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HEALTH CARE DELIVERY, ACCESS AND UTILISATION IN EMERGING COMMUNITIES AND URBAN SLUMS OF SOUTH WEST NIGERIA

A Dissertation Submitted to University of Dublin, Trinity College Dublin, for the Degree of Doctor of Philosophy (Global Health)

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DECLARATION

I, Saheed Akinmayọwa LAWAL hereby declare that this thesis entitled "Health Care Delivery, Access and Utilisation in Emerging Communities and Urban Slums of South West Nigeria" and the work presented in it are all my own. This thesis has not been submitted as an exercise for a degree at this or any other university before.

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DEDICATION

To Frances and David.

To the Lawal, Okeke, Tonade, Balogun, Cobham, Mordi, Chidi-Nebo, Dung, Offo, & Seedy families.

To Hussein Kehinde Ajibola Lawal (1989-2012), you're special.

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LIST OF ABBREVIATIONS/ACRONYMS

AIDS: Acquired Immune Deficiency Syndrome

CHF: Community Health Facility

Ecomm: Emerging Communities

EPI: Expanded Programme of Immunization

DALY: Disability-adjusted Life Years

DM: Diabetes Mellitus

FBHF: Faith-Based Health Facility

FBS: Federal Bureau of Statistics

FCT: Federal Capital Territory

FGD: Focus Group Discussion

FMoE: Federal Ministry of Education

FMoF: Federal Ministry of Finance

FMoH: Federal Ministry of Health

FM: Femi Omololu (Co-Thesis Supervisor)

GDP: Gross Domestic Product

GHF: Government Health Facility

GWD: Guinea Worm Disease

HEAP: HIV/AIDS Emergency Action Plan

HIV: Human Immunodeficiency Virus

IDI: In-depth Interview

IMNCH: Integrated Maternal, Newborn and Child Health

ITNs: Insecticide Treated Nets

JB: Joseph Barry (Thesis Supervisor)

KII: Key Informant Interview

LGA: Local Government Area

LMDGP: Lagos Metropolitan Development Governance Project

NHIS: National Health Insurance Scheme (NHIS)

NLS: National Literacy Survey

NMEC: National Mass Education Commission

NSHDP: National Strategic Health Development Plan

NPC: National Health Policy

NPHCDA: National Primary Health Care Development Agency

NPC: National Population Commission

NTDs: Neglected Tropical Diseases

NTBLCP: National Tuberculosis and Leprosy Control Programme

OM: Orthodox Medicine

OOPE: Out-Of-Pocket-Expenditure

PHC: Primary Health Care

PHF: Private Health Facility

RTA: Road Traffic Accidents

SAL: Saheed Akinmayowa Lawal (The Researcher)

SDF: Socio-Economic Factors

SDV: Socio-Economic Variables

SES: Socio-Economic Status

SSA-Sub-Saharan Africa

TB: Tuberculosis

TM: Traditional Medicine

UNHSP: United Nations Human Settlement Programme

WHO: World Health Organisation

SUMMARY

Objective

In Nigeria, over 60 percent of the population lack access to modern health care facilities. Low access and effective utilisation even where available, are affected by inadequate health workforce, low quality of care, distance, and poor policy implementation. This research examines the nature of health care in emerging communities and urban slums of south west Nigeria. The study synthesises Giddens' Structuration theory, Dahlgren and Whitehead's Social model of health, and Andersen and Newman's Framework of health service utilisation as its theoretical framework.

Method

Both quantitative and qualitative methods are used to analyse the existing social realities and health conditions in the study area. While the quantitative method was used to explore the nature of health care delivery, people's access to and utilisation of health care services and their perceptions of the performance of the health care facilities, the qualitative method (In-depth interview (IDI), Key Informant Interviews (KII), and Focus Group Discussion (FGD) was used to analyse social determinants of health and to understand the social processes by which health care services emerge and evolve.

Findings

Findings showed availability of both orthodox and traditional services in emerging communities and urban slums of south west Nigeria. These services have been in operation for more than five years. Self-diagnosis and medication are common practices in these communities and where available people prefer orthodox medicine (55.4%) to traditional medicine for treatment. People's age (β=2.49, 95% C.I=1.54-4.02), religion (β=2.58, 95% C.I=1.67-4.00), education (β=5.94, 95% C.I=2.79-12.66) are socio-demographic variables predictive of preference of orthodox over traditional medicine. There is a significant difference in the age of the respondents and utilisation of the health facility (p=0.000), but no significant gender difference (0.399) exists. The use of motorcycles (37.1%) is the main means of transport to a health facility. But not having adequate information (67.9%) is a major factor that limits people's access to a health service. The competence of health workforce (p-value=0.001) is significantly associated with the utilisation of a health facility while respondents' age (p-value=0.000), education (p-value=0.001), marital status (p-value=0.000), occupation (p-value=0.000) and income (p-value=0.000) tend to influence performance rating of health facilities. Qualitative analysis showed that socio-cultural, economic, environmental and infrastructural factors; as well as health education, ignorance and awareness levels are major determinants of health status in emerging communities and urban slums.

Conclusion

Health care delivery in emerging communities and urban slums of south west Nigeria is complex. Disparities exist within some of the communities in terms of access to and utilisation of the health services. This study recommends a need to address these inequities and patterns of social exclusion that exist through the provision of good roads, maintenance of health facilities, providing health education and information, and improving the quality of care. These will strengthen the health system in these communities for better performance and service delivery.

Key words: Health care delivery, access, utilisation, emerging communities, urban slums

Word count: 461

CHAPTER ONE
INTRODUCTION AND STUDY BACKGROUND

1.1 Background to the study

Developing countries, with 84% of the world's population, account for only eleven per cent of all health spending, as these countries account for 56 per cent of the global burden of disease but less than two per cent of global health spending (Schieber & Maeda, 1999; Worldbank, 2005; Jamison, 2006; Schieber, Gottret, Fleisher & Leive, 2007). The disparities underscore the enormous difference between developed and developing countries in terms of capacities and types of health services that can be provided. This translates into large differences in health infrastructure and outcomes (Schieber & Maeda, 1999) and existing gaps in the health systems of developed and developing countries.

In sub-Saharan Africa (SSA), gaining access to health care services is still a challenge as health systems performance is very low (Kruk & Freedman, 2008). Poor health care delivery within this region is as a result of lack of access to health care services, and ineffective utilisation where such services exist. This leads to the burden of diseases attributable to chronic disorders, such as cardiovascular disease, diabetes, cancers, and respiratory diseases in low-income and middle-income (developing) countries being higher than in high-income (developed) countries (WHO, 2005a). These chronic non-communicable and communicable diseases are recognised to exist in informal settlements, such as urban slums, low-income neighbourhoods, and in emerging communities where little is known about the magnitude, distribution, and risk factors of these illnesses before they manifest as stroke, myocardial infarctions, kidney failure, suicide, multidrug resistant TB, heart valve disease and AIDS (Riley, Ko, Unger, & Reis, 2007).

More so, in developing countries, there exist physical, financial and social barriers to the use of effective health interventions (Hanson, Ranson, Oliveira-Cruz & Mills, 2003), while weak health systems in many parts of such regions of the world are identified as one of the greatest barriers to ensuring access to essential health care (Crown Agents, 2010). In Nigeria, access and utilisation of health services is still low. According to the Pharmaceutical Society of Nigeria, 60 per cent of Nigerians, which represent 90 million of the population, do not have access to modern health care facilities and services (Baiyewu, 2011; PSN, 2011).

Notwithstanding that, in 2005 the Federal Ministry of Health (FMoH) estimated that there were a total of 23,640 health facilities of which 85.8% are primary health care facilities, 14% secondary and 0.2% tertiary. Of these facilities, 38% are owned by the private sector, which provides 60% of health care in the country (FMoH, 2005). While 60% of the public primary health care facilities are located in the northern zones of the country, they are mainly health posts and dispensaries that provide only basic curative services. Many residents in emerging communities and urban slums of south west, Nigeria are among those that have limited access to effective health care delivery. In as much as the issue of Private Out-Of-Pocket Expenditure (OOPE) in Nigeria accounts for 64% in year 2004 of the estimated $10 per capita expenditure on health (FMoH, 2004), this further limits equitable access to quality health care.

At the global level, the gap between developed and developing countries appears even more marked when the distribution of disease burden is viewed between the global north and global south. Of the estimated 1.4 trillion disability-adjusted life years (DALYs) lost in 1990, industrialized countries accounted for just 7 percent, while developing countries accounted for 93 percent (World Bank, 1993). In developed countries 81 percent of DALYs are attributable to non-communicable diseases, 12 percent to injuries, and only 7 percent to communicable diseases. In developing countries nearly half of DALYs result from communicable diseases (occurring mainly among children), about one-third, non-communicable diseases, and the remainder, injuries (World Health Organization, 1996; Global Burden of Disease, 2010).

Non-communicable diseases (most of which are chronic) will account for 69% of all global deaths by 2030 with 80% of these deaths in developing countries (Miranda, Kinra, Casas, Smith & Ebrahim, 2008). Also due to profound inequities in health, inadequate progress towards the Millennium Development Goals (MDGs), especially in sub-Saharan Africa (Haines & Cassels, 2004; Sanders, Todd, & Chopra, 2005; World Bank, 2004), major shortfalls in the human resources needed to improve delivery of cost-effective interventions (Narasimhan, 2004, WHO, 2006), and the fragmented and weakened state of health systems in many countries (Travis, Bennett, Haines, Pang, Bhutta, Hyder, Pielemeier, Mills & Evans, 2004) especially in the global south have negatively affected health systems.

Furthermore, developing countries have much lower per capita incomes (gross domestic product, or GDP), much poorer health status indicators, and fewer health-sector inputs than industrialized countries. With respect to health outcomes, mortality under age five (the probability of a child's dying before reaching his or her fifth year) in developing countries is almost ten times the level found in developed countries. Under-five mortality in sub-Saharan Africa (SSA), the region with the lowest income, is more than fifteen times higher compared to countries in the developed regions (Schieber & Maeda, 1999). Also, within developing countries access to even basic services is still one of the major barriers to better health for much of the population (Global Equity Gauge Alliance, 2004; Daniels, Flores, Pannarunothai, Ndumbe, Bryant, Ngulube et al, 2005).

As for health-sector inputs, developed countries have six times as many hospital beds and three times as many physicians per capita as developing countries have. There are also large regional differences, with sub-Saharan Africa having only 4 percent as many physicians as developed countries and South Asia having only one-twelfth of the number of hospital beds per capita. These figures reflect many factors, including income, population sizes and age distributions, and differences in underlying epidemiology. On the other hand, the number of beds and physicians per capita in Europe and Central Asia far exceeds that in developing countries (Klugman & Schieber, 1997), affecting the health status of people.

In pursuing health-sector reform, developing countries face many of the same problems regarding access, efficiency, and quality that developed countries face, although these problems are much more severe. They also face greater challenges in providing basic public health services, especially in rural areas. Moreover, inter-sectoral linkages to education, water, food, housing, energy, and other relevant sectors are critical. Given their limited incomes, revenue-raising, and administrative capacity, developing countries as a whole face serious constraints in financing basic health services, providing physical access to care, and regulating both public and private sector entities (Schieber & Maeda, 1999). In Nigeria as a developing country, access to and effective utilisation of health services is plagued by the many challenges within the health sector and across its entire social system as illustrated in the preceding and succeeding paragraphs.

1.2 Statement of the Problem

Though the development of Primary Health Care (PHC) is headed by an agency solely established for this purpose in Nigeria, the health experience of the population especially those in rural areas (Omoruan, Bamidele & Phillips, 2009), in emerging communities and urban slums has not improved as access to health services remains a challenge. Also, other factors such as poverty, illiteracy, unemployment, cultural and religious beliefs, economic instability, and lack of political will tend to limit the range and coverage of health services for people which include those living in emerging communities and slums of urban south west Nigeria. More so for people in Nigeria, preventive services are opportunistic or spontaneous and access to information and preventive healthcare is severely restricted and unaffordable for most people at risk (Nwankwo, Aniebue, Aguwa, Anarado, & Agunwah, 2011; Ayinde & Omigbodun, 2003; Gbaror & Ifeanyi, 2006; Udigwe, 2006). Lack of knowledge about risk factors in populations arguably contributes to increased mortality and morbidity because people do not have the information they need to take preventive action (Nwankwo et al, 2011; Isara & Ojedokun, 2011; Asuzu, Unegbu & Akin-Odanye, 2012).

Furthermore, in Nigeria, there exist gaps in literature on the nature of health care services in emerging communities and urban slums, the social processes by which health care services evolve and lack of access to and low utilisation of health care services. However, the increased lack of access to health care services in emerging communities is a result of the non-availability of health care facilities, and where such health facilities exist, lack of adequate equipment for treatment, insufficient medicines, and shortage of health care workers affect health service delivery. More so, the health care services in Nigeria have been characterised by short-term planning (Scott-Emuakpor, 2010) leading to inadequate drugs and vaccines for treatment of patients and weak health recording systems. Other socio-economic, cultural and environmental conditions (Dahlgren & Whitehead, 1991), social and community networks, and individual life style factors affect people's health status in such communities.

Additionally, certain predisposing, enabling and need factors (Andersen, 1995) hinder people's access and effective utilisation of the health facilities and services within emerging communities and urban slums of south west Nigeria. Within such informal settlements i.e. emerging communities and urban slums, the above mentioned factors influence the spread of

communicable and non-communicable diseases (Gruebner, Mobarak, Khan, Lautenbach, Muller, Kramer, Lakes, & Hostert, 2012) causing increased mortality and morbidity, while the health care needs of residents remain unmet. In the study area of south west Nigeria, health care services tend to function below capacity leaving residents to seek various forms of health services that further inhibit their well-being. The study therefore seeks to understand the nature of health care delivery in emerging communities and urban slums. It also is aimed at exploring how health care services emerge in the study areas, particularly in relation to access to health services and their effective utilisation in emerging communities and urban slums of the south west region.

1.3 Growth of Urban Slums in Developing Countries

The continuing growth of cities in developing countries in recent decades has been accompanied by the rapid growth of urban inhabitants living in substandard informal settlements and conditions such as slums (Chowdhury & Nurul-Amin, 2006; Morakinyo, Ogunrayewa, Koleosho & Adenubi, 2012; Acharya, 2010; Lanrewaju, 2012; Jorgenson & Rice, 2012). Slums are underserviced and unauthorised living spaces where living conditions are often appallingly poor (Chowdhury & Nurul-Amin, 2006) and unplanned. The increase in slums within urban areas is attributed to several factors but it is widely acknowledged that slum growth is largely a manifestation of poverty, and that it is impossible to prevent slum settlements in countries where poverty levels are high and urban growth rate is rapid (Chowdhury, 2003 in Chowdhury & Nurul-Amin, 2006; Chowdhury & Nurul-Amin, 2006). As a result of the complex nature of unplanned housing structures in urban slums of developing countries, city authorities find it difficult to demolish these housing units. These slum environments increase the vulnerability of the people living there to communicable diseases and other health systems challenges (Chowdhury & Nurul-Amin, 2006; Munslow, & Dempsey, 2010; Montgomery & Ezeh, 2005).

According to Chowdhury & Nurul-Amin (2006) similar to many other developing countries, Bangladesh as an example has experienced a rapid increase in urban population in the recent decades (13.5 million in 1981, 22.9 in 1990, 37.3 in 2000, and 46.4 in 2005), especially since independence in 1971 (Rahman, 2002; CUS, 1999; Islam 1996a in Chowdhury & Nurul-Amin, 2006). Nearly 47% of the 33 million urban population live below the poverty line (BBS, 2001 in Chowdhury & Nurul-Amin, 2006). These people mostly live in urban slums

and cannot meet their basic needs. In any large City of Bangladesh, slums and squatters accommodate nearly one third to one-half of the city's population (Islam, 1996a in Chowdhury & Nurul-Amin, 2006). The situation is particularly bad in Dhaka where a 1996 CUS (Center for Urban Studies) study identified some 3007 slum and squatter settlements in Dhaka Metropolitan Area (CUS, 1996 in Chowdhury & Nurul-Amin, 2006). Many studies, conducted by the Center for Urban Studies (CUS) and the Urban Studies Program (USP) reveal that the rapid urban growth has caused economic and socio-cultural improvements for some people but it has also led to deterioration in the overall urban environment, particularly causing a low or even substandard living standard for a very large number who constitute the poor (CUS, 1999; Kalam & Karim 1998; Islam & Nazem, 1996; Islam, 1996b in Chowdhury & Nurul-Amin, 2006).

According to the United Nations Human Settlements Programme (2003) the following are characteristics of urban slums: inadequate access to safe water; inadequate access to sanitation and infrastructure; poor structural quality of housing; overcrowding; and insecure residential status. Urban slums are also known to lack good roads, regular electricity supply, adequate social amenities, quality health care facilities and services, informal business establishment and also have high levels of crime, violence and social degradation (Vlahov, Freudenberg, Proietti, Ompad, Quinn, Nandi, & Galea, 2007). More so, poverty, high population density, the absence of utilities, and lack of infrastructure are common features of urban slums (Islam, 1996a; Miah et al., 1988 in Chowdhury & Nurul-Amin, 2006; UN-HABITAT, 2003). The urban poor in general and the residents of slums in particular have been affected most negatively by urban service deficiencies. The environment of slums is extremely unhygienic as they are located in sites such as solid waste dumps, open drains and sewers, low land, embankments, and often along the rail lines (BBS, 1998; CUS, 1976 in Chowdhury & Nurul-Amin, 2006; UN-HABITAT, 2003).

Certain push (rural poverty and unemployment, unaffordability of rent, loss of employer-provided accommodation) and pull factors (availability of jobs, cheaper living expenses, lack of control of land access) are among several reasons for moving from rural areas to informal settlements such as urban slums and from moving from an urban area into an urban slum (Morakinyo, Ogunrayewa, Koleosho, & Adenubi, 2012). In a study, conducted by Centre for Urban Study (CUS), Bangladesh on urban poor in 1988, findings showed that the majority of

the slums get inundated during floods. About 65% of Dhaka slums have poor drainage conditions (CUS, 1988 in Chowdhury & Nurul-Amin, 2006). There is no evidence that suggests any improvement in such situations. A USP study reveals that in the slums and squatter settlements, a single open pit latrine may have to be shared by up to 25 families (Islam, 1996a).

In Nigeria, urban slums are found across its major cities especially in Lagos State which has the highest number of officially recognised urban slums (9) in Nigeria (Olajide, 2010) and many unrecognised slum settlements in the state. These urban slums or informal settlements are similar to those found in other developing countries such as Kibera (Nairobi, Kenya), Mirpur (Dhaka, Bangladesh), Jhopadpatti of Mumbai; Kolkata; Ganesh Murthy Nagar in Colaba district (India), Favelas of Rio de Janeiro (Brazil), Lilongwe (Malawi), and Manila (Philippines). Urban slums in Nigeria continue to increase as the country is ranked as one of the countries with high slum prevalence (Arimah, 2001). The proliferation of shanty dwellings, squatter settlements and slums in most of Nigeria's major cities and other less developed nations of the world is attributed to a chain of factors (Bobadoye & Fakere, 2013; Makinde, 2012; Olotuah, 2010; Ayoade, Olurotimi, & Babatunde, 2012). Some of these factors include poverty, social exclusion, social inequality, unemployment and high income disparities between the rich and the poor. Unplanned environments and poor enforcement of sanitation laws will continue to force many people to move into urban slums.

1.4 Emergence of Emerging Communities in Nigeria

Like the concept of emerging markets, emerging economies, emerging technologies, emerging health treats, emerging research, emerging ideologies and emerging democracies of the 21st century. The concept of *Emerging communities (Ecomm)* simply refers to a conglomeration of people living in informal settlements (shanty border towns) developed mainly by increased out-migration from urban cities (such as Lagos) into newly established living spaces. These people share similar life chances, similar socio-economic status, and face challenges that cause them to find solace within housing and social units that are built with the hope of meeting their aspirations for a better life outside the core urban city centre.

Emerging communities are commonly found in developing countries with a growing urban population due to migration and rate of natural increase and growth of slum dwellers. These communities are growing out of the inability of migrants and low income people to afford

living within the urban centres. More so, their inability to secure an adequate means of livelihood further limits their chances to live in the urban areas. Such migrants over a period of time who are unable to afford the cost of housing and high household expenses in the urban areas (Olugbenga & Adekemi, 2013; Okwuashi, McConchie, Nwilo & Eyo, 2008) relocate into emerging communities mainly located along the Lagos-Ibadan expressway, outside the core urban areas of Lagos and Ogun states i.e. about 85 to 102 kilometres away from Lagos state.

Emerging communities can be categorised into informal settlements and share similar characteristics with border towns (Zeller, 2009) or peri-urban towns. This type of informal settlements establishment is driven by people, not by the government and such emerging communities are informally built settlement constructed to meet their needs for low cost housing. In addition, the rising cost of urban living in another major push factors that forces people to move into emerging communities. As the cost of urban living continues to increase in most developing countries, this will force many families to move outwards from core urban areas into such emerging communities as the 21st century unfolds.

Though similar to the concept of *arrival cities* (Saunders, 2011) due to migration which is reshaping the world, emerging communities (Ecomm) are emergent human settlements, which are informally built environments providing accommodation and opportunities for people to derive a means of livelihood. The concept of emerging communities thrives as a result of increased population growth and urbanization in major cities of the developing world (Cohen, 2004).

As people continue to move into urban spaces to seek better life in Nigeria, the resources available there become overstretched and unable to meet everyone's needs in the city. Such resources overtime become very expensive and not readily available to everyone, especially people of low income and socio-economic status. This and many other socio-economic factors will force people to relocate into emerging communities. More so, emerging communities have emerged to cater for inadequate urban planning and city management in developing countries such as Nigeria. These communities are fast becoming environments that harbour infectious diseases, due to poor health care delivery services, unplanned living arrangements, poor sanitation and hygiene, open dumpsites, and inadequate social amenities.

1.5 Glossary (Definition of Terms)

Access: Ability to gain or have the right to enter into a place. It's also a way of approaching, getting, using or admittance into a particular place or thing. Access to health care delivery is simply the ability of people to use health care services based on the availability, timeliness and full array of services needed whenever and wherever the need arises without hindrance to the services they tend to seek.

Chemist (drug store): A convenience store located within a community that sells household items and also sells drugs to people. A chemist owner may or may not demand customers to tender a doctor's prescription of the drug they want to buy. Drugs in a chemist are sold to people across the counter. Some chemist stores engage in offering health consultancy services to customers by advising them on what to buy and what not to buy. Most chemists do not have the ideal license to operate or sell drugs to people.

Community: This can be defined as "a social group of any size whose members reside in a specific locality, share government, and often have a common cultural and historical heritage". In the context of this study a community is defined as a social group of people who share similar life chances. These group do not necessarily have a common cultural background or historical heritage but have a sense of "we and togetherness" as a result of the similar economic life style they share that have made them residents of these new urban spaces. Members of such a community are heterogeneous and sometimes multi culturally diverse.

Community health facility: A community health facility is established through the cooperation of the community and their representatives to make health care delivery available to the people at an affordable cost. Such facilities are operated and managed through health personnel that are employed by the community.

Community pharmacy: Local community pharmacies are established by qualified practitioners who sell drugs to people within the community. These community pharmacies differ from chemists because owners most often demand for a doctor's prescription before selling drugs that require such. Unlike a chemist, most community pharmacies have the required licensed to operate and carry out their business.

Drug vendor (patent medicine vendor): These people engage in hawking drugs around the community. They move from house-to-house and their services mostly come cheap and are readily available.

Effective: Ability of the health system to offer good quality services as intended for the users whenever it is desired, also with the aim of producing the expected results of prevention, treatment and management of illness.

Emergence of health services: This is the social process that has led to emergence of health care services in emerging communities and urban slums. This process shapes how health care evolves, develops or emerges over time and how it's been delivered.

Emerging Communities: Emerging communities (*Ecomm*) as a concept describes the emergence of informal settlements, which are developed informally into built environments as a result of out-migration from densely populated urban centres. Emerging communities are living spaces based on an informal economic structure which offer opportunities for people to derive a means of livelihood and reside. The concept of emerging communities thrives as a result of increased population growth and urbanisation in major cities of developing countries such as Lagos, Nigeria.

Faith-based health facility: These are health care delivery services offered through religious institutions within the communities. A faith-based health facility is established and operated by religious organisations to provide health services to the people. This form of health facility sometimes is established based on humanitarian grounds.

Government health facility: This is a government public health care delivery structure located within the community. This facility is owned, funded and regulated by the government through the department of primary care in the local government area where it is located. A government health facility usually takes the form of a health centre or a health post.

Health care delivery: Various forms of health services which include orthodox and traditional. According to the World Health Organisation, "Health services, be they promotion, prevention, treatment or rehabilitation, may be delivered in the home, the community, the workplace, or in health facilities. Effective health service delivery depends on having some key resources: motivated staff, equipment, information and finance, and adequate drugs. Improving access, coverage and quality of health services also depends on the ways services are organized and managed and on the incentives influencing providers and users".

Herbal practitioner (Álagbó), spiritual and folk healer: These are people that engage in informal forms of health care services within communities. These services range from providing cures for various types of illnesses using herbal mixtures and concoctions. Some

also engage in unorthodox physiotherapy (local bone-setting), while some others invoke incantations to heal patients.

Meeting the needs: This is aimed at providing the health services for users (patients). Meeting the needs of health users is aimed at improving people's health conditions and addressing their specific health concerns.

Orthodox medicine: These are drugs made available to people through the health facility or bought from a pharmacy or chemist shop. Orthodox medicine is simply drugs produced through clinical trials and certified for use. These types of medicines are pharmaceutically manufactured with detailed dosage for use.

Private health facility: This is a privately established hospital or clinic located within the communities. Such health facilities are owned by doctors, senior nurses or midwives. This type of health facility offers basic primary care services where it is located.

Socio-demographic factors: These factors include age, gender, marital status, education, ethnicity, occupation and income among others.

Spread of communicable diseases: These are infectious diseases which include the common cold, malaria, measles, HIV/AIDS, chicken pox, ringworm, whooping cough, hepatitis A-D, flu, mumps, herpes, or STDs that can spread from person to person, and not from animal to animal nor from animal to person or vice versa. The spread of communicable diseases is dependent on a number of factors, including the agent, environment, transfer method and host.

Traditional medicine: These are herbal mixtures or concoctions derived from fruits, seeds, leaves, roots or the bark of specific plants and trees. This type of medicine is traditionally prepared without strict adherence to written down rules and guidelines.

Urban slums: A human settlement within urban areas that has the following characteristics: inadequate access to safe water; inadequate access to sanitation and infrastructure; poor structural quality of housing; overcrowding; and insecure residential status (UNHSP, 2003). Slums are defined by the United Nations Organizations as "a building or group of buildings and area characterized by overcrowding, deterioration in sanitary conditions, or absence of facilities and amenities, which because of these conditions or any of them endanger the health, safety or morals of its inhabitants or the community". Slums are also informal settlements or semi-urban settlements that are established within urban areas.

Utilisation: Is "the act of using" a particular equipment, information or service. Utilisation of health care delivery is the ability of people to use health services based on the quality of care, its safety, efficacy, continuity and respect for users.

CHAPTER TWO

NIGERIA AND STUDY LOCATIONS

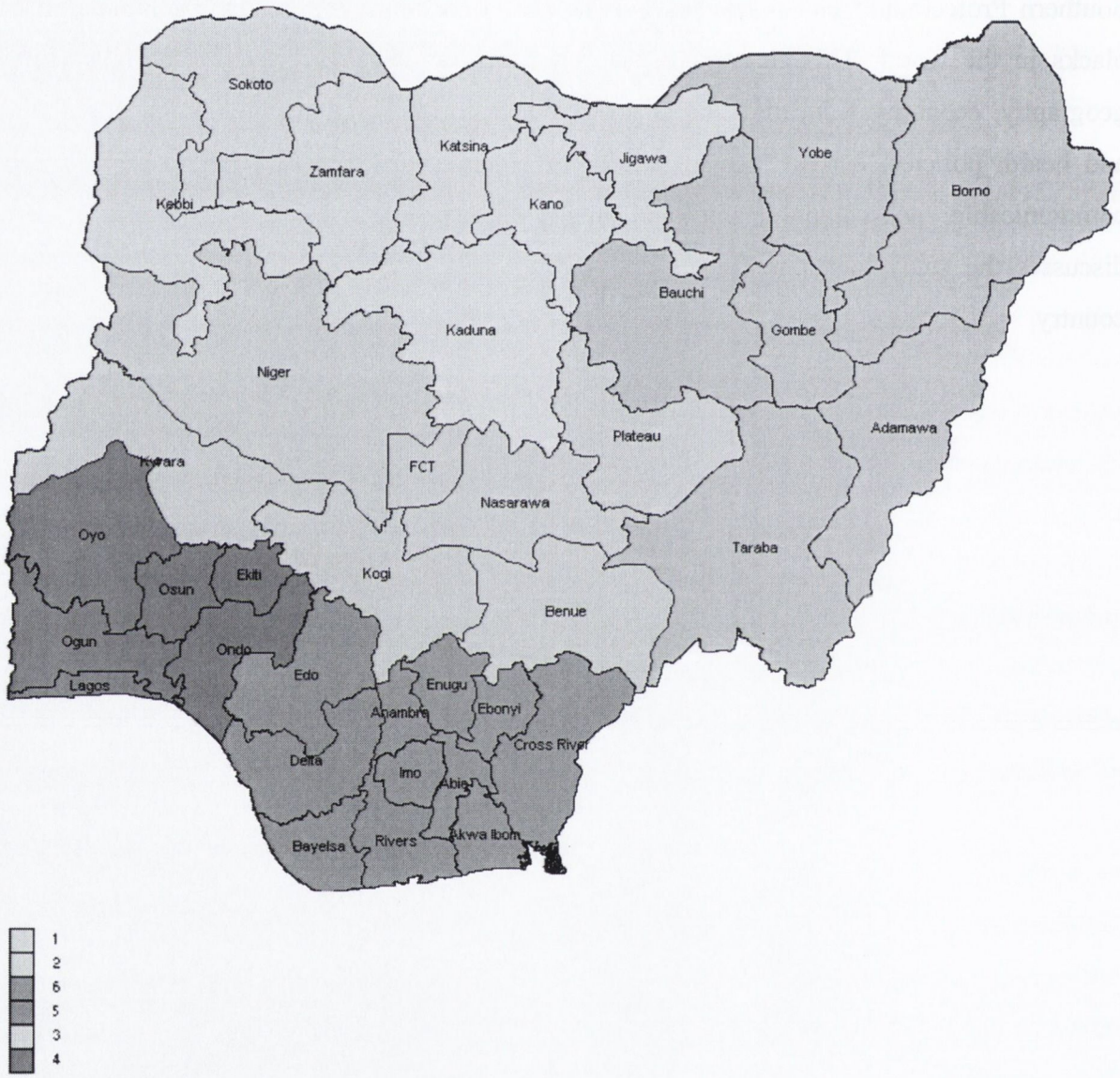
2.1 Introduction

The country Nigeria began as an entity in 1914 with the amalgamation of the Northern and Southern Protectorates and today has grown to become home to the largest population of blacks in the world. This chapter focuses on describing Nigeria in terms of its history, geography, economy, education, population and basic demographic indicators, population and health policies, current state of health in Nigeria, structure of health care delivery, communicable, non-communicable and neglected tropical diseases in Nigeria. It also discusses the study locations (Lagos and Ogun State) situated in the South West of the country.

2.2 Nigeria

Nigeria, officially the Federal Republic of Nigeria, is a federal constitutional republic which is made up of 36 states and a Federal Capital Territory (FCT), grouped into six geopolitical zones: North Central, North East, North West, South East, South South, and South West.

Figure 2.1 Map of Nigeria



Code	Zone	States
1	North West	JIGAWA [JG], KADUNA [KD], KANO [KN], KATSINA [KT], KEBBI [KE], SOKOTO [SK], ZAMFARA [ZM]
2	North East	ADAMAWA [AD], BAUCHI [BA], BORNO [BR], GOMBE [GM], TARABA [TR], YOBE [YB]
3	North Central	BENUE [BN], FCT ABUJA [FC], KOGI [KG], KWARA

		[KW], NASARAWA [NS], NIGER [NG], PLATEAU [PL]
4	South West	EKITI [EK], LAGOS [LG], OGUN [OG], ONDO [ON], OSUN [OS], OYO [OY]
5	South East	ABIA [AB], ANAMBRA [AN], EBONYI [EB], ENUGU [EN], IMO [IM],
6	South South	AKWA IBOM [AK], BAYELSA [BY], CROSS RIVER [CR], DELTA [DL], EDO [ED], RIVERS [RV],

Source: Housing Characteristics and Amenities Table, 2006 Census

2.2.1 History

The people of Nigeria have an extensive history. Archaeological evidence shows that human habitation of the area dates back to at least 9000 BC (McIntosh, 1981). The area in the region of the Benue and Cross Rivers is thought to be the original homeland of the Bantu migrants who spread transversely across most of central and southern Africa in waves between the 1st millennium BC and 2nd millennium AD (NPC-ICF Macro, 2009).

Nigeria came into existence as a nation-state in 1914 through the amalgamation of the Northern and Southern protectorates. Before this time, there were various separate cultural, ethnic, and linguistic groups which still exist, such as the Oyo, Benin, Nupe, Jukun, Kanem-Bornu, and Hausa-Fulani empires. These peoples lived in kingdoms and emirates with traditional but sophisticated systems of government. There were also other strong ethnic groups such as the Igbos, Ibibios, Ijaws and Tivs (NPC & ICF, 2014).

The British in 20th century Nigeria established a crown colony type of government after the amalgamation. The affairs of the colonial administration were conducted by the British until 1942, when a few Nigerians became involved in the administration of the country. In the early 1950s, Nigeria achieved partial self-government with a legislature in which the majority of the members were elected into an executive council of which most were Nigerians and less British. Nigeria became fully independent in October 1960 as a federation of three regions (Northern, Western, and Eastern) under a constitution that provided for a parliamentary system of governance. The Lagos area became the Federal Capital Territory (NPC & ICF Macro, 2009).

On October 1, 1963, Nigeria became a republic with different administrative structures, social groups, and distinct cultural traits. There are about 374 identifiable ethnic groups, with the Igbo, Hausa, and Yoruba as major groups. There are also 774 constitutionally recognized local government areas (LGAs) in the country (NPC & ICF Macro, 2009).

2.2.2 Geography

Nigeria is in the West African sub-region, lying between latitudes 4°16' and 13°53' north and longitudes 2°40' and 14°41' east. It is bordered by Niger in the north, Chad in the northeast, Cameroon in the east, and Benin in the west. To the south, Nigeria is bordered by approximately 850 kilometres of the Atlantic Ocean, stretching from Badagry in the west to the Rio del Rey in the east. With a total land area of 923,768 square kilometres, Nigeria is the fourteenth largest country in Africa (NPC & ICF Macro, 2009).

Nigeria is diverse in climate and topography, encompassing uplands of 600 to 1,300 metres in the North Central and east highlands, and lowlands of less than 20 metres in the coastal areas. The lowlands extend from the Sokoto plains to the Borno plains in the North, the coastal lowlands of Western Nigeria, and the Cross River basin in the east. The highland areas include the Jos Plateau and the Adamawa Highlands in the North, extending to the Obudu Plateau and Oban Hills in the South East. Other topographic features include the Niger-Benue Trough and Chad Basin (NPC & ICF Macro, 2009).

Nigeria has a tropical climate with distinct wet and dry seasons associated with the movement of the two dominant winds—the rain-bearing south westerly winds and the cold, dry, and dusty north easterly winds commonly referred to as the Harmattan. The dry season occurs from October to March with a spell of cool, dry, and dusty Harmattan wind felt mostly in the north in December and January. The wet season occurs from April to September. The temperature in Nigeria oscillates between 25° and 40°C, and rainfall ranges from 2,650 millimetres in the southeast to less than 600 millimetres in some parts of the north, mainly on the fringes of the Sahara Desert. The vegetation that results from these climatic differences consists of mangrove swamp forest in the Niger Delta and Sahel grassland in the north. Within a wide range of climatic, vegetation, and soil conditions, Nigeria possesses potential for growing a wide range of agricultural self-sufficient and export crops (NPC & ICF Macro, 2009).

2.2.3 Economy

As of 2013, Nigeria's GDP stood at $262.6 billion (World Bank, 2013). A sectoral analysis of the country's economy revealed that the contribution of Agriculture to the total GDP stood at 39 percent, a reduction compared with 40 percent in 2011. Similarly, the 18 percent and 14 percent contributions of industry and crude oil to the GDP are lower than the 2011 contributions of 19 percent and 15 percent respectively. The contributions of two other industrial sector components, solid minerals and manufacturing, stood at 0.4 percent and 4 percent in that order. The service sector as a percentage of the GDP was 20 percent, higher than the 19 percent recorded in 2011 (with the finance and insurance, communications, transportation, and utilities components contributing 3.4, 7.1, 2.7, and 2.9 percent, respectively) to the Nigerian economy (Central Bank of Nigeria, 2013).

More recent economic statistics in the second quarter of 2014 reveal that Nigeria now has the largest economy in Africa "following the rebasing exercise conducted by the government in April" (Afican Development Bank, 2014 pp. 2) with the country's GDP at $503bn (£307bn)-nearly double previous estimates and well ahead of South Africa at around $350bn. The country has one of the fastest growing economies in the world, with the International Monetary Fund (IMF's) projections of 9% in 2008 and 8.3% in 2009 now 9.2% in 2013 (Nellor, 2008; IMF, 2014). Furthermore, other sources of economic data between the years 2009 and 2014 show that the Nigerian economy on average has improved each year using selected indicators as seen in table 2.1.

Table 2.1 Recent Economic Indicators

	2009	2010	2011	2012	2013	2014(a)
GDP (US$bn) (current prices)	170.7	231.6	248.2	264.2	286.5	316.0
GDP PPP (Int'l $bn) (c)	342.5	374.3	409.7	444.3	479.3	521.4
GDP per capita (US$)	1,124	1,484	1,548	1,604	1,692	1,817
GDP per capita PPP (Int'l $) (c)	2,255	2,399	2,555	2,697	2,831	2,997
Real GDP growth (% change yoy)	7.0	8.0	7.4	6.6	6.3	7.1
Current account balance (US $m)	13,974	13,420	8,761	20,443	13,447	15,398
Current account balance (% GDP)	8.2	5.8	3.5	7.7	4.7	4.9
Goods & services exports (% GDP)	34.2	35.0	40.2	37.1	50.2	46.2
Inflation (% change yoy)	12.5	13.7	10.8	12.2	8.5	7.3

Source: Compiled by the Economic Diplomacy, Trade Advocacy & Statistics Section, Department of Foreign Affairs and Trade (DFAT), Australian Government. 2014a: Data for the first quarter of the year.

However, despite these economic improvements, the country still faces some developmental challenges such as the unemployment increase from 21.1% in 2010 to 23.9% in 2011. In general, unemployment is concentrated in the younger age group, with unemployment of 41.6% among 18-24 year olds, and 11.5% among the 45-59 year olds. While unemployment rates are higher for females (24.9%) than for males (17.7%), the states with the highest unemployment rates are concentrated in the North Eastern part of the country (see figure 2.1) and in the Niger Delta region (Economic section, US Embassy in Nigeria, 2012) of Nigeria. These high unemployment figures contribute to the growing levels of poverty in the country and prevalence of social vices. Although the Nigerian economic indicators show some level of progress and growth, it is yet to transcend into better health indicators and the provision of adequate health care delivery for its entire population.

2.2.4 Education

Education in Nigeria has been through a series of policy changes over time. The overall responsibility establishing national policies and guidelines for uniform standards throughout all levels of education is vested in the Federal Ministry of Education. These policies and guidelines are protected by various statutory instruments such as the National Policy on Education, the Education Decree No. 16 of 1985 and the 1999 Constitution of the Federal Republic of Nigeria (NPC & ICF Macro, 2009).

Accordingly, the Federal Ministry of Education focuses on six aspects of education-Early Childhood Education, Basic Education, Secondary Education, Tertiary Education, Adult and Non-formal Education, and Special Needs Education (Federal Ministry of Education, 2009). The National Policy on Education gives every child the right to tuition-free primary education. This has resulted in an increase in school enrolment and in the number of educational institutions, particularly in the public sector. The 6-3-3-4 system introduced in 1981 provides six years of primary education, followed by three years of junior secondary education, and three years of senior secondary education. The last segment of four years is for university or polytechnic education (NPC & ICF Macro, 2009).

Subsequently, the National Literacy Programme for Adults was launched, followed by the establishment of Nomadic Education to address the needs of children of migrant cattle herders and fishermen in the riverine areas. The Universal Basic Education (UBE) system,

launched in October 1999, made it compulsory for every child to be educated free of tuition up to the junior secondary school level in an effort to meet Nigeria's manpower requirements for national development (Osuji, 2004).

2.2.5 Population and Basic Demographic Indicators

Nigeria is the most populous country in Africa, the seventh most populous country in the world (NPC & ICF Macro, 2009), and the most populous country in the world in which the majority of the population is black. It is listed among the "Next Eleven" economies, and is a member of the Commonwealth of Nations. Nigeria since the 19th century has collected demographic statistics through censuses, vital registration systems and sample surveys. However, until the 1950s these were limited to certain parts of the country. Since then, there have been considerable improvements in the data collection process (NPC & ICF Macro, 2009). The population of Nigeria in 2008 was at 148 million (NPC, 2008), of which 49% are female and 51% are male.

The first attempt at a population census in Nigeria was in 1866. Subsequent censuses conducted before 1952, such as the 1911 and 1922 censuses, were restricted to specific sections of the country. The 1952-1953 enumeration was the first nationwide census. The first post-independence census, conducted in 1962, was cancelled because of alleged irregularities in its conduct. Another census, conducted in 1963, was officially accepted as seen in table 2.2.

The Population Census of 1973 was not acceptable because of irregularities that were reported in the process of enumeration and was therefore cancelled. The next census took place in 1991. The 2006 Population and Housing Census puts Nigeria's population at 140,431,790, with a national growth rate estimated at 3.2 percent per annum. With this population, Nigeria is the most populous nation in Africa. Nigeria's population is unevenly distributed across the country. Large areas in the Chad Basin, the middle Niger Valley, the grassland plains, among others, are sparsely populated. The average population density for the country in 2006 was estimated at 150 people per square kilometre (NPC & ICF Macro, 2009).

The most densely populated states are Lagos, Anambra, Imo, Abia, and Akwa Ibom. Most of the densely populated states are found in the south west and south east part of the country. Kano state, with an average density of 442 persons per square kilometre, is the most densely populated state in the north. Numerous sample surveys have been conducted in an effort to generate reliable demographic data. These include the 1965-1966 Rural Demographic Sample Survey and the 1980 National Demographic Sample Survey (NDSS) conducted by the Federal Office of Statistics and the National Population Bureau, respectively (NPC & ICF Macro, 2009).

The 1981-1982 Nigeria Fertility Survey (NFS) was the first nationally representative survey on fertility, family planning, contraceptive use, and related topics. This was followed by the first Nigeria Demographic and Health Survey (NDHS) in 1990. In 1994, the first sentinel survey was conducted to serve as a baseline study to monitor the various projects designed to achieve the objectives of the National Population Policy. In 1999, another NDHS was conducted. This was followed by a sentinel survey conducted in 2000. Another sentinel survey was conducted in 2007 to further assess the implementation of the objectives of the population policy (NPC & IFC Macro, 2009).

Table 2.2 Basic demographic indicators from various sources, Nigeria 1963-2006

Indicators	Census 1963	NFS 1981-1982	Census 1991	NDHS 2003	Census 2006
Population (millions)	55.7	84.7	88.9	U	140.4
Density (pop.sq.km)	60	92	96	U	150
Percent Urban	19	23	36.3	U	U
Crude birth rate (CBR)	66	46	44.6	41.7	U
Crude death rate (CDR)	27	16	14	U	U
Total fertility rate (TFR)	U	6.3	5.9	5.7	U
Infant mortality rate (IMR)	U	85	93	100	U
Life expectancy at birth	36	48	53.2	U	

U= Unknown (not available)

[1] Reported rates. See 2003 NDHS final report for information on data quality.

Source: National Population Commission; Federal Office of Statistics
Source: National Demographic and Health Survey (NDHS), National Population Commission 2008a.

2.2.6 Population Policies and Programmes

In response to the pattern of the population growth rate and its adverse effect on national development, the Federal Government of Nigeria approved the National Policy on Population for Development on February 4, 1988 (NPC & ICF Macro, 2009). Over the years, emerging issues such as HIV/AIDS, poverty, gender inequality, among others, gained wider recognition. This necessitated a review of the 1988 National Population Policy, giving way to the National Policy on Population for Sustainable Development launched in February 2005 by the then President of the Federal Republic of Nigeria, Chief Olusegun Obasanjo. The policy recognises that population factors, social and economic development, and environmental issues are irrevocably interconnected and are critical to the achievement of sustainable development in Nigeria (NPC, 2004).

The overall goal of the National Policy on Population for Sustainable Development is to improve the quality of life and standard of living of the Nigerian population (NPC, 2004). This is to be achieved through the attainment of a number of specific goals that include:

- Achievement of sustainable economic growth, protection and preservation of the environment, poverty eradication, and provision of quality social services,
- Achievement of a balance between the rate of population growth, available resources, and social and economic development of the country,
- Progress towards a complete demographic transition to a reasonable growth in birth rates and a low death rate,
- Improvement in the reproductive health of all Nigerians at every stage of the life circle,
- Acceleration of a strong and immediate response to the HIV/AIDS pandemic and other related infectious diseases,
- Progress in achieving balance and integrated urban and rural development (NPC, 2004).

The National Policy on Population for Sustainable Development operates on the principle that achieving a higher quality of life for people today should not jeopardise the ability of future generations to meet their own needs (NPC, 2004). To guide policy, programme planning, and implementation, the following targets were set:

- Reduce the national population growth rate to 2 percent or lower by 2015.
- Reduce the total fertility rate by at least 0.6 children every five years by encouraging child spacing through the use of family planning.

• Increase the contraceptive prevalence rate for modern methods by at least two percentage points per year through the use of family planning.

• Reduce the infant mortality rate to 35 deaths per 1,000 live births by 2015.

• Reduce the child mortality rate to 45 deaths per 1,000 live births by 2010.

• Reduce the maternal mortality ratio to 125 per 100,000 live births by 2010 and to 75 per 100,000 by 2015.

• Achieve sustainable universal basic education as soon as possible before 2015.

• Eliminate the gap between males and females in school enrolment at all levels and in vocational and technical education by 2015.

• Eliminate illiteracy by 2020.

• Achieve at least a 25 percent reduction in HIV/AIDS adult prevalence every five years (NPC, 2004).

2.2.7 National Health Policies

A national health policy targeted at achieving health for all Nigerians was promulgated in 1988 under the military administration of General Badamosi Babangida. The policy was adopted for implementation with the goal of achieving a level of health that will enable all Nigerians to achieve socially and economically productive lives (NHP, 1988). But in view of emerging issues and the need to focus on realities and trends, a review of the 1988 policy became necessary. The new policy, referred to as the Revised National Health Policy, launched in September 2004, describes the goals, structure, strategy, and policy direction of the health care delivery system in Nigeria (NPC, 2004a). Roles and responsibilities of different tiers of government, including non-governmental organisations are outlined. The policy's long-term goal is to provide adequate access to primary, secondary, and tertiary health care services for the entire Nigerian population through a functional referral system (NPC-ICF Macro, 2009).

The following principles and values underpin the Revised National Health Policy:

• Social justice, equity, and the ideals of freedom and opportunity affirmed in the 1999 Constitution of the Federal Republic of Nigeria are a basic right.

• Health and access to quality and affordable health care is a human right.

• Equity in health care for all Nigerians will be pursued as a goal.

• Primary health care (PHC) shall remain the basic philosophy and strategy for national health development.

• Good quality health care shall be assured through cost-effective interventions that are targeted at priority health problems.

• A high level of efficiency and accountability shall be maintained in the development and management of the national health system.

• Effective partnership and collaboration between various health sectors shall be pursued while safeguarding the identity of each.

Because health is an integral part of overall development, inter-sectoral cooperation and collaboration between the different health-related ministries, development agencies and other relevant institutions shall be strengthened; and a gender-sensitive and responsive national health system shall be achieved by mainstreaming gender considerations in all health programmes (NPC-ICF Macro, 2009).

The overall objective of the 2004 Revised National Health Policy is to strengthen the national health system such that it will be able to provide effective, efficient, quality, accessible and affordable health services that will improve the health status of Nigerians through the achievement of the health related Millennium Development Goals (MDGs). The main health policy targets are the following:

• Reduce the under-five mortality rate by two-thirds between 1990 and 2015,

• Reduce the maternal mortality rate by three-quarters between 1990 and 2015,

• Reduce the spread of HIV/AIDS by 2015,

• Reduce the burden of malaria and other major diseases by 2015.

The present national health policy regards primary health care as the framework to achieve improved health for the population (NHP, 2004). According to this policy, primary health care services are categorised to include health education; adequate nutrition; safe water and sanitation; reproductive health, including family planning; immunisation against five major infectious diseases; the provision of essential drugs; and disease control. The policy document requires that a comprehensive health care system delivered through the primary health centres should include maternal and child health care, including family planning services (NHP, 2004). The health sector is characterised by wide regional disparities in status, service delivery, and resource availability. More health services are located in the southern states than in the northern states. The current priorities in the health sector are in the area of childhood immunisation and HIV/AIDS prevention.

In 2009, the Federal Ministry of Health with the support of the Federal government and other relevant agencies proposed the National Strategic Health Development Plan (NSHDP) 2009-2015. The plan would result from the harmonization of Federal, States' and local governments' health plans, thereafter serving as the basis for national ownership, resource mobilisation/allocation and mutual accountability by all stakeholders-government, development partners, civil society, private sector, and local communities. The framework is based on the principles of the Four Ones: one health policy, one national plan, one budget, and one monitoring and evaluation framework for all levels of government. It also provides the template to concretize the health sector development component of the 7-point Agenda, Vision 2020 and a platform for achieving the MDGs (NSHDP, 2009).

The plan underlying the vision is *"To reduce the morbidity and mortality rates due to communicable diseases to the barest minimum; reverse the increasing prevalence of non-communicable diseases; meet global targets on the elimination and eradication of diseases; and significantly increase the life expectancy and quality of life of Nigerians"*. Its mission statement is *"To develop and implement appropriate policies and programmes as well as undertake other necessary actions that will strengthen the National Health System to be able to deliver effective, quality and affordable health*" (NSHDP, 2009). The overarching goal of the NSHDP is *to significantly improve the health status of Nigerians through the development of a strengthened and sustainable health care delivery system.*

The Federal Ministry of Health took steps to ensure the development of the NSHDP framework because Nigeria was not on target in meeting the health related MDGs. Therefore immediate and relevant actions in addressing the complexities and challenges presented by the stagnant health sector in the country will be through the NSHDP Framework. The framework will build on the following targets listed below based on other national, regional and global commitments for future health investments (NSHDP, 2009). These targets include:

- Promote the use of the NSHDP Framework for the development of the respective health plans for each tier of government;
- Ensure that the health plans encompass cost-effective interventions that strengthen the delivery of basic health services and referral services including secondary and tertiary care,

which include Integrated Maternal, Newborn and Child Health (IMNCH) strategies, malaria control, immunization, TB, HIV/AIDS, public private partnerships;

• Ensure equitable distribution and management of the human resource for health through appropriate strategies including capacity building, incentives; and task delegation;

• Ensure adequate funding for health services at all levels in the country to meet its commitment on the Abuja declaration of ensuring 15% of total national budget is allocated to health;

• Ensure that appropriate and broad based partnerships are built with the community and media to promote behavioural change towards improved health;

• Engage all stakeholders under the leadership of the FMoH to update programmes and projects to promote compatibility with the NSHDP Framework;

• Strive towards synchronized planning and review cycles in line with the annual review and planning systems in order to maximize the use of national capacities and competencies;

• Promote data collection, through harmonized reporting procedures and timelines within the national NHMIS framework; strengthen information sharing and knowledge management mechanisms for better planning;

• Ensure constituency representation in the various subcommittees of the National Council on Health to facilitate FMoH's task in effectively fulfilling its coordination role;

• Create a conducive environment for the advancement of science and research in Nigeria whilst adhering to highest ethical and scientific standards;

2.2.8 Current State of Health in Nigeria

According to an editorial in *The Lancet* of June 2011 titled; *Hope for health in Nigeria*, as the most populous country in Africa (one in four Africans lives in Nigeria), providing universal health care is no easy task. But even allowing for the difficulties posed by providing health care to a large population, the country still underperforms. Life expectancy on average at birth is 54 years for both sexes. Maternal mortality is 608 per 100, 000 live births, and the mortality rate for children younger than 5 years is more than double the global average at 157 per 1000 live births. Nigeria is the only country in the African continent to have never eradicated poliomyelitis, and only 3% of HIV-positive mothers receive antiretroviral treatment. Just 6% of the country's GDP is spent on health and there are enormous inequalities in its allocation between the rich and poor areas of the country (The Lancet, 2011).

In the 2000 World Health Report, Nigeria was ranked as the 187th of the 191 member (states) nations for its health systems performance (WHO, 2000a; Asuzu, 2004). The data reveals the fact that the country's health system is not working as a result of its under-funded health system in which the overall maternal mortality ratio is 608 per 100,000 births, while in the United Kingdom it is about 9 per 100,000. In some parts of Nigeria, the figure is up to 1,500 per 100,000. In perspective, a woman dies approximately every 10 minutes from pregnancy related causes, and the routine immunization programme is not functioning effectively, which is symptomatic of the much wider issue of Nigeria's health care delivery and Primary Health Care (PHC) system.

However, the concern for an effective health care system stems from the nature, content and implementation strategy of a country's health policy. In Nigeria, the country's National Health Policy (NHP) states that, "Primary Health Care (PHC) shall remain the basic philosophy and strategy for national health development" (NHP, 1988). As regards implementation over the years from the 1988 NHP, health care performance has remained low.

The Nigerian Health Policy declarations and commitments further assert that "Primary Health Care is the key to attaining the goal for all people of this country. Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology. This is made universally accessible to individuals and families in the community, through their full involvement and at a cost that the community and state can afford to maintain at every stage of their development in the spirit of self-reliance" (NHP, 1988). But the PHC values meant to achieve health systems that "put people at the centre of health care" (WHO, 2007d), have been poorly implemented in Nigeria (Scott-Emakpor, 2013). This is because people in government were more concerned about their personal gain, as against what people consider desirable ways of living as individuals and what they expect for their societies-that is, what people value-constitute important parameters for governing the health sector (Osibogun, 2004) and this has negatively affected the health sector over the years.

Obviously in Nigeria, people want effective health care when they are sick or injured. They want it to come from providers with the integrity to act in their best interest, equitably and

honestly, with knowledge and competence. But at present, the health care system is still being plagued by a national health policy that supports the values of equity, people-focus, community participation and self-determination embraced by the PHC movement in print, yet does not translate to and realise these values in the lives of the people (Osibogun, 2004). Over half of all health-care expenditure is through out-of-pocket payments depriving many families of the needed care because they cannot afford it (FMoH, 2004; Xu, Evans, Carrin, Aguilar-Rivera, Musgrove, & Evans, 2007), despite the much published free health care schemes. These out-of-pocket payments for healthcare are one of the sources of health financing the country, thereby causing those who lack the needed resources to be at risk. People who live in informal settlements such as emerging communities and urban slums are often prone to such diseases because they suffer from gross inequities in access to health care delivery thereby worsening their situations.

Table 2.3 Basic health and economic indicators of Nigeria

Health and Economic Statistics of Nigeria		
Under-5 mortality rate (U5MR), 1990	214 per 1,000 population	
Under-5 mortality rate (U5MR), 2011	124 per 1,000 population	
U5MR by sex 2011, male	129 per 1,000 population	
U5MR by sex 2011, female	119 per 1,000 population	
Infant mortality rate (under 1), 1990	127 per 1,000 population	
Infant mortality rate (under 1), 2011	78 per 1,000 population	
Neonatal mortality rate 2011	39 per 1,000 population	
GNI per capita (US$) 2011	1200	
Life expectancy at birth (years) 2011	52	
Total adult literacy rate (%) 2007-2011	61%	
Primary school net enrolment ratio (%) 2008-2011	58%	
Percent of Married Women 15-49 Using Contraception	All methods (15%)	Modern Methods (9%)
Non-communicable Disease Death Rate (Age-standardized, 2008) per 100,000	Males (818)	Females (793)
Deaths Due to NCDs, 2008 (%)	27%	

Source: United Nations Children's Fund (UNICEF), 2013; Population Reference Bureau (PRB), 2014.

The table above shows some basic health and economic indicators in Nigeria. Presently, the country's less than 5 years mortality rate in 2011 is at 124 per 1,000 populations. This is among the highest in the world, while infant mortality as of the same year 2011 is currently put at 78 per 1,000 populations. These indicators depict the poor nature of health care

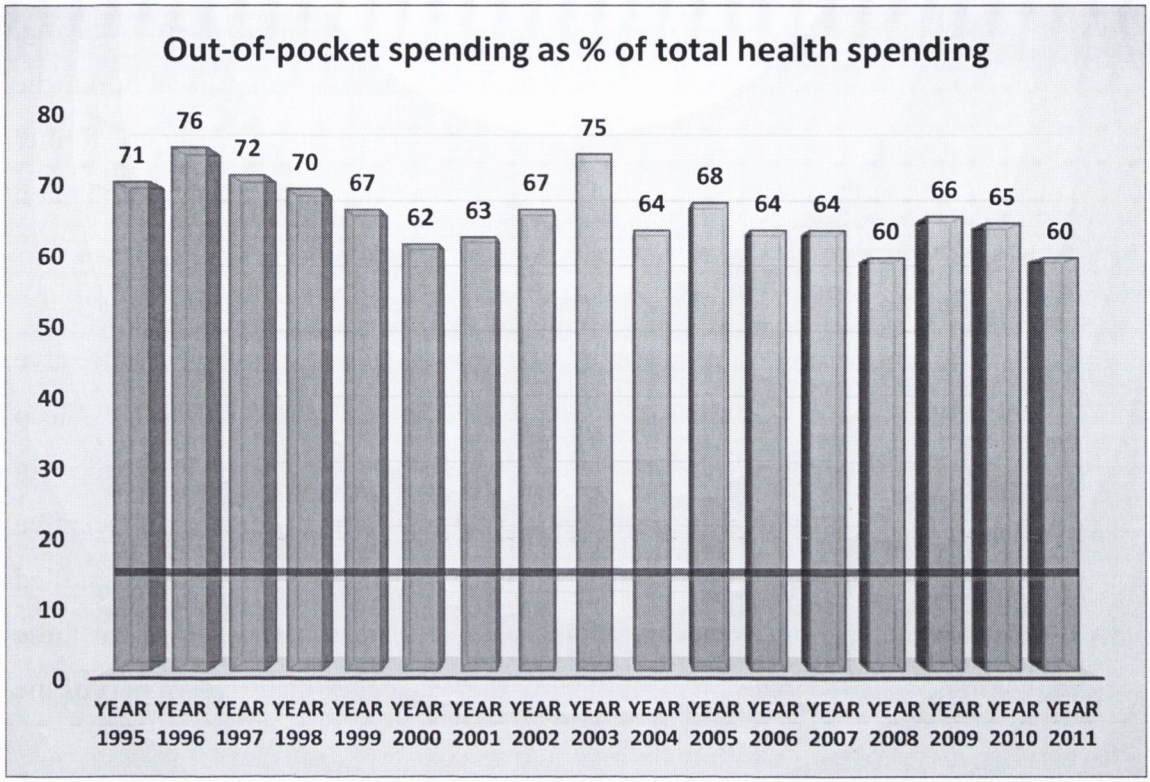
delivery and existence of a weak health system in Nigeria resulting in general poor health system performance.

2.2.9 Structure of health care delivery in Nigeria

Nigeria operates a pluralistic health care delivery system with the orthodox and traditional health care delivery systems operating alongside each other, albeit with hardly any collaboration (NPC-ICF Macro, 2009). Both the private and public sectors provide orthodox health care services in the country. In 2005, Federal Ministry of Health (FMoH) estimated a total of 23,640 health facilities in Nigeria of which 85.8% are primary health care facilities, 14% secondary and 0.2% tertiary. Thirty-eight per cent of these facilities are owned by the private sector, which provides 60% of health care in the country (FMoH, 2005). While 60% of the public primary health care facilities are located in the northern zones of the country, they are mainly health posts and dispensaries that provide only basic curative services. The Private Out-Of-Pocket-Expenditure (OOPE) in Nigeria accounts for over 64% of the estimated $10 per capita expenditure on health (FMoH, 2004), thereby limiting equitable access to quality health care services.

According to the Federal Ministry of Finance (FMoF) recent data on healthcare financing in Nigeria in 2013 showed that the Nigerian Government allocated only 5.6% of its total budget to health at the federal level (FMoF, 2013) only. Although the World Health Organization recommends that total health spending, which includes both government and private should amount to a minimum of $54 per person (WHO, 2010) each year. This is not being implemented in Nigeria, as the Government in the same year 2013 allocated $10.90 per person which is equivalent to N1, 709 for health (FMoF, 2013). This is down from $11.50 or N1, 782 of year 2012 (FMoF, 2012). This low funding for healthcare from the government infleunces households without insurance causing their health spending to amount to. More so, in 2011, 60% of all health spending remained financed directly by households as seen in table 2.4 below. Health care financing in Nigeria is derived mainly from the three tiers of government (Federal, State and Local Government), public general revenue accumulated through various forms of taxation, the health insurance institutions (private and public), the private sector (firms and households), donors and mutual health organizations (Obansa & Orimisan, 2013).

Table 2:4: Out-of-pocket spending as % of total health spending.



Out-of-pocket spending

Threshold for catastrophic expenditure

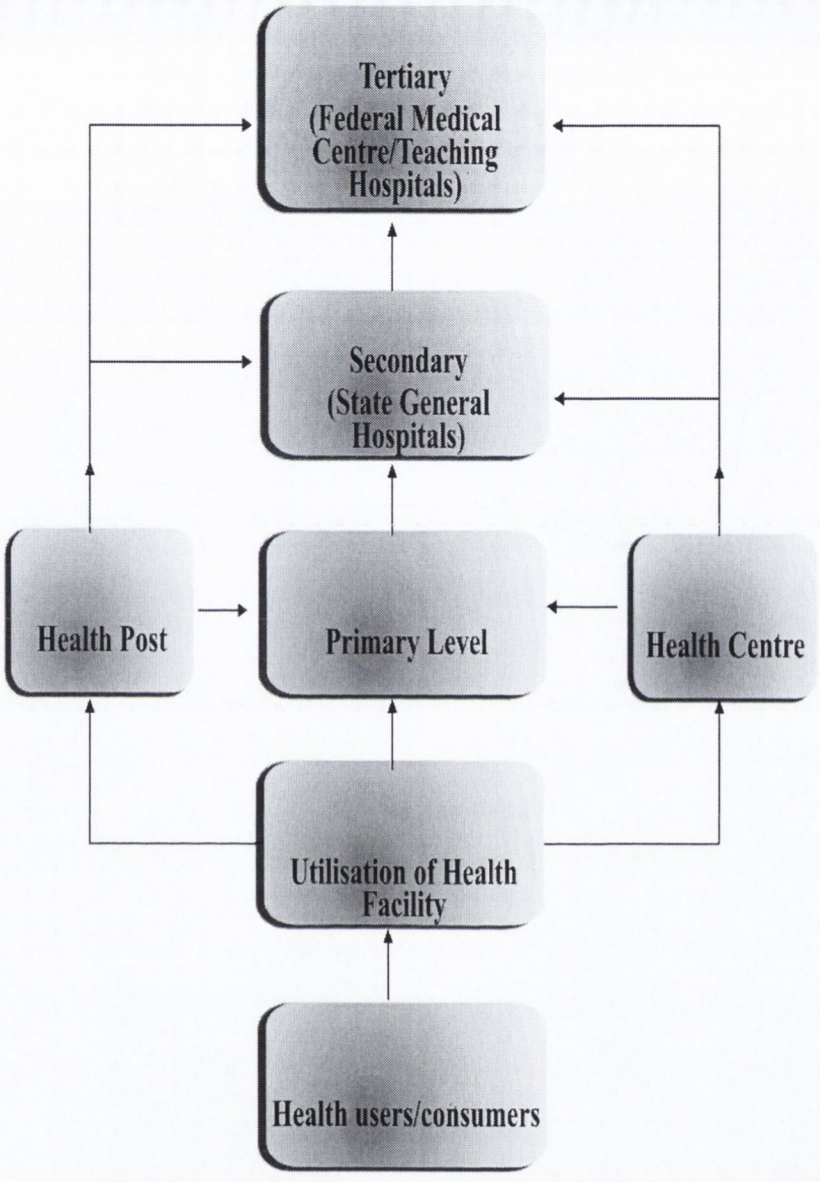
The public health service is organized into primary, secondary and tertiary levels. While the Constitution is silent on the roles of the different levels of government in health services provision, the National Health Policy ascribes responsibilities for primary health care to local Governments, secondary care to states and tertiary care to the federal level (NPC, 2008a). At the same time, a number of ministries, based at the federal level, for example, the National Primary Health Care Development Agency (NPHCDA) are currently engaged in primary health care services development and provision; the latter is evidently part of its mandate. Although national policies, formulated by the Federal Ministry of Health provide some level of standardization, each level is largely autonomous in the financing and management of services under its jurisdiction.

