

Chapter One

Introduction

1.1 Background to the study

Education is a basic human right and a key driver of human development, social progress, and economic growth. Despite this fact, a significant number of girls in Nigeria are out of school, particularly those residing in urban slums¹. The quality of life and psychological health of individuals are major indicators of a society's well-being. In developing countries like Nigeria, urban slums are often home to marginalized populations who face multiple sources of stress and hardship¹. Out-of-school adolescent's girl and young women in these areas are particularly vulnerable, as they face significant barriers to accessing basic services and opportunities for personal and professional growth. The experiences of these girls can have a lasting impact on their mental and physical health, their future opportunities, and their ability to contribute to their communities.

The issue of out-of-school adolescent's girl and young women in urban slums is a global concern with serious implications for the achievement of the United Nations Sustainable Development Goals (SDGs). According to the Global Education Monitoring Report by UNESCO, an estimated 130 million girls around the world are out of school, with the majority of them living in sub-Saharan Africa and South Asia². Poverty, gender discrimination, early marriage, and lack of safe transportation are some of the key factors that contribute to girls' dropout from school in these regions². The consequences of being out of school are severe and multi-faceted, including limited access to employment opportunities, increased vulnerability to poverty and exploitation, and compromised physical and mental health³.

In West Africa, including Nigeria, urban slums are characterized by overcrowded living conditions, inadequate access to basic amenities such as clean water and sanitation, and limited educational opportunities⁴. Rapid urbanization, population growth, and inadequate infrastructure have led to the proliferation of slums in many urban areas, including Ibadan Metropolis, the capital of Oyo State in Nigeria⁵. Ibadan Metropolis is a regional center that reflects similar challenges faced by other urban slums in the region, where out-of-school girls are disproportionately affected by poverty, gender discrimination, and limited access to education and healthcare services.

Ibadan Metropolis, with a population of over 3 million people, is characterized by stark inequalities in access to education and healthcare, with urban slums being the most affected⁵. Many families in these slums struggle with poverty, inadequate housing, and limited access to basic amenities, including education. Out-of-school adolescent's girl and young women in these slums face multiple challenges, including poverty, early marriage, domestic chores, and lack of safe transportation, which prevent them from attending school⁵. Moreover, the lack of psychosocial support services and limited access to mental healthcare exacerbate the mental health challenges faced by these girls, leading to long-term consequences on their overall well-being.

The lack of educational opportunities for out-of-school girls in urban slums is a major concern, as education is widely recognized as a key driver of socio-economic development and a path to improving individual and collective well-being. Education provides individuals with the skills and knowledge needed to participate in the workforce and to contribute to their communities. It also enhances their personal and professional prospects, providing a foundation for lifelong

learning and development. For out-of-school girls in urban slums, however, access to education is often limited by poverty, social norms, and inadequate infrastructure. Their living condition, income and decision making in life has been shown through several studies to be related to their educational level⁶. Though there are many studies among out of school girl and women in the slum, none has considered their quality of life and mental health based on the difficulties they are frequently exposed to in daily living⁷.

In addition to the lack of educational opportunities, out-of-school girls in urban slums in Nigeria often face other barriers to their health and well-being. These may include limited access to healthcare, exposure to environmental hazards, and exposure to violence and exploitation. These challenges can impact their physical and mental health, contributing to the development of mental health problems such as depression, anxiety, and post-traumatic stress disorder (PTSD)⁸.

The impact of poverty on the quality of life and mental health of individuals has been well documented in the literature. Individuals who live in poverty are more likely to experience negative outcomes related to physical health, mental health, and social well-being⁷. According to the World Health Organization (WHO), poverty is a "powerful determinant of health," and individuals who live in poverty are more likely to experience "chronic illness, lower life expectancy, and higher rates of infant and child mortality⁹." In addition, poverty is associated with increased rates of depression, anxiety, and other mental health problems.

Out-of-school girls face numerous challenges in accessing education and other opportunities that can improve their quality of life^{10,11}. Lack of education can limit their ability to find employment, maintain good health, and participate in community life. Additionally, girls who are not in school may be at greater risk of experiencing mental health problems, such as depression and anxiety¹¹.

Against this backdrop, this study aims to identify the factors that contribute to the quality of life and psychological health of out-of-school girls living in urban slums in Ibadan metropolis, Southwest, Nigeria. The findings of the study can inform interventions that can improve the well-being of these girls and promote their social and economic empowerment. Understanding the challenges faced by out-of-school girls in urban slums is crucial to addressing the broader issues of poverty and social exclusion in these areas.

1.2 Statement of the Problem

Out-of-school adolescent girls and young women in urban slums in Ibadan Metropolis, Southwest Nigeria, face multiple challenges related to poverty, lack of access to basic services, and limited opportunities for education and personal growth. These challenges can negatively impact their quality of life and psychological health, leading to increased rates of depression, anxiety, and other mental health problems. Despite the significance of these issues, there is limited research on the quality of life and psychological health of out-of-school girls in urban slums in Ibadan, and little is known about the specific socio-economic, cultural, and environmental factors that contribute to their hardship.

Given the importance of addressing the well-being of out-of-school girls in urban slums, it is essential to understand the challenges they face and the factors that contribute to their hardship. This information is critical for the development of effective interventions aimed at improving the well-being of these girls and promoting gender equality and social justice. The purpose of this study is to examine the quality of life and psychological health of Out-of-school adolescent's girl

and young women in urban slums in Ibadan Metropolis, with the aim of identifying the challenges they face and the socio-economic, cultural, and environmental factors that contribute to their hardship.

1.3 Justification of the Study

Out-of-school young women in these areas face significant challenges related to poverty, lack of access to basic services, and limited opportunities for personal and professional development, which can have negative impacts on their well-being. Despite the significance of these issues, there is limited research on the quality of life and psychological health of out-of-school girls in urban slums in Ibadan, and little is known about the specific socio-economic, cultural, and environmental factors that contribute to their hardship.

This study will provide a comprehensive understanding of the challenges faced by out-of-school girls in urban slums in Ibadan, and the factors that contribute to their hardship. The findings of this study will be used to inform the development of interventions aimed at improving the well-being of these girls, promoting gender equality, and advancing social justice. The study will also contribute to the broader body of knowledge on the quality of life and psychological health of vulnerable populations, and will help to inform future research in this area.

In addition, this study is justified because it has the potential to make a real and lasting impact on the lives of out-of-school girls in urban slums in Ibadan. By identifying the specific challenges these girls face and the factors that contribute to their hardship, this study will help to inform the

development of targeted and effective interventions aimed at improving their well-being and promoting gender equality and social justice.

1.4 Aim and Objectives of the Study:

Aim:

The study aimed assess the quality of life and psychological health of out-of-school adolescent girls and young women in urban slums in Ibadan metropolis, Southwest, Nigeria.

Specific Objectives are to:

1. examine the demographics of the out-of-school adolescent girls and young women in urban slums in Ibadan metropolis
2. assess the Quality of life (QoL) of out-of-school adolescent girls and young women in urban slums in Ibadan metropolis
3. determine the psychological health of out-of-school adolescent girls and young women in urban slums in Ibadan metropolis
4. identify factors associated with QoL among out-of-school adolescent girls and young women in urban slums in Ibadan metropolis
5. identify factors associated with psychological health among out-of-school adolescent girls and young women in urban slums in Ibadan metropolis

1.5 Research Questions:

1. What is the demographics of the out-of-school adolescent girls and young women in urban slums in Ibadan metropolis?
2. What is the Quality of life (QoL) of out-of-school adolescent girls and young women in urban slums in Ibadan metropolis?
3. What is the psychological health of out-of-school adolescent girls and young women in urban slums in Ibadan metropolis?
4. What are the factors associated with QoL among out-of-school adolescent girls and young women in urban slums in Ibadan metropolis?
5. What are the factors associated with psychological health among out-of-school adolescent girls and young women in urban slums in Ibadan metropolis?

1.6 Significance of the Study

This study contribute to our understanding of the challenges faced by this vulnerable population and the factors that contribute to their hardship. It will also help to identify gaps in our knowledge and inform the development of interventions aimed at improving the well-being of these girls and promoting gender equality and social justice.

Out-of-school adolescent's girl and young women in urban slums face significant challenges related to poverty, lack of access to basic services, and limited opportunities for personal and professional development. These challenges can negatively impact their quality of life and

psychological health, leading to increased rates of depression, anxiety, and other mental health problems. By examining the quality of life and psychological health of these girls, this study will help to shed light on the challenges they face and the factors that contribute to their hardship. The findings of this study will be used to inform the development of targeted and effective interventions aimed at improving the well-being of these girls and promoting gender equality and social justice.

Gender equality and social justice are critical for ensuring that all individuals have equal opportunities to reach their full potential and lead fulfilling lives. Out-of-school adolescent's girl and young women in urban slums face significant barriers to achieving these goals, and this study will help to shed light on these barriers and inform the development of interventions aimed at promoting gender equality and social justice. The findings of this study will be of interest to a wide range of stakeholders, including policy makers, practitioners, researchers, and community organizations, and will help to raise awareness and promote action on this important issue.

Out-of-school girls in urban slums are a vulnerable population that faces significant challenges related to poverty, lack of access to basic services, and limited opportunities for personal and professional development. By examining the quality of life and psychological health of these girls, this study will help to shed light on the challenges they face and inform the development of interventions aimed at improving their well-being. The findings of this study will be of interest to a wide range of stakeholders, including policy makers, practitioners, researchers, and community organizations, and will help to raise awareness and promote action on this important issue.

This study contributes to the broader body of knowledge on the quality of life and psychological health of vulnerable populations, and will help to inform future research in this area. The

findings of this study will be of interest to a wide range of stakeholders, including policy makers, practitioners, researchers, and community organizations, and will help to raise awareness and promote action on this important issue.

1.7 Scope of the Study

The scope of the study was limited to the urban slums in Ibadan Metropolis and does not extend to rural areas or other cities in Nigeria. The study will also be limited to out-of-school adolescent girls and young women aged 15-24 years and did not include other populations, such as boys or adult women.

1.8 Limitation of the Study

This study focused only on out school adolescent's girl and young women. So, the result cannot be generalized among all out of school persons. The cross-sectional design limits the establishment of causal relationships, while potential sampling bias and reliance on self-reported data may impact the generalizability and accuracy of findings. Cultural nuances was not be fully captured, introducing the possibility of misinterpretation. External variables beyond the study's control, such as economic conditions or family dynamics, may influence outcomes. Privacy concerns and the sensitive nature of mental health could lead to underreporting, and the absence of a comparison group and resource constraints may limit the study's depth and comprehensiveness.

1.9 Operational Definitions of Terms

1. Quality of Life: individual's overall sense of well-being, including physical health, emotional stability, social support, and access to basic necessities and opportunities.
2. Psychological Health: individual's overall psychological well-being, including their level of stress, anxiety, and depression, hopelessness and general health and their ability to cope with life's challenges.
3. Out-of-school adolescent's girl and young women: girls aged 15-24 years who are not currently attending school and are living in urban slums in Ibadan Metropolis.
4. Urban Slums: densely populated areas in Ibadan Metropolis that lack basic infrastructure and services, such as clean water and sanitation, and where residents live in poverty.

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Endnotes

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Chapter Two

Literature Review

2.1 Conceptual Review

2.1.1 Slums

The concept of slums and its definition vary from country to country and depend on the socio economic conditions of society the society in question. The term “slum”, since its first appearance in the 1820s, has widely been used to refer to areas that have poor quality housing, unsanitary conditions and act as refuge for criminals and drug abuse besides being a likely source for many of epidemics that ravage urban areas. According to Cities Alliance Action Plan, slums are neglected parts of urban towns where the state of the housing conditions and living conditions are appallingly poor¹. They are considered to range from high-density, squalid central city tenements to spontaneous squatter settlements that do not have any legal recognition or rights and are seen to sprawl at the edge of urban centers.

This study adopts the proposed definition of slums by the United Nations Expert Group Meeting held in October 2002 in Nairobi, Kenya which defined a slum to include characteristics such as: “inadequate access to safe water; inadequate access to sanitation and other infrastructure; poor structural quality of housing; overcrowding; insecure residential status”². Lack of basic services is one of the most frequently mentioned characteristics of slums with lack of access to sanitation facilities and safe water sources being the most important features. Slums are coupled with a high absence of waste collection systems, lack of electricity supply, unsurfaced roads and footpaths, poor street lighting and poor drainage facilities. This lack of basic services manifests themselves in the form of open sewers, uncontrolled dumping of waste and polluted environments among others.

UN-Habitat associate slums with a high number of substandard housing structures, often built with non-permanent materials which are unsuitable for construction of houses e.g. earthen floors, mud-and-wattle walls or straw roofs³. Slums are considered to be overcrowded with five and more persons living in a one-room unit that acts as the cooking, sleeping and living area. Apart from the housing structures being made of sub-standard materials, the layout of the slum settlement is at times hazardous because of a lack of access ways and high densities of dilapidated structures.

According to a study, lack of security of tenure is a central characteristic of slums and regards it as prima facie evidence of illegality and slum occupation⁴. Informal or unplanned settlements are often regarded as synonymous with slums with dwellers being considered as among the most disadvantaged. Slum dwellers are considered to rate far lower on human development indicators than other urban residents and have more health problems, less access to education, social services and employment with most of them having very low incomes.

Slums are characterized by lack of key government institutions and other key private and commercial systems with most banks not having branches in the slum and most slum dwellers are not able to access regular sources of finance to develop their own businesses. The few banks that have branches within the slums are faced with the challenge of offering loans to slum dwellers that lack legally registered collateral thus excluding all but the most well-off slum dwellers from obtaining loans. Slum entrepreneurs are forced to draw on informal sources of finance at exorbitant rates and very short repayment periods

2.1.2 United Nations slum definitions

The United Nations Millennium Development Goals include targets intended to encourage attention to the problems of slum dwellers, namely: “By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers”⁵. To further this cause, the UN convened a conference of experts in Nairobi, Kenya in 2002 for the purpose of determining measurable characteristics of slums that could be used as benchmarks for progress. A review of slum definitions used by governments, statistical offices, and international organizations involved in slum issues led UN-HABITAT to develop the following list of attributes of slums.

- **Lack of basic services:** A lack of basic services is one of the most frequently mentioned aspects of slums in definitions worldwide. Safe water and sanitation are the most important features, along with electricity, waste collection, surfaced roads or footpaths, rainwater drainage.
- **Substandard housing or illegal and inadequate building structures:** Slums are often associated with a high proportion of sub-standard or very dilapidated housing, built with non-permanent materials. These buildings often violate local building codes either because of the building structure or because of the space or dwelling placement laws.
- **Overcrowding and high density:** Overcrowding can be the result of multiple factors, including high occupancy rates, low space per person, multiple families sharing one

dwelling, and many single-room units. The high density with slums has been a part of both current and historical definitions of slums.

- **Unhealthy living conditions:** Unhealthy living conditions are often the result of a lack of basic services. For example, lack of sanitation can cause visible, open sewers that are breeding grounds for disease.
- **Hazardous locations:** Slums are often built on hazardous locations or places not suitable for settlement, such as on floodplains and river banks, in close proximity to or built atop waste disposal sites (such as landfills), or close to industrial plants producing toxic emissions.
- **Insecure tenure; irregular or informal settlements:** Many definitions include illegality as a measure of slumness, and a number consider informal or unplanned settlements as synonymous with slums.
- **Poverty and social exclusion:** Poverty is a central characteristic of slums. The UNHABITAT report is careful to note that rather than being an inherent characteristic of slums, it is an underlying cause of slum conditions. Social exclusion is a concept often used in Europe, referring to not only poverty but other forms of exclusion such as discrimination.

- **Minimum settlement size:** Often definitions include something about settlement size, either physically or in terms of number of households. This indicates the idea of a slum as a neighborhood, not a single dwelling.

The conference of experts developed a set of criteria and, along with them, goals intended to spur international concern and investment. They chose five criteria from the list above, deciding to not use any social criteria (such as poverty) but instead opting for a definition that relies on physical and legal characteristics of a slum. The criteria chosen were: access to improved water, access to improved sanitation, residences using durable building materials, housing of adequate space (not overcrowded), and security of tenure in place of residence.

Researchers have taken these measures and used them to define slums. Most commonly, scoring low on any of these dimensions qualifies an area as a slum⁶, although some researchers treat these measures as elements of a continuum of “slumness” along which neighborhoods fall⁷.

2.1.3 Life in Slums

In many Sub-Saharan African cities, the slum population accounts for over 70% of the urban population. By 2030, with rapid urbanization, slum dwellers will have doubled to reach two billion. Although improving the lives of slum dwellers is a target of the United Nations Millennium Development Goals (MDGs), their living conditions are still harsh; they have inadequate access to safe water, sanitation and other infrastructure; poor quality housing; overcrowding and insecure residential status⁸.

Consequently, the physical and Psychological health of slum dwellers is worse than those of non-slum dwellers. Nigeria is getting urbanized rapidly. The results showed that poverty is very common in the slums of Nigerian urban areas, rates of illiteracy are high and unemployment is very high. The living conditions are poor, with lack of basic amenities such as access to clean drinking water and poor sanitation facilities. The people live in temporary shelters such as thatched huts or tents or on pavement/railway platforms. Among those who live in temporary shelters, a big percentage does not have provision of drinking water facility and toilet facilities. The health conditions detected in the study population are poor with frequent respiratory illness and other infections. Anemia was significantly higher among females of all age groups. There is prevalence of underweight among children aged 5-10 years⁹.

A slum is an overcrowded and squalid district of a city or town usually inhabited by very poor people. Slums can be found in most large cities around the world. They are usually characterized by high rates of poverty and unemployment. Slums are breeding centers for many social problems such as crime, drugs, alcoholism and despair. And in many poor countries they are also breeding centers for disease due to unsanitary conditions¹⁰. The term “slum” speaks volumes about the plight of the urban poor. Around the world over one billion residents live in inadequate housing, mostly in slums and squatter settlements, where living conditions are poor and services are insufficient. The situation is worst in Sub-Saharan Africa where 60% of urban housing units are temporary structures¹¹.

