# HEALTHCARE DELIVERY AND FORMS OF TREATMENT OPTIONS IN SOUTHWEST NIGERIAN COMMUNITIES

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*ABSTRACT*

*In Nigeria, multiple forms of healthcare delivery are widely available to people, making health care increasingly complex. As the population of the country continues to grow, the provision of effective health services has remained a challenge causing low performance in service delivery in the entire health system. This study examined the nature of healthcare delivery in emerging communities of southwest Nigeria. A survey, comprised of 405 households, was conducted across Magboro, Ibafo and Mowe communities of Ogun State. The study found that, as complex as the healthcare delivery system is in Nigeria, the communities exhibited much wider complexities, as multiple forms of treatment options were practised. These ranged from self-medication to group-prescribed medication (GPM) in the form of household-prescribed medication, neighbour-prescribed medication, and community-prescribed medication. The combined use of orthodox and traditional medicine remained high at 32.7% despite the high preference for orthodox medicine (59.2%) over traditional medicine (8.1%). There was significant difference (p-value= 0.003) across the communities on the various types of health facilities ($X^2=19.652^a$); but there was no significant difference (p-value=0.586) across communities on the practice of self-medication, household-prescribed medication, neighbour-prescribed medication and community-prescribed medication ($X^2=4.672^a$). The study recommended increased health education and advocacy to educate people on their health and treatment options.*

## 1. Introduction

ALTHOUGH Primary Health Care (PHC) is bedrock of the Nigerian Health Policy (2004), the health experience of its population has not improved, as access to health services remains a challenge (Omoruan, Bamidele and Phillips, 2009; Awoyemi, Obayelu and Opaluwa, 2011) giving rise to various forms of treatment options in

the country, even in emerging communities (Lawal, 2014). 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 in emerging communities of southwest Nigeria (Lawal, 2014; Lawal, 2016). More so in the country, 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 and Agunwah, 2011; Ayinde and Omigbodun, 2003; Gbaror and Ifeanyi, 2006; Udigwe, 2006). The lack of knowledge on 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 and Ojedokun, 2011; Asuzu, Unegbu and Akin-Odanye, 2012).

Within emerging communities of Nigeria, barriers to the use of available healthcare services remain a social reality (Lawal, 2014) that stems from the country's weak health system (Asuzu, 2004). The weak health system has been identified as one of the greatest barriers to ensuring access to essential healthcare services; other barriers are the non-availability of healthcare services, physical limitation in terms of distance, non-availability of transport, cost of health services and reliability of such services in developing countries, among others (Hanson, Ranson, Oliveira-Cruz and Mills, 2003; Nemet and Bailey, 2000; Fairbank, 2004; O'Donnell, 2007; Kruk, Galea, Prescott and Freedman, 2007; Mattson, 2010; Awoyemi et al., 2011; Agarwal and Taneja, 2005; Otuyemi, 2001; Chaya, 2007; Obansa and Orimisan, 2013; Harris, Goudge, Ataguba, McIntyre, Nxumalo, Jikwana and Chersich, 2011).

Emerging communities are new informal settlements that have developed on the outskirts of urban centres of mega cities in developing countries, such as in Nigeria (Lawal, 2014). Emerging communities are 'new living spaces for existing urban dwellers and new migrants to the southwest region of Nigeria' (Lawal, 2016: 177). Therefore, the continuing challenge of healthcare delivery, from a demand or supply perspective, within these communities tends to affect the way healthcare facilities perform. Healthcare delivery exists in various forms within the emerging communities of southwest Nigeria. Pluralistic health care provision within these settings influences and responds to the treatment-seeking patterns of its inhabitants. People's responses can differ towards different illnesses or symptoms and, in many cases, more than one therapy source is adopted over the course of an illness (Harpham and Molyneux, 2001); this means that an array of providers offering a multiplicity of health services exist (Harpham and Molyneux, 2001). These

providers include primary healthcare centres that operate at the local government level under state ministries of health, private (for profit) hospitals, clinics, laboratories and practitioners (offering 'modern' or 'traditional' services); various types of herbal sellers; medicines purchased over the counter from mini-shops (chemist), community pharmacies, drug vendors and a variety of nongovernment providers, including faith-based and charity organizations (Lorenz, and Garner, 1995; Mwangi, 2004; Fakeye, Adisa and Musa, 2009; Oreagba, Oshikoya and Amachree, 2011; Okonkwo and Okonkwo, 2010). In practice, there is often little formal interaction and cooperation between the different types of (healthcare) providers (Ogunbekun, Ogunbekun and Orobaton, 1999) but there is a lot of informal self-referral among patients and users of healers and orthodox doctors within these communities (Lawal, 2014).

