INFLUENCES OF GENDER ON ACCESS TO HEALTHCARE SERVICES IN AMANSEA RURAL COMMUNITY, AWKA NORTH LOCAL GOVERNMENT AREA

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ABSTRACT
This research work examined the influences of gender on access to healthcare services in Amansea rural community, Awka North Local Government Area of Anambra State, Nigeria. Two research questions guided the study. The feminist theory served as the theoretical framework. The study employed a mixed methods research design using a sample size of 204 respondents. The questionnaire and in-depth interview guide were the instruments used for data collection. They we're administered on a face-to-face basis by the researcher with the aid of two research assistants. Data collected through the questionnaire were processed using the Statistical Package for the Social Science (SPSS) software application. The data were analyzed using descriptive statistics such as frequency tables, simple percentages and charts. The qualitative data collected from the field were transcribed which was thoroughly edited, and analyzed thematically using narrative method of qualitative data analysis. The study found that the nature of gender influences on access to healthcare services in Amansea community include; financial barriers, structural gender inequalities in health sector, social norms restricting female gender access to health service among others. The study also found out that the specific barriers faced by women includes; poverty, cultural hindrances, non involvement of women in decision making regarding health services etc. The study recommends actions to facilitates and improve the relation between formal and informal health sector, and to halt socioeconomic inequalities. The need to involve women organizations as intervention tools to address socio-economic and gender-based disparities in access to healthcare services in Amansea community were also recommended.
Keywords: access to health services, gender, health resources, socioeconomic disparities, women

INTRODUCTION
Access to high healthcare is the fundamental right of every individual, regardless of their socioeconomic status and gender. Access to quality healthcare plays a crucial role in maintaining and improving the health of individuals. It encompasses a broad range of services including preventive care, early diagnosis and treatment of illness and ongoing management of chronic conditions. (Grey Group International Insights, GGI Insights 2024).

Healthcare disparities continue to affect the various marginalized communities across the world. These disparities arise from a complex interplay of various factors such as socioeconomic status, Geographical location, gender or ethnic identity. Healthcare disparities can cause barriers to accessing healthcare services like lack of health insurance, inability to afford healthcare cost, transportation issues, lack of healthcare facilities in local areas. All of these can lead to negative health outcomes of marginalized communities. The villages and

communities in Amansea, Awka North LGA have in one way or the other experienced lack of access to healthcare services due to low socioeconomic status. Most of the people who reside at Amansea are not well to do and have no high earning occupations. They mainly engage in subsistence farming and have low literacy level, all of which affects their access to healthcare. Furthermore, the women tend to suffer more because of the patriarchal culture practiced by the people of Amansea. However, it is the government's responsibility to protect the interest of every member of the community especially with regards to accessing healthcare, irrespective of one's socioeconomic status and gender. As a result, the Government tried to improve healthcare access to the people by increasing the number of trained health workers and improving the quality of healthcare services through Training and capacity building initiatives. Nevertheless, despite government's efforts and improvements in healthcare access in recent years, there are still significant disparities in access to healthcare services in Amansea community. These disparities are particularly pronounced among individuals of low socioeconomic status and women. As a result of these disparities, the public health sector in the area is yet to achieve the 4A's of primary healthcare: Accessibility, Availability, Affordability and Acceptability." There is also very low level of participation of people in health projects. The low socioeconomic status and gender disparities seem to play in their inability to access quality healthcare services. It is against the backdrop of the highlighted problems that this study investigated "Influences of Gender on Access to Healthcare Services in Amansea Rural Community, Awka North LGA, Anambra state.

RESEARCH QUESTIONS

The following questions were formulated to guide the study:

1. How does gender influence access to healthcare resources and services in Amansea rural community, Awka North LGA?
2. What specific barriers or exclusions are faced by women in accessing healthcare services in Amansea Rural Community, Awka North LGA?