Overall the Nigerian health system is in a deplorable state with weak health system performance (Asuzu, 2004, Scott-Emakpor, 2013). Primary Health Care (PHC), which forms the bedrock of the national health system, is in a prostrate state because of poor political will,

gross under funding, and lack of capacity at the Primary Health Care Departments of Local Government Areas (LGAs) which is the main implementing body (NPC, 2008a). The health system remains overstretched by a burgeoning population; physical facilities are decaying, equipment is obsolete and there is scarcity of skilled health professionals. In addition, the roles of stakeholders are misaligned and coordination systems are weak. These are further compounded by the dearth of data which renders evidence based planning, policy formulation and weak health systems management difficult.

The very weak health system contributes to the limited coverage with proven cost-effective interventions. For example, immunization coverage is 23%; only 12% of under-fives sleep under insecticide treated nets (ITNs), 20% of the children in urban areas and 14% resident in rural areas with fever are appropriately treated with antimalarials at home, contraceptive prevalence rate is 15% and only 39% of women deliver under the supervision of skilled attendants (NPC, 2008a). It is important to note that wide regional variations exist for these indicators, with comparatively worse figures in the rural areas and in the northern part of the country.

Figure 2.2 Public Structure of Health Care Delivery in Nigeria.



Source: Author, 2014.

Figure 2.3 Private Structure of Health Care Delivery in Nigeria

Source: Author, 2014.

2.2.10 Communicable and non-communicable diseases in Nigeria

Like many Sub-Saharan African countries, Nigeria has a high burden of communicable, growing incidence of non-communicable and some neglected tropical diseases that are of public health importance. These diseases can be classified as (a) diseases targeted for eradication e.g. *leprosy, Guinea worm, Onchocerciasis, Poliomyelitis*; (b) Notifiable diseases e.g. *Meningitis, Cholera, Yellow Fever* (c) Diseases of public health importance e.g. *Malaria, STI/HIV/AIDS, TB* (Adeniyi, Ejembi, Igbineosun, & Mohammed, 2001) and (d) chronic illnesses e.g Cancer, Hypertension, Stroke . Whereas Nigeria has a National Disease Surveillance and Notification (DSN) system for monitoring trends and occurrence of selected communicable diseases, current information on the extent to which these diseases cause morbidity and mortality is not readily available. However, information provided in the *Report on Needs Assessment Survey,* NPHCDA, 2001, points to a high burden of diseases: e.g. malaria (50%), TB, and HIV/AIDS, which has prevalence rate of 5% (NASCP, FMoH Sentinel Survey, 2004).

Though the World Health Organisation has supported Nigeria in the prevention, control and eradication of communicable diseases over several years, the Organisation's support under CPC has mainly been for Dranunculiasis (Guinea worm disease (GWD)), Human African Trypanosomiasis (HAT), Buruli Ulcer (BU), Lymphatic filariasis (LF), Onchocerciasis, Schistosomiasis and Leprosy. These are termed Neglected Tropical Diseases (NTDs). They are diseases almost exclusively of the rural poor in low-income countries. Although safe and cost effective means of prevention and control are available, the NTDs continue to cause immense suffering and often life-long disabilities for the rural poor due to neglect. Currently Nigeria is on the verge of achieving eradication of Guinea worm disease, not having had a case for over one year as at February 2010 (WHO Nigeria, 2011).

2.2.10.1 Malaria

Malaria is the most significant public health problem in Nigeria. The economic cost of malaria, arising from cost of treatment, loss of productivity and earning due to days lost from illness, may be as high as 1.3% of economic growth per annum. The disease is a major cause of maternal mortality and poor child development. Traditionally, the malaria problem has been seen as a challenge for the health sector alone with little or no involvement by other sectors or the general community (WHO Nigeria, 2011).

At present, malaria still remains a major cause of morbidity and mortality in Nigeria, especially in children under five and pregnant women, with a prevalence of approximately 50% of the Nigerian population having at least one (1) episode of malaria annually; and 31.6% of children under five years having fever and/or convulsion due to malaria (NPC-ICF Macro, 2003). Consequently, the affected individuals/communities, especially in the rural areas, lose productivity, due to loss of man-hours from ill health, contributing to poverty and slow economic development (NPHCDA, 2007). Results of a baseline survey conducted by the Federal Ministry of Health show that most facilities do not have guidelines on the management of malaria. First action for the appropriate treatment of malaria at the community level was estimated to be 30.6% while 69.4% was inappropriate.

Lack of drugs in health facilities for anti-malaria during the week preceding the survey ranged from 15.2% for chloroquine tablets to 8.7% for the injections and 43.5% for sulphadoxine-pyrimethamine etc. In addition, it is to be noted that the current national policy for malaria control stipulates the use of Artemisinin based combination therapies (ACTs) as the drug for the treatment for uncomplicated malaria. There are however, no current statistics on the level of utilization of ACTs (NPHCDA, 2007). Furthermore, the use rate of use for ITNs in 2002 was 2% for households, 1.2% and 1.3% for children under five, and pregnant women respectively (NPC-ICF Macro, 2003). However this has risen to 6.8% in 2005 as a result of public-private sector engagement in the fight against malaria (National Malaria Situation Analysis, 2005).

2.2.10.2 Tuberculosis (TB)

An estimated 100,000 new sputum positive cases occur each year and the estimated annual risk of infection is approximately 2%. Hence, about 200,000 cases of all types of tuberculosis occur annually. As at the year 2001 in Nigeria, although treatment success was as high as 79.7% in 21 states, case detection was very low a 26.2% (NTBLCP, Annual Report 2002). With HIV/AIDS on the increase and gaining epidemic proportions, TB is also re-emerging and becoming a major public health problem (NPHCDA, 2007).

Back in 1991, the National Tuberculosis and Leprosy Control Programme was launched. The programme operates in all three tiers of government, with each level having a well-trained officer in charge of coordination in all the 774 Local Government Areas in the 36 states of

the country and FCT. But TB is still a major public health problem in Nigeria, with the country ranking 5th among the 22 high TB burden countries which collectively bear 80% of the global burden of TB. The number of TB cases notified in the country increased from 31,264 in 2002 to 90,307 in 2008; more than 450,000 TB cases have been successfully treated free of charge in the past 5 years in Nigeria. The TB burden in Nigeria is further compounded by the on-going HIV/AIDS epidemic and the emergence of multi-drug resistant tuberculosis (MDR-TB).

2.2.10.3 HIV/AIDS

Based on data from sentinel sites in the country, HIV/AIDS prevalence rates have shown an increase over the years. The series of surveys revealed an increase in median prevalence rates from 4.5% in 1995 (21 States), 4.5% in 1999 (36 States and FCT) to 5.8% in 2001 in 36 States and FCT (Human Development Report, UNDP Nigeria 2004). However, the results from the 2004 sentinel survey conducted by the Federal Ministry of Health show a marginal decline in HIV/AIDS prevalence to 5%. Male condom use during high risk sex stands at 46%, while 42.3% and 59.8% of women and men respectively knew at least two ways to prevent getting HIV/AIDS. In addition, analysis of data from the sentinel sites shows that about 85% of adult infection was attributed to heterosexual transmission of which the most infected age group is 15-49 years. As at 2001, it was estimated that 3.4 million Nigerians were living with HIV (NPC-ICF Macro, 2003).

The socio-economic implication of this epidemic is of concern to policy makers in the country. In this regard, a Presidential Committee on AIDS (PCA) which was transformed into the National Agency for the Control of AIDS was established to develop and co-ordinate a national multi-sectoral approach for controlling HIV/AIDS. To date, this Agency has developed a HIV/AIDS Emergency Action Plan (HEAP) and a set of national indicators (NNIRMS) and has been involved in a number of activities related to HIV/AIDS control and management (NPHCDA, 2007).

2.2.10.4 Cancers

Cancer remains a significant public health problem responsible for increasing morbidity and mortality worldwide. In Nigeria, the incidence and mortality from various types of cancers (breast, cervix, prostate, colon, and lung) are on the increase. Mortality from prostate cancer, the most common malignancy among Nigerian men (Osegbe, 1997, Okolo, Akinosun, Shittu,

Olapade-Olaopa et al, 2008; Obiorah & Nwosu, 2011; Ogunbiyi, 2011), is high, while gynecological cancers including breast and cervical cancers are the most common malignancies which affect Nigerian women, with more than 15000 new cases diagnosed annually (WHO, 2010; Adesunkami, Lawal & Adelusola, 2006; Adebamowo, Famooto, Ogundayo, Aniagwu, Nkwodimmah & Akang, 2008; Nnodu, Erinosho, Jamda, Olaniyi, Adelaiye et al, 2010). Presently, the HIV epidemic has also contributed to an increase in cancer prevalence including those associated with the reproductive tract-herpes and human papilloma virus. About 75-80% of cancers in Nigeria are diagnosed at an advanced stage; thus Nigerians have the poorest 5-year cancer survival rate in the world (Ogunbiyi, 2011; Ogunbiyi & Shittu, 1999; Ekwere & Egbe, 2002; Mohammed, Edino, Ochicha, Gwarzo, Samaila, 2008; Okolo, Franceschi, Adewole, Thomsa, Follen, et al, 2010).

2.2.10.5 Diabetes Mellitus (DM)

The incidence and prevalence of diabetes in Nigeria remains among the highest in the world. Globally in 2003 it was estimated that there were 150 million people with type 2 diabetes (Green, Hirsch & Pramming, 2003), and that this number will rise to 300 million by 2025 (Zimme, AIbeti & Shaw, 2001). Diabetes mellitus (DM) is a chronic metabolic disorder that is estimated to affect 4% of the world's population (Chinyelu & Ebelechukwu, 2014). In the near future, the current estimates of those affected are expected to double, especially in the African and Asian continents (Engelgau, Narayan, Saaddine & Vinicor. 2003). There exists gross underreporting of DM in African countries.

Over a decade ago, the prevalence of DM in Nigeria was 2.2% (Akinkugbe & Akinyanju, 1997 in Chinyelu & Ebelechukwu, 2014). However, isolated reports from some regions of Nigeria have found prevalence rates to range from 0.9-15% (Okeoghene, Chinenye, Onyckwerc & Fasanmade, 2007). In Nigeria, the national prevalence of DM was estimated to be 6.8% in adults older than 40 years (Abubakaria & Bhopalb, 2008). Crude prevalence rates of 7.7 and 5.7% were estimated for males and females in Port Harcourt, Nigeria (Nyenwe, Odia, Thekwaba, Ojule & Babatunde, 2003 in Chinyelu & Ebelechukwu, 2014). In another study of the prevalence of DM in Nigeria, findings showed that T2DM is the most common type of DM accounting for about 90% of cases (Familoni, Olatunde & Raimi, 2008; 2011), Sixty two percent of persons with T2DM in the northern part of Nigeria were estimated to be hypertensive (Bello-Sani & Anumah, 2009 in Chinyelu & Ebelechukwu, 2014). In 2004,

heart disease was noted in 68% of DM-related deaths among people aged 65 years or older in Nigeria (NIHP, 2011). Diabetes mellitus remains a public health challenge in Nigeria.

2.2.10.6 Hypertension and other NCDs

In a study of cardiovascular diseases in multiple centres in Nigeria, hypertension was ranked first. Hypertension and its complications constitute less than 25% of emergency medical admissions in urban hospitals in the country (Ekere, Yellowe, & Umune, 2005). It is the medical illness most frequently diagnosed in elderly Nigerians (Bella, Baiyewu, Bamigboye, Adeyemi, Ikuesan, & Jegede, 1993). Another study of 613 elderly Nigerians (398 women and 215 men) aged 65 and above conducted in Ibadan revealed that cardiovascular disease is the most common condition in this cohort, and hypertension (27.8%) was the most frequent diagnosis (Ogunniyi, Baiyewu, Gureje, et al. 2001). A similar figure was also reported in the 1990s (Bella, et al, 1993).

High blood pressure is also the most common condition associated with dementia in Nigeria. It is the most common condition in senior executives (Okojie, Isah, & Okoro, 2000) and army recruits (Awoyemi, Osagbemi, & Ogunleye, 2001). The chronic nature and slow onset of most NCDs causes late clinical presentation by patients. Often, patients present after the manifestation of recognizable complications e.g. stroke/hemiplegia, heart attack, or diabetic coma. In addition, the genetic/familial nature of some NCDs e.g. Sickle cell disease, hypertension and cardiac problems etc have frequently in the past led to superstitious beliefs amongst various communities.

2.2.10.7 Neglected Tropical Diseases

Neglected Tropical Diseases (NTDs) are a group of communicable diseases of public health importance that cause severe pain, irreversible disability and even disfigurement. These diseases predominantly occur among populations that have little or no access to good housing, safe water supply and sanitation, formal health systems and other modern amenities (NPC, 2008a). The 2008 NDHS included questions about four of these diseases-dranunculiasis (Guinea worm disease-GWD), onchocerciasis (river blindness), schistosomiasis (bilharziasis), and lymphatic filariasis (LF) (elephantiasis).

More than 32 million Nigerians in 32 states and the Federal Capital Territory (FCT) are estimated to be at risk for onchoceriasis. Nigeria accounts for 40 percent of the 40 million people infected with onchoceriasis worldwide. LF is endemic in 28 states and the FCT out of the 32 states so far mapped with an estimated 80-100 million Nigerians needing treatment. Nigeria is third in the world's burden for LF (NPC-IFC Macro, 2009). The mean national prevalence for infections with schistosomiasis and soil transmitted helminthiasis ranges from 13 percent to 100 percent across the country. Seventy-three cases of GWD were reported in Nigeria in 2007. In 2008, there were 38 cases of GWD reported in five villages in Nigeria, a significant drop from the over 653,000 cases reported when the first case search was conducted in 1987/88 (Nigeria Guinea Worm Eradication Programme, 2007).

Together, the NTDs constitute a tremendous disease burden in Nigeria, but can be treated collectively through large-scale integrated programmes that use safe and effective drugs and/or management and containment methods. Safe and cost-effective interventions for the prevention and control of these diseases are available. As a result, Mass Drug Administration (MDA) was initiated in Nigeria in 1991 for these diseases. Ivermectin is used for onchocerciasis, and the current initiative uses Community Directed Treatment with Ivermectin (CDTI or ComDT). Ivermectin and albendazole are used for lymphatic filariasis, and praziquantel and albendazole are used for schistosomiasis and soil- transmitted helminthiasis. The national control programmes have also initiated Triple Drug Administration for co-endemic diseases (schistosomiasis, onchocerciasis and lymphatic filariasis).

There are no vaccines or medications effective in preventing or treating GWD. Current eradication efforts for GWD are aimed at improving routine and active GWD surveillance with nationwide and local case searches and promotion of activities and practices that will ensure that zero GWD case status is maintained in Nigeria for a minimum of three consecutive years. All suspected cases are reported to health facilities and health workers, and investigated within 24 hours. Other eradication strategies taken include creating adequate public awareness to promote enhanced early case detection and reporting, provision of adequate safe water sources in the previously endemic villages and villages at risk, containment of cases, treatment of unsafe water sources with the chemical larvicide Abate

(temephos), and distribution of water filters (cloth and pipe) to endemic communities (NPC, 2008a).

2.3 Study Settings

The study settings are located in Lagos and Ogun states of south west Nigeria. Both states are predominantly occupied by the Yoruba speaking tribes and have been in existence since the 1960s. A total of six communities, three from each state, were selected as study sites for the research.

2.3.1 Lagos State of South West Nigeria

Lagos State is located on 6° 35' N 3°45'E. The state was created on May 27, 1967 by virtue of State (Creation and Transitional Provisions) Decree No. 14 of 1967, which restructured Nigeria's Federation into 12 states. Prior to this, Lagos Municipality had been administered by the Federal Government through the Federal Ministry of Lagos Affairs as the regional authority, while the Lagos City Council (LCC) governed the City of Lagos. Equally, the metropolitan areas (Colony Province) of Ikeja, Agege, Mushin, Ikorodu, Epe and Badagary were administered by the Western Region. The State took off as an administrative entity on April 11, 1968 with Lagos Island serving the dual role of being the State and Federal Capital.

However, with the creation of the Federal Capital Territory of Abuja in 1976, Lagos Island ceased to be the capital of the state which was moved to Ikeja. Equally, with the formal relocation of the seat of the Federal Government to Abuja on 12 December 1991, Lagos Island ceased to be Nigeria's political capital. Nevertheless, Lagos remains the centre of commerce for the country. Lagos state covers an area totalling 3,475.1 km^2 (1,341.7 sq mi). Presently, the state is home to a population of 9, 113, 605 million people (National Population Commission, 2006) from different ethnic groups. In Lagos state, the study site is comprised of two urban slums namely Makoko (Yaba Local Council Development Area), and Ajegunle (Ajeromi-Ifelodun Local Government Area), and one emerging community located in Abaranje (Ikotun-Igando Local Council Development Area) of the state in south west Nigeria.

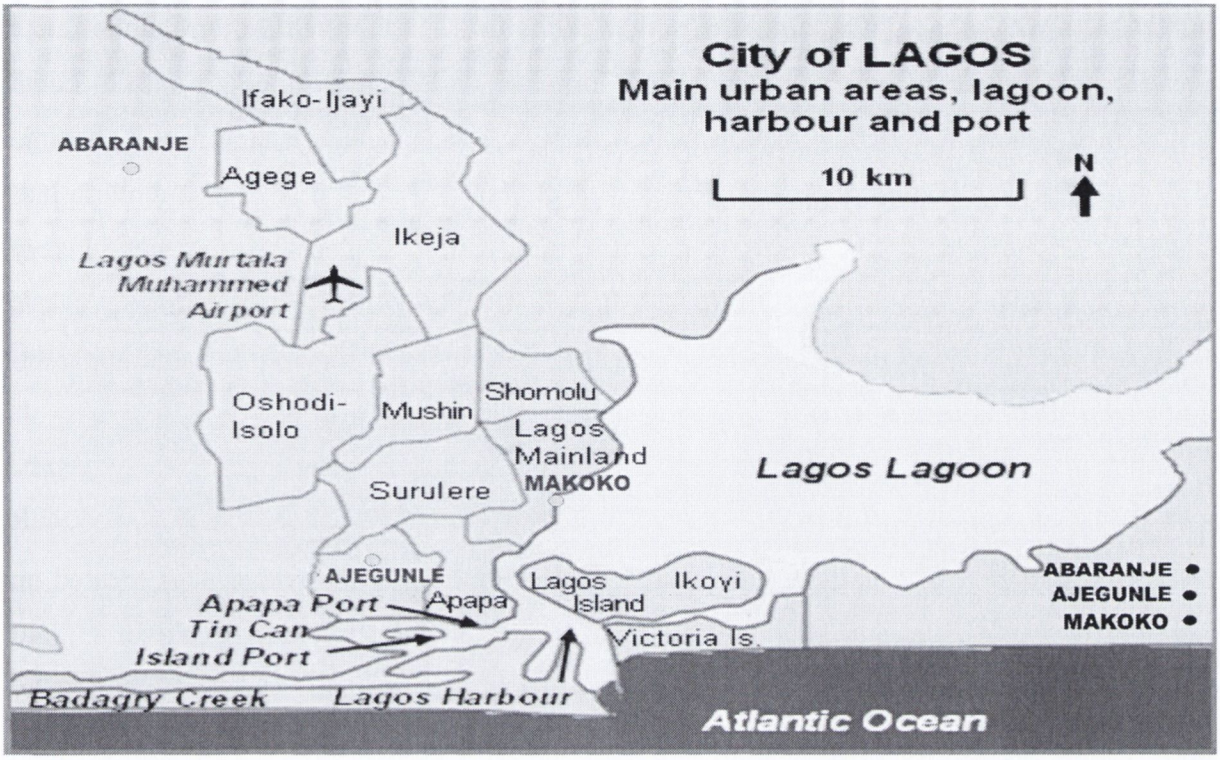
Formerly the capital of Nigeria, Lagos is a huge metropolis which originated on islands separated by creeks, such as Lagos Island, that fringe the southwest mouth of Lagos Lagoon, protected from the Atlantic Ocean by long sand spits such as Bar Beach which stretch up to

100km east and west of the mouth. From the beginning, Lagos has spread on the mainland west of the lagoon and the conurbation including Ikeja, Agege, and now reaches more than 40km northwest of Lagos Island. The city is the economic and financial capital of Nigeria (http://en.wikipedia.org/wiki/Lagos, 2013).

Lagos State's current growth rate is up to 8% per annum. It is projected to become one of the largest cities in the world by 2050. The history of Lagos municipality could be traced to the 19th century. The small Yoruba Kingdom of Lagos was once a fishing depot founded by a man known as Olofin. Olofin was the ancestor of the white cap chiefs of Lagos. On the 6th of August, 1861, the small Yoruba Kingdom of Lagos was ceded to Britain by Oba Dosumu. Thus, Lagos became the first town to experience British rule in present day Nigeria. In 1914, it was proclaimed the capital of Nigeria, and remained so until Abuja was declared as the Federal capital and the seat of Government was moved there on the 12th of December 1991.

Lagos is located on the south western part of the country and is bounded on the north by Ogun state, in the west by the neighbouring Republic of Benin and south by the Atlantic Ocean. The state is known for its beautiful beaches. Furthermore, the area of Lagos consists of two regions: the Island, which is the origin city and the mainland, which is made up of growing settlements. The climate in Lagos is tropical, hot and cold. The environment is characterised as coastal, with wetlands, sandy barrier islands, beaches, low living tidal flats and estuaries. The average temperature in Lagos is 27^0C and the annual average rainfall 1533mm. Presently the seat of government is located in Alausa within Ikeja which is the capital of Lagos state.

Figure 2.4: Map of Lagos State and study site



Source: Adapted from http://en.wikipedia.org/wiki/Lagos and Modified, 2014.

2.3.1.1 Ajegunle Community

Ajegunle community of Lagos state is located on the Island of Lagos and is home to over 800,000 people. Ajegunle is popularly known as "AJ city", and remains popular as one of the major slums of Lagos state. Based on its size and composition of various ethnic groups, Ajegunle Community is under the administration of Ajeromi-Ifelodun Local Government Area (See Pictures in Appendix XIV). Based on observations made by the researcher, Ajegunle community has several pharmacy stores/chemist shops on different streets, an estimate of seven private health facilities scattered across the community. It has one state general hospital (see appendix XIV) and a few primary health care facilities, numerous drug vendors and traditional herbal sellers that hawk their medicines/concoctions in Ajegunle community. Also within the community are health services from specialized clinics/hospitals, maternity homes, faith-based and community-led health facilities.

2.3.1.2 Abaranje Community

Abaranje community of Lagos state is located in the suburbs of Ikotun-egbe and has developed tremendously within the past decade to become home to over 100,000 inhabitants.

The community is known as Abaranje-Okerube as these communities share the same history and development process. Abaranje is currently under the newly formed Ikotun-Igando Local Government Development Area which was formerly under the former Alimosho Local Government Area. For better administrative purposes, and social development, Abaranje Community is now a major suburb of Lagos with migrants from all over Lagos moving into this growing peri-urban town and urban slum community. Modern health care delivery services did not emerge from the time these communities were formed. But these services evolved overtime as the population grew and the need for such services became apparent. (See Pictures in Appendix XIII).

2.3.1.3 Makoko Community

Makoko community of Lagos state is located in the suburb of Yaba-Iwaya. It is located on longitude 6^0 29"44N and latitude 3^0 23"99E. Makoko is home to a population of over 85, 840 people and remains one of the popular urban slums of Lagos State. Makoko is a marshy environment and has several environmental challenges which affect the life and living of the people. Similar to Ajegunle community of Lagos state, the researcher observed that several pharmacy stores/chemist shops are present on the different streets within Makoko and Abaranje. Based on the researcher's count, an estimate of over three well known private health facilities were in operation within Makoko and Abaranje community. There is no state general hospital in Makoko or Abaranje but at least one primary health care facility. In addition, numerous drug vendors and traditional herbal sellers are present in both communities. These engage in hawking their medicines/concoctions around the community. Also within both communities are health services from specialized clinics/hospitals, maternity homes, faith-based and community-led health facilities.

2.3.2 Ogun State of South West Nigeria

Ogun State is located in South-western Nigeria. It borders Lagos State to the south, Oyo and Osun states to the North, Ondo State to the east and the Republic of Benin to the west. Abeokuta is the capital of and largest city in the state. Ogun State is situated between Latitude 6.2°N and 7.8°N and Longitude 3.0°E and 5.0°E. The state was created in February 1976 from the former Western State. The 1991 census recorded a total population of 2,338,570 people. Presently, the state has a population of 3, 751, 140 million people (NPC, 2006). The state covers an area totalled 16,762 km^2 (6,471.8 sq mi).

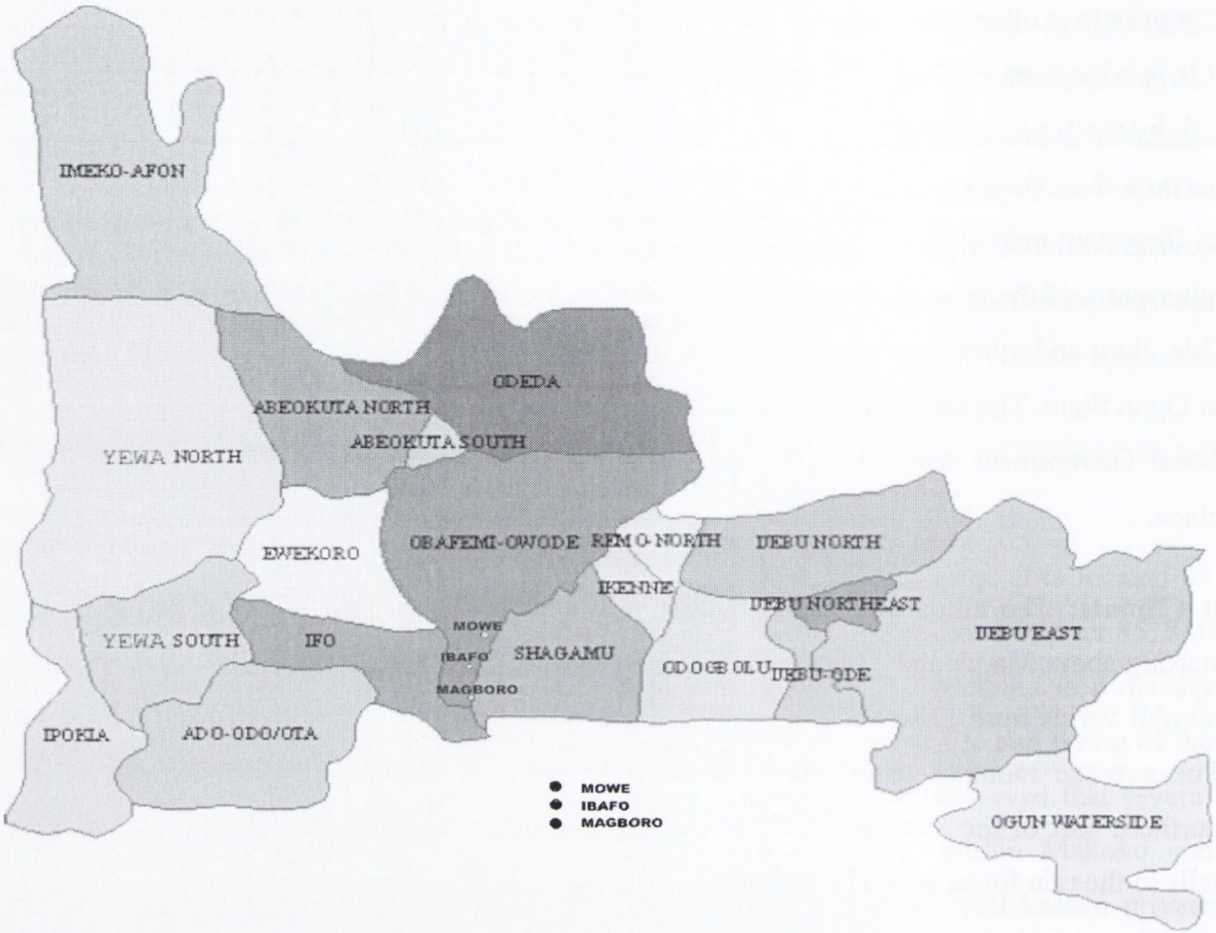
Ogun State is otherwise known as the *Gateway State*. This is in recognition of its pioneering role in education, medicine, law and divinity, on the one hand, and its strategic position as the link by road, rail, air and sea to the rest of the country. As part of the state's vision, it aims to become the internet gateway to the rest of the world from Nigeria. Abeokuta, the capital, is an important market centre and a terminus of the roads and railways coming from Lagos and other parts of the country. There are also major towns and communities like Sagamu, Ijebu-Ode, Ilaro and others that can serve as good markets for the products of the mining industry in Ogun State. The emerging communities of Magboro, Mowe, and Ibafo in Obafemi-Owode Local Government Area of Ogun state were the study locations where the research took place.

i) Climate: The climate of Ogun State follows a tropical pattern with the rainy season starting about March and ending in November, followed by the dry season. The mean annual rainfall varies from 128cm in the southern parts of the State to 105cm in the northern areas. The average monthly temperature ranges from 23°C in July to 32°C in February. The northern part of the State is mainly of derived Savannah vegetation, while the Central part falls in the rain forest belt. The southern part of the State has mangrove swamps.

ii) Topography/Ecology: The geographical landscape of the state comprises extensive fertile soil suitable for agriculture, and Savannah land in the north western part of the state, suitable for cattle rearing. There are also vast forest reserves, rivers, lagoons, rocks, mineral deposits and an ocean front.

iii) Accessibility: The state is accessible to other states in Nigeria and the outside world because of its closeness to Lagos State, which has an International Airport, a few sea ports and access to the West African sub-region. As earlier stated the state is the passage from Lagos, the former federal capital and still the commercial nerve centre of Nigeria, to any other part of the country.

Figure 2.5: Map of Ogun State and study site



Source: Adapted from http://www.nigerianmuse.com/20100527092749zg/sections/pictures-maps-cartoons/maps-of-various-states-and-their-local-governments-in-nigeria/& modified, 2014.

2.3.2.1 Magboro Community

Magboro community of Ogun state is situated between the Mountain of Fire and Miracle Ministries (MFM) camp ground and Areepo community. Magboro is also located on the Lagos-Ibadan expressway of southwest Nigeria. From Lagos state (Berger), commuters travel in less than 20 minutes to reach Magboro. But on a busy day with massive traffic on the Lagos-Ibadan expressway, commuters from either Lagos (Berger) to Magboro or from Magboro to Lagos (Berger) can spend well over an hour to reach their destination. The major highway over the years is also known to have witnessed several road traffic accidents (RTA). Because Magboro is less populated than Ibafo and Mowe, the community does not have a functional government owned health facility. However, private clinics and hospitals can be found in the innermost parts of the community, unlike in Ibafo and Mowe where government owned facilities are present and some private facilities are located on the outskirts of the towns close to the Lagos-Ibadan expressway. Magboro before the advent of Christian camp

grounds was home to less than 30,000 inhabitants but this number today is on the increase. (See pictures in appendix XVII). Land ownership in emerging communities rest in the hands of the original settlers whom were majorly from the Yoruba speaking ethnic group of south west Nigeria and highly traditional with deeply rooted beliefs in customs of their Yoruba ancestors. These settlers mainly farmers had travelled long distances from neighbouring town such as Shagamu, Owode and Ijebu. These settlers owned the lands and cultivated majorly food crops in a subsistent manner to meet their everyday needs (Lawal, 2014).

2.3.2.2 Ibafo Community

Ibafo community is located on the Lagos-Ibadan expressway of South-west, Nigeria. The community or border town as it's sometimes called is now home to over 20,000 people. Following similar development patterns as Magboro and Mowe community but more populated than both, Ibafo community is situated between Ago-Igabla, Ore-Ofe communities and the Mountain of Fire and Miracle Ministries (MFM) camp ground aka Prayer-city. Ibafo community continues to grow with the presence of the Prayer-city and Deeper Life Camp ground also located on the same Lagos-Ibadan expressway. Ibafo community has a higher number of informal settlements, shanty houses and illegally constructed housing units. The town is also popular as it provides housing for travellers to the northern part of the country especially lorry drivers. This growing number of commuters can be easily spotted across the shanty housing units close to the major expressway. Ibafo community however has a health post that functions mainly to provide ante-natal services for the general public. (See pictures in appendix XVI).

2.3.2.3 Mowe Community

Mowe community is located along the Lagos-Ibadan expressway and has a population of over 20,000 people. Mowe town is situated between the Redeemed Christian Church of God (RCCG) camp ground; Loburo community and Pakuro community. Mowe town has been in existence for over a decade but recent migration especially from Lagos State has led to its continued growth and development. Originally Mowe community was inhabited by rural farmers and settlers known as the "Ewa people" who moved from Abeokuta, Sagamu and Ijebu-ode towns to set up new farm settlements and communities. Over the years, due to the rise in urbanisation and population growth, the establishment of the RCCG camp ground, Redeemers University, and other organisations such as banks and small businesses in the

RCCG camp sites. Mowe town has grown and continues to grow with increasing structural development and emergent health challenges for the inhabitants of the community. (See pictures in appendix XVIII).

Across the three emerging communities of Ogun state, the researcher observed that several pharmacy stores/chemist shops are present on the different streets within these communities. Based on the researcher's count, each community had several private health facilities which were in operation. There are no state general hospitals in these communities, but each has at least one primary health care facility. In addition, numerous drug vendors and traditional herbal sellers are present in the three emerging communities. They hawk their goods (medicines/concoctions) around the community. Also within emerging communities as observed by the researcher are health services from specialized clinics/hospitals, maternity homes, faith-based and community-based health facilities.

2.3.3 Justification for Study Areas

Lagos state has the highest number of urban slums in Nigeria (Olajide, 2010), at present, the number of slums in the city is estimated at about 100, housing almost 70 per cent of Lagos' population. The majority of slum communities are located in the oldest settled areas of Lagos mainland, especially in marshy areas and near the lagoons (LMDGP, 2006). According to Adelekan (2010) "population densities in these slum communities range from 790 to 1,240 people per hectare, and more than 75 per cent of urban poor slum dwellers live in one-room households with an average of 4.6 persons per room. It is common for 8–10 households to live in one house structure, sharing common cooking and sanitation facilities". The increase in the number of people living in urban slums of Lagos has led to the need for health services within these communities which have emerged and evolved over time. Ogun state has a large growing population of emerging communities. This forms the reason for choosing both states in order to understand the nature of health care delivery in these informal settlements. For the purpose of the study, the following urban slum communities in Lagos state were conveniently selected, namely: Makoko (Yaba Local Council Development Area), and Ajegunle (Ajeromi-Ifelodun Local Government Area) with Abaranje (Ikotun-Igando Local Council Development Area) an emerging community in the State.

The purposive selection of Makoko, Ajegunle and Abaranje slum communities in Lagos is based on the ease of access to these communities for the researcher to conduct the study. Although several slum communities (officially and unofficially recognised) are present in Lagos State, gaining access to these communities can sometimes be a challenge. Hence the researcher purposeivley selected the slum communities where the research took place. For the emerging communities their location is clearly defined and is found along the Lagos-Ibadan expressway. The three emerging communities were the research took place were purposively selected because of the high population composition of residents. In Ogun state the following emerging communities namely Magboro, Mowe and Ibafo in Obafemi Owode Local Government Area were selected.

CHAPTER THREE

LITERATURE REVIEW, THEORETICAL AND CONCEPTUAL FRAMEWORK

3.1 Introduction

In this section, a review of existing literature on health care delivery is undertaken. The review follows a thematic perspective. Issues such as health care delivery in developing countries, health care delivery in emerging communities and urban slums, access and utilisation of health care services and social determinants of health, are reviewed. Prevention and treatment of communicable diseases, and people's perception of health care services through health facilities are also reviewed. The section provides a combination of theoretical approaches and conceptual framework that highlights the focus of the study.

3.2 Health care delivery in developing countries

People do not always get the health care they need (Musgrove, 2010) as a result of the numerous challenges they face as individuals in relation to the institutions that provide the services and the system in operation that offers health care delivery within the society. Moreover, when people don't realise that they need care (that is, demand is lacking), or they lack access to care for financial reasons, then the burden of diseases and persistence of poverty affects their lives and living. Also, when physical, structural or cultural reasons (health facilities are too costly to the patient, health care facilities are too far for patients or cultural beliefs towards modern health service) hinder their ability to seek health care (Hanson et al, 2003), then health care delivery both from a demand or supply perspective tends to underperform.

Across developing countries, when health care services are accessible for users, it is provided inefficiently (priorities are set badly or left to chance, resources are wasted through imbalances among inputs or operate at an uneconomical scale) and ineffectively (Musgrove, 2010; Schieber & Maeda, 1999), thereby causing low performance in service delivery of the entire health system. And when care is accessible, its quality is often substandard (so it does not protect or improve health as much as it could), because providers may not know what to do, or may not act on what they know (Musgrove, 2010). The entire health care delivery system in such circumstances tends not to work in the interest of the people it's meant to serve.

In 1978, the Alma-Ata declaration of the World Health Organisation (WHO) stated as an objective that countries should "make health services accessible and available to everyone wherever they live or work". But today there is the recognition that populations are left behind and a sense of lost opportunities are reminiscent of what gave rise thirty years ago to the Alma-Ata's paradigm shift in thinking about health (WHO, 2008a). The Alma-Ata conference mobilized a "primary health care movement". This consists of professionals and institutions, governments and civil society organizations, researchers and grassroots organizations that undertook the task to tackle the politically, socially and economically unacceptable health inequalities in all countries (Declaration of Alma-Ata, 1978). The declaration of Alma-Ata was clear about the values pursued; social justice and the right to better health for all, participation and solidarity. There was a sense that progress towards these values required fundamental changes in the way health care systems operated and harnessed the potential of other sectors (WHO, 2008b). But today developing countries are still plagued with the spread of diseases.

In developing countries today, adherence to the principles of the Alma-Ata declaration for effective health care delivery is lacking, as many such countries have failed in the provision of basic health care services. The concept of health care delivery is all encompassing, ranging from causation and determinants of health to a focus on health care providers, health outcomes of the population, types of health problems encountered by people, the management approach to service delivery and health interventions (Harpham & Molyneux, 2001). However, health care delivery in specific terms within this study covers the nature and range of health services from providers to consumers.

Across developing countries, one of the defining features of health care delivery, especially within urban health systems, is the diverse array of providers offering a multiplicity of services (Harpham & Molyneux, 2001). Such providers include government services run by the district council, municipal council, state or central ministry, local governments; private (for profit) hospitals, clinics, laboratories and practitioners (offering 'modern' or 'traditional' services); and a variety of nongovernment providers, including missions and charities (Lorenz & Garner, 1995). Much more are various sources of herbs (Mwangi, 2004; Fakeye, Adisa & Musa, 2009; Oreagba, Oshikoya & Amachree, 2011) and medications which include mini-shops, pharmacies, chemists, drug vendor (Okonkwo & Okonkwo, 2010), markets and various clandestine sources.

As a result of the various forms of health care delivery in practice within developing countries, it is increasingly difficult to distinguish genuine service providers, while some have argued that it is irrelevant to make such distinctions (Giusti, Criel & De Bethune, 1997; Ferrinho, Van Lerberghe & Da Cruz Gomes, 1999). This is because most developing countries are faced with a system of dual public and private practice by government-employed physicians, the introduction of private wards in some public hospitals, the self-referral of patients between healers and orthodox doctors, and between public and private facilities (Harpham & Molyneux, 2001), and the unofficial introduction of user fees into government services. The funds generated from user-fees constitute part of the existing corruption in health care delivery within Nigeria, as such funds are illegal exhorted from users and unaccounted into the National Health Accounts. are often times collected illegal from health users as government policies in certain states is against suchThese overlappings suggest an increasingly integrated and pluralistic nature of health care delivery from rural to semi-urban areas; also from urban areas to low income neighbourhoods and to informal settlements (emerging communities and urban slums). But across all these environments in developing countries, in practice there is often little formal interaction and cooperation between the different types of (health care) providers (Ogunbekun, Ogunbekun & Orobaton, 1999).

Health outcomes are unacceptably low across much of the developing world, and the persistence of deep inequities in health status is a problem from which no country in the world is exempted (WHO, 2007c). At the core of this human crisis is a failure of health systems, as those in most need of health care are often least able to afford it or judge the quality of care they obtain (Balabanova, McKee, Mills, Walt & Haines, 2010). But much of the burden of disease can be prevented or cured with known, affordable technologies. The problem still persists as getting drugs, vaccines, information and other forms of prevention, care or treatment-on time, reliably, in sufficient quantity and at reasonable cost to those who need them (WHO/USAID, 2007) remains a challenge in developing countries. In too many of these countries the systems needed to do this are on the point of collapse, or are accessible only to particular groups in the population. Failing or inadequate health systems in developing countries remain one of the main obstacles to scaling-up interventions to make the achievement of internationally agreed goals such as the MDGs a realistic prospect (WHO, 2007c).

Primary Health Care (PHC) has remained the benchmark for most countries including developing ones because the movement has tried to provide rational, evidence-based and anticipatory responses to health needs and to these social expectations (Saltman, Rico, & Boerm, 2006; WHO, 2003). In many regards, the responses of the health sector to the changing world have been inadequate and naïve. Inadequate, insofar as they not only fail to anticipate the needs of the communities they serve; but also to respond appropriately, offering often too little, too late or too much in the wrong place (WHO, 2008a).

As a developing country, a typical PHC clinic and health post in Nigeria is a small building of two to three rooms with very limited staff and services. Usually, it has only one bed for new patients, with no privacy even for women on antenatal care because the same room is used for all consultations, and sometimes for male patients too (The Guradian, 2008, pp 20-21). The Nigerian health system in general is believed to be affected by low public funding, as well as lack of staff motivation and inequitable access to health (UNICEF/FGN, 2001). Even though the problems with human resources for public health and health care, finance, infrastructure or information systems in most part of the developing world invariably extend beyond a single level of policy purview and, increasingly, across borders this raises the benchmark in terms of working effectively across government and stakeholders (WHO, 2000A; WHO, 2008a) to meet the health needs of the people and guarantee access to health care services.

Though health systems are developing in the directions that contribute little to equity and social justice, and fail to get the best health outcomes for their money people all over the world are becoming more vocal about health as an integral part of how they and their families go about their everyday lives, and about the way their society deals with health and health care. The dynamics of demand must find a voice within the policy decision making process (WHO, 2008b), as the demand for competence is not trivial. It fuels the health economy with steadily increased demand for professional care (doctors, nurses and other non-physician clinicians who play an increasing role in both industrialized and developing countries (Mullan & Frehywot, 2007).

Basically, citizens in the developing world, like those in rich countries, are not looking for technical competence alone; they also want health-care providers to be understanding, respectful and trustworthy (Bossyns & Van Lerberghe, 2004). They want health care to be

organised around their needs, respectful of their beliefs and sensitive to their particular situation in life, take into account the socio-cultural context of their families and communities where interventions may occur (Cheragi-Sohi, Bower, Mead, McDonald, Whalley, & Roland, 2006), and make life more pleasant for them by improving health equity, making health systems people-centred, promoting and protecting the health of communities and making health authorities more reliable.

3.3 Health care delivery in urban slums and emerging communities

Of the world's 6.8 billion inhabitants, around 1 billion live in slums; this figure will increase to 1.4 billion people by 2020 (UNHSP, 2003). Despite a reduction in the share of urban populations living in slums, the absolute number has continued to grow from the 1990 baseline of 650 million (UN, 2012). Not having access to safe and secure shelter and a concept of home impacts negatively on many lives, impacting on health, safety, psychological well-being, education and economic opportunities. More so, poor housing increases the risk of severe ill-health or disability by up to 25 per cent during childhood and early adulthood (Harker, 2006). A slum is a place where residents suffer from one or more of the following: inadequate access to safe water, inadequate access to sanitation, overcrowding, poorly built and maintained homes, and insecurity of tenure or the threat of eviction. Global housing poverty has many causes but the inattention of governments, the lack of planning for population movement, income levels and costs of legal housing, land markets and difficulties in securing adequate tenure (http://www.homeless-international.org/end-world-slums. Accessed 22.12.10), fuel the continuing growth of urban slums in developing countries.

More so, the urbanisation rate is attributed to natural increase and rural–urban migration. However, the rate of urbanisation often exceeds the rate of economic growth (Schouten & Mathenge, 2010). As a result, infrastructure development lags behind the population growth, particularly in the low-income areas (Konteh, 2009). Population increase in most cities is projected to be highest in slums (Paterson, Mara & Curtis, 2007). Because many slum dwellers are recent migrants from rural areas, many of them live without the social networks and kinship ties that can provide emotional, physical, and financial support in times of crisis (Majale, 2008). Root causes of slum formation include long-term failure of governments to implement structural plans, to enforce development control and to provide effective

municipal services. These trends are now influencing the growth of emerging communities as well.

In Africa the rates of urbanisation and slum formation are 4.6% and 4% respectively (UN-HABITAT, 2008, 2009; Otiso, 2003). A third of the urban population in the developing countries is estimated to be living in slums with the highest number in sub-Saharan Africa, where 62% of the urban population live in slums (UN-HABITAT, 2008, 2009). Unhygienic means of human waste disposal exposes the slum dwellers to high risk sanitation related diseases. A study undertaken in Kenya (Kimani-Murage & Ngindu, 2007) showed that the prevalence of diarrhoea among the children was highest in slums with 32% compared to Nairobi as a whole with 13%. Therefore, the health conditions in slum areas are worse compared to the general population in urban centres. Many cities are affected by severe urban poverty, pervasive and largely unacknowledged. According to the 2003 Global Report on Human Settlements, 43% of the urban population in developing regions live in "slums", while in the least developed countries, 78% of urban residents are slum dwellers.

According to the Millennium Development Goals, the slum target 11 of goal 7 aims "to have achieved a significant improvement in the lives of at least 100 million slum dwellers by 2020". As large as 100 million may seem, it is only 10% of the present worldwide slum population which if left unchecked will multiply threefold to 3 billion by the year 2050 (Schouten & Mathenge, 2010). As stated by Huchzermeyer (2006), the improvement of slums is a target 11 which stands out from the other MDGs, as most of the outcome based MDG targets are to be achieved by 2015. But as a result of the existing environmental defects in emerging communities and urban slums, e.g. insecure housing status, inadequate access to safe water, inadequate access to sanitation and other infrastructure; poor structural quality of housing; and overcrowding, residents in such communities are easily prone to both communicable and non-communicable diseases.

Health care delivery exists in various forms within urban slums and emerging communities. That is, pluralism in health care provision within these settings influences and responds to treatment-seeking patterns. Responses can differ for different illnesses or syndromes and, in many cases, more than one therapy source is contacted over the course of an illness

(Harpham & Molyneux, 2001). Within this general picture of diversity, empirical studies have suggested a number of key features of urban treatment-seeking patterns.

These features are pervasive also in emerging communities and urban slums, such that these communities accommodate high levels of quackery, common practice of herbal treatment usage and high levels of self medication with the increasing spread of local pharmacies and patent medicine vendors. However, following similar growth patterns of informal settlements, shanty towns or squatter settlements of developing countries, the social process that promotes the growth of emerging communities and urban slums is a result of rapid urbanisation in developing countries which creates massive demand for basic social amenities and infrastructure in cities, of which adequate health care services remains at the forefront of those social amenities that has become lacking or inadequate.

Health care services in emerging communities and urban slums operate in different dimensions. Self-medication (Shankar, Partha, & Shenoy, 2002; Omolase, Adeleke, Afolabi, & Afolabi, 2007), the use of drugs bought from private-for-profit shops (popularly known as "chemist") and pharmacies is a common practice in response to many illnesses/diseases (Brugha & Zwi, 1999; Osemene & Lamikanra, 2012; Afolabi 2008; Fadare & Tamuno, 2011; Arikpo, Eja & Enyi-Ido, 2009). Urban community-based studies exploring treatment-seeking for fevers, for example, have shown that the purchasing of drugs from these providers constitutes over 40% of actions taken, in most cases as the first-line response (Glik, Ward, Gordon & Haba, 1989; Carme, Koulengana, Nzambe, & Du Bodan, 1992; Mwenesi, 1993; Kilian, 1995; Molyneux, Mung Ala-Odera, Harpham & Snow, 1999).

The simple attraction of self-treatment using chemist-and pharmacy-bought drugs is as 'rational' in urban areas as it is in rural areas, emerging communities and urban slums despite relatively good physical access to health services in these communities (Harpham & Molyneux, 2001). There are still numerous shops and pharmacies offering cheap and convenient service relative to even nearby government and private facilities; drugs are readily available and, in many cases, cure or alleviate the patient's symptoms; and in some cases credit, or the option to buy drugs in small amounts, is offered (Molyneux et al., 1999). Such operations persist in emerging communities and urban slums as the relationships between drug sellers and buyers have become personal.

An extensive review on "*Urban health in developing countries*" by Harpham and Molyneux, (2001), shows that Private facilities have been shown to be an important therapy source in response to, for example, sexually transmitted diseases (STDs), malaria, TB and diarrhoea in urban (slum) settings (Ngalande-Banda & Walt, 1995; Brugha & Zwi, 1999; Brugha, Chandramohan & Zwi, 1999; Molyneux et al., 1999) as well as in emerging communities. The relatively high costs of attending private-for-profit facilities suggest that these services are accessible only to wealthy urban residents. However, a growing body of work also demonstrates heavy dependence on private facilities among low-income urban residents (Yesudian, 1994; Develay, Sauerborn & Diesfield, 1996; Hanson & Berman, 1998; Hotchkiss, Rous, Karmacharya & Sangraula, 1998; Thaver, Harpham, McPake & Garner, 1998; Molyneux et al., 1999; Ogunbekun et al., 1999; Welcome, 2011; Anyaehie, Nwakoby, Chikwendu, Dim, Uguru).

This preference for private over public health facilities (Harpham & Molyneux, 2001), despite their relatively high cost, relates to factors such as better availability of staff and drugs, relatively easy physical access, shorter waiting periods, longer or more flexible working hours, better interpersonal communication and greater confidentiality (Bennett, 1992; Brugha & Zwi, 1999 in Harpham & Molyneux, 2001). The factors are major concerns for people in emerging communities as well as those residing in urban slums. Nevertheless, *government health services* remain an important source of health care for the people. Wyss, Whitting, Kilima, McLarty, Mtasiwa, Tanner, & Lorenz, (1996), for example, interviewed 6,589 residents of Dar es Salaam about use of services over a two-week period. They found that despite a heavy dependence on private facilities by all socioeconomic groups, 'sick people of the poorest class consulted private health services less often and relied more often on governmental health services (Harpham & Molyneux, 2001). When the socioeconomic class was stratified by sex and by age, these trends remained'. In contrast, some analyses of national-level data suggest that richer households are as likely to depend on public facilities as poorer households (for example, Hotchkiss et al., 1998; Makinen, Waters, Rauch, Almagambetova, Bitran, Gilson, McIntryre, Pannarunothai, Prieto, Ubilla, & Ram, 2000). However, in Nigeria, richer households are more likely to have a personal physician or visit expensive private hospitals. Another form of service delivery is offered through faith-based hospitals that provide health services to the people in most rural communities in Africa

(Widmer, Betran, Merialdi, Requejo & Karpf, 2011). In the urban areas of developing countries such hospitals are also in operation (Oluwabamide & Umoh, 2011; Widmer et al, 2011; Kagawa, Anglemyer, & Montagu, 2012).

Traditional healers and traditional medicine (traditional healers include herbalists, diviners, folk healers, traditional birth attendants i.e. local midwives, fertility specialists and spiritualists) are an important source of health care in Africa, and much of Asia and Latin America (Harpham & Molyneux, 2001). They are estimated to be the main source of health care for 80% of rural residents in developing countries. Traditional medicine is assuming greater importance in the primary health care of individuals and communities in many developing countries (Peltzer & Mngqundaniso, 2008; WHO, 2002; WHO, 1978 in Gyasi et al., 2011). Some empirical urban studies suggest traditional healers are more likely to be consulted in the event of convulsions, nonspecific pain and psychological problems compared to other illnesses or symptoms. But today the use of traditional herbal practitioners, as the above studies have mentioned, is still prevalent and their roles have grown into offering preventive, curative, and rehabilitative care services in emerging communities and urban slums of south west Nigeria.

Use of traditional medicine (TM) embraces the ways of protecting and restoring health that existed before the arrival of modern drugs i.e. orthodox medicine (OM) (World Health Organization [WHO], 2001). WHO therefore defines TM as diverse health practices, approaches, knowledge and beliefs incorporating plant, animal, and/or mineral based medicines, spiritual therapies, manual techniques and exercises applied singularly or in combination to maintain well-being, as well as to treat, diagnose or prevent illness (WHO, 2002; 2000 in Gyasi et al., 2011). Buor (1993) in his study on the impacts of TM in the health care delivery services in Ghana argues that TM involves the use by the folk population primarily of unorthodox and unscientific methods for cure and prevention of diseases (Gyasi et al., 2011). It has been debated whether the word "traditional" should be used at all, as it implies some degree of stagnation or backwardness (Hougen et al., 1998 in Gyasi et al., 2011). These approaches to health care belong to the traditions of each culture, and have been handed down from generation to generation (WHO, 1996). China and India, for example, have developed very sophisticated contemporary and alternative medicine systems such as acupuncture for decades (Addae-Mensah, 2002; Agyare et al., 2006 in Gyasi et al., 2011). In

fact, TM reflects the socio-religious structure of the indigenous societies from which it developed, together with the values, behaviours and practices within their communities. TM ultimately aims at restoring the physical, mental and social wellbeing of the patient, through alternative health care delivery to the orthodox medical system.

Due to structural and systemic problems that face primary health care, the use of self medication, private facilities and traditional herbal practitioners over government health facilities in urban slums and emerging community's remains pronounced. Improvements in primary health care are critical to improvements in the overall health systems. In particular, primary health care is vital in turning health care systems towards keeping people well and participating in life and work, rather than just looking after people when they are sick (WHO, 2008b). Due to low funding for health in developing countries, this has resulted in high levels of communicable diseases such as HIV/AIDS and tuberculosis. In addition low funding has led to high rates of infant, child and maternal mortality, shortage in human resoucerces for health and unequal access to health care delivery (WHO, 2008b). Also, infrastructure remains poorly maintained, services are poor and unregulated commercialised health care abounds. Similarly, communities not fully involved in the PHC implementation, all of which reduces the effectiveness of the PHC approach in several areas, health care delivery in the form of self treatment from chemist-pharmacies, visits to private facilities and use of herbal concoctions in emerging communities and urban slums, will persist.

3.4 Access to health care services

The World Health Report 2000 definition of a health system includes "all the activities whose primary purpose is to promote, restore or maintain health" (WHO, 2000A). The main objectives of health systems are to improve people's health; respond to people's legitimate health expectations on the basis of need and not ability to pay; and ensure equity among the users of health care services i.e. irrespective of social class or socio-economic status health care provision should be made accessible to all persons. The main functions of a health system are: stewardship (referring to leadership, governance or oversight); health financing (including collecting, pooling and purchasing); generating/creating health resources (human and physical); and provision of health services. These functions are in line with the WHO's Framework for Action entitled *"Everybody's Business: Strengthening health systems to improve health outcomes"* which highlights six building blocks: service delivery, information, medical products and commodities, health work force, financing and leadership

and governance (WHO, 2007c). With all these in place, a health system is expected to effectively and efficiently operate to meet the needs of the people.

Some previous studies (Nemet & Bailey, 2000; Fairbank, 2004; O'Donnell, 2007; Kruk, Galea, Prescott & Freedman, 2007; Mattson, 2010; Awoyemi, Obayelu, & Opaluwa, 2011) show that the availability of transport, the cost of the service and the reliability of the service all influence the use of health services in the communities in developing countries. However, ample evidence confirms that limited access to and utilisation of effective health care is a major problem in the developing world. Many millions of people suffer and die from conditions for which there exist effective interventions. Among urban slum dwellers, households close to the main street have greater access to the auxiliary nurse/midwife or other health workers as compared to the houses deeper in the slum where paths are muddy and difficult to reach (Agarwal & Taneja, 2005). This situation affects the equitable access to and utilisaton of health services among slum dwellers and also hinders health intervention and programmes from reaching all households. This is attributed to the fact that access to healthcare remains severely limited in Nigeria (Otuyemi, 2001).

In emerging communities and urban slums, outbreaks of vaccine-preventable diseases are more common due to the high density of the population and continuous influx of new infective agents. Besides neonatal causes, which account for 37%, three other diseases, diarrhea, pneumonia, and malaria, are responsible for 40% of child deaths worldwide (Global Burden of Diseases, 2004-2008 Update). In slums in India for example studies show that causes of child mortality during the neonatal period are perinatal asphyxia, prematurity and sepsis, while in older children, infectious diseases are the commonest causes of death (Bhandari, Bahl, Taneja, Strand, Molbak, Ulvik, SommerfeltMartines, & Bhan, 2002, Khanna, Kumar, Vaghela, Sreeenivas, & Puliyel et al., 2003, Awashti & Agarwal, 2003), of which for each disease, there is at least, one effective preventive measure and one effective treatment (World Bank, 2004).

In communities where the health facility is available, accessibility becomes the problem. This contributes to significant delays in accessing health care services (Chaya, 2007, Obansa & Orimisan, 2013; Harris, Goudge, Ataguba, McIntyre, Nxumalo, Jikwana & Chersich, 2011). More so, access to health care can be defined in a variety of ways. In its most narrow sense, it refers to geographic availability. Some define access as the opportunity to use health care;

others draw no distinction between access and use. But the unavailability of the service can limit people's access. Their inability to afford the service even when it's available can limit their use of the service (Kipp, Kamugisha, Jacobs, Burnham, & Rubaale, 2001; Lagardea & Palmer, 2008). In some other cases, the unacceptability of the existing health services can undermine people's utilisation of it. Whether individuals that may or may not potentially benefit from effective health care do in fact receive it (O'Donnell, 2007) remains a thing of concern even for those in emerging and slum communities of south west Nigeria.

Like citizens in other countries of sub-Saharan Africa and parts of Asia and Latin America, people living in emerging communities and urban slums of south west Nigeria do not have access to basic social amenities such as potable water, electricity, drainage, roads, sanitation, education, health care, recreation, waste disposal facilities (DFID, 2004; Ndulu, Niekerk, & Reinikka, 2005; Ayogu, 2006; World Bank, 2006) and insufficient flow of health information. As a result of this, many urban slum dwellers in these regions live in deteriorating conditions that constitute an affront to human dignity and which come with attendant health implications (UN-HABITAT, 1992, 2003; WHO, 2005; UNFPA, 2007). These factors form part of the justification for this study, to understand the nature of health care delivery in emerging communities and urban slums of south west Nigeria and the processes by which the health system in these communities develops over time amidst the existing challenges.

Similarly, the state of health care provided to indigenous people either those in emerging communities or urban slums in Nigeria, is an often ignored and an under-researched topic. A ubiquitous challenge for indigenous communities or informal settlements globally is adequate access to and utilisation of quality health care services. Many of these communities tend to be isolated on the outskirts of the urban centre, remote semi-urban and rural locations that have limited access to ambulatory, acute and specialized health care. (Greun, Weeramanthri, & Bailie, 2002; Shah, Gunraj, & Hux, 2003), while according to Jupp, McRobbie & York (1991), settlements (such as emerging communities and urban slums) lack institutional resources and are unable to draw on the collective experience of the members who reside there.

Both emerging communities and urban slums lack good road networks (Bakeera, Wamala, Galea, State, Peterson, & Pariyo, 2009; Al-Taiar, Clark, Longenecker, & Whitty 2010; Yar'zever & Said, 2013; Cheptum, Gitonga, Mutua, Mukui, Ndambuki, & Kioma, 2014), adequate clean water supply, sufficient electricity supply, and have unplanned waste disposal systems and infrastructure. The urban poor or low income settlements constitute between twenty-five and thirty-five percent of the urban population, occupy irregular settlements, including squatter settlements, unauthorized land developments, and rooms and flats in dilapidated and uncompleted buildings (Durand-Lasserve & Clerc, 1996; Chome, 2002). Although there are no accurate figures, Nigeria has its fair share of these low-income settlements (Agboola, 1998; Agboola and Olatubara, 2003). These informal and squatter settlements for example in Port-Harcourt in the Niger-delta region of Nigeria are estimated to account for about 65% of the city's population (Obinna, et al 2010), while in Lagos over 70% of the population reside in these informal settlements and urban slum areas of the state. According to Adelekan (2010), population densities in Lagos slum communities range from 790 to 1,240 people per hectare, and more than 75 per cent of urban poor slum dwellers live in one-room households with an average of 4.6 persons per room. It is common for 8–10 households to live in one house structure, sharing common cooking and sanitation facilities for everyday living.

3.5 Utilisation of health services

In much of the world, the health sector is often massively under-funded. In 2005, 45 countries spent less than $100 per capita on health, including external assistance (National Health Accounts, 2008). In contrast, 16 high income countries spent more than $3000 per capita. Developing countries like Nigeria generally allocate a smaller proportion of their Gross Domestic Product (GDP) to health than high-income countries, while their GDP is smaller to start with and they have higher disease burdens (WHO, 2008). Also, countries that are considered as "fragile states according to the 'low-income countries under stress' (LICUS) criteria for 2003-2006" (Carvalho, 2008), have unregulated commercialized health systems that are highly inefficient and costly (Ammar, 2003) and that exacerbate inequality (Macintosh, 2007). Though not a fragile state, Nigeria, in terms of its low-income groups who constitute about 70% of the country (Nwaka, 2005), and its growing urban population of over 60 million with an urbanisation rate at 5.5% (NEEDS, 2004; FRN, 2007), has increased the number of people that cannot effectively utilise health services even where it is available.

Only 42% to 49% of the urban poor have access to safe water and electricity, respectively (NBS, 2006). The pattern of health service utilisation across the country is grossly affected. Similarly, between 2000 and 2006, the percentage of the urban population that has access to safe water in the country dropped from 81% to 73.4%, while the proportion of the population with access to sanitation within the same period also declined from 85% to 77% (World Bank, 2003; NBS, 2006). These drops in access to safe water and sanitary conditions affect the health conditions of the people. Lack of potable water, good sanitation and hygiene as a result of inadequate environmental planning and sub-standard living conditions similarly affects maternal health and child health. This translates into high mortality where maternal mortality is 840 per 100,000 populations and high under-five deaths of newborns at 241,000 that die within the first month of life in Nigeria (IMNCH, 2011).

Such poorly managed and underfunded systems are marked by frustration, reduced performance, and eventually attrition of health workers, leading to reduced quality and eventually reduced demand for the services (Kruk & Freedman, 2008). In addition they provide poor quality and, at times, dangerous care that is bad for health (WHO, 2008), in many, if not most low and middle-income countries where ineffective, under-resourced fragmentation of health services has further accelerated the development of an unregulated fee-for-service approach to health care. This is regardless of whether or not it is supplied by public, private or non-governmental organisations (NGOs) providers and the increased threat of communicable diseases in its slum cities and emerging communities where health infrastructure is not available. That is, overwhelming evidence suggests that user fees constitute a strong barrier to the utilisation of health care services, as well as preventing adherence to long term treatment among poor and vulnerable groups (James, Hanson, McPake, Balabanova, Gwatkin, Hopwood et al., 2006; Palmer, Mueller, Gilson, Mills & Haines, 2004).

In Nigeria, the geographical distribution of health services tends to be urban biased, with health facilities mainly available in some local districts only. However, this disparity reveals an uneven distribution even in urban centres. With many unplanned and officially unrecognized communities growing daily across Nigerian cities and the outskirts of the city centre, many of such emerging communities and urban slums are without access to effective

public and private health care. One of the services that generally lag behind in terms of provision in such communities is effective health care services. This has led to the speculation that residents in such emerging communities tend to have worse health outcomes than even rural dwellers. It would, therefore, be beneficial to understand how health service provision develops in such emerging communities and those within urban cities known as slums.