In view of the various forms of healthcare delivery in practice within emerging communities, it is becoming increasingly difficult to distinguish genuine health service providers from fictitious ones. Some have, however, argued that it is unnecessary to make such distinctions (Giusti, Criel, and De Bethune, 1997; Ferrinho, Van Lerberghe and Da Cruz Gomes, 1999) because most emerging communities are faced with a system of multiple public and private practices by government-employed physicians, private practitioners, between public and private facilities (Harpham and Molyneux, 2001) and the unofficial introduction of user fees (a token payment) into government services within the communities (Lawal, 2014). Also, the practice of self-medication (Shankar, Partha, and Shenoy, 2002; Omolase, Adeleke, Afolabi and Afolabi, 2007), the use of drugs bought from private-for-profit shops (popularly known as 'chemist') and pharmacies are common practices in response to many illnesses/diseases (Brugha, and Zwi, 1999; Osemene and Lamikanra, 2012; Afolabi, 2008; Fadare and Tamuno, 2011; Arikpo, Eja and Enyi-Idoh, 2009). However, as adequate access to health facilities remains a challenge for people in emerging communities of southwest Nigeria; hence, they have resulted to self-medication and group-prescribed medication as treatment options (Lawal, 2014). In addition, there is a dearth of studies in these emerging communities of southwest Nigeria on the forms of treatment options available to the people.

## 2. Theoretical Orientation

This study examined the nature of healthcare delivery in emerging communities of southwest Nigeria with reference to forms of treatment options by examining the different ways people administer treatment in the communities. The study covers

the range of services available to health seekers within emerging communities. Giddens structuration formed the theoretical orientation of the study. The use of the concepts of 'social system', 'structure' and 'agency' conceptualises healthcare delivery in the sampled communities of southwest Nigeria. The approach does not focus on the individual actor or total society 'but social practices ordered across space and time', which 'externalise the internal, and internalise the external' (Giddens, 1995) of everyday realities of social life, of which healthcare delivery is a basic part. The balancing of agency and structure is referred to as the duality of structure: that is, social structures make social actions possible, and social actions create those very structures. Both structures of health (e.g., health facilities and drug stores) and actors of health (doctors, nurses, patients, etc.) are present in emerging communities and remain interconnected (figure 1).
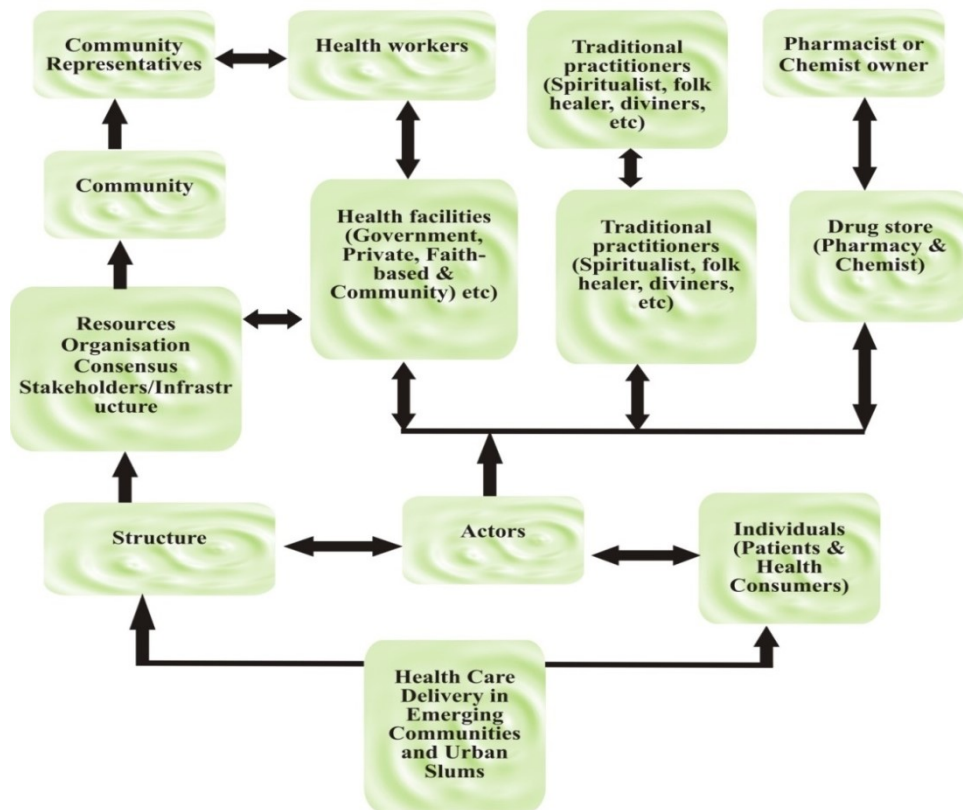