CLARIFICATION OF KEY CONCEPTS

Concept of Access to Healthcare Services: Access to health care is defined as having timely use of personal health services to achieve the best possible health outcome (IOM, 1993). Access requires gaining entry into the health-care system, getting access to sites of care where patients can receive needed services, and finding providers who meet the needs of patients and with whom patients can develop a relationship based on mutual communication and trust (AHRQ, 2010). Clinicians note that timely access to health care is important in as much as it might enable patients and physicians to prevent illness, control acute episodes, or manage chronic conditions, any of which could avoid exacerbation or complication of health conditions (NCHS, 2017b).

There are many ways to think of access, and the term *access* is often used to describe factors or characteristics that influence one's initial contact with or use of services. Anderson and Newman (2005) present a framework of health-care utilization that includes predisposing factors, enabling factors, and magnitude of illness. More recently, Levesque et al. (2013) defined access to health care by presenting five dimensions of accessibility: approachability, acceptability, availability and accommodation, affordability, and appropriateness. They saw access as the opportunity to identify health-care needs; to reach,

obtain, or use health-care services; and to have the need for services fulfilled.

Concept of Gender: Gender involves how a person identifies. Unlike natal sex, gender is not made up of binary forms; instead, gender is a broad spectrum. A person may identify at any point within this spectrum or outside of it entirely. People may identify with genders that are different from their natal sex or with none at all. These identities may include transgender, non-binary, or gender-neutral. There are many other ways in which a person may define their own gender.

Gender also exists as social constructs as gender "roles" or "norms." These are defined as the socially constructed roles, behaviours, and attributes that a society considers appropriate for men and women. A person may identify and express their gender in different ways. Gender identity is how a person feels internally, while their expression is how they present themselves to the outside world. For example, a person may identify as non-binary but present as a man to the outside world (Gilmore, 2020).

REVIEW OF RELEVANT LITERATURE ON INFLUENCE OF GENDER ON ACCESS TO HEALTHCARE SERVICES

Specific social, economic, cultural and institutional factors interact with biological factors that influence gender access to healthcare services.

Social Norms with regards to Women's and Men's Roles place Women in a Situation of Greater Vulnerability of being in Poor Health

This issue is particularly exacerbated in relation to sexuality. For instance, women are more susceptible to be infected by STIs and HIV due to gender norms limiting their power of decision and choices in matters of sexuality and sexual relations. Gender norms affect both women and men and determine the appropriate sexual behaviour they both can have. Research has shown that unequal gender relations are a key determinant in explaining the epidemic of HIV in a given country (WHO, 2009). In many contexts, men are essentially allowed multiple partners: a behaviour that increases risks of infection for their spouse. By contrast, women's lower status and value make them particularly vulnerable to HIV, as they have little or no decision-making power in sexual relations and cannot impose the use of protection (WHO, 2009; African Development Bank, 2009). Social norms might also impede women from reporting or even recognizing they might suffer STIs (African Development Bank, 2009). Young women or those not married might also be discouraged to request information about sexual matters or contraceptive methods, by fear of stigmatization (IGWG, 2011).

Discriminatory Practices Hinder Women's Access and Control over their Health.

For instance, in certain settings, women need their husband's permission before receiving health-related information or medical treatment and societal attitudes hinder women's access to those services, especially when they relate to sexual health (African Development Bank, 2009).Low levels of education among girls place them in a difficult position to access to information regarding health issues and rights and to learn how to protect them (PAHO, n.d.)

Resource to Informal or Traditional Healthcare Systems might also Increase the Risk of Women Receiving Inadequate Treatment.
Women might choose to refer to traditional health workers, who have not been properly trained to administrate care, due to a number of social reasons (for example, absence of women mid-wives in local health facilities, cultural status of traditional birth attendants, etc.) and economic reasons (for example, fees to receive maternity care). Conversely, the lack of recognition of the importance of traditional health systems for women might lead to the implementation of inadequate strategies (African Development Bank, 2009).