Slums in developing countries lack access to safe drinking water, which is one of the essentials for good health¹². Though there are municipal taps in Ibadan slums, the water is of poor quality and totally unsuitable for drinking. Regarding lighting system, as one of the measurements of

quality of life, it is seen that nearly all households in slums have no electricity in their dwelling units. In the absence of electricity, kerosene lamps are largely used in most households.

2.1.4 Conceptualizing slums

The two current dominant ways of identifying or conceptualizing slums is by physical infrastructure or by legality, while new alternatives might consider social aspects of slums as central to the definition of a slum.

2.1.4.1 Slums as places of poor infrastructure

Many policymakers, researchers, and non-governmental organizations tend to think and talk about slums as urban neighborhoods characterized by very poor infrastructure. This conception of slums is present in the Indian census, the Indian ministry of statistics, and the United Nations definitions of slums. These definitions tend to rely heavily on access to basic services that require infrastructure (such as piped water, toilets and sewers) as well as building materials of residences when determining whether or not a place is a slum¹³.

While the infrastructure of slums is indeed a very salient and important part of slumlife that demands public attention, defining slums by the physical conditions is largely unsatisfying. Rather than identifying the key component that distinguishes slums from non-slums, they contend that poor infrastructure is one piece or symptom of slumness¹⁴. Defining slums based on physical characteristics would be akin to defining schools by the presence of school buildings and

playgrounds, rather than by the relations of students, teachers, and learning that define schools. Additionally, there are many places with poor infrastructure that would not be considered slums.

There are several reasons to believe poor infrastructure and physical characteristics alone do not distinguish slums from other urban areas. Slums come to be known as much more than simply neighborhoods with poor infrastructure. In fact, sociological research in India has shown that slums come to have stigmas associated with them. For instance, studies show that slum residents often have difficulty obtaining employment when employers discover they are from the slums¹⁵. This clearly implies that slums are far more than simply areas with poor infrastructure, and furthermore, the lack of infrastructure alone is not sufficient for determining what a slum is, although many current definitions identify slums on infrastructure.

2.1.4.2 Slums as squatter settlements

A second major way policymakers and researchers conceptualize slums is as urban squatter settlements. In this view of slums, slums are illegal communities residing on land to which the residents have no right, such as land owned by the government, a university, a corporation, or other private owner. This is evident in the United Nations definition of slums as the fifth measure of slum improvement: security of tenure¹⁶. When illegal, settlements constantly face the threat of eviction and residents have no security of tenure. The question of whether or not this is a defining characteristic of slums is debatable.

The notion of slums as squatter settlements is appealing because of its inherent implication of illegality. Indeed, many slums are illegally built on public and private properties, such as university land, airports, and land adjoining railroads and highways. When this is the case, slum residents often fear the demolition of their slum when either the government or the private owner wishes to rid their property of the blight of slums. These demolition projects are not solely threats, but do often happen, and slum residents often have little recourse as they have no legal right to the land they are on. In India, sometimes court cases are brought on behalf of slum residents seeking an injunction against demolition, but typically these cases fail, if they are brought at all.

The illegality of slums is evident in several ways. Most slums around the world spring up as settlements without any municipal services such as garbage removal. Slum residents often campaign and advocate to have their slum recognized as a neighborhood and to receive the according services¹⁷. This is certainly the case in Nigeria. Until a slum is notified, neither the residents nor the community are entitled to many of the services residents of the rest of a city receive. An important aspect of slum life is the lack of public resources, often (though not always) a product of illegality. Clearly, illegality can be and often is a very salient aspect of slum life.

Defining slums as squatter settlements is appealing, but again ultimately unsatisfying. Many slums are eventually recognized as legal by their municipality and being receiving municipal services. In Nigeria there is an official recognition called declaration or notification, by which a slum is declared legal and eligible for municipal services. Defining slums as squatter settlements would suggest that these neighborhoods would cease to be slums once they are legal and no longer in danger of demolition. Realistically, the line separating slums and non-slum neighborhoods is not the line between legal recognition and ignorance.

In Nigeria, even legally recognized slums are vulnerable to redevelopment or eviction. The government may grant land tenure rights, known as "Certificate of Occupancy," to squatters and slum dwellers as a form of welfare. However, having a Certificate of Occupancy does not guarantee protection against eviction or demolition. Instead, it entitles individuals or families to compensation or an alternative plot of land if the government redevelops the area. For instance, in Lagos, the government has initiated plans to redevelop slums as part of efforts to modernize and transform the city. Private developers have been encouraged to participate in these redevelopment projects, with a portion of the new apartments allocated for current slum residents, while the rest become the developer's property for commercial purposes¹⁸. Despite the government's efforts to address housing challenges in Nigeria, the rights and security of slum dwellers remain precarious, with many at risk of displacement and homelessness.

In Nigeria, several states have established Slum Clearance Boards with the mandate of clearing and redeveloping slums, both legal and illegal¹⁹. Although larger slums may not face immediate threats of eviction or demolition like smaller ones built near highways or rail tracks, all slums are still perceived as a hindrance to modernization and development. This is particularly true for cities competing to attract foreign businesses and investments. While illegality is often associated with slums and may contribute to concerns about eviction or demolition, it is not the only factor that produces slum conditions, nor is it a universal attribute of all slums. Therefore, defining slums solely as illegal or squatter settlements is not comprehensive enough to fully capture the diverse nature of slums in Nigeria.

2.1.4.3 Slums as neighborhoods of concentrated poverty

An as yet unexplored but potentially fruitful way of conceptualizing slums is as neighborhoods of concentrated poverty. A large body of literature in American sociology has focused on the concentration of poverty in American cities, noting that neighborhoods of concentrated poverty differ considerably from non-poor neighborhoods²⁰. Though there is much debate over the specific dimensions along which high-poverty and other neighborhoods differ, there is agreement over several aspects of life in high poverty neighborhoods. First, there is often a dearth of legal economic activity, evidenced by the lack of businesses and jobs that are available in poor neighborhoods. Second, these high poverty areas tend to have fewer public resources and get less public attention than other neighborhoods. For instance, politicians often ignore high poverty, segregated neighborhoods unless as a result of gerrymandering they have incentives to campaign there. Schools and other public services tend to have far fewer resources to tackle larger problems, and therefore provide lower quality education and other public services. High poverty neighborhoods are beset by a host of problems as a result of the concentrated poverty.

There are several reasons slums may be better conceptualized as neighborhoods of high poverty. Many researchers and policymakers talk about slums with poverty being the underlying cause of the many bad living conditions residents face. The United Nations in fact states that “Income or capability poverty is not seen as an inherent characteristic of slums, but as a cause of slum conditions”²¹. If in fact we consider slum conditions to be the result of highly concentrated, abject poverty, then it makes much more sense to define and measure slums based on poverty, rather than the outcomes of slum conditions such as poor buildings or lack of services.

In terms of bringing this concept down to the level of measurement, here we may consider importing the commonly used definition of a high-poverty neighborhood from the US context, where a neighborhood where over 40% of the residents are poor is considered high-poverty²². In the developing world context, a consistent poverty line would be needed to operationalize this definition. In Nigeria, there are two plausible options for setting a poverty line. The country has an established poverty measurement system, although there has been ongoing controversy over a change in the method of calculation that occurred in the past²².

In Nigeria, the official poverty line is another option for measuring poverty levels. According to the National Bureau of Statistics, in 2019, approximately 40% of Nigerians were living below the poverty line. This poverty line is adjusted according to state and residence in urban or rural areas. Another potential measure is the international absolute poverty line of \$1.90/day, which is used by the World Bank. It is estimated that in 2019, around 41.5% of Nigerians lived below this poverty line²³. Both measures could be utilized to gauge the extent of poverty in Nigerian slums. By considering both measures, it would be possible to better understand the nature and scale of poverty in these highly concentrated areas.

This social (as opposed to physical or legal) conceptualization of slums may help policymakers and researchers better measure and identify slums and their attendant problems.

Of course, this concept, definition, and operationalization would require testing and could prove problematic for measurement. Many household surveys and even the Indian census collect no income data, so until this is done it may be difficult if not impossible to identify areas of concentrated poverty in India. However, it is likely this definition would prove extremely useful and much more consistent if implemented.

2.1.4.4 Slums as marginalized or socially excluded communities

Related to conceptualizing slums as neighborhoods of concentrated poverty is the idea of slums as marginalized communities, cut off from many public and social benefits enjoyed by the more mainstream or dominant areas. The related concept often used by European social scientists is social exclusion²⁴. Using this framework of conceptualizing slums, things like poor infrastructure and illegality are not defining characteristics of slums, but rather visible symptoms of slums being marginalized from public goods. There is no question that slums are cut off from many municipal services. Additionally, stigmas are often attached to slums. Slum residents are discriminated against; for example, in one study in India slum residents had difficulty getting a job when employers found out they resided in slum²⁵.

In Nigeria, the argument that the marginalization of slums is primarily due to their illegality may not tell the whole story. Firstly, many slums in Nigeria are legal settlements recognized by the government, which makes the connection between legality and marginalization weak at best. For instance, the popular Makoko slum in Lagos is a legal settlement. Despite their legal status, slums are often overlooked by local governments and lack basic services that non-slum neighborhoods receive, such as proper sanitation, waste disposal, and access to clean water. As previously mentioned, even legal slums are vulnerable to eviction or demolition. Redevelopment projects often target slums in the name of modernization, regardless of their legal status. Thus, it is clear that the marginalization of slums in Nigeria

cannot be solely attributed to their legal status, but rather a complex interplay of various socio-economic and political factors.

Sociological research has long shown that marginalization of neighborhoods can happen independently of legality²⁶. In western countries such as the United States, for example, predominantly black communities with high rates of poverty are by all means legal and entitled to all the public services accorded residents of any other kinds of neighborhoods. Still, this is far from the daily realities these segregated neighborhoods face. Schools in segregated, high poverty communities tend to be underfunded and have few resources. Public resources such as parks and libraries are often either located outside of high poverty neighborhoods or are in large part neglected. In addition, research has shown how residents of some high poverty or predominantly minority areas are discriminated against when job searching as a consequence of their residential location²⁷. It is clear from the American literature that the distinction of legality is not the mechanism producing public neglect and marginalization of a neighborhood.

Based on focus groups with slum residents and interviews with local NGO activists, marginalization seems to be the key factor underlying the experiences of living in slums in Nigeria. In a focus group conducted with women in a small slum community in Lagos, they listed various challenges they faced, such as lack of access to clean water, inadequate housing, and difficulty accessing education for their children²⁶. However, what underpinned all of these concerns was a sense of being marginalized and ignored by those in positions of power. The women expressed frustration that their community had been neglected for years, and that government officials and other stakeholders had failed to take their concerns seriously. It was only through the intervention of NGOs that their issues began to receive any attention. From these

conversations, it was evident that marginalization was the central issue shaping the experiences of slum residents in Nigeria.

The distinction between developing countries and the developed world when thinking of marginalization is the degree of deprivation in slums. Given the overall lower level of development in Nigeria and much of the developing world, marginalization has much more dire consequences than in a developed country. Municipal governments are often overwhelmed by rapid growth and particularly rapid growth of the poor segments of a population. In Ibadan, Nigeria, a city with a population of over three million people, the municipal government also faces significant fiscal challenges. According to a report by the Brookings Institution, Ibadan's municipal government had a per capita revenue of approximately US\$6 in 2016, compared to the per capita revenue of US\$2,379 for Washington, DC in the same year²⁷. This significant revenue disparity has resulted in a lack of resources for the government to address the needs of slum residents, further contributing to their marginalization. Slum residents in Ibadan often lack access to basic services, such as clean water, electricity, and adequate housing. These challenges are compounded by the fact that many slums are situated on floodplains or other hazardous areas, exacerbating the risks of natural disasters and making living conditions even more precarious. While the government has taken steps to address the needs of slum residents, such as the creation of a slum upgrading program, the scale of the problem remains vast, and many residents continue to feel marginalized and neglected by the municipal government. As a study notes, developing world cities lack not just financial resources but also capacity for urban services and service delivery, due to a lack of services as well as a generally severe shortage of trained, professional staff to deal with complex municipal government problems²⁸.

The reasons why slums are marginalized could be the subject of interesting and fruitful further studies. There are several overlapping and related factors that may contribute to the marginalization of slum areas. For instance, poverty is concentrated in slums, as are members of backwards castes, and more generally workers in informal, low-skilled jobs. Just as high poverty, predominantly black neighborhoods tend to become economically and socially marginalized, we may hypothesize that a similar process happens with slum settlements²⁹.

Once a place becomes known as a slum, the label alone carries a stigma. As a study notes, when official classifications are internalized, the categories are perceived to be internally homogenous³⁰. This clearly happens with the label of “slum” in Nigeria, as all slums are perceived to be homogenous, and often (as in the 19th century), the worst slums become the model of a slum in the minds of the public. Slums are often characterized as places that are unsafe, havens of crime and backwards thinking. The label of slum certainly carries many connotations with it. No rigorous research to date has examined whether crime is actually higher in slums than non-slums, but perception is widespread anyway.

In terms of measurement, it may be relatively difficult to measure marginalization. One more simple way may be to return to the idea of concentrated poverty previously discussed. It perhaps the very concentration of poverty in slums that allows politicians and other citizens to ignore and overlook slums, leaving them isolated and marginalized. As Doug Massey discussed in his Presidential address to the Population Association of America, the rich and poor are becoming increasingly segregated in the cities of the developing world, allowing the affluent to remove and separate themselves from the poor (Massey 1996). In this case, neighborhoods of concentrated poverty may be at the heart of marginalization, and may be the best way at measuring slums.

2.1.5 Existence of slums

There are many reasons for slums to develop in a city, however if we need to summarize the reasons to help formulation possible solutions to the various problems that occur due to them, then those reasons would be, according to the UN- Habitable, as follows:

- **Rapid urban- rural migration:**

Due to a significant increase in the reduction of the population engaged in agricultural activities and an increase in the job opportunities in the urban areas, people from agricultural backgrounds are migrating at a great pace in the urban areas³¹. Thus the massive increase in the population of cities becomes a huge problem for the planners to cope up with. As a result slums are formed in these cities.

- **Insecure Tenure:**

Another reason is having insecure tenures which prevent the residents of slums from having any sorts of developments in the area on a community level. Studies have revealed that community led slum development initiatives, formal or informal, are more likely to work and succeed.

- **Globalization:**

Rapid globalization has led to a major problem that equally contributes to slum formation as any other factor³². Globalization led to capitalization which further increased the social problems of

inequality and an uneven distribution of new wealth. This increased the poverty in both urban and rural areas leading to the formation of slums.

2.1.6 Quality of Life

In this in-depth literature review, quality of life was explored in various dimensions that included views on family support, relationships, emotional status, functionalities and spirituality.

Quality of life (QoL) is a multi-level and amorphous concept, and is popular as an endpoint in the evaluation of public policy (e.g. outcomes of health and social care). It has been defined in macro (societal, objective) and micro (individual, subjective) terms³³. The former includes income, employment, housing, education, other living and environmental circumstances. The latter includes perceptions of overall quality of life, individual experiences and values, and has included related, proxy indicators such as well-being, happiness and life satisfaction. Models of quality of life also ranges from needs based approaches derived from Maslow's hierarchy³³ of human needs (deficiency needs: hunger, thirst, loneliness, security; and growth needs: learning, mastery and self-actualization), to classic models based solely on psychological well-being, happiness, morale, life satisfaction³⁴social expectations³⁵ or the individual's unique perceptions³⁶. Quality of life is thus a complex collection of interacting objective and subjective dimensions³⁷.

A study distinguished between opportunities (chances) for a good life and the good life (outcomes) itself, and postulated four categories of quality of life³⁸:

1. Live-ability of the environment (environmental chances/social capital);
2. Life-ability of the individual (personal capacities/psychological capital);

3. External utility of life (a good life must have an aim other than the life itself, or higher values)
4. Inner appreciation of life (inner outcomes of life/the perceived quality of the life).

Each area of quality of life can also have effects on others. For example, retaining independence and social participation may promote feelings of emotional well-being, but the former are partly dependent on retaining health and adequate finances. These can also be influenced by local transport facilities, type of housing, community resources to facilitate social participation and social relationships. Thus, quality of life is multidimensional and its parts affect each other as well as the sum. It is also a dynamic concept, which poses further challenges for measurement. It is made up of both positive and negative experiences and affect, and values and self evaluations of life may change over time in response to life and health events and experiences. For example, consciously or unconsciously people may accommodate, adapt or adjust, to deteriorating circumstances, whether in relation to health, socio-economic or other factors, because they want to feel as good as possible about themselves and hence the perception of quality of life³⁹.

Thus when measuring change in quality of life, several variables need to be taken into account, including actual changes in circumstances, including the circumstances of interest (e.g. health), stable or dispositional characteristics of the individual (personality); behavioural, cognitive or affective processes which might accommodate the changes, such as making social comparisons, reordering of goals and values;. Social desirability bias might also be a personality characteristic, and this might facilitate people when they are adjusting to deteriorating health or circumstances, and lead to an optimistic perception of a higher quality of life⁴⁰. Past in-depth interviews with people have indicated that consideration of quality of life was dependent upon finding a balance

between body, mind and the self (spirit) and on establishing and maintaining harmonious relationships.

In a European study on quality of life in old age, it was discovered that older people nominated family relationships as being an important determinant of quality life in 17 of the studies^{41, 42, 43} found, using the SEIQoL, that 89% of the older Irish people sampled nominated family as an important aspect of their quality of life. In the UK, a study⁴⁴ found that family (usually meaning children) and social contact (often other family) were very important, with 60% and 34% respectively mentioning these.