**Figure 1: An analysis of health care delivery in emerging communities**
*Source*: Lawal, 2014: 78.

Structures and actors reflect an existing connection, such that structures of health in communities are shaped by actors and actors of health are equally reproduced by the existing structures. Figure 1 further shows that actors comprise individuals across government, private, faith and community-based facilities in communities. Other actors of health include traditional practitioners (spiritualists, diviners, folk healers, etc) and community drug stores (local pharmacists or chemist store owners). Figure 1 shows them as constituting resources, organisations, consensus, stakeholders and infrastructures for health within the emerging community. The application of structuration theory by Anthony Giddens provides insights into the complexities of healthcare delivery, with regard to how structures and actors remain interdependent for health systems to optimally perform.

## 3. Methodology

The study was conducted between July 2013 and February 2014 in Magboro, Mowe and Ibafo communities of Obafemi Owode Local Government Area of Ogun State. These emerging communities of southwest Nigeria are located along the Lagos-Ibadan expressway; between 35 to 39km from Lagos State and 34.6 to 35.1km from Abeokuta, the capital of Ogun State. Magboro is situated between the Mountain of Fire and Miracle Ministries (MFM) camp ground and Areepo community. From Lagos State, commuters travel less than 20 minutes to reach Magboro. On a busy day with massive traffic on the Lagos-Ibadan expressway, commuters from either Lagos to Magboro or from Magboro to Lagos (Berger) can spend well over an hour to reach their destinations.

Ibafo community is situated between Ago-Igbala, Ore-Ofe communities and the Mountain of Fire and Miracle Ministries (MFM) camp ground. Ibafo community continues to grow with the presence of the camp ground of some major Pentecostal churches located along the Lagos-Ibadan expressway. Ibafo has a high number of poorly constructed housing units (Lawal, 2014). The town is a popular accommodation point for lorry drivers from the northern part of the country. These long distance drivers and commuters reside in makeshift housing units close to the major expressway. Ibafo has a government health post and several private health facilities (Lawal, 2014).

Mowe community is situated between the Redeemed Christian Church of God (RCCG) camp ground, Loburo community and Pakuro community. Mowe has been in existence for over a decade, but recent migration from Lagos has led to its continued growth and development. Originally, Mowe was inhabited by rural farmers and settlers known as the 'Ewa' people who moved from Abeokuta,

Sagamu and Ijebu-Ode to set up new farm settlements and communities. There has been increased population growth because of the establishment of RCCG camp ground, Redeemers University, and small businesses within the RCCG camp and around the community (Lawal, 2014).

The study adopted the community-based descriptive design, with a sample selection cutting across different demographics. Descriptive information was obtained through a semi-structured survey instrument (quantitative approach) at the household level. The use of community-based survey was to provide health information on a large data set of the sample within emerging communities of southwest Nigeria. A pilot study was initially conducted to further determine the internal validity of the data collection instrument used; that is, to identify difficulties of household respondents in understanding data collection instruments either in the form of ambiguous or difficult questions or flow of questions; and to determine how long it took to administer the data collection instrument. In addition, the pilot study was done to familiarise the researcher and data collectors with the study setting, and provide an opportunity for the training of data collectors. The pilot was used to improve the several steps in the research process (Burns, and Groove, 2009). Findings of the pilot have been excluded from the main study. All issues raised during the pilot study were addressed prior to the main study.