In addition, gaining access to quality care is a challenge for the poor (Reniers & Tesfai, 2009), especially those in emerging communities of Ogun State and urban slums in Lagos State of south west Nigeria. Where limited health services exist, utilisation of such services is low. Also there exist current gaps in the literature to address the health needs of people in such emerging communities. Research over the years on different issues of health care delivery have been focussed on both the urban and rural areas of the country, while some studies have been done among urban slum dwellers in Nigeria. These studies are majorly in the areas of HIV/AIDS, poverty alleviation, non-communicable disease research, planned cities, understanding slums, the challenge of slums, urban slums in Lagos and waste to wealth in Nigerian slums (Adedimeji, Omololu & Odutolu, 2007; UN-HABITAT, 2003). Till date there are limited published works and available studies to understand the issues of access and utilisation of health care services, which still remain a challenge for residents in emerging communities and urban slums of south west Nigeria.

For people in informal settlements emerging communities and urban slums, access to health care is restricted particularly by geographic, socio-cultural (Eshetu & Woldesenbet, 2011; Abubakar, Van Baar, Fischer, Bomu, Gona & Newton, 2013) and financial factors (Gilson & Schneider, 2007), as several other factors determine the health behaviours of patients which may be seen in various contexts such as: physical, socio-economic, cultural and political, within developing countries. In many low and middle-income countries (LMIC) a substantial proportion of all health services are sought in the non-state sector (Bustreo, Hardin, & Axelson, 2003; Mills, Brugha, Hanson & McPake 2002; USAID-India, 2006; WHO and USAID, 2007). The utilisation of a health care system, public or private, formal or non-formal, may depend on socio-demographic factors (Mugisha, Bocar, Dong, Chepng'eno & Sauerborn, 2004; Mugavero, Norton & Saag, 2011; Scheppers, van Dongen, Dekker, Geertzen, & Dekker, 2006; Girma, Jira & Girma, 2011; Adamu, Abiola & Ibrahim, 2012;

Obiechina, Okolie, Okechukwu, Oguejiofor, Udegbunam et al, 2013), social structures, level of education, cultural beliefs and practices, gender discrimination, status of women, economic (Kevany et al., 2012; Lagarde & Palmer, 2011) and political systems, environmental conditions, and the disease pattern and health care system itself. In developing countries, the under utilisation of health services in the public sector is becoming a universal phenomenon (Shaikh & Hatcher, 2004) while bad roads are a limitation to people's gaining access to a health facility even when available within their community (Ajala, Sanni & Adeyinka, 2005; Adesiji, Dada & Komolafe, 2012). Studies on distance and health care utilisation, reveal bad roads hinder people's access when visiting a health facility (Njoku & Akpan, 2013; Ajala et al., 2005; Adesiji et al., 2012).

Access to a primary health care facility is projected as a basic social right (United Nations, 2001), but the distance separating patients and clients from the nearest health facility has been remarked on as an important barrier, particularly in rural areas thereby hindering their access to health services. Also, the client-perceived quality of services and confidence in the health provider affect health service utilisation (Duong, Binns & Lee, 2004). In a country like Nigeria, the communication factor also creates a barrier due to differences of spoken language, or cultural gaps and it can also affect the choice of a specific health provider or otherwise. The utilisation of a health facility is majorly determined by factors such as (1) Cost of care and access to the service; (2) Outcome of treatment; (3) Quality of care; (4) Service delivery (prompt, efficient and effective); (5) Availability of drugs, medicines and vaccines; (6) Staff strength (health workforce available); (7) Equipment (e.g. Number of beds, machines for treatment); (8) Health information (useful health tips and basic knowledge to stay healthy); (9) and Availability of health and social support groups or networks (Ibrahim, 2001; Ballard, 2003; Awofeso, 2010; Ezeonwu, 2013; Peabody, Taguiwalo, Robalino & Frenk, 2006). Both these macro and micro factors tend to influence people's choice of and utilisation of a health facility.

3.6 Prevention, control and treatment of diseases

Addressing the growing challenges of diseases such as cardiovascular diseases (CVD), cancer, diabetes mellitus, chronic respiratory diseases and other chronic diseases, which accounted for more than three-fifths (61%) of the estimated 58 million deaths worldwide in 2005 and about half (46%) of the global burden of diseases (WHO, 2005), is now on the

forefront of many governments and development partners' agendas. Chronic disease is a major and growing health problem globally (Komaric, Bedford & van Driel, 2012). According to WHO projections, of the 64 million people who will die in 2015, 41 million will die of a chronic disease unless urgent action is taken (WHO, 2005) to avert such occurrences.

Communicable diseases (infectious diseases) which are illnesses caused by bacteria, viruses, fungi or parasites remain a major cause of mortality and morbidity worldwide. Organisms that are communicable may be transmitted from one infected person to another or from an animal to a human, directly or by modes such as airborne, waterborne, foodborne, or vectorborne transmission, or by contact with an inanimate object, such as a contaminated door knob (CDPC, 2010). Communicable disease prevention and control however involve the surveillance for and protection from communicable diseases that may result from changes in or evolution of infectious agents (bacteria, viruses, fungi or parasites), that is, stopping the spread of infectious agents to new geographic areas or among new populations, persistence of infectious agents in geographic areas and populations, newly emerging infectious agents, or acts of bioterrorism. Communicable disease prevention and control involve isolation and quarantine, immunization, prophylactic (preventive) measures, early interventions including antimicrobial treatment, public health education and other measures (CDPC, 2010).

Although the leading causes of mortality, associated with more than 36 million deaths per year, are a result of non communicable diseases, namely cardiovascular disease, lung disease, cancers, and diabetes, (Meer & Sawhney, 2011), these NCDs remain on the rise globally. As a measure to address the growing threat of NCDs, governments, international NGOs and multi-lateral organisation have formed partnerships such as the Global Fund. Also, public health organisations such as the American Public Health Association (APHA) urge public health professionals, governments, and international and domestic organisations to take action to address the growing epidemic of NCDs especially in less developed countries (Meer & Sawhney, 2011). They give some recommendations for countries to take necessary steps and highlight the fact that many of these deaths are preventable. These include, (1) Fully account for mortality and morbidity associated with non communicable diseases in every country, (2) Develop plans to integrate non communicable disease prevention into existing and planned public health, global health, and development programming and provide the

fullest possible funding for these efforts, (3) Countries must create systems for addressing known risk factors including consumption of alcohol and tobacco, over consumption of salt, obesity, disabilities, exposure to indoor air pollution, and unsafe roadway conditions, (4) Acknowledge the poverty-related causes and exacerbations of many NCDs including malnutrition, indoor air pollution, poor access to healthcare, Type 1 diabetes, heart disease, and respiratory diseases, (5) Engage all elements of society in the prevention, care and treatment of NCDs, including faith-based organisations, academic institutions, for-profit corporations, nonprofits, governments, and foundations, and (6) Ratify and work to implement the Framework Convention on Tobacco Control (Meer & Sawhney, 2011).

At the global level, the World Health Organisation in 2002 gave the following guidelines for prevention and control of NCDs. These include:

Generating an information base for action

• Assess and monitor mortality attributable to NCD, and the level of exposure to risk factors and their determinants in the population

• Devise a mechanism for surveillance information to contribute to policymaking, advocacy and evaluation of healthcare

Establishing a national programme for promotion of health and NCD prevention

• Form a national coalition of all stakeholders

• Establish pilot prevention programmes based on an integrated risk factor approach that may be extended territory-wide

• Build capacity at the national and community level for the development, implementation and evaluation of integrated NCD programmes

• Promote research on issues related to prevention and management

Tackling issues outside the health sector which influence NCD control

• Assess the impact of social and economic development on the burden of the major NCD with a view to conducting a comprehensive, multidisciplinary analysis

• Develop innovative mechanisms and processes to help coordinate government activity as it affects health across the various arms of government

• Accord priority to activities that place prevention high on the public agenda, and mobilise support for the necessary societal action

Ensuring health sector reforms responsive to NCD challenge

• Develop cost-effective healthcare packages and evidence-based guidelines for the effective management of priority NCD

• Transform the role of healthcare management by vesting managers with responsibility not for institutions (e.g. hospitals) but for the effective management of resources to promote and maintain the health of a defined population

Source: WHO, 2002

3.6.1 Prevention, control and treatment of communicable diseases after a disater

Certain prevention, control and treatment of communicable diseases applied in the occurrence of disasters can be adopted into the existing strategies to address such communicable diseases globally. In the occurrence of disasters the most significant risk factors are population movement and displacement (Jafari, Shahsanai, Memarzadeh & Loghmani, 2011) which contribute to the occurrence and spread of communicable diseases. Additionally, overpopulation, economic and environmental devastation, poverty, lack of sanitary water, poor waste management, lack of shelter, malnutrition as a consequence of food shortages, and poor access to health care cause a dramatic increase in the rates of communicable diseases after disaster (Connolly, Gayer, Ryan, Salama, Spiegel, & Heymann D, 2004; Jensen, Meyrowitsch & Konradsen, 2010; Ivers & Ryan, 2006; Wilder-Smith, 2005; Lashley, 2003 in Jafari et al, 2011). Prevention and control of communicable diseases after disaster can include:

- Continuing advocacy for the prevention, control and treatment of communicable diseases globally through increased vaccination rates among children, mothers and healthcare workers. That is, regular vaccination of children against childhood killer diseases will eventually reduce both infant and child mortality rates.
- Also the vaccination of healthcare personnel (HCP) reduces patient mortality in long-term care facilities (Potter, Scott, Roberts et al., 1997; Carman, Elder, Wallace, et al., 2000 in CDPC, 2010) and reduces employee absenteeism and financial costs in hospitals (Wilde, McMillan, Serwint, Butta, O'Riordan & Steinhoff, 1999; Boersma, Rhames & Keegan, 1999 in CDPC, 2010). It will contribute to the reduction in spread of diseases even in the event of an outbreak; especially resource limited settings against vaccine preventable diseases and other forms of infections.

3.7 Perceptions of health care delivery services

Studies on patient's perception of health care delivery cover various aspects of health services both in developed and developing countries. For example Frimpong, Nwankwo & Dason (2010) explored patients' satisfaction with access to public and private healthcare centres in London. The results showed that public patients, as opposed to private counterparts, were dissatisfied with the service climate factors. In general, the study concluded that both public and private healthcare users faced major problems in accessing

healthcare. Such outcomes exist not only in developed countries but also in developing countries, as patients perceptions are increasingly used to measure health care quality (Rosenthal & Shannon, 1997).

People's perception about quality of care often determines whether they seek and continue to use health services (Fitzpatrick, 1991). This, however, is a result of their dissatisfaction with the inability of the health facilities to make medicines available, the long waiting time they undergo, unavailability of radiological machines like x-rays and ultrasound, and 24-hour services and deliveries not being conducted at the primary health centre (Rasheed, Arya, Acharya & Khandekar, 2012). Patients' perception of health care services and of quality of care is critical to understanding the relationship between quality of care and utilisation of health services, and increasingly it is treated as an outcome of health care delivery (Baltussen, Ye, Haddad, & Sauerborn, 2002; Reerink & Sauerborn, 1996). Baltussen et al (2002) studied perceived quality of care of primary care services in Burkina Faso and found in a community survey that respondents were relatively positive on items related to health personnel practices and conduct and to health care delivery. Among other factors that influence people's perception of health care delivery is the availability of drugs for all diseases on the spot and not for some, the adequacy of rooms and equipment in the facilities, cost of care and access to insurance schemes to reduce the cost of services (Mashego & Peltzer, 2005).

Various studies exist on the perception of health care services according to different socio-economic groups as well as the environmental aspects such as social, organisational and technological context of the service especially as it concerns quality. In other studies, Van Vuuren & Bootes (1994) found among a culturally diverse population in an urban area in South Africa that variables such as population group, age and employment status influence people's attitudes towards professional health care. In another community study in rural South Africa, Peltzer (2000) found that when people perceive medical services to be poor, the acceptability of such services will be low especially towards primary health centres.

Similarly, (Al-Qatari & Haran 1999; Andaleeb 2001; Baltussen et al., 2002; Bruce 1990; Campbell, Roland & Buetow 2000; Haddad, Fournier, Machouf, & Yatara 1998; Sofaer & Firminger, 2005; Kruk, Mbaruku, McCord, Moran, Rockers, Galea, 2009; Kruk, Mbaruku, Rockers & Galea, 2008) have examined patients' perceptions of health care delivery on a

number of issues such as attributes of quality of care (structure, process and outcome) including: (a) the health care providers available to them for different diseases, (b) the kind and nature of services provided, (c) conduct of staff (attitudes, interpersonal relations, communication skills, privacy) (d) technical form of care (examination of patients, diagnosing, interventions (injections, minor surgery, administration of drugs, satisfaction with treatment outcome), (e) health care facility (space, cleanliness, availability of toilet, accessibility to drinking water for patients, etc.), (f) organisation of health care by type such as clinic, hospital, GP, traditional, or faith healer, accessibility of service (opening hours), organised preventive care (e.g. immunisation, family planning, antenatal care on set days), mobile clinics, (g) drugs (availability, quality, willing to pay for it), and (h) waiting time (before seeing a nurse, doctor or healer).

Another level of people's perception of health care delivery takes the form of traditional medicine through traditional healers. These traditional healers are recognised, acknowledged and trusted in their communities by the people; they could therefore be used as counsellors and health educators to reduce the spread of STIs, HIV and AIDS in Africa (Mashego & Peltzer, 2005), also for the prevention of NCDs. For example, studies have revealed that the reliance on traditional healers for treatment has been successful as 60% of the children with high fever due to malaria were successfully treated with herbal medicines in Ghana, Mali, Nigeria and Zambia in 1998 (WHO, 2001). Indeed, the use of traditional medicine and the services of traditional healers by millions of Africans have been recognised by the WHO and in 1977 the World Health Assembly (WHA) drew attention to the potential and the efficacy of herbal medicine in the national health care systems. The WHA urged member countries to utilise those medicines to broaden the coverage of health care delivery in their respective countries.

Clients' perception of health care delivery in relation to the quality of services and confidence in the health provider affect the health service utilisation (Doung, Binns & Lee, 2004). In some studies, the perceived technical quality of care has been shown to strongly influence women's use of health services in developing countries (Gilson, Alilio & Heggenhougen, 1994; Mariko, 2003; Kayongo, Esquiche, Luna, Frias, Vega-Centeno & Bailey, 2006; Levesque, Haddad, Narayana & Fournier, 2006). In the United States, patients expect their health care to be efficient, with proper coordination between the many individuals and

organisations that are involved in their care (Sofaer & Firminger, 2005). Patients' perceptions may lead to different interpretations of the nature of health care delivery, therefore health services must ensure efficient and effective quality of care being offered. According to Sofaer & Firminger (2005), "patients evaluate quality of the health care organizations' structures and facilities, including easy access to the facility, parking availability, safety and security in and around the facility. In addition, patients consider the cleanliness and comfort, quality of food provided, a quiet and pleasant environment, a variety of clinical services available, use of up-to-date technology such as computers, and the visibility of the care provider in the community".

3.8 Health care challenges and unmet need for health care

Health care challenges vary from country to country and from developed to developing countries. In developing countries of sub-Saharan Africa (SSA), health care challenges can range from the shortage of health care workers at a given health facility to inadequate financing of health care facilities hence leading to poor performance in its service delivery. There are other challenges in terms of unavailability of drugs and vaccines and lack of adequate technology to promote effective health care delivery. Adequate health information for example remains lacking across most of the region (AbouZhar, 2002), as countries of SSA do not have the necessary manpower to utilise up-to-date existing technologies that are used in developed countries. In some cases, these countries due to the underfunding of the health sector do not have the capacity to provide modern forms of technology for health or do not have people with the technical skills or capabilities to operate such technologies even when they are available for use.

Another challenge in terms of health care delivery facing people in developing countries such as Nigeria with informal settlements such as emerging communities and urban slums is the insufficient supply of electricity and shortage in power supply to health care facilities. Although the poor electricity power supply across the country remains a challenge that affects its major sectors, its effect on the health care sector leads to the loss of lives that can be avoided. Poor planning and management across the health care sector continues to add to inefficiency in service delivery, while the late payment of staff salaries, high levels of unemployment, use of unqualified staff and socio-cultural barriers all contribute to the existing health care challenges facing people in Nigeria. People living in emerging

communities and urban slums of Nigeria south west region are not left out, as infrastructural and environmental challenges further contribute to increased spread of diseases. More so, due to the unplanned nature of these environments, the unavailability of well equipped health facilities and wide spread quackery adds to the growing health challenges facing the people.

In emerging communities and urban slums of south west Nigeria, the needs of the people take various forms from basic social amenities (potable water, good road, clean drainage, recreation centres, and green spaces) to adequate housing and effective transport networks. The basic social needs of people in emerging communities and urban slums contribute directly and indirectly to their public health status. In communities where social amenities are lacking, the nature of health care delivery is affected.

3.9 Effective health care delivery

There exist many indicators that provide elements to assess the effectiveness and efficiency of health service delivery. But the overall levels of effectiveness and efficiency must be appraised by reviewing as many relevant indicators as possible. In unstable contexts such as conflict situations, fragile states, and within informal settlements, effectiveness and efficiency can seldom be measured, but must be assessed by assembling discrete pieces of information, partly of a qualitative nature. Within emerging communities and urban slums, good performance in service delivery is difficult to measure. Certain pointers to the ineffectiveness and inefficiency of health care service delivery depict the state of health facilities within these environments. These pointers according to Pavignani & Colombo (2009:195-196) include:

*Pointers to **ineffective** healthcare delivery:*

- Lack of policy direction, with proliferating priorities, programmes and initiatives;
- Imbalances among levels of care and service components;
- Poor quality standards of the care provided;
- Disregard by prescribers of sound treatment guidelines;
- Poor compliance of patients with treatment regimens;
- Proliferation of crises and emergencies, suggesting that the system is poorly equipped to react to events (some unpredictable, many ordinary);
- Disease outbreaks despite the previous application of supposedly effective control measures;

• Commoditization of health care, with diagnostic and therapeutic decisions taken mainly on commercial grounds;

*Pointers to **inefficient** healthcare delivery:*

• Duplication and overlapping of services and functions. Replication of initiative;

• Allocative imbalances, with the concentration of resources at certain levels of care or on particular services, to the disadvantage of others, equally important.

• Investing in community health schemes while neglecting backup services is a classic example.

• Ambiguity of functions and duties, which are spread among several bodies and organizations;

• Disproportion between tasks and allocated resources;

• Misplacement of responsibilities, with central managers taking care of peripheral tasks;

• Low uptake of the offered health services. Sometimes, the problem is self inflicted as in the case of introducing cost-sharing schemes in high-cost emergency health services offered to impoverished populations;

• Light workloads;

• Under-use of available inputs, such as idle health workers;

• Long hospital staying times;

• High dropout rate of patients enrolled in treatment programmes;

• Multiplication of guidelines and schedules;

• Widespread waste and pilferage. Waste of donated inputs is usually considerable, due to their frequent inappropriateness, supplies unrelated to actual needs, improvised delivery lines, and the reduced value attached to goods not paid for and often not requested;

• Profusion of broken-down equipment not repaired because of lack of cash, spare parts or technical skills;

• Misplacement and misuse of technical skills, equipment and drugs (Pavignani & Colombo, 2009:195-196).

3.10 Social determinants of health

The World Health Organisation (WHO) commission takes a holistic view of social determinants of health. The poor health of the poor within countries, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, goods, and services, globally and nationally. The

consequent unfairness in the immediate, visible circumstances of people's lives; their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities, and their chances of leading a flourishing life are hampered. This unequal distribution of health-damaging experiences is not in any sense a 'natural' phenomenon but is the result of a wrong combination of poor social policies and programmes, unfair economic arrangements, and bad politics. Together, the structural determinants and conditions of daily life constitute the social determinants of health and are responsible for a major part of health inequities within and between countries (WHO, 2008).

Following the current trajectory of urban growth, city populations will age and there will be more urban sprawl and greater numbers of people living in poverty, slums, squatter or informal settlements (Campbell & Campbell, 2007), which then constitute a challenge for them to gain access and utilise health services. The proportion of the older adult population residing in cities in high-income countries matches that of younger age groups and will rise at the same pace in the 21st century. In low and middle income countries however, the share of older people in urban communities will multiply by 16 times from about 56 million in 1998 to over 908 million in 2050 (WHO, 2007d). Similarly, people with disabilities are vulnerable to health threats, particularly in urban areas and slum communities due to the challenges of a high population density, crowding, unsuitable living design, and lack of social support (Frumkin et al., 2004).

Applying healthy urban design principles, a city would be designed for a dense, residentially mixed population with easy access to services, including designated commercial and non-commercial land use; with land also set aside for the protection of natural resources and recreation. Such an urban development agenda also considers the supply of basic amenities and sufficiently developed infrastructure (Devernman, 2007). But this is not the case in emerging communities and urban slum communities as people who do not have the power, money or resources to afford the city life settle in these informal settlements rather than live in rural areas.

In addition, J. De Maeseneer (2007), states that the health system plays the role of a social determinant of health based on the following: at the macro-level-through public policy and equitable resource allocation processes. In his assessment, at the meso-level (the

community)-through performance of the decentralized policy; at the micro-level:-through factors related to the organisation of the health care system (physical, financial, psycho-social, cultural and administrative access), as well as factors related to the health care provider (skills, knowledge, approach to the patient). Across this levels, access and utilisation to health services is being affected in developing countries, also at the micro level primary health care systems may contribute to the comprehensive care of the people within communities. But the reality of the situation on ground in many poor communities especially in developing countries is worrisome as lack of adequate health care delivery still persists.

Basically, the social determinants of health advocate for three principles of action which include; (1) to improve daily living conditions of life- the circumstances in which people are born, grow, live, work and age; (2) tackle the inequitable distribution of power, money and resources-the structural drivers of those conditions of daily life-globally, nationally and locally; (3) measure and understand the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness of the social determinants of health (WHO, 2008). The WHO Commission's work embodies a new approach to development. Health and health equity may not be the aim of all social policies but they will be a fundamental result. For example the central policy importance given to economic growth: Economic growth is, without question, important, particularly for poor countries, as it gives the opportunity to provide resources to invest in improvement of the lives of the population. But growth by itself, without appropriate social policies to ensure reasonable fairness in the way its benefits are distributed, brings little benefit to health equity (WHO, 2008). The WHO social determinants of health give a holistic understanding and provide an agency-structure perspective to improve health systems in emerging communities and urban slums of south west Nigeria.

3.11 Theoretical Framework and Models

Health care delivery through primary health care (PHC) is simply essential health care made universally accessible to individuals and families in the community by means acceptable to them, i.e. through their full participation and in the context that the community and country can afford. It forms an integral part both of the country's health system, of which it is the nucleus, and of the overall social and economic development of the community. But one major impediment to health development in Nigeria remains the vibrancy of the political

commitment to the objectives of the National Health Policy, programmes, frameworks, guidelines, regulations and declarations. Thus, while the government declares its acceptance of primary health care as the strategy to achieve health for all Nigerians, it fails to fully implement the basic principles of this strategy. The mechanism for regular policy monitoring and evaluation has not been whole heartedly activated (Osibogun, 2004) as a result of corruption in government (Ribadu, 2010), therefore affecting health care delivery, and access to and utilisation of health care services across the country. However, to adequately capture and understand the nature of health care delivery in emerging communities and urban slums of south west Nigeria, a triangulation of a theory, health model and health framework was utilised in this study.

This study synthesises Giddens (1984) Structuration Theory, Dahlgren and Whitehead (1991) Social Model of Health, and Andersen and Newman's (1990s) Framework of Health Service Utilisation. All three were used to comprehensively explain health care delivery, access and utilisation in emerging communities and urban slums of south west Nigeria.

3.11.1 Structuration Theory

The theory of structuration, proposed by Anthony Giddens (1984) in *The Constitution of Society* (mentioned also in *Central Problems of Social Theory*, 1979), is an attempt to reconcile theoretical dichotomies of social systems such as agency/structure, subjective/objective, deductive/inductive, habitus/field, and micro/macro perspectives. The approach does not focus on the individual actor or societal totality "but social practices ordered across space and time", in which "externalising the internal, and internalising the external" of everyday realities of social life of which health care delivery is a part of (Giddens, 1984).

Simply put, the theory of structuration holds that all human action is performed within the context of a pre-existing social structure which is governed by a set of norms and/or laws which are distinct from those of other social structures. Therefore, all human action is at least partly predetermined based on the varying contextual rules under which it occurs. However, the structure and rules are not permanent and external, but sustained and modified by human action (Giddens, 1995). Going by this assertion, health care delivery from a structural level becomes operational when social actors make use of the services offered by the health

system. The best health care system cannot function exclusive of the actors involved because they are active agents in the construction of social realities such as use of family planning or voluntary counselling and testing services. But due to the underperformance and inefficiency of health care delivery in developing countries (Kruk & Freedman, 2008), access to and effective utilisation of health care services becomes a challenge for health users (social actors/agents) in informal settlements such as emerging communities and urban slums. Therefore, the lapses within the health system as a social structure constrain the actions of individuals on the demands from the health care system.

Giddens Structuration theory has been used across various disciplines which include management and workplace bullying (Whittington, 1992; Boucaut, 2001; Pozzebon, 2004), education (Ashley, 2010), business theory (Yates, 1997), and information science (Orlinkowski, 2000; Jones & Karsten, 2003), to show the relationship between micro and macro phenomenon in society. But for this study, the concept of structure refers to the community being studied and it's social system, while actors refers to the people in these communities that make use of various types of health care services available to them and the providers.

According to Giddens, social life is not the sum of all *micro*-level activity (e.g. dyads), but social activity cannot be completely explained from a *macro* perspective. The repetition of the acts of individual agents reproduces the structure. Social structures are neither inviolable nor permanent. The social structures constrain the actions of individual agents. Thus, structure and action constrain each other in an evolving way. This is seen when the health system underperforms and in turn affects the health status of social actors. Also, when health care workers carry out their duties ineffectively and inefficiently, the health system gets affected and services provided become distorted.

Structuration theory aims to avoid extremes of structural or agent determinism. The balancing of agency and structure is referred to as the *duality of structure*: social structures make social action possible, and at the same time social action creates those very structures. In the same vein an ineffective health care delivery system will inhibit the activities of the people; while the inability of the people to effectively function in society will hinder the effective production and reproduction of economic, political, educational, religious, legal and health system activities to ensure continuity of social life.

For Giddens, structures are rules and resources (sets of transformation relations) organised as properties of social systems. Rules are patterns people may follow in social life. Resources relate to what is created by human action; they are not given by nature naturally. The theory employs a *recursive* notion of actions constrained and enabled by structures which are produced and reproduced by those actions. Consequently, this theory has been adopted by those with *structuralist* inclinations, but who wish to situate such structures in human practice rather than *reify* them as an *ideal type* or material property. Additionally, the theory of structuration distinguishes between discursive, "What actors are able to say, or to give verbal expression to, about social conditions, including the conditions of their own action; awareness which has a discursive form" (Giddens, 1984). People within emerging communities and urban slums could be expected to participate in community health programmes, to differentiate between good health service delivery that is appropriate and those that are not. Also, practical knowledge which recognises actors as having knowledge is *reflexive* and *situated*, and that habitual use becomes *institutionalised.* Therefore the health seeking behaviours of people in emerging communities and urban slums of south west Nigeria become recognised and institutionalised within the health systems of these communities.

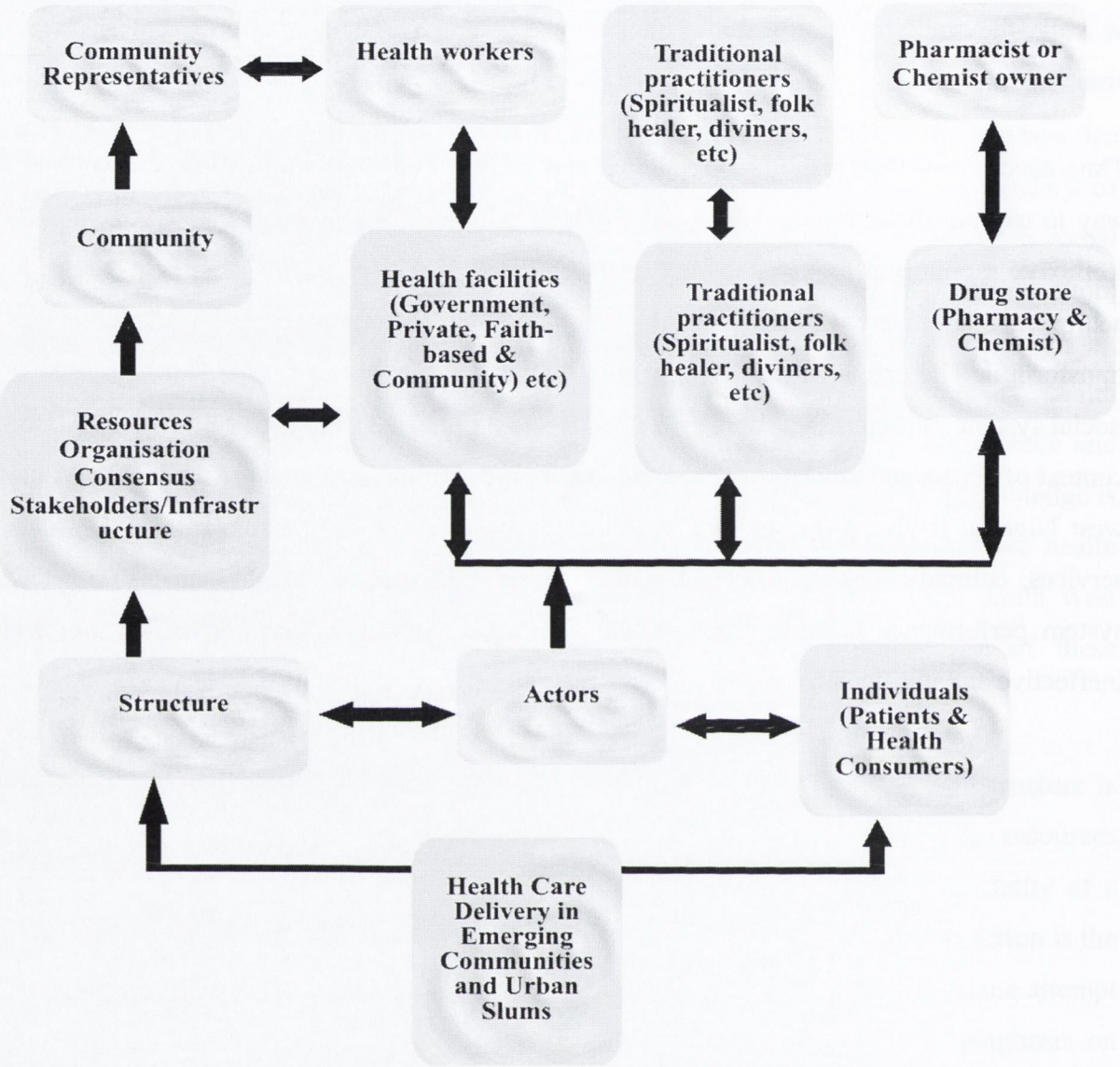
A social system can be understood by its structure, modality, and interaction. Structure is constituted by rules and resources governing and available to agents. (*Authoritative* resources control persons, whereas *allocative* resources control material objects.) The modality of a structural system is the means by which structures are translated into action. Interaction is the activity carried out by the agent acting within the social system. There has been some attempt by various theorists to link structuration theory to *systems theory* (with its emphasis on recursive loops) or the *complexity theory of organizational structure* (which emphasizes the adaptabililty that simple structures provide). Social systems have patterns of social relation that exist over time; the changing nature of space and time will determine the interaction of social relations and therefore structure (Gidden, 1984).

Agency, as Giddens calls it, is human *action*. To be human is to be an *agent*, although not all agents are human beings. Agents' knowledge of their society informs their action, which reproduce social structures, which in turn enforce and maintain the dynamics of action. Therefore actor's inability to access and utilize health care delivery will continually inhibit the development of an effective health system. Giddens defines 'ontological security' as the

trust people have in social structure; everyday actions have some degree of predictability, thus ensuring social stability. This is not always true, though, as the possession of agency allows one to break away from *normative* actions, and depending on the sum of social factors at work, they may instigate shifts in the social structure. The dynamic between agency and structure makes such *generative action* possible.

Thus agency can lead to both the reproduction and the transformation of society. Another way to explain this concept is by what Giddens calls the "reflexive monitoring of action". Reflexive monitoring looks at the ability to look at actions to judge their effectiveness in achieving their objectives: if agents can reproduce structure through action, they can also transform it. The use of Structuration theory for this study shows how Giddens' concepts of 'social system', 'structure' and 'agency' helped to conceptualize health care delivery, within the context of access and utilisation of actors in emerging communities and urban slums of south west Nigeria. It also proposes that when health systems fail to render quality health care services, contradictions may occur because certain 'rules and resources' that enable health system performance become effective and satisfactory to health users have now become ineffective and inefficient.

Figure 3.1 Structuration Theory and Health Care Delivery in Emerging Communities and Urban Slums



Source: Author, 2014.

Health care delivery in emerging communities and urban slums is centred on structure and actors when applying Giddens's Structuration Theory. As seen in the above figure, structure is simply *resources*, existing *organisations* within communities which includes health services, *consensus, stakeholders* and *infrastructures* for health. All these are described as macro factors which determine the nature of health care delivery in study location. *Resources* within communities aids the effective production of health services, more so, external resources introduced into the communities supports the provision of health services. As seen in the diagram, certain *organisations* whether public or private act in the system of healthcare

within communities. For these to be productive *consensus* must be reached among *stakeholders* within communities. Stakeholder involvement remains crtitical for effective health interventions in communities. Finally, *infrastructures* for health are present to meet the needs of actors within communities. Actors of health as seen in the diagram are present within structures and these actors are community residents who utilise health services at the health facilities in communities or through other medium.

Structure and actors reflect an existing interconnected such that structures of health in communities are shaped by actors and actors of health are equally reproduced by the existing structures. The diagram further shows that actors are comprised of individuals across government, private, faith and community based health facilities present in communities. Other actors of health include traditional practitioners (spiritualist, diviners, folk healers etc) and community drug stores (local pharmacist or chemist owners). These as seen in the diagram constitute the *resources*, *organisations*, *consensus*, *stakeholders* and *infrastructures* for health within any given emerging community or urban slum. The application of Structuration theory by Anthony Giddens provides insights to understand the complexities of health care delivery on how structures and actors remain interdependent for health systems to optimally perfom.

3.11.2 Social Model of Health

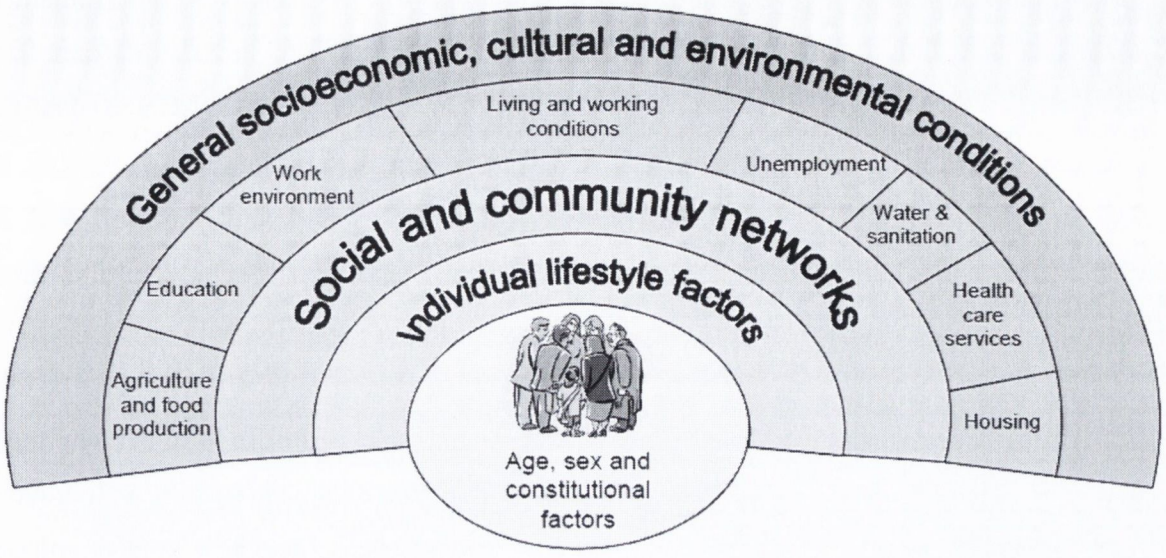
The social model of health carefully considers how wider determinants than the presence or absence of disease have an impact on people's health. Some of these wider determinants are a person's culture and belief system or levels of relative income, access to housing, educational attainment and opportunities as well as the wider environmental, political and socio-economic conditions in which people live. People's social and community networks also have an impact on health. In the study area, all of these determinants enhances or constrain people's access and utilisation of health care services.

Dahlgren and Whitehead (1991, 1993) talk of the layers of influence on health. They describe a social ecological theory of health. They attempt to map the relationship between the individual, their environment and disease. Individuals are at the centre with a set of fixed genes. Surrounding them are influences on health that can be modified. The first layer is personal behaviour and ways of living that can promote or damage health, for example,

choice to smoke or not-Individuals are affected by friendship patterns and the norms of their community. People's attitude towards their own health is a major determinant of how they respond when ill, or how they seek for health care services. Also their attitude determines how important they consider their health to be, and how they react to the nature of health care delivery available to them. The second layer is on the social and community influences, which provide mutual social support for members of the community in unfavourable conditions.

However, these influences can also provide no support or have a negative effect. Within emerging communities and urban slums the influence of social processes and structures shapes the manner in which health care is perceived and sorted. However, the network of social relations within these communities contributes significantly to how people access and utilise health care services. Also this social relation is an invisible determinant of health through which the "circulation of community information" could be to the detriment of community health or to their advantage. The third layer includes structural factors: housing, working conditions, access to services and provision of essential facilities. However, emerging communities and urban slums are plagued by structural deficiencies and offer a disadvantaged state of living which promotes the incidence and prevalence of communicable diseases.

Figure 3.2 Social Model of Health (Dahlgren and Whitehead, 1991).



Source: Dahlgren and Whitehead, 1991, 1993.

Dalgren and whitehead's model has been widely applied in several studies on within public health, psychology, sociology, environmental health, social medicine and economics. Their major argument is that the health of individuals who are endowed with age, sex and genetic factors are influenced by a number of factors referred to as layers. Dalgren and Whitehead diagrammatically present the model in the form of a rainbow (Figure 3.2 above): first, personal behaviour and ways of life that can damage or enhance people's health (Jinks, Ong & O'Neill, 2010). These are influenced by social and community networks, which in turn, are contextualised by living and working conditions and access to facilities (including health and social care). The broader economic, cultural and environmental conditions in a given society have a bearing on all the other layers within the social model of health.

For Jinks, Ong & O'Neill (2010), they justified their use of the social model of health to study knee pain and disability. The rainbow model is particularly suited to the study of knee pain and disability for a number of reasons. Firstly, it outlines the main determinants of health (for example exercise, diet, education, health services) as also core treatments for the effective care and management of knee osteoarthritis (OA) (National Institute for Health and Clinical Excellence, 2008). However, there is ample evidence of the under use of exercise,

weight loss and written information in knee pain patients (Porcheret, Jordan, Jinks & Croft, 2008 in Jinks, Ong & O'Neill, 2010). They stated that in exploring these determinants may therefore shed light on reasons for this. Secondly, items on the rainbow (for example work conditions and diet) reflect opportunities for prevention activity that have been identified in epidemiological studies and randomised clinical trials (e.g. Jenkinson, Doherty, Avery, Read, Taylor et al, 2009; Blagojevic, Jinks, Jeffery & Jordan, 2010 in Jinks, Ong & O'Neill, 2010) but which have not been explored in detail at the individual level. Thirdly, the new Musculoskeletal Services Framework recommends integrated care pathways which focus efforts at self help and prevention (UK Department of Health, 2006). Jinks, Ong & O'Neill (2010) study show the specific relevance of the social model of health to understanding knee pain and disability. They conclude that the model does have relevance at the individual level and can help formulate more dynamic and context specific approaches. That is aprooaches that resonate with the individuals' own interpretation of their lives, health and prospects for deliberate action that go beyond the duality of agency and structure Jinks, Ong & O'Neill (2010).

The Dahlgren and Whitehead Social model of health was applied by Barton and Grant (2006) to planning local human habitats. They stated that the human environment remains a major determinant of health and well-being. That is, based on modern town planning and urbanisation which originated in the nineteenth century in response to basic health problems, but in the subsequent years has become largely void from health. According to Barton & Grant (2006), humans have literally engaged in building unhealthy conditions into the local human habitat. But the connection between health and settlements are often indirect and complex. "Thus all the elements of the original Whitehead and Dahlgren diagram of the determinants of health are included in their health map, which spread out to reflect the ecosystem of the local human habitat" (Barton & Grant, 2006:4).

In two separate publications Graham (2004a, 2004b) identified goals ranging from remedying health disadvantages through narrowing health gaps to reducing health gradients based on the social model of health. For Graham, "The goal of narrowing health gaps, like remedying health disadvantages, casts health inequalities as a condition to which only those in disadvantaged circumstances are exposed (Graham, 2004a, 2004b). Strategies can therefore focus solely on disadvantaged groups, seeking to improve their health in absolute terms (the

more limited variant of the goal) and in relative terms. The second goal-to narrow health gaps-...requires a reversal of the trend towards widening health inequalities (Graham, 2004a, 2004b). To achieve it, the rate of health gain among the poorest groups needs to outstrip that achieved by the comparator group" (Graham, 2009:467).

In contrast, the goal of reducing health gradients makes clear that health is unequally distributed not only between the poorest groups and the better-off majority but also across all socio-economic groups. For a broader concept of health inequalities that recognizes that health inequalities follow a social gradient, with the health gap increasing steadily with poorer social class, interventions must therefore reach more than the most deprived, socially excluded populations. This broader framing of health inequalities demands a broader framing of policy goals. "Lifting levels of health across the population requires a rate of health gain that is greatest for the poorest, progressively lower for better-off groups and lowest for those in the most advantaged circumstances. Differential rates of health improvement in turn require differential rates of improvement in the factors that promote good health: in what are called the 'social determinants of health" (Graham, 2009).

In a systematic review by Bambra, Gibson, Sowden, Wright, Whitehead & Petticrew (2010), the authors used the widely cited Dahlgren and Whitehead social model of health to highlight the main determinants of health as a framework to help to identify the range of social determinants upon which interventions could be based (Dalgren & Whitehead, 2007). The authors concentrated mainly on the outer two layers of the model, which included macroeconomic, cultural and environmental conditions in the outermost layer; and living and working conditions and access to essential goods and services in the next layer, specifically water and sanitation, agriculture and food, access to health (and social care) services, unemployment (and welfare), work conditions, housing (and living environment), education and transport.

Bambra, Gibson, Sowden, Wright, Whitehead & Petticrew (2010:285) however, excluded reviews that only examined interventions based on the inner most layers of the model: individual lifestyle factors and social and community networks. They concluded that It appears, then, that not only is the public health systematic review evidence base weak in terms of how to tackle the social determinants, but that there are specific areas that appear

especially sparsely populated. These are sector-wide policies in education, the health system, food and agriculture, and more generally on the influence of macro-level policies on health inequalities (Bambra et al, 2010:285).

Although it is now a given that the effects of any interventions on inequalities should be assessed, the systematic review evidence base does not yet allow us to say with any confidence what the effects of interventions on reducing health inequalities are because ifferential impacts by socioeconomic position are rarely assessed. Nonetheless, one of the positive messages from this umbrella review is that there is a growing systematic review evidence base around housing and regeneration and a significant evidence base on the work environment suggesting that this is indeed a sector with significant responsibility for improving health and reducing inequalities (Bambra et al, 2010:285).

3.11.4 Framework of Health Service Utilisation

Rising social expectations regarding health and health care, fuelled by modernization, greater access to information and improved health literacy, are driving demand for more people-centred access, better community health protection and more effective participation in decisions that affect health. There is pressure on policy makers and political leaders to steer their health systems towards health equity, social justice and solidarity (WHO, 2008).

The framework of health service utilisation was initially developed in the late 1960s to assist the understanding of why families use health services; to define and measure equitable access to health care and to assist in developing policies to promote equitable access (Anderson, 1968). The purpose of this framework is to discover conditions that either facilitate or impede utilisation. The goal was to develop a behavioural model that provides measures of access to medical care. The framework was first developed in the 1960s and has since gone through four phases. Developed in the 1990s, the framework below represents the fourth phase. An individual's access to and use of health services is considered to be a function of three characteristics;

1) **Predisposing factors**: The socio-cultural characteristics of individuals that exist prior to their illness.

Social structure: Education, occupation, ethnicity, social networks, social interactions, and culture

Health beliefs: Attitudes, values, and knowledge that people have concerning and towards the health care system

Demographic: Age and Gender

2) **Enabling Factors**: The logistical aspects of obtaining care.

Personal/Family: the means and know how to access health services, income, health insurance, a regular source of care, travel, extent and quality of social relationships

Community: Available health personnel and facilities, and waiting time

Personal additions: Genetic factors and psychological characteristics

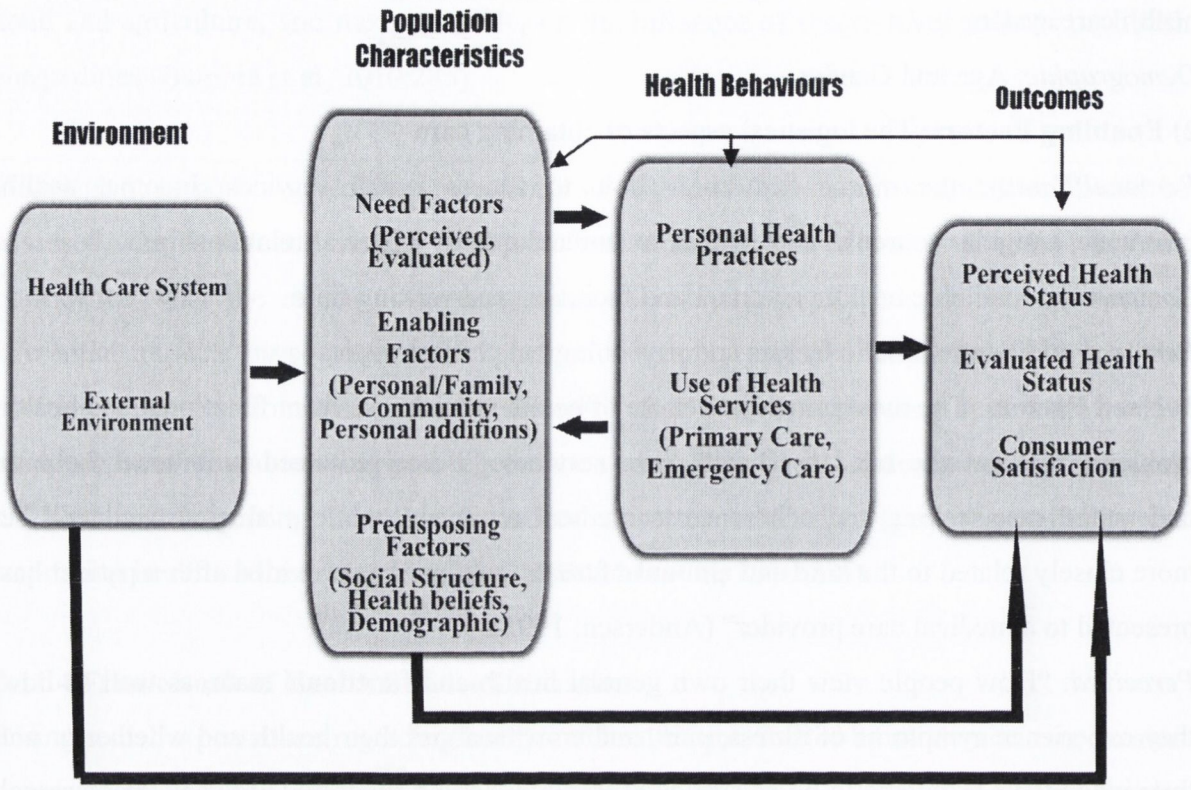
3) **Need Factors**: The most immediate cause of health service use, from functional and health problems that get the need for health care services. "Perceived need will better help to understand care-seeking and adherence to medical regimens, while evaluated need will be more closely related to the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

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

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

Andersen and Newman's framework for health service utilisation provides additional determinants of health for people in emerging communities and urban slums. The framework depicts the predisposing, enabling and need factors that determine whether or not an individual will utilise the health services available in the community.

Figure 3.3 Framework of Health Service Utilisation .



Source: Andersen (1995), Andersen and Newman (1973, 2005)

The wide application of Andersen and Newman's framework for utilisation of health services has been used by several scholars over the years. The framework simplifies and explains key factors that infleunces people to utilise health care services. According to Stein, Andersen, Koegel & Gelberg (2000), they modified they framework to their study for homeless populations to a probability sample of homeless adults. The influence of predisposing, enabling, and needs-related factors as baseline on Health Services Utilisation (HSU) was assessed, which is represented by a medical hospitalisation and/or an outpatient visit within one year after baseline. They authors stated using the Andersen-Newman framework that, "predisposing characteristics exist prior to the perception of illness; enabling resources to facilitate or impede HSU, and needs-related variables pertain to physical illness as perceived by people and evaluated by professionals" (Stein et al, 2000:213).

The study predicted that the need factor of prior poor health was a significant predictor of both hospitalisation and an ambulatory office visit. They found that when applying the framework to the general population, need is relatively less important in predicting office visits, since preventive services are also provided in the office setting (Andersen, 1995). In

these results, need was a predictor of use of ambulatory services as well as a hospitalisation among the homeless. This result indicates that ambulatory visits for acute conditions among the homeless should be recognised as an opportunity to provide them with much-needed preventive services and basic health screenings (Stein et al, 2000:225).

In a literature review based on the Andersen and Newman Framework for Health Services Utilisation, Kadushin (2004) to understand home health care. The behavioural model suggests that an individual's use of health services is dependent on predisposing factors, enabling factors, and need factors (Andersen, 1995). The review showed that there is ample evidence that different predisposing, enabling, and need variables are associated with the use of different individual home health care services and with the use of different "packages" of health services. Thus, for example, the variables associated with the use of nursing services are different from the variables associated with the use of homemaker services, (Kadushin, 2004:227).

According to Kadushin (2004), contrary to the Andersen-Newman framework, the review did not find that the variables influencing contact with services differed from the variables influencing amount of services used. However, because noting that less information was available about the influence of each variable on amount of services used than about the influence of each variable on contact with services, the findings regarding the variables that are significantly associated with the amount of services used must be regarded somewhat cautiously (p.227).

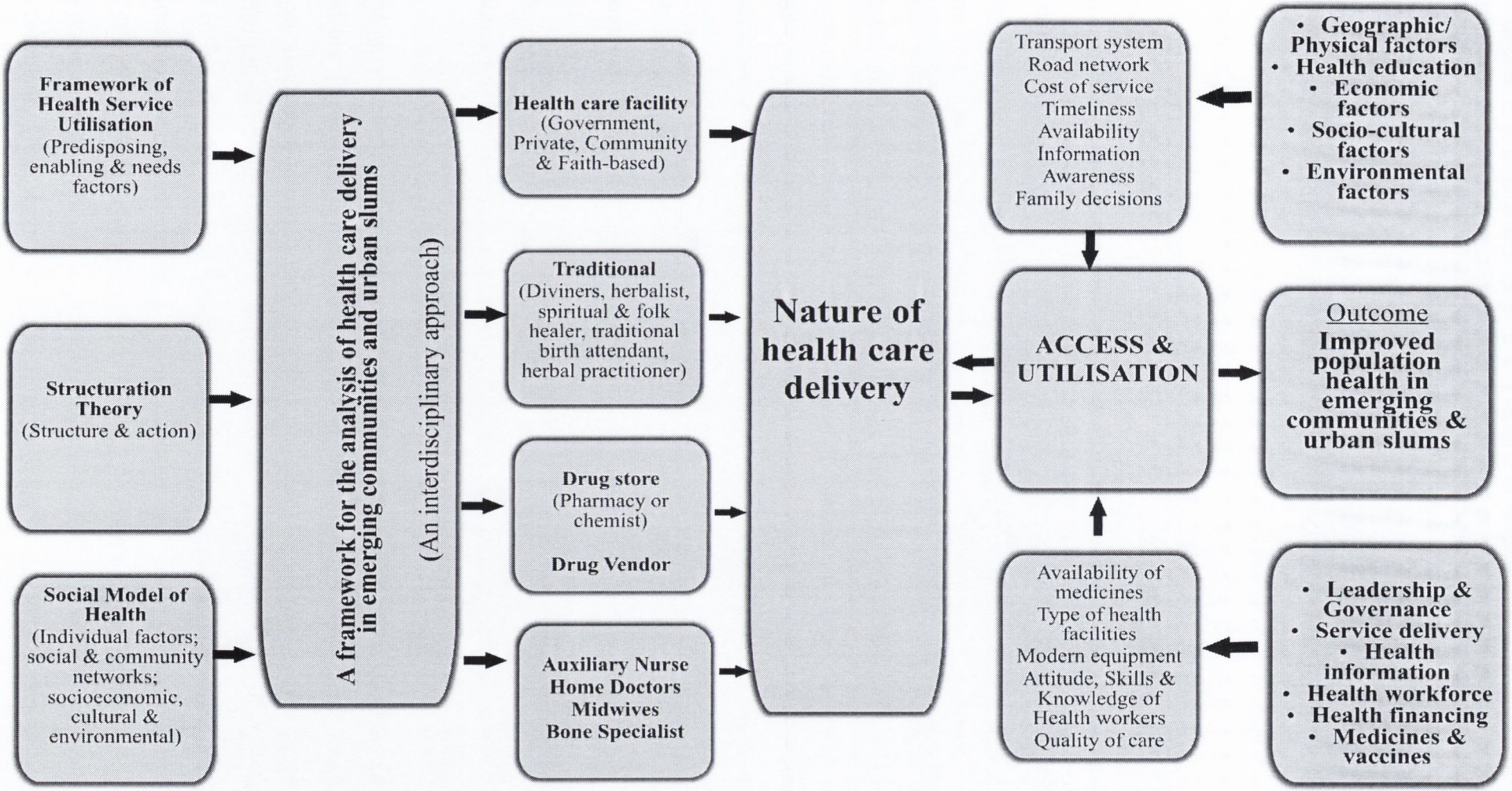
In another study focused on the prevalence of oral symptoms among adults in Ouagadougou, capital city of Burkina Faso in West Africa. Varenne, Petersen, Fournet, Msellati, Gary, Ouattara, Harang & Salem (2006) measured the associations between predisposing, enabling and needs factors and decisions to seek oral health care. They also revealed the use of oral health services and self-medication in response to certain symptoms. Part of the studies conceptual orientation was the Andersen-Newman framework of health services utilisation. The study defined a set of independent individual-level variables that may influence utilisation of oral health care: (1) predisposing socio-demographic and health beliefs factors, which can be either, modifiable (e.g. education, marital status or health attitudes such as perceived general health status and seriousness of oral disease, importance of oral health,

benefits of brushing, or perceived barriers to obtaining oral health care) or non-modifiable (e.g. age or sex). In addition, were (2) enabling characteristics, which refer to specific attributes of the individual or the community in which the individual lives (e.g. level of income, residence, family size, integration in urban life, social support) and may affect ability to access the health care system; and (3) need factors, which reflect the perceived need for oral health care (patient's perceptions of illness, impairment of quality of life) or the self assessment of health status (Varenne et al, 2006).

For this study the preceeding theory, model and framework have been used because of their unique similarities to holistically engage and decompose the subject matter on health care delivery, access and utilisation in emerging communities and urban slums of south west Nigeria. For example, Dalgren & Whitehead (1991,1992,1993) social model of health shows how various societal factors operate through people's living and working conditions to influence their health, both directly and indirectly through their health behaviour (Sheiham, Alexander, Cohen, Marinho, Moysés, Petersen, Spencer, Watts & Weyants, 2011).

The justification for the use of Structuration Theory, Social Model of Health and Framework for Utilisation of Health Services for this research has been highlighted in the preceeding sections. However, there are other theories, models or frameworks for health as highlighted in the works of Brunner & Marmot (1999) which includes early life and cultural factors to interprete the pathways to health; this is aimed primarily towards an analysis of macro social factors. Furthermore, the theoretical contribution of Bartley (2004) has drawn further attention to influences such as the physical environment of home, neighbourhood and workplace, and people's standard of living; while the work on cumulative disadvantage through the life course by Davey Smith & Kuh, (1997) and how these may be exacerbated through living in particular places (Joshi, Wiggins, Bartley, Mitchell, Gleave & Lynch, 2001) even to explain health inequalities that exist within emerging communities and urban slums of south west Nigeria.

FIGURE 3.4: Interdisciplinary framework for the analysis of health care delivery, access and utilisation in emerging communities and urban slums



3.12 Synthesis of Theoretical and Conceptual Framework for the Study

The conceptual framework adopts an interdisciplinary approach to understand the nature of health care delivery in emerging communities and urban slums of south west Nigeria. The diagram shows the combination of one theory (structuration), one health model (social model of health), and one health framework (framework of health service utilisation). All combined give an interdisciplinary approach in providing a framework for the analysis of health care delivery in emerging communities and urban slums. This framework draws from the characteristics of the various health framework, health model and social theory to become distinct. *Firstly* the Andersen and Newman's framework of health service utilisation is to discover conditions that either facilitate or impede utilisation, i.e. those predisposing, enabling and need factors that determine whether or not people will utilize a particular health service in the study area. *Secondly*, the social model of health by Dahlgren and Whitehead provides an explanation of how people's health is determined by environmental, socio-economic, cultural, social and community networks and individual's lifestyle. *Finally*, structuration theory proposed by Giddens emphasises the relationship between structures and actors. Structures are the established institutionalised mode of conduct in the society, actors being the meaning makers in each society or community. Structuration theory explains the closely knit connections between individuals as *users of health care services* and the *providers of health care services*. The theory further explains how structures of health shape people's lives and in turn actors of health care maximize the available health resources to ensure better health. The combined characteristics of all these health frameworks, social theory and health model give a comprehensive and holistic interdisciplinary approach to understand and analyse the varied nature of health care delivery, access and utilisation in emerging communities and urban slums of south west Nigeria.

The conceptual framework explains health care delivery as an existing *structure of health care* (health care facility either government, private, community or faith-based) and being influenced by *actors of health care* (health workers, traditional practitioners, folk healer, spiritual healer, drug store (pharmacy or chemist shop), drug vendor, public health official and health care users) and the existing institutions/organisations that provide health care services. All these players shape the social processes by which health care services emerge and evolve in the study area, determine people's access and effective utilisation of health care services, explain the specific factors as social determinants of health, the health challenges and the people's own perceptions of the effectiveness of health care delivery (health facility)

in their communities. Furthermore, the conceptual framework shows the factors that determine access and utilisation of health care delivery. Availability of drugs, health facility, health workforce, attitude of health workers, language barriers, transport system, income, road network, timeliness, availability, affordability contribute to the choices people make as regards when and how to access health care services and whether to utilise these health services in emerging and urban slums. Access and utilisation affect the state of health care delivery in the community, as broader factors such as geographical, physical, economic, socio-cultural, social amenities and infrastructure, health literacy, quality of care (safety, efficacy and continuity) determine the varied nature of health care in the study area. Finally, the conceptual framework shows improved access and utilisation of health care delivery in the study i.e. improved population health in emerging communities and urban slums of south west Nigeria which is a result of effective health service delivery, and adequate health workforce, increased health care financing, committed political leadership and governance, available medicines, vaccines and technology and an efficient health information system.

3.12.1 Similarities and Differences between Structuration Theory, Social Model of Health and Framework for Utilisation of Health Services.

	Structuration Theory	**Social Model of Health**	**Framework for Utilisation of Health Services**
Elements			
Origin	Sociology	Public Health	Medicine (Basic Medical Sciences)
Concepts	Structures, Action, Duality of Structure, Reflexive, Authoritative resources, Allocative resources, Normative action, Generative action.	Personal Behaviour, Way of life, Social Support, Structural factors.	Predisposing Factors Enabling Factors Need Factors
Level of Analysis (Determinants)	Social Institutions (Economy, Religion, Family, Education & Politics), Actors (Individuals)	Individual lifestyle factors, Social and community networks, General socio-economic, cultural and environmental conditions	Environment, Population Characteristics, Health behaviours, Perceived health Status, Evaluated Health Status & Consumer

			Satisfaction
Subjective/Objective (Attributes)	A combined insight on human actions and structural formations	Inclusion of people's attitudes, culture and belief systems, Income, Access to Housing, Living Conditions	An explanation of subjective and objective conditions that either facilitate or impede utilisation of health services
Deductive/Inductive	Both	Both	Both
Macro/Micro Perspectives (Mechanisms)	Both micro and macro factors explains the theory which attempts to reconcile the dichotomies focusing on social practices (healthcare delivery) ordered across space and time.	Social Model of Health Combines Micro and Macro Perspectives in Analysing Health	Framework of Health Service Utilisation is comprised of Micro and Macro Factors

Source: Author, 2014.

3.13 Significance of the study

The significance of the study lies in the fact that it systematically investigated the nature of health care delivery in emerging communities and urban slums against the backdrop of a weak health care delivery system that persist in these communities. Also, the environmental nature of urban slums comprised of unplanned living conditions, open gutters, presence of dump sites, inadequate modern toilets. These environments are plagued by various diseases and illnesses such as malaria, cholera, typhoid, and tuberculosis. More so, migratory patterns from rural to urban areas have increased the number of emerging communities in south west Nigeria that are not adequately planned, lacking basic social amenities including an adequate health facility.

The study therefore:

- Provides information on the varied nature of health care delivery in urban slums and emerging communities. That is, what type of health services are present in the study area, evolution of health services and stakeholders in the provision of health services in these communities.
- Helps in the conceptualisation of health care delivery, and utilisation in urban slums and emerging communities.
- Highlights the social determinants of access to health care services in urban slums and emerging communities in relation to what the literature says.

- Contributes to strengthening health care systems in urban slums and emerging communities of urban south west Nigeria.
- Informs policy makers on the nature of health care delivery in emerging communities and urban slums. The study provides useful data and information to better plan for the provision of health care services in the study area.

3.14 Scope of the study

The nature of the study is hinged on an interdisciplinary approach being the underlining focus of the International Doctorate in Global Health (Indigo). The study covered issues concerning health care delivery focusing on access and utilisation in emerging communities and urban slums of south west Nigeria. Firstly, thematic literatures review on health care delivery in developing countries and health care delivery in urban slums and emerging communities. Also, literature on access and utilisation of health care services and social determinants of health are reviewed. Prevention and treatment of communicable diseases, people's health challenges and unmet needs for healthcare and people's perception of effectiveness of health care services were also reviewed. Secondly, the study was carried out in emerging communities (informal settlements/border towns located on the outskirts of urban Lagos) and in urban slum communities. The method of data collection, analysis and presentation of findings was triangulated. These include the combined use of primary sources; the use of a questionnaire (quantitative) and qualitative instruments in-depth interviews, key informant interviews, and focus group discussion (qualitative). Univariate, bivariate and multivariate analysis was employed for the quantitative data while a qualitative content analysis and text narratives were used for the qualitative data.

Findings of the study are presented in tables and text of quotation (see chapter six and seven). Respondents for the study included householder, public health officers, community or women leaders, key informants (lived over 5 years in community), doctors, nurses, traditional herbal practitioners, drug store pharmacist and chemists and any other members of the community with knowledge of the broad theme concerning the nature of health care delivery in the community. Finally the geographical scope of the study is limited to selected emerging communities and urban slums in Lagos and Ogun state of south west Nigeria.

3.15 Chapter Outlines

The study is comprised of nine chapters. Chapter one includes the background of the study highlighting the underlining issues on health care delivery within developed and developing countries and how this affects people in emerging communities and urban slums. Chapter two focuses on Nigeria and the study settings of Lagos and Ogun states. Chapter three includes the literature review and conceptual-theoretical framework. Chapter four states the study aim and objectives and the research questions answered. Chapter five describes the methodology, how the study was carried out and the type of data collected. It also explains the types of data analysis employed. Chapter six presents and analyses the results from the quantitative data collected at household level. Chapter seven gives the results from the qualitative data collected and analysed using content analysis and text narratives. Chapter eight comprises the discussion of study findings which involves the combination of the quantitative and qualitative results. The final chapter nine includes the conclusions and recommendations from the study.

CHAPTER FOUR
STUDY AIMS AND OBJECTIVES

4.1 Introduction

This chapter presents the aim and objective of this study. It also shows the research questions that are being answered and why the study is significant to public health in Nigeria.