On Relationships (other/contact with others twenty one studies reported relationships (most of the time being distinct from family) as being important to chronically ill people⁴⁵. Social contact was mentioned by 34% of respondents in a survey by a study⁴⁶ and in a similar geographical area the importance of social networks was mentioned⁴⁷. Ballet al (2000) found social relationships and interactions to be nominated by cancer people in assisted living facilities. Relationships were important in 45% cancer people in mobile homes in the US studies⁴⁸. General themes such as, connectedness, involving social networks were noted⁴⁹. A study⁵⁰ also noted that networks involving friends and other social groups increased morale among patients with leukemia.

Emotional well-being or happiness was mentioned in 16 studies⁵¹. Confidence, morale and happiness were all mentioned by people in a study by⁵². A study⁵³ found that older people were concerned about misery or unhappiness which was often accompanied by a loss of hope, whilst general dissatisfaction with life was dreaded by 30% of the men in the UK study⁵⁴. Another study found that eight of 44 disabled individuals nominated mood as an important component of quality of life⁵⁵.

On religion/spirituality issues, eighteen studies found aspects of religion or spirituality to be important to cancer patients⁵⁶. Bowling's survey showed that religion was the eighth most nominated component for people with HIV and AIDS, with six percent of respondents nominating it as one of their top five components of quality of life⁵⁷. In Ireland, religion was found to be particularly important, with a study reporting that it was mentioned by US chronically ill patients⁵⁸. Aspects of beliefs were also nominated by three percent and seven percent of older people in mobile homes and nursing homes, respectively⁵⁹. Similarly, four found that people with experience of illness mentioned religion⁶⁰, while another study reported that religion was important to older terminally ill Americans⁶¹. Additionally, religion/spirituality was noted in a study of individuals living in assisted living facilities⁶².

Aspects of functionality, mobility or autonomy were mentioned in 25 cases of some other studies⁶³. Bowling found that cancer and HIV and AIDS patients were the most likely of any group to mention the ability to get out and about as being the most important area of life to be affected by illness. Autonomy was again mentioned by leukaemia patients in a study⁶⁴ and in another study⁶⁵ ability to do what one wants to do was the seventh most frequently mentioned component (17% of respondents).

In fifteen studies it was found out that finances or standards of living were important⁶⁶. Issues of safety and poor transport facilities were highlighted. In a study⁶⁷, material circumstances were found to be important and usually meant finances or a good home. Issues of cleanliness and tidiness of surroundings were raised among people in the study⁶⁸. Two percent of the patients with HIV and AIDS in the study by Burbank mentioned suitability of the home as an important component of the quality of life⁶⁹.

This literature shows that quality of life is inherently a dynamic, multi-level and complex concept, reflecting objective, subjective, macro-societal, and micro-individual, positive and negative influences which interacts together⁷⁰. There seems to be, though, no overall agreement on definitions which poses inevitable challenges for measurement. However, research has enhanced the body of knowledge on the components and determinants of life quality among all ages. The literature reveals that quality of life can theoretically encompass a wide ranging array of domains, including individual's physical health and functioning, psycho-social well-being, psychological outlook, psychological and social role functioning, social support and resources, independence, autonomy and perceived control over life, material and financial circumstances, community social capital and the external environment, including the political fabric of society. Most importantly, it encompasses the individual's perspective and assesses quality of life through the eye of the experiencer⁷¹. It is a concept which is likely to be mediated by cognitive factors.

It is clear from the above analysis that quality of life means different aspects for different people in different circumstances but what comes to light is that quality of life is a meaningful consideration during illness and treatment processes. Something to appreciate here is that the above literature portrays QOL in the developed world, something that may not be generalized in the African context.

In the Africa setting and Nigeria in particular, there are many aspects that can influence QOL among patients. Culture is one of them. A study⁷² defines culture as a system of interrelated values active enough to influence and condition perception, judgment, communication and behaviour in a given society. The culture of slum dwellers in this country is often inclined to promiscuousness, community support and traditional influences. These areas can affect the QOL in a major diverse manner as compared to traditions in the developing world.

Superstitions, beliefs and stereotypes are central in HIV and AIDS prevalence in Africa. These are areas that are not so loud in the developed world where the above literature has been explored. It is also true that the health seeking behaviour in Nigeria is remotely based on perceptions, lay professionalism, resources and the influence of the family and friends. In the developed world, it is based on an individual's decision.

Culture plays a vital role in determining the level of health of an individual, the family and the community and determination of health outcomes. In Nigeria, culture easily influences health seeking behaviour that can either impact negatively or otherwise to the quality of life of an HIV patient. For example in some communities HIV and AIDS is perceived to be "Chira" (curse) something to be treated by the local medicine man. This aspect can determine the HRQOL in women patients in Nigeria.

Another example is wife inheritance where a woman is forced to be inherited when a husband passes on even if he was HIV positive⁷³. This scenario can place a lot of stress on the woman diminishing her quality of life in the marriage. Another supporting argument is the values of extended family and community which significantly influence the behaviour of the individual.

A profound area that can affect QOL in Nigeria is stigma. Nigeria is not immune from HIV and AIDS stigma-related discriminatory practices and human rights abuses particularly in the light of the overwhelming impact of the disease in the African region. Discrimination and abuses take place in families, communities, schools, places of worship and employment and even in healthcare settings. Not forgetting the scarce resources, poverty and inaccessibility of medical care which is common in Nigeria that can highly affect the QOL of HIV and AIDS patients.

What comes to light is that a lot of research on QOL seems to have been carried out in the first world: little has been done in the 3rd world countries and therefore the need to contextualize research on HRQOL particularly in Nigeria.

2.1.7 Quality of Out Of School Girls in Slums Globally

Out-of-school girls in slums globally experience poor quality of life due to a range of challenges, including poverty, inadequate education, poor living conditions, limited access to basic amenities, and gender-based violence. These challenges can have significant negative impacts on their well-being, health, and future prospects.

Education is a crucial factor in the quality of life of out-of-school girls in slums. Lack of education limits their opportunities for future employment and economic empowerment, trapping them in a cycle of poverty. According to the United Nations Educational, Scientific and Cultural Organization (UNESCO), an estimated 130 million girls globally are not in school, with a significant proportion located in slums and other urban informal settlements⁷⁴. Girls in slums face particular challenges in accessing education due to factors such as limited availability of schools, long distances to schools, and a lack of safe transportation⁷⁵.

Poor living conditions, such as overcrowding and inadequate access to clean water and sanitation, are also major challenges that affect the quality of life of out-of-school girls in slums. The United Nations Human Settlements Programme (UN-Habitat) reports that slum dwellers are more likely to lack access to basic amenities such as clean water, sanitation, and healthcare, which can lead to health problems⁷⁶. A study conducted in India found that girls living in slums had a higher prevalence of anemia than girls living in non-slum areas, which is attributed to poor living conditions and inadequate nutrition⁷⁷.

Gender-based violence is a significant challenge for out-of-school girls in slums, with studies indicating high rates of sexual harassment and assault. A study conducted in Nairobi, Kenya, found that 48% of adolescent girls in informal settlements had experienced sexual violence, and only 9% had reported the incidents to the authorities⁷⁸. The fear of violence and harassment can also limit girls' mobility and access to education, healthcare, and other basic services⁷⁹.

Several organizations are working to address the challenges faced by out-of-school girls in slums globally. For example, the United Nations Girls' Education Initiative (UNGEI) aims to promote girls' education in slums and other marginalized areas. UNGEI has implemented programs that support girls' access to education by providing scholarships, school supplies, and other resources⁸⁰. Other organizations such as Plan International and Save the Children are also implementing programs that support out-of-school girls in slums.

2.1.8 Quality of Out Of School Girls in Slums in Nigeria

The quality of life of out-of-school girls in urban slums in Nigeria is poor due to a range of challenges, including poverty, inadequate education, poor living conditions, limited access to basic amenities, and gender-based violence.

Poor living conditions, such as overcrowding, inadequate housing, and limited access to basic amenities, are also significant challenges that affect the quality of life of out-of-school girls in urban slums in Nigeria. The United Nations Human Settlements Programme (UN-Habitat) reports that over 70% of the urban populations in Nigeria live in slums or informal settlements, where access to basic amenities such as clean water, sanitation, and healthcare is limited⁸¹. This can lead to health problems, including the spread of infectious diseases. A study conducted in

Nigeria found that girls living in slums had a higher prevalence of anemia than girls living in non-slum areas, which is attributed to poor living conditions and inadequate nutrition⁸².

Education is a critical factor in the quality of life of out-of-school girls in urban slums in Nigeria. A report by the United Nations Children's Fund (UNICEF) indicates that Nigeria has the highest number of out-of-school children globally, with over 10 million children out of school, of which a significant proportion are girls⁸³. The situation is worse in urban slums, where access to education is limited due to factors such as poverty and limited availability of schools. A study conducted in Lagos, Nigeria, found that only 60% of girls in urban slums had attended primary school, and just 20% had completed secondary school⁸⁴.

Gender-based violence is another significant challenge for out-of-school girls in urban slums in Nigeria. A study conducted in Lagos, Nigeria, found that 43% of adolescent girls in urban slums had experienced sexual violence, and only 16% had reported the incidents to the authorities⁸⁵. The fear of violence and harassment can also limit girls' mobility and access to education, healthcare, and other basic services.

2.1.9 Concept of Psychological Health

Psychological health does not exist on its own. It is an integral and essential part of overall health, which can be defined in at least three ways – as the absence of disease, as a state of the organism that allows the full performance of all its functions or as a state of balance within oneself and between oneself and one's physical and social environment⁸⁶. Which of these three definitions is used depends on the level to which the basic health needs are satisfied. These needs include food,

shelter, survival, protection, society, social support, and freedom from pain, environmental hazards, unnecessary stress and from any part of exploitation⁸⁷.

The state of Psychological health implies that the individual has the ability to form and maintain affectionate relationships with others, to perform in the social roles usually played in their culture and to manage change, recognize, acknowledge and communicate positive actions and thoughts as well as to manage emotions such as sadness. Psychological health gives an individual the feeling of worth, control and understanding of internal and external functioning. The Society for Health Education and Promotion Specialists⁸⁸ suggests that Psychological health also involves feeling positive about oneself and others, feeling glad and joyful and loving. Psychological health, like Psychological illness, is also affected by biological, social, psychological and environmental factors. The individual at the core of functioning is surrounded by the social world – in the proximal world it will include family, kinship, employers, peers, colleagues, friends and, in the distal context, society and culture.

The interaction between individuals and society becomes critical in building healthy communities, which in turn can promote Psychological health.

Vulnerabilities to Psychological ill health (or, as the Health Education Authority report (HEA) calls it, Psychological health demotion) include internal factors such as a lack of emotional resilience, poor self-esteem and social status, feeling trapped and helpless, and problems associated with sexuality or sexual orientation, isolation and poor integration. External factors contributing to this vulnerability have been described as poor social conditions (housing, poverty, unemployment), discrimination or abuse, cultural conflict, stigma and poor autonomy, among other factors⁸⁹.

T. Y. Lin (personal communication) once told one of us that he was teaching his son about Psychological health, which for him meant being at ease when with others and when alone. An individual in a state of good Psychological health will have a strong sense of self and others; they will be able (and willing) to form positive relationships and yet be comfortable in their own company. The notions of self will be very strongly influenced by culture, and whether the individual is socio-centric or egocentric will be determined by culture and personality. Any attempts to change this notion of the self may well lead to culture conflict, individual dissonance and unhappiness. The core senses of Psychological health include trust, challenge, competency, accomplishment and humour, and the capacities that Psychological health offers include the ability to develop psychologically, emotionally, intellectually and spiritually; initiate, develop and sustain mutual emotionally satisfying relationships; the ability to be aware of others and to empathize with them; and to use psychological distress as a development process and learn from it so that it does not hinder or impair further development⁹⁰.

The Mental Health Foundation notes that Psychological health is defined by how individuals think and feel about themselves and their life, and that it affects how an individual copes and manages in times of adversity⁹¹. Psychological health is seen as affecting one's abilities to function and make the most of the opportunities that are available, and to participate fully with family, workplace, community and peers. There is a close link between physical and Psychological health, as they affect each other directly and indirectly.

It is thus possible to suggest that Psychological health is a state of equipoise where the individual is at peace with them, is able to function effectively socially and is able to look after their own basic needs as well as higher function needs. Positive functionality means managing change, relationships and emotions in a constructive manner. The challenge for psychiatry is that it needs

to encompass the preservation and promotion of Psychological health in its practice, research and teaching and that it becomes actively engaged in introducing these notions into the public health efforts.

2.1.10 Factors Affecting the Psychological Health and Quality of Life of Out of School Girls

Women living in slums face a myriad of challenges that impact their quality of life. These challenges arise from various factors, including economic, social, cultural, and environmental factors. In this discussion, we will explore some of the factors that affect the quality of life of women living in slums.

1. **Economic factors:** The economic factors affecting the quality of life of out-of-school girls in slums are multifaceted and complex. Slum communities are often characterized by a lack of basic infrastructure, poor livelihood opportunities, and poor schooling facilities, which negatively impact young women⁹². In general, it has been indicated that over 13,000 girls drop out of school in Kenya annually due to early childbearing. Lack of access to basic infrastructure, such as water and sanitation facilities, is also a concern in India and it affects women and girls disproportionately by impacting on their health and dignity. Women in slums without water supplies and toilets within their homes are potentially vulnerable to different forms of violence. Therefore, addressing the socio-economic factors that contribute to poor health outcomes and limited educational opportunities is crucial to improving the quality of life of out-of-school girls in slums. One of the key economic factors affecting the quality of life of out-of-school girls in slums is poverty. Poverty is a major barrier to education and can lead to early school

dropout, particularly among girls⁹³. Girls from poor families are more likely to be out of school than boys, and they are more likely to be engaged in domestic work or other forms of labor. In addition, poverty can lead to poor health outcomes, including malnutrition, which can further impact educational opportunities and overall well-being. Poor schooling facilities and limited access to education are also economic factors that negatively impact the quality of life of out-of-school girls in slums. Schools in slum areas are often characterized by poor infrastructure, inadequate resources, and a lack of qualified teachers, which can lead to poor educational outcomes and early school dropout⁹⁴. In addition, girls may face additional barriers to education, such as cultural norms that prioritize boys' education over girls' education, early marriage, and early childbearing.

2. **Social factors:** The quality of life of out of school girls in slums is affected by various social factors. Women living in slums often face social isolation due to the lack of community support and social networks. The social stigma attached to living in a slum further exacerbates this isolation. Women living in slums also face gender-based discrimination, which limits their opportunities for educational and economic advancement⁹⁵. Social norms in some cultures prioritize male education over female education, further limiting women's access to education and economic opportunities.
3. **Cultural factors:** Cultural practices such as early marriage and forced marriage limit women's opportunities for educational and economic advancement. Women who are married early are more likely to have children at a young age, which limits their ability to attend school or work outside the home⁹⁶. Additionally, cultural practices that prioritize male education over female education limit women's access to educational opportunities.

4. **Environmental factors:** Poor environmental conditions such as inadequate sanitation, pollution, and lack of access to clean water pose significant health risks to women living in slums. These environmental factors increase the likelihood of health problems such as respiratory diseases, skin infections, and waterborne diseases⁹⁷. Women living in slums are also more likely to experience the effects of natural disasters such as floods and landslides due to their living conditions.
5. **Access to basic services:** Lack of access to basic services such as healthcare, education, and housing significantly affects the quality of life of women living in slums. Women living in slums often have limited access to healthcare services, which increases their risk of health problems. Lack of access to education limits women's opportunities for economic and social advancement. Additionally, inadequate housing conditions such as overcrowding and lack of privacy further affect women's quality of life.

2.1.10.1 Economic Factors

Economic factors play a significant role in determining the quality of life of out of school girls living in slums. Girls living in slums often face limited economic opportunities and are more likely to live in poverty compared to their male counterparts. This can result in a range of economic challenges that impact their overall quality of life.

- **Poverty**

Poverty is a significant factor that affects the quality of life of out-of-school girls living in slums. In many cases, families living in slums struggle to meet their basic needs, and education

becomes a luxury they cannot afford. Out-of-school girls are more likely to come from families living in poverty and face multiple challenges that make it difficult for them to access education⁹⁸.

According to a report by UNICEF, over 130 million girls worldwide are out of school, with the majority of them living in low-income countries⁹⁹. Poverty is a significant contributing factor to the high number of out-of-school girls, as families living in poverty often prioritize the education of boys over girls due to cultural norms and expectations.

In slum communities, poverty exacerbates the challenges that out-of-school girls face. These communities often lack basic infrastructure such as schools, and families cannot afford to send their children to schools located outside the slum. In addition, many families rely on the income generated by their children to meet their basic needs, further reducing the likelihood that out-of-school girls will receive an education.

Out-of-school girls in slums also face a higher risk of early marriage and childbearing, further perpetuating the cycle of poverty. According to the World Bank, girls who marry before the age of 18 are less likely to complete their education, more likely to experience complications during pregnancy and childbirth, and more likely to live in poverty⁹⁹.

The impact of poverty on out-of-school girls is not limited to their education and future prospects. Poverty also affects their overall quality of life, including their health and well-being. Girls living in poverty are more likely to suffer from malnutrition, infectious diseases, and other health problems due to inadequate nutrition, lack of access to clean water, and poor sanitation. These

health issues can have long-lasting effects on their physical and cognitive development, further limiting their future opportunities¹⁰⁰.

- **Lack of Access to Education**

Education is an important factor that can positively impact the quality of life of women living in slums. These women often face various challenges such as poverty, lack of access to basic services like healthcare and education, and discrimination based on their gender and social status. Studies have consistently shown that education is one of the most effective ways to reduce poverty and improve economic outcomes for individuals and communities¹⁰¹.

