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POVERTY REDUCTION PROGRAMMES AND THEIR RELATIONSHIP TO SUSTAINABLE HEALTH CARE HARNESSING IN BENUE STATE, NIGERIA

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Abstract**:** *Poverty is a menace and is widespread among underdeveloped countries. For several decades, global discussions on underdeveloped countries revolve around poverty related problems. Countries in Sub-Saharan Africa are currently with the highest level of poverty. This study is set out to explore the relationship of government poverty reduction programmes and health care harnessing in Benue State of Nigeria. The survey research design was adopted for the study and stratified random sampling technique was employed to select a sample of 2041 respondents from a population of 102,035. A modified four point likert instrument is used to gather data that is analyzed using the Pearson product moment correlation. A conclusion is drawn from the analysis that there exist a significant relationship between poverty reduction programmes such as N-Power, Youth Employment Schemes (YES), NDE, Small Medium Enterprise (SME), etc beneficiaries and sustainable healthcare harnessing variables namely, sustainable healthcare prevention, sustainable healthcare pathways and sustainable healthcare practice in Benue State. The result of the findings finally confirmed the positive relationship between poverty reduction programmes and sustainable health care harnessing among the people living in Benue State, the area of study. It was recommended that government and non-governmental organizations should intensify efforts in providing equipment in health care facilities as this will improve patronage of such facilities and hence better wellbeing for the people.*

Keywords: *Poverty Reduction Programmes, Sustainable Health Care, Harnessing.*

1.0 INTRODUCTION

1.1 General Background of the Study

The level of poverty in Nigeria today is quite disturbing as it has assumed an alarming proportion. Abdullahi (2009) in Kpelai (2013) posited that both the quantitative and

qualitative measurements attest to the growing incidence and depth of poverty in the country. The Federal Government of Nigeria in line with global contentions has been responding to ameliorate the worsening condition of the poor by shifting public expenditure towards poverty reduction programmes to cushion the effects of poverty. Poverty as a global phenomenon affects continents, nations, and peoples differently. It afflicts people in various depths and levels, at different times and phases of existence and development. Betiang, Bella, and Angioha (2021) affirmed that nations in Sub-Sahara Africa, South Asia and Latin America reflect the highest level of poverty, and consequently the lowest level of socio-economic development. These regions equally have an attendant higher level of social insecurity, violence, unrest, crime, poor capacity utilization, poor health care delivery and harnessing and generally unacceptable low standard of living (Betiang, Bella, and Angioha, 2021). Todaro and Smith (2012) posit that a person is in poverty if, a person is suffering from hunger, sickness, does not have any shelter, at the time of sickness he is not able to see a doctor, does not have any access to schools, doesn't know how to read and he does not have any job. Therefore, there is every need for government at all levels to find ways to reduce poverty if it cannot be totally eradicated as poverty has a devastating effect on human health.

Poverty reduction can therefore be referred to as a situation where more people have increased income and can be able to afford the necessities of life. Generally, poverty reduction implies that the population or the number of poor people decreases steadily over time (Herman, 2015). Poverty reduction goes along with economic growth in that as the economy grows poverty reduces drastically along the line. As a result of deficiencies in skills, the informal sector is often characterized by low productivity, low innovation uptake, and low income (Janjua, 2020). Therefore, government intervention programmes that include skill training for the poor can raise their aspirations, improve productivity, health, enhance their income, and therefore lift them out of poverty (King and Palmer, 2014; Lamb, 2011).This will go a long way in helping them to take care of themselves health wise. Poverty reduction is measured by its dimensions of job creation, income generation, wealth creation, and improved standard of living (Aende, 2023).

