies between longitude $5^{\circ} 30'$ south and 5° East in the Eastern reach. The

local Government Area shares common boundaries with Ifelodun and Edu Local Government Areas to the North, and Kogi State to the East, Oke-Ero and Irepodun Local Government Areas to the West. It also shares common boundaries with Ondo State to the South. The major towns and villages include Araromi-Opin, Osi, Eruku, Obo-Ille, Obo-Aiyegunle, Oke-Opin, Isapa, Isare, and their major occupation is farming. (see Kwara State, 2000; Ijaiya, 2010).

Materials

The materials considered for the study are informal microfinance³⁷ and primary health care³⁸. In addition to the use of secondary data, a survey aimed at generating primary data on the impact of informal microfinance on primary health care in Ekiti LGA was conducted between November 2008 and March 2009. The primary data was collected through a set of questionnaire prepared by the Institute for Development Policy and Management in Microfinance Study in Sri Lanka. The choice of the questionnaire was based on its flexibility and comprehensiveness, on how clients used their savings and loans collected from the informal microfinance institutions (see Ijaiya, 2010).

Methods: Sampling Selection Techniques and Model for Analysis of Data.

Sampling Selection Techniques

A stratified sample method was used in the selection of the respondents. In order to have an unbiased selection of sample, four villages³⁹ were randomly selected from the local government areas based on their proximity, socio-cultural and economic variations. Each village saved as our sample unit⁴⁰. In accordance to these sample units, a structured questionnaire was distributed to 50 members of the informal microfinance after a pre-field work visit to identify members of the informal microfinance in each village. This brings the total number of respondents in the LGA to 200 respondents. The questions raised in the questionnaire include background of the respondents, in terms of gender, age, occupation, educational status, household size, etc, and average monthly savings, average amount received as loans, utilization of loan like economic activities, purchase of house or building, for finance of health and education, problems encountered etc, in the last 12 months.

Model for Analysis of Data

Both qualitative and quantitative methods were used in analyzing the data collected for this study. The qualitative analysis, which was based on perception of the rural dwellers, was used to determine the impact of informal microfinance or primary health care (i.e. clients' health care) in the villages under study. The quantitative method comprises the use of descriptive statistics and a multiple regression analysis. The descriptive statistic such as, percentile was used in describing

³⁷ Informal microfinance is the provision of financial services to low-income clients or solidarity lending groups including consumers and the self-employed who traditionally lack access to banking and related services. Microfinance is also broadly defined as a movement whose objectives are to provide financial services and financial needs. The financial services include not only credit but also savings, insurance, and funds transfer. The financial needs include the several types of needs of the poor such as (i) lifecycle needs like weddings, funeral, childbirth, education, homebuilding, widowhood, old age etc, (ii) personal emergencies such as sickness, injury, unemployment, theft, harassment or death, (iii) disasters like fires, floods, cyclones, and man-made events like war or bulldozing of dwellings, and (iv) investment opportunities like expanding business, buying land or equipment, improving housing, securing a job (which often requires paying a large bribe), etc. (see Smith, 2002; Christen, Rosenberg and Ijaiya, 2004; Rutherford, 2004)

³⁸ Primary health care is the provision of first contact, person-focused, ongoing care over time that meets the health-related needs of the people. Population-oriented set of primary care services in a population, and as a population strategy, it requires the commitment of governments to develop a defined community and to address individual problem and population health at an early stage. Primary health care services involve continuity of care, health promotion and education, integration of prevention with sick care, a concern for population as well as individual health, community involvement and the use of appropriate technology. Primary health care targets acute care, aged care, mental health, drug and alcohol, sexual assault etc. and other community based health services. (see UNSW, 2010; Starfield, 2008).

³⁹ The villages are Isapa, Isare, Oke-Opin and Obo-Ile

⁴⁰ The sample unit is a village with a population of between 200 and 500 people.

the socio-demographic characteristic of the respondents, as well as the nature of the informal microfinance existing in the rural areas under study. The multiple regression analysis was used in determining the extent of relationship between informal microfinance and health primary health care (health challenges) in the study area.

The relationship between informal microfinance and primary health care is predicated on the assumption that if there is a functioning private health care market, an increase in government health system expenditure may 'crowd - out' a private health spending i.e. a household diverts its resources towards other uses once the government increases their spending on health. However, a situation where government resources are not effectively used and doctors or nurses do not show up to work at health facilities, idle health equipment, or drugs provided by government are not distributed to patients then people would be forced to finance their health needs. Earlier studies have linked income to health. (see Sala - i - Martin, 1997; Bloom and Cammy, 2003; Bloom et al., 2004; Gyinnal - Brempong and Wilson, 2004; Kamya, 2010).

Based on the above, the model is presented as follows:

$$EAsi = f(Rmfi, VHCSI) \quad (1)$$

It also follows that:

$$Rmfi = (CFi, SFi, CDFi, SSFi) \quad (2)$$

$$\text{and } VHCSI = (Gdri, Edni, Occi, HHsi) \quad (3)$$

Substituting equations (2) and (3) into equation (1), the equation thus gives a multivariate relationship.

$$EAsi = f(CFi, SFi, CDFi, SSFi, Gdri, Edni, Occi, HHsi) \quad (4)$$

With a multiple linear relationship as:

$$EAsi = \beta_0 + \beta_1 CFi + \beta_2 SFi + \beta_3 CDFi + \beta_4 SSFi + \beta_5 Gdri + \beta_6 Edni + \beta_7 Occi + \beta_8 HHsi + U \quad (5)$$

Where:

EAsi = Public health care proxied by the income generated by individual respondents economic activities.

