EFFECT OF WOMEN'S INCOME ON ACCESS TO HEALTH CARE SERVICE IN BENUE STATE, NIGERIA

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Abstract
The objective of this study is to ascertain the effect of women's income on access to health Care Service in Benue State Nigeria .The methods used include the chi-square test which validates the robustness of the model, the CUSUM square test was used to test for the stability while the Z-test was employed for the hypothesis testing of the variables. The logistic regression was used for the model estimation. The finding revealed that income, education, Age, medical cost as well as distance are key variables necessary in influencing access to health care service in Benue state. The hypothesis (Z)-test indicates that women's income is statistically significant on health care access predicted by the model .Furthermore, income was more impactful in influencing access to health care service hence, women who earn income have greater access to health care service on immunization, care service, disease treatment and antenatal care visits in Benue State. The result further showed that the chi-square statistic for diagnostic test showed that the regression model was robust and fit for the analysis. The paper recommended that there should be synergy between government, individuals and Non-governmental Organizations in establishing more affordable and efficient clinics for equal access in rural communities in all the 23 Local Government Areas in Benue State.

Key words: income, access, Health care, Women, Service

I Introduction

Income is very critical for the survivability and sustainability of individuals. It facilitates human well-being, health status and political power as well as the living standard (Monday, Khan, Chakma and Hossain, 2009**).** Limitation on women's income affect access to basic needs.

The World Bank (2001) described low income deprivation of well-being to an individual that it affects access to consumption of goods, education and health thereby rendering individuals to be vulnerable, being exposed to risk, lack of opportunity to be heard and powerlessness.

Women income should be seen as a contemplative attempt in increasing and improving the consumption patterns and livelihoods of the rural families (Haque and Yamao, 2009; Panda, 2009; Monday et al., 2009; Hoque and Itohara, 2009). Therefore, when Women earn income, it will help them improve their access to medical services; payment of children's educational fees, improve the sanitation facilities; improve the nutrition and provide good health to the family. Down (2007)

Globally, access to health care varies according to income distribution. Thus, the

developed countries tend to have a better access to health care than the developing countries (Peters *et al.*, 2008). Hnce, healthcare distribution in the Less Developed Countries follows the rich-poor lines leading to an inverse care. More so, access to income impacts frontally on the utilisation of all forms of healthcare services and differential health outcomes of users (Makita-Ikouaya *et al.*, 2010; Simões and Almeida, 2011).

Consequently, health care access among women in Benue State is a facsimile of any state in Nigeria. According to National Demographic Health Statistics (2013) 60% of pregnant women deliver their babies at home without access to antenatal care visits in the rural areas. The situation become worst in North East and North West regions of Nigeria where over 79% of pregnant women age 15-49 deliver their babies at home.(National Population Commission (NPC) [Nigeria] and ICF International 2014). while in the rest of the Regions such as South South, South East. South West as well as North Central, have only 60% of their pregnant women in deliver at home rather than a health facility.(National Population Commission (NPC) [Nigeria] and ICF International 2014]. And less than 10% of the Nigerian population have insurance cover in Nigeria. (Onwujekwe , Hanson & Uzochukwu ,2012). leaving the most vulnerable populations in Nigeria are without social and financial risk protection. Poor people constitutes about 70% of the Nigerian population.(National Bureau of Statistics , 2010). They lack access to basic health services, which social and financial risk protection should provide, because they cannot afford it.

For Women's right to be protected they are expected to have exclusive right to health access which would provides the basis for the overall well-being of their family. The health of any society cannot be guaranteed unless women's access to health care services can be made available (Ujah, 2013).

This is the motivation that inspire this study. Unfortunately, the scenario is different in Benue State due to the inability of government to provide for the necessary health services required by women as a result of problems like accessibility, availability, affordability Adequacy, acceptability and sustainability.(Agbor, 2020),

Improvement on Women's earnings can provide them access to resources to avoid being exposure to health risks. Research shows that Women with higher incomes consistently experience better health outcomes than those with low incomes and those living in poverty especially in Benue State (Agbor, 2020).

