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Research Article

An Analysis of Social Determinants Influencing Healthcare Utilisation in Selected Urban Slum Settlements in Lagos State, Nigeria

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Abstract

Background: A substantial proportion of Nigeria's urban population resides in slum settlements where structural deficiencies result in exposure to health risks. Understanding the determinants of healthcare service utilization in these environments is essential for improving population health outcomes. While previous scholarship has examined socioeconomic influences on healthcare use, limited attention has been given to identifying the most salient predictors among urban slum dwellers.
Methods: This study addresses this gap by employing a mixed-methods research design combining quantitative and qualitative approaches.
Results: The findings indicate that the presence of a known or diagnosed illness is the most significant factor prompting healthcare service utilization among slum residents in Lagos State, South-west Nigeria. Other socioeconomic and contextual variables play comparatively weaker roles. These results highlight the predominance of reactive, illness-driven healthcare-seeking behaviours in slum contexts.
Recommendations: The study recommends the development of targeted health policies and public education programmes that promote preventive care and reorient residents towards more proactive patterns of healthcare utilisation.
Key points: Critical determinant of health services utilization, Reactive healthcare orientation, Failed healthcare Policies/facilities.

1. Introduction

Across sub-Saharan Africa, an estimated 62% of the population resides in urban slum settlements characterized by inadequate social amenities, precarious living conditions, and weak health infrastructure [1]. These environments are social manifestations of structural inequality, where access to health care is constrained not merely by individual deficits but by broader socio-political arrangements. In most sub-Saharan African urban slums, health services are either unavailable, spatially inaccessible, or financially challenging for the poor to access. The privatization of healthcare and the dominance of profit-driven providers, what [2] describe as "capitalistic medical entrepreneurship", encourage forms of exclusion by placing essential services beyond the reach of low-income residents. Out-of-pocket health expenditures continue to push millions of Africans into poverty annually [3]. This illustrates the cyclical relationship between ill health and economic deprivation.

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Slum settlements, therefore, are not simply spaces of residence; they are social locations where structural disadvantage is perpetuated. They typically lack adequately equipped facilities, and where such facilities exist, they are often staffed by underqualified personnel operating within fragile healthcare ecosystems [4]. Consequently, rates of morbidity and mortality remain disproportionately high among urban slum residents in comparison to the national averages [5]. Although the Alma-Ata Declaration of 1978 articulated health as a fundamental human right, social realities in many African urban slums challenge the universality of this claim. Nigeria, despite its stated commitments to global health agendas, continues to exhibit one of the highest burdens of preventable diseases and premature mortality in the region [5]. While biomedical sciences often emphasise internal or biological determinants of disease, sociologists highlight the external, structural, and environmental contexts, poverty, gendered inequalities, educational disparities, spatial segregation, and cultural norms that shape patterns of health and illness [1]. These connected factors generate complex barriers that complicate policy efforts aimed at expanding health access for marginalized populations.

This study, therefore, seeks to empirically identify and analyse the most critical determinants of healthcare utilisation among residents of selected slum settlements in Lagos State, Nigeria. Understanding these determinants is vital for interrogating assumptions, such as the belief that improving socioeconomic factors automatically leads to increased formal healthcare usage, and for creating interventions grounded in the everyday realities of structurally marginalized communities.

Healthcare Services Utilization in Urban Slum Settlements of Lagos State, Nigeria: A Globalized Sociological Perspective

Global debates around health inequality persist because notable disparities remain in healthcare access, quality, and outcomes across social classes and geographic regions [1]. International initiatives, such as Primary Health Care (PHC), Sustainable Development Goal 3 (SDG-3), and Universal Health Coverage (UHC), have emerged to address these disparities [6]. However, the promise of health for all is undermined in many low- and middle-income countries by long-standing structural constraints, including income inequality, spatial marginalization, and infrastructure deficits [7].

Urban slums in Nigeria illustrate these structural constraints vividly. They function as social barometers of national poverty, accommodating rural-urban migrants and the urban poor whose socioeconomic precarity pushes them into informal settlements [8]. These settlements lack basic amenities and functional public services. Available healthcare facilities are often overstretched or geographically distant, resulting in further exclusion for low-income residents [9]. Even where facilities exist, their limited human and material resources undermine community trust and reduce utilization [6].

Although many slums are located near city centres, the option to seek care in more developed urban areas is often challenged by poverty, transportation costs, and social hierarchies embedded in the urban landscape [7]. Poverty continues to serve as a significant barrier to achieving UHC in Nigeria [10], contributing to high rates of communicable disease transmission in slums where residents lack access to affordable preventive and curative services [10].