A total of 405 households across the three communities of Magboro, Ibafo and Mowe participated. Households were selected using the Expanded Programme of Immunization (EPI) sampling technique (Bostoen and Chalabi, 2006). The World Health Organization's EPI sampling technique utilises a 30 cluster sampling strategy (WHO, 2001) and formed the basis of selecting the households as part of a larger study across two states of southwest (Lagos and Ogun). Prior to the use of the EPI method, the initial sample size for Lagos and Ogun states was derived using Leslie Kish (1965) formula calculation adjusted for cluster sampling. This is because of its estimation on single proportion in determining the actual sample size. The EPI method validated the total sample size in the study conducted in Lagos and Ogun. Only one eligible adult member of each household visited participated in the study. The EPI method has been used in the past studies and still remains relevant because of its significance, effectiveness, efficiency and coverage (Bennett, Woods, Liyanage and Smith, 1991; Blenzel and Claquin, 1993; UNICEF, 1997; UNICEF, 1998; Bloom, Canning and Weson, 2005; WHO, 2006; Machingaidze, Wiysonge and Hussey, 2013; Maina, Kranja and Kombich, 2013; Scott et al., 2014; Nguyen et al., 2015; Oku et al., 2017).

The first stage was the clustering into suitable enumeration areas. Five clusters were formed in each community but an equal number of 27 households were surveyed per cluster, totalling 135 households per community (Bostoen and Chalabi, 2006) as seen in figure 2. 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. 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. The iteration process was repeated until the required number was surveyed. Both male and female participants were selected based on their knowledge of health issues that concern members of the household. The data obtained in the study were analysed (data entry, data cleaning and analysis) using SPSSv21.
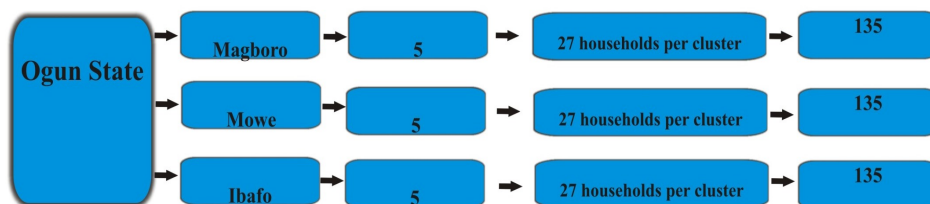


**Figure 2: Use of Expanded Programme of Immunization (EPI) sampling technique**

Ethical approval was obtained from the University of Ibadan/University College Hospital and Centre for Health Policy Management/Global Health Ethics Committee of Trinity College Dublin, Ireland. The protocol for the study was approved by both institutional review boards. All participants in the study 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 gave details about the study and its intended aim and objectives. The leaflet also provided contact information for participants who chose to clarify with contact persons at the University of Ibadan and Trinity College, Dublin.

## 4. Results
Table 1 shows the socio-demographic profile of the respondents across the three communities surveyed. The data reveal that the communities were evenly surveyed: 135 households from each community (Ibafo, Magboro and Mowe) were recruited, with a total of 405 households. On the gender of the respondents, 53.6% were male

and 44.9% were female. On the age of the respondents, 50% were between ages 26 and 40 years old, while 30.6% of the participants were between ages 16 and 25 years old and 17.8% were aged 41 years and older across the three communities. The data also show that majority had education up to the secondary school level, as 50% (n=202) of them had secondary school education, while 42.5% (n=172) had tertiary education.