4.2 Aim and Objectives of the study

The aim is to examine health care delivery, access and utilisation in emerging communities and urban slums of south west Nigeria. Specific objectives are:

1. Explore the nature of health care delivery and the social processes by which health care services evolve in emerging communities and urban slums of south west Nigeria.
2. Examine people's access to and utilisation of health care services in the study area.
3. Investigate the people's perceptions of the performance of the health care facilities in emerging communities and urban slums of south west Nigeria.
4. Ascertain specific factors as social determinants of health in emerging communities and urban slums of south west Nigeria.

4.3 Research questions

The following research questions are addressed:

1. What is the varied nature of health care delivery services in the study area?
2. How do health care services emerge and evolve in emerging communities and urban slums in south west Nigeria?
3. How do households access health care services and effectively utilise these services in emerging communities and urban slums of south west Nigeria?
4. How do residents perceive the performance of the health care facilities in emerging communities and urban slum communities in south west Nigeria?
5. Are there specific factors influencing people's health in emerging communities and urban slums of south west Nigeria?

CHAPTER FIVE
METHODOLOGY

5.1 Introduction

The complex nature of human social reality has brought about the need to adopt an interdisciplinary approach to study human behaviour. This is advocated because the use of one single research instrument to capture the complex social reality of man and his society has become inadequate. To this effect, the methodology reflects a combination of quantitative and qualitative methods. This chapter describes the research design, the study population, inclusion/exclusion criteria and reasons for study participant's selection, sample size, data retention, protection and disposal, sampling techniques, research instruments, method of data analysis and data administration.

5.2 Research Design

The research design used for this study is a community based descriptive design with the use of qualitative and quantitative data. The collection of data was cross sectional, as the mode of sample selection cut across different demographics and the methods of data collection employed covered both the qualitative and quantitative data derived.

In order to collect relevant data, descriptive information was obtained through a semi structured survey instrument (quantitative approach) at the household level on issues on the nature of health care in the communities and how the existing health system was established. Also the survey covered access and utilisation of health care services, and the performance of the community health care facility. Alongside the use of the survey instrument, the use of more than one qualitative instrument was applied to understand the social determinants of health in the community, the nature of health care in the communities and how the existing health system emerged.

Further information was derived on other aspects of the study objectives using the qualitative method from members of the communities studied on their perceptions to the effectiveness of health care delivery in the community. The study carefully considered the challenges facing the people in the communities and was keen on first getting their consent to participate in order to contribute to the understanding of the varied nature of health care delivery in the study area.

5.3 Study Population

5.3.1 Household Survey (Quantitative)

Respondents have been drawn from people living in emerging communities and urban slums. Just a single participant from each household took part in the survey. That is, households were represented either by the household heads, guardians, care givers or a member at the time of data collection. A total of 810 questionnaires produced for administration. This ensured that a large population sub-set of the entire population across the 6 communities was surveyed. A community population-based survey is used for the following reasons:

- The questionnaire essentially provided health information on a large data set of a sample population within these communities.
- In surveys, the sample should be sufficiently large so that any major subgroups contain at least 100 cases and minor subgroupas contain 20 to 50 (Fowler, 2002).
- The population-based survey was relatively easy to administer using the research assistants.
- The questionnaire used in this study had numerous questions that were asked about the subject-matter.
- Finally, the use of the survey method gave room for a broad range of data to be collected to understand the varied nature of health care delivery in the study area.

5.3.2 In-depth interviews (IDI)

In-depth interviews were conducted to understand the perspective of the providers of health care services to people living in emerging communities and urban slums of south west Nigeria. The group of health care providers comprised of community health workers (Doctors or Nurses) either working in a government health facility (health post or health centre) or a private hospital. Also public health officers based at the government health facility were interviewed. In addition to the list of participants are traditional health care providers who are practicing herbal practitioners, spiritual healers or folk healers. Finally, owners of a community based drug stores pharmacist or chemists were included. The justification for including these categories of health care providers/workers is because these various forms of health care services are readily available in the communities. All participants who took part in the in-depth interviews were conveniently and purposively selected.

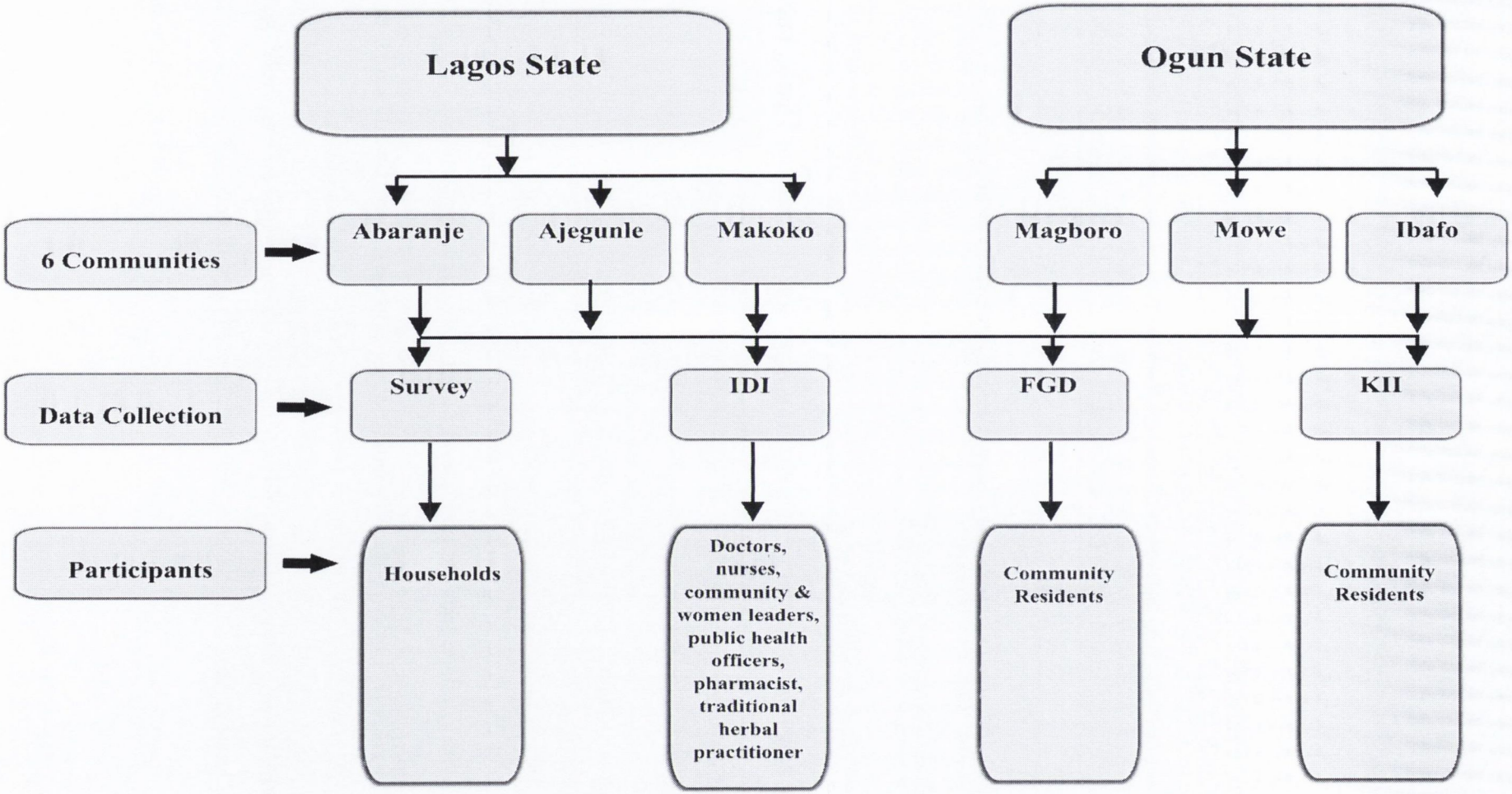
5.3.3 Key informant interviews (KII)

Certain individuals from the various communities were selected to partake in this component. The people were considered because of their long years of residing in these communities. More so, they were considered because, having lived in these communities for a very long time, they must have observed how various forms of health care services have emerged and evolved over time. Such individuals provided information on what led to the establishment of a health care facility, whether public, faith-based, community or private, and what factors precipitated the spread of the informal health care providers within the communities, including the non-registered drug stores. The key informants were purposively selected for these reasons and were recommended through the community leaders and interaction with people in the community.

5.3.4 Focus Group Discussants (FGD)

Focus group discussants were community members, both males and females that were willing to participate in the study. These people were drawn to be part of the discussion because of their individual experiences with the health care delivery system within their community. Their knowledge, attitude, perceptions and beliefs towards the various forms of health care services readily available in the community provided a holistic understanding of how health care services are being delivered to the people. Also insights from the discussions offered information on how the existing health care services emerged and evolved overtime in the community. The focus group discussions were conducted to provide answers to the complex nature of social reality in relation to health care delivery within the study area. Both men (between 22 years to 45 years) and women (between 23 years and 50 years) formed the core discussants across the various focus group sessions. The minimum age requirement for discussants was 16 years and the maximum age was 60 years. The FGDs discussants are drawn from people who reside in the communities. The reasons for limiting the age category for participants are seen in section 5.4.2.

Figure 5.1 Study Location and Population



Source: Author, 2014

The figure 5.1 above is representative of all the six locations where surveys (households), in-depth interviews (doctors, nurses, community and women leaders, public health officers, pharmacists/chemist owners, and traditional herbal practioners), focus group discussions (community residents) and key informant interviews (community residents) were held. For the household survey, a total of 755 households participated across the 6 communities of Lagos and Ogun state. For the in-depth interviews, a total of 19 were conducted across the communities among the various health care providers and community representatives listed in section 5.3.2. Six focus group discussions were held with a minimum of six participants per discussion and a maximum number of eight. Finally, six key informant interviews were held across the six locations. The qualitative aspects of the research mainly utilised convenience and purposive sampling techniques as seen in section 5.6.

5.4 Eligibility Criteria (Reasons for Study Participants Selection)

5.4.1 Inclusion Criteria for Study Participants

a) Inclusion criteria for Survey:

Household: Must be any adult member that can give valid information. That is, information about all members of the household can be obtained from such a person.

b) Inclusion criteria for In-depth Interviews:

Public Health Officers: Public health officers must have being working in the community health post for more than 1 year.

Community or Women Leaders: Such leaders must be the true community representative of the community and the local administrator within these communities.

Community Health Care Workers (Doctors or Nurses): Certified Doctors or Nurses working in the community health centre/post or in a private hospital/clinic

Traditional Herbal Practitioners: These traditional medicine sellers, folk healers or spiritual healers must be well known by the people in the community.

Local Pharmacy: Local Pharmacy must have been in operation for over one year in the community.

c) Inclusion criteria for Key Informant Interviews:

Key Informants: Key informants must have lived in the community for over 5 years. These persons offer a holistic understanding of the nature of health care and the historical antecedents in their respective communities.

d) Inclusion criteria for Focus Group Discussions:

Community Residents: Male or female residents residing in the community and have lived there for over 3 years, he or she must be above 16 years of age.

5.4.2 Exclusion Criteria for Study Participants

a) Exclusion Criteria for Survey:

Household: Not an actual adult member of the household visited and therefore cannot give valid information. That is, information about all members of the household cannot be obtained from such a person.

b) Exclusion criteria for In-depth Interviews:

Public Health Officers: Public health officers who have not being working in the community health centre/post for more than 1 year. That is, less than 1 year.

Community or Women Leaders: Such a person that is not the true community representative.

Community Health Care Workers (Doctors or Nurses): Certified Doctors or Nurses who have been working in the community health centre/post or in a private hospital/clinic for less than 6 months

Traditional Herbal Practitioners: These traditional medicine sellers, folk healers or spiritual healers etc that are not well known by the people in the community.

Local Pharmacy: Local Pharmacy that has been in operation for less than 1 year in the community.

c) Exclusion criteria for Key Informant Interviews:

Key Informants: Key informants who have not lived long in the community. That is, someone new to the community.

d) Exclusion criteria for Focus Group Discussion:

Community Residents: Male or female residents residing in the community and have lived there for less than 3 years and who is less than 16 years of age or more than 60 years old. Although 18 years is nationally recognised at the age when a teenager becomes recognised as an adult. For the purpose of research as outlined by the HPM/CGH Ethics committee of Trinity College Dublin, Ireland. Respondents who are age 16 years must be considered for participation in a community-based focus group discussion. In addition, the rationale for maximum age of respondents in the focus group discussion is simply because a few number older people may not be able to participate because of difficulties some of them may experience in coming to the venue for the discussion.

5.4.3 Recruitment of Participants and Steps Taken to Access Participants

(a) Household survey: Households were selected using the Expanded Programme of Immunization (EPI) sampling technique (Bostoen & Chalabi, 2006). The EPI approach was originally launched in 1976 by WHO and UNICEF with the aim of controlling six childhood diseases: tuberculosis, diphtheria, pertussis (whooping cough), tetanus, polio and measles (WHO, 1976). The World Health Organization EPI sampling technique utilises a 30 cluster sampling strategy (WHO, 2001) as seen in section 5.6.1. The participant for the household survey included an eligible adult member who participated in the study because such individuals could provide information on the health conditions of each household member. Steps taken to access the final sample was through the use of field assistants who resided in each of the communities where the study was conducted. Recruitment of field assistants is elaborated in section 5.8.1. Though a buddy system was established between the researcher and the communities selected, the use of the field assistants was necessary for ease of data collection. Also, the field assistants lived in the community and could easily relate to the household participant. However, the researcher was mindful of any potential bias and/or benefits arising from the 'buddy system' instituted across the six communities. The researcher was mindful to avoid being influenced by the community representatives his been relating with prior to data collection. Also the field assistants had their roles limited to the data collection but only when required by the researcher did they provide suggestions to further enhance the fieldwork.

(b) In-depth Interviews: The researcher visited the various private hospitals in the study area. Also the government owned hospitals were visited. Final participants (health care workers) who took part in the study were based on their availability, convenience and willingness to participate. Most of the participants demanded letters of approval collected from the University and some form of identification from the researcher. After this was provided, some participants insisted that all of what they said must be kept confidential and no part of it must be made available to their superiors as this may cost them their jobs. Among the facilities visited, the government owned facilities were more critical of the intentions of the researcher. Only those that were convinced of the credibility and intent of the study took part. None of these respondents were forced or cajoled to participate in the study.

On the part of community and women leaders who took part in the study, these individuals had specific locations. Each community has its own community leader popularly known as *Baale* and these traditional rulers had members of council who were learned as the traditional rulers. The researcher visited the palace of the traditional rulers, introduced himself, his intentions (the study), showed letters of approval and explained the benefit such a study would have on the community both in the immediate and the near future. The community leaders visited were very accommodating and offered to participate in the study.

Getting access to the traditional herbal practitioners, folk healers and spiritual healers was very difficult (see section 8.7 on strengths and limitation of the qualitative study). Most traditional herbal practitioners, folk healers and spiritual healers visited by the researcher were very sceptical and bluntly refused to participate. Unfortunately these groups do not always have a formal body/union in the community where you can approach them and request their permission. But most of the traditional herbal practitioners, folk healers and spiritual healers conduct their practices privately and were at liberty to refuse the researcher. Only one herbal practitioner willingly took part in the study. These herbal practitioners were not willing to disclose their treatment procedure or the nature of their services. While three pharmacists and two chemists gladly participated. Local drug stores pharmacies or chemist shops are scattered across the communities. The researcher, based on convenience, selected the pharmacies and chemist shops visited. Community pharmacies and chemist shops can be found across all of the study area and are very popular in such low income neighbourhoods.

(c) Key Informant Interviews: These participants were members of their respective communities based on suggestions from the community heads visited or collective recommendations of community members. The key informants were mostly an adult member of the community that had spent between five to ten years living in the community. They also came in recommended as having reliable information about the community on various issues affecting the people in the community. Key informants were recommended by the community representatives based on the researcher's discretion and inclusion guideline not all recommended key informants were qualified to take part in the study. All qualified key informants willingly participated in the study.

(d) Focus Group Discussion: Using a snowballing technique, participants for the focus group discussions were selected from the community. Having established relationships with some members of the community and through the assistance of field assistants respondents were drawn for the FGDs. The participants also invited other members of the community to be part of the research. Eventually the required minimum for each of the focus group discussions was derived. Participants gave their consent to be part of the study irrespective of no payment or monetary incentive from the researcher. Participants felt it was their responsibility to partake in such an endeavour that would be beneficial to their communities.

5.5 Sample Size

5.5.1 Household survey

Using Leslie Kish's (1965) formula for sample size calculation adjusted for cluster sampling. A total of 810 households were selected to take part in the study. This formula was used because of its estimation on single proportion in determining the actual sample size.

Sample size: Sample size formula = $\frac{Z^2 * p * q}{d^2}$

Where Z= 95% Confidence Level: 1.96

Where p= Lack of access to modern health care facilities according to PSN, so p=60%

Where q=1-p (the probability of having access to modern health facility)

Where d=5% limits of error: 0.05

Where: Z-scores corresponding to a one-sided test = 1.96; p = Population proportion of the outcome measure; q =1-p; and d = acceptable margin of error = 0.05. According to the Pharmaceutical Society of Nigeria, 60% (90 million) of the entire population (160 million) in

Nigeria lack access to a modern health care facility (Baiyewu, 2011; PSN, 2011). These included health care users in emerging communities and urban slums. Therefore, for a sampling error limit of 95%, a significance level of 5% and a margin of error of 0.05, the minimum required sample is **368.8**. A 10% non-response rate for possible attrition brings the total sample to **405**. This sample was applied to emerging communities and urban slums bringing the final sample size for the study to **810** (estimated household) which was distributed between the six selected communities selected from Lagos and Ogun state.

5.5.2 In-depth Interviews

In-depth interviews (IDIs) were aimed to obtain insights into health care delivery within the communities. More so, the IDIs were to offer meaning of the social and familial processes and practices that prevail within the specific locations (Conolly, 1998). Therefore, no specific sample size calculation was done to derive the category of people who could provide information, thoughts, opinions, knowledge, and share their experiences as they relate with people within the community. Using a multi-stage purposive sampling approach (Onwuegbuzie & Leech, 2007), the following participants (Public Health Officers, Community or Women Leader, Health Care Providers/Workers i.e. Doctors or Nurses, Traditional Herbal Practitioners, and Local Pharmacies and Chemist) were purposively and conveniently selected. Through prolonged engagements and persistent observations of participants in the study, the researcher (**S.A.L**) was able to understand the underlying phenomena within the communities. The length and number of interviews varied from one participant to another participant. This is because the context in which each interview took place varied and the challenges encountered during the data collection period were different in each community visited. In total 19 in-depth interviews were conducted across the six communities in Lagos and Ogun state.

5.5.3 Key Informant Interviews

Key informants were drawn from each of the study locations. A member of the community was selected finally from several key informants that were recommended from the members of the community and the community leader. After careful consideration of the various key informants, only the person with the most knowledge on health care delivery was considered. The key informants who participated in the study cannot be said to be representative of the entire population in each community, which is more than 10,000 people. But these key

informants offered insights, thoughts, opinions, knowledge, and experiences which are representative of each key informant's voice. Thus, the sampling units of particular interest are both the persons (i.e. key informants) and words (Onwuegbuzie & Leech, 2007). Unfortunately, key informant bias is a common occurrence because of the unrepresentativeness of key informants (Poggie, 1972; Pelto & Pelto, 1975; Maxwell, 1995 in Onwuegbuzie & Leech, 2007). However, final selection of key informants in each community for the study was done to increase the likelihood that the key informants' words represent those of the other study members (Sankoff, 1971; Maxwell, 1996 in Onwuegbuzie & Leech, 2007). In total six key informant interviews were conducted for the study.

5.5.4 Focus Group Discussions

Participants for the focus group discussions (FGD) were drawn from community members, both males and females. Discussions were held based on the availability of the participants' at the most convenient time. Using a snowballing approach, the researcher recruited participants. **S.A.L** asked the field assistants to assist in the recruitment by approaching people to partake in the discussions. Having established relationships with some members of the community and through the assistance of field assistants respondents were drawn for the FGDs. The participants also invited other members of the community to be part of the research. Eventually the required number for each of the focus group discussions was derived. In total six FGDs were conducted, comprised of 39 participants. No FGD was conducted in Makoko community because the researcher encountered some difficulties in organising the focus group discussions. This is attributed to the unwillingness of community members approached to participate.

Table 5.1 Participants of Focus Group Discussion

Communities	Males	Females	Total Participants
Abaranje	3	3	6
Ajegunle (FGD1)	5	1	6
Ajegunle (FGD2)	2	5	7
Magboro	5	1	6
Ibafo	2	6	8
Mowe	4	2	6
Total Participants	**21**	**18**	**39**

5.6 Sampling Technique

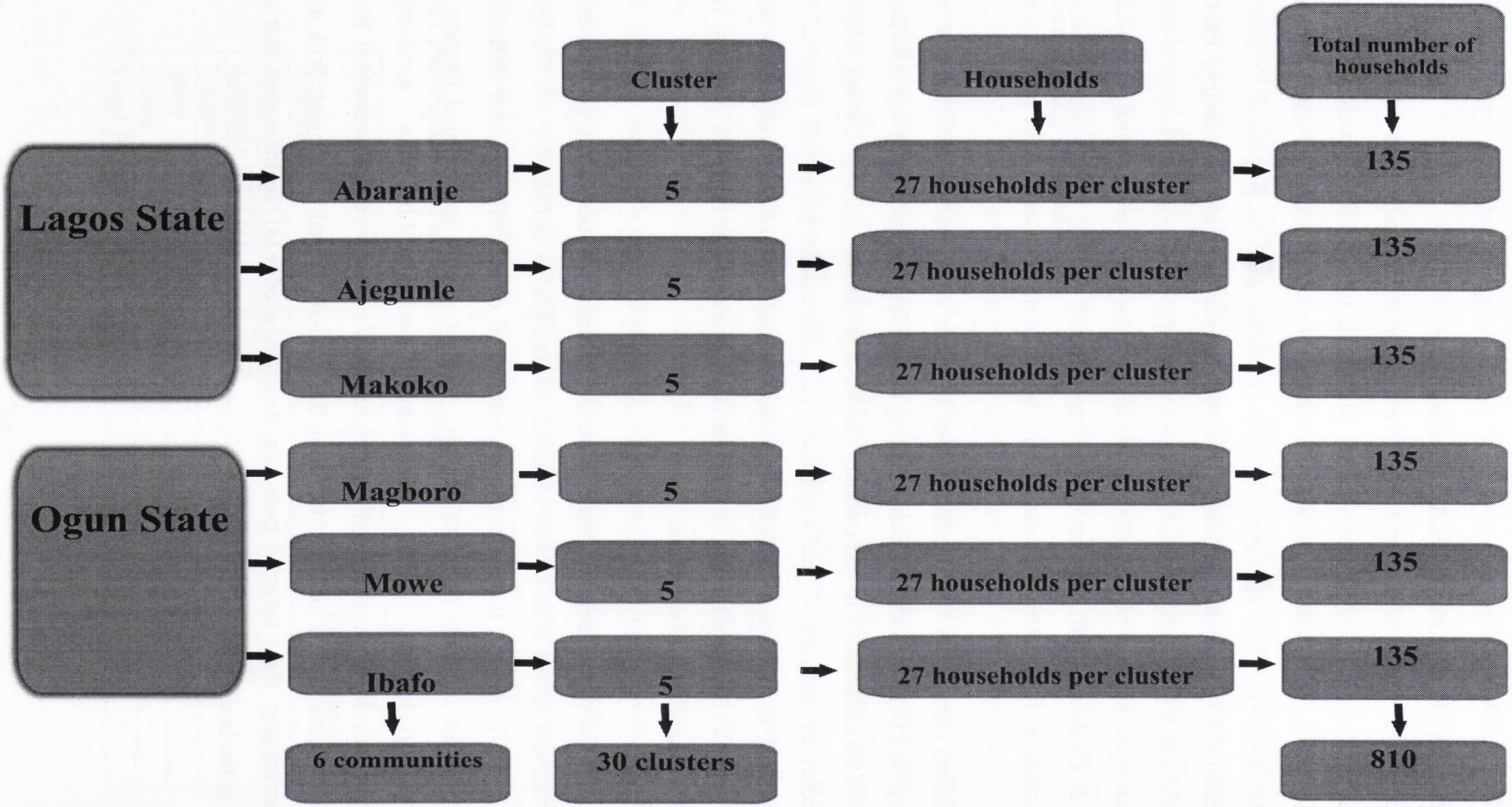
5.6.1 Household Survey Questionnaire (Quantitative)

The first stage was the purposive selection of emerging communities and urban slums in the study area (See section 2.3.3) followed by clustering into suitable senatorial districts or enumeration areas. Each cluster differed across the six communities as some communities had a higher number of clusters than others. The study adopted the Expanded Programme on Immunization (EPI) sampling method. This method can be described simply choosing a number of clusters (e.g. communities, villages) with a probability proportionate to their size, and then an equal number of selected households is surveyed in each of the selected clusters (Bostoen & Chalabi, 2006). The study, having selected the six communities, chooses the nearest location as the centre of the community which in most cases was the market place.

In each chosen cluster the EPI method helped to select (i) a location near the centre of the community, and (ii) a random household along the chosen direction pointing outwards from the centre of the community to its boundary (Bostoen & Chalabi, 2006). Having followed the EPI procedure by carrying out the steps iteratively, the closest household (door to door) to that determined in the previous step was chosen and checked for compliance with the inclusion criteria (See section 5.4.1). The iteration process was repeated until the required number of households was surveyed.

The sampling technique took into consideration the characteristics of the selected emerging communities and urban slums, both informal settlements as defined by the Dahlgren and Whitehead (1991) model. It depicts the environmental conditions (informal settlements, or community at the outskirts of urban centres), socio-economic and cultural features (major means of livelihoods, work environment and health care services) and demographic/individual factors (age, sex, population) which were all accounted for in the study. Households visited took part in filling the semi-structured instrument. Both male and female participants were selected based on their knowledge of health issues that concern members of the household.

Figure 5.2 World health organization EPI thirty-cluster sampling technique



5.6.2 In-depth Interviews and Key informant Interviews (Qualitative)

For the in-depth interviews and key informant interviews, a multi-stage purposeful sampling approach (where one sample used in IDI is not a subset of other samples used in the KII) was used to select the participants. Across the various categories of participants, (Public Health Officers, Community or Women Leaders, Community Health Care Providers/Workers i.e. Doctors or Nurses, Traditional Herbal Practitioners, and Local Pharmacies and Chemist) the researcher approached them in person, introduced the study, its purpose and requested their participation. However, not everyone approached was interested. The "use of convenience sampling in qualitative research simply involves selecting individuals or groups that happen to be available and are willing to participate at the time" (Onwuegbuzie & Leech, 2007:114).

5.6.3 Focus Group Discussions (Qualitative)

With the use of a multi-stage purposeful sampling approach for collection of the qualitative data the study also made use of the snowballing sampling technique. However, the multi-stage purposive sampling also involves selecting a sample in two or more stages. All stages incorporate purposive sampling (Onwuegbuzie & Leech, 2007:115). Multistage purposive sampling is different than mixed purposeful sampling in that the former is always sequential, whereas the latter typically involves concurrent sampling in which one sample is not a subset of other samples (Onwuegbuzie & Leech, 2007:115). The focus groups discussants were not participants in the in-depth interviews or key informant interviews. These groups were selected when the researcher, through the field assistants, approached members of the community and informed them of the research. The initial recruitment of participants across the six communities was then followed by asking such participants who had already been selected for the study to recruit other participants.

All participants for the focus group discussions were guaranteed anonymity and their verbal consent was obtained before the commencement of the discussions. The use of focus group discussions for the study obtained information from individuals who may not have had the chance to participate in the household survey and are not categorised as health care delivery providers in their respective communities which would have made them eligible for in-depth interviewing. However, these groups of community members were crucial as they remain the major users of health care services within emerging communities and urban slums of south west Nigeria.

The use of EPI sampling and the multi-stage purposeful sampling approach for the study has increased the likelihood of generating findings that are both rich in content and inclusive in scope (Kemper, Stringfield & Teddlie, 2003).

5.7 Research instruments

5.7.1 Questionnaire

A survey is very useful in eliciting a wide range of information from the study population in a short period of time. All surveys aim to describe or explain the characteristics of a specific population, such as socio demographic conditions (e.g. age, sex, education, and income) people's behaviour, practice, social and economic circumstances and people's attitudes and opinions (Burns, 2000). Also, Schnetler (1989) notes the advantages of quantitative research using the survey method. The systematic nature of the procedure ensures specificity, logicality and formality in the research process. This allows for an unbiased selection of a sample of the population under investigation so that the data are representative of this group. Use of the survey method also facilitates access to the maximum amount of data while ensuring efficiency in terms of time and financial resources.

A structured interview schedule (SIS) in the form of a questionnaire consisting of close-ended and open-ended questions was administered to the respondents (Households). The instrument is divided into six sections which includes Section A: Socio-demographic and household characteristics, Section B: Nature of health care delivery in emerging communities and urban slums, Section C: Establishment of health care facility in emerging communities and urban slums, Section D: Access and Utilisation of health care services in emerging communities and urban slums, Section E: Performance of community health care facility in emerging communities and urban slums, and Section F: Unmet health needs in emerging communities and urban slums (Appendix V)

The questionnaire contains a total of 120 variables. Both open and closed ended questions were drawn from Section A to Section F. The questionnaire was designed by the researcher (**S.A.L**) through extensive literature review under the supervision of one of the supervisors (**F.O**) and consultation with public health experts at the Faculty of Public Health, University of Ibadan, Nigeria. It was first tested in a pilot study (section 5.7.1.3) in Ibafo community to

ensure its *suitability*, *acceptability* and *clarity* for use within the study locations. More so, to ensure validity of the study findings, reliability and clarity of the data collection instruments, certain steps were undertaken in the study, which include: expert review; pilot study; training of data collectors; and supervision during data collection.

Validity and reliability are important aspects of research which absolutely encompass the quality of data collection instruments, data collection methods, study sample and other aspects of the research process. Validity is defined as the degree to which the study measures what it is supposed to measure (Bowling, 2009) while reliability of the instrument entails the extent to which the instrument can produce similar results in repeated investigations. The questionnaire is the first to be used to research on health care delivery, access and utilisation in the study location. It is not a standardised instrument used prior to this study.

The questionnaire begins with an introduction of the research to households and request for consent before commencing the actual administration to respondents (See section 5.8 Data Administration). The subsequent sections B to F are numbered 201 to 223, 301 to 322, 401 to 421, 501 to 514 and 601 to 623. Following the numbering format used in the Measure DHS country wide Demographic and Health Survey (DHS) and World Health Organization (WHO) surveys, the questionnaire ensured clarity and sequence in questions and numbering. Section B of the questionnaire which focused on the nature of health care delivery in emerging communities and urban slums had fourteen closed-ended questions and nine open-ended questions. Both open and closed ended questions narrowed down the broader research question on "what is the varied nature of health care delivery services in the study area". Other sections of the questionnaire followed a similar pattern and from section C to F, a total of 72 closed-ended and fourteen open-ended questions were asked.

Furthermore, the use of the questionnaire ensured anonymity, thereby allowing the interviewee to provide accurate responses without fear of being known. Sequential organisation questions on similar research objectives were grouped together except when a question functions as a filter to verify previously made responses. The transition between sections was clear and logical. This was taken quite seriously because poor question order may bias a respondent (Wimmer & Dominick, 2000). Skip instructions are used to exclude

respondents from questions that were not applicable to them. Questions were also clear, short and not double-barrelled.

The question sequence made use of the "funnel" approach where each section started off with a general question before they were narrowed down to more specific ones. This approach was adopted because the respondents become more interested with general questions, so placing them first increases the probability of completing the questionnaire (Smith, 1988). This structure was relevant because community population-based surveys of this magnitude require skill to retrieve responses.

The entire questionnaire administration was supervised by the researcher as trained research assistants visited households in the community and administered the instrument. Also taken into consideration during the administration was that some people may not be able to interpret some questions, or need the guidance of the field assistants to complete the questionnaire. Therefore, the questionnaire was administered as a structured interview schedule (SIS) because of the need for a high turnover which a self-administered questionnaire may not have guaranteed (Obono, 2008). The period of questionnaire administration varied from community to community but all data was collected between July 2013 and February 2014.

5.7.1.1 Expert review of data collection instruments and training of data collectors

Before the quantitative and qualitative data was collected, an expert review was sought to determine: clarity, suitability, and acceptability i.e. if the questions were clear; if the content in the data collection instrument was relevant to the study; and if the data collection instruments were designed to capture relevant information to answer the study objectives. A team of three experts which comprised two research supervisors and one statistician were independently consulted. According to Bowling (2009) expert review of data collection instruments is crucial to ensure quality in the research process.

As part of the process to ensure data quality, a one day training for data collectors was also undertaken by the PhD researcher, prior to undertaking the study. The training included the following: basic research steps; interviewing techniques; community entry behaviour and ethics of research which pertains to obtaining informed consent, data collection and data protection; briefing on the research study protocol; going through the content of data

collection instruments and administration of the questionnaire. Practical training sessions through peer interviews using the data collection instruments were also conducted as part of training (Lungu, 2013). In total, thirteen field assistants took part in the study.

5.7.1.2 Pilot study and supervision during data collection

A pilot study is defined as a smaller version of a proposed study conducted to refine the methodology, or broadly to develop and refine various steps in the research process (Burns & Grove, 2009 in Lungu, 2013). A pilot study was conducted as part of this study for the purpose of: determining internal validity of the data collection instrument; identifying difficulties to respondents in understanding data collection instruments either in form of ambiguous or difficult questions or flow of questions; determining how long it took to administer the data collection instrument; familiarising the researcher and data collectors with the study setting, data collection instrument in practical context and respondents; and to provide opportunity for training of data collectors (Lungu, 2013).

A pilot study was undertaken in February 2013 in a section of Ibafo community of Ogun state that was excluded in the main study. Data was collected from 50 eligible households that met the study eligibility criteria. Due to the experiences and findings of the pilot study, modifications were made to the data collection instrument in form of rephrasing questions and deleting some questions (pilot instrument was 19 pages and then reduced to 11 pages). Questions that appeared difficult to comprehend were removed while some were rephrased into simpler forms. In addition, to ensure quality checks of the instrument, the PhD researcher (**S.A.L**) ensured that all questions were responded to and identified if there were inconsistent responses. In situations where an instrument was not completely filled, field assistants were requested to return back to the household to seek further clarification and solicit for the information.

5.7.2 Key Informant Interview Guide

Key informants were selected through a purposive and convenience sampling approach as discussed in sections 5.4.3, 5.5.3 and 5.7.2 above. Key informants are unquestionably important in community-based research, providing information about the community and helping the researcher make additional contacts (McKenna & Main, 2013). The researcher

was mindful, however, to recognise the various ways in which the key informant perspectives can influence the research, as previous studies have shown that key informants' world views are likely to affect how they define community and what they perceive as community strengths, weaknesses, needs, and potential (Bernard, 1995; Houston & Sudman, 1975; Morris, 2009; Soucy, 2000; Warheit, Buhl Roger, & Joanne, 1978 in McKenna & Main, 2013).

The key informant guide (see appendix VII) was designed by the researcher. The guide focused on objectives one, three, and four of the study. The exclusion of objective two was because this objective required a general response from the community members and health care workers (see Questionnaire, IDI and FGD guide in appendices) and from the health care providers. The KII guide is comprised of six broad questions and these questions had ten further probe questions which in the course of the interviews the researcher had the opportunity to probe to understand the subject matter. Question one, two and three of the KII guide focused on exploring the nature of health care delivery and social processes by which health care services emerged and have evolved in emerging communities and urban slums of south west Nigeria. Questions four and five centred on investigating the perceptions of the health care facility services in emerging communities and urban slums of south west Nigeria. Questions six was to ascertain specific factors as social determinants of health in the study area.

Being community-engaged research, key informants from the six communities studied typically had a unique status that made them knowledgeable about happenings in major segments of the populations, but not general community or cultural experts as one would expect of a key informant in ethnography (McKenna & Main, 2013). Based on this, the key informants for the study were carefully selected. According to Morris (2009) key informants are frequently identified because they are elite privileged members of the community (Stephens, 2010), or experts that have been recognised by the community (Soucy, 2000). This status stems primarily from their knowledge about topics of interest to the researcher rather than of great importance to the community as a whole (McKenna, Iwasaki, Stewart & Main, 2011; Warheit, Buhl Roger & Joanne, 1978 in McKenna & Main, 2013). However, the use of key informant interviews for this study was to facilitate the gathering of information from a micro perspective from these social actors that reside in the communities, in order to understand the varied nature of health care delivery in the study area.

5.7.3 In-depth Interview Guide

The study made use of separate in-depth interview guides for the various categories of participants, (Public Health Officials, Community or Women Leaders, Community Health Care Providers/Workers i.e. Doctors or Nurses, Traditional Herbal Practitioners, Local Pharmacists and Chemist) across the six communities. The entire in-depth interview guides were designed by the researcher to answer the study objectives.

(a) Public Health Officers

The in-depth interview guide for public health officers is comprised of four sections focused on objectives one, two, three and four of the study. The guide has ten broad questions and these questions had sixteen probe questions which sufficed during the interview session to understand the subject matter. Question one, two and three of the guide focused on exploring how health care services are provided in the community and how these services emerged and have evolved in emerging communities and urban slums of south west Nigeria. Questions four and five were to examine their access to and utilisation of health care services in the study area. Questions six, seven, eight and nine focused on investigating their perceptions of the effectiveness of health care facility in emerging communities and urban slums of south west Nigeria, while question ten was to ascertain specific factors as social determinants of health in the study area. The various probe questions in the guide provided more insights on the major questions that were asked during the interview sessions.

(b) Community or Women leaders

For the community leaders, the in-depth interview guide used had four sections broken into objectives one, two and four of the study. The guide has ten broad questions and ten probe questions. Questions one to seven of the guide were on exploring the varied nature of health care services in the community and the social processes and factors that influenced how health care services emerged and have evolved in emerging communities and urban slums of south west Nigeria. Also some part of questions one to seven is to understand the varied nature of care available to the people in the community. Questions eight and nine were to examine their knowledge on the level of access to and utilisation of health care services in the study area. Questions ten was to ascertain specific factors as social determinants of health in the study area. The entire guide for community or women leaders is seen in the appendix X.

(c) Health Care Providers/Workers (Doctors, Nurses, Traditional Health Practitioners)

Among the health care providers within the community, the in-depth interview guide is comprised of all the study objectives divided into sections one to four. The guide is made up of eight broad questions and twelve probe questions which were used when necessary during the interview session with these participants. Questions one, two and three of the guide centred on exploring the nature of health care services in the community and how these services have emerged and evolve within emerging communities and urban slums of south west Nigeria. Question four was to examine their knowledge of the people's level of access to and utilisation of health care services in the study area. Questions five, six and seven were to investigate their perceptions of the health care delivery services offered by the health facility in emerging communities and urban slums of south west, Nigeria. Question eight was to ascertain specific factors as social determinants of health in the study area.

(d) Local Community Drug Store (Pharmacy or Chemist)

The in-depth interview guide for drug store (pharmacy or chemist) is comprised of three sections focused on objectives one, three, and four of the study, having ten broad questions and twelve probe questions to answer the study objectives. Question one, two and three of the guide focused on exploring the types of health care services they provide in the community and what else is available for the people in emerging communities and urban slums of south west Nigeria. Questions four to six are on the types of drugs they sold, which type people purchased the most and how often they did that. Questions seven, eight and nine were to find out their perceptions of the effectiveness of health care delivery services in emerging communities and urban slums of south west Nigeria, while question ten was to ascertain specific factors as social determinants of health in the study area.

In-depth interviews (IDIs) are open-ended, discovery-oriented methods that generate a greater depth of meaning for discussion issues. They are an aspect of qualitative research that focus on how individuals view and understand the world and construct meaning out of their experiences. It is usually narrative oriented and uses content analysis methods to select levels of communication content. In-depth interviews reveal a clear advantage over questionnaires because the concepts and words used by interviewer and interviewee alike can be clarified (Strauss & Corbin, 1990). The researcher's concepts are less likely to be imposed on the social world of participants; issues can be explored in greater depth; and the researcher does

not limit the responses to fixed choices. In-depth interviews utilise a grounded theory approach emphasizing the role of human actors in shaping and giving meaning to the world around them, stressing the interrelationships between conditions, meaning, and action (Strauss & Corbin, 1990).

In-depth interviews are very flexible compared to other research methods. They can be used to extract simple factual information from people. They can be used to ask people about their attitudes, their past, present and future behaviour, their motives, feelings and other emotions that cannot be observed directly. In-depth interviews can explore each question or issue in as much depth or superficiality as they wish (Haralambos & Holborn, 2004). IDIs are "focused" on informal conversations with a trained interviewer (Rubin & Rubin, 2004) or researcher.

In-depth interviews are used to carry out research into groups who might not otherwise consent to being the subject of research. From the viewpoint of some feminist and critical researchers, in-depth interviews allow close collaboration between interviewer and interviewee so that they can become partners in the research by taking a "non-hierarchical approach which avoids objectifying the participants" (Legard, Keegan, & Ward, 2003:140). That is, both the researcher and his interview participants are able to communicate freely such that participant's commitment to the research is expressed openly void of manupilation or deceit. IDIs can be used to generate hypotheses before the development of the questionnaire for quantitative surveys (Fisher, Foreit, Liang, Stoeckel, & Townsend, 2002). Hence the IDIs generate supplementary and open-ended responses to questions. All of the IDI guides used in this study covered all aspects of the study objectives and the themes are presented in chapter seven.

5.7.4 Focus Group Discussions Guide

A focus group is a form of qualitative research in which a group of people are asked about their perceptions, opinions, beliefs and attitudes towards a product, service, concept, advertisement, idea, or packaging (Henderson, 2009). Questions are asked in an interactive group setting where participants are free to talk with other group members. Focus group discussion produces data and insights that would be less accessible without interaction found in a group setting—listening to others' verbalized experiences stimulates memories, ideas, and experiences in participants. This is also known as the group effect where group members

engage in "a kind of 'chaining' or 'cascading' effect; talk links to, or tumbles out of, the topics and expressions preceding it" (Lindlof & Taylor, 2002:182).

Group members discover a common language to describe similar experiences. This enables the capture of a form of "native language" or "vernacular speech" to understand the situation. Focus groups also provide an opportunity for disclosure among similar others in a setting where participants are validated. For example, in the context of workplace bullying, targeted employees often find themselves in situations where they experience lack of voice and feelings of isolation. Use of focus groups to study workplace bullying therefore serves as both an efficacious and ethical means of collecting data (Tracy, Lutgen-Sandvik, & Alberts, 2006). Focus group discussions have been applied extensively in health research within developed countries and developing countries. Focus group discussions remain a useful research method in the field of health and medicine: they do not discriminate against people who cannot read or write and they can encourage participation from people reluctant to be interviewed on their own or who feel they have nothing to say (Kitzinger, 1995).

The FGD guide used for the study among community residents was designed to capture every aspect of the study objectives (section 4.2). The FGD guide is divided into sections one to four. The guide is made up of twenty-one specific questions to elicit various responses from the participants. Questions one to five of the guide centred on exploring the nature of health care services in the community and how these services have emerged and evolve in emerging communities and urban slums of south west, Nigeria. Questions six to ten were to examine the people's access to and utilisation of health care services in the study area. Questions 11 to 15 were to know what were to investigate their perceptions of the effectiveness of current health care delivery services in operation within their respective communities. Questions 16 to 21 were to ascertain specific factors as social determinants of health in the study area.

Focus group discussion is a popular method for assessing health education messages and examining public understanding of illness and of health behaviours. More so, they are widely used to examine people's experiences of disease and of health services, and are an effective technique for exploring the attitudes and needs of staff. The idea behind the use of the focus group method is that group processes can help people to explore and clarify their views in ways that would be less easily accessible in a one to one interview (Kitzinger, 1995), which with its application in this study contributes to provide a rich context of the community residents' social reality.

5.8 Data Collection and Administration

5.8.1 Questionnaire

The questionnaire was administered using field assistants who were recruited from the communities and trained on how to administer the instrument to ensure optimum data collection. The researcher also participated in questionnaire administration to households, but mainly supervised the whole process. The entire period of data collection was from July 2013 to February 2014 across the six communities in Lagos and Ogun State of Nigeria.

5.8.1.1 Recruitment of data collectors: The recruitment of field assistants began with visits to the communities from September 2012 to June 2013. The researcher during this period made contact with several people. The researcher visited community secondary schools to meet with staff and informed them of the research. The purpose of the visit was to meet with people who possess at least a secondary level of education. Most of the staff the researcher met had University degrees and understood the reason for conducting research, having done such before earning their degrees.

However, through school visits contacts were made with the help of some of the teachers who informed friends that were unemployed or engaged in a part-time job. The researcher was able to meet with University graduates who were willing to participate in the study and work as field assistants. The major criterion for participation was that field assistants must have at least a university diploma or degree based on experience of student project writing. Afterwards, the researcher conducted an assessment of interested participants and selected those who participated in the study as field assistants.

5.8.1.2 Training of data collectors: This lasted between one and two hours across the various communities where the study took place within a day. Field assistants were told about the importance of getting respondents to complete the instruments. They were told the logical sequence of the questions and why some questions were being asked. All this was to give field assistants a good understanding of the instrument and the objective of each section.

5.8.1.3 Questionnaire administration: The questionnaire administration varied across the communities. In some communities such as Ajegunle and Abaranje in Lagos state, questionnaire administration lasted for between five and seven days. In other communities

Ibafo, Mowe and Magboro in Ogun state, the questionnaire administration varied from six to seven days. This was based on the nature of the questionnaire with a total of 120 variables, which required between 30 and 40 minutes to complete. On some occasions, where the questionnaire was not completed, the field assistants had to return the following day to the respondents to complete the questionnaire. Unfortunately, in Makoko community of Lagos state, the researcher was unable to retrieve the 135 questionnaires but was only able to retrieve 80 of which 14 were not properly filled out and therefore excluded from final data analysis. Within the period from July 2013 to February 2014, the household questionnaire was administered and retrieved. The researcher also conducted interviews and focus group discussions in the study locations between these periods.

5.8.1.4 Remuneration: Field assistants were remunerated for the work based on agreements reached between them and the researcher. The minimum paid was ₦200 (€1) per questionnaire, while the maximum amount paid was ₦250 (€1.25 cents) per questionnaire.

5.8.2 In-depth Interviews and Key informant interviews

In-depth interviews (IDI) and key informant interviews (KII) were conducted by the researcher with the participants. Initial visits to the study locations began from September 2012. The IDI and KII across the different communities were unique in their own way as the respondents were different from one another. Interviewing took place from July 2013 to February 2014. Participants were purposively selected based on their roles within the communities, and their scheduled days of interviews varied. This was based on their availability and convenience. The researcher did a lot of travelling across the various communities and the major means of communication was through mobile phones to set up interview dates and place of interview. The IDI and KII lasted between 15 and 45 minutes. On no occasion were any of the interviews postponed. The constraints faced by the researcher in conducting the IDI and KII are highlighted in chapter seven.

5.8.3 Focus Group Discussions

Similar to the KII and IDI the researcher had to schedule meeting dates that were convenient for all the participants. Among the qualitative methods used the FGD was the most challenging as on many occasions when dates and time had been agreed, they were eventually cancelled because the number of participants was not sufficient to proceed. FGDs

were held between July 2013 and February 2014. No FDG was held in Makoko community as a result of the challenges encountered in organising the discussion. All the constraints and limitations encountered in the field are highlighted in chapter eight.

Figure 5.3 Data collection conducted concurrently

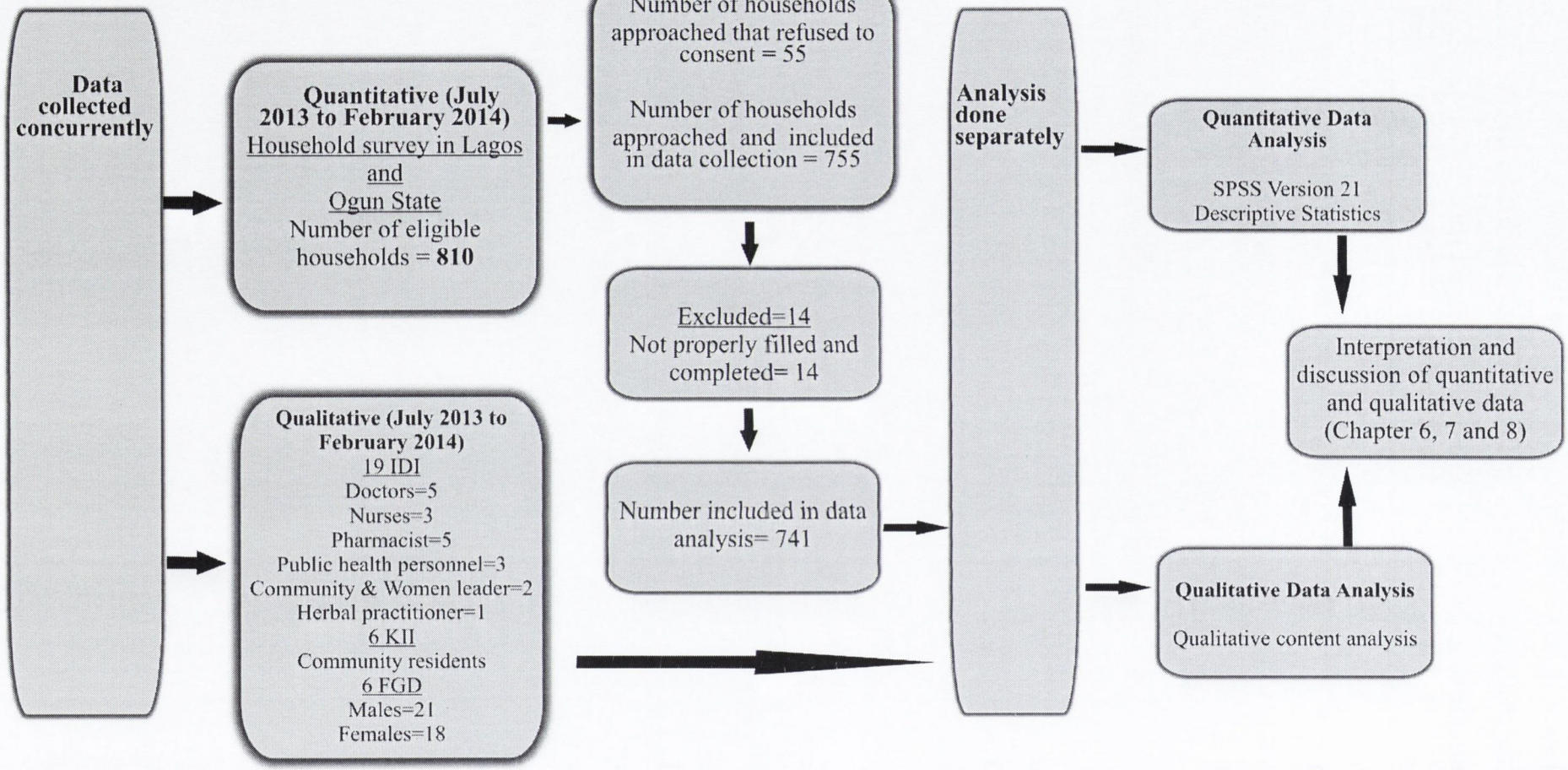
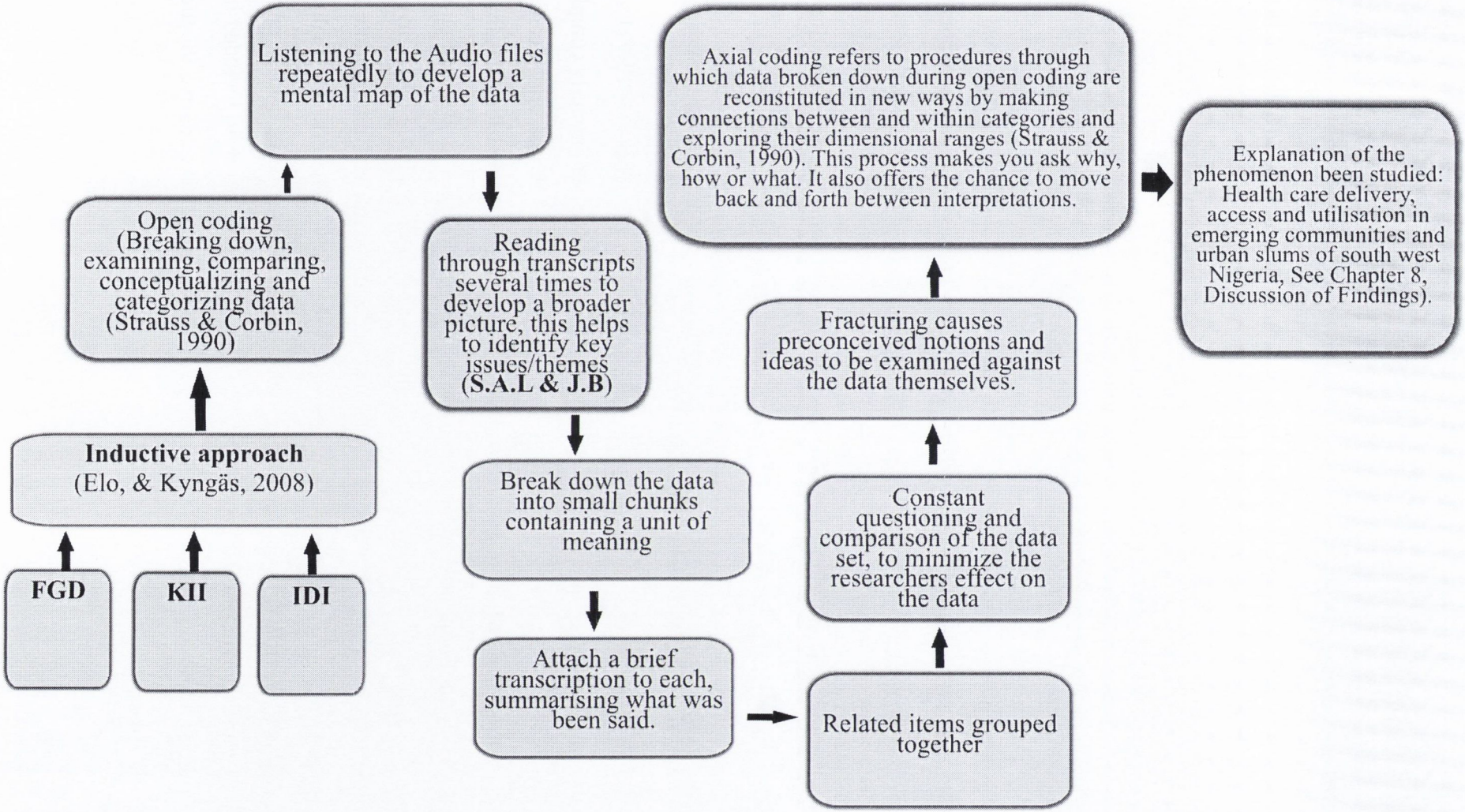


Figure 5.4 Analytical Strategy for the Qualitative Data



Source: Author, 2014

The qualitative content analysis (inductive approach) was used for this study to analyse the data (FGD, KII and IDI). This process include open coding, creating categories (Elo, & Kyngäs, 2008) for which each theme was grouped. The first step was through open coding (breaking down, examining, comparing, conceptualising and categorising data) (Strauss & Corbin, 1990), this involved listening to the audio files repeatedly to develop a mental map of the data and issues raised. This was followed by reading through transcripts several times to develop a broader picture, this helps to identify key issues. Other steps used for the qualitative content analysis is seen in figure 5.4 above.

5.9 Data Collection Conducted Concurrently

Both the quantitative and qualitative data were collected concurrently. This was due to several constraints (See section 8.3) such as the delay in obtaining ethical approval from UI/UCH ethics committee at the University of Ibadan. In addition, the delay in obtaining funds for the (data collection) fieldwork. The researcher was then left with a short period of time to collect the data based on the calendar of International Doctorate in Global Health (Indigo) programme. This led to the need to collect both the quantitative and qualitative data concurrently.

5.10 Data Analysis (Quantitative and Qualitative)

Data analysis includes the use of the Statistical Package for Social Sciences (SPSSv21). The questionnaire was first scrutinised to ensure they were properly filled. All properly completed questionnaires were inputted into the statistical software and then edited and cleaned to eliminate distortions. Descriptive statistical techniques have been implored for analysing the quantitative data in the form of frequency tables and simple percentages for the demographic characteristics and some of the study objectives. The data has been analysed into Univariate form (frequencies), bivariate form (cross tabulations and chi-square) and multivariate form (binary logistic regression) to answer the objectives of the study. The primary qualitative data (IDI, KII and FGD) have been transcribed and coded using qualitative content analysis and categorised into themes as seen in section 7.7. All the 31 trancripts were included in the final analyses and a triangulation of the qualitative data was undertaken to derive the themes from the study.

5.11 Ethics Approval Letters

Formally, the study first sought ethics approval from the University of Ibadan ethics committee based at the University College Hospital known as UI-UCH committee. After approval was obtained, then ethics approval was sought from Health Policy Management/Centre for Global Health ethics committee of Trinity College Dublin, Ireland. These ethics approval were shown to the participating member of household to assure them of the credibility of the research, while other participants of the IDIs, KIIs and FGDs were shown the same ethics approvals. These ethics approval as seen in Appendix I and II informed all participants that the study was majorly for academic purpose.

5.12 Informed Consent Forms and Participant Information Leaflet

All participants in the research were presented with an informed consent form to sign and acknowledge their willingness to participate in the study. The participant information leaflet was given to each participant. This document gave further details about the study, its intended aim and objectives. The leaflet also provided contact information for participants who chose to clarify with contact persons such as the primary supervisor based at the University of Ibadan. Both the informed consent forms and participant information leaflet is seen in Appendix III, IV and V.

CHAPTER SIX

QUANTITATIVE DATA PRESENTATION AND INTERPRETATION

6.1 INTRODUCTION

In this chapter, analysis, presentation, and interpretation of the data collected from the field work are carried out. This chapter is divided into two major sections on socio-demographic characteristics of respondents and outcomes from the objectives of the study. A total of 755 respondents participated in the study from the proposed 810 respondents. Seven hundred and forty one (741) of them completed the questionnaires.

6.2 SOCIO-DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS

This section deals with the quantitative socio-demographic characteristics of the respondents. For the quantitative data these include gender, age, religion, highest educational qualifications, ethnicity, marital status, occupation and income.

Table 6.2.1 Socio-Demographic Characteristics of the Respondents by gender, age, and religion

Location	Frequency (%)
Abaranje	135 (18.2)
Ajegunle	135 (18.2)
Ibafo	135 (18.2)
Magboro	135 (18.2)
Mowe	135 (18.2)
Makoko	66 (8.9)
Total	**741 (100)**
Gender	
Male	387 (52.2)
Female	343 (46.3)
No response	11 (1.5)
Total	**741 (100)**
Age	
16-25 years	265 (35.7)
26-40 years	372 (50.1)
41 years and above	97 (13.1)
No response	7 (0.9)
Total	**741 (100)**
Religion	
Christian	544 (73.4)
Muslims	176 (23.8)
Traditional	13 (1.8)
Others	6 (0.8)
Total	**741 (100)**

Table 6.2.1 above shows the socio-demographic profile of the respondents across the 6 communities surveyed. The findings reveal that respondents were evenly surveyed; 135(18.2%) in 5 communities namely Abaranje, Ajegunle, Ibafo, Magboro, and Mowe, while in Makoko community, an urban slum in Lagos, only 66(8.9%) of the respondents completed the survey instrument (See section 8.2.1). From the selected emerging communities and urban slums of south west Nigeria a total of 741 respondents were surveyed as seen in the table above. On the gender of the respondents, 52.2% were males and 46.3% were females.

On the age of the respondents, the majority of the respondents, 50.1%, were between ages 26 and 40 years old, while 35.7% of the participants were between ages 16 and 25 years old and 13.1% were aged 41 years and older across the six communities. As regards the religious affiliation of the participants, the study showed that majority of the participants 73.4%, were Christians as opposed to 23.8% who were Muslims.

Table 6.2.2 Socio-demographic characteristics of the respondents by highest completed educational qualifications, ethnicity, marital status and occupation

Education	**Frequency (%)**
Tertiary Institution	337 (45.5)
Secondary School	358 (48.3)
Primary School	23 (3.1)
Non formal education	18 (2.4)
No response	5 (0.7)
Total	**741 (100)**
Ethnicity	
Yoruba	399 (53.8)
Igbo	201 (27.1)
Other ethnic groups	96 (13.0)
Hausa	26 (3.5)
No response	19 (2.6)
Total	**741 (100)**
Marital Status	
Single	382 (51.6)
Married	320 (43.2)
Divorced	13 (1.8)
Cohabiting	12 (1.8)
Widowed	8 (1.1)
No response	6 (0.8)
Total	**741 (100)**
Occupation	
Formal employment	123 (16.6)
Informal employment	376 (50.7)
Not employed	133 (17.9)
Unemployed	3 (0.4)
No response	106 (14.3)
Total	**741**

Table 6.2.3 Socio-Demographic Characteristics of the Respondents income

Income (Monthly)	Frequency (%)
Less than ₦15, 000 (€75)	180 (24.3)
₦15, 000 - ₦30, 000 (€75-150)	229 (30.9)
₦31, 000 - ₦54, 000 (€150-273)	123 (16.6)
₦55, 000 - ₦74, 000	39 (5.3)
₦95, 000 and above	29 (3.9)
₦75, 000 - ₦94, 000	12 (1.6)
Income varies and no income	6 (0.8)
No response	123 (16.6)
Total	**741**

Findings from this study, the highest educational qualification of the respondents show that majority have been educated beyond secondary schooling and are still being educated. A total of 48.3% (n=358) have a secondary school education; while another 45.5% (n=337) possess a tertiary level of education. According to the ethnicity of the respondents, over 50% of the participants (53.8%, n=399) are Yoruba. The table further reveals that (51.6%, n=382) were single and (43.2%, n=320) were married. Both single and married respondents constitutes the majority (94.8%, n=702) of the participants in the study.

Respondents engaged in various forms of occupation as seen in table 6.2.2, are informally employed, while (16.6%, n=123) are formally. Disparities exist as seen in the table on the monthly income of participants. The study shows that (30%, n=229) earn between ₦15, 000 to ₦30, 000 (€75 to €150) per month, while (24.3%, n=180) earn less than ₦15, 000 (€75) monthly. Furthermore, (16.6%, n=123) earn between ₦31, 000 to ₦54, 000 (€150 to €273).

6.3 OBJECTIVE ONE

EXPLORE (THE NATURE OF HEALTH CARE DELIVERY AND) THE SOCIAL PROCESSES BY WHICH HEALTH CARE SERVICES EVOLVE IN EMERGING COMMUNITIES AND URBAN SLUMS OF SOUTH WEST NIGERIA.

The following tables below are used to depict the nature of health care delivery and the social processes by which health care services have emerged in emerging communities and urban slums of south west Nigeria.

Table 6.3.1: What are the various sources of health care services in the community?

	Health care facility	Drug store (pharmacy or chemist)	Spiritual or folk healer	Drug vendor	Total	df	p-value
Abaranje	71	33	5	6	115	15	<.05
	(61.7%)	(28.7%)	(4.3%)	(5.2%)	(100.0%)		
Ajegunle	44	38	2	0	84		
	(52.4%)	(45.2%)	(2.4%)	(0.0%)	(100.0%)		
Ibafo	58	58	8	1	125		
	(46.4%)	(46.4%)	(6.4%)	(0.8%)	(100.0%)		
Magboro	41	65	7	9	122		
	(33.6%)	(53.3%)	(5.7%)	(7.4%)	(100.0%)		
Makoko	37	11	1	3	52		
	(71.2%)	(21.2%)	(1.9%)	(5.8%)	(100.0%)		
Mowe	49	45	4	6	104		
	(47.1%)	(43.3%)	(3.8%)	(5.8%)	(100.0%)		
Total	**300**	**250**	**27**	**25**	**602**		
	(49.8%)	**(41.5%)**	**(4.5%)**	**(4.2%)**	**(100.0%)**		

Table 6.3.1 above shows the distribution of respondents according to the various sources of health care services within the community. Participants were given one choice as seen in the above table which reveals that 300(49.8%) say that a health care facility (public/private/faith-based/community) is one source, while, 250(41.5%) of the participants say that a drug store (pharmacy or chemist) is a source. Just 27(4.5%) say that a spiritual or folk healer is a source and 25(4.2%) said a drug vendor is a source. The table 6.3.1 shows a significant difference across the communities on respondent's opinions on the various sources of health care services available in the community.