A striking paradox in slum health behaviour is the high patronage of informal or unregulated healthcare providers, often preferred due to affordability, proximity, cultural resonance, or flexible payment structures [6, 7]. Similar patterns have been observed in urban slums in Bangladesh, South Africa, and elsewhere [1, 9]. However, despite widespread use, the quality of these informal services remains questionable, contributing to Nigeria's persistently high mortality rates. This unresolved paradox, high engagement with informal care despite the availability, though limited, of formal services, necessitates deeper analysis. For this reason, the present study aims to identify the most consequential factors shaping healthcare utilization among slum dwellers in Lagos State, Nigeria, thereby contributing to global sociological debates on health inequality, urban marginality, and the social organization of healthcare.

Variables Influencing Healthcare Services Utilization among Urban Slum Dwellers in Lagos State, Nigeria

Household

Household income plays a central role in shaping health-seeking behaviour, especially in contexts where healthcare is commodified. When the cost of care exceeds available income, individuals are forced to delay or forgo treatment, contributing to adverse health outcomes [11]. The financial strain associated with illness is particularly acute in slums where households must choose between paying for healthcare and meeting basic needs such as food, shelter, and education [8]. Estimates suggest that healthcare expenditure can consume up to 40% of household budgets in such environments [10, 12].

Although UHC advocates equitable access to quality health services [11], the Nigerian healthcare system continues to reflect socioeconomic stratification. Healthcare costs remain a significant deterrent to service utilization among the poor [1]. With healthcare expenses reaching as high as 25% of household income in Nigeria [12], reliance on out-of-pocket payments reinforces class-based inequalities and undermines health-seeking behaviour. The establishment of the National Health Insurance Scheme (NHIS) in 2005 represented a policy attempt to mitigate these inequities. However, its coverage remains skewed toward the formal sector, which comprises only a small fraction of the population [13]. Slum dwellers, mainly situated within the informal sector, therefore remain disproportionately uninsured and exposed to health risks [11]. Given that the study location has an estimated population of over 2.2 million [14, 15], understanding these income-related barriers becomes essential for designing inclusive health interventions.

Theoretical Underpinning

Sociological inquiry into health-seeking behaviour has emphasized the multifaceted nature of healthcare utilization, with factors spanning individual, social, cultural, and structural domains [7, 16]. Andersen's Behavioral Model (ABM) remains one of the most influential frameworks in this field. It conceptualizes healthcare utilization as a function of three categories of determinants: predisposing factors (e.g., age, gender, cultural beliefs), enabling factors (e.g., income, insurance, accessibility), and need factors (e.g., perceived or evaluated illness). Anderson's view is further supported by Kroeger's model of health-seeking behaviour. According to Kroeger, social networks and the healthcare system itself shape choices between formal and informal providers. Both models demonstrated that healthcare utilization cannot be explained solely through facility availability. Instead, its utilization is embedded in broader social systems and inequalities.

However, a critical gap persists in many earlier models that underemphasize internal or need-based factors such as illness severity, frequency of symptoms, or chronic conditions. While socio-economic and cultural variables receive substantial attention, the central role of illness itself, the primary trigger for seeking care, often remains analytically overshadowed [1]. This study addresses this limitation by placing illness-related factors at the centre of analysis, while still acknowledging the importance of the broader social context. By doing so, it offers a more balanced and empirically grounded framework for understanding healthcare utilization among urban slum dwellers in Nigeria.

2. Methods of Study

2.1. Research Design

This study employed a mixed-methods research design, combining quantitative and qualitative approaches to investigate the key determinants of healthcare service utilization among urban slum dwellers in the south-west region (Lagos metropolis) of Nigeria. The mixed-methods strategy was adopted to capture both the structural patterns influencing healthcare utilization and the lived experiences through which slum residents interpret illness, access care, and negotiate barriers embedded in their socio-spatial environments.

2.2. Study Location

The research was conducted in four Local Government Areas (LGAs) in Lagos State: Ajeromi-Ifelodun, Apapa, Lagos Mainland, and Somolu. These LGAs collectively encompass at least fifteen major slum settlements in Nigeria [14] and represent some of the most densely populated and socially marginalized urban spaces in the country. Covering an estimated land area of $87km^2$ and a population of approximately 2,268,869 residents [14]. These areas constitute a critical demonstration of urban precarity [17]. Prominent slum communities within these LGAs include Amukoko, Ago-Hausa, Olodan, Badia, Otto, Ijora, Makoko, Oko-Baba, Oko-Agbon, Abule-Nla, Mosafejo, Bariga, Abule-Ijesha, Ilaje, and Pedro. These settlements were purposively selected because they exhibit the defining characteristics of urban marginality, overcrowding, infrastructural decay, environmental hazards, and weak healthcare systems, which make them ideal sites for examining structural determinants of healthcare utilization.

