

Chapter One

Introduction

1.1. Background to the Study

Health is essential to human life and key to any known society. For its importance, the World Health Organization (WHO) defines health as the totality of human well-being, which goes beyond the absence of infirmity and disease¹. Health-seeking behaviours are the intentional processes or remedial actions people take to rectify perceived disease or ill health¹. Health-seeking behaviour cannot be holistically explained without referring to the socioeconomic characteristics (such as educational status, household income, religious affiliation, employment status, gender, and age) of the people expected to access healthcare services². Achieving good health status for most countries of the world has been a matter of scientific discourse as there remains a wide gap in accessibility of healthcare services because of socioeconomic differences among classes of people and regions of the world¹. Trying to bridge the health gap between classes of people and nations of the world has led to the development of local and international health policies that aim to ensure health for all. Notable among these policies and programmes are Primary Health Care (PHC), Sustainable Development Goal (SDG) 3, and Universal Health Coverage (UHC)³. Despite the availability of health policies and programmes in most low and medium-income countries, accessing health for many has been challenging due to factors such as income, location of the healthcare facilities, transportation etc⁴.

Urban centres are believed to be advantageous for social amenities such as healthcare facilities, transportation, and education, but this is not the reality in urban slums⁴. This facility inadequacy has led to the challenge of deprived conditions for

urban slum dwellers. Due to this deprived condition, earlier studies have reported higher morbidity and mortality rates among urban slum dwellers than non-slum dwellers^{5,6,7,8}. As a direct proportion of the socioeconomic conditions of Nigerian society, a large proportion of the urban population lives in one of the urban slums⁴. Because of the magnitude of people that are being affected by the health situation of the urban slums, a specialised study of the health-seeking behaviour of the urban slum dwellers becomes vital, and this is the core of this study⁸.

Urban slums in many Nigerian cities are social representations of the nation's poverty state^{3,4}. Many rural-urban migrants and urban poor have found their places of abode in the slum settlements due to their poor financial state⁹. Many of the slum settlements lack proper social amenities essential for livelihood. Where some of the facilities are available, they are either over-utilized due to the number of people and communities using them or distanced away from the lower class communities². Other factors associated with the health-seeking behaviour of the urban slum dwellers may be related to the fact that healthcare facilities in slum settlements are not adequately equipped with both human and medical resources that are important for the fulfilment of the reason for their creation, and this may further discourage their usage by the slum dwellers³.

Since many of the urban slums in Nigeria are located within or around the city centres, going to the planned city areas to seek healthcare services would have been an option. However, this option is hindered by poverty and the socioeconomic situation of many of the urban slum dwellers in Nigeria⁴. Poverty remains one of the inhibiting factors against the achievement of Universal Health Coverage in Nigeria¹⁰. This has led to the challenge of an increase in the spread of communicable diseases in the Nigerian urban slums because slum dwellers lack access to adequate and

affordable medical services due to financial poverty and the mode of healthcare service delivery¹⁰. Health-seeking behaviours of slum dwellers in Nigeria are determined by household financial strength and health insurance, among other factors.

Despite the challenge of poverty in most rural areas and slum settlements, there is high patronage of informal and unstructured healthcare services, which may justify financial lack as the primary obstacle against the utilization of healthcare services among slum dwellers^{3,4}. In some earlier studies of urban slums, there is more use of informal and free or subsidized health facilities in Ibadan, Port-Harcourt, Ibarapa, (Nigeria), Bangladesh, and Kwazulu Natal in South Africa compared to formal and structured medical facilities^{2,4,11,12,113}. Nigeria remains one of the countries with the highest mortality rate in the world. According to a former Federal Minister of Health in Nigeria, Professor Osagie Ehanire, “one of the reasons for the high mortality rate, especially under five mortalities in Nigeria, is the lack of access to proper medical facilities among Nigerians”. Although there is a high level of patronage for unstructured and informal healthcare in Nigeria, the standards of these services have not guaranteed the expected health outcome for Nigerians. One of the unclear issues that needs further scientific analysis is the reason for the patronage of informal healthcare services compared to the formal and structured healthcare services among urban slum dwellers. Against this background, this study intends to investigate the socioeconomic factors affecting the health-seeking behaviour of urban slum dwellers in the Lagos metropolis.

1.2. Statement of the Problem

Nigerians are exposed to health risks due to poor socioeconomic conditions and the inability to access proper healthcare services. The problem of high mortality and morbidity among Nigerians is a clear indication of the deteriorating state of health of the Nigerian populace^{5,6}. While one cannot deny that the Nigerian government has made efforts from local, state, and federal governments to ameliorate Nigerians' health problems, the success of the health policies has been questioned based on the health reality among Nigerians¹⁰. It has been documented and discussed even by the past Nigerian Health Minister (Professor Osagie Ehanire) that many Nigerians are living in poor health conditions; some Nigerians, especially people living in urban slum settlements, experience worse health conditions than others in the planned areas of the Nigerian cities^{4,5,10}. This is important because, in Nigeria alone, over 57.7 million people currently live in urban slums with unhealthy physical conditions. This number is expected to increase due to the poor socioeconomic condition in Nigeria as a whole and in Lagos as a mega city that is inadequately planned^{14,15}.

The physical representation of the Nigerian slum settlements presents a picture of poor socioeconomic and unhealthy conditions. This makes a scientific focus on the socioeconomic factors affecting the health-seeking behaviour of slum dwellers in Nigerian society important. The socioeconomic factors affecting people's health-seeking behaviour have been a scientific focus for decades. Among these studies on factors affecting healthcare services utilization is the work of Anderson¹⁶. Although scientific attention has been drawn to the problems of healthcare service utilization, many of these studies focused on the influence of factors such as income, education, and employment status with little focus on the peculiar situation of the huge Nigerian populace that live in urban slums. Although more than half of the Nigerian

urban dwellers live in the unplanned areas (slum settlements) of the city, these poor segments receive inadequate developmental attention from the government ^{14,15}.

Due to the poor governmental attention, health facilities in the slum areas are deplorable. While this present research aims to further the findings of the existing studies, much detailed attention shall be drawn towards analysing the deplorable state slum of healthcare facilities, the impact of gender, religion, and age and how these variables affect the utilization of healthcare services in the slum settlements within the Lagos State metropolis.

1.3. Aim and Objectives of the Study

The research aims to investigate the socioeconomic characteristics affecting the health-seeking behaviour of residents of slum settlements in the Lagos Metropolis, Nigeria. The specific objectives of the study are to:

- i. analyse the state of healthcare services utilization in the urban slum settlements of Lagos State metropolis.
- ii. investigate the relationship between employment status and health-seeking behaviour of residents of urban slum settlements in the Lagos metropolis.
- iii. investigate the influence of educational attainment on the health-seeking behaviour of residents of urban slum settlements in the Lagos metropolis.
- iv. examine the role of household financial status on the health-seeking behaviour of residents of slum settlements in the Lagos Metropolis.
- v. investigate the influence of age on the health-seeking behaviour of the residents of slum settlements in the Lagos metropolis.

- vi. examine the relationship between religious affiliation and health-seeking behaviour of the slum settlements in the Lagos metropolis.
- vii. examine the role of gender on the health-seeking behaviour of the residents of slum settlements in the Lagos metropolis; and
- viii. explore the role of known illness/disease on the health-seeking behaviour of residents of slum settlements in the Lagos metropolis.

1.4. Research Questions

Given the specific objectives of this study, the following research questions were attended to:

1. what is the state of healthcare services utilization in the urban slum settlements of Lagos State metropolis?
2. how does employment status affect the health-seeking behaviour of slum dwellers in the Lagos metropolis?
3. what is the relationship between educational attainment and health-seeking behaviour of slum dwellers in the Lagos metropolis?
4. how does household income affect the health-seeking behaviour of slum dwellers in the Lagos metropolis?
5. how does a known illness/disease (a disease revealed by medical tests and accepted by the patient) affect the health-seeking behaviour of slum dwellers in the Lagos metropolis?
6. what impact does age have on the health-seeking behaviour of the dwellers of slum settlements in the Lagos metropolis?
7. what is the relationship between gender and the health-seeking behaviour of slum dwellers in the Lagos metropolis?

8. what is the connection between religious affiliation and the health-seeking behaviour of slum dwellers in the Lagos metropolis?
9. Why the high patronage of informal healthcare services among the urban slum dwellers?

1.5. Hypotheses

The following hypotheses were tested in this research:

- H₀1: There is no significant relationship between employment status and the health-seeking behaviour of residents of slum settlements in the Lagos Metropolis.
- H₀2: Educational attainment is not directly related to the health-seeking behaviour of residents of slum settlements in the Lagos Metropolis.
- H₀3: The presence of a known sickness/disease has no positive relationship with the health-seeking behaviour of residents of slum settlements in the Lagos Metropolis.
- H₀4: Sex has no significant effects on the health-seeking behaviour of residents of slum settlements in the Lagos metropolis.
- H₀5: Religious affiliation has no direct relationship with the health-seeking behaviour of residents of slum settlements in the Lagos metropolis.
- H₀6: Age has no positive relationship with the health-seeking behaviour of residents of slum settlements in the Lagos metropolis.
- H₀7: Household income has no significant relationship with the health-seeking behaviour of residents of slum settlements in the Lagos Metropolis.

1.6. Significance of the Study

Health encompasses all aspects of human well-being which go beyond the absence of infirmities or diseases. Health as a social institution and the experience of the populace's well-being is very important. Nigeria is still at a high risk of maternal and children's health challenges, many of which come from the urban and urban slum centres⁴. As a socio-demographic investigation, this research extends the frontier of knowledge in Sociology of Health and Illness in the slum settlements, which need more nuanced scrutiny on account of their vast populations. It will, therefore, contribute to the existing literature stock on this crucial area of research, which will form the basis for further scholarly work.

Further, the study has both empirical and theoretical significance. Empirically, the study's findings are of scholarly and programmatic importance and might inform and improve existing preventive and public health policies. The study results aim to be available for policymakers locally, nationally, and internationally to assess and gauge Sustainable Development Goal Three (SDG 3). Theoretically, the findings will improve and complement existing theoretical views in the sociology of health, demographic and population studies, and urban sociology, among others. Based on the new findings, some theoretical underpinnings of the subject matter can be further strengthened, extended, or corroborated for their applicability to Nigeria.

1.7. Scope of the Study

This study investigated socioeconomic characteristics affecting the health-seeking behaviour of urban slum dwellers in the Lagos metropolis. The scope covered four local government areas in Lagos Metropolis, where some of the large slum settlements in Lagos State are situated. The selected local government areas are Ajeromi-Ifelodun, Apapa, Lagos Mainland, and Somolu Local Government Areas (LGAs). At least 15 slum settlements are in these local government areas¹⁷. These

four LGAs occupy about 87.0 km² area, with an estimated population of 2,268 869¹⁸. Notable among these slum settlements are Amukoko, Ago-Hausa, Olodan, Badia, Otto, Ijora, Makoko, Oko-Baba, Oko-Agbon, Abule-Nla, Mosafejo, Bariga, Abule-Ijesha, Ilaje, Pedro¹⁷. The target population covered in this study are male and female adults eighteen (18) years of age and above. The target population was drawn from the selected locations that were purposively determined from the four local governments (Amukoko/AjeromiIfelodun LGA, Bariga/Shomolu LGA, Ijora/Badia/Apapa LGA, and Makoko/Lagos Island LGA). The respondents' opinions were canvassed with the questionnaire and in-depth interview guide.

1.8. Limitation of the Study

No study can cover all that is to be known about a subject because of certain limitations or challenges in data collection. Being self-funded, this study is limited in the number of research locations covered and the size of the data collected because of limited funds. This study is cross-sectional, which gives only a snapshot of the health behaviour of the people as opposed to a longitudinal study. A longitudinal study would bring more insights regarding changes within a population over time. The researcher also encountered some logistic challenges in the data collection process, including transportation, time-consciousness of the respondents, and reluctance to fill out the questionnaire. However, all these challenges did not affect the quality and trustworthiness of the data collected.

1.9. Operational Definition of Terms

The meanings attached to terms vary from culture to culture and discipline to discipline. For this reason, this segment is dedicated to clarifying some of the terms used in this research project. The definitions given to the terms are based on their usage in the report.

Disease: This is a physiological malfunction independent of subjective feeling that results in an actual or potential reduction in physical capacities and/or reduced life expectancy. To attend to this variable, respondents were asked if there is a known (medically reported) disease in their body, and more information about this is detailed in the findings section of this report.

Health-Seeking Behaviour: This is the intentional processes or remedial actions people take to rectify perceived disease or ill health. In this study, health-seeking behaviour is measured using an individual's disposition to the utilization of healthcare services. Indicators of healthcare services utilizations are hospital admissions and releases, emergency visit to the hospital, outpatient appointments, primary healthcare utilization, visit to community pharmacies or pharmacists for potential drug prescriptions, immunization, going for diagnostic tests or health screening, home healthcare services or screening, telemedicine, visit to traditional or spiritual healers, and the utilization of preventive healthcare services. The measuring timeline for this study was within the last 12 months of access to healthcare services before the data collection period. Because of the versatile nature of the utilization of healthcare services, not all aspects of it could be covered in this research. Only three areas were focused on: visits to physical, formal healthcare centres like hospitals, clinics, or primary healthcare centres; visits to spiritual or traditional healing centres; and visits to community pharmacies or pharmacists for healthcare reasons. Other areas of healthcare services utilization could not be covered due to the limited time and financial resources available to the researcher.

Health: Health is complex to define. Although the World Health Organization's definition encompasses physical, mental, and social well-being, not merely the absence of disease or infirmity. This research focused mainly on the physiological

aspects of health using the experience of sickness within the last twelve months before the research as a measurement yardstick. Respondents were asked if they had experienced any sickness in the last twelve months.

Known Sickness: This is a subjective experience of illness which a person experiences. This is mainly the demonstration of an individual's subjective feeling of pain or discomfort. This is when an individual perceives himself or herself as not feeling well. For this study, the subjective perspective of illness was adopted.

Poverty: According to the World Bank's new international poverty line measurement, an individual must live above \$2.15 (N1,666) daily to be above the poverty line. Measuring poverty in this study, any individual living below \$2.15 per day was considered a poor person, and anybody living above \$2.15 per day was considered living above the poverty line.

Slum Settlements: These are illegal structures or settlements created by people due to the challenge of urbanization. These areas or settlements lack proper planning and are unsafe (mentally, physically, emotionally, etc) for human habitation. A formerly well-planned residential area can become a slum due to the challenge of gentrification. This may be due to the challenge of over-use. A good example of this well-planned structure, now structurally defective, is the Jakande Estates in Lagos State. Slum settlements can be around the city centres or some kilometres away from the city centres. This study shall focus on slums within some of the local government areas in the Lagos metropolis.

Socio-economic Factors: Socioeconomic factors are social conditions which affect lives and living in society. These social conditions include social status, class, culture, economy, environment, and political conditions around people that impact

their lives. For instance, income, employment, education, indiscriminate access to healthcare services, and clean environment, among others. The socioeconomic factors canvassed in this study are education, employment, income, gender, religion, age, and personal health needs of respondents. These are measured following the conventional questionnaire design approach.

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Endnotes

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Chapter Two

Literature Review

2.1 Conceptual Review

2.1.1 Health

Health is an essential part of human life. Every known society has critical attention to health because of its vitality in the sustainability of society¹. According to the World Health Organization, health is beyond the absence of disease or infirmity². It encompasses human life's physical, mental, social, and economic well-being. This description of health from the World Health Organization has led to health discourse from a holistic point of view². The multi-faceted dimension of health underscores the understanding of health from a robust perspective.

Many factors play significant roles in the state and nature of health. Some of these factors are intrinsic, while others are extrinsic³. The intrinsic factors are genetic or biologically related. Intrinsic factors, genetics, sex, and age are critical in individual health⁴. The genetic nature of a person can expose them to certain health conditions. Blood groups and genotypes are essential factors that can lay the foundation for a person's state of health. As an intrinsic factor, the sex of an individual is also critical.

Certain health conditions are particular to people of a specific sex⁴. Women, due to advancement in age, experience monthly menstruation, some as early as 9 years, and may stop this monthly cycle between the ages of 50s and 60s. The monthly experience of the menstrual flow may come with some pains, and when it stops due to menopause, it can also have some health challenges related to its discontinuity. Among other critical intrinsic factors that can affect health is age. Advancement in age affects people irrespective of their gender. Specific changes may be physiologically experienced.

Extrinsic factors such as lifestyle play significant roles. Exposure to dangerous drugs and unhealthy habits impacts human health negatively.

Socioeconomic status cannot be overemphasised for its significant role in determining people's health and well-being^{1,2}. Due to the poor socioeconomic conditions in many regions, people may find themselves in environments where necessary facilities are unavailable.

The disparity between the rich and the poor has widened the health gap between the rich and the poor, thereby causing health inequalities^{3,4}. While the rich may have access to healthcare services when due, the poor lack access to quality healthcare services. The lack of healthcare accessibility has furthered health inequalities between the rich and the poor^{1,5}. Accessibility of healthcare services is critical for addressing the health challenges faced by the populace in low-income countries. There must be an intentional agenda from the government through deliberate formulation and implementation of policies that will address the health challenges the larger proportion of the population faces.

2.1.2 Health Seeking Behaviour

Health-seeking behaviour is the actions people take to rectify health challenges⁶. This may include seeking healthcare counsel or involving in preventive measures. Health-seeking behaviour is a concept that is influenced by many factors, including class, education, employment status, religion, and cultural beliefs¹. People on the higher social ladder may have better health-seeking behaviour compared to the lower class within the same society^{1,7}. The level of intellectual advancement plays a pivotal role in health-seeking behaviour. The learned members of society have better access to health education and can appropriately utilize the health information received to their advantage. Access to information, especially in low- and medium-income countries, may not be cheap. This puts the rich and the

educated at the better edge of the path of health-seeking behaviour^{8,9}. The environment can also play a pivotal role in health-seeking behaviour. Disadvantaged members of society and the segment of society where they live may lack adequate healthcare facilities that can cater to the entire populace in the community¹. For this course, many may seek alternatives to proper healthcare or turn to self-medication, which may be improper.

Cultural factors can also affect health-seeking behaviour. Sub-cultural practice that sees anything⁷ Western as bad may disqualify the utilization of formal healthcare services even when it may be the appropriate measure to address a disease. While it may be said that specific cultural remedies may be active in rectifying some health challenges, alternative potent healthcare should not be discarded based on cultural practices or religiosity⁷. Individuals living in core rural and culturally dominated societies may have poorer health-seeking behaviour compared to those that may have been exposed due to movement towards the city or educational attainment. Health-seeking behaviour can be affected by social support systems. Social stigma from the social group an individual expects support from can affect their health-seeking behaviour.

2.1.3 Slum Settlement

Slum settlements are unapproved urban residential locations characterized by inadequate housing, poor social amenities, and unhealthy socioenvironmental conglomerations. Poor hygiene, overcrowding, precarious living conditions, and inadequate social amenities characterize slum settlements⁷. The poor socioeconomic condition and rapid but uncontrolled level of urbanization, which has led to the influx of rural migrants to the city centre, has boosted the development of slum

settlements¹. Urbanization and population growth with national poverty are the primary drivers of slum settlement in many nations, especially the world's poorer regions. Wherever the poverty level is high, this will create platforms for slum settlements to emerge. In other words, the emergence of slum settlements has a strong linear relationship with poor socioeconomic conditions^{6,7}.

Globalization and modernization have created room for inadequate distribution of wealth through the capitalistic orientation of the world economy, which emphasizes individualism over social well-being^{6,7,8}. This has caused houses in the cities to be out of reach for the poor because the houses are not created just for social goods but for profit maximisation. Due to the income disparities, the poor of the world resulted in the condition of the survival of the fittest¹. The resultant effect of this quagmire is the creation of slum settlements. As more slum settlements are created with inadequate facilities and healthcare measures, this brings about negative implications for individuals living in the slum settlements, the slum communities, and society. Slum dwellers face many challenges, among which are economic marginalization, health, and mental well-being challenges, as well as health risks that slum dwellers may face due to the inability to access necessary healthcare services when due^{1,5}. This calls for formulating and implementing health and well-being policies that will benefit all population segments irrespective of their socioeconomic status or class.

2.1.4. Socioeconomic Characteristics

Various circumstances have influenced slum dwellers' behaviour in obtaining healthcare in different places, including the metropolis of Lagos State¹. Among these factors are the financial resources available to the individual or family^{5,6}. The income level can impact slum settlement residents' ability to pay for healthcare

services. Low-income people frequently have financial obstacles that keep them from getting timely and necessary medical care^{6,7}. In addition, inadequate revenue sources could compel people to put their fundamental necessities ahead of medical costs, delaying treatment or increasing their reliance on unofficial healthcare providers. Income is important, but other characteristics greatly impact health-seeking behaviour, such as education^{10,11}. The level of education impacts health literacy, knowledge of preventative healthcare procedures, and comprehension of the range of available healthcare services. Higher educated people are more likely to take an active role in their health by following prescription guidelines, scheduling routine checkups, and leading healthier lives. On the other hand, inadequate education might cause people to be unaware of health dangers and services, which could result in less-than-ideal health results.

The frequency of disease, healthcare services, and the behaviour of seeking healthcare can all be strongly impacted by housing conditions, work status, and occupation^{1,2,3,4}. Working in slum communities typically entails ad hoc or unstable labour arrangements without social safety or job security. It may be financially impossible for those in the unorganized sector to obtain medical care since they cannot access employer-sponsored health insurance or sick leave benefits. Furthermore, harmful working conditions and exposure to environmental pollutants are common occupational risks in the informal economy, which negatively impact the health of employees and their families^{1,2}. Significant health hazards are associated with living in overcrowded and substandard housing in slum communities. These concerns include the spread of infectious diseases, respiratory ailments, and mental health issues. Health inequities within these populations are further exacerbated by limited access to waste management infrastructure, sanitary facilities,

and clean water¹. In addition to having a direct effect on physical health, an unhealthy living environment can lead to stress, worry, and social isolation, all of which can be detrimental to mental health.

2.1.5. Correlation between Socioeconomic Characteristics and Health-Seeking Behavior

One major obstacle to providing slum settlement residents with timely and proper care is their inability to pay for healthcare services, which includes consultation fees, diagnostic tests, prescription drugs, and transportation expenses^{9,10,11}. Out-of-pocket costs continue to pressure household finances and discourage people from obtaining medical assistance, even in the face of subsidised healthcare programmes and fee exemptions for specific population groups^{7,10}. Inequality in health knowledge, attitudes, and behaviours within slum settlements results from socioeconomic and educational inequality^{1,13,14}. Higher educated people are more likely to understand preventative healthcare practices, identify early illness warning signals, and use the healthcare system efficiently. Conversely, a lack of educational possibilities limits people's ability to understand medical instructions, speak with healthcare practitioners, and advocate for their own needs in terms of health. A good education can affect social networks, which play an important role in shaping health-seeking behaviour. Social networks provide emotional support, practical assistance, and access to information and resources. However, socioeconomic disadvantage can weaken social capital and social support networks in slum areas. Limited social cohesion, transient living arrangements, and social stigma associated with certain health conditions can isolate individuals from sources of support, increasing their vulnerability to poor health outcomes^{13,14}. Cultural factors intersect with socioeconomic characteristics and influence health-related beliefs, attitudes, and practices in slums. Traditional cures, religious beliefs, and cultural taboos regarding

illnesses and therapies shape people's perceptions of health care and influence their health-seeking behaviour¹. In addition, language barriers, ethnic diversity, and migration contribute to the diversity of health beliefs and practices prevalent in these communities^{1,2}.

2.2 Theoretical Framework

2.2.1 Functionalism: The Functionality of Slum Settlements

The functionalist perspective is one of the early theoretical views in sociology. Many founding fathers, like Auguste Comte, Emile Durkheim, Max Weber, and recently Talcott Parsons, are called functionalists. Functionalists view structures and units of society from the point of view of the function or the role the unit plays in the survival of the whole system. This brings the term “functional prerequisite”. From the point of view of social scientists who are adherents of functionalism, the slum has been viewed as a transitional point through which rural migrants transit into the urban system²⁹. To this school of thought, slum is part of the modernization process. In other words, the emergence of slum settlements is part of the processes through which developing societies move towards modernization. According to one of the scholars who analysed this path of thought, the emergence of slum settlements is part of the economic advancement process because these settlements act as a receiving point for rural migrants who may be unable to afford the cost of living in planned areas of the city centres²⁹. The availability of slum settlements around the city centres, therefore, acts as a cursor for the low-income rural-urban migrants²⁹. In other words, the slum settlements give the poor migrants the opportunity to work in the urban centres, develop themselves financially, and integrate appropriately into the planned areas of the city centres. One of the pioneering authorities in the study of slums, John Turner, believes that slum

settlements are essential to modernization processes³⁰. This school of thought believes that although the city centres have upward mobility opportunities, the poor migrant at the point of arrival will be unable to rent houses in the main city centres. For this reason, the slum settlements serve as accommodating points for the migrating poor who have been pulled to the city centres because of their perceived opportunities.