Table 6.3.2: For how long have these sources of health care services been working to treat sicknesses and disease in the community?

	Less than 1 week	2 weeks to 4 weeks	1 to 6 months	7 to 12 months	1 to 2 years	2 to 5 years	5 years & above	Total	df	p-value
Abaranje	17	9	11	2	6	13	60	118	30	<.05
	(14.4%)	(7.6%)	(9.3%)	(1.7%)	(5.1%)	(11.0%)	(50.8%)	(100.0%)		
Ajegunle	5	4	0	2	3	14	96	124		
	(4.0%)	(3.2%)	(0.0%)	(1.6%)	(2.4%)	(11.3%)	(77.4%)	(100.0%)		
Ibafo	7	19	10	5	6	11	72	130		
	(5.4%)	(14.6%)	(7.7%)	(3.8%)	(4.6%)	(8.5%)	(55.4%)	(100.0%)		
Magboro	13	2	16	9	25	20	47	132		
	(9.8%)	(1.5%)	(12.1%)	(6.8%)	(18.9%)	(15.2%)	(35.6%)	(100.0%)		
Makoko	9	5	1	2	3	8	30	58		
	(15.5%)	(8.6%)	(1.7%)	(3.4%)	(5.2%)	(13.8%)	(51.7%)	(100.0%)		
Mowe	18	8	15	8	7	21	47	124		
	(14.5%)	(6.5%)	(12.1%)	(6.5%)	(5.6%)	(16.9%)	(37.9%)	(100.0%)		
Total	**69**	**47**	**53**	**28**	**50**	**87**	**352**	**686**		
	(10.1%)	**(6.9%)**	**(7.7%)**	**(4.1%)**	**(7.3%)**	**(12.7%)**	**(51.3%)**	**(100.0%)**		

Table 6.3.2 reveals that respondents think the various sources of health care services have been in operation from between a week to above 5 years. The table shows that 352(51.3%) say that these services have been in operation for over 5 years. Other responses shows that 87(12.7%) say these services have been in operation from between 2 years to 5 years, while 53(7.7%) said its been in operation from between 7 months and 12 months. Other varied responses are seen in the above table. The table 6.3.2 shows a significant difference across the communities on respondent's opinion.

Table 6.3.3: How is treatment administered when a household member falls sick but does not go anywhere for treatment?

	Self medication	Household prescribed medication	Neighbour prescribed medication	Community prescribed medication	Total	df	p-value
Abaranje	71	23	10	12	116	15	.079
	(61.2%)	(19.8%)	(8.6%)	(10.3%)	(100.0%)		
Ajegunle	62	36	1	4	103		
	(60.2%)	(35.0%)	(1.0%)	(3.9%)	(100.0%)		
Ibafo	93	33	5	4	135		
	(68.9%)	(24.4%)	(3.7%)	(3.0%)	(100.0%)		
Magboro	85	28	11	7	131		
	(64.9%)	(21.4%)	(8.4%)	(5.3%)	(100.0%)		
Makoko	34	13	3	5	55		
	(61.8%)	(23.6%)	(5.5%)	(9.1%)	(100.0%)		
Mowe	82	30	7	8	127		
	(64.6%)	(23.6%)	(5.5%)	(6.3%)	(100.0%)		
Total	**427**	**163**	**37**	**40**	**667**		
	(64.0%)	**(24.4%)**	**(5.5%)**	**(6.0%)**	**(100.0%)**		

Table 6.3.3 indicates that respondents do administer treatment to a fellow household member when they do not visit a health care provider for diagnosis or treatment across the 6 communities. The table 6.3.3 shows that 427(64%) of respondents practice self medication for treatment of a household member when sick. More so, 163(24.4%) of respondents administer treatment to a household member based on a collective decision of members of the household. Other respondents either consult members of their immediate neighbourhood or

within the community for treatment of their household member when they fall sick. There is no significant difference across the communities.

Table 6.3.4: What kind of medicine do you use?

	Traditional medicine	Orthodox medicine	Both (TM & OM)	Total	df	p-value
Abaranje	14	72	47	133	10	.143
	(10.5%)	(54.1%)	(35.3%)	(100.0%)		
Ajegunle	7	65	57	129		
	(5.4%)	(50.4%)	(44.2%)	(100.0%)		
Ibafo	11	79	44	134		
	(8.2%)	(59.0%)	(32.8%)	(100.0%)		
Magboro	15	75	41	131		
	(11.5%)	(57.3%)	(31.3%)	(100.0%)		
Makoko	6	29	30	65		
	(9.2%)	(44.6%)	(46.2%)	(100.0%)		
Mowe	6	80	44	130		
	(4.6%)	(61.5%)	(33.8%)	(100.0%)		
Total	**59**	**400**	**263**	**722**		
	(8.2%)	**(55.4%)**	**(36.4%)**	**(100.0%)**		

Table 6.3.4 states that (55.4%) 400 of 722 respondents take orthodox medicine as a form of treatment when the need arises, while (36.4%) 263 of 722 respondents take both orthodox medicine and traditional medicine together, and only (8.2%) 59 of 722 respondents make use of just traditional medicine. This implies that their preference for the use of both traditional and modern medicine across emerging communities and urban slums of south west Nigeria despite the use of orthodox medicine. There is no significant difference across the communities.

Table 6.3.5: Is there a difference in gender preference for orthodox medicine to traditional medicine?

	Traditional medicine	Orthodox medicine	Total	X^2	df	p-value
Male	98 (26.6%)	270 (73.4%)	368 (100.0%)	0.562	1	0.337
Female	91 (28.6%)	227 (71.4%)	318 (100.0%)			
Total	**189 (27.6%)**	**497 (72.4%)**	**686 (100.0%)**			

Table 6.3.5 indicates that there is no significant difference between males and female respondents in terms of their preference for orthodox medicine to traditional medicine or herbs. As seen in the table 6.3.5 both males and females 427 (72.4%) prefer orthodox medicine to traditional medicine 189 (27.6%).

Table 6.3.6 Binary logistic regression showing adjusted odds ratio of socio-demographic factors that are independently associated with preference for orthodox medicine to traditional medicine

Socio-demographic factors	Sig	Preference for orthodox medicine to traditional medicine AOR	95% CI
Gender			
Male	.841	.959	.640 to 1.439
Female			
Age			
Less than 31 years old	.000	2.496	1.548 to 4.024
More than 31 years old			
Religion			
Not affiliated with Christianity	.000	2.587	1.670 to 4.007
Affiliated with Christianity			
Education			
Primary school or less	.000	5.947	2.793 to 12.660
Secondary school or higher			
Ethnicity			
Not from a Yoruba tribe	.375	1.211	.794 to 1.848
From a Yoruba tribe			
Marital Status			
Not yet married	.663	1.109	.697 to 1.764
Married, or in a relationship			
Income			
Earn less than N54,000	.413	.772	.416 to 1.433
Earn more than N54,000			

Table 6.3.6 reveals that the following socio-demographic factors associated with whether people prefer to use orthodox medicine to traditional medicine. Gender (OR=0.95, 95% C.I=0.64-1.43), *Age (OR=2.49, 95% C.I=1.54-4.02)*, *Religion (OR=2.58, 95% C.I=1.67-4.00)*, *Education (OR=5.94, 95% C.I=2.79-12.66)*, Ethnicity (OR=1.21, 95% C.I=0.79-1.84), Marital Status (OR=1.10, 95% C.I=0.69-1.76) and Income (OR=0.77, 95% C.I=0.41-1.43). Only Age, Religion and Education are significantly associated with whether people prefer to use orthodox medicine to traditional medicine.

Table 6.3.7: Is there a health facility located in this community?

	Yes	No	Total	df	p-value
Abaranje	127	5	132		
	(96.2%)	(3.8%)	(100.0%)	5	.000
Ajegunle	126	3	129		
	(97.7%)	(2.3%)	(100.0%)		
Ibafo	127	5	132		
	(96.2%)	(3.8%)	(100.0%)		
Magboro	113	18	131		
	(86.3%)	(13.7%)	(100.0%)		
Makoko	57	5	62		
	(91.9%)	(8.1%)	(100.0%)		
Mowe	117	17	134		
	(87.3%)	(12.7%)	(100.0%)		
Total	**667**	**53**	**720**		
	(92.6%)	**(7.4%)**	**(100.0%)**		

Respondents were asked to choose one option on whether or not there was a health facility in their community. Table 6.3.7 reveals that a total of 667 (92.6%) of the respondents across the six communities state that a health facility can be found in their community. Only 720 of the respondents answered the question. These health facilities vary as seen in the next table. The table 6.3.7 shows a significant difference across the communities on respondent's opinion.

Table 6.3.8: What type of health care facility is it?

	Government health facility	Religious health facility	Private health facility	Community health facility	**Total**	**df**	**p-va**
Abaranje	47	13	40	27	127	15	<.
	(37.0%)	(10.2%)	(31.5%)	(21.3%)	(100.0%)		
Ajegunle	44	9	55	18	126		
	(34.9%)	(7.1%)	(43.7%)	(14.3%)	(100.0%)		
Ibafo	38	8	74	7	127		
	(29.9%)	(6.3%)	(58.3%)	(5.5%)	(100.0%)		
Magboro	36	19	44	14	113		
	(31.9%)	(16.8%)	(38.9%)	(12.4%)	(100.0%)		
Makoko	18	8	24	7	57		
	(31.6%)	(14.0%)	(42.1%)	(12.3%)	(100.0%)		
Mowe	41	14	49	13	117		
	(35.0%)	(12.0%)	(41.9%)	(11.1%)	(100.0%)		
Total	**224**	**71**	**286**	**86**	**667**		
	(33.6%)	**(10.6%)**	**(42.9%)**	**(12.9%)**	**(100.0%)**		

Table 6.3.8 shows that 286 (42.9%) of the respondents across the six communities say that a private health care facility can be found in the community, while 224 (33.6%) say that a government health facility is available in the community. A faith-based health facility and community health facility is also available in the communities. The awareness level of respondents varied from one community to another. But as seen in the table 6.3.8 most of the respondents say that a private health facility is present in their community. This was to ascertain the awareness of the respondents on the availability of various types of health facility. The table 6.3.8 shows a significant difference across the communities on respondent's opinion.

Table 6.3.9: What led to the establishment a healthcare facility? Some factors led to the establishment of a health facility within the communities.

	Lack of health facility	Disease outbreak	Community protest	Visit of the LG chairman	Visit of the governor	Others specify	Total	df	p-value
Abaranje	69	29	9	11	2	11	131	25	<.05
	(52.7%)	(22.1%)	(6.9%)	(8.4%)	(1.5%)	(8.4%)	(100.0%)		
Ajegunle	85	7	5	3	11	4	115		
	(73.9%)	(6.1%)	(4.3%)	(2.6%)	(9.6%)	(3.5%)	(100.0%)		
Ibafo	106	6	5	4	2	4	127		
	(83.5%)	(4.7%)	(3.9%)	(3.1%)	(1.6%)	(3.1%)	(100.0%)		
Magboro	91	6	13	6	7	6	129		
	(70.5%)	(4.7%)	(10.1%)	(4.7%)	(5.4%)	(4.7%)	(100.0%)		
Makoko	36	11	4	4	0	8	63		
	(57.1%)	(17.5%)	(6.3%)	(6.3%)	(0.0%)	(12.7%)	(100.0%)		
Mowe	84	7	11	1	16	3	122		
	(68.9%)	(5.7%)	(9.0%)	(0.8%)	(13.1%)	(2.5%)	(100.0%)		
Total	**471**	**66**	**47**	**29**	**38**	**36**	**687**		
	(68.6%)	**(9.6%)**	**(6.8%)**	**(4.2%)**	**(5.5%)**	**(5.2%)**	**(100.0%)**		

Table 6.3.9 states that participants were given one choice and 471(68.6%) of 687 respondents answered the question were of the opinion that lack of a health facility led to the establishment of one in the community. As seen in the table 6.3.9 other respondents agreed that spread of disease, a community request for a health facility, visit of the local government chairman and the state governor led to the establishment of the health facility. Only 36(5.2%) of the respondents gave other responses which they specified as the presence of a faith-based organisation within the community led to the establishment of the health facility. There is a significant difference across the communities on respondent's opinion as seen in the table 6.3.9.

Table 6.3.10: What were the social processes and occurrences that led to the establishment of the health facility in the community?

Social processes that led to the establishment of the health facility	Yes	No	No response	Total
Cultural festival	128(17.3%)	576(77.7%)	37(5.0%)	741(100%)
Meetings with community members	341(46.0%)	326(44.0%)	74(10.0%)	741(100%)
Community engagement in the decision making process	408(55.1%)	291(39.3%)	42(5.7%)	741(100%)
Incidence and prevalence of a communicable disease	205(27.7%)	498(67.2%)	38(5.1%)	741(100%)
Death of a prominent community member	140(18.9%)	557(75.2%)	44(5.9%)	741(100%)

Table 6.3.10 from questions 317, 318 to 321 of the survey instrument shows the various social processes and occurrences that led to the establishment of the health facility in the community. The table reveals that respondents are of the view that meetings held with community members and community engagement in the decision making process led to the establishment of the health facility, while the occurrence of a cultural festival, incidence and prevalence of a communicable disease, and the death of a prominent community member did not significantly contribute to the establishment of a health facility in the community. The following social processes for the quantitative instrument where decided upon based on literature review, outcome of the pilot study and the researcher's interaction with the communities were the study took.

6.4 OBJECTIVE TWO

EXAMINE PEOPLE'S ACCESS TO AND UTILISATION OF HEALTH CARE SERVICES IN THE STUDY AREA.

The tables in this section are used to explain people's access to and utilisation of health care services that are available to them in emerging communities and urban slums of south west Nigeria

Table 6.4.1: How do you and your household get to the health facility in the community?

	Motorcycle	Walk	Buses	Cars	Bicycle	Taxis	Lorry	Total	df	p-value
Abaranje	16	49	20	17	8	4	4	118		
	(13.6%)	(41.5%)	(16.9%)	(14.4%)	(6.8%)	(3.4%)	(3.4%)	(100.0%)	30	<.05
Ajegunle	18	12	64	12	4	3	0	113		
	(15.9%)	(10.6%)	(55.6%)	(10.6%)	(3.5%)	(2.7%)	(0.0%)	(100.0%)		
Ibafo	66	32	0	4	12	0	1	115		
	(57.4%)	(27.8%)	(0.0%)	(3.5%)	(10.4%)	(0.0%)	(0.9%)	(100.0%)		
Magboro	66	11	3	21	3	7	0	111		
	(59.5%)	(9.9%)	(2.7%)	(18.9%)	(2.7%)	(6.3%)	(0.0%)	(100.0%)		
Makoko	5	20	13	9	3	2	4	56		
	(8.9%)	(35.7%)	(23.2%)	(16.1%)	(5.4%)	(3.6%)	(7.1%)	(100.0%)		
Mowe	58	6	2	30	6	2	1	105		
	(55.2%)	(5.7%)	(1.9%)	(28.6%)	(5.7%)	(1.9%)	(1.0%)	(100.0%)		
Total	**229**	**130**	**102**	**93**	**36**	**18**	**10**	**618**		
	(37.1%)	**(21.0%)**	**(16.5%)**	**(37.1%)**	**(5.8%)**	**(2.9%)**	**(1.6%)**	**(100.0%)**		

Respondents were asked to make one choice on how they and their household get to the health facility. Table 6.4.1 reveals that 37.1% of the respondents make use of motorcycles popularly known as "Okada" to get to the community health facility, while 21.0% of the respondents walk down to the health facility in their community. Responses were based on the distance to the health facility and there is a significant difference across the six communities.

Table 6.4.2: What are the various factors that limit people's access to the health care services in the community?

Factors that limits access to the health care services in the community	Yes	No	No response	Total
Inadequate information	503(67.9%)	205(27.7%)	33(4.5%)	741(100%)
Income/earning	220(29.7%)	465(62.8%)	56(7.6%)	741(100%)
Family decision on why	159(21.5%)	564(76.1%)	18(2.4%)	741(100%)
Family decision on when	162(21.9%)	474(64.0%)	105(14.2%)	741(100%)
Family decision on where	177(23.9%)	449(60.6%)	115(15.5%)	741(100%)
Geographical location	210(28.3%)	510(68.8%)	21(2.8%)	741(100%)
Cultural beliefs	169(22.8%)	552(74.5%)	20(2.7%)	741(100%)

Table 6.4.2 from questions 408, 411-414 of the survey instrument shows that various factors limit people's to access health care services in the community. Not having adequate information 67.9% is a major factor that can limit their access to a health service in the community even where such a service does exist. This is a vital factor as seen in the above table.

Table 6.4.3: Do you utilise the services offered at the health facility within the community?

	Yes	No	Total	df	p-value
Abaranje	79	37	116		
	(68.1%)	(31.9%)	(100.0%)	5	<.05
Ajegunle	87	34	121		
	(71.9%)	(28.1%)	(100.0%)		
Ibafo	91	43	134		
	(67.9%)	(32.1%)	(100.0%)		
Magboro	46	85	131		
	(35.1%)	(64.9%)	(100.0%)		
Makoko	36	19	55		
	(65.5%)	(34.5%)	(100.0%)		
Mowe	66	59	125		
	(52.8%)	(47.2%)	(100.0%)		
Total	**405**	**277**	**682**		
	(59.4%)	**(40.6%)**	**(100.0%)**		

Table 6.4.3 above reveals that over (59.4%) of respondents stated that they utilise a health facility in their community while (40.6%) said that they do not use the health facility.

Table 6.4.4: Why do you utilise the services offered at the health facility in the community?

Reasons for utilising the health facility	Frequency (%)
Because it is affordable	245 (33.1%)
Because it is close to me	61 (8.2%)
Just for medical check up	40 (5.4%)
Immunization and sometimes for treatment	34 (4.6%)
Because it is better than using traditional	17 (2.3%)
For ante-natal and post-natal services	8 (1.1%)
Total	**405 (100.0%)**

Table 6.4.4 shows the various reasons why people utilise the services at the health facility within their community. A total of 245(33.1%) do so because it is affordable for them. Other

respondents utilise it because it is close to them 61(8.2%). Some other utilise the health care facility just for medical check-up 40(5.4%), some of them for immunization and sometimes treatment 34(4.6%), others because it is better than using traditional medicine 17(2.3%), and the remaining make use of the community health care facility for ante-natal and post-natal services 8(1.1%).

Table 6.4.5: Age difference in the utilisation of the health facility?

	Yes	No	Total	X^2	df	p-value
16-25 years	112	120	232	20.731	2	0.000
	(48.3%)	(51.7%)	(100.0%)			
26-40 years	237	116	353			
	(67.1%)	(32.9%)	(100.0%)			
41 years and	53	38	91			
above	(58.2%)	(41.8%)	(100.0%)			
Total	**402**	**274**	**676**			
	(59.5%)	**(40.5%)**	**(100.0%)**			

Table 6.4.5 indicates that there is a significant difference in the age of the respondents and their utilisation of the health facility. Across their age groups those between 26-40 years showed more willingness 237(67.1%) to utilise the health facility compared to respondents 112(48.3%) between 16-25years and 53(58.2%) that are ages 41 years and older.

Table 6.4.6: Is there a gender difference in the utilisation of the health facility in the community?

	Yes	No	Total	X^2	df	p-value
Male	207	153	360	0.710	1	0.399
	(57.5%)	(42.5%)	(100.0%)			
Female	190	123	313			
	(60.7%)	(39.3%)	(100.0%)			
Total	**397**	**276**	**673**			
	(59.0%)	**(41.0%)**	**(100.0%)**			

The table 6.3.6 indicates that there is no significant difference between males and female respondents in terms of their utilisation of the health facility in the community.

Table 6.4.7: Do the following factors listed below affects people's utilisation of the health facility?

Factors that affects the utilisation of health facility	Yes	No	No response	Total
Lack of equipment	321(43.3%)	162(21.9%)	258(34.8%)	741(100%)
Knowledge and skills of the health care workers	446(60.2%)	246(33.2%)	49(6.6%)	741(100%)
Attitude of the health care workers	426(57.5%)	282(38.1%)	33(4.5%)	741(100%)

Table 6.4.7 from questions 417, 418 and 420 of the survey instrument show that various factors affect the utilisation of health facility in emerging communities and urban slums of south west Nigeria. The table reveals that respondents are of the view that lack of equipment (43.3%), knowledge and skills of health care workers (60.2%), and attitude of health care workers (57.5%) all affects or determines whether they will utilise the services at the health care facility within their communities.

Table 6.4.8 Binary logistic regression showing adjusted odds ratio of factors such as geographical location, income, cultural beliefs, family decisions and adequate information as influencing utilisation of the health facility

Factors influencing utilisation of the health facility	Sig	Utilisation of the health facility AOR	95% CI
Geographical location			
Yes	.782	1.055	.721 to 1.544
No			
Income			
Yes	.006	1.704	1.167 to 2.487
No			
Cultural beliefs			
Yes	.481	.854	.552 to 1.324
No			
Family decision			
Yes	.865	1.040	.661 to 1.637
No			
Adequate information			
Yes	.016	1.550	1.086 to 2.211
No			

Table 6.4.8 reveals that geographical location i.e. distance to the health facility (OR=1.05, 95% C.I=0.72-1.54), *Income (OR=1.70, 95% C.I=1.16-2.48)*, Cultural beliefs (OR=0.85, 95% C.I=0.55-1.32), Family decision on the reason to visit the health facility (OR=1.04, 95% C.I=0.66-1.63), *Lack of adequate information (OR=1.55, 95% C.I=1.08-2.21).* People's income and lack of adequate information about the health facility and what is available there significantly increased the odds of their association positively to utilisation of a health facility within emerging communities and urban slums of south west Nigeria.

Table 6.4.9: Binary logistic regression showing adjusted odds ratio of utilisation of the health facility as affected by lack of equipment, knowledge of health workers, skill of health workers and attitude of health workers

	Utilisation of the health facility		
	Sig	**AOR**	**95% CI**
Equipment			
Yes	.982	.982	.615 to 1.566
No			
Knowledge			
Yes	.001	2.332	1.411 to 3.856
No			
Skill			
Yes	.272	2.356	.787 to 2.335
No			
Attitude			
Yes	.037	1.691	.1.032 to 2.770
No			

Table 6.4.9 reveals that the following factors combined are significantly associated with people's utilisation of the health facility. That is, the overall model based on the following predictors is significant. These includes lack of equipments, (OR=0.98, 95% C.I=0.61-1.56), *knowledge of health workers, (OR=2.33, 95% C.I=1.41-3.85)*, skills of health workers (OR=1.35, 95% C.I=0.78-2.33), and attitude of health workers *(OR=1.69, 95% C.I=1.03-2.77).* As seen in the table above, knowledge of health workers (p-value=0.001) is significantly associated with utilisation of a health facility across the six communities studied. While the knowledge of health workers and attitude of health workers significantly increased the odds of their association positively to utilisation of a health facility.

Table 6.4.10: Binary logistic regression showing adjusted odds ratio of utilisation of the health facility influenced by socio-demographic factors

Socio-demographic factors	Sig	Utilisation of the health facility AOR	95% CI
Gender			
Male	.368	.847	.590 to 1.216
Female			
Age			
Less than 31 years old	.006	1.773	1.177 to 2.672
More than 31 years old			
Religion			
Not affiliated with Christianity	.990	.997	.660 to 1.507
Affiliated with Christianity			
Education			
Primary school or less	.157	1.700	.815 to 3.546
Secondary school or higher			
Ethnicity			
Not from a Yoruba tribe	.672	1.083	.747 to 1.570
From a Yoruba tribe			
Marital Status			
Not yet married	.008	1.730	1.157 to 2.587
Married, or in a relationship			
Income			
Earn less than N54,000	.695	.896	.518 to 1.550
Earn more than N54,000			

Table 6.4.10 reveals that the following socio-demographic factors are associated with people's utilisation of the health facility. Gender (OR=0.84, 95% C.I=0.59-1.21), *Age (OR=1.77, 95% C.I=1.17-2.67)*, Religion (OR=0.99, 95% C.I=0.66-1.50), Education (OR=1.70, 95% C.I=0.81-3.54), Ethnicity (OR=1.08, 95% C.I=0.74-1.57), *Marital Status (OR=1.73, 95% C.I=1.15-2.58)* and Income (OR=0.896, 95% C.I=0.51-1.55). People's Age and Marital Status are significantly associated with utilisation of a health facility in the study location. That is, people's Age, Education and Marital status significantly increased the odds of their association positively to utilisation of a health facility.

6.5 OBJECTIVE THREE

INVESTIGATE THE PEOPLE'S PERCEPTIONS OF THE PERFORMANCE OF THE HEALTH FACILITY IN EMERGING COMMUNITIES AND URBAN SLUM OF SOUTH WEST NIGERIA.

The following tables are used to depict the people's perceptions of the performance of the health facility in emerging communities and urban slums of South West Nigeria.

Table 6.5.1: General perception of the performance of the health facility?

	Poor	Fair	Average	Good	Very Good	Excellent	Total
Abaranje	17	18	43	22	12	17	129
	(13.2%)	(14.0%)	(33.3%)	(17.1%)	(9.3%)	(13.2%)	(100.0%)
Ajegunle	9	16	42	32	19	8	126
	(7.1%)	(12.7%)	(33.3%)	(25.4%)	(15.1%)	(6.3%)	(100.0%)
Ibafo	5	9	24	51	28	4	121
	(4.1%)	(7.4%)	(19.8%)	(42.1%)	(23.1%)	(3.3%)	(100.0%)
Magboro	7	12	29	37	19	10	114
	(6.1%)	(10.5%)	(25.4%)	(32.5%)	(16.7%)	(8.8%)	(100.0%)
Makoko	9	10	19	10	6	9	63
	(14.3%)	(15.9%)	(30.2%)	(15.9%)	(9.5%)	(14.3%)	(100.0%)
Mowe	10	17	35	25	25	8	120
	(8.3%)	(14.2%)	(29.2%)	(20.8%)	(20.8%)	(6.7%)	(100.0%)
Total	**57**	**82**	**192**	**177**	**109**	**56**	**673**
	(8.5%)	**(12.2%)**	**(28.5%)**	**(26.3%)**	**(16.2%)**	**(8.3%)**	**(100.0%)**

Table 6.5.1 reveals the different views of respondents on how they rated the performance of the health facility in emerging communities and urban slums of south west Nigeria. The table shows that 192(28.5%) of the respondents say the health facility performs averagely, while 177(26.3%) say its performance is good and 109(16.2%) state that the health facility performs very good. Other responses show that 56(8.3%) state that it performs excellently, 82(12.2%) say it performs fairly.

Table 6.5.2: Do certain socio-demographic characteristics influence how people rate the performance of the health facility in the community?

	Poor	Fair	Average	Good	Very good	Excellent	Total	df	p-value
Gender									
Male	28(8.0%)	53(15.1%)	97(27.7%)	94(26.9%)	56(16.0%)	22(6.3%)	350(100.0%)	5	.130
Female	28(8.9%)	29(9.2%)	90(27.7%)	82(26.1%)	52(16.6%)	33(10.5%)	314(100.0%)		
Total	56(8.4%)	82(12.3%)	187(28.2%)	176(26.5%)	108(16.3%)	55(8.3%)	664(100.0%)		
Age									
16-25 years	23(9.7%)	24(10.1%)	68(28.6%)	42(17.6%)	40(16.8%)	41(17.2%)	238(100.0%)	10	<.05
26-40 years	27(7.8%)	46(13.2%)	93(26.7%)	112(32.2%)	61(17.5%)	9(2.6%)	348(100.0%)		
41 yrs & over	5(6.0%)	12(14.5%)	29(34.9%)	23(27.7%)	8(9.6%)	6(7.2%)	83(100.0%)		
Total	55(8.2%)	82(12.3%)	190(28.4%)	177(26.5%)	109(16.3%)	56(8.4%)	669(100.0%)		
Religion									
Christian	40(8.1%)	61(12.3%)	152(30.7%)	119(24.0%)	83(16.8%)	40(8.1%)	495(100.0%)	10	.119
Muslim	27(10.4%)	19(11.7%)	37(22.7%)	52(31.9%)	23(14.1%)	15(9.2%)	163(100.0%)		
Traditional	0(0.0%)	1(11.1%)	1(11.1%)	6(66.7%)	1(11.1%)	0(0.0%)	9(100.0%)		
Total	57(8.5%)	81(12.1%)	190(28.5%)	177(26.5%)	107(16.0%)	55(8.2%)	667(100.0%)		
Education									
No Education	0(0.0%)	3(21.4%)	2(14.3%)	6(42.9%)	2(14.3%)	1(7.1%)	14(100.0%)	15	<.05
Primary	1(4.8%)	4(19.0%)	2(9.5%)	6(28.6%)	7(33.3%)	1(4.8%)	21(100.0%)		

Secondary	31(9.7%)	31(9.7%)	73(23.0%)	99(31.1%)	49(15.4%)	35(11.0%)	318(100.0%)		
Tertiary	25(7.9%)	44(13.9%)	113(35.6%)	65(20.0%)	51(16.1%)	19(6.0%)	317(100.0%)		
Total	57(8.5%)	82(12.2%)	190(28.4%)	176(26.3%)	109(16.3%)	56(8.4%)	670(100.0%)		
Ethnicity									
Yoruba	33(9.0%)	39(10.7%)	101(27.7%)	98(26.8%)	57(15.6%)	37(10.1%)	365(100.0%)	10	.914
Igbo	16(8.7%)	22(12.0%)	47(25.5%)	47(25.5%)	37(20.1%)	15(8.2%)	184(100.0%)		
Hausa	1(4.8%)	2(9.5%)	6(28.6%)	8(38.1%)	2(9.5%)	2(9.5%)	21(100.0%)		
Total	50(8.8%)	63(11.1%)	154(27.0%)	153(26.8%)	96(16.8%)	54(9.5%)	570(100.0%)		
Marital Status									
Single	35(10.1%)	37(10.6%)	115(33.0%)	67(19.3%)	52(14.9%)	42(12.1%)	348(100.0%)	20	<.05
Cohabiting	1(8.3%)	2(16.7%)	1(8.3%)	4(33.3%)	3(25.0%)	1(8.3%)	12(100.0%)		
Married	17(5.9%)	42(14.6%)	73(25.4%)	92(32.1%)	51(17.8%)	12(4.2%)	287(100.0%)		
Divorced	0(0.0%)	0(0.0%)	1(8.3%)	11(91.7%)	0(0.0%)	0(0.0%)	12(100.0%)		
Widowed	0(0.0%)	1(12.5%)	2(25.0%)	2(25.0%)	2(25.0%)	1(12.5%)	8(100.0%)		
Total	53(7.9%)	82(12.3%)	192(28.8%)	176(26.4%)	108(16.2%)	56(8.4%)	667(100.0%)		
Occupation									
Informal	26(7.6%)	40(11.6%)	88(25.6%)	118(34.3%)	53(15.4%)	19(5.5%)	344(100.0%)	15	<.05
Formal	8(6.9%)	21(18.1%)	21(37.1%)	20(17.2%)	18(15.5%)	6(5.2%)	116(100.0%)		
Not employed	9(7.8%)	9(7.8%)	9(7.8%)	21(18.3%)	21(18.3%)	19(16.5%)	115(100.0%)		
Unemployed	1(33.3%)	0(0.0%)	0(0.0%)	1(33.3%)	1(33.3%)	0(0.0%)	3(100.0%)		

Total	44(7.6%)	70(12.1%)	167(28.9%)	160(27.7%)	93(16.1)	44(7.6%)	578(100.0%)		
Income									
<N15,000	15(9.0%)	13(7.8%)	45(27.1%)	45(27.1%)	22(13.3%)	26(15.7%)	166(100.0%)	25	<.05
15,000-30,000	14(6.7%)	32(15.3%)	57(27.3%)	57(27.3%)	36(17.2%)	13(6.2%)	209(100.0%)		
31,000-54,000	7(6.3%)	11(9.9%)	31(27.9%)	39(35.1%)	21(18.9%)	2(1.8%)	111(100.0%)		
55,000-74,000	4(10.3%)	11(28.2%)	12(30.8%)	7(17.9%)	5(12.8%)	0(0.0%)	39(100.0%)		
75,000-94,000	0(0.0%)	0(0.0%)	7(63.6%)	1(9.1%)	3(27.3%)	0(0.0%)	11(100.0%)		
95,000 & >	4(15.4%)	3(11.5%)	9(34.6%)	7(26.9%)	1(3.8%)	2(7.7%)	26(100.0%)		
Total	44(7.8%)	70(12.5%)	161(28.6%)	156(27.8%)	88(15.7%)	43(7.7%)	562(100.0%)		

Table 6.5.2 shows that certain socio-demographic factors such as Age (p-value=0.000), Education (p-value=0.001), Marital status (p-value=0.000), Occupation (p-value=0.000) and Income (p-value=0.000) tend to influence people's rating of the performance of the health facility across all the communities surveyed. But people's gender (p-value=0.130), religion (p-value=0.119) and ethnicity (p-value=0.914) do not significantly influence how they rate the performance of the health facility in the community.

Table 6.5.3a: Do you think there is need for improvement in the performance of the health facility?

Need for improvement in the performance of the health facility	Frequency (%)
Yes	635 (85.7%)
No	68 (9.2%)
No response	38 (5.1%)
Total	**741 (100.0%)**

Table 6.5.3a shows that 635 of 741 (85.7%) of the respondents state that there is need for improvement in the performance of the health facility across all the communities surveyed.

Table 6.5.3b: Reasons why people think there is need for improvement in the performance of the health facility?

Reasons why there is need for improvement in the performance of the health facility	Frequency (%)
To address the lack of adequate health information being provided to the community	99 (13.4%)
Because many people don't get attended too	28 (3.8%)
To boost the communication between patients and health workers	64 (8.6%)
To enhance the general facility upgrade and human resource capacity	316 (42.6%)
To improve the quality of care and service delivery offered to people	128 (17.5%)
No response	106 (14.1%)
Total	**635 (100.0%)**

Table 6.5.3b reveals the various reasons why respondents think there is need for the improvement in the performance of the health facility across all the communities surveyed. Respondents were given once choice as seen in the table most respondents 316(42.6%) are of the view that general facility upgrade (provision of beds, provision of modern medical equipments for diagnosis and treatment, provision of drugs and vaccines, expansion in the infrastructure of the health facility, constant supply of electricity and adequate number of well trained health workers) is needed to improve the performance of the health facility within the community.

6.5.4: Binary logistic regression showing Gender, Age, and Education as factors that are significantly associated with people's perception of the efficiency of service delivery offered in the health facility

Socio-demographic factors	Perception of service delivery		
	Sig	AOR	95% CI
Gender			
Male	.122	.776	.563 to 1.070
Female			
Age			
Less than 31 years old	.801	.801	.582 to 1.102
More than 31 years old			
Education			
Primary school or less	.685	.685	.324 to 1.446
Secondary school or higher			

Table 6.5.4 reveals gender, age and education as predictors are not significantly associated with people's perception of the efficiency of service delivery in the health facility. Gender (OR=0.77, 95% C.I=0.56-1.07), Age (OR=0.80, 95% C.I=0.58-1.10), and Education (OR=0.68, 95% C.I=0.32-1.44).

Table 6.5.5: Do these factors affect the performance of the health facility?

Factors that affect the performance of the health facility	Yes (%)	No (%)	No response (%)	Total
Lack of regular electric power supply in the community affects the performance of the health facility	631 (85.2%)	100 (13.5%)	10 (1.3%)	**741 (100%)**
Lack of medicines and vaccines affects the performance of the health facility	600 (81.0%)	122 (16.5%)	19 (2.6%)	**741 (100%)**
Lack of adequate funding affects the performance of the health facility	598 (80.7%)	126 (17.0%)	17 (2.3%)	**741 (100%)**
Shortage of health workers affects the performance of the health facility	563 (76.0%)	145 (19.6%)	33 (4.5%)	**741 (100%)**

Table 6.5.5 from questions 509 to 512 of the survey instrument shows that (80.7%) are of the respondents are of the opinion that lack of adequate funding affects the performance of the health facility. Also, shortage of health care workers affects the performance of the health facility as stated by (76.0%) of the surveyed respondents. Other factors such as lack of medicines and vaccines affects the performance of the health facility and lack of regular electricity power supply also affects the performance of the health facility.

CHAPTER SEVEN

QUALITATIVE DATA PRESENTATION AND INTERPRETATION

7.1 INTRODUCTION

In this chapter, the qualitative analysis and presentation of the data collected from the field work are carried out. This chapter highlights the population composition of the participants in the study, and qualitative findings as seen in section 7.3, 7.4, 7.5 and 7.6 on the objectives of the study. This is presented in form of narratives and quotations to buttress the findings of the study. A total of 64 respondents participated in the In-depth Interviews, Key Informant Interviews and Focus Group Discussion combined, while a total of 31 transcripts were analysed.

7.2 POPULATION COMPOSITION OF THE PARTICIPANTS

This section focuses on the qualitative population breakdown of the participants into the three category of instruments used across the six locations of Lagos and Ogun State.

Table 7.2.1 Participants in In-depth Interviews

State	Communities	Status of Participant	Number of Participant
Lagos	Abaranje	Doctor	1
		Community leader	1
		Women leader	1
		Public health officer	1
	Ajegunle	Pharmacist	2
		Herbal practitioner	1
	Makoko	Nurses	2
Ogun	Magboro	Doctor	1
		Pharmacist	1
	Ibafo	Doctor	1
		Nurse	1
		Pharmacist	1
		Public health officer	1
	Mowe	Doctor	2
		Pharmacist	1
		Public health officer	1
			19

Table 7.2.2 Participants in Key Informant Interviews

State	Communities	Total Participant
Lagos	Abaranje	1
	Ajegunle	1
	Makoko	1
Ogun	Magboro	1
	Ibafo	1
	Mowe	1
		6

Table 7.2.3 Participants in Focus Group Discussion

State	Communities	Males	Females	Total Participants
Lagos	Abaranje	3	3	6
	Ajegunle (FGD1)	5	1	6
	Ajegunle ((FGD2)	2	5	7
Ogun	Magboro	5	1	6
	Ibafo	2	6	8
	Mowe	4	2	6
	Total Participants	**21**	**18**	**39**

Table 7.2.4 Total Number of Participants in the Study Using Qualitative Instrument

Qualitative Instruments	Total Participants
In-depth interviews	19
Key informant Interviews	6
Focus Group Discussion	39
	64

Table 7.2.5 Total Number of Transcripts Analysed

Qualitative Instruments	Transcripts
In-depth interviews	19
Key informant Interviews	6
Focus Group Discussions	6
	31

7.3 OBJECTIVE ONE

EXPLORE THE NATURE OF HEALTH CARE DELIVERY AND THE SOCIAL PROCESSES BY WHICH HEALTH CARE SERVICES EVOLVE IN EMERGING COMMUNITIES AND URBAN SLUMS OF SOUTH WEST NIGERIA.

This objective explores the nature of health care delivery in the study area. It also focuses on the social processes by which health care services emerged and evolved in emerging communities and urban slums of south west Nigeria. Based on this objective, the researcher found that across the communities studied, multiple health care services are provided to the people in modern or traditional form. More so, migration as a social behaviour into emerging communities and urban slums remains a social process that contributes to the emergence of social services which include health care.

Multiple Health Care Delivery Methods, Services and Treatment

Multiple methods of health care delivery persist in emerging communities and urban slums. These methods include health services provided not-for-profit by government health facility (primary health care centres or health post), faith-based organisations (hospitals or prayer houses) and non-governmental organisations. Other types of services are for profit health services provided by private health facilities (hospitals, clinics, maternity home, specialist hospitals, and community established hospital). Also, for-profit health services include community pharmacy (drug stores or chemist), patent medicine vendors (drug vendors and hawkers), private family doctor or nurses, and traditional health care services (herbal practitioners who sell herbal mixtures/concoctions, herbalist, folk or spiritual healer, bone healer and traditional birth attendant) that provide unorthodox health services. The in-depth interviews revealed that people within the community visit different places for treatment.

An in-depth interviewee stated that:

> *"Mostly we have auxiliary nurses in this area. Even the community members, they intend to go more to the pharmacies (chemist services) than going to the hospital. It is when they have serious problems. Maybe they have gone to the chemist twice, and then they now come to the hospital"* **(Female Nurse 1, Makoko, Lagos State).**

People make use of the health centres within the community, but most of its users are women who visit the place for ante-natal and post-natal services.

A community leader mentioned that:

> *"We have a health centre, that little building was built from the Better Life Programme, during the time of Babaginda (former military president Ibarahim Badamusi Babaginda 1985-1993), now we converted that place to health centre. They attend to children and pregnant women...and when the time of delivery comes; they can take them to the hospital, maybe general hospital or private hospital"* **(Male Community leader, Abaranje, Lagos State).**

Another in-depth interviewee buttressed the fact that various types of health care services are present within the community, people go to where they choose to go to for preventive or curative treatment.

A doctor noted that:

> *"Well I will say health care delivery is both by private hospital setting, local government setting and the state government hospital. Being a private hospital, we render all forms of services. Both medical management, surgical management, all aspects of social medicine, preventive services and as well as laboratory services. We also have the traditional doctors in this community"* **(Male Doctor, Abaranje, Lagos State).**

A pharmacist was of the view that:

> *"Of course there are private hospitals, but when you say private in quote, you have the ones owned by doctors, you have the one owned by qualified nurses and at the same time, you have the one by auxiliary nurses. You have the herbalist, these are the nature of care delivery at the grassroots level, so all these are present in Mowe"* **(Female Pharmacist, Mowe, Ogun State)**

More so, existing health care facilities within the communities tend to perform different task when compared to one another.

A public health officer explained that:

"No it's a bit different from a health centre. At the health post, they don't run night shift but at the health centre they always, you'll always meet medical practitioners any time of the day. But a health post, they are limited to sometimes. This is a clinical and maternity centre. We attend to different cases except for the surgery or advanced cases like that" **(Male Public Health Officer, Ibafo, Ogun State).**

Also the people's belief and practices tend to influence their use of a particular form of health service for treatment.

A response revealed that:

"But most of the people you will see in this place are still the local and illiterate people you understand. They still believe in their traditional birth attendants, they still believe in their myths and they believe in those things that somebody is doing somebody (someone is the cause of another person's affliction or ailment), they believe in using their local herbs and some believe in going to Babalawo (Folk healer), and all that" **(Male Doctor1, Mowe, Ogun State).**

"People are of the mindset that orthodox medicine comes with a lot of side effects they believe that traditional medicines don't have side effects. So maybe that one too is another factor why people patronise traditional medicines...You know traditional medicines are cheap. It cost N30 (15 cents), N50 (25 cents) N100 (50 cents). But when you think of the cost of paying the hospital bill... That is why a lot of people don't patronise the private hospitals because of their high cost of bills" **(Male Key Informant, Ajegunle, Lagos State).**

Most of these communities have been in existence longer than the various types of health services. However, several forms of health services are now present in these communities.

People receive treatment from the different sources based on the type of sickness that affects them and their preference for one form of service over another.

One of the participants noted that:

> *"It depends on the sickness the kind of thing the person is experiencing here. If it is a minor injury, you can go to the chemist; you can still also go to the hospital probably it demands stitching or something being an accident. The hospitals here they are trying to their own capacity. There are private hospitals here".* **(Male Participant, FGD, Ibafo, Ogun State)**

This finding was also supported by a Key Informant

> *"So when we say health centre, health centre cannot do operation, health centre cannot do surgery. A health centre cannot treat a bone, a broken bone. Only where women can go and born (deliver) and come out safely"* **(Male Key Informant, Abaranje, Lagos State)**

An in-depth interview participant further explained that:

> *"Besides when someone is sick, instead of going to make use of orthodox medicine (tablets) to cure the sickness, the use of herbs is useful and potent. It is what people need that is sold for them. As long as orthodox medicines have measurements, so does the use of herbs. Once the first dose of herbal mixture is sold, followed by the second dose, the sale of it to the user (consumer) will stop"* **(Male Herbal Practitioner, Ajegunle, Lagos State)**

Presence of Health Facility, Services and Treatment Option

Having a health facility in a community ensures that people have a place to go for treatment when the need arises. Such a health facility may not be a modern well-equipped health facility compared to those in major cities and urban centres of Nigeria but more than one type of health facility whether privately owned, government owned, religiously owned or community owned is present in emerging communities and urban slums of south west Nigeria.

A public health officer stated that:

> *"As you can see, we have this health facility that is provided by the local government. We have a local government that is Obafemi Owode that is where this health facility is, so and mostly this centre was rated to immunise babies 0-59 months old but later on we found out that the patronage was impressive, the local government, the PHC director now worked with the local government maybe the chairman. More staff was deployed here and then we started treatment"* **(Female Public Health Officer, Mowe, Ogun State).**

In all of the communities, health facilities varied in terms of their size, services, ownership and management.

A participant from the FGD in Ajegunle said that:

> *"Basically, you find here what you find in other places in Lagos. Infrastructure and a system, Infrastructure wise you say we have general hospitals, private clinics; we still have the unorthodox hospitals you know. Then basically nurses, home care nurses. People who are supposedly trained to be nurses come to your house to deliver health services to you...you know, for the public hospitals here, are usually crowded, lots of people. Private hospitals cut across from mushroom hospitals, two-room hospitals, one apartment, one room hospitals, to sometimes high-rise building hospitals. Then, the key thing or the key part, the one that is frequently used in my own opinion is the nurses that come to your house..."* **(Male Participant 1, FGD 1, Ajegunle, Lagos State).**

A pharmacist noted that:

> *"People around this place, they go to the health centre mostly...But there are private hospitals around here"* **(Male Pharmacist, Ibafo, Ogun State).**

Because of the small staff strength and lack of specialists health facilities offer less than 24 hours services to the community. Most health facilities simply specialise in offering basic primary health services.

A Nurse clarified that:

> *"Like simple treatments and delivery ante-natal, post-natal care, we do deliveries, maybe large injuries and treatment of large injuries. Actually we don't operate here, like I said we have a larger hospital where we can transfer our patients. But any other thing such as Malaria, Sepsis, Typhoid, we do handle over here. Things like deliveries of babies"* **(Female Nurse 1, Makoko, Lagos State)**

A public health officer mentioned that:

> *"Then we have the out-patient department and child welfare department. So what we do here, we give immunization to children from 0 to 55 months. Then we treat minor ailment and injuries. Those are the major things that we do here"* **(Female Public Health Officer, Abaranje, Lagos State)**

Further findings showed that:

> *"...we provide the primary health care service, basic immunization, basic infant welfare clinic, ante-natal, deliveries, post-natal and minor medical services...and all of that. But the major ones, like malaria fever, typhoid fever and pneumonia. All those and we do some minor surgical procedure, like suturing and other minor things"* **(Male Doctor, Mowe, Ogun State)**

Drug store services (Pharmacy or Chemist)

There are various types of drug store outlet in emerging communities and urban slums. These drug stores are privately owned by people who reside within the community or live not very far away from where their stores are located. Because of the practice of self medication and treatment, these drug stores, a pharmacy or "chemist", serve the community needs in

providing drugs to those that reside within the community. Some of these drug stores are operated by qualified pharmacists while others are not. Some owners undergo an informal type of training/apprenticeship in the sale of various types of drugs while drug stores that are owned by qualified pharmacist sometimes employ people with the knowledge of pharmacy and drug prescription to work in their store. The presence of more than one pharmacy or chemist is found in all of the study locations of Lagos and Ogun state.

A pharmacist mentioned that:

> *"Hmm, I have a pharmacy as you can see, I provide community pharmacy. I sell drugs to people in the community. In the past 4 years, I've been selling basic drugs that people would definitely need. Like anti-malaria, anti-hypertensive, we sell anti-biotic of various sorts, and name it. Since it's a registered pharmacy outlet we sell, quality drugs..."* **(Female Pharmacist, Mowe, Ogun State).**

Other pharmacists noted that:

> *"We check their blood pressure, we sell drugs and we recommend drugs"* **(Female Pharmacist, Abaranje, Lagos State)**
>
> *"Normally, they mostly complain of body pain, malaria, and all of that. You know, mostly we deal in bulk. We sell in bulk...if someone is sick and there is no place to buy drugs. Maybe the doctor prescribed a drug and there is no place to buy it. That is a big problem...You know what it means. You can't get the drug after your treatment...So I think this pharmacy contributes to people's need to stay healthy".* **(Male Pharmacist, Ibafo, Ogun State)**

Often times the type of drugs sold to customers depends on the knowledge of the pharmacist or person who attends to them. This influences their choice and sometimes changes the perception of the buyer about a particular product. A qualified pharmacist with knowledge on the ethics of their work offers the best advice to the customer. They put the well being of the customer before their profit or need to sell drugs.

A pharmacist further highlighted that:

"I'll just tell them because they have all these rashes on their bodies. I'll tell them I can't really recommend anything, and they should go to the hospital. Some may go and when they come back they do buy antibiotics for their children...If they come here and I'm not around, they'll just tell my girl is your pharmacist around, if not, they'll just go and when I return, they'll come back. So they prefer meeting with the pharmacist directly. They'll be more convinced" **(Female Pharmacist, Abaranje, Lagos State)**

Social Processes: Migration, Population Growth, Development, Socio-Economic and Political Reasons

The regular movement of people across urban and rural Nigeria has led to the influx of people into emerging communities and urban slums of Nigeria. Migration occurs daily as people seek better life chances elsewhere or move for economic, social and various other reasons. Increased growth rate in Nigeria's population especially in the past two decades has significantly contributed to the rise of emerging communities. This movement of people into emerging communities has brought about the need for essential social amenities and services which includes health care.

A key informant was of the view that:

"Well the factor that I can say has led to this basically is the influx of people coming into the town. We can say, Mowe in five years ago wasn't as congested as we have it now. We residents that stay here we used to know ourselves. We can say who is who here in the Mowe area. But right now, we have so many people coming into the town. It is a big settlement now" **(Male Key Informant, Mowe, Ogun State)**

This finding is supported by another response that:

"...Actually most of the people you see in Mowe are from Lagos..." **(Male Key Informant, Mowe, Ogun State)**

Increase population growth has further contributed to the need for a health facility in the community. An interview with a community representative revealed that:

> *"Yes, that's right. That is why we call it Abaranje-Okerube health centre. These two communities are very large and highly populated now. It is no more rural. (It has become very big)".* **(Male Community leader, Abaranje, Lagos State)**

Another major reason for the growth of people living in emerging communities is the presence of a major highway which connects the south west region with other parts of Nigeria. This highway has led to the development of the border towns along its part into informal settlements with proliferation in various health services.

A participant mentioned that:

> *Well the factors that we have here which I can say that aided or is one major thing are the road that links the country together, the Lagos-Ibadan expressway. The road has been bad for a long time causing so many accidents. So victims that have accidents are been carried here to nearby hospitals or they can be taken to major ones. So that factor alone that there is a major highway has been neglected for so long. There is casualty every day; there is therefore the need for the establishment of a hospital nearby that can take care of the first aid before people are been take to a larger hospital. I can tell you, that this situation is another factor that can lead to why a hospital is been put up around this axis"* **(Male Key Informant, Mowe, Ogun State).**

Urban slum growth is attributed to people's unemployment, low income and their inability to afford the cost of living in other parts of the city. This makes people to move into slums. Some other push factors attributed to why people migrate into urban slums include loss of employer provided accommodation and lack of privacy/independence in previous rented/shared accommodation. The pull factors include cheaper living expenses, lack of control of land access, and people tend to get a place of their own.

A respondent noted that:

> *"This environment, mere looking at it, you'll know that it is a place of low socio-economic status...When you go out,*

you'll see about 10 people seating in front of a house jobless. There is no job for them to do... Maybe, because of the joblessness, they have time for so many other things...but life here is cheap" **(Female Nurse 1, Makoko, Lagos State)**

Further findings from a participant in an FGD revealed that:

"In fact they are even happier than you. Not that they don't have money, they are not willing to leave there. I used to have a friend there. The husband will tell you, that I'm comfortable here. So it is not money that makes that them to live there. They feel like living there. If you enter some of them, their houses, there is nothing that they don't have. In that same Pako, she will tell you my husband said he can't leave here until he build his own house. That when he builds his own house, is when his going to leave"

(Female Participant 2, FGD 2, Ajegunle, Lagos State)

A key informant view is also in support of this that:

"In the evening when you see them, they will take their mats, lay it on the ground, on the dustbin, that dirt to relax and receive free breeze. They are comfortable there"

(Female Participant 1, FGD2, Ajegunle, Lagos State)

The growth of emerging communities has been influenced by political declarations by politicians and promises made towards the development of these emerging communities. The initial migration into emerging communities is attributed to population growth but overtime other factors have influenced why people move into these informal settlements.

An in-depth interviewee mentioned th*at:*

"If you look at Lagos, Lagos is over saturated in terms of population. And if I take you back to the previous governor of Ogun state, Otunba Gbenga Daniels, one of those things that he pushed for was that he was going to make Ogun state, be to Lagos, what Jersey is to New York in the United States. That is, to take the spill in its population growth. You see that statement accelerated the

rate at which people moved from into this area. But the problem was, it was just a political statement that lacked no actual backing in terms of a policy" **(Male Doctor, Mowe, Ogun State)**

7.4 OBJECTIVE TWO

EXAMINE PEOPLE'S ACCESS TO AND UTILISATION OF HEALTH CARE SERVICES IN THE STUDY AREA.

Gaining access to a modern health care facility is a concern for people in emerging communities and urban slums of south west Nigeria. However, utilisation of a health facility is based on a number of factors that affects whether or not people will visit the health facility for diagnosis and consultation, treatment, or use of health promotion services such as voluntary counselling and testing.

Proximity to health facility

Having access to a health facility in an informal settlement such as an emerging community and urban slum of south west Nigeria is essential for people to live healthy lives. Proximity to a health facility remains a major determinant of whether people will make use of the facility. The distance and time required to travel to the health facility are things people put into consideration, while the availability of transport services to the health facility in the community and the cost of the transportation service to the health facility are considered.

Findings from an in-depth interview show that:

"Well, I think Mowe health centre is still accessible to the community around. At least the minimum, actually people from afar do come here, they do come here you understand, at least taking bike of N100 down here. That means the place is a little bit far" **(Female Public Health Officer, Mowe, Ogun State)**

This finding is supported by a key informant in a different community.

"But if you come to Abaranje-Okerube no general hospital, If you go to Ijegun, no general hospital. It is not easy for someone living in Abaranje-Okerube or Ijegun to say he wants to get to Igando in an emergency situation. That is to go to Igando general hospital. It is a very long

distance. It is a very long distance..." **(Male Key Informant, Abaranje, Lagos State)**

Due to the central location of the health facility in some communities people have access to this health facility. A respondent noted that:

> *"Yes they do have easy access. The hospital is opened 24 hours. So we are here at all times, even during the midnight, we have some patients coming in...So it is very accessible to people"* **(Female Nurse1, Makoko, Lagos State)**
>
> *"You know here we're closer to them...I mean proximity and that we're easily accessible"* **(Female Public Health Officer, Abaranje, Lagos State)**

Infrastructural barrier (Lagos-Ibadan Expressway), Bad Roads and Transportation

A major hindrance to people residing in emerging communities of Ogun state is the presence of an eight lane highway. This separates Magboro, Ibafo and Mowe communities into two unequal halves. This major hindrance limits people from utilising the available service at the health facility. People who reside in the part where the health facility is located within the community are in a better position to visit the place. Those who reside on the other side across the highway find it difficult to cross to visit the health facility. When they do, other factors also contribute to influence their utilisation of the health facility such as the lack of adequate equipment for diagnosis and treatment of patients.

This is supported by an in-depth interview that:

> *"The major barrier has been this expressway. So people cannot gain access from Ibafo 2, this is Ibafo 1. So people living in Ibafo 2 always find it difficult coming to this side because of the fear of crossing the expressway. Had it been there is an overhead bridge. It would have made it easier for them to cross over. So you don't expect a side person to be crossing an expressway of six lanes. So this has been a major challenge. Most will say we wanted to come but we couldn't cross the express. So that has been the major challenge. Did you get it? Apart from some*

other people living inside at Papa, Showo, Shole and all that! They couldn't come because of the bad road. Most especially the pregnant women, they will tell you they stood for long, they don't think they can come. The roads are bad. They are not complaining about the distance but roads are bad. Most especially during the raining season"
(Male Public Health Officer, Mowe, Ogun State)

Attitude of health workers

Health workers as human resources for health play a vital role in ensuring that people are treated and taken care of especially within a health facility. The attitude of health workers if positive towards patients and users of the health facility further encourages them to utilise the service when available. But when the health workers attitude is negative towards the patients, their pattern of utilisation of health services is low. The attitude of health workers further contributes to how effective health interventions become. When a health intervention is underutilised the health status of users is grossly affected. Health workers at the community level are usually the frontline contact point people first meet in their interaction with the health care delivery system in a country. In emerging communities and urban slums of south west Nigeria, the health care workers are found in the health facilities but do not always treat all patients in the same manner.

A participant stated that:

"...the workers are not nice. The way they talk to you is not right...some of them though may be understanding but most of them especially the nurses will just shout at you...." **(Female Participant 2, FGD, Ibafo, Ogun State)**

This finding is supported by another participant who noted that:

"...the manner of approach is something else. The manner of approach is something else. There are many things that when you come in contact with the general hospital, you won't be happy..." **(Male Participant 1, FGD2, Ajegunle, Lagos State)**

Quality of health service

Quality of health service is a crucial factor that determines whether people will utilise the service or not. The quality of health service includes the nature of service delivery, the quality and type of drugs given to patients and the waiting time before treatment or consultation is derived when patients visit a health facility. How effective a health service is and the way workers efficiently discharge their duties all add to the quality of the health service offered to patients. More so, the quality of service delivery includes the cost of utilising the health services offered and the availability of a doctor/consultant to attend to the patients. In emerging communities and urban slums of south west Nigeria the quality of health care delivery is questionable as stated by various participants who were of different opinions.

A participant mentioned that:

> *"I took my baby for immunization. By the time we got there, they started some unnecessary protocol. Where is this, where is this? Yes there should be protocol for there to be orderliness. We tendered everything instead of them to ....we just had to wait and wait till about 1pm from 8am in the morning. No No No to be exact, from about 7am to 1pm....the lackadaisical approach given to those who came to patronise the so-called government hospitals is too harsh"* **(Male Participant 1, FGD2, Ajegunle, Lagos, State)**

This finding is supported by another participant who noted that:

> *"One because those in general hospital they are too tribalistic. If you don't hear their language, in fact they would just frustrate you. So going there is like taking a ticket to hell. So if you don't want to die, look for a good private hospital. Where they would look after you very well and treat what is wrong with"* **(Female Participant 1, FGD2, Ajegunle, Lagos State)**

A key informant in the same community was of a contrary opinion that:

> *"Yes, because Lagos state government have been doing a whole lot of good work. Imagine my uncle had a stroke*

last week and he was rushed there. If it was before they would have, but they attended to him immediately. I think they have upgraded the facility, the maternity ward is excellent..." **(Male Key Informant, Ajegunle, Lagos State)**

7.5 OBJECTIVE THREE

INVESTIGATE THE PEOPLE'S PERCEPTIONS OF THE PERFORMANCE OF THE HEALTH FACILITY IN EMERGING COMMUNITIES AND URBAN SLUMS OF SOUTH WEST NIGERIA

Although there exist challenges in health care delivery within emerging communities and urban slums of south west Nigeria, the people's perception of the health facilities is both negative and positive. Some of these health facilities underperform thereby causing people to seek other alternative forms of health care services readily available to them. Performance of social services ensures the constant use of such a service. In the area of health care delivery, users have a preconceived notion of what to expect and what not to expect when they make use of the services. The performance of a health service is influenced by macro and micro structures which are shaped by the existing social structures and social actors within the communities where they are located. The performance of the health facility is based on several factors which include the structure of the facility, the staff strength and the type of health services being offered to the people.

Effective and efficient health services

For health services to produce the best result for its users, its effectiveness and efficiency is paramount and must therefore be ensured at all times. Effective health systems delivery helps reduce the effects of infectious diseases on the population as patients get treatment when the need arises and where they desire to have it. But in situations where the health system is grossly underfunded and neglected, its level of efficiency in terms of cost and service delivery remains low. It continues to underperform and places more people at the risk of mortality and morbidity from preventable diseases which causes death.

A community representative was of the opinion that:

"...health care services are very poor. Though we have that of government, but it is not functioning very well.

Because sometimes if a child has Malaria and you take the child there, you may not meet them there. Even the pregnant women they don't go there, they have to go and register at a private hospital...." **(Female Women Leader, Abaranje, Lagos, State)**

While a key informant was of the view that:

"I think I'll score them 4/10. You know anything that belongs to the government in Nigeria; you can't get the best out of it. That is just it. Sometimes they abandon you, sometimes they just come and give you only drip. You know, it's still not up to standard. It is still relatively poor. Most of them don't have drugs; they still send you out to buy drugs. So they don't have those drugs there, so it's still relatively poor...Then for the drug pharmacy, I might even score them higher than the hospital. Because most of them have those drugs that you will always demand or that you demand for. If it is self medication..."

(Key Informant, Ajegunle, Lagos, State)

Some people perceive the health workers as not well qualified to carry out their task. They seem not to know how to make the best diagnosis for the patients. Even the way they respond to people's request and enquiries at the health facility is not encouraging. Also the environment is not conducive.

One of the participants in an FGD noted that:

"Like the health centre in Ibafo, have you been there? You have seen the environment, it is poor...It pays me to go to Kosofe, than to use that of Ibafo. Because they call a place a health centre, they themselves don't look healthy, they themselves are not clean, if you look at their fingers and what they put on, and you'll know that they are not alright in short. And the way they attend to somebody it doesn't make sense. That is why when they write a prescription, if you now take it to another doctor; he'll ask are they the

ones that wrote this..." **(Female Participant 2, FGD, Ibafo, Ogun State)**

Lack of modern equipment

Not having modern health care equipment housed in a modern health facility is a common feature of most health facilities across the communities visited. A health facility in these communities is simply a bungalow building which comprises three to four bedrooms. Such a facility lacks adequate space to keep and operate certain hospital equipment. Therefore it offers just basic primary health services and always refers the complex cases to a secondary or tertiary institution. Not having the required equipment to carry out its function, health facilities in the study area often find it difficult to expand in their duties and scope of operation.

A public health officer stated that:

"I think the government should do an evaluation. Not even here alone all the facilities. At least every 6 months, go there evaluate their equipments, what are you using, these are the latest equipments, this is what you should be using, this one is not good again at least they should do that... every 3 months, at least 6 months, or twice in a year. Equip them medically. Do you get it? If we have enough equipment, you'll be happy to work. Because everything will just be easy, one two and you're through. But if you're still struggling with this one, for example, the swig, if your stethoscope is not working adequately, you will manage it but you will not get the accurate results. Do you get it? **(Male Public Health Officer, Mowe, Ogun State)**

An in-depth interview participant mentioned that:

"...the health centre that is there, I'm not sure it has up to ten beds" **(Female Pharmacist, Mowe, Ogun State)**

However, some health facilities despite the challenges they are faced with are making some progress. This finding is supported by an interviewee who said that:

"For primary health care, of course you can't expect a primary health hospital to have a scanner. But we do. Our

theatre is still ok for this level. But we will improve"

(Male Doctor, Mowe, Ogun State)

Shortage of skilled health workers

A skilled work force is a vital component for health systems strengthening. The mere shortage of qualified health workers in a health facility leads to increased challenges for the entire health system. Having skilled health workers from the doctors to the nurses significantly encourages utilisation of available health services and leads to good health outcomes for the people. But the shortage of health workers in the health facility puts a strain on the available workforce.

An interview participant was of the opinion that:

> *"...we don't have enough hands. For example I'm supposed to be off duty today. But I'm here. If I'm not here the work is going to be very tedious for the number of people that are around. So I have to come around. I'm not trying to praise myself; every other person does the same. Sometimes when you do night duty, you may not go home until after clinic because when you look at the number of people on ground, you'll see that the work is going to overwhelm them so you have to wait. So we really need more hands"* **(Female Public Health Officer, Abaranje, Lagos, State)**

The continuing shortage of health workers across health facilities puts further stress on the existing workforce. Another interviewee mentioned that:

> *"...assuming you were here on Tuesday, oh God, you'll see the crowd. The population we attend too, almost 300 babies for immunisation. Yes, on Thursday like 100 that we attend too. So you see..., I'll be the one to immunise about 200 plus babies, so you can imagine the work stress. So we don't have enough working hands..."* **(Female Public Health Officer, Mowe, Ogun State)**

One of the key informants was of the view that:

"For example even in the health centre here. If you go there now, you cannot see more than one doctor. That is only one doctor and two nurses for the entire population of people here". **(Male Key Informant, Abaranje, Lagos State)**

The shortage of health workers also limits the working hours of the health facility to offer 24 hours health services.