Betiang et al (2021), posit that a sustainable health care harnessing entails improving the individual lives and the community through high quality public health care without exhausting natural resources or causing severe ecological damage. Here, individuals who are ill known as patients visit the health centre, they are treated as partners in healthcare delivery with the idea that when they are fully informed about the risks and benefits of treatments and procedures, they become happier and free to the treatment that will be administered to them. Sustainable healthcare harnessing is about understanding that our health and that of our environment around us are intrinsically linked, and acting in a way that supports both people and planet health (Bupa, 2022). Bupa, views sustainable healthcare as "healthcare that delivers high quality care in an affordable way, while minimizing the impact on the environment". It describes a system that meets the health needs of the present, without compromising the health of future generations. In practice, sustainable healthcare is underpinned by three core principles or dimensions (WHO. 2014) of sustainable ill- health prevention, sustainable healthcare pathways, and sustainable healthcare practice which this research project is anchored upon.

It is glaring to note at this juncture that sustainable healthcare harnessing cannot succeed or be possibly achieved in a society that is poverty ridden. It is as a result that government at all levels are obliged to put in place poverty cushioning measures to help in reduction of poverty of the citizenry to be able to cope with their health challenges sustainably. It has been known in Nigeria that every government embarks on one form of poverty reduction strategy or the other. However, what has remained an issue is the weak impact it has on the poor who are the target beneficiaries. The perceptions of the poor about poverty reduction programmes have been that of ineffectiveness and irrelevance in their lives as government poverty reduction efforts contributes little to their struggle to survive. Poverty is one of the most serious problems in Nigeria today. Despite the various efforts of government from independence to date, poverty has been on the increase. Nigeria's proportion of the poor has doubled over the last two decades, during which time the country received $3000 billion in oil and gas revenue (Oyemorni, 2003) cited in Kpelai (2013).

In view of this, Strategies, policies and plans have been articulated; programmes ranging from Green Revolution Programme (GRP), National Directorate of Employment (NDE), National Poverty Eradication Programme (NAPEP), N-power, Youwin, establishment of the Directorate for Food, Roads, and Rural Infrastructure (DFRI), establishment of Agricultural Development Programmes (ADP), Primary Health Care (PHC), National Economic and Empowerment Development Strategy (NEEDS), Small and Medium Enterprise Development Agency (SMEDAN), Youth Empowerment Scheme (YES), Rural Infrastructural Development Scheme (RIDS), Natural Resources Development and Conservation Scheme (NRDCS) and diverse skill training programmes have been formulated and executed over the years to aid provide financial freedom to the people that they may be able to meet their basic needs like healthcare. Individuals who benefits from these programmes especially N-Power, NDE, YES, and SME loans scheme which this research project emphases on can comfortably buy food, pay rent, clothe themselves and pay bills but many feel reluctant to visit the health facility whenever they are ill. Many carry out self- medication while others as a result of ignorance prefer the use of traditional methods in treating illness such as the use of urine for treatment of conjunctivitis known as appollo, use of herbs for illness treatment and the visitation of fortune tellers and native doctors to determine the cause of their illness.

Efforts have been made by the federal government and state government for the provision of human, financial and material resources towards the promotion of better health care delivery system. Presently, health facilities like the general hospital and primary health centres in the State have trained personnel who render health services ranging from health education, environmental health, control of communicable diseases, treatment of common diseases like malaria, typhoid, maternal and child health care which is offered for free, reproductive health, immunization against major infectious diseases, distribution of mosquito nets across board, and provision of essential drugs. There also exist effective implementation of National Health Insurance Scheme (NHIS) for federal, state and local government workers to aid them receive health care at a subsidized rate and the medical personnel in Benue State involve the people in their health treatment (Betiang, e tal 2021). Despite all the efforts and desire by the government for a healthy society, it has been observed that the level in which individuals makes practical and effective use of these

health care services is poor and slow as a result of the myopic mentality of attributing illness to superstition or sorcery and poverty by the people. Many people still consult the gods and perform rituals when they are sick, many pregnant women still visit the traditional birth attendants while others maintain unhealthy attitudes like the use of pit latrines, poor feeding habits and use of unsafe drinking water. All these somehow lead to high mortality rate and prevalence of health related diseases like cholera, guinea worm and onchocerciasis (river blindness). It is against this background that the research seeks to determine whether the various poverty reduction programmes implemented by the state government has a relationship on how the people of Benue State sustainably harness health care services.