According to Talcott Parsons, one of the sociologists who developed an early theoretical view on health, the city centres are places with opportunities to access modern healthcare facilities. While the rural migrants transit from the rural areas to the urban areas, the cost of renting houses in planned city locations may be unreachd for new entrants into the city areas. Slum settlements provided opportunities for settlement close to the city areas until rural migrants settled financially²⁹. While the new city entrants live in the slum settlements, accessing proper healthcare services is challenging due to many factors, such as availability, cost, and healthcare distance. The structural formation of the slum settlements, which was not considered in the analysis of the functionalists, is unhealthy and can lead to poor health for its inhabitants.

This opinion pointed to the imbalance of the functionalist perspective on the analysis of slum settlements and the health of the slum dwellers. This school of thought has been criticized for its weakness in seeing the disjointed economic policy in developing countries that has continually made the populace of the countries unable to afford basic human necessities. This school of thought was also criticized because it believes that people choose to stay in the slum settlements as a process towards becoming modern, as seen by modernization theorists²⁹. The functionalist perspective may have partially explained the factors responsible for the emergence

of slum settlements. Still, it is not detailed enough to explain the health and well-being of slum dwellers. This warrants the inculcation of other schools of thought in this research.

2.2.2 Marxist Analysis and Class Inequality

In the classical analysis of Karl Marx (1818-1883), the super-structure upon which social happenings are based is the economic structure of the society³¹. From the point of view of the Marxists, the populace of the society can be divided into two: the bourgeoisie and the proletariats. The bourgeoisie are the capitalists who are the owners of the factors of production. They are powerful due to their economic status in the society. On the other hand, the proletariats are the workers or the poor class who work for the capitalists to earn a living. Due to their socioeconomic conditions, they are weak and have less power. The working class only has labour power, which they use to work for the capitalists.

According to the class analysis, the political economy of slum settlements in Nigeria suggests that the policy in modern society has been class-biased. Housing and land policies, especially, are elite-centric²⁵. The geographical distribution of planned housing settlements favours the affluent class to the detriment of the poor, who cannot afford to rent or buy houses in these locations. The economic abilities of most of the populace have also been viewed as the cause of slum settlements in most developing countries²⁹. More than 70% of Nigerians live below \$2 per day. The minimum wage in Nigeria is N30,000 per month (N360,000 per year) while the average renting cost of a 3-bedroom flat in most planned areas in the cities in Nigeria is over N600,000 per year^{32,29,25}. Capitalist orientation of profit maximization has become the underlying value driving most housing projects in Nigeria, including government housing projects. This has made some of the

properties unaffordable for the poor Nigeria. This is confirmed in the case of the Badia East community, that was cleared by the Lagos State government and rebuilt. Still, the houses were only for the political/elite classes as they were unaffordable for the evicted victims of the former slum settlements⁵.

According to this school of thought, the lower classes' decision to move to, live in, or create slum settlements is based on unfavourable socioeconomic policy standards in most capitalistic-oriented modern societies. This school of thought also criticised the globalists who view the areas inhabited by the poor members of the society as areas that socially defaced modern society. To these globalists, uniformity of modernization must be ensured by clearing these areas tagged either as “slums or informal” settlements to build a modern-capitalist city centre free of slums, a “city without slums”. Unfortunately, clearing a slum settlement only led to the expansion of an existing slum settlement or the creation of a new one. This is because the cause of slum settlements, poor socioeconomic policies, is not addressed, but the effect (slum settlement) is being tackled. The solution, therefore, is to create an equitable resource distribution policy that will alleviate poverty and inequalities in all forms of Nigerian society.

The capitalistic-oriented policy and economic agenda have significantly affected the creation of essential services like healthcare. Most healthcare centres are located in the heart of the city centres. There is an imbalance in the spread of infrastructure, and the areas inhabited by the poor members of the society are deserted. The slum areas of Nigerian society have fewer healthcare facilities. Where there are, staff inadequacy and lack of essential items like drugs and medical facilities may be challenging. This situation still leads the slum dwellers to the city

to access necessary healthcare services. This abnormality continues to affect the health of the slum dwellers and, eventually, the health of the Nigerian populace.

Karl Marx's political economy view has been criticized for its over-emphasis on the economic structure as the sole determinant of social issues like choice of residence and the utilization of healthcare services. Other views believe that other institutions such as religion, culture, law, family, and education influence the choice and services individuals access. In response to this view, this research moved to the review of another theoretical perspective. This later theoretical view is believed to cover the lacuna and the inadequacies experienced by the earlier theoretical perspective reviewed in this research. This later perspective by Kroeger is therefore adopted as the ground theory for this research.

2.2.3 Health Behaviour Model (HBM)

The Health Behaviour Model, a fundamental theory in health psychology, was first introduced in the 1950s⁵⁹. This was when social scientists from various disciplines were deeply interested in understanding the factors influencing an individual's health-seeking behaviour. The model was initially presented in the 1950s by scholars such as Hochbaum and Rosenstock. It was further developed and refined in the 1970s, particularly by Rosenstock and Becker⁶⁰. The model's six key elements are:

- (i). perceived susceptibility
- (ii) perceived severity
- (iii) perceived barriers
- (iv) perceived benefits

(v) cue to action, and

(vi) self-efficacy.

Perceived susceptibility, a key element, elucidates an individual's likelihood of being exposed to or contracting a disease. According to the proponents of this model, an individual is more inclined to seek healthcare services if they perceive a risk of being exposed to a disease^{59,60}.

Another crucial element is perceived severity, which hinges on an individual's perception of the potential danger a disease can pose. According to the model, two primary factors drive health behavioural change: the wish to evade a disease and the wish to prevent disease. Based on this perspective, an individual is more likely to seek healthcare services based on their belief about the gravity of the disease or its potential impact.

Perceived barriers examine the factors that may pose challenges to an individual's access to healthcare services. These factors may be intrinsic or extrinsic.

Perceived benefits explain the positive results or experiences an individual stands to gain by utilizing a healthcare service. According to the model's proponents, this is a critical factor that can affect an individual's health-seeking behaviour.

Cue to action examines factors that trigger an individual to take health-enhancing action. This is the fifth element of the model, and the last is self-efficacy.

Self-efficacy, later added to the model's elements, measures an individual's confidence in successfully taking actions related to their health and well-being^{59,60}.

Despite this model's comprehensive presentation, overemphasising the individual's ability as the main trigger for a health-related action opens further

questions. For example, the model does not comprehensively explain the health-seeking actions of those who may have Dementia or Alzheimer's disease and who cannot be perceived or take constructive health-related action by themselves. Based on this model's inability to holistically explain socioeconomic and sociocultural factors affecting health-seeking behaviour, this review advances to evaluate Kroeger's health-seeking model.

2.2.4 Kroeger's Theoretical Postulation of Health-Seeking Behaviour

This research adopts Kroeger's theoretical model of health-seeking behaviour³³. This theoretical framework was presented in the work of Kroeger titled "Anthropological and Socio-Medical Health Care Research in Developing Countries", published in 1983. Based on the view of this theorist, the utilization of health care services, either private or public, formal or informal, paid or free, orthodox or alternatives, depends on interrelated variables such as socio-demographic factors, cultural factors, social structures, gender, socio-economic condition, environmental factor, educational attainment, religious belief etc. Further details of the variables affecting health-seeking behaviour according to the theory are pictured in the diagram below.



Figure 2.1: Kroeger's Model of Factors Affecting Health-seeking Behaviour

Source:³²

Since its introduction in 1983, it has been used to explain health-seeking behaviour in different settings, especially that of residents in developing countries³⁴. Kroeger's model is one of the most holistic theoretical models in health-seeking behaviour³⁰. This model provides platforms for examining, analysing, and interpreting intervening variables affecting health-seeking behaviour and the utilization of healthcare services in developing countries, including Nigeria. The model considers socio-demographic factors such as family size, educational attainment, household income and financial stability of the family head as variables that can affect an individual's health-seeking behaviour^{35,36}. Cultural factors were also considered essential variables in health-seeking behaviour. According to this model, certain culturally related practices may lead to self-care, using alternatives, traditional healers, and home remedies, among others³⁷. Cultural factors are among the factors causing a lack of patronage for structured and formal healthcare services³⁴. This model also considered the importance of financial and economic factors. Financial and economic factors, according to the World Bank, have been

claimed as the source of health inequalities among nations and classes³⁴. For people with low financial capacity, out-of-pocket payment is a severe financial challenge³⁴. The financial burden of health care may be the barrier that stops people from utilizing healthcare services or diverts them to alternative care.

Environmental factors are not excluded in this model⁵³. Distance and location of healthcare services may also constitute barriers and affect health-seeking behaviour negatively. Due to the capitalistic orientation of Nigerian society, medical facilities are common in the planned areas of the cities³⁹. Because of location, accessing these healthcare centres becomes a challenge due to poor transport facilities in developing countries³⁹. Kroeger's model analysed attitudes of health workers among factors affecting health-seeking behaviour as a holistic theoretical analysis³³. This applies to the Nigerian health sector, especially government hospitals². Some of the staff in government hospitals lack empathy and have negative attitudes because they believe that whether they attend to people or not, their monthly salary will come when it will. This is happening not only in Nigeria but also in other developing countries. For example, a similar case has been reported in countries in Asia³⁴. This makes people turn to alternative care where they believe the staff are warm and polite. Unfortunately, the level of care received in these unstructured and informal settings may not be standard. Other factors leading people to utilize private and informal healthcare services may include easy access, flexible operation time, and the delay people experience in trying to utilize government hospitals in developing countries³⁴.

This theoretical model has been adopted to explain the health-seeking behaviour of slum dwellers in the Lagos Metropolis because of its deepness and holistic nature. The model encapsulates the socioeconomic factors identified as

germane to understanding the health-seeking behaviour of slum dwellers in the Lagos metropolis.

2.3 Review of Empirical Studies

2.3.1 Intervening Variables Affecting Health-Seeking Behaviour of Slum Dwellers

Health-seeking behaviour can be enhanced and affected in different ways. The level of empowerment and the availability of/access to health information can affect the health-seeking behaviour of people^{1,2,3}. In low- and medium-income countries of which Nigeria falls, the level of one's education and financial status are key determinants among other factors impacting health-seeking behaviour¹. Education grants access to upward career mobility and empowers one to access and utilize information. Access to quality and health-enhancing information is a challenge among informal settlement dwellers. Some are more concerned with having their daily meal because of poor financial status than using their little financial resource to buy data or access information from sources like internet centres, newspapers, health magazines, etc. It has been reported that many of the slum dwellers live below the poverty line, according to World Bank¹. Financial strength affects health-seeking behaviour directly and indirectly. In wealthy nations with easier access to financial resources, a positive report has been given about health-seeking behaviour. Between 40% and 70% of adult Americans use the Internet to seek health-related information³.

Although not conceptualized as a stand-alone factor, Anderson categorises "information" in his health-seeking model among predisposing factors affecting health-seeking behaviour⁴. Accessing viable information can propel an individual to healthy activities. For example, going for a health check or taking healthy precautions². The importance of information as a vital factor in health-seeking

behaviour has been established in the literature, but how this information will be available to all without barriers and discrimination remains unclear^{2,3}. Considering the socioeconomic situation of the people living in the urban slums of Lagos Metropolis, there is the likelihood of finding a large group of people with poor socioeconomic status⁵. As a result of the poor status of this group of people, they may have little or no access to health-enhancing information due to low education and poor purchasing power^{1,2}. This may continue to hurt people's health-seeking behaviour. This part of the research shall comprise other sections for a detailed analysis.

2.3.2 Household Income and Health Seeking Behaviour of Urban Slum Dwellers

Healthcare costs above patients' or health seekers' income may impede the utilization of healthcare services. Spending above the income of patients in the utilization of healthcare services is among the factors prompting urban slum dwellers to poverty and ill health⁶. In the incidence of sickness, the households in the slum settlements, due to the high cost or out-of-reach cost of accessing structured health care, may opt for a cheaper alternative or forgo the utilization of healthcare services^{7,8}. Due to the limited level of household income among the households and families in the urban slum, the residents have the option of either paying for healthcare services or providing for the family's basic needs such as food, clothing, and shelter⁹. It has been estimated that healthcare expenditure can take as high as 40% of the household budget^{10,11}.

Universal Health Coverage focuses on positive health outcomes and access to quality health as a global right⁶. Despite establishing health rights as a universal right, there are peculiarities in different countries that can encourage or discourage

people's health-seeking behaviour. Nigeria is among the countries that support the affordability and accessibility of healthcare services for all. Nevertheless, many Nigerians still have discrepancies in health access despite a National Health Policy⁶.

In many low and medium-income countries, the cost of healthcare services affects the health-seeking behaviour of the populace, especially the poor^{1,6}. Healthcare costs are as high as 9.1% of household income in India and up to 25% in Nigeria¹¹. The unreachable cost of healthcare services among the poor in Nigeria can be related to the negative attitude of many regarding health-seeking behaviour, especially among urban slum dwellers. Healthcare cost challenges have negatively affected the Universal Health Coverage (UHC) tenets^{12,13}. To reduce the health risks Nigerians face, the National Health Insurance Scheme (NHIS) was implemented in 2005 to ameliorate the challenge of healthcare costs, which is affecting the health-seeking behaviour of Nigerians^{14,15}. Although this is a good move by the Nigerian government, this scheme focuses on the formal sector, which constitutes only 4% of the populace and neglects the informal sector, for which most Nigerians fall¹⁶. The urban slums constitute a vital part of the informal sector, and considering the situation around the slum settlements, they may have more health risks⁶. According to the national statistics, the current population of the study location in this research is 2,268,869^{17,18}. This fact makes the study of these people's health-seeking behaviour critical.

2.3.3 Age and Health Seeking Behaviour of Slum Dwellers

With the increase in chronological age come some physiological and biological changes in people. This may warrant (but not necessarily) some health needs in individuals as physiological changes begin to bring discomfort to the body.

The rising level of non-communicable disease has recently attracted attention in global health as people age¹⁷. The core of Universal Health Coverage (UHC) is on providing universal quality health¹⁹. While quality is essential, less emphasis is placed on the cost of health provision, which can affect people's health-seeking behaviour. The emphasis on quality and negligence towards the cost of the provision of Universal Health Coverage (UHC) has made the provision of healthcare services unaffordable for the poor¹⁹. This has made both young and old in low- and medium-income countries turn to informal health providers^{1,19}. A similar incidence has been reported in China as older people engage in self-medication or patronize community pharmacies for their health needs¹⁹. Relating this to Nigeria, among the urban slum dwellers in Nigeria, there have been reports of high patronage of informal healthcare providers compared to structured healthcare services¹. This is to show the lacuna of the government health insurance scheme, which only concentrates on the formal sector to the negligence of the informal sector²⁶. The focus of Universal Health Coverage (UHC) has been criticized for not being people-centred. A policy that is people's focus will be keen on people's needs and expectations. Still, the current monitoring of Universal Health Coverage focuses on either diseases or access to formal healthcare services¹⁹.

Older people may have medical needs due to activities and biological structure changes. Due to costs, more ageing people may turn to informal health providers or community pharmacies where people get drugs based on their financial capabilities. This situation may negatively affect the people as victims of drug abuse or wrong medication¹⁹. The effectiveness of the government's support or health policy may bring another dimension to the health-seeking behaviour of the people. While it may be believed that an increase in age may warrant the frequency of

healthcare services, this may not be necessary²⁰. Health-seeking behaviour may not be significantly related to people's age. The type of healthcare services people use may not be determined by age. Other factors such as accessibility, financial requirement, and gender, among others, may likely affect the health-seeking behaviour of people than the increase in age²⁰. Going by some empirical information, age may not necessarily warrant the utilization of healthcare services as both young and old people may have health needs at different points. This calls for people's friendly health policies to support the health needs of the working and dependent populations (old people and children).

2.3.4 Education and Health Seeking Behaviour of Slum Dwellers

Knowledge is power. Education gives access to information and helps to advance the social mobility ladder. The place of education cannot be over-emphasised in the social advances of people. The level of people's education can impact health-seeking behaviour. Among the various socioeconomic characteristics affecting health-seeking behaviour, education has been repeatedly reported^{1,21,22}. Education gives people access to information. Through the accessibility of information, individual health seekers or users can appropriate the information to improve their health. The role of education as a socio-demographic factor is multi-dimensional. The attainment of quality education can lead to social transformation. Education can lead to better economic opportunities. For this reason, the level of one's education may significantly correspond to one's financial status (not in all cases).

Linking education to health-seeking behaviour can overlap between enabling and predisposing factors in the health-seeking model⁴. Education can bring about

empowerment (enabling factor), and it can give access to health knowledge (predisposing factor) that will affect the health-seeking behaviour of an individual⁴. Poor education and inferior health education is one of the causes of poor health in most urban slums²². Due to the nature of urban slums, there is the likelihood that there may be many people with low education as the urban slum settlements are known to be transition centres for rural-urban migrants who may have migrated to the city in search of advancement opportunities²³. Based on this low educational status, slum dwellers may be disadvantaged in accessing health-related information. Where the information is available, there may be deficiencies in its utilization. Low education may negatively impact income opportunities. Not more than sixteen percent (16%) of residents of some of the slum settlements in Southwest Nigeria have above secondary school education⁶. This is a significant issue as education is important for social advancement. Either from the information advantage that education gives or the financial opportunities it gives, its non-availability will negatively impact urban slum health-seeking behaviour. Many research endeavours have also evidenced the role of education as an important variable in health-seeking behaviour^{1,2,6}.

2.3.5 Employment Status and Health Seeking Behaviour of Slum Dwellers

Employment is important for social advancement, and the type of employment can significantly impact health-seeking behaviour. People who work in the formal sector have better access to healthcare services due to the statutory registration under the National Insurance Health Scheme (NIHS), which allows the workers to access and utilize quality healthcare services of their choice²⁶. Unfortunately, the NHIS focuses on the formal sector, which covers not more than 4% of Nigerians⁶. Many slum dwellers operate within the informal sector, an area

less focused on by the NHIS^{5,6}. Many slum dwellers are either self-employed, traders, or unemployed^{5,6}. The population that is covered by the slum settlements is around 57.7% of the Nigerian population, and this is likely to increase due to poverty and the political crisis that is ravaging Nigerian society¹.

Irrespective of the residential location of people, health-seeking behaviour can be positively influenced by the availability of good social support and health policies that give access and utilization of healthcare services indiscriminately¹⁹. The present level of health-seeking behaviour of slum dwellers may not be taken as statutory from the people discriminately as the cost has also been reported to cause barriers to healthcare services utilization¹⁹. Research endeavours that use UHC as the basis for assessment of health outcomes also have challenges as they focus on eradication of disease or access to formal healthcare without much concentration on factors causing less utilization of formal healthcare⁶. This evidence may also be questioned as utilization of formal healthcare services may be less among urban slum dwellers, but that does not mean non-utilization of healthcare services, as many may turn to informal care¹. This choice of health-seeking behaviour may have been warranted by the financial resources available to the healthcare users¹⁹. This view of the choice of healthcare services utilization may also be worthy of research attention³. Since it is part of the policy of many formal organizations to have health insurance coverage for their staff, most people in formal employment may have access to healthcare services without any form of barrier. To those in the informal sector, to which most slum dwellers belong, this is still a barrier due to poor financial status and weak coverage of the informal sector by the National Health Insurance Scheme (NHIS)⁶. If this is not addressed, residents of the informal sector and slum settlements in the Lagos metropolis will continue to face health risks. It

has been established that many residents of slum settlements in Nigeria work in the informal sector⁶.

2.3.6 Health Needs and Health Seeking Behaviour of Slum Dwellers

Health needs can be explained in two different dimensions. The first dimension is the need to stay healthy to continue functioning socially as expected of one²⁴. This perspective is related to the view of Talcott Parsons, titled the father of medical sociology or sociology of health. The second dimension of health needs is to rectify or address an illness or disease that has been medically discovered. Parson addresses this perspective of health needs in explaining sickness as a deviant. Sickness is a deviant because it stops an individual from performing social roles and duties. To address this deviance, the institution of health, which has been given the functional responsibility to make people healthy, must be consulted with its professional to fulfil the functional obligation of removing the deviance (sickness) from the individual. While the individual is sick, he/she will be fulfilling what Parson called “the sick role”, which will stand as a barricade to performing social roles. Irrespective of the place of residence, it may be argued that people will do whatever they can under critical conditions to stay healthy or alive.

The importance of the need factor has been addressed earlier in the work of Anderson⁴. In this notable model, factors affecting health-seeking behaviour are categorized into three. Among them is the health needs of an individual. Despite the low financial status of slum dwellers, researchers have argued that health needs continue to prompt slum dwellers to seek healthcare services^{1,6}. The same research outcomes and others claimed that many slum dwellers used alternative care services compared to formal health services^{1,21}. The cause of the need to utilize alternative

healthcare services may need further scientific investigation as this is a critical aspect of the health-seeking behaviour of urban slum dwellers. This may also be attributed to the purchasing power of urban slum dwellers in Nigeria as a group with poor socioeconomic status^{1,6,21}.

2.3.7 Political Economy, Government Urban Renewal Policy, and the Emergence of Slum Settlements

Attention to the political economy of housing and the role of government social policy is significant in this discussion of developing slum settlements in Nigeria. The political economy focuses on the distribution of scarce resources. For instance, who gets what, when, and where resources are allocated are the basis of discussions in political economy²⁵. Recent discussion of the geography of housing has been related to this point of the political economy of housing in Nigeria. For instance, the distribution of housing in Nigeria has been biased as it has been in favour of the elite class and to the detriment of the lower cadre groups in Nigerian society²⁵. This situation has contributed to the emergence of slum settlements since most of the properties built by the Nigerian government are in high-class areas of the cities where they are unaffordable for the lower classes of Nigerian society²⁵.

The political economy of housing and property distribution looks at how government agencies are biased in formulating and implementing housing policies. These policies are detrimental to the well-being and livelihood of the lower classes, as seen in the case of Makoko and Maroko in Lagos State⁵. A critical look into housing policies and the distribution of government housing projects in Nigeria will inform one that these policies/projects are elite-centric²⁵. Nigeria's agenda of government housing has a capitalist orientation with the underlying value of profit maximization. Lucrative areas around the city centres occupied by the lower classes

are cleared in the name of urban renewal projects, rebuilt, and sold out to the political or the elite class. This capitalistic orientation with the basic ideology of profit maximization has led to the emergence of more slum settlements not only in Nigeria but the world over²⁵.

In the report by United Nations Habitat, over 860 million people live in slum settlements all over the world²⁶. Between 2000 and 2010, a minimum of 6 million people moved to the slum settlements around the urban centres yearly. While the number of slum dwellers worldwide is growing by less than 1% yearly, the population growth in Sub-Saharan Africa is growing yearly by a minimum of 4.5% due to the high inequalities in the African region²⁷. Among the African countries that have led in the developing slum settlements and high populations of slum dwellers are Botswana, Burundi, Cameroon, Cote d'Ivoire, Eritrea, Gabon, Ghana, Kenya, Zambia, and Nigeria. But among them all, Nigeria has the highest incidence of slum settlements^{25,28}. More than 60% of the urban dwellers in these countries live in slum settlements, and Lagos, one of Nigeria's mega-cities, attracts a large sum of rural-urban migrants^{5,23}. As these people find it challenging to meet the essential living cost of the city, they move to existing slum settlements or create new ones. This choice of residential location may likely have a negative effect on the health status of slum dwellers and their health-seeking behaviour⁶.

2.3.8 Nigerian Society within the Global Health Discourse: Empirical Analyses of Health Seeking Behaviour

Sociologists and other social researchers have clearly shown that health and illness are affected by socioeconomic factors, among which are income, education, gender, class and age, among others³⁷. It has been shown that a person's social class, gender and ethnic background will influence the chances of suffering ill health.

However, the most obvious is between the rich and the poor. In other words, between class groups⁴¹. The point of the argument in this analysis is a clear indication of the role of socioeconomic factors on health-seeking behaviour. Social class was universally related to mortality and morbidity rates⁴¹. People in the high social hierarchy have access to better healthcare services, which, in effect, impacts their health status⁶. Accessing quality standard healthcare services requires an individual to be within the range of the high-income class¹. Analyses allude to the fact that people in low social classes do not have the income required to utilize healthcare services since the government hospital, even though they may be cheaper to access, services are not widespread^{1,6}. This view has been earlier established⁴². This has resulted in a high mortality rate among the lower-class people. Some authorities have also argued the fact of race in the utilization and access to health care services. There is a racial explanation for healthcare services utilization⁴¹. While one may be unable to establish the impact of racial discrimination in healthcare services in Nigeria, other factors such as religion, class, employment, gender, and age have been significantly highlighted in the analysis of health-seeking behaviour^{1,6,42}.

Many factors affect health-seeking behaviour, which is found within the social fabric on which a social analysis is based. Among the factors established are:

- People in lower social classes were, in some cases, experiencing comparatively worse health than people in other classes.
- The rate of infant mortality was higher among slum dwellers and lower class in comparison to other classes.
- There was a strong inverse relationship between social class and mortality rate.

- An inverse relationship was found in many cases between social class and morbidity⁴¹.

Mortality and morbidity among slum dwellers and lower classes cannot be excluded from the socioeconomic factors available to the people⁴³. The working class has fewer support networks to help them deal with stressful life events such as losing a partner or status⁴³. In health crises such as epidemics or pandemics, slum dwellers will likely have fewer resources to meet physiological and essential needs and access healthcare services⁴³. Furthermore, many slum dwellers have lived in slums due to unemployment. This significantly influences the mental and physical health of the slum dwellers, leading to other stress factors such as higher divorce rates⁴⁴.