A public health officer stated that:

"Oh my God! Staff strength, I will say is Ok but not to adequate. In a facility like this we are suppose to have a particular number of staff running shifts. But due to the fact that we are short staffed we can't run shift. It's either you do one week permanent at a stretch or things like that. We should do morning shifts, afternoon shifts and night shifts but we can't do that because we are short staffed. So we really need more staff we need more hands". **(Male Key Informant, Abaranje, Lagos State)**

7.6 OBJECTIVE FOUR

ASCERTAIN SPECIFIC FACTORS AS DETERMINANTS OF HEALTH IN EMERGING COMMUNITIES AND URBAN SLUMS OF SOUTH WEST NIGERIA.

The following qualitative data, quotation and interpretations below are used to describe the specific factors such as social, economic, cultural, environmental, educational, lack of information, poverty, and ignorance as determinants of health in emerging communities and urban slums of south west Nigeria.

Ignorance and lack of awareness

Across these informal settlements people's literacy levels and awareness on available health interventions is low. Many people appear literate but still lack basic knowledge on personal hygiene. Also they do not always practice what they know in order to stay healthy. A respondent was of the view that:

"...One major factor is ignorance. Ignorance based on the kind of environment and the kind of upbringing that they

have as mothers. And there level of exposure, talking about their academics, or talking about the kind of food that they eat. We've discovered that their ignorant of so many things and it's going to affect how they take care of their children and how well the children will be..."
(Female Public Health Officer, Abaranje, Lagos State)

This finding is supported by another interviewee who said that:

"...well here, the major thing is ignorance....the people are ignorance of so many things whereby, you see cases where people take drugs without consulting a medical practitioner..." **(Male Doctor, Abaranje, Lagos State)**

Ignorance causes people to make the wrong choices and decisions when it comes to their health. A public health officer noted that:

"...well health workers we've been trying our best, the little we can do, but you know, the level of ignorance of our people makes them go astray a times...we thank God that in Mowe, we've changed their mentality and during their clinic we do tell them, advise them..." **(Female Public Health Officer, Mowe, Ogun State)**

Due to lack of awareness among the people, their health is at risk. Therefore increasing the level of awareness is crucial.

Another public health officer mentioned that:

"The first one I'll take about is inadequate awareness. Our people lack awareness. A lot of things that they don't know about they get it. We just need to do a little more awareness for their health needs. But I think the NGOs are trying, the government are trying, and the roll back malaria they are trying...but if people don't really know that there are a lot of these programmes, they won't benefit. Most times they come for treatment and we even go...talking to them...that government is making this provision for you. So I think the major challenge is

inadequate awareness" **(Male Public Health Officer, Mowe, Ogun State)**

A participant in an FGD noted that:

> *"On my own part to conclude is information and awareness, they say knowledge is power, and if you have information, if you're aware of this illness and what causes it, you can try and prevent it individually"* **(Male Participant 3, FGD1, Ajegunle, Lagos State)**

Health education and literacy

Health education remains crucial for people to stay healthy and live healthy lives. However, in emerging communities and urban slums people are formally educated but have very low levels of health education and awareness. Participants were keen to state that health literacy was low in their community, while government efforts to educate the people on their health were equally low. Many people lacked basic health education, awareness and information on how to prevent them and their families from becoming sick.

A nurse noted that:

> *"Actually health education matters a lot. The people are not empowered by education. Aside from their formal education, they don't have this good orientation about their health. How they should take care of themselves... Health education is the only thing I know that can bring them there"* **(Female Nurse1, Makoko, Lagos State)**

This finding is supported by an FGD participant's view that:

> *"...It is heavily needed because there are some people that don't believe in entering the hospital. But when you can be able to reach out to them, when you use the road, use the public road to speak to them. Wherever they are, they will make themselves available. But when you stay in your hospitals and you expect them to come and meet you there. You know many of us we're different in our literacy. Some know there is a general hospital there, some don't want to know. So when something that the government is giving*

cheap is available, they will not know...give proper awareness...going house to house to educate the people. You'll see their areas of weakness and then you'll be able to brush them up. Know what is wrong with them. Sometimes its illiteracy, administering the wrong thing to a child....government should be able to give them the right information". **(Male Participant 1, FGD2, Ajegunle, Lagos, State)**

Other participants from the FGD noted that:

"....they need to go to the masses, to educate people what is going on in that health centre...I believe in education such that when the people are aware....give them good education..For someone like me I liked self medication but you have to come to me and educate me on it...I believe if government put education things will be better". **(Male Participant 2, FGD2, Ajegunle, Lagos, State)**

"...government should once in a while organise health talk, free seminars and medical check...then advise people properly on how to get these services. **(Female Participant 3, FGD2, Ajegunle, Lagos, State)**

Not having the right information leads to poor choices in terms of health. That is, when health literacy is lacking within the community.

A health practitioner was of the view that:

"Health promotion is very poor. Especially, when there is nobody to educate them on what to do. That is why we're just trying to see what we can do" **(Male Doctor2, Mowe, Ogun State)**

Partnership with the community through its religious organisations helps in the promotion of health education and literacy. It also keeps the people informed of the available health services which they can benefit from.

An in-depth interviewee revealed that:

"If you were here like last week, we wrote letters to... all the churches, and some organisations, whereby we planned a free medical screening exercise. I personally, I went to some of the churches I gave lectures, I saw the pastors and gave them lectures to educate them that fine there is this doctor here that wants to do something for the community. Come and it is free. So I gave lectures just to create awareness to let people know...We have to create that awareness that services are available. Like when they are many during the immunization exercise, we give health education" **(Male Doctor1, Mowe, Ogun State)**

Socio-cultural factors

Due to the fact that life and living is informally constructed in emerging communities and urban slums of south west Nigeria, the influence of both social and cultural factors affects how people respond to their health needs. The belief system of individuals plays a major role in how they act to prevent and treat diseases. That is, an individual based on their socio-cultural beliefs will seek preventive health services if they believe they are susceptible to a disease. More so, if people do not perceive their illness as serious, they will not seek treatment or prevention. Some individuals will not take action unless the treatment or prevention is perceived as having greater benefits than cost to their well-being. Socio-cultural factors determine how and why people seek care when the need arises.

A public health officer stated that:

"So many people have so many ideas. You know where we come from; we talk about culture and tradition. We never rule that one out...I also belief in culture and I respect tradition...we still have a long way to go. That is one factor" **(Female Public Health Officer, Mowe, Ogun State)**

Due to people's beliefs, the way they tend to perceive an illness and seek treatment is often affected. A health practitioner expressed his opinion that:

"Of course, so many factors, let's say somebody with an ailment and she will tell you that she stepped on

something. What are you talking about this is serious bronchitis immemorial and the person will say it is the first wife in the home that is the cause. Because her child is the first son of the family, you know. I mean" **(Male Public Health Officer, Mowe, Ogun State)**

An in-depth interview response revealed that:

"Whatsoever may be wrong even with me, once I use herbs, such ailments will relief me immediately. I have the faith in the use of herbs. So I'll never go to a hospital. Once people come to me, it is what they want that I'll sell to them. I have a friend who was suffering from Diabetes, but once he made used of the herbs, he was cured immediately...the intake of herbs is very important to staying healthy and for our bodies...Besides it is my belief that uses of herbs works better than taking an injection to cure a sickness". **(Male Herbal Practitioner, Ajegunle, Lagos State)**

Economic factor

As a major determinant of the type of health service people seek, income remains a key economic factor that shapes people's choices on where to go for their health services. People's income in emerging communities and urban slums is low as seen in the study findings on table 6.2.2 and this affects their nutrition and limits their food choices. More so, participants agreed that not having money prevented many people from seeking the type of care they desired.

As such participants were of the view that:

"...when you go to the private hospitals, they even charge you less sometimes than the government hospitals, this is not supposed to be so..." **(Male Participant 1, FGD2, Ajegunle, Lagos State)**

Another participant from the same FGD mentioned that:

"...but like when I went to do my teeth. They say it's free but on getting there, they say N4,000 (€20). I said for

what. But when I went to private hospital, they say it's N3,000 (€15) imagine. But in the general hospital they said it's N4,000 (€20). And meanwhile when paying the money you'll go to the cashier to pay the money but this time around you'll pay the money there. They will say go to that corner. Give that man in that corner which is not right..." **(Female Participant 2, FGD2, Ajegunle, Lagos State)**

In certain situations private hospitals are at liberty to choose what to charge for a particular service. They may either increase the cost of the services or they may choose to lower the cost. An interviewee participant noted that:

"...we may charge N4, 000 (€20), some may come in without admission, just as patients with malaria. Some might come in for the same treatment and we might charge N1, 200 to N1, 500 (€6 to €7.50) depending on the person's purse. We might even charge, for example by the time we say N4, 000 (€20) and they start begging and all that... depending on what you can afford. So that is just the thing" **(Female Nurse1, Makoko, Lagos State)**

Having money to get good health care remains important. Also this helps people to afford well balanced diets at all times in order to prevent them from becoming sick. But in emerging communities and urban slums, income and earning of the people remains low.

A public health officer expressed that:

"Some mothers may come pleading that they can't even afford to buy a glove to immunize their children... And all of us that are working here, we're also mothers we won't just say because you can't afford to get a glove, we'll send you way...Really a lot of things revolve round money, I must tell you the truth. If want somebody, neat and tidy and all of that, a well-balanced diet and all that. Really, it boils down to how much I have in my pocket..." **(Female Public Health Officer, Abaranje, Lagos State)**

Environmental and infrastructural factors

The poor living conditions in emerging communities and urban slums of south west Nigeria affect the health of people who reside there. Participants gave numerous reasons why people's health is being hindered by the nature of their environment. Lack of proper environmental planning remains a key reason why emerging communities and urban slums of south west Nigeria are constantly dirty, experiencing floods, have stagnant water and open refuse dump sites. All these contribute to the spread of diseases in the communities.

A health practitioner in one of the communities noted:

> *"The major factor that I know of is lack of good drainage. Everywhere, this area itself is a marshy area. And everywhere you look, you see gutters filled with black water..."* **(Female Nurse, Makoko, Lagos State)**

This finding is supported by another participant from a different community that:

> *"Majorly in this environment now, their drainages are bad, and mosquitoes easily breed in such environments...most people that have borehole. You can imagine for like a year, they don't wash their tanks. From there before you know it one can contact Typhoid"* **(Female Pharmacist, Abaranje, Lagos State)**

Within such environments as that of emerging communities and urban slums people lack basic social amenities which include having a functional toilet facility.

An interview participant narrated that:

> *"You can count the number of houses, except these new houses. Because many of them don't have toilet and bathrooms, they just do their thing and dispose it outside... I will appreciate if there is clean and portable water. That is one of the challenges around here. Then the building of public toilets, of course you can't tell every house too. But you can enforce it that every house should have a toilet and a bathroom. If you cannot do it inside the house, you can build it outside the house. At least public toilets and bathroom too..."* **(Male Doctor1, Mowe, Ogun State)**

Due to lack of adequate public water supply in the communities, private water sources have now become readily available. People purchase drinking water from many different unknown private sources.

A medical practitioner was of the opinion that:

> *"Another thing is the source of water, as far as that is concerned, people usually dig bore-holes and some are not good for drinking. Also people around here take pure-water (sachet water), in which case some of it is not very good"* **(Male Doctor, Abaranje, Lagos State)**

This finding is supported by another participant who mentioned that:

> *"...the basic amenities that are supposed to be provided for the people in the area are not there. I want to start with water, when most people don't have water. I don't mean ordinary water, good source of water to drink. There is challenge on their health".* **(Female Pharmacist, Mowe, Ogun State)**

Besides not having a good supply of portable water in the community, the lack of good drainage systems remains a factor that promotes the spread of diseases as stagnant water is found around the communities.

An in-depth interview participant stated that:

> *"No good water system and I think the environment will contribute. Let me say, no good drainage system...all these things contribute..."* **(Male Pharmacist, Ibafo, Ogun State)**

The informal nature of the environment in emerging communities affects people's health conditions as untarred dusty road networks around the community cause people to contact respiratory tract infections during the dry season, while in the rainy season people get infected with the flu, cough and catarrh.

An interview participant noted that:

> *"Let me quickly say during rainy season, there is always a flow, most people start coughing, and they have catarrh... people have respiratory tract infections a lot...Another thing is that during dry season, Mowe is always very*

dusty, very dusty and people walk on site, you see people bringing in gravel, cement, different things, you have lots of dirt in the air and because of that the issue of respiratory tract infections keeps coming up. At the same time with different kinds of respiratory tract infections. So I can't really balance that, whether it happens more in rainy season or dry. But the one of rainy season is actually due to the weather but during dry season is actually due to dust participles in the air". **(Female Pharmacist, Mowe, Ogun State)**

7.7 Major Themes from the Qualitative Analysis

Codes	Sub-Themes	Core Themes
We have auxiliary nurses in this area We have a health centre and church hospital Health care delivery is both by private hospital setting, local government setting and the state government hospital We also have traditional doctors in the community They still believe in the use of traditional birth attendants As long as orthodox medicine have measurements, so does the use of herbs	**Objective One** Multiple health care delivery services	Nature of health care delivery
We have this health facility that is provided by the local government Infrastructure wise, we have general hospitals, private clinics They go to the health centre or community centre We provide primary health care service, basic immunization, basic infant welfare, ante-natal, post-natal	Presence of health facility	
I have a pharmacy as you can see Some may go and when they come back they buy antibiotics This pharmacy contributes to people's need to stay healthy	Drug store services (pharmacy or chemist)	
Basically the influx of people coming into the town Most of the people are from Lagos These two communities are very large and highly populated The road that links the country together, Lagos-Ibadan expressway It's a place of low socio-economic status people Political statements that lacked no actual backing	Social Processes: migration, population growth, development, socio-economic and political reasons	Evolution and emergence of health services due to social process
Mowe health centre is still accessible It is a very long distance They do have easy access Here we're closer to them	**Objective Two** Proximity to health facility	Access and utilisation of health services
The major barrier has been this expressway The roads are bad At least taking bike (motorcycle) of N100 down here. That means the place is a little bit far	Infrastructural barrier (Lagos-Ibadan Expressway), bad road and transportation	
The workers are not nice Their manner of approach is something else	Attitude of health workers	
We had to wait and wait till about 1pm from 8am in the morning	Quality of health	

In fact they would frustrate you, so going there is like taking a ticket to hell They attended to him immediately	service	
Health care services are very poor Most of them don't have drugs; they still send you out to buy drugs It pays me to go to Kosofe, than to use that of Ibafo	**Objective Three** Effective and efficient health services	Perception of the performance of health care facility
Go there evaluate their equipment I'm not sure it has up to ten beds Our theatre is still ok for this level. But we will improve	Lack of modern equipment	
So we really need more hands So we don't have enough working hands If you go there you cannot see more than one doctor I will say it's ok but not adequate	Shortage of skilled health workers	
Ignorance based on the kind of environment and the kind of upbringing that they have as mothers Well here, the major thing is ignorance The level of ignorance of our people makes them go astray a times The first thing I'll talk about is inadequate awareness To conclude is information and awareness	**Objective Four** Ignorance and lack of awareness	Social determinants of health in emerging communities and urban slums
Actually health education matters a lot They need to go to the masses to educate people Government should once in a while organise health talk Health promotion is very poor	Health education	
I also believe in culture and I respect tradition She will tell you she stepped on something Besides it is my belief that use of herbs works better	Socio-cultural factor	
They even charge you less sometimes They say it's free but on getting there, they say N4,000 (€20) Some may come in for the same treatment and we mat charge N1,200 (€6) to N1,500 (€7.50) Really a lot of things revolve around money	Economic factor	
The major factor that I know of is lack of good drainage Majorly in this environment, the drainages are bad Another thing is the source of water Mowe is always very dusty	Environmental and infrastructural factor	

CHAPTER EIGHT

DISCUSSION OF FINDINGS

8.1 INTRODUCTION

In this chapter, I discuss the findings of the study from both the quantitative and qualitative data presented and interpreted in previous chapters six and seven of the thesis. First I begin with the discussion of the quantitative findings followed by the qualitative findings. Then I show how both (Quantitative and Qualitative) research approaches as used in this study can be linked together based on their research outcomes. This chapter concludes with an explanation of how the theoretical framework used for this study is linked with the research outcomes of this study.

8.2 Quantitative Findings

8.2.1 Socio-demographic Outcome

Across the six communities surveyed in Lagos and Ogun state, 741 respondents from different households gave their views and opinions. In five of the six communities, a total of 135 households participated in the study as seen in Table 6.2.1 and they properly filled the questionnaire. But in Makoko community, only 66 households properly filled which was analysed. As a result of some of the challenges encountered in the data collection process in Makoko community such as lack of access to certain parts of the community, some households visited simply refused to partake in the study. Respondents' willingness to take part in the study was low. People expressed the fact that several people (researchers, government officials, non-governmental organisations and private organisations) in the past have visited their communities for such an exercise but to date; no significant change has taken place in their community.

Both male and female respondents took part in this study. Only a slight difference in terms of gender participation was recorded. This difference is based on respondent's willingness to participate in the study. The findings showed that more males were willing to participate than females. Less than two percent of the entire population refused to state their gender. This study accounted for gender equality in health research (Doyal, Payne & Cameron, 2003), as both males and females were accorded an equal chance of participation in each of the communities visited.

Because only one person from each household visited was allowed to respond to the instrument the age of respondents differed, as half of them were between ages 26 and 40 years old. A few older members of the household in some communities visited were the main representatives that took part in the study. The views expressed by the respondents in this study represent the entire health conditions of participating households. Less than one percent of the entire population that took part in the study did not provide their age. Age and gender are important demographic variables and are the primary basis of demographic classification. They are also important variables in the study of mortality, fertility, and nuptiality (NPC & IFC Macro, 2009).

In the south west of Nigeria, more Christians can be found when compared to other religious sects. As seen in other national surveys, health and demographic reports (NPC-IFC Macro, 2014), the south west of Nigeria is dominated by Christians. In Nigeria, according to the 2006 census data and the 2008 NDHS data most of Nigeria fell into two broad religious categories of Christians or Muslims. This study took place in the southern part of Nigeria, dominated by a Christian majority as compared to the northern part largely dominated by a Muslim majority. The issue of the Christian majority dominating the south west of Nigeria did not have any influence on this study and its outcomes.

Education as a component of health research is vital to understand the literacy levels of a people and its effect on their decision making as regards their health. Less than 45 respondents do not have a secondary level of education which in Nigeria is considered the minimum for entry into civil service jobs. Therefore, in emerging communities and urban slums of south west Nigeria the majority of the respondents are not educationally disadvantaged. A sizeable number of the respondents have a secondary school education and some others have a university education. Therefore those who took part in the study are well literate. According to the National Literacy Survey (2010) it estimates the adult literacy rate as 56.9 percent, with huge variations between states (Lagos 92.0 % and Borno only 14.5%), regions (urban 74.6 % and rural 48.7%,) and sex (male 65.1% and female 48.6%). This indicates the diaparities in literacy levels in Nigeria. This study fidnings is however limited to just two states (Lagos and Ogun) in the south west region with literacy rates as high as 92.0% and 62.8% respectively. Findings from the study reflect similar outcomes with nationally available data on both states. That is, the south west region of Nigeria as seen in the national data of the country shows that this region has the most literate population compared to other

regions of Nigeria (NMEC, 2011). While the respondents educational qualification from the qualitative findings showed that over 50 of the 64 participants had a secondary level of education.

Ethnicity remains a core aspect of demographic profiling and national data reporting in Nigeria. Over half of the respondents are from the Yoruba speaking tribe of Nigeria. These groups cover the south west states (Lagos, Ogun, Oyo, Osun, Ondo, and Ekiti) of Nigeria.

However, because this study was conducted in the south west part of Nigeria, more of the respondents turned out to be Yorubas. In other regions of Nigeria, other ethnic groups can be found in larger numbers compared to the south west. For example, the southeast of Nigeria has a large Igbo majority, while the northwest, northeast and northcentral parts of the country are dominated by the Hausas and Fulanis. Across the country, from North to South, other minority ethnic groups can be found.

Because Nigeria is a multi-ethnic country, the findings show that 13.2 percent of the people who took part in the study come from minority ethnic groups such as Ijaw, Urhobo, Edo, Deltans, Ibibio, Igala, Itsekiri, Bayelsans, Igede, Benue, amongst others. Ethnicity plays a major role in the national life and decision making of Nigerias diverse ethnic groups, the majority of such groups occupy minority status (Oyetade, 2003). That is, ethnicity remains at the core of social discourse in the country. Therefore, public health research in Nigeria make use of ethnicity as a crucial variable in understanding cultural differences to health care and how cultural patterns influences people's health behaviour (Omorodion, 1993; Jegede, 2002; Dibua, 2009).

In terms of marital status, more respondents turned out to be single. The study did not enquire whether these single respondents were engaged in any form of relationship. Hence, the only information as seen in table 6.2.2 is aimed at distinguishing how many of those that took part in the study fell into the stated categories. Of the total 741 respondents, 43 percent were married when the study took place. But less than six percent of the respondents were divorced, cohabiting or widowed.

Occupation as a socio-demographic variable gives an overview on the economic engagement of people in a given society. The study findings show that more respondents were informally employed within emerging communities and urban slums of south west Nigeria. That is, people engaged more in small medium enterprises and retail businesses such as sale of

electronics and household items, owning a fashion design and tailoring outfits, offering hairdressing and cosmetic services, barbers shops for all ages, being a food stuff distributors, owning a restaurant or general traders of goods and services within the community. Also some respondents offer private consultancy services such as being building site supervisors, engineers, plumbers, bricklayers, and computer network providers amongst others. Some other respondents engage in semi-skilled jobs such as commercial bus driving or taxis, being a motorcycle (*Okada*). Less than 20 percent of the respondents were unemployed, as of the time of data collection.

According to the National Bureau of Statistics (NBS) (2010) the national unemployment rates for Nigeria between 2000 and 2009 showed that unemployed persons constituted 13.6% in 2001, 12.6% in 2002, 13.4% in 2004, 13.7% in 2006, 14.9% in 2008, and 19.7% in 2009. Many of the unemployed have no choice but to exploit the income and self or casual employment opportunities in the informal sector of the economy (Ogunrinola, 2011). The informal sector has thus become "a major provider of employment especially in developing and transitional economies" (Khotkina, 2007). However, this study highlights that most of the respondents were informally engaged/employed. While those who were formally employed were engaged as teachers, some worked in the civil service or local government offices as junior and senior staff, while others worked as receptionists, office administrators or lab scientists in some private organisations outside the community in which they live.

The general findings on income of respondents indicates that 532 of the respondents in the study location earn less than ₦54, 000 (€273) on a monthly basis. These large numbers of respondents despite their level of education do not earn a huge income. The majority of the people living in emerging communities and urban slums still live and support their families with very little income. Less than 10% of the people living in the study area when combined earn a monthly income that is above ₦55, 000 (€275). This means that most of the respondents still constitute part of the vast majority of Nigerians who live on less than $1 a day.

8.2.2 Objective One

EXPLORE THE NATURE OF HEALTH CARE DELIVERY AND THE SOCIAL PROCESSES BY WHICH HEALTH CARE SERVICES EMERGE AND EVOLVE IN EMERGING COMMUNITIES AND URBAN SLUMS OF SOUTH WEST NIGERIA.

In exploring the nature of health care delivery in emerging communities and urban slums of south west Nigeria, certain social process give insights on how health services started and have evolved over time. However, these social processes do not always determine how health care services get established. The other factors also contribute to determine the need for health services but due to the increase in population which leads to the continuing growth of informal settlements in the world (Chowdhury & Nurul-Amin, 2006; Morakinyo et al, 2012; Acharya, 2010; Lanrewaju, 2012; Jorgenson & Rice, 2012), challenges for effective health interventions (Crown Agents, 2010) now persist in developing countries with weak health systems. These have led to the availability of various types of health services present in emerging communities and urban slums of south west Nigeria. As these communities continue to evolve and change with time, so do the various forms of health care services within the communities.

The organisation of health services in Nigeria is complex (Olakunle, 2012). It includes a wide range of providers in both the public and private sectors (private for profit providers, non-governmental organisations, community based organisations, religious and traditional care providers) (WHO-Africa Region, 2007). Therefore, various types of health facilities can be found in emerging communities and urban slums of south west Nigeria. A government health facility (GHF) i.e. a health centre or health post is available in the six communities of Abaranje, Ajegunle and Makoko (Lagos state) and Magboro, Ibafo and Mowe (Ogun state). This is a result of government policy aimed at providing health services to people in the grassroots areas of Nigeria. At least one health centre is found in each of the 774 local government areas of the country (Inegbenebor, 2013). The health centre is under the management of the primary health care department of each local government area.

Across emerging communities and urban slums of south west Nigeria as seen in this study, private health facilities (PHF) are present in the form of hospitals or clinics. Some of these PHFs specialise in specific treatments such as providing maternity services only. The majority of these facilities are established by doctors who do not necessarily reside in these

communities. Some of them do reside close to the communities less than 10 kilometres away but many such doctors work in the government secondary and tertiary hospitals in Lagos state or Abeokuta the capital city of Ogun State. Other forms of private health facilities can be found in emerging communities and urban slums in the form of specialist clinics or maternity clinics. Many are not necessarily well equipped with modern and essential equipment required of a hospital for effective operation but private care accounts for 66% of total health care in the country (Onah & Govender, 2014).

Other types of health care facility that are present in the communities take the form of faith-based or community health facilities (CHF). A community health facility is established without government or private support. Such facilities are established as an initiative of an influential member of the community or as a result of key stakeholders in the community coming together to establish such a facility. The motive behind the establishment is to meet the needs of community members and not necessarily for profit like private health facilities within the community. Faith-based health facilities are now a growing phenomenon in Nigeria, as religious organisations establish hospitals in communities to meet the health needs of the people. Most faith based organisations are not profit oriented but may require users to pay for certain services such as registration for use and purchase of drugs for treatment after diagnosis.

Findings from this study show that some people in emerging communities and urban slums prefer to visit a spiritual or traditional folk healer. This has led to the rise in the use of traditional medicine in these communities for treatment and cure of different types of infections and illnesses. Use of traditional medicine is widely practised as indicated in some studies (Mwangi, 2004; Fakeye, Adisa & Musa, 2009; Oreagba, Oshikoya & Amachree, 2011). Traditional medicine use is not limited to developing countries such as Nigeria but is practised in some developed countries (Orisatoki & Oguntibeju, 2010). Most folk healers who provide traditional medicines to people engage in preparing concoctions for those who seek their services and have several remedies for treatment of different types of illnesses.

This study's findings highlight that drug stores in the form of a pharmacy or chemist are another major source of health service in the emerging communities and urban slums of south west Nigeria. These pharmacies and chemists are owned by private individuals and established solely for profit through the sale of drugs to the people. Due to the presence of pharmacies and chemists in these communities comes the practice of self medication. People

that patronise drug stores do so to purchase drugs for personal use or for use by a household member. Studies show that self medication is rampant among many groups of people in Nigeria (Osemene & Lamikanra, 2012; Brugha & Zwi, 1999; Afolabi 2008; Fadare & Tamuno, 2011; Arikpo, Eja & Enyi-Ido, 2009).

Most people who buy drugs from the pharmacy or chemist do so with or without a doctor's prescription. General findings from this study show that across the various communities, there are various sources of health care services available to the people for use. Most of the respondents make use of a health care facility whether government, private, faith- based or a community health facility. Over 30 percent of the respondents visit a drug store to buy medicines. Other respondents make use of the various other sources of health care available in the community such as visiting a folk healer for traditional medicines, patronising a drug vendor according to Okonkwo & Okonkwo (2010), a private family doctor or an auxiliary nurse.

According to the respondents most of the various health care services have been in operation for over five years within the community. Historically, when these emerging communities and urban slums of south west Nigeria are being formed, the first type of health care service that emerges for the people comes in traditional form. Over time other forms of health care services such as the establishment of a health facility whether a government, private, community or faith-based become available to the people. All of the various types of services in these communities have received patronage from community members as seen in this study.

As a result of the proliferation of health services in emerging communities and urban slums of Nigeria, when a member of a household falls sick, treatment is derived from more than one source available in the community. Most people prefer to visit a health facility, while some others would prefer to practice self medication by visiting a drug store to purchase medicines. However, preference for use of a particular type of health care service is based on financial and other non monetary incentives which affects people's decision making (Adinma & Adinma, 2010; Okumagba, 2011; Riman & Akpan, 2012, Abdulraheem et al, 2012). Most respondents preferred to use a health facility to treat a household member when he or she falls sick.

In a situation where a household member does not go anywhere for treatment, findings reveal that self medication amongst people in emerging communities and urban slums is very high. Self medication or self administered use of drugs is practiced in all of the six communities of Lagos and Ogun state as seen in the study. In these communities when people get drugs prescribed to them by a family doctor or nurse, adherence and proper use may not be observed. People in emerging communities and urban slums have easy access to purchase drugs over-the counter for self-use. Some of these drugs may turn out to be counterfeit leading to more harm for the user (Bouwari, 2012), while some of them may not. Also the study found that household prescribed medication as a form of treatment is present in emerging communities and urban slums. This type of group prescribed-medication is when the sick person consults other members of the household in the decision making process on what type of drugs to use and what not to use. This form of medication is less documented in the literature as a form of treatment that people practise. Group prescribed medication can be attributed to the closely knitted structures of most households in African societies with "very big extended families with a pervasive role" (La ferrara, 2007). Decision making on what is suitable for persons in the home is not self determined but often times decided by all members of the household, especially the older ones. Therefore, when a household member falls ill, the same decision making process comes into perspective such that what is needed to treat the person to get better requires the opinion and views of everyone, especially the head of households or the guardians.

In this respect, other forms of group prescribed medication as findings reveal goes beyond the "significant others" to the level of engaging the neighbours or the community at large especially when the community is a small one. Neighbour prescribed medication as a form or treatment is simply the consultation of other persons outside the immediate household in communities where people reside in shared apartments and living spaces using the same bathroom, toilet and kitchen facilities with others within the same building. Consultation or suggestions can be sorted in relation to what type of medicine to consume, especially when neighbours have a relationship with one another. Neighbour prescribed medication is another type of group prescribed medication that is practised in the communities as seen in this study.

Lastly, as a form of group prescribed medication which is practised in emerging communities and urban slums of south west Nigeria is community prescribed medication. This occurs when a treatment solution is sorted at the level of engaging other community members in the

decision making process, on what should be given to a household member who is ill. Community prescribed medication or community therapy is widely practised in the study locations for treatment of the sick. Both self-medication (Shankar, Partha, & Shenoy, 2002; Omolase, Adeleke, Afolabi, & Afolabi, 2007) and group prescribed medication (household, neighbour and community) takes place without proper consultation with a doctor or medical personnel in developing countries. Findings show that when people do not visit a health service provider for treatment, they engage in self-medication and various forms of group prescribed medication for treatment of their household member when they fall sick.

In terms of medicine use among people in emerging communities and urban slums of south west Nigeria, both traditional medicine and orthodox medicine is widely used. People in the communities take medicines for several reasons which include for prevention or cure of an illness. Irrespective of the type of illness, there exists a major preference for orthodox medicine compared to traditional medicine as seen in this study. However, some people engage in combining both the orthodox and traditional medicines for treatment. But studies show that the preference for orthodox medicine over traditional medicine is influenced by people's level of education, awareness and income (Dibua, 2009). More so, people consider the mode of preparation of each form of medicine and the prescription on what to consume. Traditional medicines do not always lay much emphasis on this as compared to orthodox medicine.

Use of orthodox medicine and traditional medicine combined is now widely practiced in different countries (Osemene, Elujoba & Ilori, 2011). People perceive the combined use of both forms of medicines as more potent and effective than the use of just one form of medication (Osemene et al, 2011; Oreagba et al, 2011; Gyasi, Mensah, Adjei, & Agyemang, 2011). For example, in the treatment of malaria, some people prefer to begin with the intake of orthodox medicine and later switch to traditional medicine. Or some people begin with traditional medicine and then choose to switch to orthodox medicine. This study finding supports this assertion, as some people prefer to combine the use of both for treatment. The findings show that no significant difference exists between males and females based on their preference for the use orthodox medicine to traditional medicine. This preference can be attributed to certain factors such as their age, religious affiliation and education.

Respondents are well aware of the presence of a health facility in their community that provides essential primary health care services to the people. These health facilities render

their services during the day in the communities and often do not provide services at night. This makes health care delivery insufficient for people living in the communities. As seen in this study there exist multiple forms of health service provision as mentioned earlier. This multiplicity of health services is attributed to the poor state of health care delivery in Nigeria. Most of these health services offer a sub-standard quality of care, poorly regulated and not well managed. In emerging communities and urban slums the poor state of health services delivery has led to a proliferation of sub-standard services from doctors and nurses who offer informal services to the people at a cheap price.

This study shows that alternative forms of health care services are present in the communities. While some people prefer to seek health services and treatment from private hospitals (Welcome, 2011; Anyaehie et al., 2014), others opt for another provider. The growth of private care in Nigeria began in the late 1980s. Private health delivery has significantly increased over the years and now accounts for 66% of health care delivery, overtaking government forms of health care delivery at primary health centres or health post (primary), general hospitals (secondary) and teaching hospitals or federal medical centre (tertiary) hospitals. In 1994 government health facilities totalled 14,687 available across the country. Presently private health facilities now constitute a majority for health care delivery in Nigeria (Onah & Govender, 2014).

In rural communities of Africa studies show that faith based organisations' presence in their service to the community often include the provision of health care delivery (Widmer, et al, 2011). Also, in urban areas of some developing countries, faith based hospitals can be found to offer health care delivery (Widmer et al, 2011; Oluwabamide & Umoh, 2011; Kagawa, Anglemyer, & Montagu, 2012). People patronise these hospitals because they often times receive treatment for their sickness and teachings in accordance with religious doctrines of the organisation that operate the hospitals. In emerging communities and urban slums such faith based hospitals are present.

Community health facilities also are present across the six communities of Lagos and Ogun state. These health facilities are solely owned by the community in which they are found. Being a community led-initiative, such health facilities provide affordable services which are acceptable to the community. Unlike government health facility or a private health facility, the community health facilities are operated with the aim to make health services cost-

effective to meet the community needs. These types of health facilities were first introduced into certain communities before the advent of private health facilities or other types of health care services. In some communities, a community health facility has been in existence from the time these communities were formed.

Findings from this study reveal that the establishment of the health facility in emerging communities and urban slums has been influenced by a number of factors which includes the lack of a health facility in the community. Not having a health facility necessitated the need to make one available in each community. The provision of a health facility to people is a social need but informed by their right to life. As a duty and responsibility to the people, government must uphold the principles of universal health coverage (WHO, 2008a) which includes health equity, social justice and end of exclusion for all people. Although other factors such as the spread of a disease, the request of the community members, political visit by the state governor or local government chairman contributed to the establishment of a health facility in emerging communities and urban slums of south west Nigeria. A major reason for the establishment of such a health facility whether government, private, faith-based (religious) or community was the lack of a health facility in the communities to meet the health needs of the people.

Health care delivery in Nigeria has emerged and evolved across different regions of the country as its population continues to increase. Recent population figures are now put at 170 million (PRB, 2014). This translates into the need for more health care services to meet the need of the people. In informal settlements such as emerging communities and urban slums of south west Nigeria, the need for health care services is linked with the emergence of these communities as a result of population growth and migration into such informal settlements. These communities have received support from different stakeholders towards the establishment of the health facility. Stakeholders' engagement is a crucial component for getting things done in small communities (Griffiths, Maggs & George, 2008; Jones, Nix & Snyder, 2014). Both in urban and rural communities of Nigeria, stakeholder engagement and support to community projects is a necessary and important aspect required to get projects commissioned and get other community members to support such new initiatives (Faleti, 2014). The study found that local chiefs, council of elders, youth association, home owners association and other community groups such as women's groups such as the market women association, meat sellers association, and religious associations were in support of the

establishment of a health facility within the community. These groups form a part of the multiple stakeholders that were consulted before a health facility was established.

Various social events occur at various times in communities of Nigeria (Esu, Mbaze-Ebock Arrey, Basil & Eyo, 2011). These events often time includes the cooperation and participation of notable community members such as the chief. Sometimes an event is determined by the season of the year or the occurrence of certain social processes which shape the lives of the people. In relation to health care delivery within emerging communities and urban slums of Nigeria, certain social processes have contributed to the establishment of the health facility. These include community engagement in the decision making process on the need for a health facility. Community engagement is an important aspect which ensures that an intervention for community development works for the people. According to Mangal, Aylward & Grassly, (2014) in their report, they discussed "the potential to improve acceptance and increase demand for OPV by engaging people within communities to deliver health education". More so, when meetings are held between community members and their representatives' good decisions can be made in the interest of all parties within the community. Findings from this study reflect that representatives of the community are well consulted before a health facility is established for the people. The findings further reveal other factors such as a cultural festival, incidence and prevalence of a disease within the community (such as cholera) or the death of a prominent community member as several social processes, pattern or occurrence which equally contribute to the establishment of a health facility.

8.2.3 Objective Two

EXAMINE PEOPLE'S ACCESS TO AND UTILISATION OF HEALTH CARE SERVICES IN THE STUDY AREA.

Access to health care services is an essential component of effective health service delivery, while the utilisation of such services enables users to get diagnosis for illness and proper treatment when needed. The findings show that respondents make use of different means of transport to get to the health facility within their communities. The availability of transportation is linked with whether or not people will utilise a given health service. Some studies (Nemet & Bailey, 2000; Fairbank, 2004; O'Donnell, 2007; Kruk et al, 2007; Mattson, 2010; Awoyemi et al, 2011) show that the availability of transport, the cost of the service and the reliability of the service all influence the use of health services in communities. In rural

areas of developing countries transportation is linked to the development of the community (Olayiwola & Adeleye, 2005; Tunde & Adeniyi, 2012; Ogunowo & Oderinde, 2012). Therefore when transport services are not readily available farmers find it challenging to transport their goods to the urban cities for sale. More so, transportation is crucial to economic sustainability in any country. An effective transport system enables people get to their place of work, school or business as and when desired.

For most people who live in emerging communities and urban slums a major mode of transport remains the use of Motorcycles popularly known as "*Okada*". This mode of transport is available in major urban cities in Nigeria and remains a cost effective means of movement for many people (Olubomehin, 2012). Some other respondents also make use of buses to get to the health facility within their communities. Nigeria's public transport system, though it is largely private sector driven, offers commuters relatively affordable services from place to place (Basorun & Rotowa, 2012; Igwe, Oyebola, Ajiboshin, & Raheem, 2013). Another group of respondents prefer to walk to the health facility within their communities. This is because the distance to the health facility for them is close to their place of work or residence. Also among those who walk to the health facilities, the question of affordability of existing transport services affects their decision. Some other respondents within the study location adopt other means of transportation to the health facility. These include the use of cars, bicycles, commercial taxis and use of a lorry (small trucks). The use of a lorry however is not commonly used compared to other forms of transportation available to people in the communities.

Various factors as documented in this study act as barriers for people and these limit them from visiting the health facility. One of such barriers includes the bad roads within the communities, which limit them from visiting the health facility. Having a good motorable road in a given community helps ensure that goods and services can move with very minimal limitation (Bakeera et al, 2009; Al-Taiar, Clark, Longenecker, & Whitty 2010; Yar'zever & Said, 2013; Cheptum, Gitonga, Mutua, Mukui, Ndambuki, & Kioma, 2014). Not having adequate information to make the right choices as concerning one's health can be a limitation to visiting a health facility as seen in this study. But being informed about existing health services in a particular health facility will ensure its effective use by patients.

Gaining access to health care services in emerging communities and urban slums of south west Nigeria is not limited by geographical location, income, cultural beliefs, family decision

on why, when and where to go for treatment as seen in this study. But in some studies limited physical access to primary care is a major contributing factor to poor health of populations (Perry & Gesler, 2000). That is the physical location of a health facility if far may limit people from getting to the place because of its distance and time required to travel to and from it (O'Donnell, 2007; Awoyemi et al, 2011). Another factor such as the presence of user fees at the point of service delivery is a reason for poor utilisation of health services (Kipp, et al, 2001; Lagardea & Palmer, 2008), while income remains a major determinant for utilising health services in low income countries (Kruk et al, 2007). Findings from the study show that despite having low incomes, this does not limit people in the study area from utilising existing health services in their communities.

Family decision on the use of health services in developing countries determines whether or not a patient will seek for care. For example in Pakistan, women and children need to seek the permission of the head of the household or the men in the family to visit health services (Bhutta, Ali, Hyder, & Wajid, 2004; Shaikh & Hatcher, 2005). This is because the influence of significant others on household decisions which includes health care is highly considered by each member. But this study shows that this will not deter people from gaining access to a particular health service within the community. However, not having the right information at the right time still remains a fundamental factor that would limit people's access to health services as seen in this study. Therefore, adequate information and health education/literacy remains a vital component for effective health care delivery for people residing in emerging communities and urban slums of south west Nigeria.

The use of the services available at the health facility across the six communities shows that over 50 percent of the people visit such a facility. People's health seeking behaviour however is based on certain factors which include their socio-economic status (SES). People's SES influences them to seek health services at a health facility. That is being able to afford a given health service will increase the utilisation of such a service. In Bangladesh, richer households are nearly twice as likely to seek health care from both qualified and unqualified practitioners (Ahmed, 2005). In a study on the socio-economic status and health care utilisation in rural Zimbabwe, findings revealed that SES had a strong association with overall utilisation of health services (Kevany, Murina, Singh, Hlubinka, Kulich, Morin & Sweat, 2012) while in Burkina Faso, disadvantaged groups consult health providers half as often, as others (Develay, Sauerbron & Diesfield, 1996) within the community. In Ethiopia, richer

households are likely to seek health care both more often and with a greater intensity than poor households (Reniers & Tesfai, 2009).

Other reasons for effective utilisation of a health facility include the nearness of the place to the people. When the health facility is close to people, the use of it is more compared to when such a health facility is far off (Perry & Gesler, 2000). Proximity to a health facility influences mothers to utilise the place for delivery based on the time taken to reach such a facility (Sharma et al, 2014; Anwar, Sami, Akhtar, Chowdhury, Salma, Rahman & Konlinksy, 2008; van Ejik, Bles, Odhiambo, Ayisi, Bloklamd, et al, 2006; Wagle, Sabroe & Nielsen, 2004). Also, in seeking treatment for other types of illness, the time taken is considered by the people (Abiodun, 2011; Osungbade, 2013; Obiechina, Okolie, Okechukwu, Oguejiofor, Udegbunam et al, 2013) in Nigeria. In this study, people consider how close a health facility is to them and that influences their choice of utilisation.

Utilisation of a health facility is also based on the availability of medical check services for the people. This study found that people utilise a health facility within their community if such a service is available. More so, because these health services offer immunization services to nursing mothers, people also make use of the facility. Immunization services are regularly offered in health facilities within the communities as seen in this study. This is because immunization of children from 0-59 months is a priority for the government and the service is offered freely. Also immunization helps to reduce mortality caused by infectious diseases and protects the children to stay healthy during infancy and early childhood (Blencowe, Lawn, Vandelaer, Roper & Cousens, 2010; Andre, Booy, Bock, Clemens, Datta, John, Lee et al., 2008).

Health facilities offer ante-natal and post-natal services within the communities. This further encourages the utilisation of these services as seen in the study. Ante-natal and post-natal services are offered in primary health care facilities across Nigeria. Nigeria remains among some countries of the SSA region with high levels of fertility (PRB, 2014). Therefore the demand for ante-natal and post-natal services is equally high. In addition findings of this study show that some people in emerging communities utilise the available health facility closest to them because they prefer the services offered there to the use of traditional services. This makes the preference for the use of orthodox medicine higher than the use of traditional medicines for treatment.

Utilisation patterns of the health facility based on the age of respondents shows that a significant difference exists among them. Those between 26 and 40 years old were more likely to visits the health facility based on several reasons mentioned earlier. Also this age cohort represents the most active within the population composition in Nigeria in terms of fertility (NPC & IFC, 2014). More so, most married respondents in this study fall under this age cohort.

The study found out that when a health facility lacks the required equipment to treat patients, people were not likely to utilise the place. They stated that health facilities in their community lacked the necessary equipment for proper diagnosis and treatment. Previous studies have found that (Knight, Self, & Kennedy, 2013) when a health facility is not well equipped and lacks basic equipment for effective treatment of patients, people were more likely not to utilise such a place. Also when health facilities do not have modern health care equipment to treat people, they tend to perceive such health facilities as ineffective and not a place they should visit for treatment as seen in this study.

More so, the study found that the knowledge and skill of the health workers influences people to utilise a health facility. Having adequate knowledge and skilled health workforce are important to provide the best form of treatment to patients. Studies show that knowledge of health workers in a community health facility often influenced the way people within the community utilise the services available there (Habiba, Alrashidi, Al-otaibi, Almutairi, Makboul, & El-Shazly, 2012). Also when the health workers have the necessary skills to perform effectively at the health facility, people were more likely to visit such a place for treatment. But when the skills of the health workers are perceived to be inadequate or not sufficient to perform the task required by the patients, they were more likely not to make a repeat visit to such a health facility (Mulupi, Kiriga & Chuma, 2013).

Attitude to patients at a health facility is also a factor that limits the effective utilisation of services available at the health facility. Having the right attitude towards patients is important for health workers (Dias, Gama, Cargaleiro, & Martins, 2012). When people feel badly treated despite their payment for a service, there are more likely not to visit such a facility (Dias et al, 2012). In other studies, respondents stated that when they visited a health facility and are being treated well, they were more than likely to visit such a place again in the near future (Anand, Singh & Mohi, 2009; Adebajo, Bamgbala & Oyediran, 2003). When the treatment from health workers is bad and undermines their self esteem, they would not return

back to such a place again. Findings from this study revealed that people considered the attitudes of health workers as a factor that may limit their use of the health facility in their community, especially when such an attitude is negative toward them.

Findings of the study show that no significant difference exists between males and females in terms of their utilisation of a health facility in the study location. Whether male or female both were likely to utilise the health facility based on the earlier mentioned factors. More so, the utilisation difference between the male and female users and non-users show that more people will utilise the health facility within the community compared to those who would not despite the above mentioned limitations. Gender and utilisation of health facilities especially in informal settlements is under-researched but findings from other studies (Kevany et al., 2012; Artuso, Cargo, Brown & Daniel, 2013; Obiechina et al, 2013; Bakeera et al., 2009) show that utilisation of a health facility whether male or female is majorly as a result of factors such as the travel distance, physical location of the facility, waiting time before meeting with health personnel and the cost of the service among other factors.

As seen in this study, factors such as geographical location, income, cultural beliefs, family decisions and inadequate information combined did not influence how people utilise the health facility in emerging communities and urban slums. The findings have shown that there exists an association between these factors and the utilisation of a health facility in a given community. Socio-demographic factors such as age, education, marital status, and income tend to influence how and why people utilise health services. These factors remain a major determinant as to why health services are utilised in several communities (Mugisha, et al, 2004; Mugavero et al, 2011; Scheppers et al, 2006; Girma et al, 2011; Adamu et al, 2012; Obiechina, et al, 2013).

8.2.4 Objective Three

INVESTIGATE THE PEOPLE'S PERCEPTIONS OF THE PERFORMANCE OF THE HEALTH FACILITY IN EMERGING COMMUNITIES AND URBAN SLUMS OF SOUTH WEST NIGERIA.

Generally people perceive health care delivery services differently from one another. According to Frimpong et al., (2010) patients' satisfaction with access to public and private healthcare in London showed that public patients, as opposed to private counterparts, were dissatisfied with the service climate factors. The findings of this study show a huge disparity on how people perceive the performance of the health facility within their community. Some of the respondents felt that health facilities performed excellently, other think differently saying the health facilities within their community was of average performance and others felt their performance was below average.

Findings of the study show that certain socio-demographic factors (SDF) influenced how people rated the health facility. People's age, education, marital status, occupation and income influenced their perception of the performance of the health facility in terms of quality of care (structure, process and outcome) including: (a) the health care providers available to them for different diseases, (b) the kind and nature of services provided, (c) conduct of staff (attitudes, interpersonal relations, communication skills, privacy) (d) technical form of care (examination of patients, diagnosing, interventions (injections, minor surgery, administration of drugs, satisfaction with treatment outcome), (e) health care facility (space, cleanliness, availability of toilet, accessibility to drinking water for patients), (e) organisation of health care by type such as clinic, hospital, GP, traditional, or faith healer, accessibility of service (opening hours), organised preventive care (e.g. immunisation, family planning, antenatal care on set days), mobile clinics, (f) drugs (availability, quality, willing to pay for it), and (g) waiting time (before seeing a nurse, doctor or healer) among other factors (A1 Qatari & Haran 1999; Andaleeb 2001; Baltussen et al. 2002; Bruce 1990; Campbell et al, 2000; Haddad, et al, 1998). This study showed that the age of the respondents influenced how they perceived the performance of the facility in terms of health care services. People of older ages were more likely to think different towards the mode of health care delivery available to them, having used these services for years compared to those of lower ages. According to Van Vuuren & Bootes (1994) age has been seen to influence people's attitudes towards professional health care.

In previous studies (Caldwell, 1979) on education and infant care in developing countries, the educational status and literacy level of mothers was a major determinant of how well they will take proper care of their babies. If people especially mothers are well educated and informed within a community, they will utilise health care services and note if performance in service delivery is poor (Abuqamar, Coomans & Louckx, 2011). Health care delivery and its use are also influenced by people's marital status as seen in this study. More married people in this study rated the performance of the health facility across the six communities to be good, despite the strong rating of single people that health facilities were of average performance. The quality of care adds to how people would rate the health facility. Baltussen et al (2002) studied perceived quality of care of primary care services in Burkina Faso and found in a community survey that respondents were relatively positive on items related to health personnel practices and conduct and to health care delivery. Across the study location of Lagos and Ogun state the occupation of respondents also influence how they rated the performance of the health facility in the community. Occupation as a key socio-demographic variable has been shown to affect people's perception of health care delivery. Community health workers and their performance in service delivery to the people are improving as findings reveal that people perceive health workers to be good at their job.

Income as a socio-demographic variable (SDV) influenced how people rated the performance of the health facility in the communities. How much people earned was a key factor in determining the type of health service they wanted. The more they earned, the more likely they were to search for better health services within the community or outside their community. Therefore, income remains a key component on how people will want to rate a health facility as their socio-economic status (SES) informs what people think of a particular type of health service (Kevany et al., 2012). Findings from this study revealed that people's gender, religion and ethnicity does not influence how they perceived and rated the performance of the health facility whereas some studies (Van Vuuren & Bootes, 1994) show that gender, religion and ethnicity influenced how people rated health care within their community.

A large percentage of the respondents were of the view that there is need for improvement in the present health facilities within their communities. Improving the performance of the health facility will invariably lead to better health delivery for the people who reside in emerging communities and urban slums of south west Nigeria. Studies on improvement of

health facilities also show that when health facilities are improved better services are offered to users (Peters, El-Saharty, Siadat, Janovsky, & Vujicic, 2009; Bhattacharyya, Khor, McGahan, Dunne, Daar & Singer, 2010). Also, improved health facility performance will lead to improved general health systems performance especially in the study areas.

The study findings show that several reasons were made on why there is need for improvement in the performance of the health facility. These improvements will address the lack of adequate health information being provided to the community members. A well-functioning health information system is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health systems performance and health status (WHO, 2007c). That is, the goal of a health information system is to allow decisions to be made in a transparent way based on evidence (AbouZhar & Boerma, 2005). Such evidence should be beneficial to health users.

Furthermore, the need for improvement in the performance of the health facility is to ensure that when people visit the health facility, they receive treatment for the reason they visited. That is when people visit the place, irrespective of their socio-economic status, attention must be provided to patients by the health care workers. In situations where communication is lacking between users and providers the health facility tends to underperform in carrying out its task.

General health facility upgrade (provision of beds, modern equipment, drugs and vaccines, expansion of infrastructure to accommodate more patients) and need for increased human resource capacity for health are among the reasons why there is need for improvement in the performance of the health facility as the findings of the study revealed. Therefore when health facilities undergo upgrade to the use of modern health equipments and its human resource capacity increases, outcomes in terms of its deliverables will be increased (Peters et al, 2009; Jamison et al, 2006). Also improvement in the quality of health care and service delivery will improve the performance of the health facility. Quality of health service according to the general findings of the study is low. However, to ensure improved performance in the health system of emerging communities and urban slums, quality of service delivery must be revitalised. Quality of health service remains a major component in the evaluation of health systems performance (Arah, Klazinga, Delnoij, Ten Asbroek & Custers, 2003; Nketiah-Amponsah & Hiemenz, 2009).

The performance of the health facility in emerging communities and urban slums of south west Nigeria are being affected by the lack of medicines and vaccines for patients after diagnosis. When health workers treat patients but lack the required drug to offer the patients, the treatment procedure is incomplete. More so, when patients are required to go out and purchase drugs from community pharmacies and drug stores, they stand the risk of purchasing fake drugs because some drugs sold over-the-counter in Nigeria may turn out to be fake (Erhun, Babalola & Erhun, 2001). Findings of the study show that when a health facility lacks medicines and vaccines for patients, this affects their performance.

In addition, lack of adequate funding of the health facility especially government owned facilities affects its performance. Inadequate funding as past studies show affects the performance of the health facility and entire health system of countries (Welcome, 2011; Adeyemo, 2005; Soeters & Griffiths, 2003). More so, gross misappropriation and management are other factors which affect how health systems perform in developing countries (Ogbeidi, 2012; Lewis, 2006). In a systematic review by Basu, Andrews, Ksihore, Panjabi and Stuckler, (2012) on "Comparative Performance of Private and Public Healthcare Systems in Low- and Middle-Income Countries", private sector healthcare delivery in low- and middle-income countries is sometimes argued to be more efficient, accountable, and sustainable than public sector delivery. This can be attributed to poor health funding which affects the performance outcomes of health facilities in sub-Saharan African countries. Countries with low funding from the government to the health facilities performed poorly in their health care delivery to the people. Due to inadequate funding for health facilities as revealed in this study, their performance tend to be affected.

Health facilities do not operate in a vacuum, but are found within communities linked with the larger society. This linkage causes other macro factors to affect the performance of the health facility. Such macro factors include the lack of regular electric power supply to the communities. Generally in Nigeria, low electricity power supply across the country affects the delivery of health care to the people (Oyedepo, 2012; Olaseni & Alade, 2012; Benson, 2011). In informal settlements where housing and development is often not planned, power supply remains low because government presence cannot be felt in these communities in terms of infrastructural development. As the major distributor of electricity in the country, the Nigerian government is still unable to generate and sufficiently distribute electricity to every community (Oyedepo, 2012). Hence, people living in emerging communities and urban

slums still lack adequate electricity supply for daily living, which equally affects the performance of the health facility located within these communities.

Shortage of health workers according to the study findings also affects the performance of the health facility. Health facilities in these communities do not have the required amount of manpower to attend to the large populations of people that reside within these communities. Shortages of health workers have been found to affect the performance of health facilities in developing countries (Hongoro & Normand, 2006).

8.3 Strengths, constraints and limitations of quantitative Study

The study provides data on the nature of health care delivery in emerging communities and urban slums of south west Nigeria. Since there is a lack of sufficient published literature on understanding the nature of health care delivery in emerging communities and urban slums of south west Nigeria. This study provides useful health information to understand the study locations. The major strength of the study is that it provides documented data on the subject matter for reference and understanding of the realities people in the study locations are faced with. The study also offers evidence to support existing literature on issues of access and utilisation of health care services as documented in other countries. In addition, it provides information on new findings to understand the health system that exist in the study locations. This study had several constraints before data collection commenced in July 2013. First, it took 6 months to obtain ethical approval from the UI/UCH ethics committee at the University of Ibadan. Second, the process of obtaining funds for data collection was approved through the Bursary Department of University of Ibadan. This process from the time of request for funds to the final approval took over 3 months. Third, the 6 months strike of Academic Staff Union Universities and the 3 months strike of the Non-academic Staff Union of Universities also contributed as a constraint, as it was difficult to get principal officers to approve money meant for the (data collection) fieldwork and the researcher's expenses. A limitation in this study is that data collection in Makoko community of Lagos state was challenging as respondents approached declined to participate in the study (see section 8.2.1). A total of 80 respondents took part in the study of which fourteen questionnaires were considered inadequate for analysis as responses were scanty and incomplete. Hence only 66 questionnaires that were properly filled were included in the study, analysed and reported as seen in table 6.2.1. Another limitation of the study is that findings do not represent the nature of health care delivery in the entire south west region of Nigeria and the entire country.

8.4 Qualitative Findings

The use of focus group discussions, key informant interviews and in-depth interviews for the study provides a robust understanding of the existing social realities from the perspective of both the providers and users of health care delivery within the study area.

8.4.1 Population composition

A total of 64 participants took part in the KII, IDI and FGDs across the six communities and a total of 31 transcripts were derived from the qualitative instruments used and analysed (See sections 7.2.1 to 7.2.5). The selection of participants included community residents (FGD and KII) and health practitioners and community representatives (IDI). The number of doctors, nurses, pharmacist, public health personnel, herbal practitioner, community leader and women leader varied as seen in table 7.2.1. The key informant interviews consisted of six participants, one from each community while twenty-one males and eighteen females participated in the FGDs in four of the six communities.

8.4.2 Objective One

EXPLORE THE NATURE OF HEALTH CARE DELIVERY AND THE SOCIAL PROCESSES BY WHICH HEALTH CARE SERVICES EMERGE AND EVOLVE IN EMERGING COMMUNITIES AND URBAN SLUMS OF SOUTH WEST NIGERIA.

8.4.2.1 Multiple health care delivery methods, services and treatment

Across the communities findings shows that multiple methods of health care delivery are in operation. People living in emerging communities and urban slums have more than one choice option when it comes to where to visit for treatment. Some people choose to utilise the services available at a GHF which is a primary health centre or a health post. Such a health facility is usually a small building comprising three to four rooms as seen in the communities while other people may choose to visit a private hospital/clinic close to where they live or one that is less than 2km from their homes. Other forms of health care services are available to the people. Such services come in traditional form, while others come through the drug store (pharmacy or chemist), and through some medical practitioners (family doctors and auxiliary nurses).

People find it easy to walk into a drug store (pharmacy or chemist) to purchase drugs for treatment because it's available, accessible, affordable and widely acceptable by community members as a place to go for cost-effective treatment while some people would first seek the

services of an auxiliary nurse or call on a family doctor before going to the drug store to purchase the drugs they've been prescribed. Others will just go directly to buy the drugs and make use of them. According to Hardon, Hodgkin & Fresle (2004) self medication with non-prescription and prescription drugs is a problem in developing countries where pharmacies freely supply medicines over the counter, as do informal drug shops and small groceries. Sometimes people even self-medicate with prescription drugs on the advice of traditional healers. Various other forms of health care services remain available in the communities. These include the services of herbal practitioners, spiritualist/folk healers and patent medicine vendors. The herbal practitioners sell different kinds of herbal mixtures and concoctions (traditional medicine) as seen on page 341 of the appendix. Their services come very cheap and are easily accessible for those that need them.

Although traditional medicine use is beneficial as some studies have revealed the reliance on traditional healers for treatment has been successful as 60% of the children with high fever due to malaria were successfully treated with herbal medicines in Ghana, Mali, Nigeria and Zambia in 1998 (WHO, 2000b). However, the abuse by some of its users and lack of clear prescription for use undermines the wide acceptance of traditional medicines as forms of treatment today in this study while people make use of such services offered by these auxiliary nurses and family doctors within the communities due to easy access, informal practice and reduced cost of treatment. Also, due to its intrinsic benefits, users derive from their services findings of this study shows that some people would first choose to visit any of these other available health services within the community before considering visiting a health facility if the symptoms and sickness persist.

Different forms of services are available to the people at the health facility within emerging communities and urban slums of south west Nigeria. Some of these health facilities as the findings of the study reveal offer preventive, curative and laboratory services to the people. While government health facilities mostly operate during the day, some private health facilities on the other hand offer 24 hours services to the people. Both types of health facilities also provide other forms of health services such as ante-natal and post-natal treatment for pregnant women in the community. At the point of delivery some of the women would prefer to go to the health centre than going elsewhere for their delivery. Studies show that choice of place of delivery is dependent on a number of factors which includes cost of care and a reasonable quality of care (Doug, Binns & Lee, 2004).

The availability of private health care practice is on the increase each day in Nigeria (Scott-Emuakpor, 2010, Welcome, 2011; Obansa & Orimisan, 2013) and their presence can be felt within the communities such that doctors and nurses can establish hospitals or clinics of their own if they have the resources to do so. According to (Welcome, 2011; Obansa & Orimisan, 2013) the rise in private health facilities in Nigeria is attributed to the failure of government health facilities. Also, low funding and mismanagement which affects government health facilities have made people become dissatisfied with the type of treatment being offered to them there (Lewis, 2006). However, both the government and private health facilities in carrying out their services sometimes refer patients to a much bigger facility (secondary or tertiary) if such cases are complicated and they lack the manpower or equipment to treat such.

People's belief influences how and why they seek particular forms of health treatments. Findings from this study shows that traditional practices persist among the people in the communities. That is as a form of treatment option, people will visit the services of a traditional healer popularly known as "*Babalawo*" or make use of services offered by herbal sellers in the form of mixtures and concoctions. These are sold to people in small quantities on the street or roadside corners within the community. Some of these herbal sellers own small shops where people come to purchase dry leaves, roots, dry bark of trees or already made concoctions for treatment of illnesses. According to Pal & Shukla, (2003) herbal medicines are now in great demand in the developing world for primary health care not because they are inexpensive but also because of better cultural acceptability, better compatibility with the human body and minimal side effects. Some people according to the study findings prefer to use traditional/herbal medicines because of their belief that it has minimal side effects, both for the now and in the future compared to orthodox medicines. Also another major reason is because it comes cheap, is locally available and less complicated (Gupta & Raina, 1998) in usage compared to orthodox medicines.

The type of sickness which affects people in the study area is another reason for their choice of a particular treatment option over another. Treatment seeking behaviour is different across age groups, ethnic and religious groups (Scheppers et al, 2006; Shim, Compton, Rust, Druss & Kaslow, 2009). Also based on people's income their mode of treatment is necessitated by the ability to afford the cost of treatment they want. For people who suffer from bone injuries caused mainly by road traffic accidents, the likely option for treatment is traditional according to the findings of the study. But for women seeking treatment for their child the

likely option and first point for health services will be to visit the health facility. Treatment options for many people in the study area are influenced by the nature and type of illness (life-threatening illness or minor illness) that is affecting them.

8.4.2.2 Presence of health facility, services and treatment option

In emerging communities and urban slums of south west Nigeria, the presence of a health facility can be seen as stated by the respondents in the study. But these health facilities vary in terms of their ownership, size, and services rendered to the people in the community. Some of these facilities deliver care based on the staff strength they have, the availability of a doctor to attend to patients, and their ability to provide more than one treatment option to patients. As observed these health facilities work with little supervision from the local or state government Ministry of Health and therefore make decisions in their own interest and not necessarily in the interest of the people they serve.

Provision of basic primary health care to the community residents is made available at the health facilities. Findings show that health facilities in the study locations provide services such as immunization, basic infant welfare, and treatment of malaria, typhoid and pneumonia among other diseases. Health facilities in informal settlements have been found to offer preventive, curative, rehabilitative but not reconstructive services due to their limited capacity and focus on the poor (Doherty, Rispel & Webb, 1996; Muriithi, 2013).

Health care delivery in emerging communities and urban slums of south west Nigeria includes the provision of health treatment services from existing qualified community pharmacies and non-qualified outlets such as a "*chemist*". Due to the increased practice of self medication in the study area, the increase of these drug stores is found within the community. The practice of self medication among urban dwellers has been well documented in literature (Harpham & Molyneux, 2001). For people in informal settlements, such practices are common as residents visit these pharmacies or chemists to purchase medicines but these practices have not been widely documented in the literature. Some of the pharmacies/chemists in the study area provide health consultancy services for their customers while others would suggest that customers first visit a health facility to meet with a doctor and then come to buy the drugs as prescribed. The request of people who visit these pharmacies and chemists vary, hence the need for such drugs stores to engage in the sale of various types of medicines for different treatment based on a licensed permit to function.

8.4.2.3 Drug store services (pharmacy or chemist)

Some community pharmacist and chemist owners engage in offering diagnosis and treatment services to customers. This practice is common in informal settlements as the study indicates. More so, such practices occur mainly in communities where people have limited access to a health facility and now have to rely on the knowledge of the pharmacist or drug store owner for treatment (Bello & Bello, 2013; Okonkwo & Okonkwo, 2010; Faduyile, Oparah & Oreagba, 2012). As a result of this they play the role of doctors to treat people that require their services.