One of the ways education can positively affect the lives of women living in slums is through improved physical health. Due to limited access to basic healthcare services, women in slums are at a higher risk of health problems such as malnutrition, infectious diseases, and reproductive health issues. Education can provide these women with knowledge about healthy behaviors such as proper nutrition, hygiene practices, and family planning¹⁰². It can also empower them to advocate for their own health needs and access healthcare services when necessary.

In addition to physical health, education also has a significant impact on the Psychological health of women living in slums. Poverty, overcrowding, and social isolation can lead to high levels of stress for women living in slums. Education can equip women with coping skills to manage these stressors and improve their Psychological well-being¹⁰³. It can also help women develop critical thinking skills that enable them to analyze situations objectively and make informed decisions about their lives.

Furthermore, education can improve the social relationships of women living in slums. Women who have completed higher levels of education are more likely to have strong social networks and supportive relationships than those who have not completed high school or college. Education provides individuals with opportunities to develop social skills such as communication, teamwork, and leadership. Additionally, higher levels of education often lead to better job opportunities and higher incomes, which can improve an individual's social status¹⁰⁴.

Finally, education can significantly impact the economic status of women living in slums. Research has consistently shown that individuals with higher levels of education earn more money over their lifetimes than those without a college degree or high school diploma. This is because education provides individuals with the skills and knowledge necessary to succeed in the job market. Additionally, higher levels of education often lead to better job opportunities and promotions, which can increase an individual's earning potential and improve their economic status¹⁰⁵.

Despite the numerous benefits of education, there are still significant disparities in educational attainment across different populations. Women living in slums often face various obstacles to accessing education, such as poverty, lack of access to schools, and cultural norms that prioritize male education over female education¹⁰⁶. Additionally, women living in slums often face discrimination based on their gender and social status, which can further limit their opportunities for educational and economic advancement.

Education is a crucial factor that can positively impact the quality of life of women living in slums. It can improve physical and Psychological health, social relationships, and economic status. However, to fully realize these benefits, we must address the barriers that prevent women

living in slums from accessing education, such as poverty, lack of access to schools, and discrimination based on gender and social status.

2.1.10.2 Social Factors

Social factors are issues that affect many people within a society. It is a group of common problems in present-day society and ones that many people strive to solve. It is often the consequence of factors extending beyond an individual's control. Social factors that affect out of school girls in urban slums include; Gender discrimination, early marriage,

- **Gender Discrimination**

Gender discrimination is a significant factor affecting the quality of life of out-of-school girls living in slums. Girls living in slums face numerous challenges related to their gender, including limited access to education, early marriage, and restricted mobility. These challenges can have a significant impact on their physical, emotional, and social well-being.

One of the most significant challenges facing out-of-school girls living in slums is limited access to education. Girls are often expected to prioritize household chores and caregiving responsibilities over their education, which can lead to high dropout rates. This lack of education can have long-term consequences for their economic opportunities and overall quality of life.

In many slum communities, girls are not encouraged or allowed to attend school due to cultural norms that prioritize boys' education over girls'¹⁰⁷. Families may view investing in their daughters' education as a waste of resources since they will eventually marry and leave the household. This mindset perpetuates gender inequality and limits girls' opportunities for personal growth and economic advancement.

Restricted mobility is also a significant challenge facing out-of-school girls living in slums. Girls may be discouraged from leaving their homes or traveling alone due to safety concerns or cultural norms that restrict women's mobility. This can limit their access to healthcare services, educational opportunities, and social networks. Girls who are unable to leave their homes or travel alone may miss out on educational opportunities or social events that could help them develop important skills and relationships. This can limit their opportunities for personal growth and economic advancement.

Gender discrimination also affects out-of-school girls' economic opportunities. Women in slum communities often work in low-paying jobs with little job security or benefits. Girls who are unable to complete their education may be forced into these types of jobs at an early age, limiting their earning potential and economic mobility.

In addition to these challenges, out-of-school girls living in slums may also face discrimination based on other factors such as ethnicity or religion¹⁰⁸. Discrimination based on these factors can further limit their access to educational opportunities and economic resources. Girls who belong to marginalized groups may face additional barriers to accessing education or employment opportunities due to discrimination or bias.

To address these challenges, it is essential to promote gender equality and empower girls and women in slum communities. This can be done through initiatives that promote girls' education, provide access to healthcare services, and address gender-based violence¹⁰⁹. It is also important to engage with community leaders and families to change cultural norms that restrict women's mobility and limit their opportunities.

One effective strategy for promoting girls' education is providing scholarships or financial incentives for families who allow their daughters to attend school. This can help overcome cultural barriers by providing a tangible benefit for investing in girls' education. Another strategy is providing mentorship programs or after-school activities that encourage girls' personal growth and development. These programs can help build confidence, develop leadership skills, and provide a supportive network of peers.

Addressing gender-based violence is also critical for promoting gender equality in slum communities. This can be done through awareness campaigns, legal reforms, and support services for survivors of violence. Engaging with community leaders and families is essential for changing cultural norms that perpetuate gender inequality. This can involve working with religious leaders, community organizations, or local government officials to promote gender equality and challenge discriminatory practices.

- **Early Marriage**

Early marriage is a significant factor affecting the quality of life of out-of-school girls living in slums. It is a complex issue that requires a multidimensional approach to address its consequences for girls' health, education, and overall well-being. This paper discusses the social and economic factors that contribute to early marriage and its impact on the quality of life of out-of-school girls living in slums. It also suggests strategies for addressing this issue.

In many slum communities, poverty is a major contributing factor to early marriage¹¹⁰. Families may marry off their daughters at a young age to reduce the economic burden on the household. This often leads to girls being withdrawn from school, as they are expected to prioritize household duties over their education. A study conducted by the United Nations Population Fund

(UNFPA) found that girls living in slums were more likely to be married before the age of 18 than those living in non-slum areas¹¹¹. The study also found that poverty and lack of education were the primary reasons for early marriage.

Limited access to education is a significant consequence of early marriage for girls. Once married, girls are often expected to prioritize household duties over their education, leading to high dropout rates. This lack of education limits their economic opportunities and overall quality of life. According to a report by the World Bank, girls with secondary education are more likely to delay marriage and have fewer children, which can lead to improved health outcomes for both the mother and child¹¹².

Gender inequality and social norms are also significant factors contributing to early marriage. In many slum communities, girls are viewed as a burden on the household and are expected to marry early and prioritize household duties over their education and personal aspirations. This mindset perpetuates gender inequality and limits girls' opportunities for personal growth and economic advancement.

Early marriage also has serious consequences for girls' health. Girls who marry early are more likely to experience domestic violence, have limited access to healthcare services, and face higher rates of maternal mortality¹¹³. A study conducted by the International Center for Research on Women (ICRW) found that girls who marry before the age of 18 are more likely to experience sexual, physical, and emotional abuse from their partners than those who marry later¹¹⁴.

Girls who marry early also face limited opportunities for personal growth and development. Once married, they are often expected to prioritize household duties over their own interests or career aspirations. This perpetuates gender inequality by limiting women's opportunities for economic advancement.

To address the issue of early marriage, it is essential to promote girls' education and empower girls and women in slum communities. Providing financial incentives or scholarships for families who allow their daughters to attend school can help overcome cultural barriers to girls' education. Additionally, mentorship programs or after-school activities that encourage personal growth and development can help build confidence, develop leadership skills, and provide a supportive network of peers.

Addressing gender-based violence is also critical for addressing early marriage in slum communities. This can be done through awareness campaigns, legal reforms, and support services for survivors of violence. Engaging with community leaders and families is also essential for changing cultural norms that perpetuate early marriage. This can involve working with religious leaders, community organizations, or local government officials to promote gender equality and challenge discriminatory practices.

In conclusion, early marriage is a significant factor affecting the quality of life of out-of-school girls living in slums. It has serious consequences for their health, education, and overall well-being. Poverty, gender inequality, and social norms are significant contributing factors to early marriage. Addressing this issue requires a multidimensional approach that promotes girls' education, addresses gender-based violence, and challenges discriminatory cultural norms. It is

essential to empower girls and women in slum communities to promote gender equality and improve the quality of life for all members of society.

2.2 Empirical Review

2.3 Theoretical Framework

- **Social Determinants of Health (SDOH) framework**

The Social Determinants of Health (SDOH) framework provides a valuable lens through which to understand the complex interplay of factors that shape the quality of life and psychological health of out-of-school girls in urban slums. This framework emphasizes the idea that health is not only determined by individual behaviors and genetics, but is also shaped by broader social, economic, and environmental factors. In this essay, we will explore the SDOH framework and how it can be applied to the topic of quality of life and psychological health of out-of-school girls in urban slums.

The SDOH framework identifies a range of factors that can impact health outcomes, including income, education, employment status, housing, access to healthcare, social support networks, and the built environment. Each of these factors can have a direct or indirect impact on an individual's health status, and they are often interrelated and mutually reinforcing.

One key social determinant of health that is particularly relevant to the topic of quality of life and psychological health of out-of-school girls in urban slums is poverty. Poverty can impact health outcomes in a number of ways, including limiting access to healthy food, safe housing, and

quality healthcare. Poverty can also lead to social isolation and stress, which can contribute to poor Psychological health outcomes. For out-of-school girls in urban slums, poverty can be a major barrier to accessing education and employment opportunities, which can further limit their ability to improve their quality of life and overall health.

Another important social determinant of health is education. Education has been shown to be a key predictor of health outcomes, with higher levels of education associated with better health status and longer life expectancy. For out-of-school girls in urban slums, lack of access to education can limit their ability to acquire the knowledge and skills necessary to improve their quality of life and make informed decisions about their health.

Employment status is another social determinant of health that can impact the quality of life and psychological health of out-of-school girls in urban slums. Unemployment and underemployment can contribute to poverty and social isolation, both of which can have negative impacts on Psychological health outcomes. In addition, lack of access to stable employment can limit girls' ability to access healthcare and other resources that can improve their health outcomes.

Access to healthcare is also a key social determinant of health. Inadequate access to healthcare can limit girls' ability to receive preventative care, diagnose and treat health conditions, and manage chronic illnesses. In addition, inadequate healthcare access can contribute to social and economic marginalization, further limiting girls' ability to improve their quality of life and overall health.

The built environment is another important social determinant of health that can impact the quality of life and psychological health of out-of-school girls in urban slums. The physical

environment in which individuals live can impact their access to healthy food options, safe spaces for physical activity, and clean air and water. In addition, the built environment can impact social cohesion and sense of community, which can contribute to positive Psychological health outcomes.

Finally, social support networks are an important social determinant of health that can impact the quality of life and psychological health of out-of-school girls in urban slums. Social support can come from family members, friends, community organizations, and other sources, and can help to mitigate the negative impacts of poverty, unemployment, and other social determinants of health. Social support can also contribute to a sense of belonging and connectedness, which can promote positive Psychological health outcomes.

- **Intersectionality Framework**

Intersectionality is a theoretical framework that was introduced by legal scholar and critical race theorist Kimberlé Crenshaw. It highlights how different forms of oppression, such as racism, sexism, classism, and ableism, intersect and overlap in complex ways to shape individuals' experiences and outcomes. The framework posits that social identities such as race, gender, class, and sexuality are interdependent and cannot be studied in isolation. Rather, they must be understood as mutually constitutive and interact to create unique experiences of discrimination, disadvantage, and privilege.

Intersectionality can be a useful framework for understanding the quality of life and psychological health of out-of-school girls in urban slums. These girls often face multiple forms of oppression and marginalization based on their gender, social class, and location. For example,

they may be denied access to education and employment opportunities because of their gender, and they may also face discrimination and stigma because they live in urban slums.

At the intersection of these multiple identities and experiences, out-of-school girls in urban slums face unique challenges to their quality of life and psychological health. For instance, studies have shown that girls who are out of school are more likely to experience poor Psychological health outcomes such as anxiety, depression, and low self-esteem. They may also be at increased risk of gender-based violence, including sexual violence, due to their lack of education and limited opportunities for economic empowerment.

Additionally, out-of-school girls in urban slums often face barriers to accessing healthcare and other social services, which can negatively impact their quality of life. For example, they may lack access to adequate nutrition, clean water, and sanitation, which can lead to poor physical health outcomes such as malnutrition and infectious diseases.

Furthermore, the intersectionality framework emphasizes the importance of acknowledging the unique experiences and needs of different subgroups of out-of-school girls in urban slums. For example, girls from different ethnic or religious backgrounds may face different forms of discrimination and may have different cultural practices that affect their health outcomes. Additionally, girls with disabilities may face additional barriers to accessing education and healthcare, which can impact their quality of life and psychological well-being.

In order to address the complex and intersecting challenges faced by out-of-school girls in urban slums, interventions must be developed that take into account the intersectionality of their

identities and experiences. This requires an understanding of how different forms of oppression and marginalization interact and intersect to impact their health and well-being.

For example, interventions that address the educational needs of out-of-school girls must also address the structural barriers that prevent them from accessing education, such as poverty and gender discrimination. Health interventions must also take into account the social determinants of health that impact the quality of life of out-of-school girls, such as access to clean water, adequate nutrition, and safe living conditions.

Moreover, interventions must be designed with the participation of out-of-school girls themselves, as they are the experts on their own experiences and needs. By involving girls in the design and implementation of interventions, programs can be tailored to their unique experiences and needs, and can be more effective in addressing the complex and intersecting challenges they face.

2.5 Summary of Gaps in Literature

There is a lack of specific research on out-of-school girls living in urban slums in Ibadan metropolis. This is a gap in the literature that needs to be addressed, as these girls are particularly vulnerable to social, economic, and health-related challenges that may impact their quality of life and psychological health.

Additionally, while some studies have explored the impact of poverty, gender-based violence, and other social determinants of health on quality of life and psychological health in urban areas,

more research is needed to better understand these complex interactions and their specific impact on out-of-school girls in urban slums in Ibadan metropolis.

Further studies are also needed to explore potential interventions and solutions that can improve the quality of life and psychological health of these girls, particularly through education and access to healthcare services. Overall, the available literature highlights the importance of addressing social inequalities and promoting health equity in urban areas, particularly for vulnerable populations like out-of-school girls living in slums.

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Chapter Three

Methodology

3.1. Research Design

A Cross-sectional research design was used. This design assessed the Quality of life (QoL) and psychological health, the challenges, and factors contributing to the mental health of out-of-school adolescent girls and young women. Quantitative research design allow for the collection of numerical data on the quality of life and psychological health of out-of-school adolescent girls and young women in urban slums.

Study Site

Oyo State is one of the 3 states from the old Western region and the fifth largest and most populous in Nigeria¹. Ibadan is the capital city and it is the third most populous city in Nigeria. There are 33 LGAs in Oyo state, 11 of which are in Ibadan². Five of the LGAs are referred to as Urban while the remaining 6 are called semi-urban. It houses the first university in Nigeria- the University of Ibadan. It has many public and private primary and secondary schools for the teaming population estimated at over 7 million in 2016. Two local government areas were selected among LGAs in Ibadan with urban slums out of the 11 LGAs. **Ibadan Northwest** has 11 wards with population of 259,166 (2015) and occupies areas such as Onireke, Ayeye, Dugbe, Inalende, Ologuneru and markets such as Agbeni, Eleyele, Dugbe, Ayeye. **Ibadan North** has 12 wards with an estimated population of 856,988 (2017) and areas such as Agodi, Beere, Mokola, Adeoyo, Bodija, Sango, Samonda, Agbowo, Oyo road.

3.2. Study Population

The out-of-school adolescent girls and young women of urban slums in Ibadan metropolis aged between 15-24 years were the study population. These age ranges are regarded as 'Youth' by the WHO classification.

3.2.3 Eligibility Criteria (Inclusion/Exclusion)

a. Inclusion criteria

- Out-of-school adolescent girls and young women between the ages of 15-24 years as of the period of the survey will be included.
- Adolescents and young women who may have been to school but are no longer going to school
- Those school-aged adolescents and young women who may never have been to school at any time
- Those who can provide written informed consent.

b. Exclusion criteria

- Those who were less than 15 years old or greater than 24 years old were not eligible even if they were out of school
- Those who could not give informed consent were excluded from the study.

3.3. Sample Size and Sampling Techniques

When determining the sample size for descriptive studies with populations bigger than 10,000, Fisher's formula was used to establish the minimum sample size. The following variables were taken into account when calculating the sample size for this study:

- ❖ Estimated population of out-of-school adolescent girls and young women
- ❖ A standard normal deviate of 1.96,
- ❖ 95% confidence interval
- ❖ The acceptable margin of error is 5%.

Based on Fisher's formula, that is

$$n = \frac{Z^2 p (1 - p)}{d^2}$$

Where: n - minimum sample size required

d - Is the margin of error 5%

z - Confidence level 95%

p - The estimated proportion of out-of-school girls, 38%⁴

$$n = (1.96)^2 * 0.38(1 - 0.38)$$

$$(0.050)^2$$

$$n = \frac{3.8416 * 0.38 * 0.62}{0.0025}$$

$$n = \frac{0.905}{0.0025}$$

$$0.0025$$

$$n = 362$$

Correcting for a possible non-response rate of 10%, the final calculation was $362/0.9 = 402$

The sample size of this study was increased to **402**.

Multistage sampling techniques were used. Out of the 11 LGAs in Ibadan metropolis, 2 LGAs were selected out of the 5 LGAs with urban slums, from which 2 wards were selected each, by random sampling. Simple random sampling was used to select participants from numbered household units. If there is more than one person per household meeting the criteria for selection, balloting was used to elect the participant.

3.4. Description of the Research Instrument:

Quantitative information was obtained on demographic variables of the study population, along with measurements of the Quality of life of participants using the WHO Global Quality of Life Questionnaire⁵. This questionnaire was also based on housing type, nutrition, level of education, occupation/trade, income and support system, governance and basic rights.