**Table 1: Socio-demographic characteristics of respondents**

| Variables | Frequency (N) | Percentage (%) |
|---|---|---|
| **Communities** | | |
| Ibafo | 135 | 33.3 |
| Magboro | 135 | 33.3 |
| Mowe | 135 | 33.3 |
| Total | 405 | 100 |
| | | |
| **Gender** | | |
| Male | 217 | 53.6 |
| Female | 182 | 44.9 |
| | | |
| **Age** | | |
| 16-25 years | 124 | 30.6 |
| 26-40 years | 203 | 50.1 |
| 41 years and above | 72 | 17.8 |
| | | |
| **Educational level** | | |
| Non-formal education | 12 | 3.0 |
| Primary School | 18 | 4.4 |
| Secondary | 202 | 49.9 |
| Tertiary | 172 | 42.5 |
| | | |
| **Occupation** | | |
| Informal employment | 214 | 52.8 |
| Formal employment | 73 | 18.0 |
| Not employed | 63 | 15.6 |
| | | |
| **Income** | | |
| Less than ₦15, 000 ($75.38) | 96 | 23.7 |
| ₦15, 000 - ₦30, 000 ($75.38-150.75) | 152 | 37.5 |
| ₦31, 000 - ₦54, 000 ($155.78-271.36) | 73 | 18.0 |
| ₦55, 000 - ₦74, 000 ($276.38-371.86) | 21 | 5.2 |
| ₦75, 000 - ₦94, 000 ($376.88-472.36) | 5 | 1.2 |
| ₦95, 000 and above ($477.39-) | 11 | 2.7 |

The respondents were engaged in various forms of occupation. Some were informally employed (52.8%, n=214), while others (16.6%, n=123) were formally employed. Informal employment entails setting up small businesses, such as mini-shops for petty trading, barbing salons, hair dressing salons, open market trading, mechanics shops etc. Those in formal employment worked in the local government offices, private organisations and schools. Disparities existed in their monthly

incomes, as 23.7% of them earned less than ₦15,000 ($75.38), 37.5% earned between ₦15,000 and ₦30,000 ($75.38 and $150.75), 18.0% earned between ₦31,000 and ₦54,000 ($155.78 and $271.36); 5.2% earned between ₦55,000 and ₦74,000 ($276.38 and $371.86), 1.2% earned between ₦75,000 and ₦94,000 ($376.88 and $472.36), while 2.7% earned ₦95,000 ($477.39) and above.

**Table 2: Traditional and orthodox medicine use in emerging communities**

|         | *Traditional medicine* | *Orthodox med.* | *Both (TM and OM)* | *df* | *p-value* |
|---------|---------|---------|---------|-----|---------|
| Ibafo   | 11 (8.2%)  | 79 (59.0%)  | 44 (32.8%)  |     |         |
| Magboro | 15 (11.5%) | 75 (57.3%)  | 41 (31.3%)  |     |         |
| Mowe    | 6 (4.6%)   | 80 (61.5%)  | 44 (33.8%)  | 4   | 0.392   |
| Total   | 32 (8.1%)  | 234 (59.2%) | 129 (32.7%) |     |         |
| Test    | $X^2$=4.102[a] |         |         |     |         |

Table 2 shows that 59.2% of the respondents take orthodox medicine as a form of treatment option when the need arises, while 32.7% take both orthodox medicine and traditional medicine together. Only 8.1% of the respondents use traditional medicine solely. The result shows a general preference for the use of orthodox medicine and the combined use of traditional and orthodox medicine across the study communities. Moreover, there is no significant difference across the communities in terms of their level of preference for one form of medicine over the other.

**Table 3: Various types of health care facilities in emerging communities**

|         | *Government facility* | *Faith-based facility* | *Private facility* | *Community facility* | *df* | *p-value* |
|---------|---------|---------|---------|---------|-----|---------|
| Ibafo   | 38 (29.5%)  | 8 (6.2%)    | 76 (58.9%)  | 7 (5.4%)   |     |         |
| Magboro | 36 (28.3%)  | 24 (18.9%)  | 50 (39.4%)  | 17 (3.4%)  |     |         |
| Mowe    | 41 (34.7%)  | 14 (11.9%)  | 50 (42.4%)  | 13 (1.0%)  | 6   | 0.003   |
| Total   | 115 (30.7%) | 46 (12.3%)  | 176 (47.1%) | 37 (9.9%)  |     |         |
| Test    | $X^2$=19.652[a] |         |         |         |     |         |