8.4.2.4 Social processes: migration, population growth, development, socio-economic and political factors

Social processes forms life patterns and shape communities in the transition from rural into peri-urban and then urban cities. These social processes according to (Tilly, 1983) are what explains a way of life of a group of people and shows how they engage with the wider society based on comparisons among social experiences. Various occurrences form the social processes for societies. Some of these include migration across time and space. These migratory patterns take place across informal settlements. Migration has led to the emergence of emerging communities and an increase in urban slum dwellers of south west Nigeria. As a social process influenced by push and pull factors, migration leads to population growth in the communities people move into. Findings from this study reveal that migration as a social process influences the development of emerging communities and increase of urban slum communities in south west Nigeria. Migration from rural to urban areas has led to population growth in Nigerian cities such as Lagos (Omololu & Lawal, 2013), thereby leading to increased competition for resources. As life in the city centre of Lagos gets more demanding and economically challenging, people move into emerging communities and urban slums. Also, within Lagos state, new communities are being formed and merged into one community as expressed by participants in the study.

Infrastructural development is another reason for the emergence of informal settlements in south west Nigeria. A finding from the study explains how the presence of a national highway has led to development and continues to influence people to migrate into emerging communities. The provision and presence of basic social amenities in specific regions, states, cities, towns, counties, district, and communities significantly influences people to migrate (Aworemi et al, 2011; Adesiji, Omoniwa, Adebayo, Matanmi, & Akangbe, 2009). The

presence of a major highway according to the study has translated into the need for health services because victims of road traffic accidents (RTAs) along the highway require prompt attention/treatment. Therefore the establishment of a hospital in emerging communities was as a result of the aim to reduce mortality caused by RTAs along the highway. Another reason that has lead to migration of people into emerging communities which has lead to the emergence of health care in this area is attributed to a political promise of development for the communities made by the previous political administration of Ogun state. Such glimpses of hope for development mislead people to migrate into these informal settlements of Magboro, Ibafo and Mowe communities along the Lagos to Ibadan expressway.

Many push and pull factors contribute to the migration of people into the urban slums of Lagos Nigeria. Officially, only nine urban slum areas (Makoko, Ajegunle, Ilaje-barija, Iwaya, Bariga, Itire, Agege, Badia (Ijora), and Amukoko) are well documented in the state (LMDGP, 2014; Olajide, 2010). But historically, by 1981, 42 slum communities or "blighted areas" had been identified in Lagos metropolis. At present, the number of slums in the city is estimated at about 100, housing almost 70 per cent of Lagos' population. The majority of slum communities are located in the oldest settled areas of mainland Lagos, especially in marshy areas and near the lagoons (LMDGP, 2006 in Adelekan, 2010). Population densities in these slum communities range from 790 to 1,240 people per hectare, and more than 75 per cent of urban poor slum dwellers live in one-room households with an average of 4.6 persons per room. It is common for 8–10 households to live in one house structure, sharing common cooking and sanitation facilities (Adelekan, 2010). Not having a sufficient income to pay for housing and accommodation is among the various reasons that force people to move into urban slums which provide cheap housing and living expenses. More so, people have access to land at no cost, to build make shift structures and small housing units for living. Findings from this study show that people who reside in urban slums consider their living spaces as conducive for them and their families irrespective of the environment challenges attributed to these areas.

8.4.3 Objective Two

EXAMINE PEOPLE'S ACCESS TO AND UTILISATION OF HEALTH CARE SERVICES IN THE STUDY AREA.

8.4.3.1 Proximity to health facility

Factors influencing people's access and utilisation of health care services are complex and multifaceted. In developing countries gaining access to a health facility remains a challenge for the poor (Chaya, 2007; Obansa & Orimisan, 2013; Harris et al, 2011). But the ease of access to a health facility for most people in Makoko, Abaranje, Ajegunle communities of Lagos state enables them to utilise the services available at the existing health facilities while in Magboro, Ibafo and Mowe communities of Ogun state gaining access to a health facility remains difficult for most of the people especially if such a facility is located on the other side of the community which requires them to cross the eight lane Lagos-Ibadan highway. Although past studies (Perry & Gesler, 2000) show that distance (geographical location) to the health facility is a major determinant of whether or not people will visit the health facility, some other studies state that distance alone cannot simply explain utilisation of health care services (Jahn, Dar Iang, Shah & Diesfield, 2000). The findings from this study further show that different factors are attributed to why people may or may not utilise existing health services within their communities at a health facility. Despite those limitations, distance to a health facility is still among the major limitations for most people.

As seen in this study, the challenge of distance is a major determinant on whether people can access and utilise health services. In general, the issue of distance to the health facility is more of a challenge for some people within the communities in Ogun state than in Lagos State. People who reside in Lagos have several options of what type of health facility they will prefer to visit for treatment and care. From having to visit a government health facility or the choice of a private health facility, other options are available for people in Lagos. But for some people in Magboro, Ibafo and Mowe, gaining access to a health facility especially when they live in the interior parts of the communities and have a long distance to travel before getting to the health facility remains a challenge. This study also shows that some disparities exist for people in these emerging communities as some who live near the health facilities have easy access to the place compared to those who live afar. Although this study is not aimed at comparing people who have easy access to a health facility to those who do not have easy access to a health facility, however, its findings reveal that such disparities exist within

the communities of Magboro, Ibafo and Mowe in Ogun state. These disparities show that within the same community's access to and utilisation of a health services remains unequal.

8.4.3.2 Infrastructural barrier (Lagos-Ibadan Expressway), bad roads and transportation

A limiting factor in gaining access to a health facility in Magboro, Ibafo and Mowe communities is the Lagos-Ibadan highway. Over the years the highway has undergone several renovations to serve the population of users that ply the road daily. Magboro, Ibafo and Mowe communities of Ogun state have been separated into two unequal halves by this highway for years. People who live on the part of the community where health facilities are not located find it difficult to cross the highway and gain access to the part of the community where health facilities are located. This affects their ability to visit the health facility when the need arise. More so, some people's homes are located in the interior parts of these communities. Such people as observed cannot afford to live close to the core community areas and market spaces because of the cost for rent. This group of people have to travel a far distance to get to the health facility within the communities and face some difficulties doing this.

According to the study findings bad roads are another factor which limit people living in the interior parts of emerging communities. Even when people do get a means of transport, the bad roads within the communities can serve as a deterrent for them and can cause them to underutilise the available health services within their communities. Bad roads have been found to be a limitation for people to gain access to a health facility even when available within their community (Ajala, Sanni & Adeyinka, 2005; Adesiji, Dada & Komolafe, 2012). Studies on distance and health care utilisation, reveal bad roads hinder people's access when visiting a health facility (Njoku & Akpan, 2013; Ajala et al, 2005; Adesiji et al, 2012). More so, when roads are not in good order people find it difficult to go to a health facility and resort to alternatives sources of health care treatment within their communities.

As seen in the study, there are several transport options available to the people and this does not seem to limit people from gaining access to a health. Availability of an effective and efficient transport system is an important factor that determines whether or not people can gain access to health care services within their communities (Parkhurst, Rahman & Ssengooba, 2006). Where transport is lacking or not sufficient the pattern of utilisation of a health service would be reduced and health services at a health facility will remain

underutilised. In emerging communities and urban slums, people have more than one choice of transport to a health facility. But for those living in interior parts of emerging communities, the waiting time is long at the bus stops or parks before a good means of transport becomes available to them. Adequate transportation and health care utilisation in developing countries have been found to be closely related. People will visit and utilise a health facility if the mode of transport is effective and available to them (Kevany et al, 2012).

8.4.3.3 Attitude of health workers

Attitude of health workers at the health facility is a factor which determines whether or not people will utilise the services offered to them. Attitude of health workers remains an important parameter for measuring the performance of health workers at the health facility (Tilahun, Bezatu, Egata, & Reda, 2012; Gonzaga, Kiguli-Malwadde, Francis, & Rosemary, 2009). Having the right attitude to work enhances productivity and output for workers (Dieleman & Harnmeijer, 2006). In the health sector, having the right attitude to work enables health workers provide the best form of health care services to the patients. Findings from this study show that health workers attitude towards the patients can be unpleasant and makes users unhappy whenever they visit a health facility. Generally, studies (Dias et al, 2012; Oyo-Ita et al, 2008; Asuquo, Etuk & Duke, 2000) show that when the attitude of health workers is perceived to be negative towards the user of health services, his or her utilisation of such service will diminish over time even when such services are available and accessible. According to Professor William James (1842-1910), an American philosopher and psychologist, "the deepest principle in human nature is the craving to be appreciated". This includes sick persons and their relatives that visit a health facility for treatment. Showing a positive attitude to users of the health facility further encourages them to utilise the services when available (Tilahun et al, 2012; Kayombo et al, 2012).

Attitude of health workers at the community level and health care utilisation in developing countries have been closely linked together (Oyo-Ita et al, 2008). Whether the health facility is a public or private establishment, when people perceive the attitude of the health worker as negative towards them, their utilisation of such a facility will diminish. In emerging communities and urban slums, participants stated that they put into consideration the attitude of the health workers and this tends to influence their decision. More so, this determines their choice of whether or not they should visit the health facility within the community.

8.4.3.4 Quality of health service

Findings on the quality of care and health service in emerging communities and urban slums of south west Nigeria highlighted that the quality received was low. This is because health workers at the facilities were not well organised in carrying put their duties. Also people experienced long waiting times before services can be delivered to them. In some situations patients do not receive the treatment they sought because of the long time they spend waiting before they get attended to. Long waiting time at a health facility was reported to reduce service quality, discourages users and leads to under utilisation of existing health facilities in the community. However, when the quality of service delivery is well organised and people spend a short time waiting before they get attended to, the demand side and utilisation of health services is high (Haddah & Fourier, 1995; Jack-Ide & Uys, 2013; Emelumadu et al, 2014). Health facilities that have modern equipment with health workers who are committed to work are more likely to perform better and offer better quality of care. A well functioning health facility will offer good quality service to patients and users whether it is found in a developed or developing country.

Quality of care remains an important indicator in determining the performance of a health system (Ibrahim, 2001; Ballard, 2003; Weiner at al, 2006). A decline in the quality of care may cause frustration among patients (Hutchinson, Do & Agha, 2011), especially the poorest women, who usually suffer poor treatment, as health workers are likely to give preference to wealthy women who offer tips and bribes. As seen in the study, people in the FGDs expressed frustration when they visited the health facility within the community. They complained about the poor treatment they got from the health workers as their manner of approach was very bad. Also as a non-native of Yoruba language, FGD participants expressed their disappointment because when at the health facility, the health workers will put them aside and attend to those who understood their native language first before coming to them. Among other things studies show that decreased quality in delivering care services may be the result of increased workload or declining staff morale across health facilities.

8.4.4 Objective Three

INVESTIGATE THE PEOPLE'S PERCEPTIONS OF THE PERFORMANCE OF THE HEALTH FACILITIES IN EMERGING COMMUNITIES AND URBAN SLUM OF SOUTH WEST NIGERIA.

8.4.4.1 Effective and efficient health services

This study showed that perceptions of the effectiveness and efficiency of the health facilities in the communities is low. These health facilities are not performing at their best causing people to bypass one health facility such as the GHF to a PHF or faith-based health facility. Some women bypass nearby health facilities and spend more time and money to deliver at health facilities where the quality is, or is perceived to be, higher (Kruk, Mbaruku, McCord, Moran, Rockers, Galea, 2009; Kruk, Mbaruku, Rockers & Galea, 2008). That is, people's perception of a health facility affects their pattern of utilisation. Although some facilities are better equipped than others, the study results show that respondents believe that health services which belong to the government are not effective and efficient in their delivery as compared to those offered at a private hospital or clinic. This can be attributed to several reasons which include poor funding of the health facilities.

Furthermore, this study highlights that people perceive the health workers within their communities to be unqualified to perform the roles assigned to them within the health facilities. Therefore this affects their utilisation of the health facility. For example, how women perceive quality of care affects their utilisation levels. The effective and efficient use of health interventions promotes health systems performance, especially in developing countries (Kruk & Freedman, 2008; Arah et al., 2003). More so, health workers' efficiency ensures that patients receive treatment as and when due and undergo proper care within the health facility. Although these health facilities are located in informal settlements, the effective and efficient delivery of services will encourage people to utilise the place irrespective of its ownership and control. But if services fall short of expectations, this deters them from its use. Findings show that people are been discouraged from utilising the services offered at the health facilities within their communities because they perceive the services to be of a low quality.

Health care utilisation is based on the effectiveness and efficiency of service delivery at the health facility (Kruk & Freedman, 2008; Basu et al., 2012). When a health facility cannot employ the services of qualified health personnel to work and users perceive existing workers

as unqualified, this will affect how they view the mode of service delivery. Studies (Dubois & Singh, 2009; Buchan & Aiken, 2008) show that having the right mix of qualified health personnel in a health facility causes people to perceive the services offered there as better and of good quality. Despite people's educational attainement, misconceptions and cultural beliefs make some people perceive the services offered at the health facility as not adequate for the treatment of certain illness as seen in this study. This makes people to seek alternative forms of treatment such as the use of traditional medicines.

8.4.4.2 Lack of modern equipment

Lack of modern equipment undermines the performance of a health facility especially when located within an informal settlement or rural area of developing countries. The availability of equipment enhances the utilisation of health services at a modern health facility. But when such facilities lack the required equipment, (Peabody et al, 2006) utilisation is affected and the performance of the health workers remains low. This study highlighted that health facilities in emerging communities and urban slums lack sufficient equipment. This causes such facilities to underperform in carrying out their task. More so, when equipment at the health facility becomes weak and needs a replacement but it is not replaced, the test results derived using such an equipment will turn out inaccurate information. This will also lead to wrong diagnoses and hasty conclusions being reached by health workers treating patients at the facility. The use of good working modern health care equipment across health facilities is important as this helps to produce the best results for patients (Peabody et al., 2006).

Furthermore, the availability of modern equipment for diagnosis, treatment, rehabilitation and cure of illness among patients increases the performance of a health facility. In developing countries health facilities located in rural areas, peri-urban areas and some urban areas have been reported to lack modern equipment (Peabody et al., 2006). Due to such lack of modern equipment, health systems performance remains low (Kruk & Freedman, 2008) in developing countries and this continues to be a challenge for health users. Such lack of modern equipment forces people to seek alternative forms of health care. The poor performance of health facilities attributed to non-usage of modern equipment continues to prolong the illness, of patients as timely diagnosis and treatment is delayed. More so, lack of modern equipment is also associated with the lack of well trained personnel to operate this equipment at the health facilities and this reduces the performance of the health facility as seen in this study.

8.4.4.3 Shortage of skilled health workers

Another factor which remains a challenge facing health systems in developing countries is the shortage of a health workforce (Ezeonwu, 2013; Awofeso, 2010). There exists a shortage of health professionals working in rural areas worldwide (Hamilton & Yau, 2004; Grobler, Marais, Mabunda, Marindi, Reuter, & Volmink, 2009), due to their preference to work in urban areas (Awofeso, 2010). In addition, shortage of health workers in informal settlements is also high (Ziraba, Mills, Madise, Saliku, & Fotso, 2009; Mutua, Kimani-Murage, & Ettarh, 2011) thereby affecting the performance of health facilities. This study shows that health facilities do not have enough staff to work and provide health services to patients. For those presently working in these facilities, they suffer from stress and exhaustion due to work overload. Health workers as this study shows tend to work overtime by assisting their colleagues on duty. According to some public health officer interviewed working overtime is a regular occurrence as other colleagues too may be expected to do the same even when they are not on duty.

The continued strain as a result of the shortage of health workers affects the quality of delivery patients receive; and this affects the performance of the health facilities and health system in general as seen in this study. This shortage is attributed to several factors which include the lack of qualified health personnel suitable for employment or the poor structuring that exists within health systems such that health facilities in urban areas have more health workers compared to facilities in informal settlements and rural areas. The influx of health workers from rural areas to urban areas is a common phenomenon in developing countries (Awofeso, 2010) such that health facilities in informal settlements are left with few workers to attend to a large population of people within the communities. In addition, shortage of health workers affects performance of the health facility as seen in this study because health facilities are unable to run 24 hours services to the community. Instead, health workers are only available to attend to people during the day. Findings of this study shows that health facilities require more staff to work there to improve their performance and meet the needs of the people within emerging communities and urban slums of south west Nigeria.

8.4.5 Objective Four

ASCERTAIN SPECIFIC FACTORS AS SOCIAL DETERMINANTS OF HEALTH IN EMERGING COMMUNITIES AND URBAN SLUMS OF SOUTH WEST NIGERIA.

8.4.5.1 Ignorance and lack of awareness

Ignorance and lack of awareness are pervasive in the study area among the people. The findings from this study reveal that people engage in self medication because of their ignorance of the importance of consulting a doctor for proper diagnosis and prescription. Ignorance on how to keep healthy and the best ways to live healthily among the people causes them to make wrong decision concerning their health such as non-compliance with prescription drugs or consumption of unhealthy foods. Ignorance remains a major factor that influences people negatively causing them not to utilise health services even when such services are available to them (Ndikom & Ofi, 2012). Ignorance further hinders people from getting the right health information and intervention they require. In addition to ignorance is lack of awareness that existing health facilities within their communities offer specific health programmes or organise free medical check up services. This also affects people's health as seen in the study. Therefore when people have the right information and knowledge at the right time, ignorance and lack of awareness on what health benefits are available to them to stay healthy is avoided.

People in emerging communities and urban slums are ignorant of things such as how to take proper care of their children especially infants and children as the findings of this study reveals. As a result of their ignorance on proper child care as a determinant of health, infant and child mortality in Nigeria remains high at 78 per 1,000 and 124 per 1,000 populations respectively in 2011 (UNICEF, 2013). More so, not visiting the health facility for ante-natal and post-natal treatment can also be attributed to ignorance and lack of awareness that such services exist. Findings show that people are not aware of the available free health programmes at the government health facility which are beneficial to the people in the study location.

8.4.5.2 Health education and literacy

As seen in past studies on the importance of health education, health promotion and health literacy, these are important for effective public health programme implementation (Nutbeam, 2000). In developing countries health education and literacy remain low, especially in rural areas where people do not have easy access to a health facility (Nutbeam,

2000). But where health education and literacy is available people are well informed to make the right decisions concerning their health. As seen in the study from the qualitative findings, people are not well educated and informed about their health and how to stay healthy at all times and this makes it impossible for people to make right health choices. That is, not knowing the importance of visiting a certified midwife at the health centre instead of an unqualified nursing practitioner within their community because the latter is cheap, can cause people to put their life at risk. Health education for people in informal settlements such as emerging communities and urban slums is low as seen in the study. Health education is important for people to stay healthy. More so, health literacy concerns the knowledge and competencies of persons to meet the complex demands of health in modern society (Sorensen et al., 2012).

The responsibility of effective public health education and health literacy awareness rest on the government at all levels to ensure that people in communities are informed and well educated. Ensuring that health literacy is taken serious in schools is a responsibility of the government. When government establishes a health facility within the community, more needs to be done to re-orientate and educate the people on what services are available to them there whether it is free or not. Giving the right information to educate and make the people more literate in matters of their health is one of the main responsibilities of the Ministry of Health. People in the community need to be told by public health experts what is needful and what is not when it comes to their health.

Community partnerships and engagement with religious organisations within the community is a way to educate the people as seen in the study findings. Religion plays a vital role in the life of Nigerians and the moral education of its adherents. Therefore, religious leaders need to be used as agents of change to educate and inform their members on the importance of staying healthy. Also through the churches, mosque and other religious homes people will be made to understand the value and importance of utilising available health services within the community either at the health centre, private hospitals, and faith-based clinics or community health facilities as they choose.

8.4.5.3 Socio-cultural factors

Socio-cultural factors have been well documented to influence people's health choices in developing countries (Eshetu & Woldesenbet, 2011; Abubakar et al, 2013). Socio-cultural factors have been found to influence people's choice of health provider (Ewa et al, 2012),

place of delivery (Ewa et al, 2012; Kitui, 2013), utilisation of a health facility or service (Bakeera et al., 2009), and foods for consumption and behaviours. This study highlighted that culture and tradition play a vital role in people's decision making on when and where to seek health care services/treatment. Some people in the study are guided by their social and cultural beliefs even in terms of their health and they have certain preconceived ideas about the benefits of a particular type of health service provider. This further influences their choices and why they seek health care treatment.

Socio-cultural factors continue to shape people's belief in a particular form of treatment over all other types, irrespective of existing evidence that shows that new forms of treatment which surpass earlier ones exist. As seen in the study a participant was assertive in his belief in the use of herbs for treatment, stating that going to the hospital was of no importance to him. He went further to state that taking of herbs works better that using orthodox medicine or forms of treatment for a particular sickness such as Malaria fever. Socio-cultural factors remain a core determinant of health for people in developing countries.

8.4.5.4 Economic and financial factors

Income has been shown to be an important element in accessing and utilising health services (Kevany et al., 2012; Lagarde & Palmer, 2011). Findings from the qualitative study show that user fees for health care services are in operation in the communities. People do not access and utilise health care services for free but at a particular cost. Whether it is a visit to a government health facility, private health facility, faith-based facility or community health facility, people are required to pay for health care services as seen in the study. In Nigeria, user fees were introduced by the Nigerian Government in 1998 under the Bamako Initiative which advocated for cost sharing and community participation to increase the sustainability and quality of health care (FMoH, 1994). Over the years, user fees have been in operation across health facilities in the country. Although it was proposed that user fee would increase the resources available for health care and improve efficiency as well as equity in health care (World Bank 1987; James, Hanson, McPake, Balabanova, Gwatkin, Hopwood, et al, 2006) the available evidence on the impact of user fees is equivocal (Olakunle, 2012). Hence the bone of contention is whether to retain or remove user fees (James et al, 2006).

The findings from the study show that health care delivery at the government health facility is been publicised as free to the people but in reality users state that when you visit the facility for treatment people are required to pay for the treatment. Private providers on the other hand

are at liberty to dictate their user charges as people are levied based on their socio-economic status. The issue of user fees in Nigeria has attracted scholars; however, there is a dearth of information on the effect of user fees on revenue generation, health care seeking behaviour, access to care, efficiency, and utilisation of services in Nigeria (Olakunle, 2012). According to Ogunbekun, Adeyi, Wouters & Morrow (1996), they reported that without accompanying visible quality improvement, user fees resulted in lower utilisation of health care services (Yisa, Fatiregun & Awolade, 2004). This is evident in emerging communities and urban slums as seen in the study findings. A study that evaluated the effect of user fees on availability of drugs reported that user fees has not led to increased drug availability (Sambo, Lewis & Sabitu, 2008), the same is evident in the study location although another study reported that payment of user fees had given rise to excessive drug prescription (Uzochukwu, Onwujekwe & Akpala, 2002).

Some negative effects have also been reported on the impact of user fees on health seeking behaviour and equity (Uzochukwu, Onwujekwe & Eriksson, 2004). For participants in the focus group discussion of this study, payment of fees meant that when they don't have the money, they'll be unable to receive treatment. In a study by Uneke, Ogbonna, Ezeoha, Oyibo, Onwe & Ndukwe, 2009), it was reported that the majority of study participants would prefer paying user fees if they are affordable and would guarantee efficient and quality service. However, it should be noted that the willingness to pay does not translate to ability to pay. The ability to pay might require poor households sacrificing their longer term economic well-being. This is referred to as catastrophic health expenditure and this has been shown to be high in Nigeria (Onoka, Onwujekwe, Hanson, & Uzochukwu, 2010). According to Olakunle (2012), the use of waivers and/or exemptions in Nigeria has also been suggested, but the implementation of waivers and exemptions is fraught with challenges that have made it ineffective in many settings (Gilson, Russel & Buse, 1995). Such difficulties include identification of eligible poor, limited administrative capacity, willingness of the health workers in enforcement of the guidelines, and inconsistencies in granting of exemptions (Kivumbi & Kintu, 2002). Results from this study show that user fees for health services in emerging communities and urban slums remain in operation and this influences people's health and well-being.

8.4.5.5 Environmental and infrastructural factors

There exist some environmental and infrastructural factors which affects people in emerging communities and urban slums of south west Nigeria. According to the study findings, not having a good drainage system contributes to the spread of communicable diseases such as malaria fever in the community. Life in a good environment for people in developing countries will help them live healthy lives. When people lack access to safe water, access to sanitation and infrastructure, when they live in poor housing structures or become overcrowded in a home (UNHSP, 2003), they become easily susceptible to communicable infections. The environment of slums remain extremely unhygienic as they are located at sites such as solid waste dumps, open drains and sewers, low land, embankments, and often along rail lines (UN-HABITAT, 2003).

The findings of this study further highlight that in general the environments of emerging communities and urban slums are very poor as open stagnant drains are common within their environment. Some of these open gutters are filled with dirty and coloured black water that causes mosquitoes to breed easily. Also people in these communities do not practice basic hygiene often such as hand washing; as such they spread infections around the household and community very easily. While some people who own private water sources engage in selling of water to the people within the community, this study reports that they do not often clean the tanks they use for storing the water. Hence people who patronise them are easily prone to water borne diseases such as typhoid.

Because people lack basic social amenities in these communities studied, not very many homes have essential toilet facilities. Studies have shown that the majority of the people who reside in informal settlements do not have access to a modern toilet facility (Morakinyo et al, 2012). This further puts them at risk of getting infections from pit latrines which are dug behind their homes. Open defecating remains a common practice in emerging communities and urban slums of south west Nigeria. According to a joint UNICEF and World Health Organization report in 2012, more than 1.1 billion people in the world practice open defecation. The largest number of these people are in India (626 million), followed by Indonesia (63 million), Pakistan (40 million), Ethiopia (38 million), and Nigeria (34 million). This study finding reveals that many people in emerging communities and urban slums engage in open defecating as a result of lack of modern toilet facilities in their homes. Also because public toilet are not commonly found in these environments, this further encourages

people to defecate outside their homes in the open field, inside the open gutters or along waterways (canals) in the community.

Lack of clean pipe-borne water is another factor that affects people's health in the study area as seen in the study findings. More so, because people purchase drinking water from various private water sources, they become vulnerable to contact water-borne infections. Such water sources are unclean but remain the major source of water available to the people in the community. People have little choice but to purchase their water from these sources. Not having access to good clean water for people living in developing countries affects their health (Pruss-Ustun, Bartram, Clasen, Colford, Cumming, Curtis, Bonjour, et al, 2014).

Another factor that affects people's health is the dusty and marshy nature of the communities as seen in this study. Because the roads in these communities are untarred, during the dry season, many dusty particles can be found in the air and this causes lower respiratory tract infections in the people. Lower respiratory tract infections have been found to be the major cause of morbidity and mortality in the world (Moellering, 2004). For people in emerging communities and urban slums of south west Nigeria, the major cause of such an infection is attributed to the unhealthy nature of the environment they live in.

8.5 Strengths, constraints and limitations of the qualitative study

All three qualitative instruments used for the study comprehensively addressed the subject matter on examining the nature of health care delivery in emerging communities and urban slums of south west Nigeria. The study made use of the fundamental elements considered in designing in-depth interviews, key informant interviews and a focus group discussion guide. The design of each instrument was based on existing literature on health care delivery, issues of access and utilisation of health services, perceptions of the performance of health facilities, and the factors influencing the spread of diseases in informal settlements. These were extensively consulted to guide the forming of questions in each instrument. Similar constraints as highlighted in section 8.3 affected the process of data collection for the qualitative study. As a result of the constraints experienced due to delay in the approval of funds for the data collection, the proposed 30 IDIs, 12 KIIs and 12 FGDs could not be obtained as the researcher was left with a limited time to obtain the required data set. In addition, identifying herbal practitioners to partake in the study was a challenge as those approached declined to participate in the research. Only one herbal practitioner as seen in

table 7.2.1 was willing to participate in the study. Also, not all the participants approached took part in the study, only those that were willingly. The decline of some of these people can be attributed to their suspicion of the researcher despite him presenting them with the ethics approval letters from UI/UCH and HPM/CGH ethics committees and identification as a student. However, this study is limited to two states in south west Nigeria and findings may not be generaliseable to other populations not residing in such an environment.

8.6 Linking the quantitative and qualitative findings

Both the quantitative and qualitative outcomes of this study provide new findings on the nature of health care delivery in emerging communities and urban slums of south west Nigeria. The study made use of different groups of respondents as the quantitative data was derived from selected households across the six communities while the qualitative study participants were residents and providers of health services in the communities. Those who participated in the survey did not take part in the FGD, IDI or KII. The reason was to accommodate responses from a larger group of people within the community on the nature of health care delivery. More so, because members of the communities where the study was carried out are heterogeneous as a result of their religious affiliation, ethnicity background, educational qualification, marital status and socio-economic status. Therefore, their different opinion on the subject matter holistically explains health care delivery across the six communities in Lagos and Ogun State. The triangulation of space, time, people and research instruments in the study was to enable the research elicit responses from a broad category of people who live or work in the communities.

8.6.1 Objective One

Findings from both the quantitative and qualitative data highlight that multiple health care delivery systems are in operation in emerging communities and urban slums of south west Nigeria. These forms of health care delivery include the presence of different types of health facility namely health centre or health post (government), private hospital/clinic/maternity home, specialist centre (private ownership), community (community ownership), and faith-based hospitals/clinics (religious ownership). In these communities the services of traditional care providers are present (herbalists, diviners, folk healers, traditional birth attendants, and spiritualists), drug stores (pharmacy or chemist) or patent medicine vendors (drug peddlers) while informal medical practitioners (auxiliary nurses, family doctors and midwives) also

offer health services to the people. A multiplicity of health services are a common feature of developing countries (Harpham & Molyneux, 2001). This makes health care delivery very complex in Nigeria (Olakunle, 2012).

The availability of drug stores either a pharmacy or chemist, is seen in both the quantitative and qualitative findings. Some people will prefer to visit the drug store first before visiting the health facility as seen from the IDIs and FGDs because it is accessible, available and widely patronised by people in the community while the quantitative data shows that the majority of the people first choose to visit a health facility. This disparity may be attributed to several factors which may include people's age and education which influences how they perceive the health facilities within the communities.

The findings from the quantitative data show the years of operation as most of these various forms of health care services have been in operation in the communities. The qualitative data however does not provide information on the years of operation. Self medication was found to be a common practice by the people as reported by the quantitative and qualitative data. Because of the availability of drug stores close to people in the communities, they have easy access to purchase drugs and some of these drugs come at cost-effective prices making it affordable for them. Self medication with non-prescription and prescription drugs is especially a problem in developing countries where pharmacies freely supply medicines over-the-counter, as do informal drug shops and small groceries. Sometimes people even self-medicate with prescription drugs on the advice of traditional healers (Hardon, Hodgkin and Fresle, 2004). The practice of self medication among the people in the study area is a major reason for the proliferation of drug stores within the communities.

Other forms of medication and treatment were reported by the quantitative study as the results show that people also engage in group-medication which takes the form of household prescribed medication, neighbourhood prescribed medication and community prescribed medication or form of treatment. This is now a treatment option as seen in the findings whereby consultation is made with people outside the immediate household. They provide treatment options and solutions based on their experience in the use of a particular treatment or knowledge on the efficacy of the treatment. According to Hardon, Hodgkin & Fresle, (2004) people keep stocks of leftover medicines in their homes, and re-use them or give them to neighbours or relatives who request them. The qualitative data did not provide any information on group medication as a form of treatment option used by the people but instead

emphasised that people will prefer to first consult an auxiliary nurse or family doctor for treatment before they consider visiting a health facility in their community if symptoms persist.

Both the qualitative and quantitative data reported that people in the study area make use of traditional medicines in the form of herbal mixtures or concoctions. The medicines are available through a visit to an herbalist (*Babalawo*), diviners, folk healers, traditional birth attendants, bone healer and spiritualists for treatment. More so, traditional medicines are now been sold in well packaged form similar to orthodox medicines as seen on page 329 of the appendix. While herbal sellers can be seen during the day hawking these medicines across the street within the community at very cheap cost, traditional medicines use remains widely accepted in the community as the study reveals. Both the quantitative and qualitative data reveals that some people prefer a combined use of orthodox and traditional medicines for treatment of a particular ailment. Such preference is highlighted further in the quantitative data of this study.

The presence of a health facility in the communities is reported in both the quantitative and qualitative findings of this study. The facilities vary in terms of their size, ownership and service delivery. Such health facilities carry out basic primary health care services and in situations where such patients cannot be treated at the facility, referral from the health facility is made to other secondary and tertiary facilities within the states to treat the patient. The presence of a health facility within the community provides people with the opportunity to get proper diagnosis and consultation from a medical practitioner, other than visiting a non-medical personnel for treatment.

Social processes which have contributed to the emergence and continuing evolution of health care delivery in the communities differ as seen in the quantitative and qualitative data. However results from the qualitative and quantitative data shows that migration represents a social process people engage in as they move from urban Lagos into emerging communities of Magboro, Ibafo and Mowe while some other people instead of going outside the city of Lagos prefer to relocate into urban slums within the state.

Besides migration within and outside Lagos state leading to population growth in emerging communities and urban slums, another form of social process is attributed to infrastructural development along emerging communities of Ogun state. However, findings from both the quantitative and qualitative results show that when people move into these communities, there is increased need for social amenities and services which includes the need for health services. This forms the core reason for the emergence of health care delivery systems whether formal or informal in emerging communities and urban slums of south west Nigeria. Results from the qualitative data emphasised the presence of the Lagos-Ibadan highway as a social process aimed at development which has further led to how health services have evolved in emerging communities. When an accident occurs on the highway, findings show that people require immediate treatment before been taken to a secondary or tertiary hospitals if need be. Hence the presence of the highway has given rise to the emergence of new health services within the communities and the evolution of existing health services based on demand for treatment.

8.6.2 Objective Two

Findings from both the quantitative and qualitative study reveals that access and utilisation of health care services in the study area is determined by certain factors which include, distance (travel time), user fee (finance), transportation, road network, family decision, information, type of service, knowledge and skill of health workers, attitude of health workers, quality of the service, available equipments, waiting time, communication and socio-demographic factors. These factors determine if people can get to the health facility and whether they can make use of the services. Results from both data shows that distance to a health facility varies from one community to another community. In urban slum communities, distance is not considered as a major barrier or limitation for people in gaining access to a health facility. But in emerging communities (Magboro, Ibafo and Mowe), distance to the health facility is considered a key factor because some members of the community live in the interior parts of the community called new sites. These new sites are far from the core community centre and market places.

Transportation as seen in from both the quantitative and qualitative findings is available for the people and does not pose a grave challenge in visiting a health facility. Various forms of transport services are available for people to choose from. Although other forms of

transportation are available across the six communities, most people choose to take a motorcycle *(Okada)* to get to the health facility. The qualitative study findings did not lay much emphasis on transportation but they highlight that when roads are bad people will have a limited access to a health facility in the community, more so, when they live in the interior parts of that community and have long distances to travel.

Both the quantitative and qualitative findings agreed that transportation, attitude of health workers, quality of service, user fees, knowledge and skills of health workers and use of modern equipments for treatment of patients are reasons that determine whether or not they will utilise a given health service. People were of the opinion as seen in the findings that they put these factors into consideration before deciding on whether or not they want to use a given health facility in the community. The quantitative findings showed further that people use these health facilities because of the services which they offer to them which include immunisation for babies, ante-natal and post-natal services and for medical check-up services to know their health status. More so, the quantitative data on access and utilisation of health services in the communities shows that when people have the right information about what is available for them at the health facility, they were more likely to use the place.

Only the quantitative data showed findings that people's age was a determinant of their utilisation of services at the health facility within the community. Also it shows that no form of gender variations in terms of utilisation exist between males and females in the community while other socio-demographic variables such as gender, religion, education, ethnicity, marital status and income can influence people to utilise the health facility services in their community. The qualitative findings on the other hand provide information that long waiting time can deter people from utilising the services that are available at the health facility while language can also be a limiting factor for them not to utilise the services at the health facility. The quantitative findings reveal that people's income does not deter them from utilising services but findings from the qualitative study showed that user-fees is a factor that limits utilisation of health services.

8.6.3 Objective Three

The perception of health facilities in the study area is reported by the quantitative and qualitative findings. There exists a huge disparity on how people perceived the perception of the health facility as reported by the quantitative data but the qualitative data showed that

government health facilities are not effective and efficient in their service delivery compared to a private health facility. This according to this study is attributed to poor funding. Both the quantitative and qualitative report differently on how people in the study location perceived the health facilities in their communities.

Only data from the quantitative findings provide information on the influence of certain SDF on how people perceived and rated the health facilities in their communities. That is, people's age, education level, marital status, occupation and income influenced how their perceived they services of the health facilities. The findings reveal some disparities based on the socio-demographic factors and how people rated the performance of the health facility. For example, education has been shown to be a key determinant on whether people will utilise a given health service or not, also people's educational level influences how they perceive health services offered in the community. Both the quantitative and qualitative data results showed that people in the study area perceived the quality of health care services to be low. That is, available services been offered at the health facilities in the community are of low quality and this affects their performance.

Furthermore, findings from all the instruments highlight that shortage of health workers and qualified personnel tend to affect the performance of the health facilities. This undermines the ability of the health facilities to meet the need of all the people within the communities. More so, when the number of health workers is not sufficient service delivery becomes inadequate to meet the demand for healthcare. Also, this positively reinforces the way people perceive the performance of health facilities inadequate to meet all their health needs.

On the performance of the health facility within communities, the quantitative results showed that poor communication between providers and users affects the performance of the health facilities. Also, due to lack of sufficient hospital beds and modern equipments for treatment of patients, they tend to rate the health facilities low in term of their service delivery. When a health facility cannot provide medicines and vaccines for patients such health facilities are perceived as ineffective in their commitment to keep people healthy. In addition, findings from the quantitative data showed that lack of a constant electric power supply to the health facility within the community hinders its performance, hence becoming inefficient.

The qualitative data on the other hand provides a different set of findings not captured by the quantitative data. It reveals that cultural beliefs influence people to perceive services offered

at the health facility for treatment of certain illness as inadequate. For example, in treating an infection attributed to a spiritual or witchcraft attack, people will not visit a health facility because of their belief that the solution is beyond orthodox medicine. Also, the qualitative findings show people's upbringing influences their preference for traditional medicine to orthodox medicine. This makes them view the services offered at the health facility to be inadequate and ineffective. The qualitative findings further showed that due to staff shortage across the health facilities, present health workers are overburdened with too much work and this affects their performance. From both the quantitative and qualitative study findings people's perception of the performance of the health facility remains low in emerging communities and urban slums of south west Nigeria.

8.7 Theoretical framework and research outcomes

8.7.1 Structuration Theory

A combined use of a theory, model and framework provides an interdisciplinary approach to examine the nature of health care delivery in the study area of south west Nigeria. The various types of health facilities present in the communities according to Giddens's structuration theory are categorised as *social structures* which are governed by a set of norms, laws and responsibility to provide health care services to the people. The health facilities as seen in the study findings perform different tasks in terms of service delivery to the people. These facilities act as institutionalised modes of conduct for health care delivery in emerging communities and urban slums and operate based on its closely knitted relationship with the (*social actors*) community members.

As seen in this study the various social structures are functional in the communities based on their resources, organisation, consensus and approval from community stakeholders (*structures of health*). In each community where the study took place, a government health facility, private health facility, faith-based health facility and community health facility are present for the people to utilise. The services offered through the various health facilities cannot be utilised in isolation. The health facilities existence and operations are dependent on people in the communities. Also, the people are equally dependent on the services of the various health facilities offered to them. This form of relationship according to Giddens is referred to as a *duality of structures* because social structures make social action possible, and at the same time that social action creates those very structures (Giddens, 1984).

People utilise the health facilities for various reasons as seen in the study findings. Some because the services are affordable, because it is close to them, for medical check-up services, treatment of an ailment, for maternal delivery services and because they prefer it to the use of traditional medicine. The health facilities within the communities as health structures provide services based on their capacity and demand from the people in the community. Based on Structuration Theory, *structures of health* and *actors of health* are simply interdependent and interconnected for health care delivery to be meaningful, readily available and utilised by the people in the study area. Other types of structures of health are present in the communities. These include drugs stores in the form of pharmacy and chemist shops. Both offer drugs to people who purchase them over-the-counter, based on prescription and non-prescription bases. The pharmacist and chemist owner are simply social agents within the social system of the communities in which they serve. For Giddens, the constitution of agents and structures are not independent of one another, the properties of social systems are seen as both medium and outcome of practices of actors, and those system properties in turn organise the practices of actors (Ritzer, 2008). Therefore, the functions of the drug store in the communities as seen in the study findings further explain the nature of health care delivery in the study area.

Finally, as one of the main propositions of structuration theory, the rules and resources drawn upon in the production and reproduction of social action are at the same time the means of system reproduction (duality of structure)' (Giddens, 1995). There is, in effect, duality of structures that forms the health systems of emerging communities and urban slums of south west Nigeria. In fact, due to the multiple nature of health care delivery in these communities, a "*multiplicity of systems and structures*" is in operation within these communities. Structure, as virtual rules, and system, as institutions, are conveniently conflated in the acting individual, so that individuals reproduce the system (Archer, 1982). Therefore health systems in these communities will continue to emerge and evolve in the quest for improved health care delivery.

8.7.2 Social Model of Health

The use of the social model of health highlights the wider determinants of health on the people in emerging communities and urban slums of south west Nigeria. The findings from this study reflect the various layers of health according to Dahlgren and Whitehead (1991; 1993; 2007). For people who live in emerging communities and urban slums of south west Nigeria, a relationship between them, their environment and the diseases around them persists. People are at the core of the system of health care delivery within these communities. Although they are surrounded by various influences on their health, these include certain socio-demographic factors which contribute to the nature of health care delivery in the communities as seen in the study. People's age, gender, ethnicity, education, marital status, occupation and income affect their pattern of utilisation of health services and inform their perception of health services offered at the health facilities.

Findings in this study show that people's age, education and marital status tend to influence their pattern of utilising the health facility within the communities in which they live. In addition according to this model, gender as a variable shows that there is no significant difference between males and females in term of their utilisation of the health facility that is available to them in their communities. People's beliefs and attitudes towards their health is a major determinant on how they respond when ill. Also the way people in these communities seek for health care services, how important they consider their health to be, how they access and utilise health services and how they react to the nature of health care delivery is evident in this study as related to the Dahlgren and Whitehead (1991) model. The model as seen in this study concentrates on improving the health and wellbeing of populations in the study area by addressing the social and environmental determinants of health. This includes socio-cultural factors, economy/income, education, and the poor state of the environments people live in among other factors.

General socioeconomic, cultural and environmental factors which include living and working conditions of people in emerging communities and urban slums affect their access and utilisation of health care services. Because these communities are largely underveloped in terms of infrastructure and availability of social amenities, the environment often is dirty and affects people's health. Also as reported in the study, the presence of stagnant water in urban slums and heaps of solid waste on street corners of these communities, all contribute to affect people's health consitions. More so, the unplanned community development caused by

poorly constructed housing arrangements contributes to affect people's health. According to the social model of health, other macro factors such as people's education, unemployment, water and sanitation and work environment all contributes as determinants of health in emerging communities and urban slums of south west Nigeria.

As seen in this research, social and community networks that exist between and among residents of emerging communities and urban slums contributes to the promotion of certain health habits and these tend to influence people's health conditions. A good example is the influence of household, neighbour and community prescribed medications for treatment of individuals within certain households. These modes of drug presecription for treatment of a person without consultation with a doctor thrives as a result of the nature of social and community networks which exist across these communities. Finally, the individual lifestyle factors which are evident in this research based on people's age, education, marital status, occupation and income tend to influence how people perceive and rate the health facility in their community.

8.7.3 Framework for Health Care Utilisation

Andersen and Newman's framework for healthcare utilisation is reflected in the study outcomes as predisposing factors as *Social structure*: people's education, occupation, ethnicity, social networks, social interactions, and culture influence their pattern of utilisation of health services. While for some people their *Health beliefs*: Attitudes, values, and knowledge that people have concerning and towards the health care system determine whether or not they will use available services. Findings show that some people preferred the use of traditional medicines based on the belief in its efficacy. This is mainly reflected in the qualitative findings compared to the quantaitayive findings. More so, people's preference is seen in the study as their perceptions to the type of service recereived in the health facility are documented in this study. Also, *Demographic*: Age and Gender, Education, Religion, Ethnicity, Marital status, and Occupation were significant in determining people's health. Certain enabling factors also contribute to heath care services in emerging communities and urban slums of south west Nigeria. These include *Personal/Family*: the means and know how to access health services, income, health insurance, a regular source of care, travel, extent and quality of social relationships between health providers and users. While *Community*: Available health personnel and facilities, and waiting time for health treatment all shape people's choices and decisions, but *Personal additions*: Genetic factors and psychological

characteristics were not pronounced as attributes that influence health care delivery in Nigeria. Finally, need factors of utilisation of health services in emerging communities and urban slums explains certain *Perceived notions*: of how people view their own general health and functional state and the importance and magnitude they attach to seeking professional help (Andersen, 1995) from the various health facilities in the communities while the notions expressed by the medical personnel in this study clearly shows the various professional judgments about people's health status and their need for medical care (Andersen, 1995) within the communities.

8.8 Strategy for publication in peer-reviewed journals

As a contribution to knowledge, findings from this study are currently being written as manuscripts for publication in peer-reviewed journals. Submissions will be made to selected journals based on consultation with thesis supervisors. A total of five manuscripts are expected to be written from this thesis, this will include: a review paper, a mixed-methods study paper, a qualitative study paper, a quantitative study paper, and an exploratory research paper. Manuscripts will be written by the researcher and sent to co-authors to review and make useful comments tand contributions to strengthen the manuscript before submission will be made to the selected journals.

CHAPTER NINE

CONCLUSION AND RECOMMENDATIONS

9.1 Introduction

This chapter gives the conclusions reached in this study, together with recommendations for the Government, non-governmental organisations (NGOs), community, multi-lateral agencies and for further research based on the findings from this study on health care delivery, access and utilisation in emerging communities and urban slums of south west Nigeria.

9.2 Conclusion

This PhD research pioneers public health research on health care delivery with a focus on access and utilisation in emerging communities and urban slums of south west Nigeria. Prior to this study other studies have been done in the study area on infrastructure and social amenities, the environment, poverty alleviation, maternal and child health and slum upgrading. However, no study before this thesis has examined the health system of these communities with a focus on understanding the varied nature of health care delivery within the communities, issues of access and utilisation, performance of the health facility from the users' perspective and the social determinants of health. The findings of the study are useful in developing new programme interventions and policy implementation to improve health care delivery in emerging communities and urban slums of south west Nigeria.

Understanding what exists in terms of available health service delivery and why people use these particular health services are important in making effective health interventions to improve the health systems in emerging communities and urban slums of south west Nigeria. Within these communities multiple forms of health care services are available to the people. This thesis highlights the various reasons that inform people's choice of one form of health service over another type of service, despite the obvious merits and demerits associated with each type of health care service in the community. The complexity of health care delivery in Nigeria is well documented in literature but in emerging communities and urban slums of Nigeria, there are limited numbers of studies as regards this complexity. Hence this study has offered findings on the complex nature of health care delivery in the study area both from the providers' and the users' perspectives.

The concept of "*emerging communities*" is introduced into the discourse of global health research. As populations continue to grow and people continue to migrate from one place to another, new communities will emerge and be formed as new living spaces. This thesis provides data to support the concept of emerging communities in Nigeria, a trend that is associated with human development in a developing country context. In his book titled "*Arrival Cities*", Saunders argues that the emergence of new cities across the world as a result attributed mainly to human migration. But this thesis presents findings on informal settlements that are being described as emerging communities whose emergence is based on their characteristics and distinct social processes. This thesis also shows that one of the main factors that has brought about the rise of emerging communities is the migration of people from Lagos and other parts of Nigeria into these informal settlements located on the Lagos-Ibadan highway of Ogun State, Nigeria. While in urban slums, it reiterates previous findings on certain push and pull factors that forces people to relocate into urban slums in Lagos state, Nigeria.

The practice of group prescribed medication (GPM) is common in the communities studied. This takes the form of household prescribed medication, neighbour prescribed medication and community prescribed medication. All these are ways people adopt to encourage the practice of treatment without consulting a physician for a proper diagnosis. There is no clear distinction between emerging communities in Ogun state and urban slums of Lagos state when it comes to the nature of health care delivery. However, huge disparities exist within some of the communities in terms of access to and utilisation of the health facility, irrespective of the type of facility they want to visit. People who live in emerging communities, especially those that live in the interior parts of the communities experience some difficulties in getting to a health facility. There is therefore need to address these health inequities and social exclusion that exists as regards access and utilisation of a health facility. This study supports the need to adopt an interdisciplinary approach to understand, explain and interprete health challenges which affects people who reside in emerging communities and urban slums of south west Nigeria.

Lack of cooperation and effective collaboration from the stakeholders in Nigeria's health system has made the delivery of health services complex. As multiple parties operate to provide health services to the people of Nigeria based on their respective interests, to achieve

substantive progress will remain a challenge. With a well coordinated integration of all parties involved and the effective implementation of existing national health policies and declarations, quality health care can be made available to people in emerging communities and urban slums of south west Nigeria. This thesis acknowledges the complexities that exist when studies are done to address health systems' challenges from a population health viewpoint.

9.3 Recommendations

The following recommendations are suggested based on the findings of the two research methods of this PhD research on health care delivery, access and utilisation in emerging communities and urban slums of south west Nigeria.

9.3.1 Government

As the main institution with the responsibility of enacting and implementing health policies for the people of Nigeria, the following are suggested to the Government at all levels (Federal, State and local) of public administration to improve the current state of health care delivery in the country.

- Counting and proper documentation of health facilities: There is need for the government to embark on the counting of authorised health facilities in operation within emerging communities and urban slums. Having the exact number of such facilities whether government public owned, private, community of faith-based health facilities will help the government to better regulate the nature of health care delivery in the study area.
- Regular monitoring and evaluation of health facilities: Monitoring and regular process evaluation on a quarterly or bi-annual basis of the existing health facilities in the study area is required. When health facilities are well monitored, Government will know what type of facilities are in operation within these communities, the number of facilities there are, what type of services they provide and whether such facilities are qualified to operate. The complexity been experienced in the Nigerian health system can be addressed when effective monitoring and evaluation is done and guidelines for operation are adhered to by all the health facilities (government, private, faith-based and community) working in these communities. Through the monitoring and evaluation of health facilities in these communities, Government will know the needs and can take action to meet those needs.

- Proper regulation of drug stores (Pharmacies and Chemists): Having a pharmacy or chemist to sell drugs to the people in the community is essential but these drug stores need to be well regulated by the Government. Through this regulation, small shops and outlets that provide drugs illegally for purchase will be closed. More so, beyond the renewal of licenses to operate, Government must monitor the activities of these drug stores and ensure that they comply with the standard guidelines required to engage in the sale of over-the-counter drugs to the people. Those drugs that require a medical prescription from certified health personnel must not be sold without such a prescription. Also through proper regulation, only qualified pharmacists will be permitted to open and operate a drug store in the communities while those pharmacies and chemist shops that engage in the sale of fake drugs will be identified and made to face the penalty of law for engaging in such businesses. Proper regulation of pharmacies or chemist shops will also help to prevent drug abuse in emerging communities and urban slums of south west Nigeria.
- Health education and promotion for people in informal settlements: Educating the people in these communities to make them well informed on health matters, will help prevent them from utilising health services offered by quacks and unauthorised health personnel within their communities. In addition, many lives lost to quackery practices by unqualified medical personnel will be averted. Also health education and promotion will keep the people well informed on issues that concern their health and that of the community where they live. Health education and promotion will further help discourage the wide practice of self-medication or group prescribed medication (GPM) that is rampant in these communities.
- Increased funding and maintenance of health facilities: When health facilities are well funded, the quality of care and service delivery will be improved. This will also translate into proper maintenance of equipment, procurement of modern equipment and technologies for treatment, lead to the provision of hospital beds, and change the perception of the people about the health facility. In general, increased funding will lead to improvement in the health care delivery system in these communities which will further contribute to better health system performance in Nigeria. When health facilities are properly funded the health information system available will enable health workers make the right choice when delivering services to the users by making

well informed decisions as regards the health of the health user. In addition, better funding should lead to the provision of drugs and vaccines for the health facility.

- Proper planning and infrastructural development of informal settlements: Informal settlements require proper planning to improve on the current state of the environments. These environments lack good drains, adequate water supply, adequate public toilet facilities and electric power supply. All these are among some of the challenges people face in emerging communities and urban slums of south west Nigeria. Therefore Government intervention is required to make these environments more habitable for the people. For example, the Lagos Metropolitan Development and Governance Project (LMDGP) funded by the World Bank needs to begin executing its recent findings to improve the environments of urban slums in the state. The government of Ogun state needs to commence re-planning these emerging communities of Ogun state. Government presence in the provision of social amenities in informal settlements of Nigeria needs to be increased to meet the needs of the growing population of people who live in these communities.
- Good roads and effective transportation system: As a responsibility of the local government authorities where communities are located, it is imperative for them to provide good road networks for the people within these communities. For those who reside in the interior parts of emerging communities, having a good road network that is motorable will further encourage them to gain access to the health facility and utilise its services. More so, when such communities have effective transportation systems, this will further encourage people to move from their homes to the health facility with ease.

9.3.2 Non-governmental organisations

The presence of non-governmental organisations (NGOs) in Nigeria is felt in the area of health care, missionary engagement, charitable giving to the poor and less privileged, the care for orphans and vulnerable children and alleviation of poverty within disadvantaged communities. Therefore, NGOs engaged in health sector development and service provision can work in emerging communities and urban slums of south west Nigeria.

- Traditional (herbal) medicine use: In emerging communities and urban slums of south west Nigeria, people engage in the use of herbs for treatment of an ailment. Through NGOs, traditional (herbal) medicine practitioners within the communities can be

asked to form a body to guard against the illegal sale and distribution of herbs to the people. People within these communities through the NGOs can be provided with a list of practitioners that are been recommended by this body. Although this issue remains debatable as various type of practitioners find it difficult to submit to a particular body that will regulate their activities, there is a need for people to become aware that not all practitioners may have the required skill and knowledge to perform the task for which they say they can; more so because various practitioners adopt more than one form of treatment for a particular ailment. Hence, with the presence of a body at the community level to monitor these informal providers' activities, this will prevent the abuse and incessant use of herbs by the people.

- Health awareness and literacy: NGOs at the community level can provide health awareness for the people by offering them health seminars, health talks in their respective native languages and the importance of consulting with the right health providers within the community. Through these health literacy programmes issues such as the importance of medical check-ups will be addressed, educating the people on why they need to check themselves and know their health status. Also, mothers will be informed of the benefits of taking their babies for immunization to a certified health facility within the community while pregnant women within the community will be empowered with the right information on how to stay healthy and they will be told where to go for ante-natal and post-natal services within their communities.
- Addressing socio-cultural beliefs and ignorance: Socio-cultural beliefs remain a major hindrance to utilising health interventions. Therefore, NGOs within the communities can provide public enlightenment campaigns, home visitation and market sensitization programmes to the people on staying healthy. NGOs through the community representatives can organise health programmes for all gender and age categories of people so that issues of family and reproductive health, adolescent health and, child health will be comprehensively covered and existing forms of cultural beliefs and ignorance towards orthodox care and medicines will be addressed. In doing this, NGOs will be able to form support groups such as a male support group to educate them on the role of the husband in ensuring proper health for the family, issues of gender discrimination and women's rights when it comes to health care.
- Advocacy for quality health care to be delivered to informal settlements: Through NGOs at the community level, advocacy for the delivery of quality health care

services can be demanded from the health facilities. NGOs can speak on behalf of the people to the service providers, Government and other international bodies engaged in health care delivery to people in emerging communities and urban slums. In terms of quality of care, NGOs can support the people within the community to address issues such as poor treatment from health workers, the issue of long waiting time before consultation or treatment is administered and also addresses communication and language barriers that hinder the people from receiving the health services they require.

9.3.3 Multi-lateral development agencies

- Focus on improving human resources for health: These agencies should focus on an aspect of health systems' strengthening such as human resources for health. By doing so, they are likely to have a greater impact in the country by building capacity across regions and various levels of government. More so, by focusing on making human resources for health widely available, this will address the challenge of shortage of health workers and reduce the workload of the present staff in health facilities within Nigeria, including those in emerging communities and urban slums of south west Nigeria.
- Establish community-based health financing mechanism: Multi-lateral agencies can contribute to existing community-based health financing mechanisms in Nigeria. In regions where such is already in operation, these can be improved upon and extended to cover people in emerging communities and urban slums of south west Nigeria. As donor agencies, their contribution to health financing in Nigeria, will improve the allocation received by health facilities from the Government, create a pool for private health facilities and other forms of health facilities to gain access to funding to make them more efficient and effective in their service delivery.

9.3.4 Further Research

In the immediate future, further research can be undertaken within emerging communities and urban slums in the following areas to improve the health system of these communities:

Health policy and systems research

- Conduct research on unmet need for health care as a limitation on access and utilisation of health facilities in emerging communities

- The use of Faith-based healing as an alternative form of health care delivery in informal settlements of Nigeria
- Conduct studies to determine the impact of national public health campaigns on the health of people in emerging communities and urban slums of Nigeria
- The benefits and dangers of traditional medicine use in emerging communities and urban slums of Nigeria
- An assessment of referral services offered at primary health care facilities for people in urban slums of south west Nigeria.

Health policy and management research

- An assessment on immunization coverage and factors determining its use in emerging communities of south west Nigeria
- An evaluation of the roll-back malaria programme as implemented in emerging communities and urban slums of Nigeria
- Health seeking behaviour of people in emerging communities of south west Nigeria: should be examined.
- Communicating with health workers at a local health facility in selected urban slums of Lagos state, Nigeria: addressing barriers and challenges faced by people of low socio-economic status.
- An investigation on the role of community drug stores (pharmacies and chemist shops) in the promotion of quality health care delivery in emerging communities and urban slums of Nigeria: Implications for consumers.

Health systems strengthening in Nigeria

- An assessment of health facilities in emerging communities and urban slums of Nigeria. For example a look at the quality of care, availability of health workforce, the availability of drugs and vaccines.
- An assessment of corruption as a bane to effective health systems performance in informal settlements of Nigeria.
- The use of health insurance and its effect on health outcomes of people in emerging communities and urban slums of Nigeria should be explored.
- Conduct research to document the impact of electricity supply on effective health care delivery in Nigeria.

Communicable and non-communicable diseases

- An investigation of the factors influencing the incidence and prevalence of diseases in emerging communities and urban slums of south west Nigeria.
- Socio-economic impact of HIV/AIDS on families living in emerging communities and urban slums of south west Nigeria.
- Epidemiology of cancers in emerging communities and urban slums of Nigeria.
- Non-communicable diseases in black populations living in emerging communities of Nigeria: A study of Hypertension, congestive heart failure and diabetes.
- Empowering communities for cancer prevention through health literacy: A study of informal settlements in Nigeria.
- Population ageing in an African context: The effects of non-communicable diseases on the family structure in Nigeria.

Maternal and child health

- Conduct research on gender discrimination and intimate partner violence in emerging communities and urban slums of Nigeria.
- Labour room delivery: perceptions of spousal presence among women attending a health facility in selected urban slums of Lagos state, Nigeria. This will provide information on the perceptions of women attending a health facility about the presence of their spouses during delivery, determining the effect of the spouse on birth outcome. This study will test the buffering and direct effects hypothesis within the Nigerian context on social support and birth outcomes.
- Choice of service provider and factors influencing women in emerging communities and urban slums of Nigeria.
- Capacity building for auxiliary nurses/midwives in emerging community and urban slum: A Pilot Scheme.
- Improving human resouces for healthin emerging communities and urban slums of Nigeria: Adopting a Servive, Training, Efficiency and Management (STEM) Approach

Infrastucture Research

- Water, sanitation and hygiene (WASH) in emerging communities and urban slums of Nigeria: A population-based survey.

- Public-Private partnerships for the provision of clean water in emerging communities and urban slums of Nigeria.
- Waste management in emerging communities and urban slums of Nigeria.

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APPENDICES

Appendix I: Ethics Approval Letter UI-UCH University of Ibadan

INSTITUTE FOR ADVANCED MEDICAL RESEARCH AND TRAINING (IAMRAT)
COLLEGE OF MEDICINE, UNIVERSITY OF IBADAN. IBADAN, NIGERIA.
Director: Prof. A. Ogunniyi, B.Sc(Hons), MBChB, FMCP, FWACP, FRCP (Edin), FRCP (Lond)
Tel: 08023038583, 08038094173
E-mail: aogunniyi@comui.edu.ng

UI/UCH EC Registration Number: **NHREC/05/01/2008a**

NOTICE OF EXPEDITED REVIEW AND APPROVAL

Re: Health Care Delivery, Access and Utilization in Emerging Communities and Urban Slums of South West, Nigeria

UI/UCH Ethics Committee assigned number: UI/EC/12/0229

Name of Principal Investigator: **Saheed A. Lawal**

Address of Principal Investigator: Department of Sociology
University of Ibadan, Ibadan

Date of receipt of valid application: 30/07/2012

Date of meeting when final determination on ethical approval was made: **N/A**

This is to inform you that the research described in the submitted protocol and other participant information materials have been reviewed and *given expedited approval by the UI/UCH Ethics Committee.*

This approval dates from 28/12/2012 to 27/12/2013. If there is delay in starting the research, please inform the UI/UCH Ethics Committee so that the dates of approval can be adjusted accordingly. Note that no participant accrual or activity related to this research may be conducted outside of these dates. *All informed consent forms used in this study must carry the* UI/UCH EC *assigned number and duration of* UI/UCH EC *approval of the study.* It is expected that you submit your annual report as well as an annual request for the project renewal to the UI/UCH EC early in order to obtain renewal of your approval to avoid disruption of your research.

The National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations and with the tenets of the Code including ensuring that all adverse events are reported promptly to the UI/UCH EC. *No changes are permitted in the research without prior approval by the* UI/UCH EC *except in circumstances outlined in the Code. The* UI/UCH EC *reserves the right to conduct compliance visit to your research site without previous notification.*

Professor A. Ogunniyi
Director, IAMRAT
Chairman, UI/UCH Ethics Committee
E-mail: uiuchirc@yahoo.com

INSTITUTE FOR ADVANCED MEDICAL RESEARCH AND TRAINING (IAMRAT)
COLLEGE OF MEDICINE, UNIVERSITY OF IBADAN. IBADAN, NIGERIA.
E-mail: imratcomui@yahoo.com

UI/UCH EC Registration Number: **NHREC/05/01/2008a**

Notice of Renewal of Approval

Re: Health Care Delivery, Access and Utilization in Emerging Communities and Urban Slums of South West, Nigeria

UI/UCH Ethics Committee assigned number: UI/EC/12/0229

Name of Principal Investigator:	**Saheed A. Lawal**
Address of Principal Investigator:	Department of Sociology University of Ibadan, Ibadan
Date of receipt of valid application:	17/01/2014
Status	**2nd Year Approval**

This is to inform you that the UI/UCH Ethics Committee has received your 1st year report for the above titled research. The report indicates the activities done so far which include administration of questionnaire in the selected communities, indepth interview and focus group discussions. Data entry, coding and transcription has commenced while plan for project write-up will start soonest.

The Committee notes the contents of the report and having found it satisfactory, hereby approves the request for renewal of approval **for one year only.**

This approval dates from 28/12/2013 to 27/12/2014. If there is delay in starting the research, please inform the UI/UCH Ethics Committee so that the dates of approval can be adjusted accordingly. Note that no participant accrual or activity related to this research may be conducted outside of these dates. *All informed consent forms used in this study must carry the* UI/UCH EC *assigned number and duration of* UI/UCH EC *approval of the study.* It is expected that you submit your annual report as well as an annual request for the project renewal to the UI/UCH EC early in order to obtain renewal of your approval to avoid disruption of your research.

The National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations and with the tenets of the Code including ensuring that all adverse events are reported promptly to the UI/UCH EC. *No changes are permitted in the research without prior approval by the* UI/UCH EC *except in circumstances outlined in the Code. The* UI/UCH EC *reserves the right to conduct compliance visit to your research site without previous notification.*

UI/UCH EC
03 FEB 2014
APPROVED
COLLEGE OF MEDICINE, U.I.

Professor A. Ogunniyi
Director, IAMRAT
Chairman, UI/UCH Ethics Committee
E-mail: uiuchirc@yahoo.com

Appendix II: Ethics Approval Letter HPM/CGH Trinity College Dublin

COLÁISTE NA TRÍONÓIDE, BAILE ÁTHA CLIATH | TRINITY COLLEGE DUBLIN
Ollscoil Átha Cliath | The University of Dublin

Saheed Akinmayowa Lawal,
Department of Sociology,
University of Ibadan,
Nigeria

3rd September 2012

Re: Health Care Delivery, Access and Utilisation in Emerging Communities and Urban Slums of South West, Nigeria.