2.3.9 Financial Challenge and its Impacts on Nigerians Health Seeking Behaviour

Studies of areas where factories have closed in both the USA and the UK show higher levels of ill health, especially in the months when the redundant workers knew they would soon be unemployed³⁷. Longitudinal studies show higher levels of mortality among unemployed men⁴⁵. This is because the unemployed either have little or no access to the utilization of health care services. Authorities have asked questions about the utilization of healthcare services and the socio-economic status of people. Why are the poor more likely than the affluent to suffer serious health problems and have a shorter life span⁴⁶? Some might think that poor people choose not to take care of themselves. But the fact is that members of the poor population confront a daily environment containing many health threats than the environment of the more affluent. Features of their workplaces, community settings, neighbourhoods, and living quarters put people who are impoverished at particular risk for health problems⁴⁷. For instance, many students of the University of Lagos

trek from Bariga to the school because of a lack of financial capacity. Sometimes, these students in this situation find it difficult to concentrate a few minutes after their arrival while the lecture may already be going on (personal observation). This situation results in a short-term mental disorder for students going through the experience. The argument is that the income available to people determines their health status and access to healthcare services.

2.3.10: Environmental Impacts on Nigerians' Health Seeking Behaviour

Features of slum settlements, neighbourhoods and living quarters contribute to health problems among poor people⁴⁸. Older buildings, where the slum dwellers are likely to live, may have dangerous materials such as asbestos and lead paint, insects and rodents, and deficient heating and electrical systems. Skyrocketing rental costs have forced many low-income families to double or triple up in apartments and houses⁴⁸. This also stresses that overcrowding of dwellings magnifies stress and facilitates the spread of infectious diseases⁴⁹. Homeless individuals and Families are particularly vulnerable to illness accidents and violent episodes such as mugging because of their constant exposure to life on the streets⁴⁶, and homeless shelters pose a danger such as tuberculosis⁴⁸. The rise of slum settlements in the low and medium regions of the world may contribute to health risks, and poor socioeconomic conditions may further lead to negative health-seeking behaviour⁴⁸.

2.3.11 Inadequate Healthcare Coverage in Nigeria

In the National Health Policy of Nigeria 1989, Nigeria "health for all shall be ensured for all Nigerians in the year 2000'. Currently, in the year 2023, health for all is not yet achieved. This shows the failure of the Nigerian health sector/policy⁴². The United States spend more money on health each year than any other nation in the world⁴¹. This has helped to maintain the quality of life and health status in the

United States. In many African nations, including Nigeria, the healthcare system does not embrace all these nations' citizens. The health status of many Nigerians is low compared to other countries in the global West⁴². To enhance the quality of health status in the global West, the nations in this region provide either a national health insurance system or a system of national health services that covers everyone⁴¹. For example, the government of the United Kingdom provides for the health needs of all through the National Health Service (NHS). Legal residents of the United Kingdom are not denied healthcare services because they cannot afford them³⁷. Healthcare in Britain is considered a right. In Nigeria, healthcare is treated like any other commodity in a market economy⁴². You get what you can pay for. This stresses the argument that the income available determines the healthcare services people receive.

2.3.12 Health Care as a Market Commodity

Factors preventing people from utilizing healthcare services are numerous. And because of the variety of these factors, one may not be able to touch all the factors. One of the inadequacies of the Nigerian healthcare system stems from treating healthcare as a commodity to be bought and sold in a market system. In the United States, physicians have long been independent entrepreneurs⁴¹. This fact is also applicable to the Nigerian healthcare system. People with low income will always find it challenging to access healthcare services because most medical doctors always want to live in the area where the rich stay and at the same time have their offices or consulting centres in these areas of the affluent³⁷. This made many slum settlement residents unable to have easy access to healthcare services utilization. In the slum settlements and rural areas of Nigeria, the availability of adequately equipped hospitals is very scarce⁴².

Physicians tend to migrate to urban metropolitan areas and their sprawling suburbs. In such communities, they can affiliate with high-quality medical facilities that service more affluent households can afford⁴¹. But this also means that people living in slum settlements of the country, in small towns and reservations, go underserved⁴¹. Some medical doctors reserve their services for the highly affluent in a U.S. healthcare development called "concierge or Boutique" medicine. These physicians provide care only to those who can spend thousands of dollars a year beyond their private health insurance premiums⁴¹. Boutique doctors select patients based on their ability to pay and give them on-call, pampered treatment. Compared to other doctors, these physicians see far fewer patients, spend more time with each of them, routinely call upon the most expensive diagnostic tools and tests, and provide highly personalized one-on-one follow-up care⁴¹. Doctors taking this route may rationalize that, in this way, they can use their training to provide the very best of care. Yet, this emerging healthcare system dramatically illustrates how healthcare is linked to economic inequality.

2.3.13 Problems of Healthcare Delivery and Health-Seeking Behaviour in Nigeria

The world has always been a place of contradictions. It is a world committed to human equality, yet it is full of inequalities; a world of spectacular natural beauty, but it is also full of pollution; a world of high ideals and dedication to peace, but it is also full of records of social injustice and violence; a world of unprecedented material affluence for some people but it is also a world of poverty and malnutrition for many⁴². It is a world of health for some people and sickness for others. One of the major problems facing Nigeria and many low-income countries is that of healthcare delivery⁴². One explanation for the distorted development of healthcare in underdeveloped countries such as Nigeria focuses on the consequences of economic

and political dependency, characteristic of underdeveloped countries in relation to industrialized countries by providing them with medical care that imitates those available in the advanced countries which are drawn by a net outflow of capital to the capital owning and creditor advanced capitalist nations. Therefore, healthcare design in Nigeria originally circumvented the interest of the common man but provided for the needs of the elite⁴².

The orthodox medical system imported into Nigeria during the colonial period is still up against formidable odds to alleviate disease and discomfort⁴¹. The health problems of the 1940s are still with us today. Essentially, medical services are inaccessible to and affordable to the common man⁴². The medical profession of underdeveloped countries, like the advanced countries, obstructs programmes and reforms in healthcare as they try to protect their control over medical practices, status, and income⁵⁰. They placed the profession and members' interests above those of the people's need for accessibility to health services. In Nigeria, medical practices and access to utility have generally remained small elite rights, the priority for curative rather than preventive healthcare⁴².

The policy of the Nigerian government as related to the health sector allocates below WHO speculation in terms of financial budget. This has put the funding of this sector in the hands of private/profited-oriented individuals who placed the cost of accessing healthcare services above the reach of the common man. Only 1.5 per cent of the total expenditure was allocated to health between 1985 and 1996, compared with an average of 8.8 percent allocated for defence and security during the same period⁴⁶. This is about six times the share of health. About 1% of the annual budget is allocated for health compared with 3% for defence and security³⁸. Unlike other African countries, Nigeria allocated less than five percent

recommended by the World Health Organization (WHO). For example, between 1992 and 1998, Ghana allocated seven percent for health, Kenya allocated six percent; Tanzania allocated six percent and Zambia eight percent⁴². Therefore, the healthcare delivery problem in Nigeria is rooted in the nation's political economy^{42,51,52}.

2.3.14 Inequalities in Healthcare and Health-Seeking Behaviour in Nigeria

Many factors can be responsible for inequalities in access to health. Some of these problems have been highlighted in the National Health and Population Policy of Nigeria 1989:

1. Inadequate supply of physicians
2. Poor distribution of health facilities
3. Cost of health service
4. Access to safe drinking water
5. Access to sanitation
6. Shortage of drugs
7. Infrastructural facilities
8. Attitude of the health workers
9. Health education strategies

Inadequate Supply of Physicians: As mentioned earlier, medical education in Nigeria remains elitist, which is mostly accessible to the children of the upper and middle classes⁴². It becomes very difficult for brilliant but indigent students to enter medical schools because they are very expensive since the government is not providing support⁴². Therefore, medical education in Nigeria is accessible to those who can afford it. Hence, the physician ratio in Nigeria is about 1 to 10,000 persons⁴². Even the few available are concentrated in the urban areas, neglecting

slum settlements and rural areas where more than 65 percent of the Nigerian populace reside⁵³. As a result, the lower-class people have no access to qualified physicians, hence the patronage of quack doctors, herbalists and spiritual homes⁴².

Poor Distribution of Health Facilities: The location of healthcare facilities has been a major source of problems in healthcare delivery in Nigeria⁵⁴. Since Nigeria's policy is curative and hospital-based, healthcare and facilities are not within the reach of the poor people who encounter health problems in their day-to-day subsistence activities. They have little or no access to healthcare, and where they have at all, the cost of such provision is enormous⁴². The healthcare facilities' locations are very far from some communities' especially slum settlements in Nigeria. A study conducted by DFRRI discovered that Nigeria has about 100,000 communities, which were only served by 10,711 health establishments⁵⁴. This means a ratio of one facility to about ten communities. Today, the situation is worse due to poor funding for the health sector. Most of the health institutions in Nigeria have been closed⁴².

Cost of Health Care Service: Studies have shown that among lower income groups, reduction in monetary cost is usually associated with increased use of health care services^{42,54}. In Nigeria, the cost of healthcare services is enormous, sometimes out of the reach of the common man. Having patterned Nigeria's health system after the American healthcare system, it became a fee-for-service approach⁴². As a result, it is a matter of "money for hand back for ground" syndrome. Therefore, it is a commodity rationalized by the price mechanism. In this situation, healthcare service in Nigeria is primarily for those who can afford it, indicating the capitalist mode of production. Production of health services is a capitalist venture in Nigeria compared with the welfarist approach in Britain³⁸. This is, however, the resultant effect of the

lower GNP per capital of Nigeria, the source of people's impoverishment, and they have no access to necessities of life like safe drinking water^{42,54}.

Access to Safe Drinking Water: What goes into one's body goes a long way to affect one's health status. Clean water is one of the prerequisites for good health, just as a clean environment. Increasing environmental degradation and pollution have rendered water in the slum settlements and many communities in Nigeria unsafe for human consumption. As a result, water has become a commercial commodity, the affordability of which is determined by the price mechanism. Many Nigerians do not have access to safe drinking water. The situation has become critical because it is becoming increasingly difficult to maintain the dam pipes and procure water treatment chemicals due to the poor financial condition of the government⁴². This situation left the water supply in the hands of private operators, which also worsened the situation. Apart from the cost of "take away" water, there is a poor-quality control measure to ensure the safety of roadside water supplies by water vendors. This puts those who can even afford to buy the so-called "treated" or "pure" water at high risk⁴².

Access to Sanitation: Sanitation is a function of income apart from other determinant factors such as residence, age, sex, education and so on. The sanitation situation of many slum settlements, as discovered during this research, is worrisome. High-class people have access to sanitation than lower-class people⁴². Following the colonial policy, the Nigerian elite isolated themselves from the common men and resided where functional environmental sanitation services were available⁴². From empirical observation, most Nigerians cannot provide basic toilets in their homes. Some houses in the slum settlements studied in this research use open spaces and drainage as sources of refuse disposal. In the slum settlements of the Lagos State

metropolis (Nigeria), the major concern of people is how to get daily bread. When people cannot eat well, there may be little or no motivation for things that have no direct and immediate consequences on their lives. In Nigeria, only 35 per cent of Nigerians (40 per cent urban and 30 per cent rural) had access to adequate sanitation between 1990 and 1995⁴². In a situation where refuse disposal services are in the hands of private operators, very few people may be able to afford them, and where the government is rendering such services at all, it is an epileptic one. Hence, the heaps of refuse and human, as well as animal faeces littering the streets, the consequences of which are environmental pollution and eventually poor health status among the slum dwellers (lower class people) who constitute more than 90 percent of the Nigerian populace⁴².

Shortage of Drugs and Health-Seeking Behaviour in Nigeria: Many have described Nigerian hospitals as mere consulting clinics. Since the government of Nigeria is investing less in the health sector, which has made access to essential facilities like drugs become the show of the 'fat cats'. This situation has become problematic recently due to the government's attitude towards health. In the budget, while about 10 percent is allocated to defence and security, less than 2 percent is allocated to the health sector between 1990 and 1995⁴². This shows that health is given less priority. Due to the high cost of drugs, people tend to patronize roadside drug peddlers and hawkers and fall victim to drug abuse. This situation worsens daily, with increasing anxiety about economic and political deterioration.

Infrastructural Facilities and Health-Seeking Behaviour in Nigeria: The disparity in the distribution of healthcare services is still apparent in the south-west region of Nigeria, from where this research collected its data despite the health policy expounded in the fourth development plan to reduce inequality in the spatial

distribution of health facilities in the country⁵⁷. This same situation applies to other infrastructural facilities. Infrastructural facilities and functional health facilities are ingredients for better health conditions⁵⁴. The PHC programme has infrastructural facilities as a significant component of its operations, establishing DFRRRI in 1986⁴². However, DFRRRI was to accomplish this objective with an initial allocation of N433 million in 1986 and an increased budgetary allocation of N500 million in 1987. This is an example of failed health policy in Nigeria, as DFRRRI and many other government projects developed to date have not solved the health problems of Nigerians⁴².

The Attitude of the Health Workers in Nigeria: Its Impact on Health Seeking

Behaviour: Studies in Nigeria have shown that health workers, especially nurses/midwives, are difficult workers in the hospital setting^{42,54,55,58}. Their mode of interaction with patients is strained on most occasions. Patients also suffer from strained relationships among health workers, such as nurses/doctors relationships; incessant strikes in hospital settings are products of the capitalist mode of production in the health sector. While doctors go on strike to press for their rights, other workers do the same, and patients usually bear the consequences of these actions. When this happens, it usually results in high mortality rates⁴². Hence, patients have no confidence in health workers and hospital services. Within the hospital setting, there is also the problem of favouritism; since health workers belong to a particular class, they tend to favour friends and colleagues and, in most cases, put aside professional ethics to embrace bribery. All these favour the elite more than the less privileged people, which constitutes problems in the wheel of progress in healthcare delivery in Nigeria.

Strategies of Health Education and Health Seeking Behaviour in Nigeria:

Health education in Nigeria is a class issue because the elites have more access to health information than the lower people. Health education mostly comes through radio, television, and print media, which are more accessible to the elites. On rare occasions, health workers come to the grassroots to talk to people physically due to a lack of logistics support⁴². Formal education plays an important role in accessibility to health education. Studies^{42,55,58} have shown that literacy is a function of accessibility to health information. But in Nigeria, where the adult literacy rate is as low as 49%, most elitist classes can read health information and have access to radio and television⁴². They have a better understanding of the information being disseminated. Therefore, to some extent, health education in Nigeria is designed and channelled through sources that are most favourable to the elites. Hence, the majority of the people who are the commoners have little or no access or knowledge about matters affecting themselves and their health⁴².

2.4 Conceptual Framework

The slum population in the Lagos State metropolis are faced with enormous socioeconomic challenges that negatively impact their health-seeking behaviour^{5,6}. These variables include poverty, limited access to essential services, failed or poor social amenities, cultural beliefs, and kidnapping^{1,5,6}. Embarking on a scientific endeavour that will expand the knowledge and understanding of this critical area is vital for formulating social policies and developing interventions to address the peculiar healthcare needs of the population of slum settlements in the Lagos State metropolis (Nigeria). By exploring the existing literature, it is discovered that essential parts of the current body of knowledge in the sociology of health and social sciences, in general, have detailed analyses of the role of poverty, income, employment status, and education^{1,39,40}. By synthesising existing views, this research

investigates the impact of gender, age, and cultural beliefs, which are variables with potential impact on the health-seeking behaviour of the residents of slum settlements in the Lagos State metropolis. Further investigation into the impact of gender, age, and cultural beliefs marks the essential contributory areas of this research to the existing body of knowledge. From this point, the gap covered by this current research also emerges.

In line with the focus of this study, Anderson's conceptual framework of health-seeking behaviour has been adapted. This framework further buttresses and shows the connection between factors affecting health-seeking behaviour. Variables in this framework are closely related to what has been analysed in Kroeger's theoretical model of health-seeking behaviour. According to this framework, beyond the improvement or availability of health facilities, other factors must be considered by policymakers. This framework believes that socio-economic factors play critical roles in the utilization of healthcare services. Among these factors are employment status, religious views, cultural practices, gender, and age, which may affect access and the type of healthcare services people use. This framework further supports the theoretical view of Kroeger, analysed earlier in this chapter.

CONCEPTUAL FRAMEWORK DIAGRAM

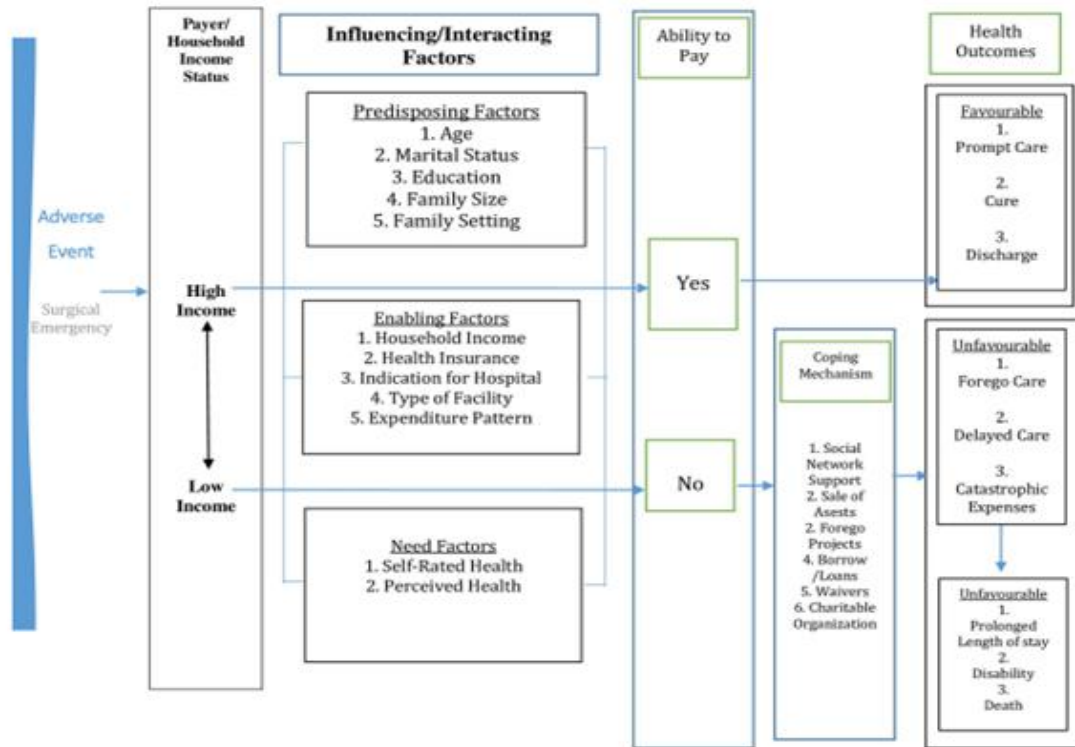


Figure 2.2: Anderson’s Conceptual Framework of Health Seeking Behaviour.

Source: ⁶

2.5 Summary of Gaps in Literature Reviewed

Analyzing the relationship between socioeconomic characteristics and health-seeking behaviour reveals numerous crucial conclusions and exposes significant gaps in knowledge. The analysis emphasizes the indisputable impact of socioeconomic factors, such as income, education, employment, and access to healthcare, on a person's health-seeking behaviour. Lower socioeconomic level is frequently linked to delayed or insufficient healthcare utilization. People with lower incomes and educational levels frequently encounter substantial healthcare obstacles. These obstacles include a lack of transportation, low health knowledge, and financial limitations. The review emphasizes the presence of healthcare disparity. Socioeconomically deprived populations are more likely to disregard medical advice

and postpone seeking healthcare and treatment for illnesses. Health-seeking behaviour and socioeconomic level have a complicated link. Because of the many interconnections involved, it is challenging to identify a single cause and effect. Cultural and social norms also influence health-seeking behaviour. These elements may either increase or decrease the influence of socioeconomic status. Due to poor socioeconomic factors, health-seeking behaviour is worsened by disparities in healthcare infrastructure, quality, and accessibility. According to the analysis, resolving these discrepancies requires several policy actions, including healthcare, education, and economic reforms.

While there is a link between socioeconomic status and health-seeking behaviour, there is a need for more research to determine the causal mechanisms and pathways that link these variables. Understanding how these factors interact can inform more effective interventions. Current research often focuses on individual socioeconomic factors in isolation. There is a need to explore the intersectionality of multiple factors, considering how they collectively impact health-seeking behaviour. Many studies (reported) including this are cross-sectional, which limits the ability to conclude the long-term effects of socioeconomic status on health-seeking behaviour. More effective interventions may result (from longitudinal studies) from understanding how these elements interact. Future research should examine the intersectionality of many factors, considering how they affect behaviour related to seeking health. Evaluating the effectiveness of interventions to mitigate socioeconomic factors' impact on health-seeking behaviour is a gap in the literature. Identifying successful strategies is crucial for improving healthcare equity. Most research has been conducted in high-income countries, creating a gap in our knowledge about how these relationships play out in low and middle-income

settings. Expanding research to include a more global perspective is essential. The review primarily focuses on socioeconomic and structural factors. There is a gap in the literature regarding evaluating interventions intended to lessen the effect of socioeconomic factors on health-seeking behaviour. Finding effective tactics is essential for enhancing healthcare equity. Scientific knowledge of how these linkages operate in low- and middle-income settings is lacking because most research has been done in high-income nations. It is crucial to broaden the research to incorporate a broader global viewpoint. Many available literature concentrates on structural and socioeconomic aspects. More study is required to understand how social elements, like culture, religion, gender, group philosophies and health attitudes, mediate the link between socioeconomic position and health-seeking behaviour. The impact of technological developments such as telehealth and mobile health applications on health-seeking behaviour in the context of socioeconomic inequalities is an emerging area that warrants further research. Addressing these knowledge gaps will help better understand how socioeconomic factors influence health-seeking behaviour and help develop more effective strategies to reduce health disparities.

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Chapter Three

Methodology

3.1 Research Design

This study adopted a cross-sectional research design utilizing the mixed methods approach involving collecting quantitative and qualitative data. The survey research method provides a broader coverage of the situation under study and is fast and economical. The cross-sectional (survey method) was selected because it enabled the researcher to collect data from the study population simultaneously, analyse it, and make inferences based on the data collected. This study is descriptive, and by this, factors affecting the health-seeking behaviour of slum dwellers of the Lagos state metropolis are analysed through univariate, bivariate, and multivariate statistics. In contrast, the qualitative data was analysed using content and thematic analysis methods.

3.2 Population of the Study

The respondents for this study were selected from the slum dwellers in Apapa, Ajeromi-Ifelodun, Lagos Island, and Shomolu LGAs of Lagos State. The principle of social inclusion was observed while conducting this research. For this reason, the study was non-discriminative. Every individual within the population of study who satisfied the criteria for the study population was included based on availability. The respondents for this study comprised males, females adults aged eighteen (18) years and above willing to participate and who had valid information needed for this study.

The study areas or locations where the population for this research were selected are slum settlements in Lagos State, Nigeria. Lagos is one of the metropolitan cities in the western region of Nigeria. Lagos State was created in 1967 through the States Creation and Transitional Provisions Decree No. 14 of 1967, which restructured Nigeria into 12 states. The State has five administrative divisions:

IBILE (Ikeja, Badagry, Ikorodu, Lagos Island, and Epe Division). Lagos was the Federal Capital Territory before the seat of the national government was moved to Abuja on 12th December 1991. Although Lagos has ceased to be Nigeria's capital city, it remains Nigeria's commercial hub. Lagos state's correct population has been controversial because Lagos State and Federal Government figures are at variance. Even researchers and social investigators are not in agreement on the population of Lagos State. Hence, the estimate of the 2020 population of Lagos State varies from 14.3 million to over 20 million^{1,2}. Whether 14.3 million or 20 million, the common view among social researchers and demographers is that Lagos State is among the fastest urbanized states in Nigeria, alongside Kano, Abuja, and Port Harcourt. Lagos is the most populous city in Africa and is projected to have a population growth rate of 3.3% annually¹. The leading cause of population growth in Lagos State can be attributed to the challenge of uncontrolled rural-urban migration. It is estimated that a minimum of 6,000 new migrants enter Lagos daily, and Lagos usually receives an estimated migrant figure of 700,000 annually³.

It is estimated that Lagos has over 1500 slum settlements⁴. For the limitation of resources, this present study was conducted within four location government areas in Lagos State, where some of the slum settlements in Lagos State are situated. The selected local government areas are Ajeromi-Ifelodun, Apapa, Lagos Mainland, and Somolu Local Government Areas. At least 15 slum settlements are in these local government areas⁵. The four selected Local Government Areas are part of the local councils in the Lagos State metropolis, and this is the rationale for their purposive selection. These four local government areas occupy about 87.0 km², with an estimated population of 2,268, 869^{6,7}. Notable among these slum settlements are Amukoko, Ago-Hausa, Olodan, Badia, Otto, Ijora, Makoko, Oko-Baba, Oko-Agbon, Abule-Nla, Mosafejo, Bariga, Abule-Ijesha, Ilaje, Pedro⁵. The target population were sampled from four (4) slum settlements purposively selected from four local

governments within the Lagos metropolis. The areas purposively selected are Amukoko from Ajeromi Ifelodun LGA, Bariga from Shomolu LGA, Ijora-Badia from Apapa LGA, and Makoko from Lagos Mainland LGA. Respondents' opinions from these settlements were canvassed with the questionnaire and in-depth interview guide.