2.3. Study Population and Sampling Procedures

The study population consisted of adult residents aged 18 years and above who provided informed consent to participate. Due to the absence of a recent and reliable sampling frame, largely a result of demographic fluidity, population mobility, and the informal nature of slum settlement expansion, non-probability sampling techniques (purposive and accidental sampling) were employed. To enhance representativeness across the selected LGAs, 100 participants were purposively drawn from each local government area, resulting in a total quantitative sample of 400 respondents. Selection was based on accessibility, willingness to participate, and residence within the identified slum clusters. Qualitative participants were selected using purposive sampling criteria that focused on diversity in terms of gender, age, health-seeking experiences, and household socioeconomic profiles.

2.4. Data Collection Instruments

Two primary data collection tools were used:

1. **Structured Questionnaire:** Designed to capture demographic characteristics, patterns of healthcare utilization, socioeconomic conditions, illness experiences, and perceptions of healthcare accessibility and affordability.
2. **In-Depth Interview (IDI) Guide:** Used to collect qualitative narratives from sixteen (16) participants, enabling a deeper exploration of social, cultural, and economic factors shaping health-seeking behaviours. This qualitative component enabled the study to illuminate the meanings that residents assign to illness, their interpretations of formal versus informal healthcare, and the social dynamics that influence their decisions.

2.5. Data Analysis

Quantitative data were coded and analysed using the Statistical Package for the Social Sciences (SPSS).
The analysis proceeded at two levels:

Univariate analysis: Frequency distributions and descriptive statistics were used to summarize patterns of healthcare utilization and respondent characteristics.

Multivariate analysis: Multiple logistic regression was employed to examine the relationships between independent variables (e.g., income, religious affiliation, and presence of illness in the participants) and the dependent variable (healthcare service utilization).

Qualitative data were analysed using content analysis, involving systematic coding, thematic categorization, and interpretation of emergent patterns. This analytical strategy ensured that the qualitative findings complemented and enriched the quantitative results, offering a more holistic sociological understanding of healthcare utilization.

2.6. Ethical Considerations

Ethical protocols were observed. Participants were clearly informed of the study's purpose, assured of confidentiality, and provided voluntary consent. Only individuals who confirmed that they were 18 years or older were included in the study. Names and identifying information were omitted to protect anonymity, and respondents were assured of their right to withdraw at any stage without consequence.

2.7. Limitations of the Methods

The study was geographically limited to four LGAs in Lagos State due to resource constraints. With additional funding, a broader comparative study involving multiple states or regions could offer more generalizable insights. Furthermore, the use of non-probability sampling, necessitated by the absence of a current and reliable sampling frame, limits the extent to which findings can be statistically generalized to all slum residents in Nigeria. However, the methodological rigour applied in both data collection and analysis strengthens the reliability and validity of the findings. The mixed methods design also mitigates some sampling limitations by providing rich contextual and experiential insights that complement quantitative trends.

3. Results

3.1. Socio-demographic Characteristics of Respondents:

Table 1 presents the socio-demographic profile of the respondents across the four selected slum settlements in Lagos State. The gender distribution indicates a near-balanced composition, with 48% males and 47.3% females, suggesting no significant gender bias in participation. This balance provides a relatively even platform for understanding gendered variations in health-seeking behaviours.

The age distribution indicates that individuals of working age predominantly occupy the settlements. Nearly half (48%) of the respondents fall within the youthful age cohort (18–35 years), while 39.8% belong to the middle-aged group (36–55 years). Only about 10% are 56 years and above. This demographic structure is characteristic of urban informal settlements where young and economically active populations concentrate in search of livelihood opportunities.

Educational attainment among respondents reflects limited access to formal schooling, a pattern consistent with broader patterns of structural disadvantage in urban poverty contexts. About 5% reported having no formal education, while 39.3% had either completed primary school or attended but did not finish secondary schooling. Approximately 40% were senior secondary school graduates, and only 14.5% had accessed tertiary education. These findings indicate that nearly four out of five respondents (79.1%) lack a tertiary education. This demonstrates the link between educational exclusion and residence in urban slum environments.

Ethnic composition reveals that the majority of respondents are Yoruba (58%), followed by Igbo (18.8%) and Hausa (3.5%) ethnic groups. Respondents from other Nigerian ethnic minorities account for 17.8%, with one non-Nigerian African participant. This distribution reflects the ethnic heterogeneity typical of Lagos slums but also points to localized Yoruba dominance in the studied clusters.

Employment patterns demonstrate the centrality of informality in the economic lives of slum dwellers. Although 11.3% of respondents reported being unemployed and 12.3% employed in wage labour, a substantial 75.5% identified as self-employed or engaged in informal businesses. This supports existing scholarship, which identifies the informal economy as the principal livelihood system for urban poor populations.