**Table 4: Forms of treatment administration in emerging communities**

|         | *Self-medication* | *Household prescribed medication* | *Neighbour prescribed medication* | *Community prescribed medication* | *Df* | *p-value* |
|---------|---------|---------|---------|---------|-----|---------|
| Ibafo   | 93 (68.9%)  | 33 (24.4%)  | 5 (3.7%)    | 4 (3.0%)   |     |         |
| Magboro | 85 (64.9%)  | 28 (21.4%)  | 11 (8.4%)   | 7 (5.3%)   |     |         |
| Mowe    | 82 (64.6%)  | 30 (23.6%)  | 7 (5.5%)    | 8 (6.3%)   | 6   | 0.586   |
| Total   | 260 (66.2%) | 91 (23.2%)  | 23 (5.9%)   | 19 (4.8%)  |     |         |
| Test    | $X^2$=4.672[a] |         |         |         |     |         |

Table 3 shows that 47.1% of the households survey reported that a private healthcare facility is present within their community, while 30.7% reported that a government health facility (health post or health centre) is available in the community. Also, faith-based health facility (12.3%) and community health facility

(9.9%) are available in the communities surveyed; and the awareness levels of households varied from one community to another. Respondents had the choice of picking just one answer and most of them were of the opinion that a private health facility was more visible in their community. This was to ascertain the awareness of the households on the availability of the various types of health facilities that were in operation in the community. There is a significant difference across the communities on the various types of healthcare facilities.

Table 4 indicates that people do engage in treatment administration when they do not visit a healthcare provider for diagnosis or treatment. The result shows that 66.2% of the respondents practise self-medication for the treatment of an ailment. More so, 23.2% of the respondents administer treatment to household members based on collective decision of members of the household. Other respondents either consult members of their immediate neighbourhood (5.9%) or within the community (4.8%) for the treatment of household members when they fall sick. There is no significant difference across the communities on the practice of self-medication, household-prescribed medication, neighbour-prescribed medication and community-prescribed medication.

## 5. Discussion

Although this study was conducted in Lagos and Ogun states, only findings in emerging communities of Ogun were reported in this report. The results showed that there are various ways by which people administer treatment across the three communities surveyed in Ogun State. The study accorded an equal chance of participation to both male and female, thereby ensuring gender equality in health research across the communities studied. The respondents' views on healthcare facilities and forms of treatment in emerging communities varied. However, age and gender remained important demographic variables and were the primary basis of demographic classification. These are also important variables in the study of mortality, fertility and nuptiality (NPC-ICF, 2009).

In the study communities, the respondents were literate, as they all possessed secondary level of education, while a sizeable number of them had university education. This finding is reflected in the national data on education for Ogun State (NMEC, 2011), with estimates on adult literacy rate at 62.8%. People across these communities were also engaged in various types of informal employment. These retail businesses includeed the sale of electronics, household items, fashion design or tailoring outfits, hairdressing, cosmetics and beauty shops, barbers shops, and restaurants. In addition, some of them offered private consultancy services, as

building site supervisors, engineers, plumbers, bricklayers, and computer network providers, among others. Others engaged in semi-skilled jobs, such as commercial bus driving, taxis, or motorcycles (*okada*). According to the National Bureau of Statistics (2010), unemployment rate for Nigeria in 2009 was 19.7%. Many of the unemployed engage in self or casual employment opportunities within 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 (Khotikna, 2007).

Furthermore, study found that those formally employed in the study area were engaged as teachers, while some work in the civil service or local government offices as junior and senior staff. Others work as receptionists, office administrators or laboratory scientists in some private organisations outside the community in which they live. Consequently, there were significant differences in their income levels, as some earned higher than others. This is linked with the type of occupation people engage in within the communities. Families tend to have low incomes to support them and this continues to force many into poverty, especially when unplanned expenses for healthcare services arise as a result of sickness.