The exact population figure of some of these slum settlements is not documented, but as reported, at least 60% of urban dwellers in many cities in West African countries, including Nigeria, live in one of the slum settlements⁵. Threading upon this assumption of 60% of urban dwellers living in slum settlements, it can be argued that more than half of the estimated population of the four local government areas of interest for this study live in one of these slum settlements. This is used, therefore, as the basis upon which the sample size for this study was drawn.



Figure 3.1: The Study Location Comprising Slum Settlements to be Studied.

Source: ⁵

3.3 Sample and Sampling Techniques

This research adopted non-probability sampling (purposive, quota, and accidental) methods to collect qualitative and quantitative data for this research. The rationale for this choice is based on the non-availability of a probable sampling frame for the study population. The researcher studies four local government areas from where four slum settlements were purposively selected. The quota sampling principle was applied, by sampling the opinion of one hundred respondents from each of the slum settlements. The respondents (adults 18 years and above) were selected within the slum settlement areas: Ijora-Badia, Makoko, Bariga, and Amukoko⁵. Only adults (residents who are eighteen years and above) were purposively selected for this research. The principle of accidental sampling also played significant roles as the researcher only sampled the opinion of those who were available as at the time of the research, and who have valuable information related to the needs of the research. The estimated population for the four local government areas is 2,268, 869^{6,7}. From this figure, 400 (100 from each of the slum settlements) respondents (adults) were purposively selected. This sample size was determined using the Taro Yamane modified sampling formula¹¹. The sampling formula is as follows:

$$n = \frac{N}{1 + N(e)^2}$$

n = sample

N = Area population: the official figure for Ajeromi-Ifelodun, Apapa, Lagos Island, and Shomolu, according to the federal government figure, is 2,268,869^{6, 7}.

$$(e)^2 = (0.05)^2$$

$$n = \frac{2,268,869}{1 + 2,268,869 (0.05)^2}$$

$$n = 2,268,869$$

$$2,268,869 (0.0025)$$

$$n = \frac{2,268,869}{5,672.1725}$$

$$n = 400$$

Sample size = 400

The targeted sample size that was used for this study was four hundred (400) slum settlement dwellers from the listed four local government areas (Apapa, Ajeromi-Ifelodun, Lagos Island, and Shomolu Local Government Areas) in Lagos State. Four hundred (400) questionnaire was distributed to four hundred slum dwellers in the study locations (100 from each local government area). Along with the 400 respondents selected and used for this study, 16 in-depth interview participants were purposively selected to generate the qualitative data. These include medical practitioners, four alternative care practitioners, four formal healthcare service users, and four alternative care users. These in-depth interviewees were selected from each local government area used in this research. For the in-depth interviews, sixteen participants were selected: four informal healthcare users, four formal healthcare users, four informal healthcare practitioners, and four informal healthcare practitioners.

3.4 Description of the Research Instruments

This research used the questionnaire and the in-depth interview guide as the data collection instruments. Using a questionnaire enabled the collection of large quantitative primary data useful for this study. The questionnaire developed for this study was distributed among slum dwellers in the selected locations. Those outside the jurisdiction of the selected study locations were not questioned for their opinion. The questionnaire was given to those purposively selected for this study using non-probability sampling techniques. The questionnaire was carefully constructed in line with the research objectives and hypotheses. To complement the weakness of a

structured questionnaire, in-depth interviews were conducted. An in-depth interview guide was designed, which allowed the researcher to question and probe respondents regarding the research's subject matters.

The questionnaire comprised two (2) sections. Section A solicited socio-demographic data that constituted the independent variables, while section B sought responses on the research objectives and captured data about the dependent variables. The questionnaire was designed to capture the socio-demographic information of the respondents and their responses to health-seeking behaviour.

3.5 Validity of Research Instrument

To test the validity of the research instrument for this study, a pretest was conducted using Oworoshoki, a slum settlement in Lagos State, different from the ones purposively selected for this research. The outcome of the pretest proved the strengths and weaknesses of the research instruments before the main data collection for the study. Given this, necessary adjustments were made to the instruments before the final research endeavour. For the pilot study, forty (40) questionnaires (10% of the determined sample size) were distributed among the participants. In contrast, four in-depth interviews (25% of the planned in-depth interviews) were conducted to test the validity of the research instruments (questionnaires and in-depth interview guide). To further ascertain the validity of the research instruments, the project supervisor and other experts in the department were consulted to develop a perfect instrument for this research.

3.6 Reliability of the Research Instrument

To test the reliability of the research instruments for this study, a pre-test was conducted with the planned instruments used for this study. This helped to validate the reliability of the research instruments and minimize outcome errors because of the weakness of the research instruments. For the pilot study, 40 respondents were used as the pre-test samples. Data collected using a questionnaire was analysed with SPSS and R (an advanced quantitative analysis software).

The reliability score of the data can be explained along the lines of the regression analysis computed for this research (see chapter four). The model explained 57.3% of the variance in healthcare service utilization in the last 12 months. This indicates that the model has moderate explanatory power in predicting healthcare service utilization based on the included predictor variables. The overall prediction accuracy of the model stands at 81.9% in correct cases. This suggests that the model has a high level of accuracy in classifying individuals into those who utilize healthcare services and those who do not.

3.7 Methods of Data Collection

The research instrument (questionnaire) was distributed to collect quantitative data from the selected sample of respondents for the study. In-depth interviews were conducted to collect qualitative data useful for the study. The in-depth interview participants include healthcare practitioners (formal and informal) and healthcare users (both formal and informal healthcare users) knowledgeable about healthcare usage in the slum areas. Combining these two data collection methods added value to the outcome of this study. The administration of the research instruments was done through face-to-face research administration. Although this method has its challenges, it remains the most reliable means of data collection,

especially in low and medium-income countries, among which is Nigeria. This is the basis for its adoption to collect data for this study.

The research instruments were administered differently within the same period of the data collection. However, the quantitative instruments were administered first before the collection of the qualitative data. Firstly, the quantitative data were collected with the use of structured questionnaire. While collecting the quantitative data, knowledgeable respondents were identified who have valuable information that would be useful for the research. The consent of these respondent were sought, and at a later time, one-on-one interview were conducted with the respondents to collect the qualitative data used in the research. The respondents interviewed for the qualitative data were selected among within the same study location where the quantitative data were collected.

Due to the volume of data collected for this report, the services of research assistants and fieldwork coordinator was employed who worked with the principal research in the collection of the research data. The research assistants who are professional data collectors were further given special training to understand the needs of this research. The research's orientation guided the collection of the research data in each of the slum settlements that was studied, and the principal researcher coordinated the data collection activities to ensure the set objective of the research was met.

3.8 Method of Data Analysis

The quantitative data were analysed using univariate, bivariate and multivariate procedures, and the results were displayed in frequency, percentage, and multiple regression. This warranted the development of predictive models

relevant to explaining health-seeking behaviour among urban slum dwellers. The Statistical Package for Social Sciences (SPSS) version 16.0 was used to analyse the primary quantitative data collected for the study. In testing the hypotheses, binary logistic regression was used to test the relationships between the independent variables (IVs) and the dependent variable (DV). The rationale for the use of binary logistic regression is based on its effectiveness in testing dependent variables that have two layers of responses^{8,9,10}. The dependent variable of the research, which is health-seeking behaviour, has two layers of responses (yes and no). This warrants the use of binary logistic regression and correlational statistics as viable statistical tools for confirming the research hypotheses.

The content analysis and thematic method were used to analyse the qualitative data. This method allows researchers to extract qualitative responses from research participants and use these extracted statements to answer research questions, as stated at the beginning of the study. This method is common among anthropologists and ethnographers but is also useful for sociologists and other professionals in social sciences and humanitarian disciplines.

3.9 Ethical Approval

Embarking on this research was not without the proper approval and the authorities and lecturers in the Department of Sociology, Lead City University, Ibadan, Oyo State. Research instruments which were used to collect used for the report were viewed, corrected, and amended by lecturers and the supervisor of this thesis. Ethical principles such as informed consent, anonymity and confidentiality were taken seriously in this research. Participants for this study were duly informed of the purpose of the research, which is to contribute to the body of scientific

knowledge. The respondents' identities are concealed in this report as part of the ethical rules in social sciences research. The permission of the communities' authorities in the slum settlements was sought for smooth research activities in the study locations.

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Chapter Four

Results and Discussion of Findings

4.1 Presentation of Data

This chapter presents the results and discusses the findings concerning the social context of the study and the results of previous sociological research on health-seeking behaviour. Factors affecting health-seeking behaviour are not alien to the social fabric of the society in which they are found. The socioeconomic conditions of slum settlements, which are critical factors affecting the utilization of healthcare services, are highlighted by the findings of this study. For a robust analysis, qualitative and quantitative data collected during this research are systematically presented for a logical discussion and informed scientific decision.

Interpretation of Table 4.1:

Table 1 below shows the socio-demographic data collected for this research. The sex distribution of the respondents shows that 48% were males, while 47.3% were females. Of the respondents, 4.8% did not specify their gender. This shows slightly more males than females among the respondents. The data on age distribution shows that 48% of the respondents are in the youthful age group, between ages 18 and 35 years, while 39.8% can be categorised as middle-aged between ages 36 and 55. About 10% of the respondents are in the old age group, 56 years and above. The findings show that the slum areas comprise a large population of working-age people.

Data collected on the educational status of the respondents shows that 5% of the respondents have no formal education, and 39.3% of the respondents have primary education or some attended secondary school without graduating. About 40% have attained the status of senior secondary school certificate holders. Less

than 15% (14.5%) of the respondents claimed they had attended tertiary institutions, while 1.5% did not specify their educational status. This shows that many respondents (79.1%) have not attained tertiary education, which is in consonance with the educational status expected in slum areas. Yoruba is the dominant ethnic group, with 58%, followed by the Ibo/Igbo ethnic group, with 18.8% of the respondents. The Hausa ethnic group comprises only 3.5% of the respondents. Respondents from other ethnic groups in Nigeria are 17.8%; only one respondent is a foreigner from another African country. This data shows that most of the respondents for this research are of the Yoruba ethnic group.

Of the respondents, 11.3% are unemployed, while 12.3% claim to be employed. The majority, 75.5% of the respondents, claimed to be self-employed or have a business. Less than 2% (1.5%) of the respondents for the study did not specify their employment status. It can be inferred from this data that most respondents for this study are employed in the informal sector of the Nigerian economy. Over thirty-eight percent (38.5%) of the respondents for this study are single, while 48.3% are currently married at the time of this data collection. The divorced or separated group among the respondents comprises 2.8%.

The table shows that 11.8% of respondents have a household size of 1-3 members; the majority of the respondents, 66%, have household size of 4-6 members. Another 20.8% of the respondents claimed to have a minimum of seven (7) people in their household. The finding suggests that fertility rates are still high in the slum settlements of the Lagos State metropolis. Religious affiliation of the respondents indicates that 31% are Christians, while 42.3% are Muslims. Traditional worshipers among the respondents are 4%, while about 22% of the respondents did

not specify their religion. This shows that the number of respondents who are Muslims in this research is higher than others.

Table 4.1: Percentage Distribution of Respondents by Socio-demographic characteristics

Variables	Frequency	Percent
Sex		
Male	192	48.0%
Female	189	47.3%
Missing Value	19	4.8%
Total	400	100.0%
Age		
18-35	192	48.0%
36-55	159	39.8%
56 and above	41	10.3%
Missing value	8	2.0%
Total	400	100.0%
Educational Attainment		
None	20	5.0%
Below SSCE/Secondary School	157	39.3%
SSCE/Secondary School	159	39.8%
Tertiary	58	14.5%
Missing value	6	1.5%
Total	400	100.0%
Ethnic Group		
Yoruba	232	58.0%
Ibo/Igbo	75	18.8%
Hausa	14	3.5%
Other tribes from Nigeria	71	17.8%
Foreigners from other African countries	1	.3%
Missing value	7	3.5%
Total	400	100.0%
Employment Status		
Unemployed	45	11.3%
Employed	49	12.3%
Self-employed/Business	301	75.3%
Missing value	5	1.3%
Total	400	100.0%
Marital Status		
Single	190	38.5%
Currently married	193	48.3%
Divorced and widow/widower	11	2.8%
Missing value	6	1.5%
Total	400	100.0%

Table 4.1 Continued**Number of People in the Household**

Below 3	47	11.8%
Between 4 and 6	264	66.0%
7 and above	83	20.8%
Missing value	6	1.5%
Total	400	100.0%

Religious Affiliation

None	87	21.8%
Christianity	124	31.0%
Islam	169	42.3%
Traditional	16	4.0%
Missing value	4	1.0%
Total	400	100.0%

Monthly Income

N50,000 and less	232	58.0%
N51,000 – N100,000	125	31.3%
N101,000 and above	25	6.3%
Missing value	18	4.5%
Total	400	100.0%

Estimated Daily Spending

Below N1,700	39	9.8%
Above N1,700	350	87.5%
Missing value	11	2.8%
Total	400	100.0%

Sector of Employment

Informal sector	311	77.8%
Formal sector	36	9.0%
Not currently working in any sector	34	8.5%
Missing value	19	4.8%
Total	400	100.0%

Daily Activities

Full housewife and nursing mother	46	11.5%
Student	30	7.5%
Apprentice	32	8.0%
Working	269	67.3%
Applicants	14	3.5%
Missing value	9	2.3%
Total	400	100.0%

Source: Researcher's Fieldwork, 2023

According to data collected on monthly income, 58% of the respondents claimed to earn no more than N50,000 monthly, while 31.3% claimed they earned between N51,000 and N100,000 as their monthly income. Of the respondents, 6.3%

claimed they earned a monthly income of N101,000 and above, while 4.5% did not specify their monthly income. This finding implies that most of the respondents or residents of slum settlements are low-income earners, as 58% claimed to have a monthly income of not more than N50,000.

Of the respondents, 77.8% claimed to be working in the informal sector of the Nigerian economy, while only 9% claimed they were working in the formal sector of the economy. Those who were currently not working at the time of the data collection were 8.5% of the respondents, while 4.8% of the respondents did not specify their sectors of employment. This shows that the informal economy is the leading sector providing a haven of employment for the majority of Nigerians. Information on daily activities reveals that 67.3% of the respondents reported themselves as working; 11.5% claimed to be full housewives and nursing mothers, while 7.5% claimed to be students. Eight percent of the respondents claimed to be learning trades (apprentice), and 3.5% reported that they were applying for jobs at the time of the data collection.

Healthcare Services Utilization

Interpretation of Table 4.2:

Table 4.2 below presents the distribution of the study respondents by healthcare utilization in the last 12 months. According to the results in the table, 81% of the respondents for this research claimed they had utilized healthcare services in the last twelve months before the research. Among the respondents, over 17% claimed they had not used healthcare services in the last twelve months. The type of healthcare services preferred by respondents was also investigated in this research, as displayed in Table 4.2. From the responses, over 23% preferred traditional and spiritual care services whereas, 51% preferred orthodox medicine;

21% prefer both spiritual/traditional and hospital/clinical care; over 2% did not respond to this question.

Respondents' opinions were sampled on reasons for utilizing their healthcare services. The results shows that 11% of the respondents reported that their choice is influenced by cultural/traditional or spiritual beliefs, while 50% claimed their healthcare services utilization is based on socialization – what they have been introduced to and used to. Among the respondents, 12% used healthcare services based on the availability of the services, while 22.8% claimed their choices have been influenced by affordability. Respondents were asked whether they had experienced sickness in the last twelve months before the survey, 77.5% of the respondents affirmed while 21% said they had not experienced sickness, and 1.8% did not specify their health status in the last 12 months. Further, respondents were asked if they have a disease in their body which may require regular medical attention. Of the respondents, 11% said “Yes”, while 87.3% said they have no disease in the body that may require regular medication.

To probe further, the respondents were asked if they had been diagnosed with any disease in the last 12 months before collecting this data. Among them, 72.8% said they have been diagnosed with a disease or infection in the last 12 months, while 24.8% said they have not. This finding suggests that the prevalence of disease in the slum settlements of the Lagos State metropolis is high, given the overwhelming percentage of the respondents who had been diagnosed with a disease. Among the respondents, 61.8% had been diagnosed with malaria, 5.3% said they had been diagnosed with high blood pressure, 2% said they had been diagnosed with tuberculosis, and 3% said they had been diagnosed with diabetes; 17.5% said they had been diagnosed with other types of diseases not listed among the categories. Of

the respondents, 10.5% did not specify if they had been diagnosed with any disease in the last 12 months before collecting this data.

On the kind of healthcare services needed in the community, 48.5% of the respondents said they wanted formal healthcare services in the communities, such as hospitals, clinics, or health centres. In comparison, 4% said they wanted traditional or spiritual care centres; 24.5% said both traditional/spiritual care and hospitals/clinics are needed in the communities of this study. Somewhat surprising (21.5%) of the respondents felt they needed no healthcare facilities in the communities of this study. A question was raised if respondents have enough of the healthcare facilities needed in the communities of this study; only 34.5% of respondents replied in affirmative, while the majority (63.7%) said they did not have enough of the needed healthcare facilities in the communities of this research. Virtually all the respondents (93.5%) believed that if the needed healthcare facilities are provided in the communities, more people would utilize the healthcare services. A few (2%) of the respondents are of the opinion that the availability of healthcare facilities in the community may not improve the level of utilization among the slum settlements.

On a question on the main obstacle to the utilization of healthcare facilities in the community, 50.7% mentioned the cost of accessing healthcare services. Another 27.8% said the attitude towards healthcare services could be a barrier or discouragement to utilising healthcare services, and 9.5% mentioned distance as a barrier. Another obstacle mentioned is the belief and tradition of the people (4.8%); 5.8% mentioned other reasons. From this analysis, the cost of accessing healthcare services is a significant factor affecting healthcare services utilization, as most of the respondents for this research claimed. This study shows that only 4.3% of

respondents utilize healthcare services monthly, while 57.8% only utilise healthcare services when needed, e.g., when they are sick or diseased. Among the respondents, 18.3% of health facilities said they regularly use medical facilities for check-ups, and 18.3% use health facilities infrequently. From these findings, it can be inferred that most slum dwellers utilize healthcare services only when there is a sickness or disease, mainly because of healthcare services cost.

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Table 4.2: Percentage Distribution of Respondents by Healthcare Services Utilization

Variables	Frequency	Percent
Utilised healthcare service in the last 12 months		
Yes	324	81.0%
No	69	17.3%
No response	7	1.8%
Total	400	100.0%
Type of Healthcare Utilised		
Formal	173	43.3%
Informal	29	7.2%
Both	168	42.0%
No response	30	7.5%
Total	400	100.0%
Which do you prefer, traditional healthcare services or hospital care		
Traditional/Spiritual Care Services	95	23.8%
Hospital or clinical care	204	51.0%
Both	84	21.0%
None	7	1.8%
No response	10	2.5%
Total	400	100.0%
What made you utilise the healthcare service you utilised?		
Because of my traditional/cultural, and spiritual beliefs	44	11.0%
Because that is what is available around me	48	12.0%
That is the care service I was introduced to, and I have been using it	200	50.0%
That is what I can afford	91	22.8%
No response	17	4.3%
Total	400	100.0%
Have you experienced any sickness in the last twelve (12) months		
Yes	310	77.5%
No	84	21.0%
No response	6	1.6%
Total	400	100.0%
Do you have a sickness/disease that requires medication from time to time?		
Yes	44	11.0%
No	349	87.3%
No response	7	1.8%
Total	400	100.0%
Have you been diagnosed with any disease in the last 12 months e.g high blood pressure, tuberculosis, malaria, diabetes		
Yes	291	72.8%
No	99	24.8%
No response	10	2.6%
Total	400	100.0%

Table 4.2 Continued**If yes, which one of these?**

High blood pressure	21	5.3%
Tuberculosis	8	2.0%
Malaria	247	61.8%
Diabetes	12	3.0%
Others	70	17.5%
No response	42	10.5%
Total	400	100.0%

What type of healthcare services do you think is needed in this community?

Hospital/Clinic/Health Centre	194	48.5%
Traditional/Spiritual Care	16	4.0%
Both	98	24.5%
None	86	21.5%
No response	6	1.5%
Total	400	100.0%

Do you have enough of this wanted health facility in this community

Yes	138	34.5%
No	255	63.7%
No response	7	1.8%
Total	400	100.0%

If this health facility is provided in this community, will it make more people use healthcare services?

Yes	374	93.5%
No	8	2.0%
No response	18	4.6%
Total	400	100.0%

What is the main reason you may not use a healthcare service?

The cost of the service	203	50.7%
My belief and tradition	19	4.8%
Distance of the healthcare service	38	9.5%
The attitude of the healthcare workers	111	27.8%
Others	23	5.8%
No response	6	1.5%
Total	400	100.0%

How often do you utilise healthcare services

Every month	17	4.3%
Only when there is a need	231	57.8%
For a scheduled medical check-up	73	18.3%
Not frequently	73	18.3%
No response	6	1.6%
Total	400	100.0%

Source: Researcher's fieldwork, 2023

Thematic Analysis of Health-Seeking Behaviour

Thematic analysis in research is a type of analysis in which the researcher studies responses from a set of respondents and identifies themes from the responses in line with the research focus or objectives. This research is designed to critically discuss the socioeconomic factors affecting health-seeking behaviour in the Lagos State metropolis. The themes to be analysed in this qualitative section will jostle along the corridor of these variables of interest.

Interpretation of Table 4.3:

A. Themes from Type of Healthcare Services Used by Respondent

As Table 4.3 below shows, qualitative data from the responses have been designated along thematic areas for easy understanding. The themes extracted from the responses are categorised into **formal healthcare, traditional healthcare, and herbal healthcare**. Types of healthcare services that are used in the slum settlements of the Lagos State metropolis are influenced by many factors. Due to the socioeconomic conditions of the Lagos State metropolis dwellers, some use formal healthcare, which can be primary healthcare centres or hospitals with various units for both in and out-patients. Since there is no restriction on the types of healthcare services that the Lagos State metropolis slum dwellers can utilize, some respondents claimed they use traditional healthcare and herbal cures when sick. It is also evident from the responses that healthcare services are not rigidly used along a path, as some respondents use orthodox medicine (hospital or health centre) and traditional and herbal medicine.

Table 4.3: Thematic Analysis of the Type of Healthcare Service Respondents Prefer

S/N	Excerpts	Preliminary codes	Codes	Themes
1	I use only medical healthcare services.	Medical healthcare service	Formal healthcare	Formal healthcare.
2	I use the healthcare centre.	Healthcare centre	Formal healthcare	Traditional healthcare.
3	Hospital and traditional healthcare.	Hospital and traditional healthcare	Hospital Traditional	Herbal cure.
4	Traditional healthcare.	Traditional healthcare	Traditional	
5	Traditional healthcare	Traditional healthcare	Traditional	
6	Traditional Healthcare	Traditional healthcare	Traditional	
7	Herbal/traditional healthcare.	Herbal/traditional healthcare	Herbal Traditional	
8	I use herbal healthcare services.	Herbal healthcare	Herbal	
9	Herbal.	Herbal	Herbal	
10	Medical healthcare services.	Medical healthcare	Formal healthcare	
11	Herbal healthcare service.	Herbal healthcare	Herbal	
12	Formal healthcare.	Formal healthcare	Formal healthcare	
13	Hospital.	Hospital	Formal healthcare	
14	Formal healthcare services (hospital).	Formal health care (hospital)	Formal healthcare	
15	I prefer to use formal healthcare service.	Formal healthcare	Formal healthcare	
16	Formal healthcare service.	Formal healthcare	Formal healthcare	

Source: Researcher's Fieldwork, 2023

Interpretation of Table 4.4:

B. Themes from Healthcare Services Used by Slum Dwellers

Table 4.4 presents the results of the thematic analysis of healthcare used by people in the slum. As can be noticed, the first question is personalised to the respondents. In contrast, the second question is based on the respondents' observations regarding knowledge of the types of healthcare services people use in the locations of this research. Three themes were delineated:

Formal healthcare, herbal healthcare, and traditional/spiritual homes. Many factors influence the usage of healthcare services in slum settlements. For example, the more educated in the areas use formal healthcare services because they believe in the effectiveness and specificity of the treatment of diseases. Apart from using formal healthcare services, the educated respondents also used healthcare services not only when they were sick but also for routine medical check-ups. Other factors, such as upbringing and affordability, also play essential roles in utilising healthcare services among the residents. Due to the influences of some of these factors, some utilise herbs and traditional medicines to treat whatever illnesses they may experience.