Marital status data indicate that 38.5% of respondents were single, 48.3% were married, and 2.8% were divorced or separated, suggesting relatively stable household structures despite economic vulnerability.

Household size distribution reflects high fertility norms and extended household arrangements. Only 11.8% of respondents lived in small households (1–3 persons). A majority (66%) resided in households of 4–6 persons, while 20.8% reported living with seven or more household members. Such large household sizes have implications for household health expenditures, dependency ratios, and caregiving practices within resource-constrained environments.

Religious affiliation reveals that 42.3% of respondents identified as Muslim, 31% as Christian, and 4% as adherents of traditional religions. This aligns with the religious demography of Lagos but also suggests that health beliefs and practices may be shaped by religious pluralism.

Monthly income data further demonstrate the financial poverty of slum residents. A majority (58%) earned no more than ₦50,000 per month, while 31.3% earned between ₦51,000 and ₦100,000. Only 6.3% reported incomes above ₦101,000. These figures confirm that most households fall within low-income categories. This reinforces the argument that economic constraints significantly shape healthcare utilisation patterns.

Occupational sector analysis shows that 77.8% of respondents worked in the informal sector, compared with only 9% in the formal sector, while 8.5% were not working at the time of data collection. Daily activity patterns further show that 67.3% were actively working, 11.5% were full-time housewives or nursing mothers, 7.5% were students, 8% were apprentices learning a trade, and 3.5% were job seekers. This distribution reflects a labour environment dominated by casual, unstable, and low-income work typical of urban slum economies.

Taken together, these socio-demographic characteristics paint a picture of a population that is young, economically vulnerable, informally employed, modestly educated, and operating within large household units, all factors that have significant implications for healthcare access, affordability, and utilization.

Table 1: Percentage Distribution of Respondents by Socio-demographic characteristics

Variables	Frequency	Percent
Sex		
Male	192	48
Female	189	47.3
Total	381	95.3
Age		
18-35	192	48
36-55	159	39.8
56 and above	41	10.3
Total	392	98.1
Educational attainment		
None	20	5.0
Below SSCE/Secondary School	157	39.3
SSCE/Secondary School	159	39.8
Tertiary	58	14.5
Total	400	98.6
Ethnic Group		
Yoruba	232	58.0
Ibo/Igbo	75	18.8
Hausa	14	3.5
Other tribes from Nigeria	71	17.8
Foreigners from other African countries	1	.3
Total	393	98.4
Employment status		
Unemployed	45	11.3
Employed	49	12.3
Self-employed/Business	301	75.3
Total	395	98.7
Marital status		
Single	190	38.5
Currently married	193	48.3
Divorced and widow/widower	11	2.8
Total	394	98.5
Number of people in the household		
Below 3	47	11.8
Between 4 and 6	264	66.0
7 and above	83	20.8
Total	394	98.5
Religious affiliation		
None	87	21.8
Christianity	124	31.0
Islam	169	42.3
Traditional	16	4.0
Total	396	99
Monthly income		
N50,000 and less	232	58.0
N51,000 – N100,000	125	31.3
N101,000 and above	25	6.3
Total	382	95.5
Estimated daily spending		
Below N1,700	39	9.8
Above N1,700	350	87.5
Total	389	97.2
Sector of employment		
Informal sector	311	77.8
Formal sector	36	9.0
Not currently working in any sector	34	8.5
Total	381	95.2
Daily activities		
Full housewife and nursing mother	46	11.5
Student	30	7.5
Apprentice	32	8.0
Working	269	67.3
Applicants	14	3.5
Total	391	97.7

Source: Researcher's Fieldwork (2023).

3.2. Healthcare Services Utilization

Table 2 presents the distribution of respondents by their patterns of healthcare service utilization in the twelve months preceding the survey. A substantial majority (81%) reported using some form of healthcare service during this period, while 17% indicated that they had not sought any care. This high rate of utilization suggests that illness episodes and health needs are frequent among slum residents, despite financial and structural barriers. The preference for the type of healthcare service varied considerably. Fifty-one per cent of respondents preferred orthodox medical care (hospitals and clinics), while 23% relied primarily on traditional or spiritual healing systems. An additional 21% reported using a combination of both orthodox and traditional/spiritual care, reflecting a pluralistic health-seeking culture that is widely documented in African urban contexts. These findings highlight the coexistence of biomedical and indigenous healing systems, suggesting that a combination of accessibility, cultural significance, and local trust in alternative systems influences healthcare choices.