The World Health Organization Quality of Life (WHOQOL-BREF) is a 26-item questionnaire that assesses an individual's Quality of life. It was developed by the World Health Organization (WHO) to provide a brief and culturally sensitive measure of quality of life that can be used in a variety of settings and populations. The WHOQOL-BREF assesses four domains of quality of life: physical health, psychological health, social relationships, and environment. Each domain contains items that assess specific aspects of that domain, such as physical pain, energy and

fatigue, ability to work, personal relationships, and access to healthcare. Participants were asked to rate their level of satisfaction with each aspect on a 5-point scale, with higher scores indicating higher levels of satisfaction. The WHOQOL-BREF has been validated and used in a wide range of populations, including healthy individuals and those with various health conditions⁶. It has been translated into over 100 languages, making it a versatile and accessible tool for measuring quality of life.

Their psychological health was assessed using the DASS (Depression Anxiety Stress Scale), Beck Hopelessness Scale, Rosenberg Self Esteem Scale, and the General Health Questionnaire (GHQ-12) to assess their mental health as it relates to anxiety and depression⁷.

The DASS stands for Depression, Anxiety and Stress scale, a set of 21-item questionnaire. Each question is measured on Likert scale of “Never, sometimes, Often and Almost Always”. The scores for each of the 3 DASS scales containing 7 items each are calculated by summing the scores for the relevant items. The Beck Hopelessness Scale assesses the level of hopelessness that participants feel in the last one week. They are expected to answer True/false questions and the scoring was on point basis. The Rosenberg Self-Esteem Scale is a 10-item scale that measures self-worth using both positive and negative feelings about the self. A 4-point Likert scale ranging from ‘Strongly Agree to Strongly Disagree’ is used to score. The GHQ is a 12-scoring item, useful for assessment of common mental disorders based on anxiety and depression, loss of confidence and social dysfunction. The scoring method of 0-0-1-1 will be used to attain scores between 0-12 with the higher score representing worse mental health.

3.7. Data Collection

Data was collected quantitative using pre-validated structured self-administered questionnaire. The instrument would be administered both in Yoruba and English. This enables the study participants to engage with the instrument in their mother tongue and also have the freedom to choose to answer the English or Yoruba version of the questionnaire. Research assistants was made available for participants who need extra assistance with answering the questionnaire. This includes those participants who are unable to read or write. An informed consent form was attached to the questionnaire. It explains the research study and guarantee confidentiality and the required consent from the participant to participate in the research study.

3.8. Data Analysis

Quantitative data analysis:

Data was cleaned, data entry and coding was done using SPSS IBM version 23.

1. **Descriptive statistics:** The responses from questionnaire (WHOQOL-BREF) or the will be summarized using descriptive statistics such as frequencies, percentages, means, and standard deviations. This will provide an overview of the sample characteristics and the distribution of responses to individual questions.
2. **Bivariate Analysis(Chi square):** to examine the relationship between socio demographic characteristics and perceived quality of life and psychological well being among respondents.

3. Multivariate analysis: To examine the relationships between multiple variables such as quality of life, psychological health, and other factors, multivariate method-regression analysis will be used. The level of significance will be undertaken at $p < 0.05$.

3.9. Ethical Approval

Ethical approval for this study was obtained from the Oyo State Ministry of Health Department of Planning Research & Statistics Division (AD 13/479/536^A). An information statement was provided to all participants prior to obtaining informed verbal consent. To ensure informed verbal consent from participants, the information statement was read in Yoruba or English language depending on participant's preference. Participants were informed that their participation will be voluntary and that they would be free to decline participation or withdraw their consent at any time. They would not have to answer any question that they did not feel comfortable with, and they could withdraw at any time or simply choose not to answer a particular question. Anonymized data was stored on password-protected Laptops during data collection. Data was stored on secure and password-protected computers.

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Chapter Four

Results and Discussion of Findings

This chapter presents the findings of the study and the discussion. The results are presented in the other, in which the objectives were stated in Chapter one of the study.

4.1.1 Demographic Data Analysis

Research Questions One; what is the demographics of the out-of-school- young women in urban slums in Ibadan metropolis

The study included 407 participants, with an average age of 19.71 years and a standard deviation of 2.771. The majority of participants (51.4%) were over 20 years old. Participants were primarily skilled workers (51.4%), followed by trading (18.4%), apprentices (12.8%), factory workers (16.0%), and a small percentage (1.5%) reported having no specific vocation.

Most participants had completed secondary education (61.9%), while a significant proportion had no formal education (5.7%) or incomplete primary education (11.5%). Some had completed primary education (20.9%). 40.8% of participants' mothers had completed secondary education, 25.8% had primary education, 17.7% had tertiary education, and 15.7% had no formal education. 45.7% of participants' fathers had completed secondary education, 25.6% with tertiary education, 16.2% with primary education, and 12.5% with no formal education.

Most participants identified as Christians (43.0%), 56.3% identified as Muslims, and a small percentage (0.7%) belonged to other religions. The study predominantly consisted of Yoruba individuals (84.0%), with 16.0% representing other tribes. Most participants belonged to nuclear families (62.2%), with smaller proportions in polygamous families (29.2%), single-parent

families (4.7%), or orphans (3.9%). The majority of participants were single (75.4%), with a smaller percentage being married (12.5%), cohabiting (10.8%), or divorced/separated (1.2%).

62.9% of participants reported being sexually active, while 37.1% were not. The majority of those who reported being sexually active had their first intercourse between the ages of 17-19 (60.2%), followed by 14-16 (28.9%), and 20-22 (10.9%). 17.9% of participants had children, while 82.1% did not. A significant portion of participants (83.5%) reported being aware of contraceptive methods. Among those aware of contraceptives, 85.5% had used contraceptives before, while 14.5% had not. Various contraceptive methods were used, with male condoms being the most common (81.6%), followed by pills (35.2%), emergency contraceptives (15.6%), and female condoms (19.1%).

The majority of participants (55.8%) had a monthly income of less than 20,000 Naira, while 21.9% fell in the 20,000-30,000 Naira range, and 22.4% earned more than 30,000 Naira which is the minimum wage in the country. A significant portion of participants had self-employed fathers (66.6%) and self-employed mothers (59.7%). Some fathers were employed (22.9%), while mothers were more likely to be housewives (20.1%). A smaller percentage of fathers were unemployed (10.6%) and mothers were unemployed (7.6%). Approximately one-third of participants had a micro-business (33.9%), and most had savings (79.4%). About 40.8% of participants had the support of a socioeconomic group. A significant portion of participants reported experiences of sexual harassment (31.9%), while a smaller number reported experiences of rape (17.7%) and the use of illicit drugs (24.6%)

Table 4.1: Socio demographic Characteristics of Respondents

Variable	Frequencies	Percent (%)
Age (N=407)	407	
Mean ± SD	19.71 ± 2.771	
Age (N=407)		
<20 years	198	48.6
>20 years	209	51.4
Vocational Education (N=407)		
Apprentice	52	12.8
Trading	75	18.4
Skilled workers	209	51.4
Factory workers	65	16.0
Nothing	6	1.5
Educational Status (N=407)		
No Formal Education	23	5.7
Incomplete Primary Education	47	11.5
Complete Primary Education	85	20.9
Complete Secondary Education	252	61.9
Mother's Level of Education (n=407)		
No Formal Education	64	15.7
Primary Education	105	25.8
Secondary Education	166	40.8
Tertiary Education	72	17.7
Father's Level of Education (n=407)		
No Formal Education	51	12.5
Primary Education	66	16.2
Secondary Education	186	45.7

Tertiary Education	104	25.6
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Religion(N=407)

Christianity	175	43.0
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Islam	229	56.3
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Others	3	.7
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Tribe(N=407)

Yoruba	342	84.0
--------	-----	------

Non-Yoruba	65	16.0
------------	----	------

Family Type (N=407)

Nuclear Family	253	62.2
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Polygamous Family	119	29.2
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Single Parent	19	4.7
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Orphan	16	3.9
--------	----	-----

No of Siblings (N=407)

0	4	1.0
---	---	-----

1	21	5.2
---	----	-----

2	54	13.3
---	----	------

3	109	26.8
---	-----	------

4	219	53.8
---	-----	------

Family Position (N=407)

1-5	391	96.1
-----	-----	------

6-10	16	3.9
------	----	-----

Marital Status (N=407)

Single	307	75.4
--------	-----	------

Married	51	12.5
---------	----	------

Divorced/Separated	5	1.2
--------------------	---	-----

Co-Habiting	44	10.8
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**Are You Sexually Active
(n=407)**

Yes	256	62.9
-----	-----	------

No	151	37.1
----	-----	------

**Age at First Intercourse
(N=256)**

14-16	74	28.9
-------	----	------

17-19	154	60.2
-------	-----	------

20-22	28	10.9
-------	----	------

**Do You Have Children
(N=407)**

Yes	73	17.9
-----	----	------

No	334	82.1
----	-----	------

If Yes, How Many (N=73)

1	48	65.8
---	----	------

2	23	31.5
---	----	------

3	2	2.7
---	---	-----

**Are You Aware of
Contraceptive Use (N=407)**

Yes	340	83.5
-----	-----	------

No	67	16.5
----	----	------

**Have You Used
Contraceptives Before
(N=256)**

Yes	219	85.5
-----	-----	------

No	37	14.5
----	----	------

Male Condom (N=256)

Yes	209	81.6
-----	-----	------

No	47	18.4
----	----	------

Female Condom (N=256)

Yes	49	19.1
-----	----	------

No	207	80.9
----	-----	------

Pills (N=256)

Yes	90	35.2
-----	----	------

No	166	64.8
----	-----	------

Injectables (N=256)

Yes	11	4.3
-----	----	-----

No	245	95.7
----	-----	------

IUCD (N=256)

Yes	5	2.0
-----	---	-----

No	251	98.0
----	-----	------

Implant (N=256)

Yes	23	9.0
-----	----	-----

No	233	91.0
----	-----	------

Female Sterilization (N=256)

Yes	2	.8
-----	---	----

No	254	99.2
----	-----	------

Male Sterilization (N=256)

Yes	2	.8
-----	---	----

No	254	99.2
----	-----	------

Emergency Contraceptives (N=256)

Yes	40	15.6
-----	----	------

No	216	84.4
----	-----	------

Monthly Income (minimum wage = 30,000 Naira) (N=407)

<20,000	221	55.8
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20,000-30,000	89	21.9
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>30,000	91	22.4
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Father's Occupational Status(N=407)

Employed	93	22.9
----------	----	------

Self Employed	271	66.6
---------------	-----	------

Unemployed	43	10.6
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**Mother's Occupational Status
(N=407)**

Employed	51	12.5
Self Employed	243	59.7
Unemployed	82	20.1
Housewife	31	7.6

**Do You Have A Micro
Business (N=407)**

Yes	138	33.9
No	269	66.1

Do You Have Savings (N=407)

Yes	323	79.4
No	84	20.6

**Do You Have the Support Of
A Socioeconomic Group
(N=407)**

Yes	166	40.8
No	241	59.2

**Have You Experienced Sexual
Harassment (N=407)**

Yes	130	31.9
No	277	68.1

**Have You Experienced Rape
(N=407)**

Yes	72	17.7
No	335	82.3

**Have You Ever Used Illicit
Drugs (N=407)**

Yes	100	24.6
No	307	75.4

Source; Field Survey, 2023

4.2 Presentation of Data

Research Question Two: Quality of life of out-of-school adolescent girls and young women in urban slums in Ibadan metropolis

The physical domain, with a mean score of 9.7101 and a standard deviation of 1.90138, assesses the participants' physical well-being. The scores in this domain range from 4 to 15, indicating variations in physical health and well-being among the participants. The psychological domain, with a mean score of 13.1106 and a standard deviation of 2.01840, focuses on the psychological aspects of well-being. Scores range from 7 to 20, suggesting variations in psychological health and well-being within the study population. This domain, with a mean score of 10.1057 and a standard deviation of 1.75357, measures the level of independence of the participants. Scores in this domain vary between 5 and 16, reflecting different levels of independence among the individuals. The social relationship domain, with a mean score of 9.6143 and a standard deviation of 2.04291, assesses the quality of participants' social relationships. Scores in this domain range from 4 to 16, indicating variations in the quality and strength of social connections. This domain, with a mean score of 12.4128 and a standard deviation of 2.09424, evaluates the environmental factors influencing the participants. Scores range from 5 to 19, indicating differences in how environmental factors affect the participants. This domain, with a mean score of 10.4496 and a standard deviation of 1.96316, measures the importance of spiritual, religious, and personal beliefs in the participants' lives. Scores in this domain vary between 4 and 16, reflecting the diversity of spiritual and personal beliefs among the participants

Table 4.2: Health-Related Quality of Life

Physical Domain (n=407)	407	Highest number = 15
Mean ± SD	9.7101 ± 1.90138	Lowest number = 4
Psychological Domain (n=407)	407	Highest number = 20
Mean ± SD	13.1106 ± 2.01840	Lowest number = 7
Level of Independence Domain (n=407)	407	Highest number = 16
Mean ± SD	10.1057 ± 1.75357	Lowest number = 5
Social Relationship Domain	407	Highest number = 16
Mean ± SD	9.6143 ± 2.04291	Lowest number = 4
Environmental Domain (n=407)	407	Highest number = 19
Mean ± SD	12.4128 ± 2.09424	Lowest number = 5
Spiritual, Religion and Personal Belief	407	Highest number = 16
Mean ± SD	10.4496 ± 1.96316	Lowest number = 4

Source; Field Survey, 2023

Figure 4.1 below shows the perceived general quality of life of respondents and it was shown that 67% have good quality of life

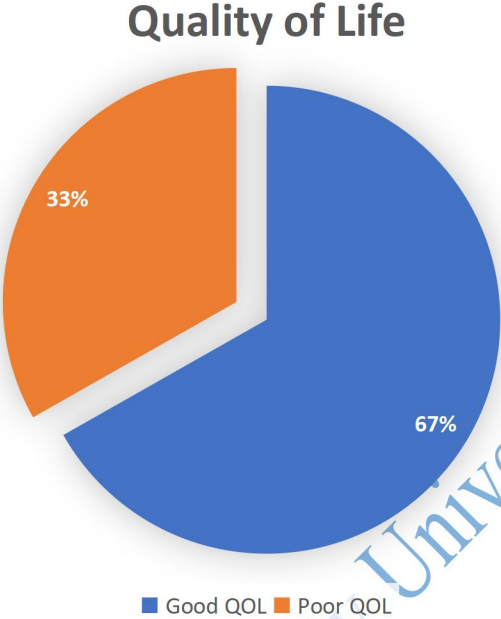


Fig 4.1: Perceived General Quality of Life of the Participants

Source; Field Survey, 2023

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Figure 4.2 below shows the perceived general health status of the participants, about 68% of respondents have good perceived good health status

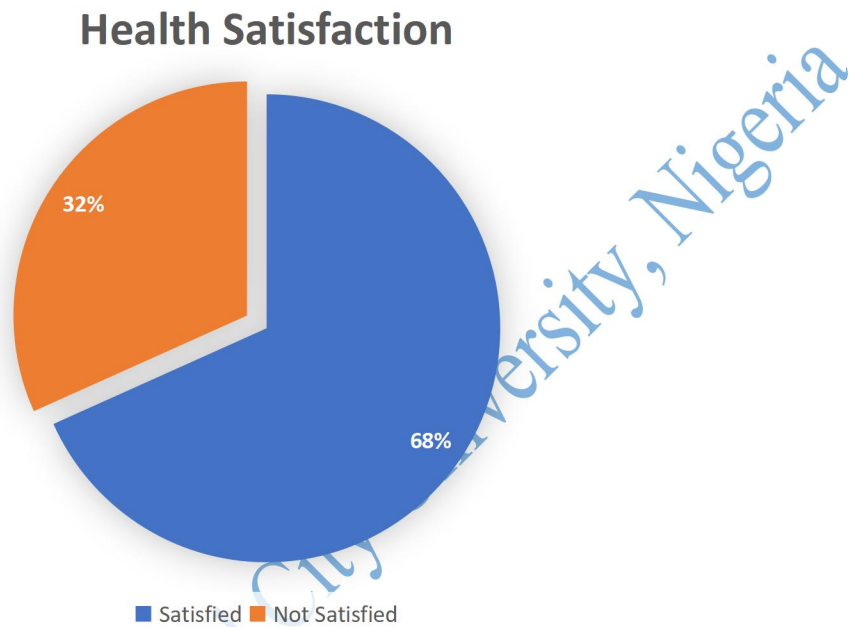


Fig 4.2: Perceived General Health Status of the Participants

Source; Field Survey, 2023

Research Question Three: Psychological Health of out-of-school adolescent girls and young women in urban slums in Ibadan metropolis

A. Level of Depression

Out of the total participants, 80.1% reported having a low level of depression, while 19.9% reported a high level of depression. This indicates that the majority of participants in the study experienced low levels of depression.

Table 4.3: Level of Depression

Variables	Frequencies	Percent (%)
Level of Depression		
Low level of depression	326	80.1
High level of depression	81	19.9

Source; Field Survey,2023

B. Level of Anxiety

A significant majority of participants, 77.5%, reported having a low level of anxiety, while 22.4% reported a high level of anxiety. This suggests that most participants in the study experienced low levels of anxiety.

Variables	Frequencies	Percent (%)
Level of Anxiety		
Low level of anxiety	316	77.5
High level of anxiety	91	22.4

Source; Field Survey,2023

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C. Level of Stress

In the stress category, 63.9% of participants reported having a low level of stress, while 36.1% reported a high level of stress. This indicates that a substantial portion of the study population experienced higher levels of stress.

Variables	Frequencies	Percent (%)
Level of Stress		
Low level of stress	260	63.9
High level of stress	147	36.1

Source; Field Survey,2023

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D. Hopelessness Scale

Among the participants, 75.4% reported being hopeful, while 24.6% reported high level of hopelessness. The majority of participants had hope

Variable	Frequencies	Percent (%)
Hopelessness Scale		
Hopeful	307	75.4
Hopeless	100	24.6

Source; Field Survey,2023

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D. Self-Esteem Scale

The majority of participants, 52.3%, reported having low self-esteem, while 47.7% reported high self-esteem. This suggests that a significant portion of the participants had lower self-esteem levels.