Table 4.4: Thematic Analysis of Healthcare Services that People in the Rural Settlement Use

S/N	Excerpts	Preliminary codes	Codes	Themes
1	People in this community use medical and herbal healthcare services based on their choices.	Formal healthcare Herbal care.	Formal healthcare Herbal care.	Formal healthcare. Herbal care. Traditional/spiritual care homes.
2	We use herbal and medical care services in this community.	Herbal care Formal healthcare.	Herbal care Formal healthcare.	
3	Formal and informal healthcare services (hospital and traditional care.	Hospital Traditional healthcare.	Formal healthcare Traditional healthcare.	
4	Most people prefer to use hospital.	Hospital	Formal healthcare.	
5	They prefer both, but I will say they use traditional healthcare services mostly.	Formal healthcare Traditional healthcare.	Formal healthcare Traditional healthcare.	
6	“Informal healthcare (traditional)”	Traditional healthcare.	Traditional healthcare.	
7	People around here use both medical and herbal healthcare services.	Formal healthcare Herbal care.	Formal healthcare Herbal care.	
8	Everybody has their choices in this community. I do herbs mostly.	Herbal care.	Herbal care.	
9	Herbal healthcare I think because of the amount of customers we get on a daily basis.	Herbal healthcare.	Herbal care.	
10	Medical healthcare.	Medical centre.	Formal healthcare.	

**Table 4.4
Continued**

11	<i>I no go fit talk for people oo, but as for me, na alagbo me prefer oo.</i>	Herbal care.	Herbal care.
12	Majority use hospital while few use both.	Hospital Traditional healthcare.	Formal healthcare Traditional healthcare.
13	Both formal and informal care	Formal healthcare Informal healthcare.	Formal healthcare Traditional healthcare.
14	Hospital and traditional care.	Hospital Traditional healthcare.	Formal healthcare Traditional healthcare.
15	I noticed people prefer to use the formal healthcare service. There's a hospital around and I've seen people come here a lot, both literate and illiterate.	Hospital.	Formal healthcare.
16	Majority use hospital while few use both.	Hospital Traditional healthcare.	Formal healthcare Traditional healthcare.

Source: Researcher's Fieldwork, 2023.

Interpretation of Table 4.5:

C. Themes from why the choice of a particular healthcare service

Factors affecting the utilization of healthcare services are multiple, as from the qualitative data collected among the slum dwellers in the Lagos State metropolis slum settlements. These factors have been categorised along thematic areas for easy understanding. According to the responses, factors affecting healthcare services utilization can be categorised into eight different areas: **Belief in the type of healthcare, Accuracy of treatment, Upbringing, Accessibility, Preference,**

Affordability, Health insurance, and Health need. The responses showed the importance of the socialization processes as many of the respondents showed that their beliefs in the effectiveness of the healthcare services influence their usage of healthcare services. This response showed the importance of family and socialization institutions in Nigerian societies. Confirming the critical roles of socialization, respondents claimed that their upbringing influenced the types of healthcare services they utilize presently. Both those who preferred traditional and orthodox medicine claimed that their choices of healthcare services are influenced by their upbringing. Other factors discovered to be influencing healthcare services utilization include accessibility, accuracy of treatment, and choice of the patient, which can be influenced by other factors, affordability, health insurance, and the state of human health. The theme of accessibility, discovered in this area, calls for urgent attention. For example, respondents claimed that during an emergency, the closest healthcare services, either orthodox or traditional, might be utilised as the people concerned may have no choice. Health insurance played a critical role as explained by one of the respondents who is a formal healthcare practitioner. According to him:

“Low-income level, lack of healthcare exposure or insurance and high cost of living. Also, some people think medical treatments are expensive”.

Among many factors explained by this respondent is the role of health insurance. He agreed that healthcare services are expensive, and for this reason, only those who work in organizations that have health insurance access formal healthcare services when due or necessary.

Table 4.5: Thematic Analysis of the choice for the utilization of a particular healthcare

S/N	Excerpts	Preliminary codes	Codes	Themes
1	Formal healthcare practitioner: Hospital is the best because people believe it is modern and things are really changing, and they go on with technology. You have to undergo a test to know the particular thing that is wrong with you, and they'll treat you according to what is wrong with you.	People use hospital because they believe it is advanced,	Belief in the type of healthcare.	Belief in the type of healthcare. Accuracy of treatment. Upbringing. Accessibility. Preference. Affordability. Health insurance. Health needs.
2	Formal healthcare practitioners: Formal healthcare is preferable because the formal healthcare service is better now, workers are educated, and there's always a prescription of what you want to use.	People use hospitals because they can give accurate prescriptions.	Accuracy of treatment.	
3	Formal healthcare user: Because we're in a civilized world now and the knowledge of Hospital care is highly different from traditional care, they know much about health so far that's what they studied in school.	Because of the belief in the knowledge of the healthcare professional in the formal healthcare sector.	Belief in the type of healthcare.	
4	Formal healthcare user: My parents don't really use traditional healthcare, so we've been using the formal healthcare service.	Upbringing.	Upbringing.	
5	Formal healthcare practitioner: Well, people believe in the medical practitioners via medication, surgery and check-ups.	Belief in formal healthcare.	Belief in the type of healthcare.	

Table 4.5 Continued

6	Informal healthcare practitioner: Firstly, because the traditional care (herb) is fast, and they are available every time to attend to people.	Fast to reach. Accessibility.	Accessibility.
7	Informal healthcare practitioner: It is what I've been introduced to, and I've been using it.	Upbringing.	Upbringing.
8	Informal healthcare user: Because some people like me prefer herbs, some don't even like medicine but herb.	Preference.	Preference.
9	Informal healthcare user: I choose the traditional healthcare service because everything we take in is from herbs.	Herbs are natural.	Belief in the type of healthcare.
10	Formal healthcare practitioner: It is cheaper and affordable. Also, it has been introduced to them since childhood.	Cheaper. Upbringing.	Affordability . Upbringing.
11	Formal healthcare user: Low-income level, lack of healthcare exposure or insurance and high cost of living. Also, some people think medical treatments are expensive.	Low-income. Health insurance. Health needs.	Affordability . Health insurance.
12	Herbal care practitioner: Affordability, I think, because in this our current economy in this country, and I'm not saying medical healthcare is not good, but herbal healthcare is very affordable.	Cost. Affordability.	Health need. Affordability .
13	Formal healthcare user: Because it is what I Was born into, and I prefer it.	Upbringing.	Upbringing.

Table 4.5 Continued

14	Herbal healthcare user: <i>Na because e dey very affordable for we wey dey this community.</i>	Affordability.	Affordability
15	Herbal healthcare practitioner: It is the use of medical equipment for check-ups, prescriptions, and treatments. The sickness/health issue is well-identified.	Health need.	Health need.
16	Herbal healthcare user: Well, it depends on the condition of the sick person. Most times, they get referred to a hospital or lab.	Health need.	Health need.

Source: Researcher's Fieldwork, 2023.

Interpretation of Table 4.6:

D: Thematic Analysis of Factors Affecting the Utilization of Healthcare Services

Factors affecting the utilization of healthcare services from the response extracted from this section are multiple, as already explained earlier. Eight thematic areas were as influencing variables affecting healthcare services utilization. The factors in this area are Sickness, Medical check-ups, **Nature/age, Distance, Affordability, Effectiveness, Cultural orientation, and Organization of the healthcare system.**

Respondents utilized healthcare services in the Lagos State metropolis for various reasons. These reasons can be seen from the thematic areas above. Age is an important variable which influences the utilization of healthcare services. Due to advancements in age, certain parts of human physiological makeup will be adjusted, which may call for the utilization of healthcare services. For example, a young lady who started experiencing monthly menstruation may have monthly painful experiences, which can lead to seeking medical attention. Also, a person of age may have some changes in sight, bones, ears, and mobility, leading to frequent usage of

healthcare services. Distance of healthcare services is also a critical factor affecting the utilisation of healthcare services. Due to the challenges of transportation and uneasy accessibility of some social infrastructure like transportation, people may have challenges accessing a healthcare centre far from them. Although many factors affect healthcare usage, the most potent among them is people's health needs. From one of the respondents who is a formal healthcare practitioner:

“Most times when there is a health need. A few people come for medical check-ups, but the majority of the people in this area will only come for medical services when they are sick”.

The presence of sickness or disease is one of the factors leading to frequent usage of healthcare services. This point was also noted in the quantitative data as the relationship between the presence of a known disease in the body of a person and healthcare service utilization was very strong.

Table 4.6: What are the factors that usually lead to the utilization of healthcare services among people in this community?

S/N	Excerpts	Preliminary codes	Codes	Themes
1	Formal Healthcare User: People use medical services when they are sick.	When people are sick	Sickness.	Sickness. Medical check-ups. Nature/age. Distance.
2	Medical Healthcare practitioner: A deteriorating health condition. People also use healthcare services for medical check-ups.	Deteriorating health condition. For medical check-ups.	Sickness. Medical check-ups.	Affordability. Effectiveness. Cultural orientation. Organization.
3	Informal Healthcare User: People use healthcare services when there is a health need. Some people prefer herbs because it is natural.	When there is a health need. People use herbs because it is natural.	Sickness. Nature.	
4	Alternative healthcare user: People use healthcare services, particularly herbal cures, because there is a need.	When there is a health need.	Sickness.	
5	Alternative healthcare practitioner: There are many old people around this community, and due to their age, there is a need for frequent usage of healthcare service.	Age factor.	Nature.	
6	Informal medical practitioner: Firstly, traditional care is very close to them. Herbs flush all sickness totally.	Closeness to the people. Due to sickness.	Distance. Sickness.	
7	Herbal practitioner: Herbal treatments are affordable. It has proven to be very potent by various users.	Affordability. Effectiveness.	Affordability. Effectiveness.	

Table 4.6 Continued

8	Herbal user: It is based on choices. Herbal cures are very affordable. It has been introduced to us since childhood. Also, some people have a phobia for hospitals, drugs or tablets, and syringes.	Choices. Affordability. Due to cultural orientation.	Choice. Affordability. Cultural orientation.
9	Formal healthcare practitioner: Well due to the rate of typhoid and malaria in the community, people fall sick from time to time. Herbal healthcare is affordable for them to access.	Due to infections. Sickness. Affordability.	Sickness. Affordability.
10	Formal healthcare practitioner: People patronize medical services due to health challenges.	Health needs.	Sickness.
11	Herbal healthcare user: Malaria and fever.	Malaria and fever.	Sickness.
12	Formal healthcare practitioner: Most times when there is a health need. A few people come for medical check-ups.	Health needs. Medical check-ups.	Sickness. Medical check-ups.
13	Formal healthcare user: When there is a health need.	Health needs.	Sickness.
14	Formal medical practitioner: People use healthcare services when they are sick. When this happens, they come to the government hospital because they believe it is cheap to access.	Sickness. Affordability.	Sickness. Affordability.

Table 4.6 Continued

15	Formal healthcare user: People use healthcare services when they are sick. Formal healthcare centres are used because it is more organised.	Sickness. Organization.	Sickness. Organization.
16	Formal healthcare practitioner: People go to the hospital when they are sick.	Sickness.	Sickness.

Source: Researcher (2023).

Interpretation of Table 4.7:

E: Thematic Analysis of Reason for Healthcare Services Usage

According to the themes in this section, which are **medical checks, health needs, antenatal and post-natal**, residents of the urban slum settlements in the Lagos State metropolis essentially use healthcare services due to the call of nature. For example, men and youths in the area come when they are sick, while most who come around for healthcare services are either in for ante-natal or post-natal. Not many, but some do use healthcare services occasionally for medical check-ups. From the responses, there is a popular theme that people's health needs are the influencing factor leading to the utilization of healthcare services. This finding calls for the public orientation of Nigerians on the need to utilize healthcare services.

Table 4.7: Is it just for a medical check-up or because there is a health need?

S/N	Excerpts	Preliminary codes	Codes	Themes
1	Formal healthcare user: for both medical check-ups and when there is a health need.	Medical check-ups.	Medical check-ups.	Medical checks.
2	Formal healthcare practitioner: When there is a health need. Also for antenatal and post-natal.	Health needs. Health needs. Antenatal. Post-natal.	Health need. Health need. Ante-natal. Post-natal.	Health needs. Ante-natal. Post-natal.
3	“Informal healthcare user: When there is a health need, and occasionally for check-ups.	Health needs. Medical check-ups.	Health need. Medical check-ups.	
4	Alternative healthcare user: for both medical check-ups and treatment of disease.	Treatment. Medical check-ups.	Treatment. Medical check-ups.	
5	Alternative healthcare practitioner: People in this vicinity come for treatment when they are sick. If there is no sickness, they may not come.	Sickness.	Sickness.	
6	Informal medical practitioner: When there is a health need.	Health need.	Health need.	
7	Herbal practitioner: Most of the time when there is a health need.	Health need.	Health need.	
8	Herbal user: When there is a health need.	Health need.	Health need.	
9	Herbal healthcare practitioner: When there is a health need. Also for prevention from diseases.	Health need. Prevention of diseases.	Health need. Prevention.	
10	Formal healthcare practitioner: People patronize healthcare services when there is a health need and occasionally for check-ups.	Health needs. Medical check-ups.	Health need. Medical check-ups.	

Table 4.7 Continued

11	Herbal care user: For health reasons and for medical check-ups.	Health need. Medical check-up.	Health need. Medical check-up.
12	Formal healthcare practitioner: Nigerians essentially use healthcare services when they are sick.	Sickness.	Sickness.
13	Formal healthcare user: When there is a health need, and for medical check-ups.	Health need. Medical check-ups.	Health need. Medical check-up.
14	Formal healthcare practitioner: When they are sick.	Sickness.	Sickness.
15	Formal healthcare user: Mostly when there is a sickness.	Sickness.	Sickness.
16	Formal healthcare user: It is for both reasons. For medical check-ups, and when there is a sickness.	Health need. Medical check-ups.	Health need. Medical check-up.

Source: Researcher's Fieldwork, 2023.

Interpretation of Table 4.8:

F. Thematic Analysis of How Often People Utilize Healthcare Services

From the themes (**frequently, when there is a health need, during ante-natal and post-natal**) discovered in this section, those with underlying health issues frequently use healthcare services.

“Only when they are sick (informal healthcare user).”

Response from a formal healthcare user: “Anytime I need me, I go to the hospital (formal healthcare user)”

“When there is a health need.” Response from another (formal healthcare user)

From some of the responses above extracted from different respondents in this research, health needs is the main factor that usually leads the slum settlements

residents in the Lagos State metropolis to the utilization of healthcare services. Many extraneous variables may also be responsible for this. For example, the Nigerian economy is unstable, leaving millions of youths jobless. This may affect the level of income available to people. Those with pressing health needs may not consider it necessary to utilize healthcare services.

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Table 4.8: How frequently do people utilize healthcare services?

S/N	Excerpts	Preliminary codes	Codes	Themes
1	Medical healthcare user: I use the medical services frequently for medical check-ups to keep myself in check. Not only when I am sick.	Frequently.	Frequently.	Frequently. When there is a health need. During ante-natal and post-natal.
2	Formal healthcare practitioner: People do come for medical services when there is an urgent need, e.g. accident, childbirth or sickness.	When there is an urgent health need.	When there is a health need.	
3	Informal healthcare user: I use healthcare services from time to time.	From time to time.	Regularly.	
4	Alternative healthcare user: I use healthcare services when there is a need. Not frequently.	When there is a need.	When there is a health need.	
5	Alternative healthcare practitioner: I really can't say. Some people come regularly and some people come only when they are sick.	Some regularly. Some when they are sick.	Regularly. When there is a health need.	
6	Informal healthcare practitioner: Anytime because sickness happens all the time.	Anytime there is sickness.	When there is a health need.	
7	Herbal cure practitioner: Not frequently only when there is a need to do so.	Only when there is a health need.	When there is a health need.	
8	Herbal cure user: I come regularly especially because of the herbs that cure pile.	Regularly for prevention.	Regularly.	

Table 4.8 Continued

9	Herbal cure practitioner: People come to this place regularly to get different types of herbs “ <i>agbo</i> ”.	Regularly.	Regularly.
10	Formal healthcare practitioner: People come when there is a need to take care of health needs and for immunization.	When there is a health need. For prevention.	When there is a health need.
11	Herbal care user: Anytime I am not feeling well, I visit the <i>alagbo</i> place. Only when I am sick.	Only when there is a health need.	When there is a health need.
12	Formal healthcare practitioner: When people are sick. Then the pregnant women come for ante-natal and post-natal.	When people are sick. During the ante-natal and post-natal period.	When there is a health need. For ante-natal. For post-natal.
13	Formal healthcare user: When there is a health need.	When there is a health need.	When there is a health need.
14	Formal healthcare practitioner: When there is a health need.	When there is a need.	When there is a health need.
15	Formal healthcare practitioner: Only when they are sick.	Only when they are sick.	When there is a health need.
16	Formal healthcare user: <i>Anytime I need me, I go to the hospital.</i>	Anytime there is a health need.	When there is a health need.

Source: Researcher’s Fieldwork 2023

Interpretation of Table 4.9:

G. Thematic Analysis of the Factors that Determine the Use of a Particular Healthcare Services

The roles of socioeconomic factors cannot be ignored by leaders and policymakers when utilising healthcare services. While efforts in certain quarters have been made to put standard healthcare services in place, critical socioeconomic variables have been ignored at the development stages of some of these projects, and these variables eventually affect the utilization of the facilities. According to the themes developed from responses in this section, factors affecting healthcare services utilization can be further categorised into nine variables: **Income, Education, Culture, Employment status, Age, Health condition, Gender, Antenatal, and Post-natal.** The cultural and religious orientation of the people of Nigeria is essential when developing policies. While an adequate facility may be available in a particular location, someone not convinced to utilise such service on the platform of culture and religion may experience fatality, as explained in the literature section of this report. Income is another major factor affecting healthcare services utilization among the residents of slum settlements in the Lagos State metropolis. From the response below from an herbal healthcare user:

“Me na herbal I don dey use since and because e dey affordable fo me and anybody wey wan use am”

The information deduced from this response, this respondent has settled for the use of local concoction on the reason of financial lack or affordability of the local concoction known as “*agbo*” among the Yoruba people of Nigeria. Knowledge is power. The role of education cannot be overemphasized in the discussion of the health and well-being of the people. Many people who have experienced early

mortality on the platform of ignorance could have been saved if they had proper educational knowledge that could guide them in the path of objectivity. During the Ebola crisis, there was a variety of information on how to protect themselves from the virus. One of the unfounded theories was the use of salt water for bathing. Those who engaged in these acts did not have a good story to tell of the experiences based on mythology and unproved hypotheses. For this reason, health orientation and access to quality education are not negotiable. Culture, income, employment status, and age play vital roles in healthcare services utilization. This calls for a holistic view in formulating policies and developing frameworks and models to eradicate the erratic condition of healthcare services utilization affecting Nigerians' health conditions. Addressing these factors will bring positive outcomes in Nigerians' healthcare services utilization and eventual health status.

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Table 4.9: What are the factors that determine the use of a particular healthcare service among the following factors (age, gender, income, education, culture, employment status)?

S/N	Excerpts	Preliminary codes	Codes	Themes
1	Formal Healthcare Practitioner: Income is the most factor, not age	Income.	Income.	Income. Education. Culture.
2	Formal healthcare practitioner: Income, because some private hospitals will not be affordable and most people in this rural area are traders, their income might not be enough to use the hospital, especially the private hospital.	Income.	Income.	Employment status. Age. Health condition. Gender. Ante-natal. Post-natal.
3	Formal HealthCare User. All Factors	All factors.	All factors.	
4	Formal healthcare user: I'll go with education. Although most of them are illiterates, they know it works. The money to use for formal healthcare is more than what they can afford, but they still use it because they have a knowledge about it.	Education. Income.	Education. Income.	

Table 4.9 Continued

5	<p>Formal healthcare practitioner: Well I'm going to be talking about the age factor first, people above age 45, 50 and so on should visit the hospital for frequent medical check-ups and proper medication also.</p>	Income.	Income.
		Education.	Education.
		Culture.	Culture.
		Employment status.	Employment status.
	<p>Now talking about income, by education, culture, employment, and status, an uneducated person can't be able to read or write so he or she won't actually know what is being administered to them via medication, now let's talk about employment to get the best medical healthcare services you have to be financially capable to take care of your medical bills thank you.</p>	Age.	Age.
6	<p>Informal healthcare practitioner: All, even rich people want herb care because most of the medicine causes heart failure, and kidney failure, but the natural herb cures everything and wash away everything that is not good in the body.</p>	Health condition.	Health condition.
7	<p>Alternative healthcare Practitioner: People use it because of their culture and age and like I said earlier, there are a lot of elder people here, so age is another factor.</p>	Culture.	Culture.
		Age.	Age.
8	<p>Informal healthcare User: There are important factors e.g. ante-natal or post-natal.</p>	Ante-natal.	Ante-natal.
		Post-natal.	Post-natal.

Table 9 Continued

9	Alternative healthcare user: I think age and gender and culture.	Age. Gender.	Age. Gender.
10	Formal healthcare practitioner: "I would say, income level or health insurance".	Culture. Income. Health insurance.	Culture. Income. Health insurance.
11	Formal healthcare practitioner: "Education"	Education.	Education.
12	Herbal healthcare user: "Well like I said earlier our services (Herbal) are very affordable and effective, for both the old and young low-income, less educated different cultures and both the employed and non-employed".	Income. Education. Culture. Employment status.	Income. Education. Culture. Employment status.
13	Formal healthcare user: "Well I don't have anything to say but anytime a person is not feeling well that person should go to the hospital there's no factor for this".	Sickness.	Sickness.
14	Herbal healthcare user: " <i>Me na herbal I don dey use since and because e dey affordable fo me and anybody wey wan use am</i> ".	Income. Upbringing.	Income. Upbringing.
15	Herbal practitioner: "Well, I would say it is more of income level and upbringing or belief".	Income. Upbringing.	Income. Upbringing.
16	Herbal user: "I'll choose income level. Yes, that's a major factor here".	Belief. Income	Belief. Income

Source: Researcher's Fieldwork, 2023

Interpretation of Table 4.10:

H. Thematic Analysis of the Impact of the Factor Mentioned on Healthcare Services Utilization

From the responses extracted in this section, socioeconomic variables, which have been the focus of this research, are variables within the social system. At the same time, some are natural, like age and gender. The impact these variables will have on an individual is determined by the society where the person finds himself or herself. Based on the themes extracted from the respondents' verbal responses, the following are the consequences socioeconomic variables can have on healthcare services utilization in Nigeria. Among others, socioeconomic variables can lead to accessibility problems, medical guidance, advancement in age can lead to frequent use, educational knowledge can better enhance health knowledge, wrong socialization/belief can affect healthcare usage negatively, and lack of income can lead to using health only where there is a health need. These results can further be related to earlier studies which have been reviewed earlier in this report.

Table 4.10: Can you explain how these factors you mentioned impact healthcare service utilization in this community?

S/N	Excerpts	Preliminary codes	Codes	Themes
1	Formal healthcare practitioner: If there is not enough money, people won't use the hospital, and that makes them use the traditional service that is affordable or rather go to a government hospital which there would be a Long queue or short of staff which will take time especially if it is emergency.	Financial status. Affordability Easy access.	Access.	Accessibility. Medical guidance. Advancement in age can lead to frequent use. Educational knowledge can better enhance health knowledge.
2	Formal healthcare practitioner: Income of an individual in the vicinity is a major thing, and in an environment with literates, they tend to use the hospital because they know about it and are well paid. But illiterates who don't know and don't have an income go for the traditional treatment.	Types of healthcare	Types of healthcare	Wrong Socialization/belief can affect healthcare usage negatively. Lack of income can lead to the use of health only where there is a health need.
3	Formal healthcare user: It is for one good i.e. the doctor will tell you this is what you should do and this is what you shouldn't do.	Medical guidance.	Medical guidance.	
4	Formal healthcare user: There's still an understanding that formal healthcare works better even with their little education.	Trust in the formal healthcare services.	Trust in the formal healthcare services.	

Table 4.10 Continued

5	Formal healthcare user: Okay, well, the aged should frequently go for medical check-ups, both male and female, it doesn't matter your culture or tribe; we should endeavour to get medical treatment and check-ups.	Advancement in age. Medical check-up.	Advancement in age. Medical check-up.
6	Informal medical practitioner: Firstly traditional care (herb) is cheap, and it is available around the people”.	Affordability . Accessibility.	Affordability. Accessibility.
7	Alternative healthcare practitioner: “Traditional medicine has really just helped a lot in all aspects”.	Trust in the healthcare services.	Trust in the healthcare services.
8	Informal healthcare user: “They prefer both because they both work together.	Trust in the healthcare services.	Trust in the healthcare services.
9	Alternative healthcare user: Someone that's older would prefer to use the traditional healthcare service and not everyone can afford the hospital.	Advancement in age. Affordability .	Advancement in age. Affordability.
10	Formal healthcare practitioner: Well, finance or health insurance plays an important role. To achieve the best results on treatments and medications, it is advisable to be financially insured.	Finance.	Finance.

Table 4.10 Continued

11	<p>Formal healthcare user: Education exposes you to a lot about your total well-being. Note that most drugs or tablets are made from our natural herbs. Our body also needs the right proportion of medication after a medical checkup or test, or else it malfunctions. Only medical healthcare services guarantee you of that.</p>	Education.	Education.
		Health need.	Health need.
12	<p>Herbal healthcare practitioner: It has really impacted many lives in this community because people come to me on a daily basis to explain what is wrong with them, and after applying the medication I prescribe to them (<i>Agbo</i>) they find themselves better afterwards, and again it is very affordable.</p>	Accessibility.	Accessibility.
		Affordability	Affordability.
13	<p>Formal healthcare user: Well, age, income, employment status also, because as we grow old, we need to visit the hospital frequently, and you have to have a good income to get the best medical healthcare service based on our economic status in the country.</p>	Age.	Age.
		Income.	Income.
		Employment status.	Employment status.
14	<p>Herbal healthcare user: <i>I no go lie this herbal healthcare service wey dey this community dey really help us ooo at least we wey no too get money for this community this herbal healthcare dey help us oo.</i></p>	Affordability	Affordability.