Respondents were further asked to indicate the reasons underlying their healthcare choices. About 11% attributed their decisions to cultural, traditional, or spiritual beliefs, while 50% reported that their choices were informed by socialization and familiarity with the service. Another 12% emphasized the availability of services, while 22.8% cited affordability as a determining factor. These responses highlight the intersection of culture, social learning, and economic constraints in shaping healthcare-seeking patterns in informal settlements. Regarding illness experiences, 77.5% of respondents reported being sick within the previous twelve months, while 21% indicated they had not experienced any sickness. When asked if they had any chronic condition requiring ongoing medical attention, 11% responded affirmatively, whereas 87.3% denied having such conditions. However, when explicitly probed about diagnoses received within the last year, 72.8% reported having been diagnosed with a disease or infection. This discrepancy suggests the possibility of under-recognition or under-reporting of chronic health conditions, possibly due to limited access to diagnosis or low health literacy.

The most commonly reported illness was malaria (61.8%), followed by high blood pressure (5.3%), tuberculosis (2%), and diabetes (3%). Additionally, 17.5% reported other illnesses not captured in the predefined categories of this survey. The predominance of malaria aligns with known environmental and infrastructural vulnerabilities of slum communities, including overcrowding and poor sanitation.

When asked about healthcare needs within their communities, 48.5% expressed a desire for improved formal healthcare facilities (hospitals, clinics, and health centres). Only 4% indicated a preference for traditional or spiritual care centres, while 24.5% felt that both systems should coexist. Notably, 21.5% believed that no additional healthcare facilities were needed, a response that may reflect fatalism, limited expectations of public service delivery, or satisfaction with existing informal or alternative care arrangements.

Perceptions of the adequacy of the existing healthcare infrastructure were overwhelmingly negative. Only 34.5% believed their communities had adequate healthcare facilities, while 63.7% stated that they did not. Furthermore, an overwhelming 93.5% believed that the provision of more facilities would lead to increased healthcare utilization. A small minority (2%) disagreed, possibly reflecting entrenched reliance on traditional systems or mistrust of formal healthcare.

Respondents identified multiple obstacles to healthcare utilization. Cost emerged as the most significant barrier, cited by 50.7% of respondents. Attitudes toward healthcare services, including negative staff behaviour or perceived discrimination, were cited by 27.8%. Distance (9.5%) and traditional beliefs (4.8%) also emerged as barriers, along with a range of other factors (5.8%). Collectively, these findings suggest a complex interplay of structural, economic, and cultural factors that shape healthcare access in slum environments.

Frequency of healthcare utilization further illuminates behavioural patterns. Only 4.3% of respondents used healthcare services on a monthly basis, and 18.3% accessed services regularly for check-ups. A majority (57.8%) sought care only when sick, reinforcing the observation that healthcare engagement is largely reactive rather than preventive among slum residents. This aligns with broader sociological and public health literature highlighting the role of poverty, limited health literacy, and infrastructural deficits in discouraging preventive care.

Overall, these findings demonstrate that while illness prevalence and healthcare utilization are high. Cost, availability, cultural norms, and perceptions of health among slum dwellers shape usage. Slum residents navigate a pluralistic healthcare landscape in which formal and informal systems coexist, reflecting broader socio-economic and cultural dynamics of urban marginality.

Table 2: Percentage Distribution of Respondents by Healthcare Services Utilization

Variables	Frequency	Percent
Utilised healthcare service in the last 12 months		
Yes	324	81.0
No	69	17.3
Total	393	98.2
Type of Healthcare Utilised		
Formal	173	43.3
Informal	29	7.2
Both	168	42.0
Total	370	92.5
Which do you prefer, traditional healthcare services or hospital care		
Traditional/Spiritual Care Services	95	23.8
Hospital or clinical care	204	51.0
Both	84	21.0
None	7	1.8
Total	390	92.5
What made you utilise the healthcare service you utilised?		
Because of my traditional/cultural, and spiritual beliefs	44	11.0
Because that is what is available around me	48	12.0
That is the care service I was introduced to, and I have been using it	200	50.0
That is what I can afford	91	22.8
Total	383	95.7

Table 2 (continued)

Variables	Frequency	Percent
Have you experienced any sickness in the last twelve (12) months		
Yes	310	77.5
No	84	21.0
Total	394	98.4
Do you have a sickness/disease that requires medication from time to time?		
Yes	44	11.0
No	349	87.3
Total	393	98.2
Have you been diagnosed with any disease in the last 12 months e.g high blood pressure, tuberculosis, malaria, diabetes		
Yes	291	72.8
No	99	24.8
Total	390	97.4
If yes, which one of these?		
High blood pressure	21	5.3
Tuberculosis	8	2.0
Malaria	247	61.8
Diabetes	12	3.0
Others	70	17.5
Total	358	89.5
What type of healthcare services do you think is needed in this community?		
Hospital/Clinic/Health Centre	194	48.5
Traditional/Spiritual Care	16	4.0
Both	98	24.5
None	86	21.5
Total	394	98.5
Do you have enough of this wanted health facility in this community		
Yes	138	34.5
No	255	63.7
Total	393	98.2
If this health facility is provided in this community, will it make more people use healthcare services?		
Yes	374	93.5
No	8	2.0
Total	382	95.4
What is the main reason you may not use a healthcare service?		
The cost of the service	203	50.7
My belief and tradition	19	4.8
Distance of the healthcare service	38	9.5
The attitude of the healthcare workers	111	27.8
Others	23	5.8
Total	394	98.5
How often do you utilise healthcare services		
Every month	17	4.3
Only when there is a need	231	57.8
For a scheduled medical check-up	73	18.3
Not frequently	73	18.3
Total	394	98.4