Variables	Frequencies	Percent (%)
Self-Esteem		
High Self-esteem	194	47.7
Low Self-esteem	213	52.3

Source; Field Survey,2023

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E. The General Health

The data shows that 29.5% of participants reported no distress in their general health, while 70.5% reported distress in their general health. This indicates that a majority of the participants experienced significant distress in their general health.

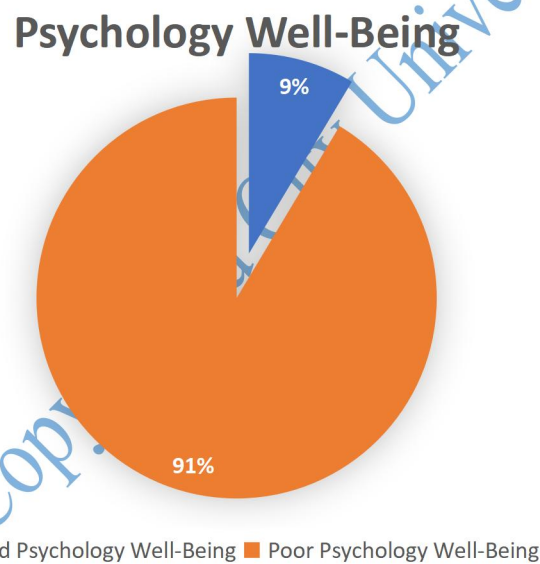
Variables	Frequencies	Percent (%)
The General Health		
Without distress	120	29.5
Severe distress	287	70.5

Source; Field Survey,2023

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F. Psychological Well-Being

The overall psychological well-being shows that 91.4% of participants reported poor psychological well-being, while only 8.6% reported good psychological well-being. This suggests that the majority of participants had lower psychological well-being levels. Good psychological well-being was obtained from participants who had low level of depression, anxiety, and stress, participants who were hopeful, had high self-esteem and were without distress.



Source: Field Survey, 2023

These findings provide important insights into the mental health and psychological well-being of the study participants. They indicate the prevalence of depression, anxiety, stress, hopelessness, self-esteem, distress, and psychological well-being among the participants

Research Question Four: Factors Associated With Qol among Out-Of-School Adolescent Girls and Young Women in Urban Slums in Ibadan Metropolis

Bivariate Analysis of the Demographic Characteristics of Quality of Life among Out-of-School Girls and Young Women and Socio demographic Characteristics

Table 4.3 below shows the bivariate analysis between perceived quality of life of out of school girls and young women and socio demographic characteristics. Educational status, fathers educational status, family type, mothers occupational status, having saving, support from socioeconomic groups , sexual harassment experience and usage of illicit drugs all show significant association with perceived quality of life of resounded

The table below shows that there is no significant difference in the quality of life based on age, both those under 20 years and those over 20 years have similar proportions of good and poor quality of life. The data revealed that individuals with higher levels of education tend to have a better quality of life. Those with complete secondary education have a higher proportion of good quality of life compared to those with no formal education or incomplete primary education.

Young women engaged in skilled work or handwork appear to have a better quality of life, while those who are traders or have nothing to do seem to have a higher proportion of poor quality of life. Participants with parents who have higher levels of education tend to have a better quality of life. This is evident from the data on both mother's and father's level of education. The religious affiliation of the participants does not appear to have a significant impact on their quality of life.

The majority of Yoruba participants seem to have a better quality of life compared to non-Yoruba participants, given the geographical location of the study. Those from nuclear families appear to

have a better quality of life compared to those from polygamous families, single-parent families, or those who are orphans. Individuals with more siblings (3 or more) seem to have a better quality of life compared to those with fewer siblings. Single individuals have a higher proportion of good quality of life compared to those who are married, divorced/separated, or cohabiting. Being sexually active and having children do not seem to significantly impact the quality of life. Participants who use contraceptives have a higher proportion of good quality of life.

Individuals with a monthly income greater than 30,000 units of currency have a notably better quality of life compared to those with lower income levels. Participants with employed or self-employed parents tend to have a better quality of life. Having a micro business and savings are associated with a better quality of life. Those who receive support from a socioeconomic group tend to have a better quality of life. Participants who have experienced sexual harassment, rape, or have used illicit drugs have a higher proportion of poor quality of life.

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Table 4.3: Bivariate Analysis of the demographic characteristics of quality of life among out-of-school girls and young women

Variable	Good Quality of Life(n=272) (%)	Poor Quality of Life(n=135) (%)	P-Value
Age			0.887
<20 years	133(48.9)	65(48.1)	
>20 years	139(51.1)	70(51.9)	
Educational Status			0.045*
No Formal Education	14(5.1)	9(6.7)	
Incomplete Primary Education	39(14.3)	8(5.9)	
Complete Primary Education	60(22.1)	25(18.5)	
Complete Secondary Education	159(58.5)	93(68.9)	
Vocational Education			0.268
Apprentices	30(11)	22(16.3)	
Trader	50(18.4)	25(18.5)	
Skilled worker/ handwork	143(52.6)	66(48.9)	
Factory workers	43(15.8)	22(16.3)	
Nothing	6(2.2)	0(0)	
Mother's level of education			0.068
No formal education	47(17.3)	17(12.6)	
primary education	74(27.2)	31(23)	
secondary education	112(41.2)	54(40)	
tertiary education	39(14.3)	33(24.4)	

Father's level of education			0.027*
No formal education	37(13.6)	14(10.4)	
primary education	46(16.9)	20(14.8)	
secondary education	132(48.5)	54(40)	
tertiary education	57(21)	47(34.8)	
Religion			0.436
Christianity	123(45.2)	52(38.5)	
Islam	147(54)	82(60.7)	
Others	2(0.7)	1(0.7)	
Tribe			0.323
Yoruba	232(85.3)	110(81.5)	
Non-Yoruba	40(14.7)	25(18.5)	
Family Type			0.002*
Nuclear family	180(66.2)	73(54.1)	
polygamous family	78(28.7)	41(30.4)	
Single parent	9(3.3)	10(7.4)	
Orphan	5(1.8)	11(8.1)	
Number of siblings			0.496
0	2(0.7)	2(1.5)	
1	13(4.8)	8(5.9)	
2	39(14.3)	15(11.1)	
3	78(28.7)	31(23)	
≥ 4	140(51.5)	79(58.5)	

Position in the family			0.998
1 st	81(29.8)	40(29.6)	
2 nd	87(32)	44(32.6)	
3 rd	58(21.3)	29(21.5)	
4 th or more	46(16.9)	22(16.3)	
Marital Status			0.162
Single	203(74.6)	104(77)	
Married	30(11)	21(15.6)	
Divorced/Separated	4(1.5)	1(0.7)	
Co-habiting	35(12.9)	9(6.7)	
Are you sexually active?			0.394
Yes	175(64.3)	81(60)	
No	97(35.7)	54(40)	
Do you have children			0.299
Yes	45(16.5)	28(20.7)	
No	227(83.5)	107(79.3)	
Contraceptive use			0.360
Yes	224(82.4)	116(85.9)	
No	48(17.6)	19(14.1)	
Have you used contraceptive before			0.949
Yes	150(55.1)	74(54.8)	
No	122(44.9)	61(45.2)	

Monthly income			0.143
<20000	159(58.5)	68(50.4)	
20000-30000	52(19.1)	30(22.2)	
>30000	61(22.4)	37(27.4)	
Father's occupational status			0.914
Employed	61(22.4)	32(23.7)	
Self-employed	183(67.3)	88(65.2)	
Unemployed	28(10.3)	15(11.1)	
Mother's occupational status			0.034*
Employed	28(10.3)	23(17)	
Self-employed	175(64.3)	68(50.4)	
Unemployed	52(19.1)	30(22.2)	
Housewife	17(6.2)	14(10.4)	
Do you have a micro business?			0.863
Yes	93(34.2)	45(33.3)	
No	179(65.8)	90(66.7)	
Do you have saving			0.004*
Yes	227(83.5)	96(71.1)	
No	45(16.5)	39(28.9)	
Support of a socioeconomic group?			0.018*
Yes	122(44.9)	44(32.6)	
No	150(55.1)	91(67.4)	

Have you experienced sexual harassment 0.006*

Yes	99(36.4)	31(23)
No	173(63.6)	104(77)

Have you experienced rape 0.808

Yes	49(18)	23(17)
No	223(82)	112(83)

Have you ever used illicit drugs 0.013*

Yes	77(28.3)	23(17)
No	195(71.7)	112(83)

Source; Field Survey, 2023

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Factors Associated With Qol among Out-Of-School Adolescent Girls and Young Women in Urban Slums in Ibadan Metropolis

Table 4.4 shows a number of factors influencing the participant's quality of life. Following adjustment of the twenty one significant associated variables in the logistic regression analysis (a significance value < 0.05), only seven risk factors made a statistically significant contribution to the quality of life which are Educational status ($p = 0.032, 0.055$), Father's level of education ($p = 0.029$), Mother's occupational status ($p = 0.008$), Savings ($p = 0.003$), Sexual Harassment ($p = 0.004$), Experience of rape ($p = 0.016$), Use of illicit drugs ($p = 0.016$). Participants with incomplete primary education had significantly lower odds of reporting poor quality of life compared to those with complete secondary education AOR of 0.329(95% CI: 0.120,0.907), and AOR of 0.506(95% of 0.252,1.016) respectively. Other educational categories did not show significant associations. Participants with fathers who had secondary education had significantly lower odds of reporting poor quality of life compared to those with no formal education AOR of 0.441(95% CI: 0.212,0.919). Other father's education categories did not show significant associations. Participants with mothers who were self-employed had significantly lower odds of reporting poor quality of life compared to those with housewives as mothers AOR of 0.260(95% CI: 0.096,0.704). Participants with savings had significantly lower odds of reporting poor quality of life compared to those without savings AOR of 0.368(95% CI: 0.192,0.707). Participants who reported experiencing sexual harassment had significantly lower odds of reporting poor quality of life (AOR of 0.382(95% CI: 0.198,0.737). Participants who reported experiencing rape had significantly higher odds of reporting poor quality of life (AOR of 2.659(95% CI: 1.204,5.873). Participants who reported ever using illicit drugs had significantly lower odds of reporting poor quality of life (AOR of 0.4119(95% of 0.199,0.848).

Table 4.4: Factors Associated with Quality of Life among Out-of-School Adolescent Girls and Young Women

Variables	COR (95%CI)	P-Value	AOR (95%CI)	P-Value
Psychological Well being				
Good Psychological Well-being	1.38(0.68,2.81)	0.371	2.01(0.82,4.99)	0.129
Poor Psychological Well-being	Ref	Ref	Ref	Ref
Age				
<20 years			0.89(0.456,1.74)	0.734
>20 years			Ref	Ref
Educational Status (N=407)				
No Formal Education			0.81(0.22,2.89)	0.748
Incomplete Primary Education			0.39(0.12,0.90)	0.032*
Complete Primary Education			0.56(0.25,1.01)	0.055*
Complete Secondary Education			Ref	Ref
Mother's Level of Education (n=407)				
No Formal Education			0.57(0.17,1.88)	0.363
Primary Education			0.89(0.34,2.38)	0.823
Secondary Education			0.92(0.38,2.22)	0.854
Tertiary Education			Ref	Ref
Father's Level of Education (n=407)				
No Formal Education			0.47(0.15,1.46)	0.194
Primary Education			0.55(0.22,1.42)	0.222
Secondary Education			0.44(0.21,0.92)	0.029*
Tertiary Education			Ref	Ref
Religion(N=407)				
Christianity			0.36(0.02,7.75)	0.515
Islam			0.66(0.03,14.32)	0.792

Others	Ref	Ref
Tribe(N=407)		
Yoruba	0.51(0.25,1.07)	0.075
Non-Yoruba	Ref	Ref
Family Type (N=407)		
Nuclear Family	0.13(0.03,0.56)	0.006
Polygamous Family	0.13(0.03,0.59)	0.008
Single Parent	0.25(0.04,1.60)	0.144
Orphan	Ref	Ref
No of Siblings (N=407)		
0	1.57(0.17,14.43)	0.687
1	0.67(0.18,2.44)	0.547
2	0.43(0.17,1.11)	0.080
3	0.47(0.24,0.95)	0.035
4	Ref	Ref
Marital Status (N=407)		
Single	2.081(0.783,5.530)	0.142
Married	1.268(0.344,4.673)	0.721
Divorced/Separated	0.311(0.015,6.483)	0.451
Co-Habiting	Ref	Ref
Are You Sexually Active (n=407)		
Yes	1.11(0.57,2.14)	0.749
No	Ref	Ref
Do You Have Children (N=407)		
Yes	1.76(0.69,4.51)	0.232
No	Ref	
Monthly Income (minimum wage = 30,000 Naira) (N=407)		

<20,000	0.78(0.39,1.54)	0.477
20,000-30,000	0.65(0.28,1.53)	0.335
>30,000	Ref	Ref
Father's Occupational Status(N=407)		
Employed	0.51(0.17,1.50)	0.224
Self Employed	0.59(0.238,1.50)	0.276
Unemployed	Ref	Ref
Mother's Occupational Status (N=407)		
Employed	0.84(0.26,2.62)	0.765
Self Employed	0.26(0.09,0.70)	0.008*
Unemployed	0.44(0.15,1.29)	0.138
Housewife	Ref	Ref
Do You Have a Micro Business (N=407)		
Yes	1.06(0.57,1.95)	0.852
No	Ref	Ref
Do You Have Savings (N=407)		
Yes	0.38(0.19,0.71)	0.003*
No	Ref	
Do You Have the Support of a Socioeconomic Group (N=407)		
Yes	0.67(0.38,1.15)	0.152
No	Ref	
Have You Experienced Sexual Harassment (N=407)		
Yes	0.38(0.19,0.74)	0.004*
No	Ref	Ref
Have You Experienced Rape (N=407)		

Yes	2.65(1.20,5.87)	0.016*
No	Ref	Ref
Have You Ever Used Illicit Drugs (N=407)		
Yes	0.41(0.19,0.85)	0.016*
No	Ref	

Source; Field Survey, 2023

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Research Question Five: **Factors Associated With Psychological Well-Being among Out-Of-School Adolescent Girls and Young Women in Urban Slums in Ibadan Metropolis**

Bivariate Analysis of the Demographic Characteristics of Psychological Well-Being among Out-Of-School Girls and Young Women and Socio Demographic Characteristics

Table 4.5 below shows that there is no significant difference in psychological well-being based on age. Both those under 20 years and those over 20 years exhibit similar proportions of good and poor psychological well-being. Educational attainment plays a vital role in psychological well-being. Those with complete secondary education have a significantly higher proportion of good psychological well-being, while those with no formal education or incomplete primary education exhibit a higher proportion of poor psychological well-being. The type of occupation also influences psychological well-being. Young women engaged in skilled work or handwork tend to have better psychological well-being compared to those who are traders or have no specific occupation. The educational background of both mothers and fathers significantly impacts psychological well-being. Participants with parents who have higher levels of education tend to experience better psychological well-being.

Religious affiliation does not seem to have a substantial impact on psychological well-being. Yoruba participants appear to have better psychological well-being compared to non-Yoruba participants, likely influenced by the geographical context of the study. Individuals from nuclear families tend to have better psychological well-being compared to those from polygamous families, single-parent families, or those who are orphans. Having more siblings (3 or more) is associated with better psychological well-being.

The position in the family hierarchy does not seem to have a significant impact on psychological well-being. All participants in the "Good Psychological Well-being" category are single, indicating that they might have more stable mental health. In contrast, the "Poor Psychological Well-being" group includes participants with various marital statuses. Being sexually active or having children does not appear to significantly impact psychological well-being. Participants who use contraceptives tend to have better psychological well-being. A higher monthly income, especially exceeding 30,000 units of currency, is associated with better psychological well-being. Participants with employed or self-employed parents tend to have better psychological well-being. Having a micro business does not seem to have a significant impact on psychological well-being. However, participants with savings tend to have better psychological well-being. Receiving support from a socioeconomic group is associated with better psychological well-being. Participants who have experienced sexual harassment, or rape, or have used illicit drugs tend to have a higher proportion of poor psychological well-being, indicating the need for mental health support and interventions for these individuals.