Table 4.10 Continued

15	Herbal healthcare practitioner: Income level - Herbal treatments are very affordable. People tend to use it more around her.	Income. Upbringing.	Income. Upbringin g.
	[2] Upbringing or belief - Mostly people born and brought up here use herbs more because they have been introduced to them since childhood, so they grow up dependent on it.	Belief.	Belief.
16	Herbal healthcare user: Well, due to the high cost of living, people in this community highly depend on herbs. Hospitals and clinics here are quite expensive.	Affordability	Affordabil ity.

Source: Researcher's Fieldwork, 2023

Interpretation of Table 4.11:

I. Thematic Analysis of Respondent's Personal View of the Effects of Social Factors on Healthcare Services Utilization

Private clinics are expensive: According to the responses generated from the respondents, private clinics are very expensive to patronize. However, some people who opted for alternative care would have loved to patronize formal healthcare for the cost. Government hospitals that would have been of help to solve the health needs of the people are not close by, and the ones closer to the community are understaffed, which usually cause delay and fatality as some people in an emergency may not have such a long time to wait.

There is a need for more government hospitals. **Staff shortage in government hospitals:** In line with the ongoing discussion, most available government clinics around the slum settlements are understaffed. There is the challenge of staff shortage. Even the available health workers in government hospitals are not friendly. This

unfriendliness may be caused by pressure and the monthly remuneration of government staff, which cannot take care of their needs. The people in the slum settlements of the Lagos State metropolis, in their plea, have called for **more healthcare services (private and government-owned)** within the slum settlements. This is necessary because these are residents and citizens of the Federal Republic of Nigeria, and they contribute in one way or another to the economy of Nigeria. There is a need for the government of Nigeria, through public orientation, to educate the public on the physiological makeup of people, which may require attention from time to time. As deduced from the responses, those who **understand the body structure** within the slum settlements use healthcare services occasionally for their medical check-ups. According to responses from herbal healthcare practitioners and traditional healthcare practitioners, **government support through funding and policies** will go a long way to put Nigerian alternative and traditional healthcare services in better shape globally. Based on this set's responses, government support is important, and **the Nigerian police should be cautioned against harassment of traditional healthcare and alternative healthcare practitioners**. It must be stated that traditional healthcare and alternative healthcare practitioners are citizens of Nigeria who are legitimately exercising their fundamental human rights. While it can also be said that some criminals under traditional care may have been involved in inhuman acts, this is not common to all traditional healthcare and alternative healthcare practitioners. It is important for the government of Nigeria to support and empower healthcare practitioners in Nigeria. This will lead to the availability of **more healthcare practitioners who are knowledgeable** and better equipped for the services they render. To curb the drug abuse and medical hazard crisis, it is important that Nigerians **run medical tests before taking prescriptions** or being

involved in self-medication, which can lead to the challenge of drug abuse. Based on these extracts, there is a need for **medical enlightenment, more free medical services, and public orientation or medical education for the public**. Based on the views of some of the residents in the slum settlements whose opinions were sampled for this research, if the above issues are addressed, there would be better healthcare behaviour among Nigerians.

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Table 4.11: Do you have any other comment or personal view on factors that can impact the utilization of healthcare services?

S/N	Excerpts	Preliminary codes	Codes	Themes
1	Formal healthcare practitioner: In this community, we have a private hospital, but they don't seem to be affordable for the traders, so we need government hospitals and more healthcare centres, and people should also be enlightened about modern medicine because there are people that still believe in the traditional works better, so when people know about the Hospital am sure people will be using it and if it is affordable for them to use.	Private clinics are expensive. There is a need for a government hospital.	Private clinics are expensive. There is a need for a government hospital.	Private clinics are expensive. There is a need for more government hospitals. Staff shortage in government hospitals. Need for more healthcare services (private and government-owned). Understanding of the body structure. Government supports to traditional healthcare through funding and policies. The Nigerian police should be cautioned against the harassment of traditional healthcare practitioners. Need for more knowledgeable healthcare practitioners. Medical tests should precede medical prescriptions. There is need for medical enlightenments. More free medical services
2	Formal healthcare practitioner: Government should recruit employees; there is shortness of staff.	Staff shortage in government hospitals.	Staff shortage in government hospitals.	

Table 4.11
Continued

3	<p>Formal healthcare user: As for me, I'll advise people to go to the hospital whenever they're feeling sick, or they're feeling anything in their body, though the traditional care is working too in its own terms because it has been in existence before the hospital, I still prefer Hospital care.</p>	<p>Preference for hospital care.</p>	<p>There is a need for a government hospital.</p>	<p>should be made available. There is need for public orientation or medical education of the public.</p>
4	<p>Formal healthcare user: There should be more healthcare services in this community, either private or government owned. There are only a few here.</p>	<p>More healthcare services.</p>	<p>More healthcare services (both private and government-owned).</p>	
5	<p>Formal healthcare practitioner: Well, I'd advise us to study our bodies closely so as to know when we should go for a check-up, treatment, and so on thank you.</p>	<p>Understanding the body system.</p>	<p>Understanding the body system.</p>	

Table 4.11
Continued

6	<p>Informal healthcare practitioner: Firstly, Government should assist the traditional healthcare practitioner in Lagos here because they use the money to buy the herbs and bring it here, secondly, Government should see to the issues or security agencies on the highway stopping and delaying of transportation of herbs. And Government should organize orientation for people to use herb care too and should be taken to the hospitals. Herb should be included in medical care at the hospitals.</p>	<p>Government support for traditional care.</p> <p>Policies should be made to support herbal medicine.</p> <p>Police should stop harassing herbal medicine practitioners.</p>	<p>Government support for traditional medical practitioners.</p> <p>Caution to the police on the harassment of traditional healthcare practitioners.</p>
7	<p>Informal healthcare practitioner: There are some people that also practice modern medicine and do not have in-depth knowledge about it and to me, traditional medicine is the best.</p>	<p>Some practitioners lack detailed knowledge.</p>	<p>Need for knowledgeable healthcare practitioners.</p>

Table 4.11
Continued

8	Informal healthcare user: Whenever you're feeling anything within you, you first go for a check to know the nature of your health, so after the check-up and there is no change, the person should try traditional care (herb).	Medical tests should precede prescription.	Medical tests should precede prescription.
9	Informal healthcare user: I'll tell people to focus more on herbs, and we can also use these herbs and foods.	Herbs should be used more.	Herbs should be used more.
10	Formal medical practitioner: I feel people in this community need to be enlightened on the importance of medical health care services like checkups, antenatal, means of childbearing, postnatal and drug usage. However, it is advisable for medical healthcare centres to conduct free services like checkups and treatments once in a while.	There is a need for medical enlightenment. Free healthcare services should be made available.	There is a need for medical enlightenment. Free healthcare services should be made available.
11	Formal medical user: Due to the high cost of living here, people tend to use healthcare services that fit their budget.	People use healthcare services that they can afford.	People use healthcare services that they can afford.

Table 4.11
Continued

	I'll advise that any preferred choice of medication should be taken in the right proportion.		
12	Herbal healthcare practitioner: I don't have much to say in this, just as the saying that our health is our wealth, so we should endeavour to take good healthcare of ourselves, and our families. Thank you.	Health is wealth.	Health is wealth.
13	Formal healthcare user: Our health is our wealth, so let's not neglect any health signs.	Avoid health negligence.	Avoid health negligence.
14	Herbal healthcare user: <i>Well I go just say na herbal healthcare me dey use, and nah because e dey affordable and very effective thank you.</i>	Affordability. Effectiveness.	Affordability. Effectiveness.
15	Herbal healthcare practitioner: Well, herbs are good and natural.	Good. Natural.	Good. Natural
16	Herbal healthcare user: The use of both services is good. I think it is important we understand our body system and know the one that works best for it.	Understanding of the body system.	Understanding of the body system

Source: Researcher's Fieldwork, 2023.

4.2.2. Presentation of Regression Analysis Results

Hypotheses are tentative statements which a researcher sets out to test. Hypotheses are to be developed per the research objectives or questions. Seven hypotheses were formulated to test the health-seeking behaviour of slum dwellers in the Lagos State metropolis. The presentation in this section shows the use of binary logistic regression statistics. This research adopted the use of p-value, among others, as the significant yardstick for confirming the stated hypotheses. Statistical computation below, generated through Statistical Package for Social Scientists (SPSS), formed the basis for this research's hypotheses are accepted/rejected as scientifically valid.

Interpretation of Table 12

A logistic regression was performed to ascertain the effects of Sex Age, Educational Attainment, employment status, religious affiliations, monthly income, and the possibility of experiencing sickness in the last 12 months on the likelihood that participants will utilise healthcare services in the last 12 months. The model explained 57.3 % (Nagelkerke R^2) of the variance in the utilisation of healthcare services in the last 12 months. Overall, the model was able to predict 81.9% of cases correctly.

From the results, Educational attainment ($P=0.014$), Employment status ($P=0.002$), and Experienced sickness in the last 12 months ($P=0.000$) added significantly to the model. Therefore, education attainment, employment status and the possibility of experiencing sickness in the last 12 months are strong predictors for utilising healthcare services in the last 12 months among slum dwellers in the Lagos State metropolis.

Conversely, Gender ($P=0.494$), Age ($P=0.891$), Religious affiliation ($P=0.098$), and monthly income ($P=0.885$) did not add significantly to the model.

Consequently, Gender, Age, Religious affiliation, and monthly income are not good predictors of healthcare service utilisation in the last 12 months.

Religious affiliation indicates that Christians were 4.038 times more likely to utilise healthcare services in the last 12 months than those with no religion ; similarly, those of Islamic religion were 2.18 times more likely to use healthcare services in the last 12 months than those with no religion.

On the effect of the state of employment, those who are employed are 1.54 times more likely to utilise healthcare services in the last 12 months than those who are not employed.

The possibility of experiencing sickness is a critical factor affecting health-seeking behaviour. Those who have reported being sick in the last 12 months are 34.47 times more likely to utilise healthcare services in the last 12 months than those who haven't experienced sickness in the last 12 months.

Increasing educational attainment was associated with a decreased likelihood to utilise healthcare services in the last 12 months. This may be because educated people have better access to health information, which may prevent them from sickness.

Table 4.12: Binary Logistic Regression Analysis (Multivariate)

Variable	Category	Coefficient (B)	Standard Error	Odds Ratio (Expected (B))	95% CI		P-value
					Lower	upper	
Sex	Male (Ref)			1			
	Female	0.273	0.40	1.31	0.601	2.876	0.494
Age	18 – 36 (Ref)			1	0.724	2.62	0.891
	36-55	0.75	0.45	1.078	0.135	3.89	0.869
	56 and above	0.322	0.858	0.724	0.72	0.135	0.707
Educational Attainment	None (Ref)			1			0.014
	Below Secondary School	-2.21	0.795	0.110	0.23	0.522	0.005
	Secondary School	-1.912	0.761	0.148	0.033	0.656	0.012
Employment Status	Tertiary School	-3.04	0.970	0.48	0.007	0.321	0.002
	Not employed (Ref)			1			0.002
	employed	0.437	0.720	1.547	0.377	6.350	0.544
Religious Affiliations	Self-employed	-1.22	0.663	0.293	0.08	1.074	0.064
	None (Ref)			1			0.232
	Christianity	1.396	0.844	4.038	0.773	21.097	0.098
Monthly Income	Islam	0.781	0.853	2.18	0.410	11.612	0.360
	Traditional Worshipers	0.522	1.205	1.686	0.159	17.895	0.665
	Less than N50,000 (Ref)			1			0.885
Experienced sickness in the last 12 months	N51,000 – N100,000	0.190	0.475	1.209	0.476	3.068	0.689
	N100,000 – N150,000	-0.420	0.936	0.657	0.105	4.118	0.654
	N150,000 and above	-0.260	1.400	0.771	0.050	11.996	0.853
Experienced sickness in the last 12 months	No (Ref)			1			
	Yes	3.54	0.438	34.47	14.596	81.421	0.000

Source: Researcher's Fieldwork, 2023. Ref means Reference Category

4.2 Presentation of Research Questions

Research Question One

What is the state of healthcare services utilization in the urban slum settlements of Lagos State metropolis?

It was observed during data collection that formal healthcare facilities are few and far between in the slum areas of this study. The scarcity of modern healthcare facilities in these heavily population settlements creates problems of access and affordability, among others. In this environment of paucity of healthcare facilities, the utilization of healthcare services in the slum settlements of the Lagos State metropolis is worrisome, according to the data collected for this research. From the responses from the quantitative data, 57.8% of the respondents said they utilized healthcare services, and only when there was a need (when they were sick). To complement this point, information from the qualitative data was also extracted:

“There is no need to visit healthcare practitioners to the best of my view. I only visit healthcare practitioners when I am sick, and that is if I use drugs and am still unwell”.

My use of healthcare services happens only when there is a need. For example, when one member of the family needs medical attention, then, the hospital may become necessary.

“Most times when there is a health need. A few people come for medical check-ups, but the majority of the people in this area will only come for medical services when they are sick.

From a respondent speaking in pidgin English:

Anytime I need help medically, I go to the hospital. If everything dey okay, I no dey go hospital go give my money to doctors for nothing.

Responses from the respondents for this research showed that many respondents have a poor orientation to utilising healthcare services. This may have been affected by many factors, such as the affordability of healthcare services and the socioeconomic characteristics of the residents of the slum communities studied

in this research. According to the responses unravelled on the factors affecting healthcare services utilization, the view below was expressed by one of the respondents who is a formal healthcare practitioner.

Income is a major factor affecting healthcare services utilization. Income as a factor affects not only the utilization of healthcare services but also the type of healthcare services utilized. Private hospitals which are available in the community are not affordable and most people in this rural area are traders, their income might not be enough to use the hospital, especially the private hospital. This has led many to the utilization of herbal healthcare or spiritual home.

The response above complements the point raised in the quantitative findings.

According to the quantitative data collected, 50.7% of the respondents said income is the main factor affecting the use and the type of healthcare services utilized.

Sometimes, when people have health emergencies, they will need to either trek a long distance or look for a vehicle to move them before they can access the healthcare facilities needed. The needed healthcare facilities are distanced from the community. We need to go to the city. Otherwise, you use what you can have access to. Many people use alternative healthcare or herbal cure not because they want to but because of the distance to go before you can access formal healthcare services.

From this response, distance is a major barrier affecting health-seeking behaviour in the slum settlements. As observed during this research, many slum settlements lack the necessary social amenities for human well-being. The distance between the healthcare facilities and the residents of the slum settlements in the Lagos State metropolis may cause negative health-seeking behaviour, leading to health quagmire among the slum settlements residents.

Research Question Two

How does employment status affect the health-seeking behaviour of slum dwellers in the Lagos metropolis?

Employment status is a socioeconomic variable that can affect many aspects of an individual life. For example, employment status can affect income and choice of residence. These factors can impact human health directly and indirectly. People who work in the formal and regulated sector of the economy have a higher tendency to better health-seeking behaviour than those who work in the informal or unregulated sector of the Nigerian economy. This view is justified by the qualitative response from a respondent who is a formal healthcare practitioner:

Type of employment can have a serious impact on the utilization of healthcare services. Many of the people in this community are traders or business people while some are not working. Those who are working in offices have health insurance. If they are sick, there is no need to manage or go for herbal care. Their health insurance covers them and their family members in some cases. Because many of the people are low-income earners and do not have health insurance, utilizing healthcare services is a problem for them. Many have died from sicknesses which are curable. If they are employed in good organizations with health insurance coverage, they could have been averted.

These qualitative responses support quantitative data, indicating that 77.8% of the respondents work in the informal sector. Most of these people may be people without regular employment and have traits of irregular income. Due to the nature of their employment, they may not also have health insurance, which in Nigeria is essentially available for people in formal employment. The absence of healthcare insurance for most slum dwellers constitutes a significant barrier to easy access to proper healthcare services. This may, therefore, affect the utilization of healthcare services.

Research Question Three

What is the relationship between educational attainment and health-seeking behaviour of slum dwellers in the Lagos metropolis?

Knowledge is power. Through education, knowledge is developed. According to the data from the socio-demographic section of this report, only 14.5% of the respondents studied for this research have attained or are still going through higher education programmes. Over 71% of the respondents have no more than a secondary school education, which may impact their level of knowledge. The p-value (0.014) computed was lesser than 0.050 which shows a significant relationship between educational attainment and health-seeking behaviour of the residents of slum settlements in the Lagos State metropolis. Responses from the qualitative section also throw more light on the relationship between education and health-seeking behaviour:

Many of the people in the area are not very lettered. This affects their behaviour as well as their health-seeking behaviour. Even when a health sensitization programme is organised, many of them may not come, and those who come may not be able to maximize the importance of the information at their disposal.

When I am sick, I utilize herbs because that is what is handed over to me. It is effective and it is easily accessible. Going to doctors sometimes may worsen the situation because of medical terms that may not be very clear to people with lower levels of education.

From the responses above, education plays a pivotal role in health-seeking behaviour. Due to the low educational attainment of slum dwellers in Lagos, their health-seeking behaviour is adversely affected. .

Research Question Four

How does household income affect the health-seeking behaviour of slum dwellers in the Lagos metropolis?

Data collected in this research underscore the importance of income at the household and individual levels as a factor that can affect health-seeking behaviour. Although the p-value (0.885) statistics between income and health-seeking behaviour shows that there is no significant relationship between the income level and health-seeking behaviour of the residents of slum settlements in Lagos State, the qualitative responses showed that level of household income can play a significant role. It was revealed that 89.3% of the respondents earned not more than N100,000 monthly. This shows that most of the respondents are low income-earners.

Income is a major factor in health-seeking behaviour. Most of the people in the slum settlements are low-income earners some private hospitals will not be affordable and most people in this area are traders, their income might not be enough to use the hospital, especially the private hospital.

Low-income level, lack of healthcare exposure or insurance and high cost of living. Also, some people think medical treatments are expensive.

The low-income status of the people may also be connected to the state of educational attainments among slum dwellers in the Lagos State metropolis. As already established, over 71% of the respondents have no more than secondary school education. The level of educational attainment can significantly affect employment status and income eventually. Low-income status can impact health-seeking behaviour negatively as Nigeria is tending towards fee-for-service practice, especially for essential services like health.

Research Question Five

How does a known illness/disease (a disease revealed by medical tests and accepted by the patient) affect the health-seeking behaviour of slum dwellers in the Lagos metropolis?

According to the quantitative data for this study, 57.8% of the respondents claimed they only utilized healthcare services when sick or when they had a health challenge. The p-value of the relationship between sickness and health-seeking behaviour of the slum dwellers in the Lagos State metropolis is 0.000. This is lower than 0.05 which shows, as expected, that being sick is a strong predictor of healthcare services utilization among the residents of the slum settlements in the Lagos State metropolis. The following views emanate from the responses obtained through in-depth interviews:

People in this community don't come for healthcare services until there is a sickness or disease which they are unable to manage.

I don't fall sick and when I feel sick in my body, I take herbs without going to the hospital.

Why must I go to the hospital if I am not sick to give my money to doctors? Unless there is a problem with my health that is beyond what I can endure. If I am okay, I don't go to the hospital at all even in years.

According to the information inferred from the responses above, residents in the slum areas visit healthcare practitioners mostly when sick or when there is a disease in their body, conceptualized in this research as a “known disease or sickness”. Based on these results, the higher the presence of sickness or disease among the dwellers of Lagos State metropolis slum settlements, the more their patronage of healthcare practitioners. There is a need for the slum dwellers in the Lagos State metropolis to be re-orientated on their health-seeking behaviour. Sickness or disease must not be the only reason for utilising healthcare services.

Research Question Six

What impact does age have on the health-seeking behaviour of the dwellers of slum settlements in the Lagos metropolis?

The relationship between age and health-seeking behaviour of slum dwellers in Lagos State was not significant as the p-value was computed at 0.89. However, the responses from the qualitative data showed the valuable impact age can have on health-seeking behaviour.

Age is a significant factor in health-seeking behaviour. While other factors such as education, income and employment have their roles in health-seeking behaviour, certain physiological changes occur in people because of age which leads to the frequency of healthcare services usage.

Among the people who usually come for medical attention, children and the elderly seem to have the highest figure. Young people especially young men hardly come around until the situation has gone beyond what they can bear. This shows that certain behaviours are exhibited in relation to health-seeking behaviour which can be explained along the region of age-group.

The responses above underscore the importance of age as a socio-demographic factor which can impact healthcare service utilization. Some sicknesses are age-related, e.g., bone weakness, vision dimness, etc. This is not to conclude that every aged person will have to go through frequent experiences of sickness. Although only 10.3% of the respondents in this research reported being age 56 years and above, the majority who are between age 18 years and 55 years 87.8% also need regular medical attention in order not to have many incidences of sickness due to poor medical facilities or their unavailability as propounded by Talcott person.

Research Question Seven

What is the relationship between gender and the health-seeking behaviour of slum dwellers in the Lagos metropolis?

Gender considerably influences health-seeking behaviour, as evident among the slum dwellers in the Lagos State metropolis. Although the p-value of the relationship between gender and health-seeking behaviour is insignificant, women have a higher ratio (1.31) of seeking healthcare services than men. Responses from the qualitative data underscore the role of gender in seeking health care services.

There are many things that come with being a woman. For example, teenage boys may have less reason to seek medical attention compared to their female counterparts monthly. Young ladies even adult women still have challenges with menstrual cramps which is not the case with boys/men.

More of the patients that come to the clinic are women. Some of them are facing the challenges that come with, pregnancy, childbearing or menopause which is a normal order of aged women.

We have fewer men than women coming for medical attention. A lot of men who come for herbal cures may just need sexual enhancement. If everything is okay with men, they hardly seek medical attention.

According to the data for this research, gender significantly impacts health-seeking behaviour. Women especially need more medical attention as they progress physiologically. Advancement chronologically affects physiological formations and biological attributes, which affect both men and women. More attention may be needed in terms of research and policy which can delineate health models for men and women based on their physiological requirements.

Research Question Eight

What is the connection between religious affiliation and the health-seeking behaviour of slum dwellers in the Lagos metropolis?

There is no significant relationship between religious affiliation and health-seeking behaviour. The p-value was calculated at 0.232 which is higher than 0.05 acceptable significance for this research. However, from the qualitative responses, religion may have a very strong influence on the health-seeking behaviour of people. The influence could be positive or negative. For example, responses from the qualitative data exposed some facts that show religion as a key socio-economic variable in the analysis of health-seeking behaviour.

My religion taught me to be modest and not expose myself to danger. For example, I have been taught that taking alcohol is bad, and indulging in smoking can cut short one life. Although uncertainty can happen, carefulness can help in improving one's health.

My faith teaches me what to accept medically and what not to accept. For example, we do not accept blood transfusions no matter the situation. This is not popular but that is what we practice.

Among the respondents in the quantitative study of this research, only 4.8% said their utilization of a particular healthcare service is influenced by their religious views. For example, some of them did not receive the COVID-10 vaccine because they believed it was a way the anti-Christ is influencing human life.

Research Question Nine

Why the high patronage of informal healthcare services among the urban slum dwellers?

From earlier research, questions have been raised on the reasons for the high level of informal healthcare patronage among urban slum dwellers, even though the level of healthcare utilization is generally low among the slum dwellers. A clue on the

factors responsible for this occurrence has been highlighted in this research. From the qualitative findings obtained from the informal healthcare users:

People in this area make use of what is available. Although, what is available may not be the best but since it is accessible and it serves the immediate it, then it is used.

The informal healthcare services is easy to access. They are readily available. Some of the workers may also attend to you in the local language which makes it okay for people with low level of education.

The traditional or informal medicine is cheap compared to clinic or hospital. Many people are struggling financially. Accessing expensive healthcare is not an alternative for now. This makes many people to use traditional healthcare services when it is essential for them to access healthcare services.

From the responses above, three important themes may be critical to the high patronage of informal healthcare services among urban slum dwellers. These three themes are accessibility, availability, and affordability. These themes will be discussed in the succeeding section of this research.

4.3. Test of Hypotheses

H₀₁: There is no significant relationship between employment status and the health-seeking behaviour of residents of slum settlements in the Lagos Metropolis.

Interpretation of Table 4.13:

Based on the statistical calculation for this hypothesis, the p-value is 0.02, less than 0.050. This showed that employment is significantly related to the health-seeking behaviour of slum dwellers in the Lagos State metropolis. From the binary logistic regression, it was further analysed that those in formal employment have better health-seeking behaviour compared to those in the informal sector or those who are self-employed in the slum settlements. The odd ratio, which shows the significant differences between each category of the respondent, is computed at 1.547 for the employed compared to 0.293 for the unemployed category.