Available statistics from the World Health in Nigeria (UNICEF and WHO (2015) shows that the maternal mortality ratio for Nigeria has remained quite high by 814 per 10, 000 live births, the average life expectancy at birth as at 2017 was 53.9 % compare with life expectancy of 93 in japan and 80 in Switzerland (UNDP, 2007). Besides, 11,854 deaths from infectious diseases were reported in Nigeria in 2006 and 15,680 in 2007. In 2005, HIV/syphilis sero prevalence rate in Nigeria was 11.4% and 1% in developed countries (NBS, 2007).

The high rate of maternal mortality and under-five mortality in Nigeria is largely due to inadequate immunization coverage, lack of awareness on part of the public, poor nutrition, unsafe water and poor sanitary environment (Eneh, 2011).

Studies done by other scholars such as Bintabara,Nakamura, & Seino (2018); Shehrin, Mark, Shahidul, Mohammad, Asiful, Syed, Hanifi William, Saseendran, & Abbas (2019) and Hunter, Harrison, Portela , & Bick (2017) justified the this study because these

Scholars investigated the effect of income, insurance type, race/ethnicity, marital status, education, and health status on the number of physician visits and the likelihood of having unmet access need. as well as effects of cash transfers and vouchers on the use and quality of maternity care services and income provision improve healthcare utilisation in the continuum of maternal care for poor pregnant women, These studies were conducted on environment that have both social cultural, economic and demographic differences.Non of these studies looked at the effect of women income on health care service in Benue State hence this study will fill this gap..

Women living in Benue state have the least access to health care and other health facilities that could supply safe life as well as improved health, only 26% of women in the ruralcommunities have access to health care service in Benue state implying a small level of access to health care service delivery among women in Benue State (UNICEF, 2005). This imply that about 74 percent of women in Benue State do not have adequate access to health care services. The link and crucial component of health related to population and socio-economic development is not the case in Benue State. The health indicators in Benue State are thefefore appalling.

Based on the above, this research has sought to answer the basic question: What is the effect of income of women on access to health Care Service in Benue State, Nigeria? While the specific objectives are: (i) To ascertain the effect of women's income on access to health Care Service in Benue State, Nigeria . The hypotheses of the study is: **H_{01}:** income has no effect on access to health Care service in Benue State, Nigeria.

II Literature Review

2.1.1 Concept of Women's Income

According to Micevska and Rahut (2008), Women's Income refers to different kinds of activities that attract or generate money for women which are found in both rural and urban areas such as crop production, fish production, animal rearing, farming activities, food processing as well as paid jobs.

In another vein, Pathways, (2011) explain that Women's Income is a vehicle that facilitates improved access to education, health care and employment or livelihoods. For instance, there is evidence to support the claim that education facilitates changes in cognitive ability and that this, in turn, supports women and girls 'critical awareness and their ability to question and reflect on their lives.

Income correlates highly with risk factors for chronic disease: for example, people who have lower family income have higher rates of heart disease, stroke, diabetes, or hypertension, and have four or more common chronic conditions (NCHS, 2017). People in families whose income is less than the acceptable poverty level are more likely to be obese and to smoke cigarettes than wealthier people.

One can therefore deduced from the foregoing definitions as stated above by the authors that Women's Income helped in need actualization; medication, nutrition, payment of children school fee. People with low incomes tend to have more restricted access to medical care, and face greater financial barriers to affording deductibles, copayments, and the costs of medicines and other health care expenses.

2.1.2 Access to Health Care

According to Susanne, (2013) Access to health care is concerned with helping people to

command appropriate health care resources in order to preserve or improve their health. Access is seen as a complex concept which includes four fundamental aspects. If services are available and there is an adequate supply of services, then the opportunity to obtain health care easily exists, and a population may 'have accesses to services. The extent to which a population 'gains access' also depends on financial, organisational and social or cultural barriers that limit the utilisation of services.

National Healthcare Quality Report, (2013) states that Accesss to helath care requires three distinct steps (i) Gaining entry into the health care system (usually through insurance coverage) (ii) Accessing a location where needed health care services are provided (geographic availability) (iii) Finding a health care provider whom the patient trusts and can communicate with (personal relationship)

While (Access and Disparities in Access to Health,(2016) stressed that Access to health care impacts one's overall physical, social, and mental health status and quality of life. Access to care often varies based on race, ethnicity, socioeconomic status, age, sex, disability status, sexual orientation, gender identity, and residential location.