Structural Gender Inequalities in Health sector Interventions Reinforce Gender Disparities in Health Status, Access and use of Health Services
The power relations established in the relationship between the healthcare user and the healthcare provider is greater when the user is a woman and the provider a man, as there are socially pre-existing inequalities in women and men's social status and education (IGWG, 2011). Health care providers are not exempt from gender stereotypes and biases with regard to the respective roles of women and men in the household and the community. For instance, they might demonstrate negative attitudes towards users (and especially women) seeking reproductive health knowledge and advice, thus impeding their access to healthcare (African Development Bank, 2009).

Financial Barriers can prevent Women from accessing Health care
Healthcare can be expensive, and its cost has specific repercussions for women, who are less likely to have paid work and to experience the health benefits linked to formal employment (HOM, 2006). When maternal healthcare services charge user fees, it has a substantial impact on the rate of women who make use of those services during pregnancy and childbirth, and can increase maternal mortality (WHO, 2009). The same is true of the high cost of contraceptives, which limits women's access to sexual and reproductive health services (African Development Bank, 2009).The costs of follow-up health services might also deter women from continuing treatment. Furthermore, as primary caregivers, women face higher health costs than men due to their greater use of healthcare for themselves and the people they care for. The negative impact of healthcare costs on women's health and their economic independence are reinforced by the deterioration of public health systems in developing countries and by privatization, made without appropriate guarantees of universal access to affordable, quality health care services (Asian Development Bank, n.d). Research has shown that healthcare privatization is often associated with higher costs for basic services and that women and girls are most at risk of being excluded from treatment and care (Oxfam, 2009).Certain groups of women face additional difficulties to access healthcare due to its cost, including elderly women, young women, unwed women, etc

Multiple Roles that Women perform affect their Health and their Access to Healthcare:
The gender-based division of labour impacts on responsibilities to take care of the sick and the elderly at home or in health facilities. Women are often in charge of providing the care that dependents cannot receive in the formal health system. Their contribution is not recognised nor valued and they do not receive sufficient social, economic, or psychological support (Asian Development Bank, 2019). Research has shown that women's responsibilities in the household

partly explain why women tend to wait longer than men before seeking medical care. Women often deny their health issues by fear of disrupting household functioning. This approach means they receive delayed treatment, or inadequate follow up, with disastrous consequences on their health (African Development Bank, 2009). For instance, women might not be willing to get to hospital if it is located far from their house and no childcare facilities are provided.

THEORETICAL FRAMEWORK: THE FEMINIST THEORY

The feminist theory was propounded by Mary Wollstonecraft 1792. It is a theoretical approach that seeks to understand the ways in which gender and power intersect, and how these intersections contribute to social and political inequalities between men and women. This theory aimed to challenge the gender-based discrimination and oppression experienced by women. Feminist theory recognized that gender is a social construct that is shaped by cultural, historical and political factors. It highlights the way in which gender intersects with other social categories such as race, class, sexuality and ability to create complex and intersecting forms of oppression and privilege. One of the key tenets of feminist theory is the belief that women's experiences, perspectives and voices have been historically marginalized and silenced in patriarchal societies. Feminist theorists argue that this marginalization is perpetuated through social norms and institutions that prioritize masculine values and ways of being, and that the exclusion of women from positions of power and influence is both a cause and a consequence of gender inequality.

This theory is relevant to this study because it argues that denial of woman to access healthcare services is rooted in patriarchal structures that promote the subordination of women and reinforce gender inequalities. The theory also points to the ways in which gender disparities is often normalized and even condoned in certain cultural contexts. For example, traditional gender roles that position women as submissive and passive which is obtainable in Awka North LGA can contribute to a culture in which deprivation against women is seen as acceptable or even necessary to maintain social order. The theory also highlights the ways in which social institutions can perpetuate gender disparities. Feminist theorists argue that addressing gender disparities require not just individual interventions, but also structural changes that challenge patriarchal structures that promote gender equality. This may involve implementing policies and programs that provide support for marginalized women such as shelters, counseling services and free healthcare services. It may also involve education campaigns and cultural initiatives that challenge traditional gender roles and promote healthy relationships based on mutual respect and equality.