Source: Researcher's Fieldwork, (2023).

3.3. Logistic Regression Analysis

A binary logistic regression model was employed to examine the influence of religious affiliation, monthly income, and experience of sickness in the past 12 months on the likelihood of utilizing healthcare services within the same period. The model accounted for 57.3% of the variance in healthcare utilization (Nagelkerke $R^2 = 0.573$). This indicates a moderately strong explanatory power for behavioural outcomes in complex urban slum environments. Overall, the model correctly classified 81.9% of all cases, demonstrating good predictive accuracy. Among the independent variables entered into the model, experience of sickness in the last 12 months emerged as the only statistically significant predictor (p = 0.000). This finding suggests that recent illness episodes significantly influence healthcare-seeking behaviour among slum residents. Individuals who reported being sick within the previous year were 34.47 times more likely to utilize healthcare services compared with those who had not been sick. This substantial odds ratio demonstrates the predominance of reactive rather than preventive health-seeking behaviour in low-income urban contexts, where residents typically seek care only when illness becomes acute or unavoidable.

By contrast, religious affiliation (p = 0.098) and monthly income (p = 0.885) did not significantly contribute to the predictive model.

Although not statistically significant, the odds ratios for religious affiliation are nonetheless noteworthy: Christians were 4.04 times more likely, and Muslims 2.18 times more likely, to utilize healthcare services relative to respondents with no religious affiliation. These trends may reflect the social support networks, normative expectations, and organizational structures embedded within religious communities, which can shape knowledge about illness, trust in biomedical systems, or pathways to care. However, the lack of statistical significance suggests that these influences are insufficiently strong or too diffuse within the studied population to predict healthcare utilisation independently.

Similarly, the non-significant effect of monthly income suggests that, within the context of the extreme deprivation characteristic of urban slums, income differentials may be too narrow to distinguish meaningfully between those who seek healthcare and those who do not. In such settings, other structural constraints, such as cost of services, availability of facilities, and cultural norms, may override economic differences in shaping healthcare decisions.

Overall, the regression analysis highlights illness experience as the dominant driver of healthcare utilization among slum dwellers in Lagos. This aligns with broader sociological literature emphasising that marginalised populations often engage with formal healthcare systems primarily when confronted with immediate health crises, rather than for preventive or routine care. The findings demonstrate the need for community-level interventions that aim to improve preventive health practices, enhance health literacy, and expand accessible primary healthcare services within slum settlements.

Table 3: Binary Logistic Regression Analysis (Multivariate)

Variable	Category	Coefficient (B)	Standard Error	Odds Ratio (Expected B)	95% CI		P-value
					Lower	upper	
Religious Affiliations	None (Ref)			1			0.232
	Christianity	1.396	0.844	4.038	0.773	21.097	0.098
	Islam	0.781	0.853	2.18	0.410	11.612	0.360
	Traditional Worshipers	0.522	1.205	1.686	0.159	17.895	0.665
Monthly Income	Less than N50,000 (Ref)			1			0.885
	N51,000 – N100,000	0.190	0.475	1.209	0.476	3.068	0.689
	N100,000 – N150,000	-0.420	0.936	0.657	0.105	4.118	0.654
	N150,000 and above	-0.260	1.400	0.771	0.050	11.996	0.853
Experienced sickness in the last 12 months	No (Ref)			1			
	Yes	3.54	0.438	34.47	14.596	81.421	0.000

Source: Researcher Fieldwork, (2023)

Ref in the table 3 above means Reference Category.

3.4. Test and Interpretation: Hypothesis (H1)

A known sickness or disease has a positive relationship with the utilization of healthcare services among dwellers of slum settlements in Lagos State, Nigeria. The statistical test for this hypothesis shows a p-value of 0.000, which is below the 0.05 threshold. This indicates a statistically significant relationship between having a known sickness or disease and the utilization of healthcare services among slum residents in Lagos State. The logistic regression coefficient of 3.54 further demonstrates a positive association, showing that the presence of illness substantially increases the likelihood of seeking healthcare. In practical terms, the higher the burden of sickness among slum dwellers, the more likely they are to engage with healthcare services.