2.2. Theoretical Orientation

The theoretical underpinning of the study is premised on the theory of Andersen Behavioural in 1968 . This theoretical framework adopted offers insights on the mechanism and context underlying the conditions that either facilitate or impede health care use (Andersen 1968). An individual's access to health care service is considered to be a function of three characteristics:

(1) Predisposing Factors: The socio-cultural characteristics of individuals that exist prior to their illness. (i) Social Structure: Education, occupation, ethnicity, social networks, social interactions, and culture. (ii) Health Beliefs: Attitudes, values, and knowledge that people have concerning and towards the health care system (iii) Demographic: Age and Gender

(2) Enabling Factors: The logistical aspects of obtaining care. (i) Personal/Family: The means and know how to access health services, income, health insurance, a regular source of care, travel, extent and quality of social relationships (ii) Community: Available health personnel and facilities, and waiting time (iii) Possible additions: Genetic factors and psychological characteristics

(3) Need Factors: The most immediate cause of health service use, from functional and health problems that generate the need for health care services. "Perceived need has better helped to understand care-seeking and adherence to a medical treatment, while evaluated need has been more closely related to the kind and amount of treatment that will be provided after a patient has presented to a medical care provider." (Andersen, 1995)

(i) Perceived: "How people view their own general health and functional state, as well as how they experience symptoms of illness, pain, and worries about their health and whether or not they judge their problems to be of sufficient importance and magnitude to seek professional help." (Andersen, 1995)

(ii) Evaluated: "Represents professional judgment about people's health status and their need for medical care." (Andersen, 1995).

Based on the above explanation, Anderson Behavioural Theory has been adopted for this study to provide the basis for explaining the effect of women's income on access to health care delivery service in Benue State.

2.3. Empirical Review

A study was conducted by Goudge, Gilson, Russell, et al (2009) on income Affordability, availability and acceptability barriers to health care for the chronically ill: Longitudinal case studies from South Africa. They used qualitative longitudinal research and employed descriptive analysis of textual data of household interactions with the health system. They found that 74% of health problems were 'chronic', 48% of them had no treatment action taken in the previous month and only 12 (35%) were receiving regular treatment. Livelihoods exhausted from previous illness and death, low income, and limited social networks, prevented consultation with monthly expenditure for repeated consultations was as high as 60% of income. Also, interrupted drug supplies, insufficient clinical services at the clinic level necessitating referral, and a lack of ambulances further hampered access to care. However, productive patient-provider interactions not only facilitated appropriate treatment action but enabled patients to justify their need for financial assistance to family and neighbours, and so access care. They concluded that strengthening the public sector is very important not only to improve drug supply chains, ambulance services, referral systems and clinical capacity at public clinics, and to address the financial constraints faced by the socially disadvantaged, but also to think through how providers can engage with patients in a way that strengthens the therapeutic alliance.

A related research conducted by Hunter, Harrison, Portela , & Bick (2017) on the effects of cash transfers and vouchers on the use and quality of maternity care services using the Joanna Briggs Analysis. They found that out of 51 studies (15 more than previous reviews) and 22 cash transfer and voucher programmes suggest that approaches tied to service use (either via payment conditionalities or vouchers for selected services) can increase use of antenatal care, use of a skilled attendant at birth and in the case of vouchers, postnatal care too. The strongest evidence of positive effect was for conditional cash transfers and uptake of antenatal care, and for vouchers for maternity care services and birth with a skilled birth attendant. However, effects appear to be shaped by a complex set of social and healthcare system barriers and facilitators. Studies have typically focused on an initial programme period, usually two or three years after initiation, and many lack a counterfactual comparison with supply-side investment. They concluded that future research should use multiple intervention arms to compare cost-effectiveness with similar investment in public services, and should look beyond short- to medium-term service utilisation by examining programme costs, longer-term effects on service utilisation and health outcomes, and the equity of those effects.