To support the statistical results generated through regression analysis, which showed that there is a significant relationship between employment status and health-seeking behaviour, correlation statistics of Cramer’s V, which stands at .157, showed a strong relationship between employment status and health-seeking behaviour of the slum dwellers in the Lagos State metropolis. This further justified the importance of employment as this can further affect other areas such as income and personal development.

Table 4.13 Employment and Health-Seeking Behaviour

Variable	Category	Coefficient (B)	Standard Error	Odds Ratio (Expected (B))	95% CI Lower upper		P-value
Employment Status	Not employed			1			0.002
	Employed	0.437	0.720	1.547	0.377	6.350	0.544
	Self-employed	-1.22	0.663	0.293	0.08	1.074	0.064

Source: Researcher’s Fieldwork, 2023

H₀₂: Educational attainment is not directly related to the health-seeking behaviour of residents of slum settlements in the Lagos Metropolis.

Interpretation of Table 4.14:

According to the statistical test for this hypothesis, the p-value is 0.014. This shows a significant inverse relationship between educational attainment and health-seeking behaviour of the residents of slum settlements in the Lagos State metropolis.

Analysing the relationship between education and health-seeking behaviour of the slum dwellers in Lagos State metropolis, Cramer’s V computed at .116 demonstrated a strong relationship between educational attainment and health-seeking behaviour. This further corroborates the multi-regression analysis, which showed a significant inverse relationship between educational attainment and health-seeking behaviour of the slum dwellers in the Lagos State metropolis. The

regression coefficient showed that the higher the level of educational attainment, the lesser the tendency of utilizing healthcare services (such as visit to the hospital, traditional healing centre or community pharmacy/pharmacists). Three parameters were used to analyse utilization of healthcare services in this research which had been mentioned above. The result may not necessarily indicates that higher receivers have poorer health-seeking behaviour compared to those with lesser educational attainment in general. This may mean that higher education receivers may utilize healthcare services in a pattern that is not conventional For instance, there is the availability of telemedicine which is accessible to the educated. This may serve as an alternative to the healthcare services covered in this research.

Table 4.14: Educational Attainment and Health-Seeking Behaviour

Variable	Category	Coefficient (B)	Standard Error	Odds Ratio (Expected (B))	95% CI Lower upper	P-value
Educational Attainment	None			1		0.014
	Below	-2.21	0.795	0.110	0.23 0.522	0.005
	Secondary School					
	Secondary School	-1.912	0.761	0.148	0.033 0.656	0.012
	Tertiary	-3.04	0.970	0.48	0.007 0.321	0.002

Source: Researcher's Fieldwork, 2023

H03: The presence of a known sickness/disease has no positive relationship with the health-seeking behaviour of residents of slum settlements in the Lagos Metropolis.

Interpretation of Table 4.15:

According to the statistical test for this hypothesis, the p-value is 0.000, less than 0.05. Based on this statistical output, there is a significant relationship between the presence of a known sickness or disease and the health-seeking behaviour of slum dwellers in the Lagos State metropolis. According to the multiple regression analysis computed for this hypothesis, the coefficient stands at 0.568, which indicates a

positive relationship between the presence of a known sickness or disease and the health-seeking behaviour of slum dwellers in the Lagos State metropolis. This means the higher the challenge of sickness among the slum dwellers, the more they are likely to seek utilization of healthcare services. For every increase in known diseases among the slum dwellers, the health-seeking behaviour will increase by 0.568.

The correlational analysis of the relationship between sicknesses (diagnosed diseases) and health-seeking behaviour demonstrated that sicknesses are the main determinants of health-seeking behaviour among slum dwellers in the Lagos State metropolis. The correlation statistics (Cramer's V) computed at .454 showed a very strong relationship between the presence of diagnosed (known diseases) diseases and health-seeking behaviour. This further corroborates the regression analysis, which computed the p-value at 0.000. Based on these statistical results, it is concluded that sickness or disease is the main factor prompting the utilization of healthcare services among the slum dwellers in the Lagos State metropolis.

Table 4.15: Experiences of Sickness in the Last Twelve (12) Months and Health-Seeking Behaviour

Variable	Category	Coefficient (B)	Standard Error	Odds Ratio (Expected (B))	95% CI		P-value
					Lower	upper	
Experienced sickness in the last 12 months	No			1			
	Yes	3.54	0.438	34.47	14.596	81.421	0.000

Source: Researcher's Fieldwork, 2023

H04: Sex has no significant effects on the health-seeking behaviour of residents of slum settlements in the Lagos metropolis.

Interpretation of Table 4.16:

The p-value for this hypothesis was computed at the statistical value of 0.494, which is higher than the significant level of 0.05. This shows no significant relationship between the sex of the slum dwellers in the Lagos State metropolis and health-seeking behaviour. Based on the statistical hypothetical rule, the alternative hypothesis is rejected, and the null hypothesis is accepted.

To further support the multivariate analysis in the regression table above, the correlation computation in the table below confirmed that the relationship between sex and health-seeking behaviour is insignificant, as the Cramer's V computation revealed a figure of .051, which can be interpreted as no or very weak relationship. This further justified the rejection of the alternative hypothesis, which asserts a significant relationship between gender and health-seeking behaviour.

Table 4.16: Sex and Health-Seeking Behaviour

Variable	Category	Coefficient (B)	Standard Error	Odds Ratio (Expected (B))	95% CI		P-value
					Lower	upper	
Gender	Male			1			
	Female	0.273	0.40	1.31	0.601	2.876	0.494

Source: Researcher's Fieldwork, 2023

H15: Religious affiliation has no direct relationship with the health-seeking behaviour of residents of slum settlements in the Lagos metropolis.

Interpretation of Table 4.17:

According to the statistical calculation for this research, the p-value figure for the hypothesis between religious affiliation and health-seeking behaviour stands at 0.565, which is greater than the acceptable regional value of 0.050. Based on this statistical output, the alternative hypothesis is rejected, and the null hypothesis, which states

that there is no significant relationship between religious affiliation and health-seeking behaviour of slum dwellers in the Lagos State metropolis, is accepted for this research.

Although the binary logistic regression analysis showed no significant relationship between religion and health-seeking behaviour, the correlation statistics showed that religious affiliation can affect health-seeking behaviour. The Cramer's V computation showed a figure of .194, demonstrating a strong relationship between religious affiliation and health-seeking behaviour. This corroborates the qualitative finding of this study, where it is discovered that certain vaccines were ignored as a result of religious beliefs.

Table 4.17: Religious Affiliation and Health-Seeking Behaviour

Variable	Category	Coefficient (B)	Standard Error	Odds Ratio (Expected (B))	95% CI		P-value
					Lower	upper	
Religious Affiliations	None			1			0.232
	Christianity	1.396	0.844	4.038	0.773	21.097	0.098
	Islam	0.781	0.853	2.18	0.410	11.612	0.360
	Traditional Worshipers	0.522	1.205	1.686	0.159	17.895	0.665

Source: Researcher's Fieldwork, 2023

H₆: Age has no positive relationship with the health-seeking behaviour of residents of slum settlements in the Lagos metropolis.

Interpretation of Table 4.18:

Age is a significant socio-demographic variable in health-seeking research such as this. Due to advancement in age, physiological changes may occur that may warrant frequent utilization of healthcare services. This assumption has been proved invalid by the statistical result of the p-value in this section, which stands at 0.891, higher than 0.050. The outcome of this statistic is assumed that there is no

significant relationship between age and health-seeking behaviour of slum dwellers in the Lagos State metropolis.

According to the statistics computed on the relationship between age and health-seeking behaviour, Cramer's V statistics, computed at .063, show a weak relationship. This further corroborates the result of the regression, which showed that there is no significant relationship between age and health-seeking behaviour. Based on the statistical output, the alternative hypothesis predicted for this section was rejected.

Table 4.18: Age and Health-Seeking Behaviour

Variable	Category	Coefficient (B)	Standard Error	Odds Ratio (Expected (B))	95% CI		P-value
					Lower	upper	
Age	18 – 36			1	0.724	2.62	0.891
	36-55	0.75	0.45	1.078	0.135	3.89	0.869
	56 and above	0.322	0.858	0.724	0.72	0.135	0.707

Source: Researcher's Fieldwork, 2023

H₀7: Household income has no significant relationship with the health-seeking behaviour of residents of slum settlements in the Lagos Metropolis.

Interpretation of Table 4.19:

Household income is very important in the analysis of health-seeking behaviour. However, this is not enough reason to assume that an increase in household income will proportionally lead to an increase in health-seeking behaviour, as statistically proven in this research. According to the p-value computed for this hypothesis, 0.885 is higher than 0.050, the acceptable regional value for this research. This shows that there is no significant relationship between the income of the residents of slum settlements in the Lagos State metropolis and health-seeking behaviour.

The correlational analysis of the relationship between sicknesses (diagnosed diseases) and health-seeking behaviour demonstrated that sicknesses are the main determinants of health-seeking behaviour among slum dwellers in the Lagos State metropolis. The correlation statistics (Cramer's V) computed at .454 showed a very strong relationship between the presence of diagnosed (known diseases) diseases and health-seeking behaviour.

Table 4.19: Income and Health-Seeking Behaviour

Variable	Category	Coefficient (B)	Standard Error	Odds Ratio (Expected (B))	95% CI		P-value
					Lower	upper	
Monthly Income	Less than N50,000			1			0.885
	N51,000 – N100,000	0.190	0.475	1.209	0.476	3.068	0.689
	N100,000 – N150,000	-0.420	0.936	0.657	0.105	4.118	0.654
	N150,000 and above	-0.260	1.400	0.771	0.050	11.996	0.853

Source: Researcher's Fieldwork, 2023

4.4. Discussion of Findings

The foregoing analyses in this chapter focused on interpreting data collected during the research. Here the findings of the study are discussed vis-à-vis results of previous studies. The discussions are tailored towards the research objectives and questions stated at the beginning of the research.

The goal of attaining a healthy society has made nations of the world focus on not just the biological aspect of health but also the social aspect of it^{1,3}. Many factors are responsible for health-seeking behaviour, including employment status. According to the p-value of this research, which was computed at 0.024, lower than 0.050, the employment status of people significantly affects their health-seeking behaviour. Responses from the qualitative data showed that employment plays a pivotal role in

health-seeking behaviour. Those who are employed in the formal sector sometimes have access to registered healthcare because of their registration under the National Insurance Health Scheme. This scheme covers the healthcare expenses of the employees in some formal organizations. It also caters for a number of their family members depending on the terms and condition of the health care scheme.

Confirming the validity of the research findings stated above, scholars argue that while employment may not prompt people into utilizing healthcare services, employment status allows the availability of resources that may assist in case healthcare services are needed^{1,5,6}. As earlier cited in this report, in the speech of the immediate outgoing Minister of Health for Nigeria, some preventable fatality has occurred due to the inability of Nigerians, especially people in rural and slum areas, to access needed healthcare services. In some of the studies conducted in South Asia countries, employment status could determine many things, including accessibility of healthcare services. Many countries that fall within the category of low-income countries are operating the fee-for-service principle, and this policy is already affecting many essential services, including healthcare services. Earlier research on health-seeking behaviour confirmed a similar research output in Nigeria^{5,6}. The role of employment status as a socioeconomic variable affecting health-seeking behaviour cannot be overemphasised^{5,6}. For example, it has been argued that many urban slum dwellers, because of the failure of the Nigerian economy, are either unemployed or self-employed, while only a few work in the formal sector - the majority work in the informal sector, which lacks health insurance coverage. The inability to secure formal employment within the professional or formal sector has implications. Many working in the informal sector may lack regular income or savings to sustain them during a crisis. Lacking regular income from reliable

employment may affect health-seeking behaviour. The challenge in this regard is that the informal sector is not properly covered by the health insurance policy in Nigeria. Many Nigerians, especially people in the slum settlements who work within the informal economy, are at risk due to this lacuna.

The role of social factors such as educational attainment on health-seeking behaviour is critical. Based on the statistical calculation of the influence of educational attainment on health-seeking behaviour, the p-value statistics stands at 0.050, which is a borderline value. This still proves that there is a significant relationship between educational attainment and Health-seeking behaviour. Educational attainment is very critical as education advancement can lead to information appreciation⁷. To corroborate the statistical value which confirmed in this research that education plays a significant role in health-seeking behaviour, an earlier study among Americans established the critical role of education in health-seeking behaviour. Those who have education have the advantage of appreciating health information. Education knowledge gives advantages in many ways, among which is health-seeking behaviour. In a health crisis, passing information to a diverse population with a high level of illiteracy is a serious challenge¹. Giving health information to a vast population of people with different cultural views and low levels of education has impacted the success of Nigerian health policies, and this may continue if the educational attainment statistic among Nigerians remains at the same level^{5,6}. According to the percentage distribution of respondents for this research, only 14.5% of the respondents claimed to have attained education up to the tertiary level. More than 80% of the respondents have neither education nor secondary school certificates. This is a matter of concern as it is predicted through regression statistics that for every decrease in the level of illiteracy in the slum

settlements of the Lagos State metropolis, there will be an increase in the level of residents' health-seeking behaviour. This calls for more support from Lagos State and Nigerian governments, supporting Nigerians towards educational advancement. From an empirical point of view, the researcher had personally discovered that people with high educational status utilize healthcare services more than the semi or final illiterates⁸. This is due to their level of exposure. The fact that educated people visit their GP (General Practitioner) from time to time rather than relying on self-medication¹.

The emphasis of the sociology of health is the analysis of social factors affecting the health and well-being of people³. Health inequality can be caused by various factors, including household income. Poverty impacts nations and people in many ways, including health-seeking behaviour. Many Nigerians are living below the poverty line. The findings from this research has delineated the vital role of income or household income on the utilization of healthcare services.

Based on the response from the qualitative section, household income plays a significant role in the health-seeking behaviour of slum dwellers in the Lagos State metropolis. Many Nigerians have been stratified along class lines⁹. You either belong to the upper class or the lower class. Developed countries like the United Kingdom, Canada, and the United States of America have three categories of class: upper, middle, and lower class. The class you belong to will determine the benefit you will get or enjoy in society. This brings to reality the usefulness of Karl Marx's analysis. To Marx (1818-1883), modern societies are divided into two regional classes: the capitalist, which he called the bourgeoisie and the working class or masses, which he called the proletariats. While the upper class (bourgeoisie), according to Karl Marx, have access to all the good things in society, the masses

serve the capitalist with their working power to earn a daily living. Not being able to work means not being able to earn. This made the working class seek more work, leading to health negligence or poor health-seeking behaviour.

Although Nigerian society has witnessed the introduction of the National Health Insurance Scheme (NIHS), out-of-pocket payment (OOPP) continues to be a popular practice for essential services such as health. In times of emergency, family members of an individual in need of urgent medical attention may have to rationalise between paying for health services and attending to other important needs such as food and shelter^{5,6}. The research findings further confirmed the reliability of the theory of Abraham Maslow. According to Maslow, there are five hierarchies of needs, which are levels of human needs, which are physiological, security needs, social needs or acceptance needs, esteem needs, and self-actualization.

Among these needs, the most important is the first level of need, "physiological needs". To Maslow, until this first level of needs is met, human beings may not progress to the level of other needs. Poverty-stricken homes/households often lack enough to eat. The government of the United States uses the term "food secure" to describe those households that always have access to enough food for an active, healthy life, with no need for recourse to emergency food sources or other extraordinary coping behaviours to meet their basic food needs¹². The present condition of Nigerian society can be described as a "state of food insecurity". The current salary scale of public workers in Nigeria has been titled "take-home which cannot take workers home".

Without adequate food, people lose their ability to resist or regain health after falling ill or experiencing serious injury. Dietary deficiencies can lead to malnutrition

associated with anaemia, tuberculosis, and osteoporosis¹². Pregnant women who do not eat adequately will likely give birth to low-weight babies who often suffer from mental retardation and other disabilities¹¹. Low weight in babies due to malnutrition has also been directly linked to a higher likelihood of infant mortality¹². Malnutrition frequently undermines the health of the elderly as well as children. Some members of the poverty population suffer from living amid conditions of violence. What does this mean? Pls use conventional terms.

For example, poverty contributes to a high rate of homicide in the United States¹². While poverty is affecting the United States of America, causing homicide, Nigerians have become victims of kidnapping as unemployed youths look for both legal and illegal means to survive. A society with a high poverty level cannot be in good health¹¹. In low-income sections of many cities, some residents, children and adults resort to deadly weapons to protect themselves and handle conflict with others¹¹. The world health system has failed to meet the needs (health needs) of people from low-class families or families¹¹. This is not only peculiar to low-income countries such as Nigeria; developed countries such as the United Kingdom and the United States of America are not excluded in the failure of the health system to meet the health needs of low-income earners and slum dwellers. Using the United States health sector as a case, the Health Care System has failed to provide adequate services to tens of millions of low-income people without adequate health insurance coverage. Poor people often find that the care they need is inaccessible and unaffordable. Consequently, they are more likely than the more affluent to be without the care they need or to postpone seeking it at greater risk to their health¹¹.

Religion plays a significant role in people's lifestyles and ways of living. Religion is a set of beliefs and practices about sacred things¹⁰. Religion is associated with three sources of fear namely:

- (i) The physiological facts of birth, puberty, disease, and death.
- (ii) The contract of man with the world around him and with the forces of nature and
- (iii) The individual class with his fellow man¹⁰.

According to the qualitative findings in this research, some of the responses further proved the validity and influence of religious affiliation in health-seeking behaviour.

Going by some of the responses in the qualitative section, the importance of religiosity in health-seeking behaviour among Nigerians is very critical. For example, some religious views argue against the use of certain vaccines. Even if they are available, the faithful of those religious groups may not accept their administration on them or their family members.

The responses further show that analysis of social factors cannot be done exclusively with idiosyncrasies. Some scholars cited earlier in the literature believe that society makes people what they are. For example, it may be assumed that people could not access healthcare services because they could not afford them, not because they decided to of their own volition without the influence of social factors¹¹. But this view can be contradicted by looking at it from the viewpoint of individuals who, because of their beliefs (religious belief), neglect the use of healthcare services. Some people believe that as a member of a particular religious group, one should not use drugs or visit healthcare providers. This emphasizes religious belief on a valid scale, as it can affect healthcare-seeking behaviour.

Findings from this research showed the importance of age and gender and how this affects health-seeking behaviour. The responses from some of the respondents authenticate the vitality of age in health-seeking behaviour. Advancement in age may come with certain physiological changes which can result in the frequent use of healthcare services. This calls for critical attention to the age factor of the Nigerian populace when deciding or formulating policy. Age is an important factor that dictates healthcare facility usage. With old age comes various chronic health conditions^{11,12}, some of which are disabling. Old people are vulnerable to various problems: heart conditions, rheumatism and arthritis, vision and hearing problems and numerous other maladies¹¹. The unpalatable conditions that come with old age make the elderly visit healthcare providers frequently compared to younger people. Gender is another factor which cannot be underrated in health-seeking behaviour.

Many adults who live in poverty, and even more of those who live just above the official government poverty line, are either unemployed or are in low-paying employment^{5,6}. Many of the slum dwellers, due to the unavailability of enough jobs for the working population, engage themselves with jobs in the informal sector⁵. The jobs often involve physical strength stressful and hazardous labour¹¹. Men and women holding low-wage jobs in agriculture, forestry, fishing, manufacturing, construction, transportation/utilities and wholesale and retail trade have high occupational injury rates¹¹. This alludes to the fact that resource access will determine health status and healthcare services utilization. In addition, many workers (particularly in manufacturing) are routinely exposed to toxic fumes and substances that can cause acute and chronic illnesses and diseases. This justifies the life-course argument. According the life-course perspective, daily experiences of people may impact on their health and well-being¹¹.

Female-headed households are more likely to be poor than male-headed or dual-headed households; single women raising families face serious problems affording and gaining access to health care ^{2,11,12,13}. Many low-income female-headed households are forced to rely on a government-sponsored healthcare program^{11,12}. Biases and shortcomings in the healthcare system treatment of women contribute to women's problems getting adequate care¹². According to the United States Department of Health and Human Services report, one-tenth of women aged 45-64 have some form of health disease. Heart disease is the number one cause of death among women and more women than men die from their heart attack¹².

Low-income/low-wage workers often lack the power to improve health and safety conditions in the workplace. Although unions and community groups have struggled successfully to end some of the most blatant abuses¹¹, much remains to be done. A tragic reminder of this involved chicken processing workers in North Carolina. Such work is stressful and injurious; chicken processing workers are three times more likely to be injured than other workers in North Carolina ¹¹. Common injuries include carpal tunnel syndrome, an extremely painful condition affecting the nerves of the wrists, which stems from repetitive work on the processing line¹¹. A fire at Imperial Food Products in Hamlet, North Carolina, in 1991 caused 25 deaths and injured 56 workers. As described in one press account, "With the raging, many workers died attempting to flee through emergency exits, which were chained shut supposedly because workers were stealing chickens. The dead left bloody footprints where they had desperately tried to beat down the doors"¹¹.

This kind of case happened in the Ikorodu Area of Lagos State between the years 2000/2001 in a foot-wear factory where many able-bodied young men were roasted because the Lebanese always locked up the workers in the middle of the night while

working. They locked them up to forestall stealing their products. But while protecting products, the lives of future leaders were wasted (personal observation). Despite such horrible stories and the struggles to end them, health and safety standards and provisions for their enforcement remain a problem in many developing towns and even in some states in the USA, particularly for non-unionized, low-wage workers¹².

Responses from the quantitative and qualitative results proved a strong link between a known sickness or disease and the health-seeking behaviour of the residents of slum settlements in the Lagos State metropolis. This has also been established in regional studies of the health-seeking behaviour of lower-income settlements in West Africa ^{5,6,13}. The p-value statistics computed on the influence of sicknesses on the utilization of healthcare services arrived at 0.000, which is less than 0.050. The regression coefficient stood at 0.568, demonstrating that health-seeking behaviour will increase for every increase in sickness. Responses from the qualitative section also support the validity of this hypothesis.

What can be inferred from the above explanation is a cursor of how the health needs of the people can influence health-seeking behaviour. Although the pattern between sickness and health-seeking behaviour is hypothetically strong, this is dangerous because people essentially use healthcare services when sick^{5,6}. A study of South Asian cities proved a similar direction between sickness and health-seeking behaviour¹³. This essentially further proved the validity of Maslow's hierarchy of needs hypothesis earlier discussed. In an unstable economy, people prefer to use the available income for essential needs such as food and shelter rather than going for medical check-ups to know the state of their health. Going to the hospital or seeking

a healthcare professional's services becomes unavoidable when a sickness or disease is discovered in the body.

Earlier questions have been raised by researchers on the factors causing a high level of informal healthcare services among urban slum dwellers^{5,6}. Based on the findings of this research, three themes appeared to be critical. The three factors which have been highlighted in this research are accessibility, availability, and affordability. Healthcare cost can affect its usage. Many Nigerians are living below the poverty line^{8,9}. This makes the usage of expensive service a privilege only few Nigerians enjoy. Accessibility and availability of healthcare services are also very critical, and these factors affect the utilization of healthcare services. Some of the facilities may be located in the affluent areas of the city⁸. This may discourage its essential usage due to poor transportation infrastructure. Even if some of the services are available, accessibility may be challenging because of cost, bureaucratic protocol, and level of users' level of education⁶.

Endnotes

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Chapter Five

Conclusion

5.1 Summary of Findings

The sociological analysis of health-seeking behaviour is vital to the scientific body of knowledge, but its peculiarity is also vital in health policy formulation and the orientation of the general populace regarding their well-being. This study focused on the socioeconomic factors affecting health-seeking behaviour in slum settlements of Lagos State metropolis, using the sociological lens as the scientific analysis tool. The research laid the background of the study where vital concepts such as health, sickness, disease, illness, poverty, socioeconomic factors, and slum settlements were clarified.

Chapter two of the research focused on three dimensions of scientific explanations within a single chapter. The dimensions were conceptual analysis, theoretical analysis, and empirical analysis of the health-seeking behaviour of the Lagos State metropolis slum settlements residents. Important socioeconomic variables such as household income, age, gender, education, religion, employment status, and the state of an individual's health were given detailed, attentive analysis. Due to the researcher's recognition of the impact of globalization on Nigerian society (Lagos State), scientific attention was given to the discourse of Nigeria within the global space and how attachment affects the health-seeking behaviour of Nigerians. To look critically at the factors that affect the utilization of healthcare services, an extensive literature review was undertaken from both the local and international perspectives. This ensured that our horizons, as sociologists, are not limited to our local environment alone but also global scientific inquiries. The research reviewed relevant theories and concepts that explained the health-seeking behaviour of people in the low-and-medium income countries. Among these theories

and models are functionalist theory, conflict theory, and Kroeger's theory of health-seeking behaviour. Anderson's conceptual model of health-seeking behaviour was also analysed in this report.

Chapter three of the research laid a solid background for the step-by-step processes through which the research was conducted. This chapter explained essential methodology components such as study location, population, sampling size, sampling frame, sampling selection formula and processes, and data analysis method. The research used the mixed method and multi-dimensional path in data collection and analysis. This rigorous approach enhanced and supported the reliability and validity of the findings of this advanced sociological research. To avoid breaching ethical rules, respondents for this study were residents of the slum settlements who were eighteen (18) years and above and gave consent to be interviewed.