These findings establish sickness or disease as the primary determinant of healthcare service utilization in the studied population. The p-value (0.000) confirms that illness is a strong and reliable predictor of healthcare-seeking behaviour among urban slum residents. This pattern aligns with broader evidence that marginalized populations tend to rely on health facilities only when symptoms become severe or unmanageable.

3.5. Support from Qualitative Data

The qualitative interviews reinforce the statistical findings. As one healthcare practitioner in the community explained:

"People in this community do not come for healthcare services until there is a sickness or disease they cannot manage."

Similarly, respondents from the slum settlements expressed a clear tendency toward symptomatic healthcare-seeking:

"I do not fall sick, and when I feel sick, I take herbs without going to the hospital."

"Why must I go to the hospital if I am not sick?… Unless there is a problem with my health that is beyond what I can endure. If I am okay, I do not go to the hospital at all, even in years."

These narratives highlight a deeply rooted pattern of reactive rather than preventive healthcare behaviour. Illness must reach a certain threshold before residents perceive it as legitimate or necessary to seek biomedical intervention.

3.6. Interpretation and Implications

Taken together, both quantitative and qualitative findings indicate that slum residents utilize healthcare services primarily in response to illness, conceptualized in this study as "known sickness or disease." This behavioural pattern suggests limited uptake of preventive care, low health literacy, and possible financial or cultural barriers to engaging with healthcare systems in the absence of acute symptoms. From a sociological perspective, these behaviours reflect the lived realities of poverty, limited access, and constrained health choices, where healthcare becomes an emergency resource rather than a routine part of everyday life.

The findings demonstrate the need for community-level reorientation toward preventive healthcare practices. Relying solely on illness-driven healthcare seeking poses significant risks, including late diagnosis, unmanaged chronic conditions, and increased healthcare costs

over time. Targeted health education, improved accessibility of primary care, and culturally grounded community engagement strategies are therefore essential to shift healthcare utilization from crisis-driven to preventive and routine.

4. Discussion

The findings of this study demonstrate a strong and statistically significant association between the presence of a known sickness or disease and the utilization of healthcare services among slum dwellers in Lagos State, Nigeria. This pattern aligns with existing regional studies on healthcare utilization in low-income settlements [1, 11, 18]. These studies similarly identify illness episodes as one of the primary triggers for seeking medical care in impoverished urban contexts. The statistical results of this research, particularly the p-value of 0.000, provide empirical support for this conclusion. Qualitative evidence reinforces this pattern: both healthcare practitioners and residents consistently emphasized that care is sought mainly when illness becomes severe or unmanageable. The strength of this relationship, while expected, raises concerns. The pattern of healthcare utilization that is heavily illness-driven reflects a reactive orientation to health, rather than one grounded in prevention or early diagnosis.

Preventive healthcare behaviours, such as routine check-ups, are essential for reducing long-term morbidity, yet respondents described utilizing medical services only during periods of acute illness. This behaviour is not simply cultural; the socioeconomic realities of slum life shape it. Studies in low-income settings have noted that the high cost of care, encouraged by fee-for-service systems and limited insurance coverage, discourages residents from seeking routine medical attention [1, 11]. Thus, the reliance on healthcare primarily in times of crisis likely reflects economic hardship, limited access to well-equipped facilities, and mistrust arising from previous negative experiences.

The relationship observed in this study echoes findings from research in other Global South contexts. For instance, in several South Asian cities, [18] reported that illness was the primary driver of healthcare utilization among poorer populations. Nevertheless, the authors also emphasized that this tendency is shaped not only by sickness but also by extrinsic factors such as cost, accessibility, and institutional quality, factors that similarly influence healthcare behaviour in the Lagos slums. These observations are consistent with Andersen's Behavioural Model of Health Services utilization, which posits that healthcare utilisation results from the interplay of predisposing characteristics, enabling resources, and need factors [7]. Need, here represented by sicknessis central, but it does not operate independently of broader socioeconomic and institutional conditions.

In relation to income, the findings of this study suggest that more financially stable slum dwellers are less likely to use local healthcare services. This pattern may be attributed to the poor condition of many healthcare facilities within the slums, which are often inadequately equipped and staffed by underqualified personnel. Previous studies have similarly documented limitations in slum-based health centres, prompting residents with greater financial means to seek care in higher-quality facilities outside the community. This behaviour can be understood through Maslow's hierarchy of needs [19]. After meeting basic physiological needs, individuals with more stable financial resources may prioritize safety and security, which extends to safe and reliable healthcare. Fear of misdiagnosis, mistreatment, or inadequate services may therefore drive wealthier residents to bypass local facilities, leading to lower utilization rates among this subgroup despite higher capacity to afford care.