Also, a study by Shehrin, Mark, Shahidul, Mohammad, Asiful, Syed, Hanifi William, Saseendran, & Abbas (2019) on how income provision improve healthcare utilisation in the continuum of maternal care for poor pregnant women? Experience from Bangladesh. A Cross-sectional surveys were carried out in the Chattogram and Sylhet divisions of Bangladesh. Using Cluster Regression analysis. They found that a significantly higher proportion of voucher-recipients belonged to the high-utilisation cluster compared to non-voucher recipients (43.5% vs. 15.4%). For the poor voucher recipients, the probability of belonging to the high-utilisation cluster was higher compared to poor non-voucher recipients (33.3% vs. 6.8%) and the probability of being in the low-utilisation cluster was lower than poor non-voucher recipients (13.3% vs. 55.4%). They concluded that income programme including voucher programme enhanced uptake of the complete continuum of

maternal care and the benefits extended to the most vulnerable women. Another study investigated in Ethiopia by Tamirat, Tessema, & Kebede (2020) on Factors associated with the perceived income barriers of healthcare access among reproductive-age women in Ethiopia: Using a generalized estimating equation (GEE) model. They found that the magnitude of perceived barriers of healthcare access among reproductive-age women was 69.9% with 95% to at least one or more of the four reasons. The result further showed that rural resident , age, divorced/separated, had no health insurance coverage, poorer and middle wealth no education, primary education and secondary education factors associated with the perceived barriers of health care access. They concluded that a significant proportion of women of reproductive age faced barriers to healthcare access, of which money and distance were the most frequently perceived barriers.

A nother study conducted in Sub-Sahara Africa by **Azuh, Adeyemi, & Oluwatomisin** (2021) on income decision of women access to healthcare services in sub-saharan Africa. Using dynamic panel model and Generalized Method of Moments (GMM) They harmonized the theoretical strands in the literature by describing the measure of access determinants as three main components; *i*. Health service availability, *ii*. Health service utilization and *iii*. Health service decision. The result showed that health service decision indicators such as female bank account ownership, female labour force participation, attainment of basic education and female household headship were important in enhancing women's access to healthcare facilities. They concluded that women's health outcomes were more responsive to health service utilization; implying that service utilization is an important proof of healthcare access in Africa.

III Methodology

The analytical tools and technique employed for this work includes: Chi-Square Goodness of Fit Tests (Omnibus test) to ascertain the robustness of the model, the normality test and the Z- test for testing the hypothesis and a logistic model is used as a method of estimation The entire test is based on 5 percent level of significance (LOS).

3.1 The Model

The model for the study is the logistic model. A Logistic model is a model that takes two values called a binary value(0.1) .For a dependent variable that takes a yes or no answer, while the independent variables takes quantitative values. It is parsimonious, it provides effective argument and the predicators appear to be intuitively reasonable. The model operates under the assumption of a distribution of disturbance.

Logistic regression is used when the dependent variable is dichotomous. The binary dependent variable takes on the values of zero (0) (if the such event cannot happen) and one (1) (if such even will happen).Economically we can say the two events are independently and identically distributed with the type 1 extreme values distribution with cumulative distribution function.

3.2 Model Specification

The study adopts the logistic model proposed by work of Maddala (1983) on Limited-Dependent and Qualitative Variables selection using Logit model which estimates the probability of accessibility to health care facilities for the j- choice for a decision maker with characteristic x.

Logistic model is parsimonious. The model operate under the assumption of a distribution of disturbance.

Thus the model of this study is specified as:

$$P(Y) = \frac{e^{\pi i}}{1-e^{\pi i}} \quad \text{---------- 3.3}$$

Where Y measures health care access, then Y might have access (1), Y does not have access (0), linearizing equation (3.1), we have

$$\text{Logit}(Yi) = \frac{pi(y=1)}{1-pi\,(y=0)} = \beta_0 + \beta_1 X1 + \beta_2 X2 + \beta_3 X_3 + \beta_4 X_4 + \beta_5 X_5 + \text{--} + \beta_n X_n + \varepsilon_n \quad \text{---3.4}$$

Where:

Logit (Yi) is binary values for Access to health l care service, pi/1-pi is the ratio of the probability that women have access to to that women do not have access to health care service.