Rmfi = facilities provided by microfinance institutions.

VHCSI = vector of household characteristics of individual respondent

CFi = the amount of credit facilities provided to an individual respondent by informal microfinance in the last 12 months.

SFi = the amount saved by an individual respondents with the informal microfinance in the last 12 months.

CDFi = combating of diseases based on the medical support or the amount provided an individual respondent to procure medicine by the informal microfinance in the last 12

months.

SSFi = the social services facilities based on the nature of social services and the amount provided an individual respondent by the informal microfinance.

Gdri = gender of head of individual household (0 for otherwise, 1 for male.)

Edni = education attained by individual head of household (0 for no school, 1 for primary, 2 for secondary, 3 for tertiary).

Occi = occupational status of individual head of household (0 for unemployed, 1 for farm activities, 2 for non-farm activities.)

HHsi = household size of individual household based on the number of people in a household.

β_0 = Intercept

$\beta_1, \beta_2, \dots, \beta_8$

= parameter estimates (or co-efficient) associated with the role of informal microfinance on health care of the rural dwellers under study.

U = error terms.

To estimate the model, a multiple regression analysis was used to test the validity of the variables under investigation. This has to do with the determination of whether or not the estimates are meaningful and statistically significant to our investigation. The model was therefore verified under two major criteria: (i) a-priori criteria which is based on the signs and magnitudes of the co-efficient of the variables under consideration; (ii) statistical criteria based on statistical theory and usually referred to as the First Order Least Square Test. The following statistical criteria were used: R-square, F-statistic and t-test. The R-square (R^2) is concerned with the overall explanatory power of the (equation) regression, the greater the R^2 the better the fit. F-statistics is used to test the overall significance of the regression analysis and the t-test is used to test the significant contribution of each independent variable. (see Koutsoyiannis, 1977; Charemza and Deadman, 1992; Oyeniyi, 1997; Asika, 2002; Araoye, 2003; Ogunbameru, 2004; Greene, 2008).

The a-priori expectations or the expected behaviour of the independent variables (CFi, SFi, CDFi, SsFi, Gdr, Edu, Occ, HHs) on the dependent variables (EAsi) in the model are Cfi>0., Sfi>0., CDFi>0., SSFi>0., Gdri <0., Edui>0., Occi>0., HHi>0.. An indication that the more the values of the independent variables the more the value of the healthcare services in the rural areas.

RESULT AND DISCUSSION

The result of the multiple regression analysis conducted at 5 per cent level of significance presented in Table 1 was based on the 174 questionnaire returned from the 200 questionnaire distributed to the respondents. The result shows that R^2 is 0.86 which means that more than 80 per cent of the variations of the dependent variables is explained by the explanatory variable. The errors terms take care of the less than 20 per cent which are variables that cannot be included in the model because of some qualitative features. The F-statistics is 10.16 which is greater than the tabulated F-statistic of 2.86 at 5 per cent level of significance. This implies that the model is useful in determining if any relationship exists between informal microfinance institutions and primary health care in Ekiti Local Government Area (LGA) of Kwara State.

Holding the vector of household characteristic constant, the co-efficient and associated t-values of the components of the facilities provided by informal microfinance institutions used in the study indicate that the amount provided to meet health challenges has the expected signs.

Statistically, it is significant at 5 per cent level. Thus, satisfies our a-prior expectations. That is, the more the fund provided as credit facilities, the more the rural dwellers have access to primary healthcare services. This finding is consistent with the findings of Substad and Cheu, 1999; Ver-sluyesen, 1999 and 2000; Donahue, 2000; Johnson and Morduch, 2008 that clients use fund provided as credit facilities by informal microfinance to procure medicine and meet their health challenges.

Table 1: Regression Results of Primary Health Care and Informal Microfinance Institutions in Ekiti LGA, Kwara State

Explanatory variables	Coefficient estimates and t-value
Intercept (t)	-12081.91 (-0.82)
CR (t)	200.55 (2.10)*
β ₁ CDE (t)	3784.05 (0.31)*
β ₂ Gender (t)	320.04 (1.41)
β ₃ Edu (t)	998.97 (0.62)
β ₄ Occ (t)	10.80 (0.07)
β ₅ HH (t)	2597.35 (0.98)
β ₆ AGE (t)	-2044.15 (-0.33)
β ₇ Mar (t)	-457.65 (-0.33)
R ² Adjusted	0.86
F-statistics	0.78
No. of observations	1076
	174

Source: Author's Computations (2010). Significant at 5 per cent of significant

CONCLUSION

Given the empirical analysis of the relationship between informal microfinance and primary health care in Ekiti LGA, findings show that there is a positive relationship between informal microfinance and primary health care. Therefore, there is need to improve and sustain the activities of the informal microfinance in the rural areas so that the dwellers can have more access to funds to finance their health needs.

Base on the above, the study thus recommends that clients of the informal microfinance should ensure regular higher savings and prompt repayment of loan in order to improve and sustain the activities of informal microfinance on one hand. On the other hand, it will ensure that clients have more access to fund to meet their health needs. Besides, this would solve the problem of small credit and default among clients in the LGA.

Government should complement the activities of the informal microfinance by ensuring that drugs are available and cheap in the rural areas of Ekiti. Besides, government should recruit health staff with skills that are appropriate to the health priorities of rural areas, maintenance their poor equipments, and bring health facilities closer to the rural areas. Infrastructural facilities such as roads, electricity etc., should be provided to make the rural areas more accessible. This will reduce the money spent on travelling to receive health care.

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