Table 4.5: Bivariate Analysis of the demographic characteristics of psychological well-being among out-of-school girls and young women

Variable	Good Psychological Well-being(n=35) (%)	Poor Psychological Well-being (n=372) (%)	P-Value
Age			0.002*
<20 years	26(74.3)	172(46.2)	
>20 years	9(25.7)	200(53.8)	
Educational Status			0.098
No Formal Education	0(0)	23(6.2)	
Incomplete Primary Education	7(20)	40(10.8)	
Complete Primary Education	10(28.6)	75(20.2)	
Complete Secondary Education	18(51.4)	234(62.9)	
Vocational Education			0.534
Apprentices	7(20)	45(12.1)	
Trader	8(22.9)	67(18)	
Skilled worker/ handwork	15(42.9)	194(52.2)	
Factory workers	5(14.3)	60(16.1)	
Nothing	0(0)	6(1.6)	
Mother's level of education			0.114
No formal education	2(5.7)	62(16.7)	
primary education	14(40)	91(24.5)	
secondary education	12(34.3)	154(41.4)	

tertiary education	7(20)	65(17.5)	
Father's level of education			0.383
No formal education	2(5.7)	49(13.2)	
primary education	4(11.4)	62(16.7)	
secondary education	20(57.1)	166(44.6)	
tertiary education	9(25.7)	95(25.5)	
Religion			0.796
Christianity	14(40)	161(43.3)	
Islam	21(60)	208(55.9)	
Others	0(0)	3(0.8)	
Tribe			0.211
Yoruba	32(91.4)	310(83.3)	
Non-Yoruba	3(8.6)	62(16.7)	
Family Type			0.799*
Nuclear family	23(65.7)	230(61.8)	
polygamous family	8(22.9)	111(29.8)	
Single parent	2(5.7)	17(4.6)	
Orphan	2(5.7)	14(3.8)	
Number of siblings			0.589
0	0(0.0)	4(1.1)	
1	2(5.7)	19(5.1)	
2	5(14.3)	49(13.2)	
3	13(37.1)	96(25.8)	

≥ 4	15(42.9)	204(54.8)	
Position in the family			0.481
1 st	8(22.9)	113(30.4)	
2 nd	13(37.1)	118(31.7)	
3 rd	10(28.6)	77(20.7)	
4 th or more	4(11.4)	64(17.2)	
Marital Status			0.006*
Single	35(100)	272(73.1)	
Married	0(0)	51(13.7)	
Divorced/Separated	0(0)	5(1.3)	
Co-habiting	0(0)	44(11.8)	
Are you sexually active?			0.003*
Yes	14(40)	242(65.1)	
No	21(60)	130(34.9)	
Do you have children			0.004*
Yes	0(0)	73(19.6)	
No	35(100)	299(80.4)	
Contraceptive use			0.716
Yes	30(85.7)	310(83.3)	
No	5(14.3)	62(16.7)	
Have you used contraceptive before			0.421
Yes	17(48.6)	207(55.6)	

No	18(51.4)	165(44.4)	
Monthly income			0.012*
<20000	23(65.7)	204(54.8)	
20000-30000	11(31.4)	78(21)	
>30000	1(2.9)	90(24.2)	
Father's occupational status			0.010*
Employed	14(40)	79(21.2)	
Self-employed	21(60)	250(67.2)	
Unemployed	0(0)	43(11.6)	
Mother's occupational status			0.600
Employed	4(11.4)	47(12.6)	
Self-employed	18(51.4)	225(60.5)	
Unemployed	10(28.6)	72(19.4)	
Housewife	3(8.6)	28(7.5)	
Do you have a micro business?			0.746
Yes	11(31.4)	127(34.1)	
No	24(68.6)	245(65.9)	
Do you have saving			0.002*
Yes	35(100)	288(77.4)	
No	0(0)	84(22.6)	
Support of a socioeconomic group?			0.180

Yes	18(51.4)	148(39.8)	
No	17(48.6)	224(60.2)	
Have you experienced sexual harassment			0.745
Yes	12(34.3)	118(31.7)	
No	23(65.7)	254(68.3)	
Have you experienced rape			0.052*
Yes	2(5.7)	70(18.8)	
No	33(94.3)	302(81.2)	
Have you ever used illicit drugs			0.002*
Yes	1(2.9)	99(26.6)	
No	34(97.1)	273(73.4)	

Source: Field Survey 2023

Factors Associated With Psychological Well-Being among Out-Of-School Adolescent Girls and Young Women in Urban Slums in Ibadan Metropolis

Table 4.6 shows a number of factors influencing the participant's quality of life. Following adjustment of the twenty-one significant associated variables in the logistic regression analysis (a significance value < 0.05), only two factors made a statistically significant contribution to psychological well-being which are monthly income ($p = 0.045$) and use of illicit drugs ($p = 0.024$). Participants with monthly incomes of 20,000-30,000 Naira had a higher adjusted odds ratio of AOR of 15.403 (95%CI: 1.066,222.663) for good psychological well-being, and this result was statistically significant ($p = 0.045$). Other income categories did not show a significant association. Participants who reported ever using illicit drugs had a significantly higher adjusted odds ratio of AOR of 19.169 (95%CI: 1.468, 250.244) for good psychological well-being, and this result was statistically significant ($p = 0.024$).

Table 4.6: Factors Associated with Psychological Well-being among Out-of-School Adolescent Girls and Young Women

Variables	AOR (95%CI)	P-Value
Age		
<20 years	1.657(0.312,8.803)	0.554
>20 years	Ref	Ref
Educational Status (N=407)		
No Formal Education	59253859.721(0.000 .	0.998
Incomplete Primary Education	0.623(0.127,3.054)	0.559
Complete Primary Education	0.612(0.160,2.341)	0.473
Complete Secondary Education	Ref	Ref
Mother's Level of Education (n=407)		
No Formal Education	1.985(0.207,19.012)	0.552
Primary Education	0.333(0.049,2.280)	0.263
Secondary Education	0.843(0.152,4.670)	0.845
Tertiary Education	Ref	Ref
Father's Level of Education (n=407)		
No Formal Education	0.430(0.037,4.980)	0.499
Primary Education	0.401(0.054,2.960)	0.370
Secondary Education	0.711(0.187,2.707)	0.617
Tertiary Education	Ref	Ref
Tribe(N=407)		
Yoruba	0.353(0.055,2.252)	0.271

Non-Yoruba	Ref	Ref
Family Type (N=407)		
Nuclear Family	6.710(0.270,166.951)	0.246
Polygamous Family	3.554(0.120,104.909)	0.463
Single Parent	1.290(0.029,56.925)	0.895
Orphan	Ref	Ref
No of Siblings (N=407)		
0	148206782.088(0.000)	0.999
1	2.552(0.145,45.014)	0.522
2	0.776(0.134,4.502)	0.777
3	0.567(0.152,2.112)	0.398
4	Ref	Ref
Are You Sexually Active (n=407)		
Yes	1.482(0.365,6.015)	0.582
No	Ref	Ref
Do You Have Children (N=407)		
Yes	72649144.178(0.000)	0.996
No	Ref	
Monthly Income (minimum wage = 30,000 Naira) (N=407)		
<20,000	1.529(0.463,5.053)	0.486
20,000-30,000	15.403(1.066,222.663)	0.045*
>30,000	Ref	Ref

Mother's Occupational Status**(N=407)**

Employed	1.049(0.101,10.866)	0.968
Self Employed	1.502(0.207,10.916)	0.688
Unemployed	0.670(0.072,6.220)	0.725
Housewife	Ref	Ref

Do You Have A Micro Business**(N=407)**

Yes	1.111(0.319,3.874)	0.868
No	Ref	Ref

Do You Have the Support of a Socioeconomic Group (N=407)

Yes	0.372(0.110,1.254)	0.111
No	Ref	

Have You Experienced Sexual Harassment (N=407)

Yes	0.448(0.139,1.441)	0.178
No	Ref	Ref

Have You Experienced Rape (N=407)

Yes	5.752(0.727,45.494)	0.097
No	Ref	Ref

Have You Ever Used Illicit Drugs**(N=407)**

Yes	19.169(1.468,250.244)	0.024*
No	Ref	

Source; Field Survey, 2023

4.2. Discussion of Findings

The study involved 407 participants, primarily young adults with an average age of 19.71 years, which is similar to a finding from another study that shows that the mean age of the study participants was 20 years.¹ The study also found that participants came from diverse vocational backgrounds, with skilled workers being the most common group. Educational backgrounds varied, with a significant proportion having completed secondary education, while some had no formal education or incomplete primary education. This is in contrast to the study that showed that majority of the participants had completed primary education.¹ The participants' parents also exhibited diversity in their educational levels, with varying proportions of mothers and fathers holding different levels of education. Additionally, the majority of participants identified as either Christians or Muslims, with a smaller percentage belonging to other religions. This is in line with a study that showed that Christianity and Islam were the major religions of the study participants but more Muslims out-of-school youths than their counterparts in other religions.² The study mainly comprised Yoruba individuals. This is similar to a study that found that the majority of the participants are Yoruba, and also not far from expectations given the geographical settings of the survey.²

Regarding family structures, most participants belonged to nuclear families, with smaller proportions in polygamous families, single-parent families, or orphans. In terms of marital status,

the majority of participants were single, with a smaller percentage being married, cohabiting, or divorced/separated. This finding is similar to a study that found that a little over half of the participants were currently married.¹ A significant portion of participants reported being sexually active, with their first sexual experiences typically occurring between the ages of 17-19. A notable number of participants had children, and the majority were aware of contraceptive methods, with a significant percentage having used contraceptives. Male condoms were the most common contraceptive method used. This finding is similar to a study that found the majority of the participants were sexually active and the majority had children.² These findings also contradict a study that found low levels of contraceptive practices among the majority of out-of-school youths.²

Participants' income levels varied, with the majority earning less than 20,000 Naira per month, which is less than the minimum wage given by the governments. Many had self-employed parents, and a significant portion of participants had micro-businesses and savings. A notable proportion also had the support of a socioeconomic group. The study also highlighted instances of sexual harassment, rape, and the use of illicit drugs among the participants. These findings are similar to a study that found that a little more than half of the participants had savings and also not up to half of them had a micro business, three-quarter of them had the support of socioeconomic group members, and just a few numbers of the participants have used any illicit drug.¹

The study assessed the participants' quality of life across multiple domains, including physical, psychological, independence, social relationships, environmental factors, and the importance of spiritual and personal beliefs. Each domain was characterized by a mean score and standard deviation, showcasing variations in well-being and life experiences among the participants. The

study found that the majority of the participants had a good quality of life. This finding is similar to a study done in Kenya, which shows that 1326 (28.2%) of the study participants belonged to the Low QoL group, 1445 (36.1%) to the Average QoL group and 1427 (35.7%) to the High QoL group.³ A logistic regression analysis identified significant associated variables impacting quality of life, which include educational status, father's level of education, mother's occupational status, savings, Sexual Harassment, experience of rape, and use of illicit drugs. This finding is similar to a study that showed that receiving money from working, sexual harassment at school, being sexually active, forced sex, physical assault, being robbed, threats to hurt you, threats for the family to be hurt, being publicly humiliated, stopping activities because of monthly menstruation problems and having to do something to get sanitary pads were predictive of persistent QoL problems.³

The study showed that less than one-quarter of the participants had high levels of depression symptoms, and anxiety symptoms, and one-quarter of the participants had high levels of stress symptoms. Less than one-quarter of the participants felt hopeful, close to half of the participants had high self-esteem and one-third of them were without distress. These findings are similar to a study that showed that the prevalence of depressive and anxiety symptoms among out-of-school AGYW was high, at 36% and 31% respectively.¹ The findings from this study also contradict a study that showed a significant number of high self-esteems among grade 12 participants.³

A logistic regression analysis identified significant associated variables impacting psychological well-being. Of the twenty-one variables examined, only two factors emerged as statistically significant contributors to psychological well-being: monthly income and the use of illicit drugs. Participants with monthly incomes between 20,000-30,000 Naira had a significantly higher adjusted odds ratio for good psychological well-being. Similarly, participants who reported ever

using illicit drugs had a significantly higher adjusted odds ratio for good psychological well-being. This is in line with a study that showed that protective effect of economic status and social capital on depressive and anxiety symptoms. Having a person to rely on for emotional support was protective against anxiety and having savings protective against depressive symptoms. This implies that programs that help AGYW build social, networking as well as entrepreneur skills may help prevent anxiety and depression.¹

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Endnotes

¹Kuringe, Evodius, Jacqueline Materu, Daniel Nyato, Esther Majani, Flaviana Ngeni, Amani Shao, Deusdedit Mjungu et al. "Prevalence and correlates of depression and anxiety symptoms among out-of-school adolescent girls and young women in Tanzania: A cross-sectional study." *PLoS One* 14, no. 8 (2019): e0221053.

²Atere, A. A., E. O. Wahab, O. E. Ajiboye, H. O. Shokoya, A. A. Akinwale, and A. S. Oyenuga. "Awareness of STIs and contraceptives use among out-of-school youths in Nigeria." *Studies on Ethno-Medicine* 4, no. 2 (2010): 131-137.

³Spinhoven, Philip, Garazi Zulaika, Elizabeth Nyothach, Anna Maria van Eijk, David Obor, Eunice Fwaya, Linda Mason, Duolao Wang, Daniel Kwaro, and Penelope A. Phillips-Howard. "Quality of Life and Well-Being Problems in Secondary Schoolgirls in Kenya: Prevalence, Associated Characteristics, and Course Predictors." Edited by Palash Chandra Banik. *PLOS Global Public Health* 2, no. 12 (December 19, 2022): e0001338. <http://dx.doi.org/10.1371/journal.pgph.0001338>.

⁴Birndorf, Susan, Sheryl Ryan, Peggy Auinger, and Marilyn Aten. "High self-esteem among adolescents: Longitudinal trends, sex differences, and protective factors." *Journal of Adolescent Health* 37, no. 3 (2005): 194-201.

Chapter Five

Conclusion

5.1 Summary of Findings

The general objective of the study was to assess and to understand the quality of life and psychological health of out-of-school adolescent girls and young women in urban slums in Ibadan metropolis, Southwest, Nigeria due to a noted gap in research in this area. The study conducted a thorough review of existing literature to establish this gap and set clear objectives, definitions, and scope for the research.

The study involved 407 participants, primarily young adults with an average age of 19.71 years, from diverse vocational and educational backgrounds, with varying levels of parental education and religious affiliations. The study revealed that the majority of participants identified as Christians or Muslims, and most belonged to nuclear families. The study assessed the participants' quality of life across multiple domains, including physical, psychological, independence, social relationships, environmental factors, and the importance of spiritual and personal beliefs. The study found that the majority of the participants had a good quality of life, with only a small proportion belonging to the low QoL group. The study also identified significant associated variables impacting quality of life, which include educational status, father's level of education, mother's occupational status, and religion. The study also highlighted instances of sexual harassment, rape, and the use of illicit drugs among the participants. A significant portion of participants reported being sexually active, with their first sexual experiences typically occurring between the ages of 17-19. The study found that a notable number of participants had children, and the majority were aware of contraceptive methods.

Regarding family structures, most participants belonged to nuclear families, with smaller proportions in polygamous families, single-parent families, or orphans. In terms of marital status, the majority of participants were single, with a smaller percentage being married, cohabiting, or divorced/separated. A little over half of the participants were currently married. Overall, the study provides valuable insights into the quality of life and well-being of young adults in Nigeria, highlighting areas of strength and areas for improvement. The findings can inform policies and interventions aimed at improving the quality of life and well-being of young adults in Nigeria and other similar contexts. The study also contributes to the existing literature on the quality of life and well-being of young adults in Nigeria, providing a basis for future research in this area.

5.2 Conclusion

In conclusion, this study has offered a comprehensive exploration of the quality of life and psychological well-being of out-of-school adolescent girls and young women in urban slums in Ibadan, Southwest Nigeria. With a diverse and representative sample, we have gained valuable insights into the challenges and strengths of this demographic.

The findings underscore the significance of education, parental education, and socioeconomic stability in shaping the quality of life of these young adults. The majority of participants reported good quality of life, despite the presence of challenges such as sexual harassment, experiences of rape, and illicit drug use. The influence of income on psychological well-being highlights the importance of economic stability for mental health. This research serves as a vital resource for policymakers and organizations seeking to improve the well-being of young adults in Nigeria. It calls for targeted interventions that address the identified factors impacting quality of life and mental health, with a focus on education, economic empowerment, and mental health support.

This study has not only filled a crucial gap in the literature but has also set the stage for future research and action to enhance the lives of out-of-school adolescent girls and young women in urban slums. By recognizing their unique challenges and strengths, we can work towards a more promising and equitable future for this vibrant and resilient demographic.

5.3 Recommendation

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

1. **Education Access and Support:** Initiatives should be developed to improve access to education for out-of-school adolescent girls and young women. This can include scholarship programs, flexible learning opportunities, and mentorship programs to encourage them to return to formal education or acquire vocational skills.
2. **Economic Empowerment:** Interventions aimed at economic empowerment, such as skills training and job placement programs, should be implemented. These programs can help enhance the financial stability of young adults, thus improving their overall quality of life.
3. **Mental Health Services:** Given the prevalence of psychological distress in the study participants, there is a clear need for accessible and affordable mental health services. Programs that provide counseling, support, and education on mental health issues can be instrumental in addressing this concern.
4. **Sexual and Reproductive Health Education:** Comprehensive sexual and reproductive health education should be provided to equip young adults with the knowledge and tools to make informed decisions about their sexual health. This can include information on contraceptives, safe sex practices, and the prevention of sexual harassment and assault.

5. **Community Support:** The involvement of local communities and support networks is crucial. Building and strengthening community-based organizations and support groups can provide a safety net for out-of-school adolescent girls and young women.
6. **Preventing Substance Abuse:** Programs focused on substance abuse prevention and rehabilitation should be established, with a particular emphasis on the risks associated with illicit drug use.
7. **Research and Monitoring:** Continuous research and data collection are essential to understand the evolving needs and challenges of this demographic. Regular monitoring and evaluation of programs are vital to ensure their effectiveness and relevance.
8. **Policy Advocacy:** Advocacy for policies that support the rights and well-being of out-of-school adolescent girls and young women is critical. This includes policies that promote access to education, economic opportunities, and protection against sexual harassment and violence.
9. **Gender Equality and Empowerment:** Empowering young women and girls through programs that promote gender equality and challenge traditional gender roles can contribute to their overall well-being.
10. **Collaborative Efforts:** Collaboration among government agencies, NGOs, community organizations, and other stakeholders is essential for a coordinated and effective response to the challenges faced by out-of-school adolescent girls and young women.