1.2 Statement of the Problem

Benue State government has a burning desire that the quality of life of its citizens is sustainably improved through good health care delivery system. The health care delivery system in the state has suffer neglect in terms of funding and provision of health care equipment despite government efforts in recruitment of staff, building of general hospitals and primary health care centres within the local government areas in the state. These neglects has resulted in high infant and maternal mortality, poor quality of care rendered by health practitioners, prevalence of diseases and increase health complications from those who seek health care. The goal of citizens of the Benue State who seeks health care service is to get the best that will put them in a state of optimal health but this is not possible as high fees are charged from health care seekers, distance exist between location of health care facility and where the people live or work and poor attitude of health care providers. People rather prefer to rely on traditional methods of health care as a result of poverty (Betiang, 2021).

Successive administration have through the state government embarked on one form of poverty reduction programmes ranging from free medical care to pregnant women and children between the ages of 0-5. What has remained unanswered is the extent to which these programmes have actually impacted on the target population – the poor. There still exist a considerable gap between the target objective of reducing poverty and sustainable health care harnessing among people living in Benue State which is the reason for this study.

Based on its multi-dimensional nature, poverty is usually perceived using different criteria. This accounts for the numerous attempts in defining poverty; each definition tries to capture the perception of the proponent or the poor as to what the term is. Narayan, Ropers, and Jencks (2000) captured the definition from the point of view of the poor in different countries in the following perspectives: “Poverty is humiliation, the sense of being dependent and of being forced to accept rudeness, insults and indifference when we seek help”. Poverty could denote a state of deprivation as not having enough to eat, a high rate of infant mortality, a low life expectancy, low educational opportunities, poor water, inadequate health care services, poor utilization of health care services, unfit housing and a lack of active participation in the decision making process. It could also denote, along this line, “absence or lack of basic necessities of life” or “lack of command over basic consumption needs such as food, clothing and or shelter”. The link between good health and poverty is inextricable (Betiang, etal 2021).

The premium placed on health and its comprehensive nature is reflected in the World Health Organization’s definition of health as not only the absence of disease, but, even a

limited access to health care is classified as sickness. Little wonder then three out of the eight Millennium Development Goals (MDGs) dwell on health related issues – goal four, five and six, - which deal with reducing child mortality; improving maternal health; and combating HIV/AIDS, malaria and other diseases respectively. Poverty is both a consequence and a cause of ill health. Ill health, malnutrition and high fertility are often the reasons why households end up in poverty or sink even further into poverty if they are already poor. The illness of a breadwinner results in lost income as well as unanticipated health care costs. High fertility not only reduces the availability of resources for other household members, but also reduces the earning opportunities for women. Malnutrition contributes to ill health and has serious consequences for both mothers and children.

As the World Bank (2001) Health, Nutrition and Population (HNP) Report affirms, poverty is also a cause of ill health. It asserts that poor countries – and poor people within countries – experience multiple conditions that combine together to cause greater levels of ill health than in those who are better off. They assert that the poor lack the financial resources to pay for health services, food, clean water, sanitation, and other key inputs that help to produce good health. In addition, the facilities serving the poor are often dilapidated, inaccessible, lacking in even basic medicines, and poorly run. Claeson and Bos (2011) also toe this line when they posit that poor people are also disadvantaged by a lack of knowledge about prevention and when to seek health care. They tend to live in communities that have weak institutions and social norms that are not conducive to good health. In short, poor people are caught in a "vicious circle that their poverty breeds ill health, which in turn conspires to keep them poor". Good utilization of health services improves the health status of the population as revealed by study carried out by Adams and Awunor (2014) in Etsako Local Government Area (LGA) of Edo State who discovered that community perceptions of poor quality and inadequacy of available services determine largely the level of usage of primary health care facility in the state.