According to Chowdhury and Nurul Amin (2006), Morakinyo, Ogunrayewa, Koleosho and Adenubi (2012), Acharya (2010), Lanrewaju (2012) and Jorgenson and Rice (2012), as populations continue to increase globally, informal settlements will be on the rise in developing countries due to poor urban planning, rising social inequality and poverty. Several challenges to effective delivery of health services in such informal settlements are attributed to their complex nature of health. In Nigeria, the sources and organisation of health services remain complex, according to Olakunle (2012). Such complexity in the system of healthservice provision is present within emerging communities and has continued to encourage the combined use of traditional and orthodox medicines for treatment. This is means that, after taking orthodox medicine, if people do not feel well, they switch to traditional medicine, which is often in the form of herbal mixture and concoction. The use of traditional medicine in Nigeria is well documented in health research, as people take such medicine for the treatment of various types of illness or disease and for various reasons (Mwangi, 2004; Fakeye et al., 2009; Oreagba et al., 2011).

Most of the traditional medicines consumed do not have prescriptions and instructions for usage like orthodox medicines, which should appear confusing and should deter the average educated person from using them. This continued use is often ascribed to the influence of socio-cultural factors. Studies show that the preference for orthodox medicine over traditional medicine can be influenced by

level of education, awareness and income (Dibua, 2009). However, the current study found that people in emerging communities, rather than depend solely on traditional medicines, prefer to use them in combination with orthodox medicine. The use of both types of medicines in a combination is widely practised in different countries (Osemene, Elujoba and Ilori, 2011). People perceive the combined use of both medicines as more potent and effective than the use of one form (Oreagba et al., 2011; Osemene et al., 2011; Gyasi, Mensah, Adjei and Agyemang, 2011).

The study also found that, from one emerging community to the other, people's preferences as regards the use of one form of medicine over the other did not differ, meaning that their environment continued to influence their decisions. Thus, the environment, among many other social determinants of health, continues to shape health behaviour in emerging communities of southwest Nigeria.

Healthcare facilities in emerging communities are of various types, such as government facility, faith-based facility, private facility and community facility. Among these facilities are the health centres controlled by the government at the grassroots under the local government authorities. Health centres are located within these communities usually in the form of a small building with five to six rooms. In Nigeria, health centres are available in each of the 774 local government areas (Inegbenebor, 2013). Such facilities do not perform surgeries nor attend to secondary cases; they refer patients to general hospitals within the state.

Another type of facility present within emerging communities is the private hospital, established and operated by individuals (medical doctors) to provide health services. Private care in Nigeria accounts for 66% of the total health care in the country (Onah and Govender, 2014). Unlike government-owned facilities operating in a community, private hospitals carry out their functions based on the experience of the owners, whom sometimes are equally engaged as government workers in other health facilities outside the community, which stresses the dual roles some doctors in the country's health sector (Kyaddondo and White, 2003; Ferrinho, Van Lerberghe, Fronteira, Hipolito and Biscaia, 2004).

Other sources of health services are faith-based organizations, which often solely establish health facilities in the communities. They also provide primary healthcare services especially to their members. This study also found that the provision of health services through community-owned facilities presents several complexities in the Nigerian health system. Like faith-based facilities, the community-owned facilities (hospitals or clinics) are not-for-profit and are mostly the initiatives of a community or some privileged members of the community, as a form of social responsibility. Studies have shown that people's preference for a

certain healthcare service is based on their financial and other non-monetary incentives which affect their decision in relation to their health (Adinma and Adinma, 2010; Okumagba, 2011; Abdulraheem, Olapipo and Amodu, 2012).

In emerging communities, people adopt different ways to treat themselves when they do not want to visit healthcare providers. The two major ways are: self-medication and group-prescribed medication. Self-medication is widely practised across emerging communities in Nigeria, as people visit drug stores to purchase medicines over the counter to treat common illnesses or diseases. Most often, they do so without a proper prescription from the doctor (Fakeye, Adisa and Showande, 2012; Adje and Oli, 2013). They explain how they feel to the pharmacy attendant or chemist owner and then allow the person to make suggestions to them based on what they have described. Self-medication is a public health challenge in most developing countries, such as Nigeria (Osemene and Lamikanra, 2012; Afolabi, 2008; Fadare and Tamuno, 2011; Arikpo, et al., 2009).