The theory has been criticized on the grounds of essentialism which suggests that feminist theories may perpetuate the notion of a fixed, universal female identify. It has also been criticized for lack of attention to men's issues.

MATERIALS AND METHODS

The location of study is Amansea in Awka North LGA of Anambra State, Nigeria. Amansea consists of five villages namely: Orebe, Amaowelle, Umuokpala, Egbeagu and Okeukwa. The population consists of natives who are mainly farmers. Others are civil servants, business owners and students. The people are known for farming, block industries and hospitality business. The area has a very rich cultural heritage as evidenced by the periodic celebration of indigenous festivals such as the New Yam festival.

The population of Amansea community is estimated at 76,858 (Awka North L.G.A Department of Planning and Statistics, 2023). However, the target population for this study is the adult residents of Amansea aged 18 years and above. This is because people within that age range are generally mentally developed enough to participate in a study of this nature. From the target population, the sample size of 204 was generated using the Taro Yamane (1967: 581) formula for determining sampling size.

The sample is a true representation of the total population. This sample size is adequate in view of the time, financial and material resources available to the researcher and for all the statistical computations.

The mixed method research design was used for the study. Multi-stage sampling technique was combined with simple random option in selecting204 respondents. However 4 persons were purposively selected for in-depth interview. The questionnaire and in-depth interview guide were the instruments used for data collection and we're administered on a face-to-face basis by the researcher with the aid of two research assistants. Data collected with the questionnaire were processed using the Statistical Package for the Social Science (SPSS) software application. The data were analyzed using descriptive statistics such as frequency tables, simple percentages and charts. The qualitative data collected from the field were transcribed which was thoroughly edited, and analyzed thematically using narrative method of qualitative data analysis.

FINDINGS AND DISCUSSION

A total of two hundred and four (204) questionnaire schedules were administered by the researcher; out of which six (6) were misplaced during the field survey. Therefore, only one hundred and ninety-eight (198) correctly filled and returned copies of questionnaire were used for analysis in this study. The response rate is (97.1%). The quantitative data were also complemented by data from the in-depth-interview.

Personal Data of Respondents This section deals with the analysis of socio-demographic characteristics of the respondents like gender, age, level of educational attainment, religious affiliation, marital status and income.

Table 1: Distribution of Respondents by their Socio-Demographic Characteristics

Social Demo-graphic Variables		Frequency	Percent
Age	18-27	144	72.7
	28 -37	39	19.7
	38- 47	8	4
	48 and above	7	3.5
	Total	**198**	**100.0**
Sex(Gender)	Male	102	51.5
	Female	96	48.5
	Total	**198**	**100.0**
Religious Affiliation	Christianity	194	98
	Islam	1	0.5
	Traditional	3	
	African religion		1.5

	Total	**198**	**100.0**
Level of education	SSCE/WASCE	25	12.6
	OND/NCE	19	9.6
	HND/B.Sc	114	57.6
	Post-Graduates	40	20.2
	Total	**198**	**100.0**
Marital status	Single	192	97
	Married	6	3
	Divorced	0	0
	Separated	0	0
	Widowed	0	0
	Total	**198**	**100.0**
Occupation	Civil servant	10	5.1
	Entrepreneur	101	51
	Artisan	1	0.5
	Unemployed	86	43.4
	Total	**198**	**100**
Place of resident	Rural	188	95
	Urban	10	5
	Total	**198**	**100**
Income	1000- 20000	133	67.1
	21000 – 35000	34	17.1
	36000 - 55000	5	2.5
	56000 and above	26	13.3
	Total	**198**	**100**