Also, Katung (2010) found out in Plateau State using 360 mothers that high cost of drugs (29.0%), service charges (19.0%), easy access to traditional healers (39.0%) and difficulty in getting transport to health facility (30.0%) were the major factors that cause non-attendance of people to health facility. Similarly, study on factors influencing the choice of health care providing facility among workers in a local government secretariat in southwest, Nigeria identified that satisfaction with services rendered in terms of ease of getting care and short waiting times were predictors for preference of health care facility (Uchendu, Illesanmi & Olumide, 2013). Buttressing the findings, Odetola (2015) using a descriptive study with a sample of 160 pregnant women and correlation analysis as test statistics discovered that proximity to health facilities from place of residence, affordability of service rendered in terms of costs and quality of services rendered were active determinants of choice of health institutions among them.

This is so because people especially in the rural area will be able to access health services adequately when the services they receive are of quality standard and within their economic power. In support, study by Sule, Ijadunola and Onayade (2012) cited in Betiang, e tal (2021) identified high cost of services, lack of drugs and availability of a physician as barriers to utilization of primary health care facilities by rural dwellers in southwest Nigeria. This scenario of instituting and implementing several poverty reduction programmes in the country and Benue State in particular yet there is prevailing poor healthcare in the state has posed the researcher to seek to establish the relationship

between poverty reduction programmes beneficiaries and sustainable healthcare harnessing by residents of Benue State.

1.3 Purpose of the Research Project

The main purpose of this study was to evaluate the relationship of the poverty reduction programmes on sustainable health care harnessing among the people living in Benue State.

1.4 Hypothesis of the Research Project

The research hypothesis that guided the study is: There is no significant relationship between poverty reduction programmes and sustainable health care among the people living in Benue State.

2.0 CONCEPTUAL CLARIFICATIONS

2.1 Poverty

As it has been mentioned above, poverty manifests itself in different and various dimensions, and hence is susceptible to varying definitions and understanding. The Central Bank of Nigeria (1999) views poverty as "a state where an individual is not able to, as limited access to social and economic infrastructure such as education, health, portable water and sanitation; and consequently, has limited chance of advancing his or her welfare to the limit of his or her potentialities". Whereas the above definition of poverty is deductive, the World Bank (2000) on the other hand utilized inductive approach to uncover various dimensions of poverty such as well-being, psychological, basic infrastructure, illness and assets. One of such definitions is "the lack of what is necessary for material well-being especially food, but also housing, land, and other assets. In other words, poverty is the lack of multiple resources that leads to hunger and physical deprivation". Another of such definitions is "the lack of voice, power, and independence that subjects them to exploitation. Their poverty leaves them vulnerable to rudeness, humiliation, and inhumane treatment by both private and public agents of state and the hierarchy of society from whom they seek help".

Based on its multi-dimensional nature, poverty is usually perceived using different criteria. This accounts for the numerous attempts in defining poverty; each definition tries to capture the perception of the proponent or the poor as to what the term is. Narayan, Ropers, and Jencks (2000) captured the definition from the point of view of the poor in different countries in the following perspectives: "Poverty is humiliation, the sense of being dependent and of being forced to accept rudeness, insults and indifference when we seek help". Poverty could denote a state of deprivation as not having enough to eat, a high rate of infant mortality, a low life expectancy, low educational opportunities, poor water, inadequate health care services, poor utilization of health care services, unfit housing and a lack of active participation in the decision making process. It could also denote, along this line, "absence or lack of basic necessities of life" or "lack of command over basic consumption needs such as food, clothing and or shelter".

However, the above scenario has persisted not as a result of nonchalant attitude and non-recognition of the problem at hand. It has also not come by as a result of lack of

response to the yearning of the teeming poor people to be liberated from their rather deplorable and frustrating state of near-despair. No Nigerian Government, be it military or civilian, has come without introducing and leaving behind one form of poverty alleviation or reduction programme meant to reduce the level of poverty, give hope and succor to the poor and, or move towards some sort of wealth creation (Betiang e tal 2021).