β_0 = constant, β_1 - - -β_5 are logistic regression coefficients health care service, X_1- -Xn are independent variables

ε_n = Error term

Fitting in the variables of our interest, the model is expressed as

$$\Pr(AHC = Ji) = \beta_0 + \beta_1 INC + \beta_2 MedCost + \beta_3 Age + \beta_4 EDUC + \beta_5 Dist + \mu \text{ - ---3.3}$$

Where $Ji = \{1 \text{ if } J_i > 0, 0 \text{ otherwise}$

Where:

AHC =Access to health care service (1 if family members have access to health care and 0if otherwise)

INC=income of women measure in Naira, MedCost =Medical fees measured in Naira,

Age= Age of Years of women measured by number of years ,EDU =Number of years of schooling, Dist.=Distance to the health facility(measured by the number of kilometres covered)

The apriori expectation becomes, $\beta_1, \beta_3, \beta_4 > 0$, (expected to be positive); and $\beta_2, \beta_5 < 0$ (expected to be negative).

3.3 Variable Definition

S/N	Variable	Type
1	Access to Health Care Implies women are not denied from contacting some health care providers in their Local Government Areas.	Dependent
2	Income This is the amount of money earned by women in a year measured in Naira	Independent
3	Age This is the number of years live by a women it is measured in years	Independent
4	Medical Cost fees charged in accessing health services measured in naira terms	Independent
5	Education Number of year of schooling	Independent
6	Distance How far a women is from a health f facility (measured in kilometers)	Independent

IV Result Analysis

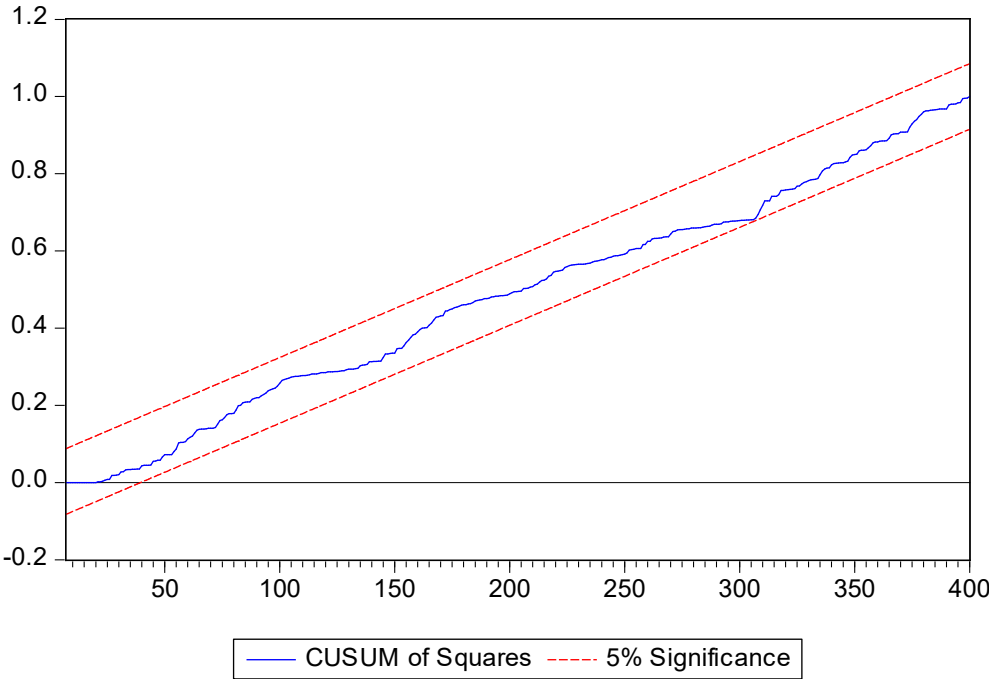
4.1.1 . Chi-Square test

		Chi-square	df	sig
Step1	step	19.685	5	0.001
	Block	19.685	5	0.001
	Model	19.685	5	0.001

Source: Field data (2021)

In table 4.1, the model chi-square has a value of 19.685 with 5 degrees of freedom, and a probability of $p = 0.01 < \alpha = 0.05$ level of significant. Thus, the indication is that the overall model is very significant when all the five independent variables are entered.