Application 06/2012/04

Dear Akin,

Thank you for your submission of the above proposal to the HPM/CGH REC.

The REC has given ethical approval to the proposed study, pending the receipt of your local ethical approval.

Yours sincerely,

C. Normand.

Prof. Charles Normand
Chair of the HPM/CGH REC

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An Lárionad Pholasaí agus Bhainistíocht Sláinte/Lárionad na Sláinte Domhanda
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Appendix III: INFORMED CONSENT FORM (Focus Group Discussion)

Please use the exact wording below for the Participant's ***Declaration of Agreement*** *and the* ***Statement of Investigator's Responsibility****:*

PROJECT TITLE: Health Care Delivery, Access and Utilisation in Emerging Communities and Urban Slums of South West Nigeria.

PRINCIPAL INVESTIGATOR: S. Akinmayọwa Lawal

BACKGROUND

The study aims to examine the nature of health care delivery in emerging communities and urban slums of South west Nigeria. The goal of this research is to find ways of improving access and increase effective utilisation of health care services in the selected communities. The immediate benefit will be an awareness of socio-demographic and structural factors influencing the spread of communicable diseases and increase of non-communicable diseases in your community. The long term benefit will comprise policy and programme intervention(s) that improve access to quality health care services, increased utilisation for prevention, treatment and cure of illnesses in your locality.

All information collected in this study will be given code numbers and no name will be recorded. This cannot be linked to you in anyway and your name or any identifier will not be used in any publication or reports from this study. As part of my responsibility to conduct this research properly, officials from NHREC and ethics committee in UI/UCH University of Ibadan and HPM/CGH, Centre for Global Health, Trinity College Dublin, Ireland may have access to these records.

DECLARATION:

I have read, or had read to me, the information leaflet for this project and I understand the contents. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights. I understand that I may withdraw from the study at any time and I have received a copy of this agreement.

PARTICIPANT'S NAME: .....
CONTACT DETAILS: .....
PARTICIPANT'S SIGNATURE: .....
Date:.....

Where the participant is incapable of comprehending the nature, significance and scope of the consent required or is under 18 years old, the form must be signed by a person legally competent to give consent.

NAME OF CONSENTER, PARENT or GUARDIAN:.....
SIGNATURE:.....
RELATION TO PARTICIPANT:.....

Statement of investigator's responsibility: I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

INVESTIGATOR'S SIGNATURE:..... **Date:**.....

PARTICIPANT INFORMATION LEAFLET (Focus Group Discussion)

Study Title: Health Care Delivery, Access and Utilisation in Emerging Communities and Urban Slums of South West Nigeria.

Name of Investigator: S. Akinmayọwa Lawal

Name of Supervisors: Prof. Joseph Barry and Dr. Femi. O. Omololu

This study is conducted in fulfillment of the Ph.D. Global Health degree at Trinity College Dublin, Ireland.

1. **Research purpose and procedures**: The study aims to examine the nature of health care delivery in emerging communities and urban slums of South west Nigeria. The goal of this research is to find ways of improving access and increase effective utilisation of health care services in the selected communities. Your involvement in the study will not exceed one year. You would not spend more than two hours per session during data collection. The procedure is a descriptive research and will involve human participants. **Procedure**: Participants will be required to participate once. Focus group discussion will last between 45-60 minutes.

2. **Risks and discomforts**: You may become emotionally disturbed in the course of the study; questions will bother on privacy issues including unmet health needs and this may lead to emotional discomfort. However, you may decide not to answer specific questions that you find disturbing. You are also free to withdraw at anytime if the risk is deemed unbearable.

- **Research-related injury: NIL**
- **Unforeseeable risks**: **NIL**

3. **Potential benefits**: There are no personal benefits for participating in this research. The immediate benefit will be an awareness of socio-demographic and structural factors influencing the nature of health care delivery in your community.

4. **Alternative procedures or treatments**: This study will offer no alternative procedures or courses of treatments at any point in time of your involvement.

5. **Provisions for confidentiality:** All information collected in this study will be given code numbers and no name will be recorded. This cannot be linked to you in anyway and your name or any identifier will not be used in any publication or reports from this study. As part of my responsibility to conduct this research properly, officials from NHREC and ethics committee in University of Ibadan and HPM/Centre for Global Health, Trinity College Dublin, Ireland may have access to these records.

6. **Voluntary participation and the right to discontinue participation without penalty:** Your participation in this research is entirely voluntary. You can also choose to withdraw from the research at any time and this will not have any adverse consequences. Please note that some of the information that has been obtained about you before you chose to withdraw may have been modified or used in reports and publications. These cannot be removed anymore. However the researcher promise to make good faith effort to comply with your wishes as much as is practicable. Also any significant new findings discovered during the

course of your participation in this study will be provided to you based on your willingness to continue.

7. **Contacts for additional information:** Primary contact person: Researcher; Email: lawals@tcd.ie or sakinlawal@gmail.com; Phone: 08058536815. Department of Sociology, University of Ibadan Contact Person: Primary Thesis Supervisor; Email: oluwagbayi@yahoo.com; Phone: 08033291127. Centre for Global Health, Trinity College Dublin Contact Person: Indigo Coordinator; Email: ogenna.uduma@tcd.ie; Phone: +35318964177.

8. **Termination of participation by the investigator:** Your participation in this study will be terminated by the investigator if you become sick and unable to continue or you become indisposed on (2) two occasion of a planned meeting without genuine reasons.

9. **Permissions:** the investigator has obtained permission to conduct the study from the community leaders, community representatives and state ministry of health. The study has also obtained ethical approval from the HPM/CGH Research Ethics Committee at Trinity College Dublin, as well as from the Health Research Ethics Committee of the University of Ibadan and the Chairman of this Committee can be contacted at BIODE Building 2, Room T10, Institute for Advanced Medical Research and Training (IMRAT), College of Medicine University of Ibadan. Telephone: 08032397993. Email: uiuchirc@yahoo.com.

10. **Access to Interview Transcript:** Participants can access their transcript recordings when they make such a request.

Appendix IV: INFORMED CONSENT FORM (In-depth Interview)

Please use the exact wording below for the Participant's ***Declaration of Agreement*** *and the* ***Statement of Investigator's Responsibility****:*

PROJECT TITLE: Health Care Delivery, Access and Utilisation in Emerging Communities and Urban Slums of South West Nigeria.

PRINCIPAL INVESTIGATOR: S. Akinmayọwa Lawal

BACKGROUND

The study aims to examine the nature of health care delivery in emerging communities and urban slums of South west Nigeria. The goal of this research is to find ways of improving access and increase effective utilisation of health care services in the selected communities. The immediate benefit will be an awareness of socio-demographic and structural factors influencing the spread of communicable diseases and increase of non-communicable diseases in your community. The long term benefit will comprise policy and programme intervention(s) that improve access to quality health care services, increased utilisation for prevention, treatment and cure of illnesses in your locality.

All information collected in this study will be given code numbers and no name will be recorded. This cannot be linked to you in anyway and your name or any identifier will not be used in any publication or reports from this study. As part of my responsibility to conduct this research properly, officials from NHREC and ethics committee in UI/UCH University of Ibadan and HPM/CGH, Centre for Global Health, Trinity College Dublin, Ireland may have access to these records.

DECLARATION:

I have read, or had read to me, the information leaflet for this project and I understand the contents. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights. I understand that I may withdraw from the study at any time and I have received a copy of this agreement.

PARTICIPANT'S NAME: .....
CONTACT DETAILS: .....
PARTICIPANT'S SIGNATURE: .....
Date:.....

Where the participant is incapable of comprehending the nature, significance and scope of the consent required or is under 18 years old, the form must be signed by a person legally competent to give consent.

NAME OF CONSENTER, PARENT or GUARDIAN:.....
SIGNATURE:.....
RELATION TO PARTICIPANT:.....

Statement of investigator's responsibility: I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

INVESTIGATOR'S SIGNATURE:..... **Date:**.....

PARTICIPANT INFORMATION LEAFLET (In-depth Interview)

Study Title: Health Care Delivery, Access and Utilisation in Emerging Communities and Urban Slums of South West Nigeria.

Name of Investigator: S. Akinmayọwa Lawal

Name of Supervisors: Prof. Joseph Barry and Dr. Femi. O. Omololu

This study is conducted in fulfillment of the Ph.D. Global Health degree at Trinity College Dublin, Ireland.

1. **Research purpose and procedures**: The study aims to examine the nature of health care delivery in emerging communities and urban slums of South west Nigeria. The goal of this research is to find ways of improving access and increase effective utilisation of health care services in the selected communities. Your involvement in the study will not exceed one year. You would not spend more than two hours per session during data collection. The procedure is a descriptive research and will involve human participants. **Procedure**: Participants will be visited twice. First Interview will last between from 15-55 minutes. A second interview may be in four (4) months which will last 20-45 minutes to clarify issues raised in the first interview.

2. **Risks and discomforts**: You may become emotionally disturbed in the course of the study; questions will bother on privacy issues including unmet health needs and this may lead to emotional discomfort. However, you may decide not to answer specific questions that you find disturbing. You are also free to withdraw at anytime if the risk is deemed unbearable.

- **Research-related injury: NIL**
- **Unforeseeable risks**: **NIL**

3. **Potential benefits**: There are no personal benefits for participating in this research. The immediate benefit will be an awareness of socio-demographic and structural factors influencing the nature of health care delivery in your community.

4. **Alternative procedures or treatments**: This study will offer no alternative procedures or courses of treatments at any point in time of your involvement.

5. **Provisions for confidentiality:** All information collected in this study will be given code numbers and no name will be recorded. This cannot be linked to you in anyway and your name or any identifier will not be used in any publication or reports from this study. As part of my responsibility to conduct this research properly, officials from NHREC and ethics committee in University of Ibadan and HPM/Centre for Global Health, Trinity College Dublin, Ireland may have access to these records.

6. **Voluntary participation and the right to discontinue participation without penalty:** Your participation in this research is entirely voluntary. You can also choose to withdraw from the research at any time and this will not have any adverse consequences. Please note that some of the information that has been obtained about you before you chose to withdraw may have been modified or used in reports and publications. These cannot be removed anymore. However the researcher promise to make good faith effort to comply with your

wishes as much as is practicable. Also any significant new findings discovered during the course of your participation in this study will be provided to you based on your willingness to continue.

7. **Contacts for additional information:** Primary contact person: Researcher; Email: lawals@tcd.ie; Phone: 08058536815. Department of Sociology, University of Ibadan Contact Person: Thesis Supervisor; Email: oluwagbayi@yahoo.com; Phone: 08033291127. Centre for Global Health, Trinity College Dublin Contact Person: Indigo Coordinator; Email: ogenna.uduma@tcd.ie; Phone: +35318964177.

8. **Termination of participation by the investigator:** Your participation in this study will be terminated by the investigator if you become sick and unable to continue or you become indisposed on (2) two occasion of a planned meeting without genuine reasons.

9. **Permissions:** the investigator has obtained permission to conduct the study from the community leaders, community representatives and state ministry of health. The study has also obtained ethical approval from the HPM/CGH Research Ethics Committee at Trinity College Dublin, as well as from the Health Research Ethics Committee of the University of Ibadan and the Chairman of this Committee can be contacted at BIODE Building 2, Room T10, Institute for Advanced Medical Research and Training (IMRAT), College of Medicine University of Ibadan. Telephone: 08032397993. Email: uiuchirc@yahoo.com.

10. **Access to Interview Transcript:** Participants can access their transcript recordings when they make such a request.

Appendix V: INFORMED CONSENT FORM (Key Informant Interview)

Please use the exact wording below for the Participant's ***Declaration of Agreement*** *and the* ***Statement of Investigator's Responsibility****:*

PROJECT TITLE: Health Care Delivery, Access and Utilisation in Emerging Communities and Urban Slums of South West Nigeria.

PRINCIPAL INVESTIGATOR: S. Akinmayọwa Lawal

BACKGROUND

The study aims to examine the nature of health care delivery in emerging communities and urban slums of South west Nigeria. The goal of this research is to find ways of improving access and increase effective utilisation of health care services in the selected communities. The immediate benefit will be an awareness of socio-demographic and structural factors influencing the spread of communicable diseases and increase of non-communicable diseases in your community. The long term benefit will comprise policy and programme intervention(s) that improve access to quality health care services, increased utilisation for prevention, treatment and cure of illnesses in your locality.

All information collected in this study will be given code numbers and no name will be recorded. This cannot be linked to you in anyway and your name or any identifier will not be used in any publication or reports from this study. As part of my responsibility to conduct this research properly, officials from NHREC and ethics committee in UI/UCH University of Ibadan and HPM/CGH, Centre for Global Health, Trinity College Dublin, Ireland may have access to these records.

DECLARATION:

I have read, or had read to me, the information leaflet for this project and I understand the contents. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights. I understand that I may withdraw from the study at any time and I have received a copy of this agreement.

PARTICIPANT'S NAME: .....
CONTACT DETAILS: .....
PARTICIPANT'S SIGNATURE: .....
Date:.....

Where the participant is incapable of comprehending the nature, significance and scope of the consent required or is under 18 years old, the form must be signed by a person legally competent to give consent.

NAME OF CONSENTER, PARENT or GUARDIAN:.....
SIGNATURE:.....
RELATION TO PARTICIPANT:.....

Statement of investigator's responsibility: I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent.

INVESTIGATOR'S SIGNATURE:..... **Date:**.....

PARTICIPANT INFORMATION LEAFLET (Key Informant Interview)

Study Title: Health Care Delivery, Access and Utilisation in Emerging Communities and Urban Slums of South West Nigeria.

Name of Investigator: S. Akinmayọwa Lawal

Name of Supervisor: Prof. Joseph Barry and Dr. Femi. O. Omololu

This study is conducted in fulfillment of the Ph.D. Global Health degree at Trinity College Dublin, Ireland.

1. **Research purpose and procedures**: The study aims to examine the nature of health care delivery in emerging communities and urban slums of South west Nigeria. The goal of this research is to find ways of improving access and increase effective utilisation of health care services in the selected communities. Your involvement in the study will not exceed one year. You would not spend more than two hours per session during data collection. The procedure is a descriptive research and will involve human participants. **Procedure**: Participants will be recruited based on suggestions from community heads and recommendations of community members on the most knowledgeable individual that will provide accurate and reliable information. Such a participant will be visited twice. First Interview will last between 15-55 minutes. A second interview may be in three (3) months which will last 15-45 minutes to clarify issues raised in the first interview.

2. **Risks and discomforts**: You may become emotionally disturbed in the course of the study; questions will bother on privacy issues including unmet health needs and this may lead to emotional discomfort. However, you may decide not to answer specific questions that you find disturbing. You are also free to withdraw at anytime if the risk is deemed unbearable.

- **Research-related injury: NIL**
- **Unforeseeable risks**: **NIL**

3. **Potential benefits**: There are no personal benefits for participating in this research. The immediate benefit will be an awareness of socio-demographic and structural factors influencing the nature of health care delivery in your community.

4. **Alternative procedures or treatments**: This study will offer no alternative procedures or courses of treatments at any point in time of your involvement.

5. **Provisions for confidentiality:** All information collected in this study will be given code numbers and no name will be recorded. This cannot be linked to you in anyway and your name or any identifier will not be used in any publication or reports from this study. As part of my responsibility to conduct this research properly, officials from NHREC and ethics committee in University of Ibadan and HPM/Centre for Global Health, Trinity College Dublin, Ireland may have access to these records.

6. **Voluntary participation and the right to discontinue participation without penalty:** Your participation in this research is entirely voluntary. You can also choose to withdraw from the research at any time and this will not have any adverse consequences. Please note that some of the information that has been obtained about you before you chose to withdraw

may have been modified or used in reports and publications. These cannot be removed anymore. However the researcher promise to make good faith effort to comply with your wishes as much as is practicable. Also any significant new findings discovered during the course of your participation in this study will be provided to you based on your willingness to continue.

7. **Contacts for additional information:** Primary contact person: Researcher; Email: lawals@tcd.ie; Phone: 08058536815. Department of Sociology, University of Ibadan Contact Person: Thesis Supervisor; Email: oluwagbayi@yahoo.com; Phone: 08033291127. Centre for Global Health, Trinity College Dublin Contact Person: Indigo Coordinator; Email: ogenna.uduma@tcd.ie; Phone: +35318964177.

8. **Termination of participation by the investigator:** Your participation in this study will be terminated by the investigator if you become sick and unable to continue or you become indisposed on (2) two occasion of a planned meeting without genuine reasons.

9. **Permissions:** the investigator has obtained permission to conduct the study from the community leaders, community representatives and state ministry of health. The study has also obtained ethical approval from the HPM/CGH Research Ethics Committee at Trinity College Dublin, as well as from the Health Research Ethics Committee of the University of Ibadan and the Chairman of this Committee can be contacted at BIODE Building 2, Room T10, Institute for Advanced Medical Research and Training (IMRAT), College of Medicine University of Ibadan. Telephone: 08032397993. Email: uiuchirc@yahoo.com.

10. **Access to Interview Transcript:** Participants can access their transcript recordings when they make such a request.

Appendix VI: Quantitative Instruments (Survey)

QUESTIONNAIRE

Serial No.....

Centre for Global Health
Trinity College Dublin
7-9 Leinster Street South
Dublin 2, Ireland

Introduction and Consent

Greetings, my name is Saheed Akinmayọwa Lawal, a doctoral student of the Centre for Global Health, Trinity College Dublin, Ireland. I am conducting a survey that asks women and men about various health issues. I would very much appreciate your participation in this survey. This information will help the government to plan health service delivery in emerging communities and urban slums of south west, Nigeria. The survey usually takes between 30 and 40 minutes to complete. Whatever information you provide will be kept strictly confidential and will not be shown to other persons.

As part of the survey I would first like to ask some questions about your household. All of the answers you give will be confidential. Participation in the survey is completely voluntary. If we should come to any question you don't want to answer, just let me know and I will go on to the next question; or you can stop the interview at any time. However, we hope you will participate in the survey since your views are important.

At this time, do you want to ask me anything about the survey?

May I begin the interview now?

.....	.....
Signature/thumbprint of respondent	Signature of interviewer
.....	.....
Date	Date

Socio-demographic and Household characteristics

NO	QUESTIONS	CODING CATEGORY	VALUES	SKIP
101	What is your Gender	Male Female	( )1 ( )2	
102	How old are you	16-20 21-25 26-30 31-35 36-40 41-45 46-50 50+	( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7 ( )8	
103	What is your religion	Christian Muslim Traditional Others specify.....	( )1 ( )2 ( )3 ( )58	
104	What is your highest educational qualification	Non formal education Primary School Secondary school Tertiary Institution	( )1 ( )2 ( )3 ( )4	
105	What ethnic group are you	Yoruba Igbo Hausa Others specify.....	( )1 ( )2 ( )3 ( )58	
106	What is your marital Status	Single Cohabiting Married Divorced Widowed	( )1 ( )2 ( )3 ( )4 ( )5	
107	Do you have children	Yes No	( )1 ( )2	If no, skip to 109
108	How many children do you have	1 child 2-5 children 6-8 children More than 9 children	( )1 ( )2 ( )3 ( )4	
109	Does anyone in this household suffer from any type of disability	Blindness Cripple Deafness None Others specify.....	( )1 ( )2 ( )3 ( )4 ( )58	
110	What do you do for a living	.....		

111	How much do you earn monthly	Less than ₦15,000 ₦ 15,000-30,000 ₦ 31,000-54,000 ₦ 55,000-74,000 ₦ 75,000-94,000 ₦ 95,000and above	( )1 ( )2 ( )3 ( )4 ( )5 ( )6	

Nature of health care delivery in emerging communities and urban slums

201	What are the various sources of health care services in the community	Health care facility Spiritual Healer Folk Healer Drug store (pharmacy or chemist) Drug vendor Others specify.....	( )1 ( )2 ( )3 ( )4 ( )5 ( )58	If no, skip
202	For how long have these services been working to treat sicknesses and diseases in the community	**Weeks/Months/Years** Less than 1 week 2 weeks to 4 weeks 1 to 6 months 7 to 12 months 1 to 2 years 2 years to 5 years 5 years and above	 ( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7	
203	When a member of your household falls sick or gets an infection, where do you go for treatment	Health care facility Spiritual Healer Folk Healer Drug store (pharmacy or chemist) Drug vendor Others specify.....	( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )58	
204	If you do not go anywhere for treatment, how is treatment administered to the sick person	Self-medication Household-prescribed medication Neighbour-prescribed medication Community-prescribed medication	( )1 ( )2 ( )3 ( )4	
205	How often do you visit any of these health care services	Once in a months Once in 2-5months Once in 6 month Once in a year Others specify.....	( )1 ( )2 ( )3 ( )4 ( )58	
206	Does the doctor or healer give you a good diagnosis of the sickness or disease	Yes No	( )1 ( )2	If no skip
207	If yes, how adequate is the diagnosis	....		
208	What kind of medicines do you use	Traditional medicine	( )1	

		(TM) Orthodox medicine (OM) Both (TM & OM) Others specify.....	( )2 ( )3 ( )58	
209	How much do you buy the drugs	.....		
210	Does the drug price stop you from buying other things for the family	No Yes	( )1 ( )2	If no skip
211	If yes, how does it affect you	.....		
212	Do you prefer the traditional form of health care service to the orthodox or western medicine offered at a health facility	Traditional medicine Orthodox medicine Both (TM & OM)	( )1 ( )2 ( )3	
213	Do you think members of the community would prefer the traditional form of health care service to that offered at a health care facility	Yes No	( )1 ( )2	If no skip
214	If yes, what is your reason	....		
215	Do you know if this form of health care services is widely supported by members of the community	Yes No	( )1 ( )2	If no skip
216	If yes, how do you know	.....		
217	Can you name the various type of sicknesses or diseases that the traditional form of health care service treats	.....		
218	Has any member of your household visited or used the traditional form of health care before	Yes No	( )1 ( )2	If no skip to 301
219	If yes, what type of sickness or disease was this called	.....		
220	For how long did the treatment last	**Weeks/Months/Years** Less than 1 week 2 weeks to 4 weeks 1 to 6 months 7 to 12 months 1 to 2 years 2 years to 5 years 5 years and above	 ( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7	
221	If no, what was your reason	....		
222	Do you prefer the traditional type of health care service for members of your household to orthodox or western medicine	Yes No	( )1 ( )2	
223	What is your reason for such a preference	....		

Establishment of health care facility in emerging communities and urban slums

301	Is there a health facility located in this community	Yes No	( )1 ( )2	
302	What type of health care facility is It	**Government health facility** **Faith-based health facility** *Registered facility* *Non-registered facility* *Substandard facility* **Private health facility** *Registered facility* *Non-registered facility* *Substandard facility* **Community health facility** *Registered facility* *Non-registered facility* *Substandard facility*	( )1 ( )2 ( ) ( ) ( ) ( )3 ( ) ( ) ( ) ( )4 ( ) ( ) ( )	
303	Where is the health facility located	Close to the market Close to the chief's house Close to the church Close to the mosque Others specify.....	( )1 ( )2 ( )3 ( )4 ( )58	
304	How far is the health facility from where you live (residents)	**(a) Walk** Less than 5 minutes 5 minutes to 15 minutes 16 minutes to 30 minutes 30 minutes to 60 minutes Over 1 hour **(b) Bicycle/Others** Less than 5 minutes 5 minutes to 15 minutes 16 minutes to 30 minutes 30 minutes to 60 minutes Over 1 hour	 ( )1 ( )2 ( )3 ( )4 ( )5 ( )1 ( )2 ( )3 ( )4 ( )5	
305	What mode of transportation do you often use to get to the health facility	Bicycle Motorcycle Car Bus Lorry None of the above	( )1 ( )2 ( )3 ( )4 ( )5 ( )6	
306	How long has there been a health facility in this community	**Weeks/Months/Years** 7 to 12 months 1 to 2 years 2 years to 5 years 5 years and above	 ( )1 ( )2 ( )3 ( )4	
307	Who facilitated the building of the health facility for the community	Local government State government Federal government Community Philanthropist NGO	( )1 ( )2 ( )3 ( )4 ( )5 ( )6	

		Religious body Partnership Private	( )7 ( )8 ( )9	
308	What led to the establishment of the health care facility	Lack of health facility Disease outbreak Community protest Visit of the LG chairman Visit of the state governor Others specify.....	( )1 ( )2 ( )3 ( )4 ( )5 ( )58	
309	What was the nature of health care services available in the community before the health facility was established	Traditional Visit to spiritualist Visit to folk healer Visit to the village shrine Visit to the river to bathe Conducting of sacrifices Others specify.....	( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )58	
310	Would you say these health services cured the diseases it intended too	Yes No	( )1 ( )2	
311	To what extent were these health services meeting the needs of the people	Not at all Low extent Average Large extent	( )1 ( )2 ( )3 ( )4	
312	Who do you know was in support of the establishment of the health care facility in the community	Local Chief Council of elders Youth association Landlords association Others specify.....	( )1 ( )2 ( )3 ( )4 ( )58	
313	Do you think people in this community are in support of the establishment of a health care facility	Yes No	( )1 ( )2	
314	Is the provision of a health care facility among the immediate needs of the people in the community	Yes No	( )1 ( )2	
315	How did you get treatment to a sickness or disease before the health facility was built	Spiritual Healer Folk Healer Drug store (chemist or pharmacy) Drug vendor Others specify.....	( )1 ( )2 ( )3 ( )4 ( )58	
316	Does your cultural belief support the use of orthodox/western medicine for treatment of an illness or diseases	Yes No	( )1 ( )2	
317	Was there a cultural festival that led to the establishment of the health care facility	Yes No	( )1 ( )2	
318	Was there any meetings held among community members that facilitated the establishment of the health care facility	Yes No	( )1 ( )2	
319	Would you say the people were involved in the decision making process that led to the establishment of the health care facility	Yes No	( )1 ( )2	
320	Was there an incidence or spread of a disease in the community that led to the establishment of the health care facility	Yes No	( )1 ( )2	

321	Was the death of a prominent member of the community reasons for the establishment of the health care facility	Yes No	( )1 ( )2	
322	What other factors or events can you list that influenced the establishment of the health care facility	....		

Access and Utilisation of health care services in emerging communities and urban slums

401	Do you utilise the services offered at the community health facility	Yes No	( )1 ( )2	If no, skip to 406
402	If yes, what is your reason	....		
403	How do you and your household get to the health care facility in the community	**(a) Public Transport** Bicycle Motorcycle Cars Taxis Buses Lorry **(b) Private Transport** Bicycle Motorcycle Cars Taxis Buses Lorry **Walk**	 ( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )7	
404	How far is the health facility from where you live (residents)	**Walk** Less than 5 minutes 5 minutes to 15 minutes 16 minutes to 30 minutes 30 minutes to 60 minutes Over 1 hour **Others specify.....**	 ( )1 ( )2 ( )3 ( )4 ( )5 ( )58	
405	How far is the health facility from where you work	**Walk** Less than 5 minutes 5 minutes to 15 minutes 16 minutes to 30 minutes 30 minutes to 60 minutes Over 1 hour **Others specify.....**	 ( )1 ( )2 ( )3 ( )4 ( )5 ( )58	
406	Where is the health facility located in the community	Close to the market Close to the chief's house Close to the church Close to the mosque Others specify..... Not Sure Don't know	( )1 ( )2 ( )3 ( )3 ( )58 ( )68 ( )98	
407	What would you consider a barrier to your	Bad road network	( )1	

	visiting the health care facility when the need arise	Lack of money Inadequate transportation Lack of information Cost of health service Others specify.....	( )2 ( )3 ( )4 ( )5 ( )58	
408	Does your geographical location limit your access to health care services in the community	Yes No	( )1 ( )2	
409	Are you or is any member of your family an handicap	Yes No	( )1 ( )2	If no skip
410	If yes, does this limit your access to health care services in the community	Yes No	( )1 ( )2	
411	Is your income/earnings the reason why you can't access health care services in the community	Yes No	( )1 ( )2	
412	Do your cultural norms, values, customs or beliefs limit your access to health care services in the community	Yes No	( )1 ( )2	
413a	Does family decision on why you should visit the health facility a limitation on your access to health care services in the community	Yes No	( )1 ( )2	
413b	Does family decision on when you visit the health facility limiting your access to health care services in the community	Yes No	( )1 ( )2	
413c	Does family decision on where to go for health treatment limiting your access to health care services in the community	Yes No	( )1 ( )2	
414	Do you think not having adequate information can affect your access to health care services in the community	Yes No	( )1 ( )2	
415a	Are detection and treatment available at the health facility	Yes No	( )1 ( )2	If no skip to 416
415b	What type of equipment's are these	---------- ---------- ---------- ---------- ---------- ----------		
415c	Are these equipment's presently working in the health care facility	Yes No	( )1 ( )2	
415d	Have you ever used any equipment for detection or treatment of a disease	Yes No	( )1 ( )2	
415e	Does lack of equipment's at the health facility affect your utilisation of health care services in the community	Yes No	( )1 ( )2	
416	How often do you visit the community health care facility for treatment or consultation	Once a week Once in two weeks Once in a months Once in 2-5months Once in 6 month Others specify.....	( )1 ( )2 ( )3 ( )4 ( )5 ( )58	
417	Does the knowledge of the health workers	Yes	( )1	

	influences your utilisation of health care services at the health facility	No	( )2	
418	Would you say the skills of the health workers influence your pattern of utilisation of health services at the health facility	Yes No	( )1 ( )2	
419	If yes, what are your reasons	Understand my complaints Offers the right treatment Offers the right advise Offers referral when necessary	( )1 ( )2 ( )3 ( )4	
420	Would you say the attitude of health workers in the health care facility affects your utilisation of health care services	Yes No	( )1 ( )2	
421	If yes, what are your reasons	Considers my opinion Shows me some respect Addresses me politely They disrespect me Others specify.....	( )1 ( )2 ( )3 ( )4 ( )58	

Performance of community health care facility in emerging communities and urban slums

501	How would you rate the performance of the health care facility	Poor Fair Average Good Very good Excellent Others specify..... Not sure Don't know	( )1 ( )2 ( )3 ( )4 ( )5 ( )6 ( )58 ( )68 ( )98	
502	What is your reason for this	....		
503	Based on your rating of the performance of the health care facility, is there need for improvement	Yes No	( )1 ( )2	
504	If Yes, state why or how	....		
505	If No, give reason(s)	....		
506	Would you say the health care facility performs efficiently in its service delivery to the community	Yes No	( )1 ( )2	
507	Do the health care workers and personnel perform effectively in carrying out their duties	Yes No	( )1 ( )2	
508	Does the performance of the health care facility encourage effective	Yes No	( )1 ( )2	

	utilisation of health services among community members			
509	Would you say lack of adequate funding affects the performance of the health care facility	Yes No	( )1 ( )2	
510	Does the shortage of health workers affect the performance of the health care facility	Yes No	( )1 ( )2	
511	Does the lack of medicines, vaccines, and hospital beds affect the performance of the health care facility	Yes No	( )1 ( )2	
512	Does lack of electricity in the community affect the performance of the health care facility	Yes No	( )1 ( )2	
513	What other factors affect the performance of the health care facility in the community	Yes No	( )1 ( )2	
514	In what ways do you think or suggest the performance of the health care facility be improved	....		

Unmet need for health care in emerging communities and urban slums

601	What are your essential health needs in the community	Essential drugs and vaccines Family planning unit Voluntary counselling and testing Ambulance service Emergency obstetric care Others specify.....	( )1 ( )2 ( )3 ( )4 ( )5 ( )58	
602	Are all of these health care needs being met at the health care facility	Yes No	( )1 ( )2	
603	If No, give reason	....		
604	What are your health care needs in this household that are not being met	....		
605	Presently, are there any other means you have adopted to meet your health needs	Yes No	( )1 ( )2	
606	If Yes, what is this type of medium of health care called	....		
607	If No, give reason	....		If no, skip to 612
608	When did you begin to use this medium of health care delivery to meet your health needs	Less than a month Over 6 months Over 1 year Others specify.....	( )1 ( )2 ( )3 ( )58	

609	Would you say this medium of health care delivery has worked to cure illnesses of diseases	Yes No	( )1 ( )2	
610	If yes, explain	....		
611	If No, give reason	....		
612	What do you understand to be an unmet need for health	....		
613	Would you say not having the knowledge of a disease is an unmet need for health	Yes No	( )1 ( )2	
614	Is your inability to meet with a physician or health worker an unmet need for health	Yes No	( )1 ( )2	
615	Is not having access to health care service in the community an unmet need for health care	Yes No	( )1 ( )2	
616	Is your inability to communicate with the health care workers at the health care facility an unmet need for health	Yes No	( )1 ( )2	
617	Is the non-provision of adequate equipment's in the health facility an unmet need for health in the community	Yes No	( )1 ( )2	
618	Is the lack of medicines, vaccines and other essential drugs at the health facility an unmet need for health	Yes No	( )1 ( )2	
619	Does lack of community awareness on specific prevention methods, treatment and cure available at the health facility an unmet need for health	Yes No	( )1 ( )2	
620	Is the lack of an effective transport system in the community part of an unmet need for health in the community	Yes No	( )1 ( )2	
621	Is the lack of health support groups and social networks an unmet need for health in the community	Yes No	( )1 ( )2	
622	Is the lack of functional family planning unit at the health facility an unmet need for health	Yes No	( )1 ( )2	
623	What other issues not mentioned do you categorise as an unmet need for health care in the community	....		

Appendix VII: KEY-INFORMANT INTERVIEW GUIDE (Community resident)

Objective 1: Explore the nature of health care delivery and social processes by which health care services evolve in emerging communities and urban slums of south west Nigeria.

1 What is the nature of health care services offered in the community?
2 Generally, how did health care services emerge within the community?

Probe for

- All forms of health care service provided to the people in the community.
- The parties that offer such health services and reasons on how health services have evolved in your community?

3 What are the factors responsible for the establishment of the health care centre in your community?

Probe for

- Socio-cultural, political, environmental and economic factors such as the promise of a politician made to the people.
- The inability of people to afford alternative forms of delivery
- The need to mark an annual event or remembrance of a notable community personality
- Other socio-cultural, income, proximity of services, transportation and cost.

Objective 3: Investigate the people's perceptions of the health care facility services in emerging communities and urban slum of south west Nigeria.

4 What is your perception about the health care services offered by the health facility in your community?
5 What standards will you prefer?

Probe for

- Knowledge of modern health care delivery,
- Quality of service desired and
- Suggestions on how current services can be improved upon.

Objective 4: Ascertain specific factors which influences people's health in emerging communities and urban slums of south west Nigeria.

6 What are the specific factors that influence people's health in this community?

Probe on

- Macro and micro factors that affect and influence people's knowledge, attitudes and behaviours with regards to their health.

Appendix VIII: IN-DEPTH INTERVIEW GUIDE (Public Health Officer)

Objective 1: Explore how health care services is provided in the community and how these services emerged and have evolved in emerging communities and urban slums of south west Nigeria.

1 How is health care delivery provided in the community?
2 What are the existing types of health care services available to people in the community?
3 Do you know how health care services emerge in the community and how have it evolved over the years?

Probe for

- The nature of local government policies that supports the establishment of health care centres in the community,
- How does the government collaborate (work) with the community and other bodies to establish health care centres?

Objective 2: Examine the level of access to and utilisation of health care services in the study area.

4 How do households gain access to health care services in the community to treat diseases such as Malaria, Tuberculosis, Diabetes, HIV and other infections?

Probe on

- Social, cultural, economic and geographical factors such as distance to health care centre and
- Proximity of health services to the people,
- Available mode of transportation and its cost,
- People's beliefs and preference for traditional medicine,
- Cost of health service and charges for health service.

5 Does the government or NGO's encourage people to effectively utilise health care services provided at the health care centre in the community?

Probe about

- Government's or NGO's advocacy and health promotion campaigns within the community to sensitize people on the benefits of using the health centre and
- Advantage of getting professional medical treatment, diagnosis and referral if necessary.

Objective 3: Investigate the people's perceptions of health care delivery services in emerging communities and urban slum of south west Nigeria.

6 Would you say the staff strength in the health care centres is adequate for the community?
7 How well are the health care workers paid for their duties and obligations?

8 What are the factors that affect the prompt payment of workers' salaries in the health care centres?

9 Are the equipment's and health facilities adequate in the health care centres?

Probe for

- Knowledge on the number of workers in the community health care centre e.g. number of doctor or nurses per patients,
- Treatment of health workers by the government at the grassroots level,
- Factors that may hinder workers from getting paid regularly, and
- Need for modern equipment's for diagnosis and treatment of patients at the community health centre,
- Nature of health information system in operation at the health centre,
- Government commitment to provide adequate health care services to the people in the community.

Objective 4: Ascertain specific factors which influences people's health in emerging communities and urban slums of south west Nigeria.

10 What are the specific factors that influence people's health in this community?

Probe on

- Macro and micro factors that affect and influence people's knowledge, attitudes and behaviours with regards to their health.

Appendix IX: IN-DEPTH INTERVIEW GUIDE (Pharmacy or Chemist)

Objective 1: Explore the types of health care services they provide in the community, and what else is available for the people in emerging communities and urban slums of south west, Nigeria.

1 What type of health care service do you provide the community?
2 Do you know how the health care system works in the community?
3 What types of health care services do you know is available to people in the community?

Probe for

- Number of years he/she has offered the community this service,
- Knowledge of the existing health care delivery system in the community, and
- Types of health services available for the people to access when the need arise.

4 What types of medicines do sell in the community?
5 Which types of medicines do people regularly purchase form you?
6 How often do people visit the community pharmacy and what is the reason for this?

Probe on

- The nature of medicines sold, whether expired or fake,
- What the medicines actually do and what people actually buy them for,
- What types of medicines are sold more often compared to others,
- Reasons for the increased purchase of specific medicines in the past three to six months.
- An approximate number of people that visit the community pharmacy daily and
- Why the number may appear higher on specific days and not on other days.

Objective 3: Investigate the people's perceptions of health care delivery services in emerging communities and urban slum of south west Nigeria.

7 Would you say your business significantly contributes to meeting the health needs of community members?
8 What are the factors that affect the progress of your business in the community?
9 Do you think the people appreciate the presence of your business in the community and the services you offer them?

Probe on

- The relationship of between pharmacist and members of the community, and
- Factors that have contributed to the success or promotion of the business in the community.

Objective 4: Ascertain specific factors which influences people's health in emerging communities and urban slums of south west Nigeria.

10 What are the specific factors that influence people's health in this community?

Probe on

- Macro and micro factors that affect and influence people's knowledge, attitudes and behaviours with regards to their health.

Appendix X: IN-DEPTH INTERVIEW GUIDE (Community Leaders: Male and Female)

Objective 1: Explore exploring the varied nature of health care services in the community and the social processes and factors that influenced how health care services emerged and have evolved in emerging communities and urban slums of south west Nigeria.

1 What is the nature of health care services within your community?
2 Generally, how did health care services emerge within your community?
3 What are the other forms of health care services available to the people in the community?
4 How have these various forms of health care services evolved in the community over the years?

Probe on

- The traditional forms of health care delivery in the community, cultural beliefs and norms attributed to these forms of health care services,
- How these forms of health services have been improved upon over the years and
- The people's patronage of both the traditional health service and modern health care service.

5 Does your community have a health care centre?
6 What were the factors responsible for the establishment of the health care centre?
7 Do you support the establishment of a community health centre?

Probe for

- Why does the community have an health care centre, the socio-cultural and, political factors such as the promise of a politician made to the people which led to its establishment,
- The desire of the people for an alternative forms of health service delivery,
- The need to mark an annual event or remembrance of a notable community personality,
- Lack of confidence in the traditional systems of health care delivery

Objective 2: Examine the level of access to and utilisation of health care services in the study area.

8 Do people in the community utilise the services offered at the community health centre?
9 What do you think is their reasons for utilising such health services?

Probe for

- Community acceptance of the health care centre,
- Why you think people utilise the services offered at the health care centre

Objective 4: Ascertain specific factors which influences people's health in emerging communities and urban slums of south west Nigeria.

10 What are the specific factors that influence people's health in this community?

Probe on

- Macro and micro factors that affect and influence people's knowledge, attitudes and behaviours with regards to their health.

Appendix XI: IN-DEPTH INTERVIEW GUIDE
(Doctors, Nurses, Traditional Herbal Practitioners, Folk Healers or Spiritual Healers)

Objective 1: Explore the nature of health care services in the community and how these services have emerged and evolve in emerging communities and urban slums of south west Nigeria.

1 What is the nature of the health care service in this community?
2 What types of health care services do you provide to members of the community?
3 Do you know how health care services have emerged in the community and how have it evolved over the years?

Probe for

- All forms of health care service provided to the people either for fee or for free and the reasons for choosing to work in the community or
- Factors that lead to your working in this community.

Objective 2: Examine the level of access to and utilisation of health care services in the study area.

4 How do households access the health care services you provide in the community to diagnose an illness, prevent getting an infection and seek cure or treatment for diseases such as Malaria, Tuberculosis, Diabetes, HIV and other infections?

Probe for

- Social, cultural, economic and geographical factors such as distance to health care centre and proximity of services, transportation and cost of travel, people's beliefs and preference for traditional medicine, cost of health service and fee for service that limits access to and utilisation of health services.

Objective 3: Investigate the people's perceptions of the health care delivery services offered by the health facility in emerging communities and urban slum of south west Nigeria.

5 Would you say the staff strength in the health care centres is adequate for the community?
6 Do the health care workers have the necessary skills and knowledge to effectively carry out their duties?
7 Are the equipment's and health facilities adequate in the health care centres?

Probe for

- Knowledge of number of workers in the community health care centre e.g. number of doctor or nurses per patients,
- Treatment of health workers by the government at the grassroots level,
- Factors that may hinder workers from getting paid regularly, and
- Need for modern equipment's for diagnosis and treatment of patients at the community health centre,
- Nature of health information system in operation at the health centre,

- Government commitment to provide adequate health care services to the people in the community,
- Training of health care staff,
- Issues of shortage in health workers (Human resources for health).

Objective 4: Ascertain specific factors which influences people's health in emerging communities and urban slums of south west Nigeria.

8 What are the specific factors that influence people's health in this community?

Probe on

- Macro and micro factors that affect and influence people's knowledge, attitudes and behaviours with regards to their health.

Appendix XII:
FOCUS GROUP DISCUSSION GUIDE (Community Residents-Male and Female)

Objective 1: Explore the varied nature of health care delivery, factors that led to the establishment of a health facility and the social processes by which health care services evolve in emerging communities and urban slums of south west Nigeria.

1. What is the nature of health care services offered in your community?
2. Generally, how did health care services emerge within your community?
3. What are the forms of health care services available in your community?
4. Which of these health care services do you use?
5. What is your reason for this preference?

Objective 2: Examine the level of access to and utilisation of health care services in the study area.

6. How do people gain access to health care services in the community and does having money make access to health service easier?
7. Do you think people in the community utilise the health services offered at the health centre and what are the reasons for the utilisation of these health services?
8. What factors do you think influences people to utilise the services offered at the health care centre and would you say people prefer to utilise the services at the health centre compared to those offered elsewhere?
9. Do you utilise the service offered at the health centre or elsewhere?
10. What are your reasons for utilising this health service offered at the community health centre?

Objective 4: Investigate the people's perceptions of the effectiveness of health care delivery services in emerging communities and urban slum of south west Nigeria.

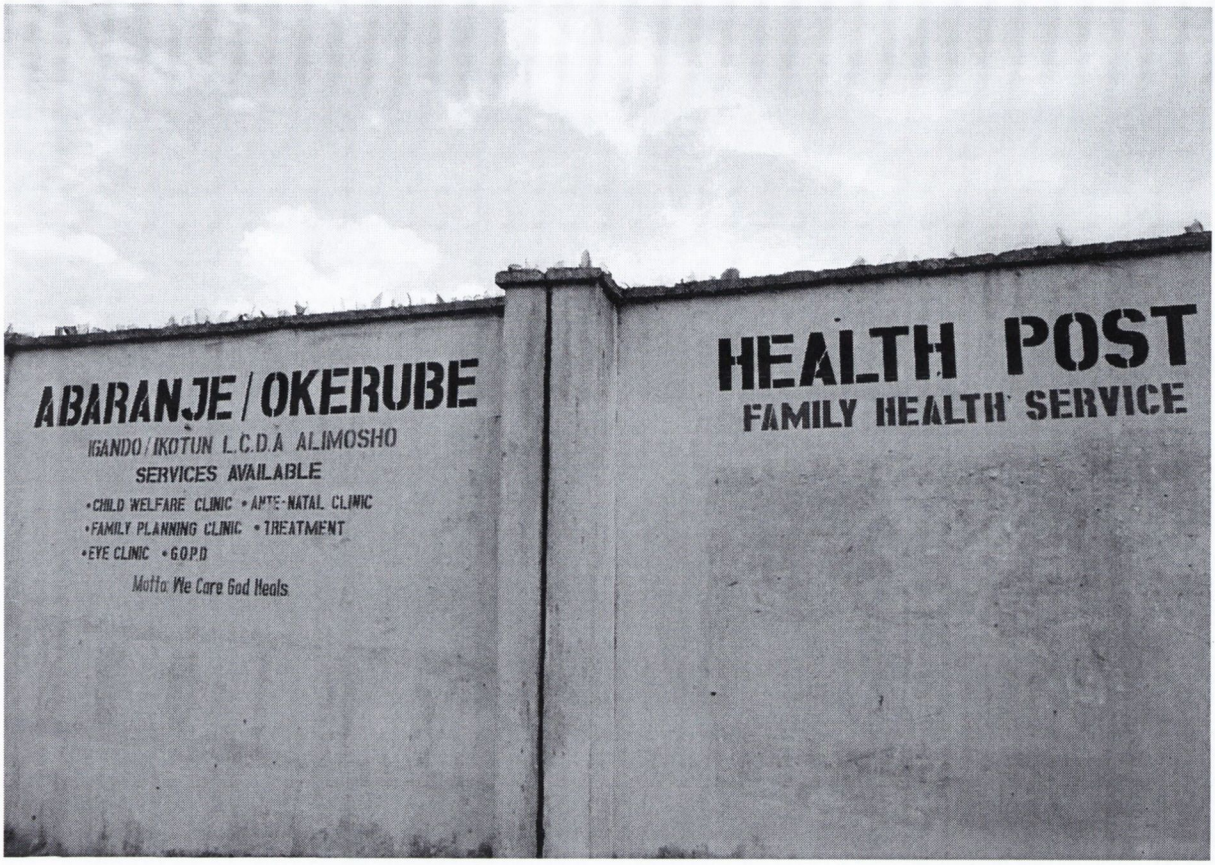
11. What is your perception on the effectiveness of the health care services available to the community through the health centre and do you think the health workers there are performing as they should?
12. Have you had a personal experience while you visited the health centre, which you can share and does the doctor or nurses address patients well?
13. How long is the average time that you have spent when you visited the health care facility before you got treated or attended too?
14. Where you eventually attended too? Did you get to complain about this?
15. How do you think the services at the health care centre can be improved? What else.....

Objective 3: Ascertain specific factors which influences people's health in emerging communities and urban slums of south west Nigeria.

16. What are at are the specific factors that influence people's health in this community?
17. Would you say health education and literacy significantly contributes to people's health?
18. Does ignorance and lack of awareness about one's health affects a person?

19. What are those socio-cultural factors that determine how and why people seek for health care services?
20. Are there certain financial constraints which affect people in their quest for good health?
21. Does this environment affect the health of the people in this community? What else.....

Appendix XIII: Abaranje Community



Fence of Abaranje/Okerube Health Post (Above)



Better-Life Hospital Abaranje, Lagos (Above)

Appendix XIV: Ajegunle Community



Road entrance into Ajegunle slum community



Makeshift toilet/bathroom in Ajegunle slum (Above)



Open drain at Ajegunle slum (Above)

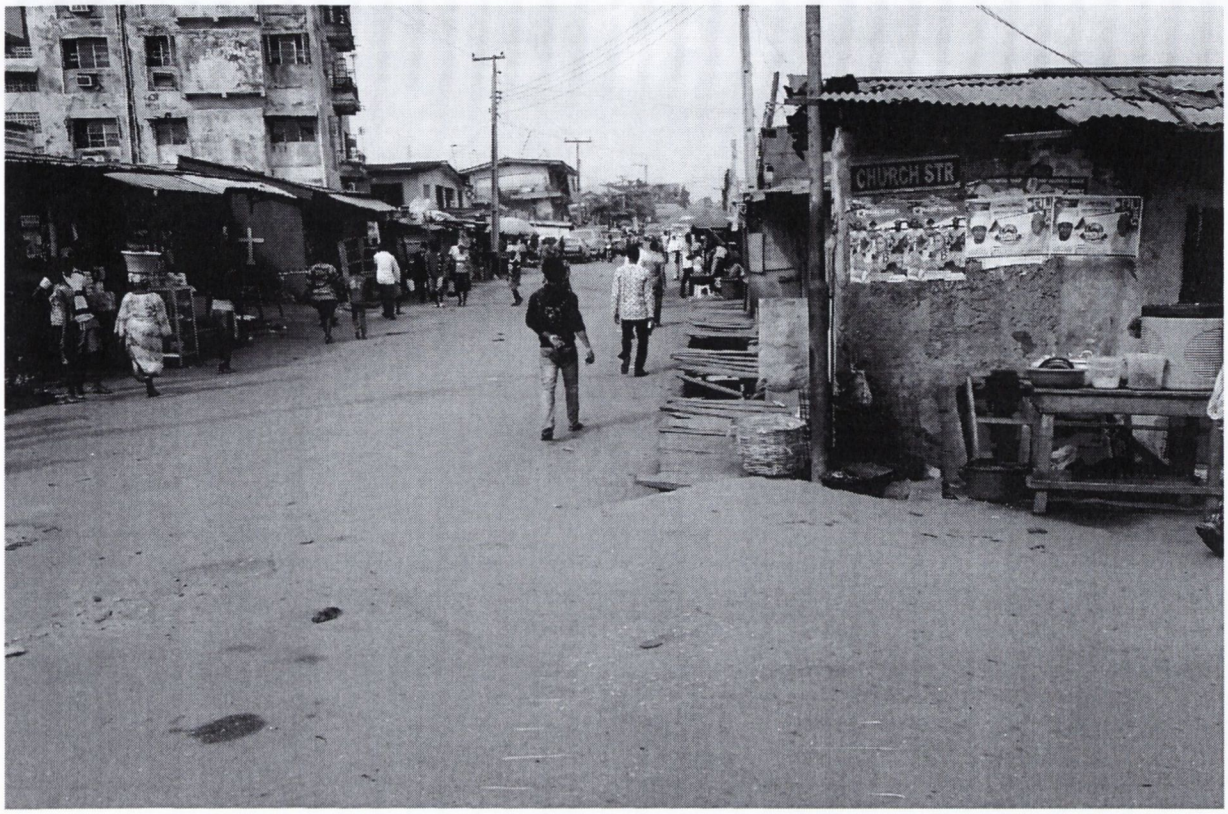


Smoked fish making in Ajegunle slum (Above)



Ajeromi Ifelodun LGA (Host LGA of Ajegunle slum community) (Above)

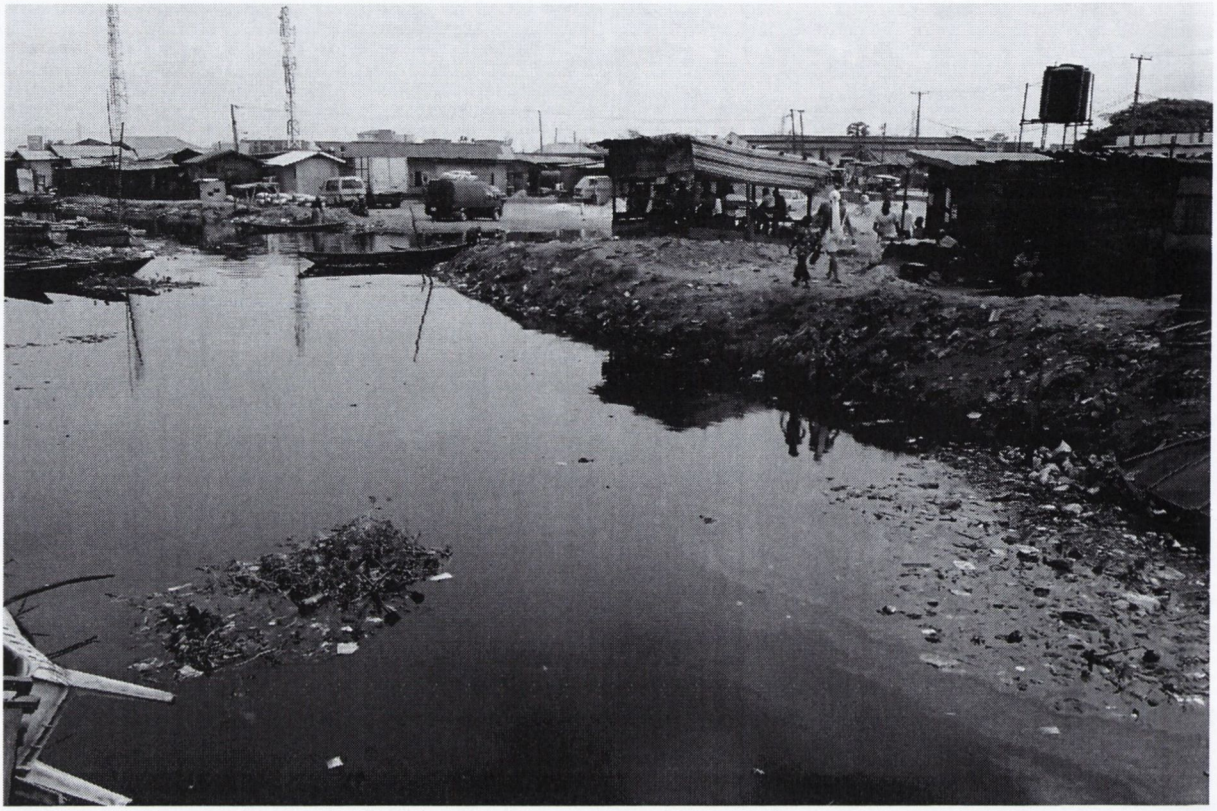
Appendix XV: Makoko Community



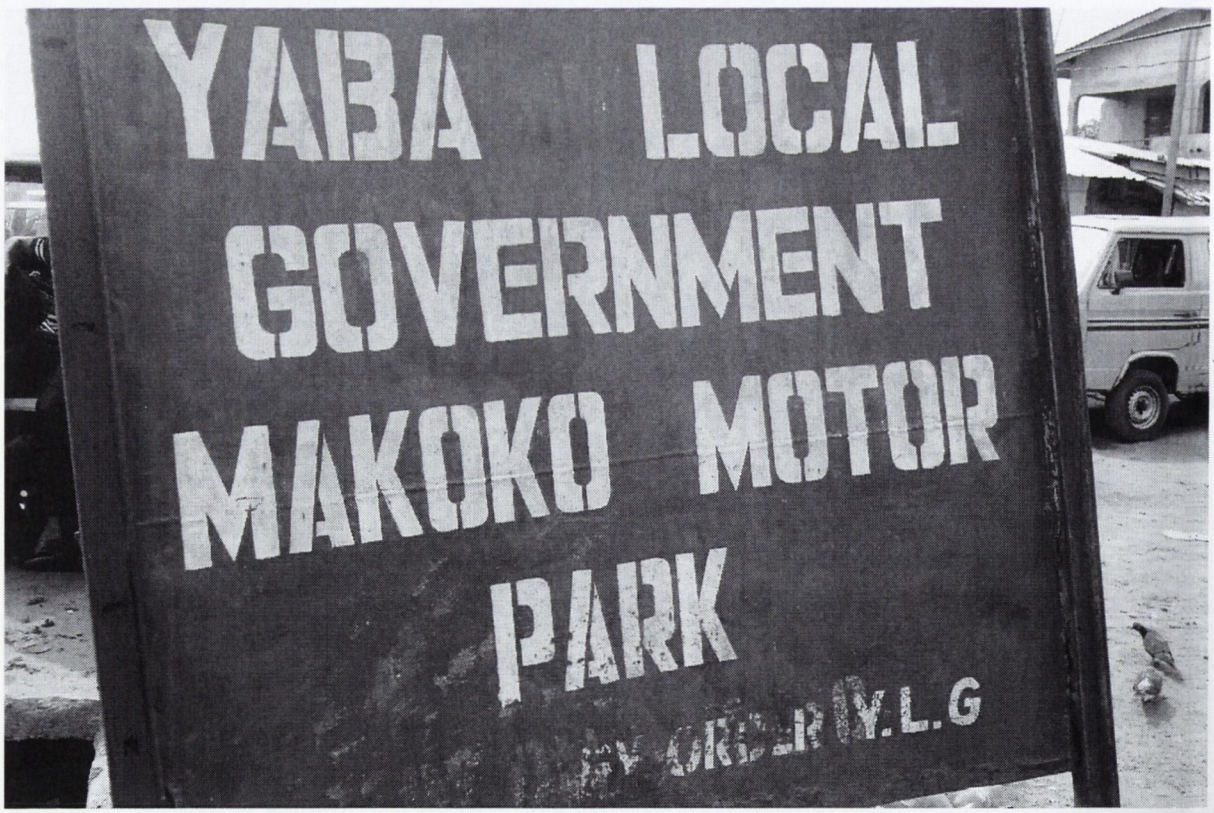
Church Street, Makoko, Yaba, Lagos (Above)



Flood on church street, Makoko, Yaba, Lagos (Above)



Open drain with black water in Makoko, Yaba, Lagos (Above)



Yaba Local Government Makoko Motor Park (Above)



St. Daniel's Hospital, Makoko, Yaba, Lagos (Above)

Appendix XVI: Ibafo Community



Ibafo Health Centre Sign Post (Above)



Arial view of Lagos-Ibadan Expressway (Above)

Appendix XVII: Magboro Community



Welcome sign at entrance into Magboro community (Above)



Lagos to Ibadan Expressway (Above)

Appendix XVIII: Mowe Community



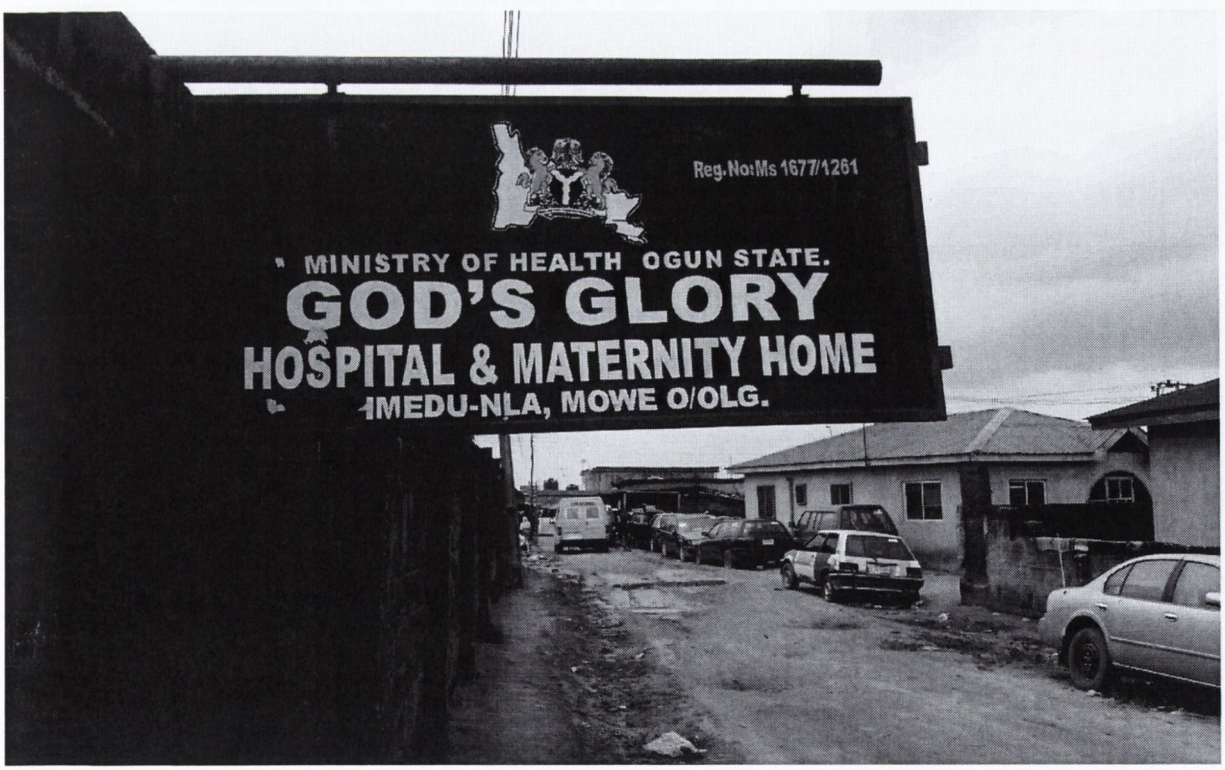
Arial view of Mowe community (Above)



Major entrance road into Mowe community (Above)



Bimon Hospital visited for an in-depth interview (Above)



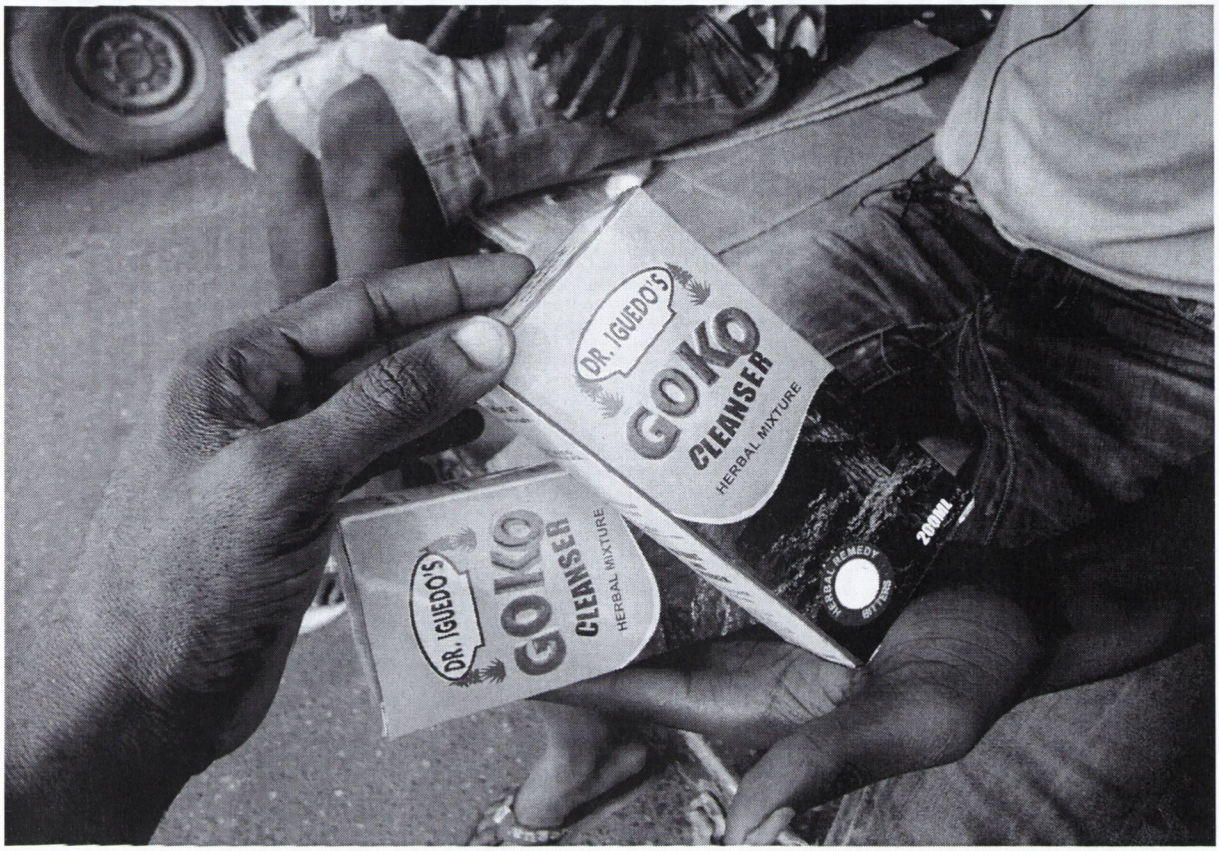
God's Glory Hospital & Maternity Home (Above)

Appendix XIX: Orthodox Medicines Sold in Pharmacies and Chemist Shops



Orthodox medicines bought across the counter (Above)

Appendix XX: Traditional Medicines



Packaged traditional herbal mixture sold on the street (Above)



Unpackaged traditional herbal mixture sold on the street (Above)