The findings also highlight the complex role of religious affiliation in shaping healthcare behaviour. Religion, defined as a set of beliefs and practices concerning sacred matters [20], provides a moral and explanatory framework through which individuals interpret illness and the healing process. Although religious affiliation was not a statistically significant predictor in the regression model, the odds ratios suggest that Christians were more likely to utilize healthcare services than those without a religious affiliation, followed by Muslims. Qualitative responses also indicated that religious beliefs influence healthcare decisions, either directly through teachings on medicine or indirectly through social networks and religious leaders who shape attitudes toward illness and healing. In some religious traditions, specific medical interventions may be discouraged or prohibited, which can affect patterns of utilization [20]. These findings show the need to consider religious factors within broader sociological analyses of health behaviour, especially in a religiously diverse nation such as Nigeria.

Overall, the study's findings reinforce the notion that healthcare utilization in slum environments is shaped not by isolated factors but by a constellation of socioeconomic, cultural, and institutional conditions. At the same time, sickness remains the most significant predictor of healthcare-seeking behaviour, cost, facility quality, income, and religious beliefs interact to shape when, where, and why slum residents seek care. These results suggest that improving healthcare utilization will require interventions that extend beyond expanding facility availability. Efforts must also address affordability, strengthen service quality, incorporate culturally sensitive engagement strategies, and promote health literacy aimed at shifting behaviours from crisis-driven to preventive healthcare-seeking.

5. Conclusion

This study puts forward the centrality of health status, specifically, the presence of a diagnosed sickness or disease, in shaping healthcare service utilization among urban slum dwellers in Lagos State, Nigeria. Given that an estimated 67% of the world's urban population resides in slum-like conditions [1], understanding the mechanisms behind healthcare utilization in such settings remains a pressing sociological and public health concern. While previous studies have identified an array of socioeconomic and contextual determinants of healthcare use, the multiplicity of factors examined often obscures the relative importance of specific predictors [1, 11]. This study addresses that gap by isolating and empirically assessing the principal factors influencing healthcare utilization among slum residents.

The findings demonstrate that, among the diverse internal and external determinants examined, the presence of illness is the most potent predictor of healthcare utilization. This pattern reflects not only the material and structural constraints operating within slum environments but also aligns with Maslow's hierarchy of needs, in which physiological needs are foundational and prompt action before all others. In contrast, income levels and religious affiliation, though relevant, play comparatively weaker roles in predicting healthcare service use. These results collectively suggest that healthcare seeking remains predominantly reactive, triggered primarily by the experience of bodily distress.

The predominance of illness-driven healthcare utilization raises critical concerns for health outcomes within slum communities. When individuals seek care only after symptoms become severe or unmanageable, opportunities for early detection, preventive care, and long-term disease management are significantly reduced. This reactive pattern, documented in both the qualitative and quantitative components of this research, advocates for a pressing need for systematic public health education and preventive health interventions.

Recommendations

1. **Strengthen Health Education and Preventive Healthcare Culture:** National and sub-national governments in Nigeria and across sub-Saharan Africa should develop sustained health education programmes aimed at shifting healthcare-seeking behaviour from reactive to preventive. Public health campaigns should emphasise the importance of routine check-ups, early diagnosis, and timely intervention.
2. **Improve Access, Availability, and Affordability of Healthcare Services:** Policies must prioritise expanding affordable healthcare to underserved populations, irrespective of socioeconomic status. This includes reducing dependence on out-of-pocket payments, strengthening existing health insurance schemes, and improving the geographical distribution of primary healthcare facilities.
3. **Upgrade Healthcare Infrastructure in Slum Settlements:** The study reveals that financially stable slum residents tend to avoid local clinics, likely due to concerns about the poor quality of facilities and unqualified personnel. Improving the quality of healthcare infrastructure, ensuring adequate equipment, trained staff, and regulatory oversight, would enhance trust and increase utilization across all socioeconomic groups.
4. **Integrate Sociocultural Factors into Healthcare Policy Planning:** While religious affiliation plays a less dominant role than illness in prompting healthcare usage, it still exerts a meaningful influence. Policymakers should engage religious leaders and institutions as partners in public health advocacy, leveraging their authority to encourage evidence-based healthcare practices.

In summary, the study concludes that illness remains the primary catalyst for healthcare utilization among slum dwellers, overshadowing economic, religious, and contextual factors. To improve health outcomes in these communities, governments and stakeholders must adopt a proactive, preventive, and structurally responsive approach that addresses both the behavioural and infrastructural barriers to equitable healthcare access.

Article Information

Disclaimer (Artificial Intelligence): The author(s) hereby declare that NO generative AI technologies such as Large Language Models (ChatGPT, COPILOT, etc.), and text-to-image generators have been used during writing or editing of manuscripts.

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