Fig. 4.1 CUSUM of Squares for the model of Access to Health Care



The model stability analysis on the other hand represents graphically the cumulative sum of recursive residuals squares (CUSUM of square) together with critical lines of 5% significance. Since the sum of recursive residuals squares line lies inside the two critical lines Access to health care regression equation parameters are considered stable. Hence the model is good to be estimated.

4.1.3 Logistic Regression Estimation on Access to health care

Variable	β	Z-stat	S.E	OR (95% CI) Lower upper	Prob.
C	-0.908702	-1.741006	0.521941	0 .763	0.0817
INC	1.8607	0.327345	5.67E-07	1.000 (1.000 -1.000)	0.742
AGE	0.008780	-0.704081	0.01247	1.000 (1.000 - 1.0000)	0.481
MedCOST	- 2.3706	0.379149	6.26E-06	0.982 (0.958 - 1.006)	0.704
EDU	0.084102	3.250209	0.025876	1.133 (0.904 - 1.421)	0.0012
DIST	-0.038596	-3.890826	0.009920	0.965 (0.947 - 0.984)	0.0001

Source: Source: e-view 2021

The model above shows that all the explanatory variables were correctly signed in line with the apriori expectation. The result indicates that for every one unit change in the probability of women annual income will result to 1.860 increases in the probability of accessing health care service in Benue State holding other explanatory variables constant. In order words, there is a positive linear relationship between annual income of women and access to health care service delivery in Benue State. This implies that women who earn income have greater access to health care service on women immunization, delivery service, disease treatment and antenatal care visits in Benue State. In terms of the odd ratio, when the annual income of women attending health facility is increased by one unit the odd ratio is 1.0000 times large therefore, women of child bearing age is 1.0000 times likely encouraged from accessing health care service.

Also, a unit change in the probability of women age will lead to an increase of 0.008780 in the probability of accessing health care service in Benue State holding other explanatory variables constant. This implies that there is a positive relationship between ages of women and access to health care service delivery in Benue State.

In terms of the medical cost, a unit change in the probability of medical cost will result to - 2.370 decrease in the probability of accessing health care service in Benue State holding other explanatory variables constant. This means there is a negative relationship between medical cost (fee charges) and access to health care service delivery in Benue State. Furthermore, when the medical cost of women attending health facility is increased by one unit the odd ratio is 0.982 times large therefore, women of child bearing age are 0.982 times likely lower in accessing health care service. As women become advanced in age the greater the need for access to health care service. Younger ladies are less likely predisposed to having access to health care service in Benue State. Regarding the age of women it shows that a one unit increase in odd ratio of 1.0000 times large indicates that women of child bearing age are 1.0000 times likely increase in accessing health care service. This finding was supported by studies done by Jones, Peter and Dadson (2018) who analysed determinants of antenatal healthcare utilization by pregnant women in third Trimester in Peri-urban Ghana. From the regression result, age, household size, and occupational status were identified as the important socioeconomic determinants of antenatal care utilisation among the respondents.

Similarly, a unit change in the probability of educational levels of women will lead to 0.084102 increase in the probability of accessing health care service in Benue State holding other explanatory variables constant. This also implies that there is a positive relationship between educational level and women access to health care service delivery in Benue State.

The results also demonstrates that a unit change in the probability of distance to facility will lead to - 0.038596 decrease in the probability of accessing health care service in Benue State holding other explanatory variables constant. Also, when the distance to facility is increased by one unit the odd ratio is 0.965 times large therefore, women of child bearing age are 0.965 times likely discouraged from accessing health care service. This typify that there is an inverse relationship between distance to facility and access to health care service delivery in Benue State. This also confirms the frequent cases of death among women occasioned by distance barrier to rural communities to locate a health facility on time before dying. Similarly, when the educational level of women is increased by one unit, the odd ratio is 1.133 times large therefore, women of child bearing age are 1.133 times likely to enhance accessing health care service.