2.2 Poverty Reduction

Kpelai (2013) affirms that poverty reduction is all formal activities geared towards lowering the prevalence and rate of poverty in the country. Poverty reduction programmes are aimed at raising people's incomes and increasing the power of low-power group so that it nearly equates that of the high-power group. Poverty reduction can therefore be referred to as a situation where more people have increased income and can be able to afford the necessities of life. Generally, poverty reduction implies that the population or the number of poor people decreases steadily over time (Herman, 2015). Poverty reduction goes along with economic growth in that as the economy grows poverty reduces drastically along the line.

2.3 Health

Health which is a state of complete physical, mental and social well-being and not merely the absent of diseases or infirmity (World Health Organization, 1978) is vital to having an active working population which leads to economic development .When an individual is healthy, the person can partake in community services and decision process and can be a good source of knowledge reservoir for the community. A healthy society is made possible through an effective health care delivery system which should be concerned with preventive, rehabilitative, promotive and curative services rendered by health practitioners at the primary, secondary and tertiary health institutions (Ihejiamaizu, 2002).

2.4 Health Care

Health care is the identification of health needs and problems of the people within the society and providing them with the requisite medical care (Innocent, Uche & Uche, 2014), thus the need for sustainable health care system.

2.5 Sustainable Health Care System

Betiang e tal (2021) posit that a sustainable health care system entails improving the individual lives and the community through high quality public health care without exhausting natural resources or causing severe ecological damage. Here, individuals who are ill known as patients visit the health centre, they are treated as partners in care delivery with the idea that when they are fully informed about the risks and benefits of treatments and procedures, they become happier and free to the treatment that will be administered to them.

2.6 Sustainable Health Care Harnessing

Sustainable healthcare is about understanding that our health and that of our environment around us are intrinsically linked, and acting in a way that supports both people and planet health (Bupa, 2022). Bupa, views sustainable healthcare as "healthcare that delivers high quality care in an affordable way, while minimizing the impact on the environment". It describes a system that meets the health needs of the present, without compromising the health of future generations.

2.7 A Brief Empirical Review of the Research Study

Poverty is both a consequence and a cause of ill health. Ill health, malnutrition and high fertility are often the reasons why households end up in poverty or sink even further into poverty if they are already poor. The illness of a breadwinner results in lost income as well as unanticipated health care costs. High fertility not only reduces the availability of resources for other household members, but also reduces the earning opportunities for women. Malnutrition contributes to ill health and has serious consequences for both mothers and children. As the World Bank (2001) Health, Nutrition and Population (HNP) Report affirms, poverty is also a cause of ill health. It asserts that poor countries – and poor people within countries – experience multiple conditions that combine together to cause greater levels of ill health than in those who are better off. They assert that the poor lack the financial resources to pay for health services, food, clean water, sanitation, and other key inputs that help to produce good health. In addition, the facilities serving the poor are often dilapidated, inaccessible, lacking in even basic medicines, and poorly run. Claeson and Bos (2011) also toe this line when they posit that poor people are also disadvantaged by a lack of knowledge about prevention and when to seek health care. They tend to live in communities that have weak institutions and social norms that are not conducive to good health. In short, poor people are caught in a "vicious circle that their poverty breeds ill health, which in turn conspires to keep them poor". Good harnessing of health services improves the health status of the population as revealed by study carried out by Adams and Awunor (2014) in Etsako Local Government Area (LGA) of Edo State who discovered that community perceptions of poor quality and inadequacy of available services determine largely the level of usage of primary health care facility in the state.

Also, Katung (2010) found out in Plateau State using 360 mothers that high cost of drugs (29.0%), service charges (19.0%), easy access to traditional healers (39.0%) and difficulty in getting transport to health facility (30.0%) were the major factors that cause non-attendance of people to health facility. Similarly, study on factors influencing the choice of health care providing facility among workers in a local government secretariat in southwest, Nigeria identified that satisfaction with services rendered in terms of ease of getting care and short waiting times were predictors for preference of health care facility (Uchendu, Illesanmi & Olumide, 2013). Buttressing the findings, Odetola (2015) using a descriptive study with a sample of 160 pregnant women and correlation analysis as test statistics discovered that proximity to health facilities from place of residence, affordability of service rendered in terms of costs and quality of services rendered were active determinants of choice of health institutions among them. This is so because people especially in the rural area will be able to access health services adequately when the services they receive are of quality standard and within their economic power.