Field survey 2024

Table 1 show that 144(72.2%) constituting the majority of the respondents are within the age bracket of 18-27 years. The mean age of respondents is 22.5 years old. It could be seen also that 102(51.5%) of the respondents are Males, while 96(48.5%) are Females. 194(98%) of the respondents are Christians, 1(0.5%) respondents are Islam while 3(1.5%) respondents are of the Africa Traditional Religion. Similarly, 25(12.6%) respondents have SSCE as the highest education attained, 19(9.6%) respondents are of OND/NCE, 114(57.6%) respondents are of B.Sc./HND, while 40(20.2%) respondents had Post-Graduate Degree. 10(5.1%) of the respondents are civil servants, 101(51%) respondents are entrepreneur, 1(0.5%) respondent identified as an artisan, while 86(43.4%) respondents are unemployed.188(95%) of the respondents indicated that they reside in the rural, while 10(5%) respondents identified urban. 133(67.2%) of the respondents earns between #1000- #20000 monthly, 34(17.2%) respondents earn #21000-#35000 monthly, 5(2.5%) respondents earn #36000 - #55000, while 26(13.3) earns #56000 and above. Table1also shows that majority of the respondents are single, 6(3%) are married, while there were no responses for separated, divorced or widowed.

Analysis of Research Question

How does gender influence access to healthcare resources and services in Amansea Rural Community, Awka North LGA?

Table 2: Distribution of Respondents' by their Views on whether Gender has influence on Access to Healthcare Service in Amansea Community

Responses	Frequency	Percent
Yes	198	100
No	0	0
Total	**198**	**100**

Field survey 2024

Table 2 shows that 198 (100%) respondents held the view that gender influence access to healthcare service in Amansea community. Thus, all the respondents held the view that gender influence access to healthcare service in Amansea community.

Table 3: Distribution of Respondents' by their Views on the Nature of Gender Influences on Access to Healthcare Service in Amansea community

Responses	Frequency	Percent
Structural female gender related inequalities in health sector	13	6.6
Resort to informal / traditional healthcare system by men	70	36.4
Financial barriers/Exclusions faced mainly by women	97	49
Social norms restrict female gender access to health services	10	5.1
All of the above	8	4
Total	**198**	**100.0**

Field survey 2024

Table 3 shows that 97(49%) respondents held the view that financial barriers or financial exclusions is the nature or type of gender influences on access to healthcare service in Amansea community, while 8(4%) of the respondents indicated all of the above. Thus, majority of the respondents are of the opinion that financial barriers impede women access to healthcare service in Amansea community. Response from the qualitative instrument states thus;

> …..One can categorically state that women are the ones suffering or at the receiving end in whatever policies or programmes that are enacted to better lives. In relation to healthcare, do you know that some women are not allowed to visit the hospital on their own when they are ill expect there is approval by the husband or father. Even in situations where an adult female goes to see a doctor for medical issue, more times they enquire for her husband or a male figure in her life. My dear, females have always been at the disadvantage point even with their level of education. The society made it so (IDI, 22year, Female, Student)

Research Question 2

What specific barriers or exclusions are faced by women in accessing healthcare services in Amansea Rural Community, Awka North LGA?

Table 4: Distribution of Respondents by their views on Specific Barriers or Exclusions faced by Women in Access to Healthcare Services at Amansea Community

Responses	Frequency	Percent
Poverty	53	26.8
Lack of insurance and inability to pay for services	102	51.5
Cultural hindrances	25	17.2
Non-availability regarding decision making of needed services	9	4.6
Total	**198**	**100**

Field survey 2024

Table 4 shows that 102(51.5%) of the respondents indicated lack of insurance and inability to pay for service as barriers of low socioeconomic status of women's access to healthcare services in Amansea community, while 9(4.5%) of the respondents opted for non-availability regarding decision making of needed service . Summarily, a good number of the respondents are of the view that lack of insurance and inability to pay for service are barriers of low socioeconomic status of women's access to healthcare services in Amansea community.