4.1.4 Hypothesis Testing

$H0_1$. Income has no relationship with access to health care delivery service in Benue State.

Table 4.3 Z- test for income and access to health care

Test Statistic	Value	df	prob
t-statistic	5.161466	394	0.0000
F-Statistic	26.64073	(1,394)	0.0000
Chi-square	26.64073	1	0.0000

Null Hypothesis Income ≠0

Normalized Restriction (=0)	Value	Std.Err.
Health care access	-0.63885	0.039918

Restrictions evaluated at observation (t=1)

From table 4.4 the chi-square (χ^2) statistic is 26.64073 with df= 1 greater than a probability of p = 0.000 at α = 0.05 level of significant. Therefore the null hypothesis was rejected ($H0_1 = 0$) which states that income has no relationship with access to health care service in Benue State. And conclude that income φf women is statistically significant on health care access predicted by the model .

4.2 Discussion of Findings

The cursory regression result on effect of women's income on access to health care delivery service on annual income variable with β =1.8607 shows a positive relationship between annual income of women and access to health care service. As many rural women are disposed to more income, the greater access to health care service utilization in Benue State. On the contrary, inadequate income among rural women in Benue State has impeded women access to health care service. Increased income among women will enable them attend to immunization, disease treatment and antenatal care visits as required. This finding was supported by studies done by Goudge, Gilson, Russell, et al (2009) they found that low income, and limited social networks, prevented consultation with monthly expenditure for repeated consultations was as high as 60% of income.

Also, the variable on age with β = 0.008780 implied that the age of respondents was positively and significantly associated with access to health care service. As women become advanced in age the greater the need for access to health care service. Younger ladies are less likely predisposed to having access to health care service in Benue State. This finding was supported by the work of (Zhang, Lei , Strauss, & Zhao, 2017) in China who opined that adequate access to medical care is particularly critical to health conditions and well-being of older adults who generally have greater needs for care and treatment to manage diseases than their younger counterparts.

Furthermore, the result on medical cost shows β = - 2.3706 indicating an indirect association between medical cost and health care service. In order words, a reduction in medical cost will bring about an increase in access to health care service in Benue State. While an increase in medical cost will affect access to health care. The decision making process among women in attending health facility is jointly taken by their spouse hence, the cost of medical care (such as fees on consultancy, disease treatment, surgery, and other ailments) among others usually pose a challenge especially when it is very high. So, the higher the medical cost, the lower the chances of women in accessing health care service in Benue State.

Similarly, educational level with β =0.084102 shows that there is a direst association

between educational level and access to health care service. Implying that the higher a women acquire education the greater access to health care service delivery in Benue State. In order words, low level of education among women limit their awareness of having need to access health care service in Benue State. When women acquire better education they are better equipped to be capable of identifying danger signs and easily understand the bad consequence of not having access to health care services.

A cursory look at the regression further revealed that coefficient of distance β= -0.038596, portend an indirect association between access to health care and distance to health facility. In Benue State, so many rural women grapple with the challenges of going far distances (greater than 19 km) before reaching a health facility thus, making it more burdensome for them in accessing heath care service. This also confirms the frequent cases of death among women occasioned by distance barrier in rural communities to locate a health facility on time before dying. Summarily, a large proportion of women remain deprived of these life-saving health services. This findings agreed with the work of the Centre for Population and Environmental Development (CPED 2017) policy brief series, highlighted that underutilization of adolescent sexual and reproductive health services is due to ascribed service costs and distance to the facility.

V. Recommendations

Based on the findings of this study, the following recommendations were made.

(1). There should be synergy between government, individuals and Non-governmental Organizations in establishing more affordable and efficient clinics for equal access in rural communities in all the 23 Local Government Areas in Benue State. .

(2). The international donor Organizations such as World Health Organization (WHO),United Nations International Children Emergency Fund (UNICEF), United Nations Population Fund (UNFPA), United Nations Development Programme (UNDP), World Bank and others should be magnanimous enough in providing health grants to women as a financial safety nets in accessing health care services delivery in Benue State.

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