In support, study by Sule, Ijadunola and Onayade (2012) identified high cost of services, lack of drugs and availability of a physician as barriers to harnessing of primary health care facilities by rural dwellers in southwest Nigeria. This scenario has posed the researcher to evaluate poverty reduction programmes and sustainable health care harnessing in Benue State, Nigeria in particular.

3.1 Design of the Research Study

The research design used for this study is the survey design. According to Isangedighi, Joshua, Asim and Ekuri (2004), this design involves the collection of data to accurately and objectively describe the nature of a situation as it exists at the time of observation.

Also, survey design depends basically on observations, interviews, telephone calls and questionnaires as means of data collection as it allows for easy generalization of findings to larger populations once representativeness of the sample is assured.

1.8 Research Area of the Study

This study was conducted in the Benue State, Nigeria. The area covers 23 Local Government Areas (LGAs) which are: Kwande, Ushongo, Vandeikya, Konshisha, Katsina-Ala, Ukum, Logo, Buruku, Gboko, Tarka, Guma, Makurdi, Gwer-West, Gwer-East, Otukpo, Ohimini, Agatu, Okpokwu, Oju, Ogbadibo, Obi, Ado, Apa. Benue State was created on February 3, 1976. It was one of the seven new states created by the military administration headed by the late General Murtala Muhammed, which increased the number of states in the federation from twelve to nineteen. The state derived its name from the River Benue which is the second largest river in the country and the most outstanding geographic feature in the state. At creation, the state comprised of three local governments in the Tiv-speaking areas, namely Gboko, Katsina-Ala, and Makurdi; one local government (Otukpo) in the Idoma-speaking areas and three local governments (Ankpa, Idah and Dekina) in the Igala-speaking areas, which were excised from Kwara state. Today, however, with the creation of more states and local governments in 1991, the Igala-speaking local govrnments were excised to form part of the present day Kogi state. Presently, Benue state has twenty-three local governments, with the Tiv speaking area having fourteen while the Idoma-Igede area has nine local governments as mentioned above.

Location: The state's geographic location in the country is quite unique: it lies roughly in the middle of the country and shares boundaries with six other states: Nassarawa to the North, Taraba to the East, Kogi and Enugu states to the West and Ebonyi and Cross-River states to the South. It also shares an international boundary with the Republic of Cameroun on the South-East. Benue state has a landmass of 33,955 square kilometers and lies between Latitudes 6.5° and 8.5° North and Longitudes 7.47° N and 10 East.

State Capital: Makurdi, the state capital was established in the early twenties and gained prominence in 1927 when it became the headquarters of the then Benue Province. Being a river port, it attracted the establishment of trading depots by companies such as UAC and John Holt Limited. Its commercial status was further enhanced when the Railway Bridge was completed and opened in 1932. In 1976, the town became the capital of Benue State and presently serves also as the headquarters of Makurdi Local Government Area.

Climate and Vegetation: Based on Koppen's Scheme of Classification, Benue State lies within the AW Climate and experiences two distinct seasons, the wet/rainy season and the dry/summer season. The rainy season lasts from April to October with annual rainfall in the range of 100-200mm. The dry season begins in November and ends in March. Temperatures fluctuate between 23 – 37 degrees Celsius during the year. The south-eastern part of the state adjoining the Obudu-Cameroun mountain range, however, has a cooler climate similar to that of the Jos Plateau. The vegetation of the State consists of rain forests which have tall trees, tall grasses and oil palm trees that occupy the state's western and southern fringes while the Guinea savannah is found in the eastern and

northern parts with mixed grasses and trees that are generally of average height. Benue's topography is mainly undulating plains with occasional elevations of between 1,500m and 3,000m above sea level. The state's main geological formations are sandy-loam shelf basement complex and alluvial plains. These together with its location in the transition belt between the north and south ecologies and a favourable rainfall pattern account for its support for a wide variety of crops.