Similar to self-medication is the practice of group-prescribed medication. Group-prescribed medication as a form of treatment option is wider and more complex, because it goes beyond the individual to include members of a household, the neighbourhood or community. This form of treatment option occurs when the sick person consults a wider social network in his/her decision-making process on what type of medicines to use. Group-prescribed medication can be linked to the close-knit structure of most households in African societies, having large family sizes with relatives who play important roles (La Ferrara, 2007). More so, group dynamics tend to influence people's decision making even in the area of healthcare, such that group-prescribed medication is widely practised across emerging communities in the forms of household-prescribed, neighbour-prescribed and community-prescribed treatments. These forms of medication do not imply a written prescription by a certified medical doctor.

Household-prescribed medication comes about when health decisions in the home is not self-determined but decided by members of the household, especially the older members. They decide on what is best for the sick individual in order to get well. Somewhat similar but different, neighbour-prescribed medication is a situation whereby persons outside the immediate household are consulted, especially within shared apartments, which share same bathroom, toilet or kitchen facilities. This often takes place between neighbours who already have an existing relationship built on years of residing together in the same building or compound. Also, certain socio-cultural factors (ethnicity, trust, belief, religion, and norms) tend to influence people to make use of such forms of treatment (Fayehun and Omololu,

2009; Okposio, Unior and Ukpeteru, 2012; Nnonyelu and Nwankwo, 2014). The last type of group-prescribed medication is community-prescribed medication. This occurs mainly when a treatment solution is sought beyond the immediate household or neighbour by interacting with and engaging the wider members of the community for treatment solutions and without consulting a medical doctor; despite the presence of various types of healthcare facilities within that community.

According to the structuration theory (Giddens, 1995), the various types of health facilities present in emerging communities are categorised as social structures which are governed by a set of norms, laws and responsibilities to provide healthcare services. These facilities, as seen in this study, act as institutionalised modes of conduct for healthcare delivery in emerging communities and they operate based on close knit relationship with community residents (social actors). The various social structures are functional in these communities based on their resources, organisation and consensus and approval from community stakeholders (structures of health). The existence and operations of health facilities depend on people in the communities. Also, the people are equally dependent on the services of the various facilities offered to them. This form of relationship, according to the theory, is referred to as the duality of structures, because social structures make social actions possible, while social actions create those very structures (Giddens, 1984). Due to the multiple nature of healthcare delivery, a multiplicity of systems and structures operates within the study communities. These healthcare facilities and forms of treatment in emerging communities will continue to emerge and evolve in the quest for improved healthcare delivery.

**Conclusion and Recommendations**

Healthcare delivery remains complex and a challenge for people living in emerging communities of southwest Nigeria. This must be addressed to improve the health services that exist and also make the service providers more effective. Although various sources of health services still persist in emerging communities, there is a need for renewed public-private cooperation to improve health services by engaging effectively with all stakeholders. In addition, health literacy programmes in the study communities will help deter people from unhealthy behaviours, such as self-medication and group-prescribed medication. There is the need to intensify health education promotion and advocacy by government, civil society and non-government organisations, private organisations and other community members to help curtail the practices of self-medication and group-prescribed medication.

Across the study emerging communities, there is a need for the immediate enumeration of the health facilities in operation. Knowing the exact number of such facilities, whether government-owned (public), private, community or faith-based facilities will help to better regulate the health system within the study area. There is the need to regularly monitor and evaluate the activities of these health facilities, on a quarterly or bi-annual basis. This will help guard against quackery. Besides, monitoring and evaluation will provide the ministry of health with vital information on whether such facilities are qualified to operate, the type of facilities in operation, their number and nature. The complexity in the Nigerian health system can be addressed when regular monitoring and evaluation exercises are carried out. Also, the problem of poor healthcare delivery can be addressed if existing facilities are made to adhere to the established code of conduct and health laws in Nigeria.

In addition, when health facilities are well funded, the quality of care and service delivery will be improved. This will translate to proper maintenance of equipment, procurement of modern equipment and technologies for treatment, leading to the provision of hospital beds, and change attitudes of people on the healthcare system. In general, increased funding will lead to improvement in the healthcare system in the study communities and, consequently, health system performance in Nigeria. When health facilities are properly funded, health workers would have access to quality health information and, thereby make the right choices when delivering services to end-users. In addition, better funding should lead to the provision of quality drugs and vaccines for the populace.

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