In chapter four, quantitative and qualitative data collected during this research exercise were presented logically and scientifically. For logical clarity, the chapter was separated into four aspects. The first aspect presents the frequency data (univariate) analysis; the second aspect is based on the research results, while the third aspect of the report presents analysis on the test of the hypotheses for the study. The last part of the chapter focused on discussing the research findings. Statistical Package for Social Scientists (SPSS) and R quantitative analysis software were used to analyse quantitative data collected during this research. Statistical Package for Social Scientists was used to analyse the frequency data, while the correlation and regression data were analysed using R quantitative software. This software computed and analysed the p-value and coefficient statistics of the variables of interest as important to this study. Analysing the qualitative data also took a bi-dimensional approach as thematic and content analysis methods were used to draw

necessary information from the respondents' comments. The discussion section of chapter four shows a scientific synthesis of the findings in this research and proves from existing studies. The researcher was able to juxtapose the dimension of the socioeconomic factors on the health-seeking behaviour of slum dwellers in the Lagos State metropolis. Gaps discovered in earlier research were analysed within this chapter.

5.2 Conclusion

This research concludes by emphasising that the government of Nigeria and leadership of international organizations working within the Nigeria socio-geographical space must take cognizance of the role of socioeconomic factors in health-seeking behaviour. While earlier studies could not establish a direct linear relationship between age and health-seeking behaviour, the qualitative finding in this research showed that the physiological makeup of humans changes due to advancements in age. For this reason, the elderly and children may require access to healthcare facilities due to their health needs. This further supports the earlier argument that the ages of people may impact their health-seeking behaviour.

Due to different physiological make-ups of men and women, women and girls in the slum settlements in the Lagos State metropolis were found to more frequently utilize healthcare services compared to men in the slum settlements. The findings of this research further expanded that natural order, such as the period of postnatal and antenatal, is critical for both mothers and their children. This further explained the frequent usage of healthcare services by women in the slum settlements of the Lagos State metropolis compared to men within the same settlements. This emphasizes the importance of gender in health-seeking behaviour.

The role of employment has been established in this research. Some respondents admitted not using healthcare services regularly because of the nature of their employment, which may not give room for such. One of the respondents, a formal healthcare practitioner, explained that employment type is very significant to healthcare services utilization. To him, those with viable employment in the community, with the health insurance package as part of their employment benefits, utilize the healthcare services properly and when needed. Those without such employment opportunities only come when sick or in an emergency. This underscores the importance of the employment status of the slum settlement residents in health-seeking behaviour. Related to employment status, this study corroborates that household income is significantly related to health seeking-behaviour. Income affects the type of healthcare services an individual utilizes and the frequency of health facility usage. This shows that the personal and household (disposable) income of the residents of slum settlements affect their health-seeking behaviour.

Religion is an institution that influences other agents of socialization, such as family and culture. Religion's influence on family and upbringing cannot be neglected in this research's analysis of health-seeking behaviour. From the responses, some of the respondents claimed they utilized the type of healthcare they used because of their upbringing and their beliefs. Those responses showed the vitality of parenting and religion in health-seeking behaviour.

Education is critical, and knowledge is power. Education creates room for upward mobility and access to information. Slum settlement residents who are educated have better access and opportunity to health information that may significantly affect their well-being and healthcare services utilization. The

regression coefficient for the relationship between education and health-seeking behaviour indicates that for every increase in the number of educated people in the slum settlement, health-seeking behaviour increases. The qualitative responses further support the validity of educational attainment on the health-seeking behaviour of the residents of slum settlements in the Lagos State metropolis.

The most potent factor affecting health-seeking behaviour (utilization of healthcare services) is the presence of known sicknesses and diseases. All the respondents from all the locations of this research confirmed that most residents come for medical services when they are sick or have an injury that requires urgent medical attention. This further suggests the instability of the Nigerian economy, which has made less income available to the people; therefore, the available income must only be used on essentials. Without sickness or disease, the funds available will be used for other essentials such as food and shelter.

This research addressed critical questions which have been asked by earlier research on the factors responsible for a high level of informal healthcare services patronage among urban slum dwellers. Availability, accessibility, and affordability were discovered from the findings of this research as critical factors responsible for informal healthcare services utilization among the urban slum dwellers.

5.3 Recommendations

Based on these research findings, the government of Nigeria at all levels must consider the impact of socioeconomic factors when making decisions on health policy development or programme implementation. This study has argued that one of the problems associated with utilising healthcare services in Nigeria is linked to employment opportunities. To ameliorate this quagmire, the government of Nigeria

must create employment opportunities for Nigeria, and support those with entrepreneurship skills with necessary resources.

Furthermore, the research discovered that the capitalistic orientation that is shaping the healthcare sector in Nigeria is negatively impacting on the health-seeking behaviour, and the healthcare services utilization among the residents of slum dwellers. To alleviate the problems, the Nigerian government must ensure that socialistic tenets guide the provision of healthcare services. This is by ensuring that healthcare services are offered to Nigerians based on their health needs, and not based on their capacity to pay for the healthcare services.

From the qualitative findings, it was revealed that Nigerians in the slum settlements utilized the informal healthcare services more on the basis of availability, accessibility, and affordability. Most of the slum settlements lack adequate government funded healthcare services, and the private healthcare facilities that are available are sometimes out-of-reach for the poor. This warranted informal and unstructured healthcare facilities with unguaranteed healthcare services quality. This research therefore recommend provision of more healthcare facilities in the slum settlements. And for easy accessibility of the poor class, this research recommends government support and subsidization of healthcare services in the private sector to allow their easy utilization by the majority of Nigerians who reside in the informal and slum settlements. Nigeria should have a welfare programme for its citizens and prioritise health care delivery especially for the less privileged.

Income was one of the major determinants of healthcare services utilization as revealed in the qualitative findings of this research. Therefore, this research recommends that the government of Nigeria should put a policy in place that can

encourage those who are not financially capable to access healthcare services. For example, in the United Kingdom, the National Health Services (NHS) cater for health needs irrespective of their financial status.

The research discovered those in formal employment utilized formal and structure healthcare services more than those without formal and structure employment. The findings showed that this happened because of the benefit of health insurance policy that allowed those in the formal sector have access to structured healthcare services. Since many Nigerians in the slum settlements work in the informal sector or self-employed, this research therefore recommends that health insurance in Nigeria should be extended to cover those in the informal sector, where the majority of the slum dwellers in the Lagos State metropolis work.

This study found that the presence of a known sickness or disease as the most potent reason Nigerians use healthcare services. This should be corrected. This research, therefore, recommends that public medical orientation on the utilization of healthcare services should be given to Nigerians. Healthcare services should not be essentially used when there is a sickness, but there is a need for medical check-ups for people to maintain good health and avoid health emergencies which may result from the late discovery of health problems.

One of the profound findings of this research is the factors associated to high level of informal healthcare services usage among urban slum dwellers. This gap has been mentioned but not covered in earlier research. Availability, accessibility, and affordability of informal healthcare services has been the pull factors responsible for its high usage among urban slum dwellers. This research therefore recommends that the government of Nigeria at all levels ensure that healthcare facilities are available,

accessible, and affordable to Nigerians irrespective of their socioeconomic backgrounds.

As shown in the findings of this research, educational attainment played a significant role in the health-seeking behaviour of the slum dwellers in the Lagos State metropolis. Therefore, this research recommends formulating national, state, and local policies to make education available to all. This recommendation is very critical as it is revealed in this research that education is among the socioeconomic factors with a strong predictive model for health-seeking behaviour.

Lastly, as discovered in the qualitative findings of this research, many of the slum settlements in the Lagos State metropolis lacked adequate healthcare facilities. Where they are available, they are under-staffed and ill-equipped. It is therefore recommended that the government of Nigeria and Lagos State government as the host state of this research should pay more attention to the healthcare facilities development in the slum settlements for the purpose of supporting the health and well-being of Lagosians and Nigerians.

5.4 Contribution to Knowledge

This study on the socioeconomic factors affecting the health-seeking behaviour of slum dwellers in Lagos State metropolis presents a significant analysis of a population that often experiences enhanced vulnerability in accessing healthcare services. As a solid contribution to the body of knowledge in sociology (specifically sociology of health), the study contributed to, and extended the frontier of knowledge in the analysis of health-seeking behaviour. The study provided a deep local understanding of the complex relationship between socioeconomic factors and health-seeking behaviour. With its diverse urban landscape, Lagos State provides a unique environment to study the impact of socio-economic factors, hence the choice

of slum settlements within the Lagos State metropolis as the base for this research. Being one of Africa's most populous States, the state of Lagos provides a valid basis for exploring the impact of urbanization on health-seeking behaviour. Through the foreground of the prevailing socio-economic factors of slum dwellers, the study gives a complete picture of the health-seeking behaviour of slum dwellers. One of the study's most important contributions is its ability to point at policy lacuna, which has led to the negligence of the poor section of the Nigerian geographical space, among which are the slum communities in Lagos State. This gap addressed the systemic challenges that slum dwellers face in seeking health services, such as infrastructure inadequacy and lack of economic empowerment.

Analyses presented in this report are relevant beyond the sociological field as the researcher took a holistic and interdisciplinary measure to analyse health-seeking behaviour among slum dwellers in the Lagos State metropolis. It is recognized that many disciplines influence socioeconomic factors and health-seeking behaviour. Using an interdisciplinary approach, this research drew from sociology, economics, public health, economics, and urban planning, among others, to comprehensively understand the subject. The research aligns with the UN's Sustainable Development Goals (SDGs), particularly Goal 3 (Good Health and Well-being) and Goal 10 (Reducing Inequalities).

Despite their detailed analysis, earlier research could not cover the reasons for Nigeria's high usage of informal healthcare services. Among others, this research found that Nigerians utilized informal healthcare services more based on factors such as availability, accessibility, and affordability. Many respondents claimed that informal healthcare providers' services are cheaper, and they can easily access them in the community compared to formal healthcare services that may be miles away

from the healthcare users. Where they are available, they are expensive, and the workers are not friendly¹⁰. This critical gap enhances the utilization of informal healthcare services compared to formal healthcare services. This is a further improvement and coverage of gaps in earlier research.

5.5 Suggested Area for Further Research

This research confirmed that the most potent reason for the utilization of healthcare services by the residents of slum settlements in the Lagos State metropolis is the presence of known sicknesses and diseases, this can be further researched. This research also covered an essential gap in knowledge which highlighted factors responsible for the high level of informal healthcare services patronage among urban slum dwellers. Availability, accessibility, and affordability of health services were major factors found in this research as the factors leading to urban slum dwellers to the utilization of healthcare services. The study also discovered that although education is expected to have a positive relationship with the utilization of healthcare services, the areas of healthcare services covered in this research showed that the more educated in the slum settlements have lesser usage of the available facilities within the slum settlements. This may mean that the more educated utilised other forms of healthcare services, for example, internet or tele-medicine which was not covered in this research. Future research should investigate how different diseases or sicknesses can warrant the frequency of healthcare services usage among slum dwellers in Nigeria. Also, future research should look at the utilization of other forms of healthcare services such as tele-medicine, home-care healthcare services, and other forms of healthcare services that were not covered by this research.

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Appendices



Department of Sociology
Faculty of Social and Management Sciences
Lead City University, Ibadan, Oyo State

Questionnaire

Dear Respondent,

I am Michael Olusegun Demehin- a PhD student in the Department of Sociology, at Lead City University, Ibadan, Oyo State, Nigeria. I am currently conducting a study on **“Socioeconomic Factors and Health Seeking Behaviour of Slum Dwellers in Lagos Metropolis”**.

The responses from you are solely required for academic purposes, and your identity shall not be revealed. The responses shall be treated with the utmost confidentiality.

Kindly respond appropriately and truthfully as the information supplied by you will be used to respond to the objectives of this study.

Thank you for your time.

Michael Olusegun Demehin

mike4win2007@gmail.com

Section A: Socio-Economic Characteristics

Please tick [√] the option that best describes you.

1. Gender: Male [1] Female [2]
2. Age: 18 - 35 [1] 36 – 55 years [2] 56 years and above [3]
3. Educational Attainment: None [1] Below SSCE/Secondary School [2] SSCE/Secondary School [3] Tertiary [4]
4. Ethnic Background: [1] Yoruba [2] Ibo/Igbo [3] Hausa [4] Other Tribes from Nigeria [5] Foreigners from other African countries
5. Employment Status: [1] Not Employed [2] Employed [3] Self-Employed/Trading/Business
6. Marital Status: [1] Single [2] Married [3] Single Parent [4] Divorced/Separated [5] Widow.
7. How many people live in your household? [1] Below 3 [2] Between 4 and 6 [3] 7 and above
8. What is your religious affiliation? None [1] Christianity [2] Islam [3] Traditional Worshiper [4] Others, specify
9. Can you categorize your monthly income? [1] N50,000 and less [1] 51,000 – N100,000 [3] N101,000 – N150,000 [4] N151,000 and above
10. Can you estimate your daily spending? [1] Below N1,700 (\$2.15) [2] Above N1,700 (\$2.15).
11. What sector of the Nigerian economy do you work in? [1] Informal sector [2] Formal sector [3] Not currently working in any sector.
12. What do you do currently in terms of your daily activities? [1] I am a mother and I take care of the children [2] I am a student [3] I am currently learning a trade [4] I am working [5] I am looking for a job.

SECTION B: Accessed Healthcare Services and Types of Healthcare Accessed s

SN	Questions	Responses	Code
13.	Have you utilized healthcare services in the last 12 months?	Yes No	1 2
14.	What type of healthcare service did you utilize	Formal healthcare e.g hospital, clinic, health centre Informal healthcare e.g herbal centre, traditional healing service or spiritual centre I have used both	1 2 3
15	Which do you prefer traditional healthcare services or hospital care?	Traditional/Spiritual Care Services Hospital or clinical care None Both	1 2 3 4

16	What made you utilize the healthcare service you utilized?	Because of my traditional/cultural and spiritual beliefs. Because that is what is available around me. That is the care service I was introduced to, and I have been using it. That is what I can afford.	1 2 3 4
17	Have you experienced any sickness in the last twelve (12) months	Yes No	1 2
18	Do you have a sickness/disease that requires medication from time to time?	Yes No	1 2
19	Have you been diagnosed with any disease in the last 12 months e.g. high blood pressure, tuberculosis, malaria, diabetes?	Yes No	1 2
20	If yes, which one of these	High blood pressure Tuberculosis Malaria Diabetes Others, specify	1 2 3 4 5
21	What type of health do you think is wanted in this community	Hospital/Clinic/Health Centre Traditional/Spiritual Care Both None	1 2 3 4
22	Do you have enough of this wanted health facility in this community	Yes No	1 2
23	If this health facility is created in this community, will it make more people to use healthcare services?	Yes No	1 2
24	What is the greatest reason you may not use a healthcare service	The cost of the service My belief and tradition Distance of the healthcare service The attitude of the healthcare workers Others, specify	1 2 3 4 5
25	How well do you utilize healthcare services	Every month Only when there is a need. For a scheduled medical check-up Not frequently	1 2 3 4
26	Does your work require you to utilize medical services when you need to?	Yes No	1 2



Department of Sociology
Faculty of Social and Management Sciences
Lead City University, Ibadan, Oyo State

In-depth Interview Guide

Dear Respondent,

I am Michael Olusegun Demehin- a PhD student in the Department of Sociology, at Lead City University, Ibadan, Oyo State, Nigeria. I am currently conducting a study on **“Population Growth and the Emergence of Slum Settlements in Nigeria”**.

The responses from you are solely required for academic purposes, and your identity shall not be revealed. The responses shall be treated with the utmost confidentiality.

Kindly respond appropriately and truthfully as the information supplied by you will be used to respond to the objectives of this study.

Thank you for your time.

Michael Olusegun Demehin
mike4win2007@gmail.com

1. What type of healthcare service do you utilize?
2. What type of healthcare services do people in this settlement use?
3. Do you utilize healthcare services within the community or you go to the city centres to use healthcare services?
4. What is/are the factor(s) that usually lead to the utilization of healthcare services among the people in this community?
5. Is it just for medical check-ups or because there is a health need e.g. sickness/disease?
6. How frequently do you/people utilize healthcare services?
7. What are the factors that determine the use of a particular healthcare service among the following factors (age, gender, income, education, culture, employment status)?
8. Can you expatiate how these factors you have mentioned impact healthcare services utilization in this community?
9. What type of healthcare do you/people prefer to you in this neighbourhood?
10. Why is the choice for the utilization of this type of healthcare service?
11. Do you have any other comment or personal view on factors that can impact the utilization of healthcare services?

Pictorial Analysis of the Slum Settlements in the Lagos State Metropolis. These pictures were taken during the fieldwork in Amukoko, Ijora-Badia, Bariga, and Makoko in Lagos State.

A pictorial view of one of the formal health care services in one of the slum settlements in Lagos State that was studied in this research.



Picture of a variety store in one of the slum settlements in Lagos State metropolis area.



A typical site of the slum settlements in one of the slums studied during this research.



A pictorial view of slum settlement in the Lagos State metropolis. This shows an unhealthy setting. Yet, people work and live there.



Lead City University

Site of one of the formal healthcare centres in one of the slums studied during this research.



Another formal healthcare centre in the slums studied in this research



Lead City University

Picture of the advanced or more organized area in the slum settlements



Picture of the advanced or more organized area in the slum settlements with an unhealth drainage system



A view of possibly an organized area in the slum that has deteriorated due to gentrification



A typical view of slum areas in the Lagos State metropolis



A typical view of slum areas in the Lagos State metropolis (Con'd)



A typical view of slum areas in the Lagos State metropolis (Con'd)



A typical view of slum areas in the Lagos State metropolis and the drainage system



Picture of one of the facilities in the slum area



A typical slum area road in Lagos State



A view of a centre that also engaged in free medical services in one of the slums









Road and environmental apperances in some of the slum areas in the Lagos State metropolis



A typical view of a slum area frontage view in the Lagos State metropolis



A typical view of a slum area frontage view in the Lagos State metropolis (Con'd)



A back view of a government facility in the slum area in the Lagos State metropolis



Presentation of daily life in the slum settlements



A surrounding of healthcare facility with an abandoned health facility Toyota Hiace bus





Environmental appearances and roads in the slum settlements in Lagos State, Nigeria



Environmental appearances and roads in the slum settlements in Lagos State, Nigeria (Cont'd)



Environmental appearances and roads in the slum settlements in Lagos State, Nigeria (Cont'd)



Environmental appearances and roads in the slum settlements in Lagos State, Nigeria (Cont'd)



Environmental appearances and roads in the slum settlements in Lagos State, Nigeria (Cont'd)



Environmental appearances and roads in the slum settlements in Lagos State, Nigeria (Cont'd)



Environmental appearances and roads in the slum settlements in Lagos State, Nigeria (Cont'd)



Environmental appearances and roads in the slum settlements in Lagos State, Nigeria (Cont'd)



Environmental appearances and roads in the slum settlements in Lagos State, Nigeria (Cont'd)



Daily life in the slum settlements in Lagos State



Daily life in the slum settlements in Lagos State (Con'd)



Frontage of a government facilities in two of the slum settlements of Lagos State



Side view and frontage of a government facilities in two of the slum settlements of Lagos State



Appearance of a life of survival of the fittest in the slum settlement



Daily life in the slum settlements in Lagos State (Con'd)



Market areas in the slums of Lagos State



Back view of a government facility



Views of the slum areas



Views of the slum areas (Con'd)



Views of the slum areas (Con'd)



Views of the slum areas (Con'd)



Views of the slum areas (Con'd)



Views of the slum areas (Con'd)



Views of the slum areas (Con'd)



Bio-data

A. Personal Data

1. Full Name: Michael Olusegun **DEMEHIN**
(2/4, Owoeye Close, Lambe, via Akute, Ogun State/ mike4win2007@gmail.com / +234 8163132346).
2. Date and Place of Birth: 12th February 1981/ Ajegunle, Ikorodu Road, Lagos State.
3. Nationality: Nigerian.
4. Marital Status: Married.

B. Educational Institutions Attended with Dates and Qualifications:

- i. Primary Education:
Anglican Primary School, Ajegunle Ikorodu Road, Lagos State, 1993, Primary School Leaving Certificate.
- ii. Secondary Education:
Pakoto High School, Ayede Ifo, Ogun State, 2002, Senior Secondary School Certificate.
- iii. Higher Educational Institutions Attended with Dates and Qualifications:
Lead City University, Ibadan, Oyo State 2021-2024 PhD in view Sociology.
University of Lagos, Lagos State 2011-2013 M.Sc. Sociology
University of Lagos, Lagos State 2006-2009 B.Sc. Sociology
University of Lagos, Lagos State 2004-2006 Diploma in Social Development & Administration.

C. Work Experience with Dates:

- i. Senior Lecturer and Course Coordinator (Health and Well-being), London School of Science and Technology, Birmingham, United Kingdom 2022-date.
- ii. Director of Research and Administration, Forthward Development Foundation (Part of G-Thoms Group), 2015-2021.
- iii. Group Director, G-Thoms Consultancy Services Limited, 2015-2021.

D. Awards and Fellowships

Postgraduate Trainee, Consortium for Advanced Research Training in Africa (CARTA) Workshop on Social Science Research Methodology for Postgraduate Students. The Faculty of the Social Sciences Seminar Room, University of Ibadan, Nigeria. (19-21st June 2017).

E. Membership of Academic Professional Bodies:

- i. Higher Education Academy, United Kingdom.
- ii. American Sociological Association, United States.
- iii. Institute of Management Consultants of Nigeria.

F. Research and Publications:

1. Thesis/Dissertation

Demehin, M. O. Socioeconomic Characteristics and Health-Seeking Behaviour of Residents of Slum Settlements in Lagos State Metropolis, Lead City University, Ibadan, Oyo State, Nigeria [PhD Thesis in view], 2024.

2. Research Papers Under Publication Consideration with Sage:

Demehin, M. O and Isiugo-Abanihe, U.C. "Only When It Is Essential": An Empirical Study of the Essential Determinant of Healthcare Services Utilization in Some Urban Slum Settlements in (Lagos State) South-west Nigeria, 2024. Paper still under consideration with Sage Journals.

Demehin, M. O and Isiugo-Abanihe, U.C. Socioeconomic Correlates of the Effects of Educational Attainment on Health-Seeking Behaviour of Urban Slum Dwellers in Nigeria: An Insight from the Lagos State Metropolis in Nigeria, 2024. Paper still under consideration with Sage Journals.

Demehin, M. O and Isiugo-Abanihe, U.C. Employment Situations and Intervening (Intrinsic and Extrinsic) Variables Affecting Health-seeking Behaviour: An Empirical Study of the Urban Slum Dwellers in Lagos State, Nigeria, 2024. Paper still under consideration with Sage Journals.

3. Published Works:

Michael Olusegun Demehin, Saheed Adekunle Raji & Modupe Ala, 2024: Unveiling the multifaceted dimensions: a sociological inquiry into kidnapping in Nigeria. *Crime Law Soc Change* (2024). <https://doi.org/10.1007/s10611-024-10159-5>.

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Aremu Femi and **Demehin Michael**, 2013: Youths for Sustainable Development in Nigeria. Lagos, Nigeria: Kings and Queen Publications.

Idedia Lucky and **Demehin Michael**, 2006: Beyond Limits. Lagos, Nigeria: Michodey Nigeria Publications.

4. Unpublished Research Works:

Demehin, Michael Olusegun, 2013: Socioeconomic Factors and Women's Involvement in Political Activities in Nigeria. Lagos: Department of Sociology, University of Lagos, Nigeria (M.Sc. Thesis Unpublished).

Demehin, Michael Olusegun, 2009: Disposable Income as a Determinant of Health Care Services Utilization in Nigeria. Lagos: Department of Sociology, University of Lagos, Nigeria (B.Sc. Research Project Unpublished).

Demehin, Michael Olusegun, 2006: An Assessment of Social Welfare Homes and Systems in Nigeria. Lagos: Department of Sociology, University of Lagos, Nigeria (Diploma Research Project Unpublished).

G. Major Conferences Attended with Dates:

Exploring the Impact of Formative Feedback in Higher Education: A Socio-Empirical Analysis using the Sociological Framework of Latent and Manifest Functions. Bridging the Gap: Embracing Diversity in Higher Education in Higher Education Teaching and Learning, London, United Kingdom, 2023.

Reinventing Fieldwork Placement in Social Care Education In The Covid-19 Era: A Necessity Towards Blending Theory With Practice, Defining Pedagogy and Andragogy for Inclusion and Widening Participation, Birmingham, United Kingdom, 2022.

H. References

Professor Uche C. Isiugbo-Abanihe

Department of Sociology
Lead City University
Ibadan, Oyo State
Tel: +234 08037135054
Email: ucheabanihe@yahoo.com

Professor Lekan Oyefara

Department of Sociology
University of Lagos
Akoka, Lagos State.
Tel: +234 07033912171
Email: oyefara@yahoo.com

Noorin Tasnim Chowdhury

Department of Health and Social Sciences
London School of Science and Technology
Aston Campus, United Kingdom.
Tel: +44 (01) 21 643 6774 Ext: 228
Email: noorin.chowdhury@lsst.ac

Signature

Date

The University Compliance Certification

This is to certify that the thesis by Michael Olusegun DEMEHIN with matric no LCU/PG/002323 in the Department of Sociology, Faculty of Management and Social Sciences. Lead City University, Ibadan is in full compliance with the approved University format and style.

Signature

Date

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