The People: The state comprises of several ethnic groups: Tiv, Idoma, Igede, Etulo, Abakpa, Jukun, Hausa, Akweya and Nyifon. The Tiv are the dominant ethnic group, occupying 14 local government areas, while the Idoma and Igede occupy the remaining nine local government areas. Most of the people are farmers while the inhabitants of the riverine areas engage in fishing as their primary or important secondary occupation. The people of the state are famous for their cheerful and hospitable disposition as well as rich cultural heritage.

Traditional and Chieftaincy Institutions: The Benue state government accords high respect for the traditional rulers in recognition of their role as custodians of culture and as agents of development. In order to enhance their contribution to governance, government has established a three-tier traditional council system made up of local government area traditional councils, area traditional councils and the state council of chiefs. The local government (area) traditional council is made up of district heads in a local government and is headed by a chairman who is a second class chief. The two area councils are the Tiv Traditional council and the Idoma Traditional Council. The former is made up of all traditional rulers in the fourteen Tiv-speaking local government areas with the Tor-Tiv as the Chairman, while the latter is made up of nine Idoma/Igede-speaking local governments and has the Och'Idoma as the Chairman. The state council of Chiefs has the Tor-Tiv V, His Royal Majesty, Orchivirigh Professor James Iorzua Ayatse as chairman with His Royal Majesty Och'Idoma IV, Agabaidu Elias Ikoyi Obekpa and all second class chiefs/chairmen of the local government traditional councils as members.

Mineral Resources: Benue State is blessed with abundant mineral resources. These resources are distributed in the Local Government Areas of the state. Of these mineral resources, only limestone at Tse-Kucha near Gboko, Kaolin at Otukpo , and few mineral resources in few areas are being commercially exploited.

Natural Resources: Benue State is the nation's acclaimed Food Basket because of its rich agricultural produce which includes yams, rice, beans, cassava, potatoes, maize, soya beans, sorghum, millet and cocoyam. The state also accounts for over 70% of Nigeria's soya bean production. Agriculture is the mainstay of the economy, engaging over 75% of the state farming population. The State also boasts of one of the longest stretches of river systems in the country with great potential for a viable fishing industry, dry season farming through irrigation and for an inland water highway. The vegetation of the southern parts of the state is characterized by forests, which yield trees for timber and provide a suitable habitat for rare animals. The state thus possesses potential for the development of viable forest and wildlife reserves.

Culture: Benue State possesses a rich and diverse cultural heritage which finds expression in colourful cloths, exotic masquerades, supplicated music and dances. Traditional dances from Benue State have won acclaim at national and international cultural festivals. The most popular of these dances include Ingyough, Ange, Anchanakupa, Swange and Girinya among others.

3.2 Population of the Research Project

The population of the study consisted of all adult citizens living in the five (5) Local Government Areas of the State from eighteen (18) years and above as they were considered matured for the study. The population is 102,035 as adapted from the official gazette of the Federal Republic of Nigeria (Vol. 96, 2018) and distributed as follows.

Table 1

Population Figure for the Five Local Government Areas in Benue State is:

LGA	Males	Females	Total
Oju	8,744	8,753	17,497
Gboko	10,134	9,430	19,564
Makurdi	12,450	8,105	20,555
Otukpo	9,400	13,587	22,987
Kwande	11,276	10,156	21,432
Total	**52,004**	**50,031**	**102,035**

Source: FRN, Official Gazette, Vol. 96, Abuja, February, 2018

3.3 Sampling Technique

Stepwise sampling technique was adopted in selecting the sample for this study. Firstly, stratified sampling technique was used to divide the study area into five strata. This implies that Oju is stratum 1, Gboko 2, Makurdi 3, Otukpo 4 and Kwande 5. In each stratum, purposive sampling was adopted in the selection of the health facilities and people who visit the facility. Here, general hospital which is funded by the State Government in each LGA and one primary health centre which is funded by the Local Government Authority was selected making a total ten health facilities. Every individual that visited the health centre for medical care was purposively selected to get the sample for the study. Each of the selected facility was visited by the researcher twice. All questionnaires given to the sampled persons were fully returned as the researcher guided the people in filling the items.