5.4 Contribution to Knowledge

1. **Understanding a Vulnerable Demographic:** This research sheds light on the often-overlooked demographic of out-of-school adolescent girls and young women living in urban slums. By focusing on their well-being, it provides a deeper understanding of their challenges, strengths, and unique needs.
2. **Quality of Life Assessment:** The study employs a comprehensive assessment of quality of life across various domains, providing insights into the physical, psychological, independence, social, environmental, and spiritual aspects of well-being. This multi-dimensional approach adds depth to the understanding of quality of life in this context.
3. **Psychological Well-Being:** By examining factors contributing to psychological well-being in this demographic, the research highlights the importance of economic stability and the intriguing relationship between illicit drug use and well-being. These findings contribute to the understanding of mental health in similar populations.
4. **Social and Health Factors:** The study's findings on sexual harassment, rape, sexual activity, and contraceptive use provide valuable data on the social and health factors affecting out-of-school adolescent girls and young women. This information can inform targeted interventions in these areas.
5. **Policy and Program Implications:** The research generates recommendations for policy and program development, offering actionable insights for policymakers, organizations, and stakeholders working to improve the lives of young adults in urban slums. It serves as a foundation for evidence-based initiatives and interventions to address the challenges faced by this demographic.

5.5 Suggestions for Further Research

This study focused on out-of-school adolescent girls and young women in Ibadan, Oyo State; it is suggested that further studies in the field can be done:

1. Effectiveness of Educational Interventions and Support Programs for Out-of-School Adolescent Girls and Young Women: A Comparative Assessment.
2. Assessing the Prevalence of Sexual Harassment and Violence Among Out-of-School Adolescent Girls and Young Women and Its Impact on Contraceptive Choices.
3. Barriers and Facilitators to Contraceptive Uptake Among Out-of-School Adolescent Girls and Young Women.

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WHO

Do Not Copy, Lead City University, Nigeria

Informed Consent Form

Lead City University

Ibadan, Oyo State

**Quality Of Life and Psychological Health of Out-Of-School Adolescent Girls and Young
Women in Urban Slums in Ibadan Metropolis, Southwest, Nigeria**

Principal investigator

Olubunmi Oni

PUBLIC HEALTH DEPARTMENT, LEAD CITY UNIVERSITY

LEAD CITY UNIVERSITY, TOLL GATE, IBADAN

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PURPOSE OF THE STUDY

My name is Olubunmi Oni, a postgraduate student of Lead City University, Ibadan. I am conducting a study on the Quality of Life and Psychological Health of Out-Of-School Adolescent girls and young women in Urban Slums in Ibadan Metropolis, Southwest, Nigeria

I am interested in understanding quality of life and psychological health of out-of-school adolescent girls and young women in urban slums in Ibadan metropolis, Southwest, Nigeria. I equally want to assess quality of life and psychological health of out-of-school adolescent girls and young women in urban slums in Ibadan metropolis, Southwest, Nigeria. Your insight and response to the research questionnaire will assist me understand the quality of life and psychological health of out-of-school adolescent girls and young women in urban slums.

RESEARCH PROCEDURE

If you agree to be in this study, you will be asked to answer questions about yourself as well as questions about your general health. These questions will be asked using a structured questionnaire. To fill the questionnaire will take about 5 to 10 minutes of your time.

RISKS AND BENEFITS

There is minimum or no risks if you take part in this study. There are incentives and the information you provide will help you improve on your overall health.

COMPENSATION

There is no monetary compensation for this study. Participation is also voluntary.

CONFIDENTIALITY

Like it is stated above, your comments will not be anonymous. Every effort will be made by the researcher to preserve your confidentiality. Only the research team will have access to the answered questionnaires. Confidentiality and privacy will be maintained by keeping all materials under lock and key. Your name will not be recorded at any point in the course of filling in the questionnaire.s

CONTACT INFORMATION

If you have questions at any time about this study, or you experience adverse effects as the result of participating in this study, you may contact the researcher whose contact information is provided on the first page. If you have questions regarding your rights as a research participant,

or if problems arise which you do not feel you can discuss with the Primary Investigator, please contact the Institutional Review Board at Lead City University, Ibadan, Oyo state.

VOLUNTARY PARTICIPATION

Your participation in this study is voluntary. It is up to you to decide whether or not to take part in this study. If you decide to take part in this study, you will be asked to sign a consent form. After you sign the consent form, you are still free to withdraw at any time and without giving a reason. Withdrawing from this study will not affect the relationship you have, if any, with the researcher. If you withdraw from the study before data collection is completed, your data will be returned to you or destroyed.

CONSENT

I have read and I understand the provided information and I have had the opportunity to ask questions. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and without cost. I understand that I will be given a copy of this consent form. I voluntarily agree to take part in this study.

Participant's signature _____ Date _____

Investigator's signature _____ Date _____

Questionnaire

Lead City University

Department of Public Health

SECTION A: SOCIO-DEMOGRAPHIC DATA

1. Age as at last birthday
2. Educational status (a) No formal education () (b) incomplete primary education () (c) complete primary education () (d) complete secondary education ().
3. Vocational education.....
4. Religion: Christianity () Islam () Other (Specify)_____
5. Tribe: Yoruba()Igbo () Hausa () Other (Specify)_____
6. Family type: (a) nuclear family () (b) polygamous family () (c) Single parents () (d) Orphan ()
7. Marital status: (a)single (b) married (c) divorced (d) co-habiting
8. Do you have children: (a) yes () (b) no ()
if yes how many
9. What is your monthly income

Baseline Characteristics
Please tick where appropriate:

Psycho-social	Yes	No
1. Do you have a micro business		
2. Do you have savings		
3. Do you have support of a socio-economic group		
4. Have you experience violence from a sexual partner		
5. Have you ever used illicit drugs		

SECTION B: HEALTH-RELATED QUALITY OF LIFE ASSESSMENT TOOL

Kindly indicate your level of response

Key: Not at all, A Little, Moderate Amount, Extreme Amount

PHYSICAL DOMAIN

S/N	Statement	Not At all	A Little	Moderate Amount	Extreme Amount
1.	How have you felt that physical pain prevents you from doing what you need to do?				
2.	Do you have energy for everyday life?				
3.	How satisfied are you with your sleep?				
4.	How much are you bothered by any physical problems related to your HIV infection?				

PSYCHOLOGICAL DOMAIN

S/N	Statement	Not At all	A Little	Moderate Amount	Extreme Amount
5.	How much do you enjoy life?				
6.	How well are you able to concentrate?				
7.	How satisfied are you with yourself?				
8.	Are you able to accept your bodily appearance?				
9.	How often do you have negative feelings such as blue mood, despair, anxiety and depression?				

LEVEL OF INDEPENDENCE DOMAIN

SN	Statement	Not At All	A Little	Moderate Amount	Extreme Amount
20.	How well are you able to get around?				
21.	How satisfied are you with your ability to perform your daily living activities?				
22.	How satisfied are you with your capacity for work?				
23.	How much do you need any medical treatment to function in your daily life?				

SOCIAL RELATIONSHIP DOMAIN

SN	Statement	Not At all	A Little	Moderate Amount	Extreme Amount
24.	How satisfied are you with your personal relationships?				
25.	How satisfied are you with the support you get from your friends?				
26.	How satisfied are you with your sex life?				
27.	How satisfied are you with your participation in leisure activities?				

ENVIRONMENTAL DOMAIN

SN	Statement	Not At all	A Little	Moderate Amount	Extreme Amount
28.	How safe do you feel in your daily life?				
29.	How satisfied are you with the conditions of your living place?				
30.	How satisfied are you with your access to health services?				
31.	To what extent do you have the opportunity for leisure activities?				
32.	How healthy is your physical environment?				

SPIRITUAL, RELIGION AND PERSONAL BELIEFS

SN	Statement	Not At all	A Little	Moderate Amount	Extreme Amount
33.	To what extent do you feel your life to be meaningful?				
34.	To what extent are you bothered by people blaming you for your HIV status?				
35.	How much do you fear the future?				
36.	To what extent do you have the opportunity for leisure activities?				

GENERAL QUALITY OF LIFE

SN	Statement	Not At all	A Little	Moderate Amount	Extreme Amount
37.	How would you rate your quality of life?				
38.	How satisfied are you with your health?				

SECTION C: Psychological Well-Being

A. DASS (Depression Anxiety Stress Scale) 21

Please read each statement and tick which indicates how much the statement applied to you over the past week. There are no right or wrong answers.

	Never	Someti mes	Often	Almost always
1. I found it hard to wind down				
2. I was aware of dryness of my mouth				
3. I couldn't seem to experience any positive feeling at all				
4. I experienced breathing difficulty (e.g. excessively rapid breathing, 5. breathlessness in the absence of physical exertion)				
6. I found it difficult to work up the initiative to do things				
7. I tended to over-react to situations				
8. I experienced trembling (e.g. in the hands)				
9. I felt that I was using a lot of nervous energy				
10. I was worried about situations in which I might panic and make a fool of myself				
11. I felt that I had nothing to look forward to				
12. I found myself getting agitated				
13. I found it difficult to relax				
14. I felt down-hearted and blue				
15. I was intolerant of anything that kept me from getting on with what I was doing				
16. I felt I was close to panic				
17. I was unable to become enthusiastic about anything				
18. I felt I wasn't worth much as a person				

19. I felt that I was rather touchy				
20. I was aware of the action of my heart in the absence of physical 21. exertion (e.g. sense of heart rate increase, heart missing a beat)				
22. I felt scared without any good reason				
23. I felt that life was meaningless				

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B. Beck Hopelessness Scale

Instructions: The Beck Hopelessness Scale is a self-report scale that was made to assess and measure the level of hopelessness that you're feeling. Please answer each question by selecting TRUE or FALSE based on how you've been feeling for the past week prior to answering this assessment, including today.

Questions	Yes	No
1. I look forward to the future with hope and enthusiasm		
2. I might as well give up because I can't make things better for myself		
3. When things are going badly, I am helped by knowing they can't stay that way forever		
4. I can't imagine what my life would be like in 10 years		
5. I have enough time to accomplish the things I most want to do		
6. In the future, I expect to succeed in what concerns me most		
7. My future seems dark to me		
8. I expect to get more good things in life than the average person		
9. I just don't get the breaks, and there's no reason to believe I will in the future		
10. My past experiences have prepared me well for the future		
11. All I can see ahead of me is unpleasantness rather than pleasantness		
12. I don't expect to get what I really want		
13. When I look ahead to the future, I expect I will be happier than I am now		
14. Things just won't work out the way I want them to		
15. I have great faith in the future		
16. I never get what I want so it's foolish to want anything		
17. It is very unlikely that I will get any real satisfaction in the future		
18. The future seems vague and uncertain to me		
19. I can look forward to more good times than bad times		
20. There's no use in really trying to get something I want because I probably won't get it		

C. OSENBURG SELF-ESTEEM SCALE

Instructions Below is a list of statements dealing with your general feelings about yourself. Please indicate how strongly you agree or disagree with each statement.

Questions	Strongly Agree	Agree	Disagree	Strongly Disagree
1. On the whole, I am satisfied with myself				
2. At times I think I am no good at all				
3. I feel that I have a number of good qualities				
4. I am able to do things as well as most other people				
5. I feel I do not have much to be proud of				
6. I certainly feel useless at times				
7. I feel that I'm a person of worth, at least on an equal plane with others				
8. I wish I could have more respect for myself				
9. All in all, I am inclined to feel that I am a failure				
10. I take a positive attitude toward myself				

D. The General Health Questionnaire-12 (GHQ-12)

Kindly indicate your level of response

	Not at all	No more than usual	Rather than usual	Much more than usual
1. Have you recently been able to concentrate on what you're doing?				
2. Have you recently lost much sleep over worry?				
3. Have you recently felt that you are playing a useful part in things?				
4. Have you recently felt capable of making decisions about things?				
5. Have you recently felt constantly under strain?				
6. Have you recently felt you couldn't overcome your difficulties?				
7. Have you recently been able to enjoy your normal day-to-day activities?				
8. Have you recently been able to face up to your problems?				
9. Have you recently been feeling unhappy or depressed?				
10. Have you recently been losing confidence in yourself?				
11. Have you recently been thinking of yourself as a worthless person?				
12. Have you recently been feeling reasonably happy, all things considered?				

Bio-data

A. Personal Data

Name: Olubunmi Oluseun ONI
Sex: Female
Marital Status: Married
State of Origin: Ogun
Local Government of Origin: Abeokuta South
Nationality: Nigerian
Religion: Christianity
Discipline: Dental Surgery
Number of Children: Three
Address: Ibadan, Oyo State, Nigeria
Telephone: +2348033538267
Email: ireayodent@yahoo.com

B. Educational Institutions Attended with Dates

Master's in Public Health in view
Bachelor of Dental Surgery 2000
West Africa School Certificate 1990

C. Working Experience

Oyo State Hospital Management Board 2000-2013
University College Hospital 2013-2023
Oyo State Hospital Management Board 2023- present

D. Awards and Fellowships:

Fellow Medical College in Dental Surgery (FMCDS) 2023

E. Professional Membership:

Nigerian Medical Association (NMA)

Nigerian Dental Association (NDA)

F. Publications:

Oni OO, Ibiyemi O. FLUORIDE CONTENT OF COMMERCIALY PACKAGED SACHET WATER IN IBARAPA LAND, SOUTHWEST, NIGERIA. *Ann Ib Postgrad Med.* 2023 Jun;21(1):30-34. PMID: 37528819; PMCID: PMC10388419.

ME OSUH , JA EMIOLA , OO ESAN, FT AMUSA , IO ADEGBOYEGA , **OO ONI**, JI OSUH , FB LAWAL , S TUNDEALAO, T ABIONA, Learning effectiveness of the online mode of study during the COVID-19 pandemic: Perspectives of the clinical medical and dental students from a Nigerian university , *Nigerian Journal of Medical and Dental Education*: Vol. 5 No. 2 (2023): Nigerian Journal of Medical and Dental Education

Fagbule OF, Emenyonu UK, Idiga E, **Oni OO**, Ijarogbe OA, Osuh ME, Lawal FB, Owoaje TO, Ibiyemi O. Using traditional rhyme (folk song) as a tool for oral hygiene promotion (UTRATOHP) among children in rural communities in Nigeria: A protocol for a randomised controlled trial. *PLoS One.* 2023 Jun 2;18(6):e0280856. doi: 10.1371/journal.pone.0280856. PMID: 37267257; PMCID: PMC10237381.

Osuh ME, Fagbule OF, **Oni OO**. Oral health practices and status of workers in a tertiary institution attending an oral health outreach programme in Ibadan, Nigeria. *Nig J Dent Res* 2021; 6(1):74-82

G. Major Conferences Attended with Dates

Olubunmi O. Oni, Olushola Ibiyemi. Fluoride content of commercial packaged sachet water in Ibarapaland, Southwest, Nigeria. Oral Presentation For Hatton's competition, IADR Conference 2021, Lagos

O. O. Oni, O.F. Fagbule, F. B. Lawal. Factors associated with self-reported halitosis among community-dwelling adults in Nigeria. Poster presentation at International Association for Dental Research (IADR), June 2019, Canada.

Mary E. Osuh, Omotayo F. Fagbule, Ejiro Idiga, **Olubunmi O. Oni**.. Oral health behavior and status of workers of a tertiary institution in Ibadan, Nigeria. Poster Presentation at IResearch conference 2019, University of Ibadan.

Olubunmi O. Oni, Olushola Ibiyemi- Attitude to HBV infection and Vaccination in Public Dental Clinics (Submitted for Presentation at IADR, March 2020, Washington.

NADPH Conference 2017

Pan African Medical Journal Conference Proceedings.

H. **Referee**

Referees

Dr Folake Lawal

Dept. of Periodontology and Community Dentistry

University College Hospital

Ibadan

Dr Olowolafe Tunbosun

Dept. Public Health

Lead City University

Ibadan

Signature

Date

The University Compliance Certification

This is to certify that this thesis by Olubunmi Oluseun ONI with Matric No. LCU/PG/002756 in the Department of Public Health, Faculty of Allied and Health Sciences, Lead City University, Ibadan is in full compliance with the approved University format.

Signature

Date

Do Not Copy, Lead City University, Nigeria

TELEGRAMS.....

TELEPHONE.....



MINISTRY OF HEALTH
DEPARTMENT OF PLANNING, RESEARCH & STATISTICS DIVISION
PRIVATE MAIL BAG NO. 5027, OYO STATE OF NIGERIA

Your Ref. No.
All communications should be addressed to
the Honourable Commissioner quating
Our Ref. No. AD 13/479/ 536

th
Date 05 SEPTEMBER 2023

Nigeria

NAME OF PRINCIPAL INVESTIGATOR: ONI OLUBUNMI
TITLE OF STUDY: QUALITY OF LIFE AND PSYCHOLOGICAL HEALTH OF OUT-OF-SCHOOL YOUNG WOMEN IN URBAN SLUMS IN IBADAN METROPOLIS, SOUTHWEST, NIGERIA.
RESEARCH INSTITUTION: LEAD CITY UNIVERSITY, IBADAN.
NREC ASSIGNED NUMBER: NHREC/OYOSHRIEC/10/11/22
DATE OF RECEIPT OF VALID APPLICATION: 14/09/2023

NOTIFICATION OF EXECUTIVE APPROVAL OF PROTOCOL

This is to notify you that the Oyo State Ministry of Health Research Ethics Committee (HREC) has concluded to give executive approval to your research proposal after necessary reviews and corrections under the regulations guiding experiment in human subjects.

2. This approval is for a period of (1) one year from 22nd September, 2023 to 22nd August, 2024. If there is hindrance in starting this research, please inform the Oyo State HREC so that dates of approval can be adjusted accordingly. Note that no activity related to this research may be conducted outside these dates. No changes are permitted in the research without prior approval by Oyo State HREC.
3. All forms and questionnaires used in this study must carry the HREC assigned number and the duration of HREC approval. You are to note further that the National Code of Health Research Ethics requires you to comply with all Institutional guidelines, rules and regulation of the codes. Please ensure that any adverse effect from your study is quickly reported to the HREC Oyo State Ministry of Health, Ibadan.
4. You are expected to submit a report to this committee every three (3) months from the date of this approval. The Oyo State HREC reserves the right to conduct compliance visit on your research sites without previous notification.
5. I thank you.


Dr. Abbas Gbolahan
 Director, Planning, Research & Statistics
 Secretary, Oyo State Research Ethics Review Committee