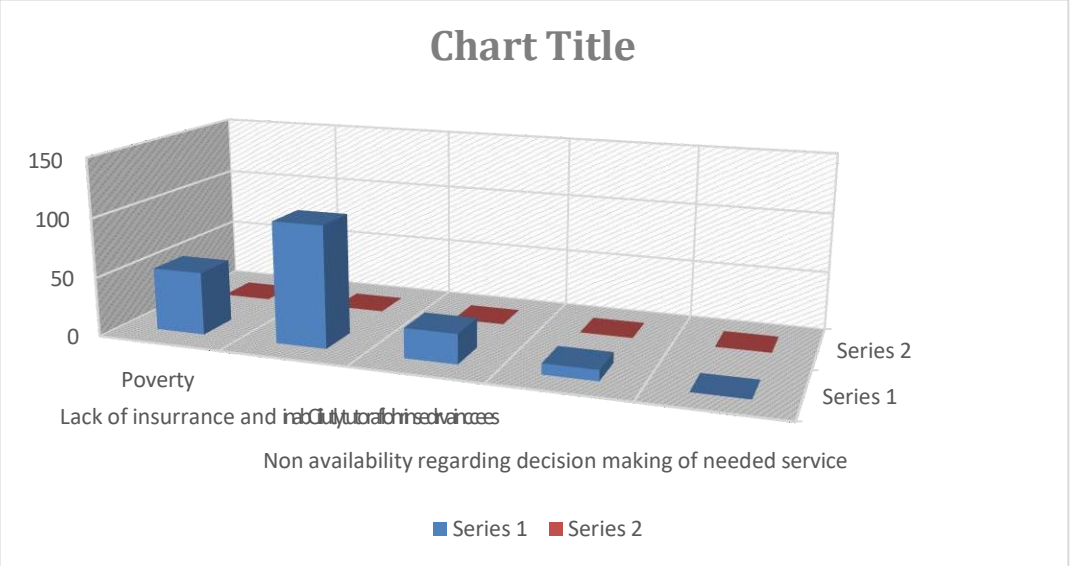

Fig 1. Diagram showing respondents' by their views barriers of low socioeconomic status of women's access to healthcare services in Amansea community.

CONCLUSION

This research work was conducted to study the influences of gender on access to healthcare services among the people of Amansea community, Awka North LGA, Anambra state. Based on findings, it could be concluded that t there are barriers that hinder women access to healthcare services. There are also institutions that encourage the persistence of gender disparities in healthcare services in the study location. Improvement in access of women to health services will be best actualized by dismantling existing barriers.

RECOMMENDATIONS

Based on the research findings, the researcher put forward the following recommendations:

1. **Avoid reinforcing Socioeconomic Inequalities:** It is important to ensure that healthcare services are accessible and affordable for all members of the community, regardless of their socioeconomic status. This can be achieved by implementing policies and programs that promote health equity and reduce disparities.
2. **Involving Women's Organizations**: Involving women's organizations, women groups, unions, neighbourhood associations and cooperatives in the decision-making process and in problem identification, strategy formulation and implementation can help to ensure that the needs and perspectives of women are taken into account and they can also provide valuable insights on the challenges faced by women in accessing healthcare services, and can play a crucial role in advocating for improved healthcare outcomes for women.
3. **Building Actions to Facilitate and Improve the Relation between the Informal and Formal Health System**: Building actions to facilitate and improve the relations between formal and informal health systems can help to ensure that patients receive comprehensive and coordinated care. This can be achieved through collaboration and partnership-building between formal healthcare providers and informal health systems, as well as through the integration of traditional and conventional healthcare practices.
4. **Engaging Men:** Engaging men in the decision-making process and involving them in efforts to improve access to healthcare services can help to ensure that the needs and perspectives of all community members are taken into account. Men can also play a crucial role in advocating for improved healthcare outcomes for themselves and their families.

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