3.4 Sample

The sample for this study was 2041 individuals representing 2% of the population who visit the health facility for medical care. This sample was evenly shared among the sampled facilities of which each had 204 individuals.

3.5 Instrumentation

A self-developed modified four-point likert scale questionnaire tagged “Poverty Reduction Programmes and Sustainable Health Care Harnessing” (PRPASHCH) was used to gather data. The instrument had two sections –section “A” and “B”. Section A contained items seeking information on the demographic characteristics of the respondents while section B contained items that looked at how poverty reduction programmes can be used to achieve sustainable health care harnessing.

3.6 Data Analysis and Discussion of Findings

Data collected from this study was analyzed using Pearson Product Moment correlation. The result of the analysis is presented in table 2

Table 2
Pearson Product Moment Correlation Analysis on Poverty
Reduction Programmes and Sustainable Health Care Utilization (n= 2041)

Variables	∑X ∑Y	∑X2 ∑Y2	∑XY	R
Poverty reduction programmes (x)	26069	707910	671021	0.564
Sustainable Health Care Harnessing (y)	27370	652477		

Significant at .05, df = 1078, critical r =0.065

Result of analysis shows that the calculated r-value of 0.564 was greater than the critical value of 0.065 at .05 level of significant with 2039 degree of freedom. The result showed a significant positive relationship between poverty reduction programmes and sustainable healthcare harnessing. That is, where more poverty reduction pen Access article distributed under the terms of the Creative Commons License programmes are implemented, the more sustained is health care harnessing as people will no longer complain of the high cost of seeking medical attention and as such the null hypothesis was rejected.

This indicates that the respondents agreed that government programmes on poverty reduction have and can still possibly relate positively on their health care practices in terms of access, affordability and availability to health care. This will drastically reduce the rate of infant and maternal mortality; control the spread of endemic and epidemic diseases and promote health research to curb of health though minimal as most poor people are not beneficiaries of the programme. This position tends to suggest that perhaps, the federal government of Nigeria has kept faith in conforming to the World Bank's prescription through the Poverty Reduction Strategy Papers (PRSP) for implementing sustainable and comprehensive healthcare programmes. The PRSP prescribes a stratified approach that is at the household level; the community level; the health services level; supporting sectors level and of course the government programmes and actions level. This could be responsible for the positive impact/influence that these programmes have recorded on health care practice among the people.

This finding also tend to agree with the finding by Odetola (2015) who discovered that proximity to health facilities from place of residence, affordability of service rendered in terms of costs and quality of services rendered were active determinants of choice of health institutions among them. Similarly, Akan (2013) revealed in a study that rural communities in Cross River State were progressively achieving better health status as a result of the programmes of government and other non-governmental organizations, especially the United Nations Development Programme (UNDP). Butressing the result, Obadan (2014) revealed that people in the rural areas still live below the poverty line and their lives is characterized by disease, hunger and high infant mortality rate despite the various poverty reduction programmes enacted by government. This is so as these programmes are not easily accessed by the rural dwellers within the district.

4.1 Conclusion

From the result of the study, it was concluded that government activities aimed at ensuring poverty-reduction have significant relationship on sustainable health care harnessing among the people of the study area, although very few people could visit the health care facility. Many who are sick rather depend on the traditional methods of health care as a result of insufficient funds which are not even enough to cater for their basic needs.

4.2 Recommendations

In other to achieve a sustained health care harnessing by people within the state, the government and even non-governmental bodies should equip health care facilities to reduce the cost of health care so that people who are ill can freely visit the health facility. Similarly, the various poverty reduction programmes *such as N-Power, Youth Employment Schemes (YES), NDE, Small Medium Enterprise (SME)* being enacted by the State government should be such that target the actual rural poor people within the all part of the state rather than concentrating these in the urban areas so as to improve their means of livelihood this will enable them seek health care immediately when they are sick.

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