

**PUBLIC PERCEPTION ON SOCIAL INEQUALITY AND
HEALTH SEEKING BEHAVIOUR: A STUDY OF
DIABETES IN ILE IFE, OSUN STATE**

BY

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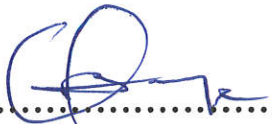
**A RESEARCH PROJECT SUBMITTED TO THE
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CERTIFICATION

This is to certify that this study was carried out by **OLADOSU FOLASHADE MARY**, Federal university Oye Ekiti, Ekiti state, Nigeria

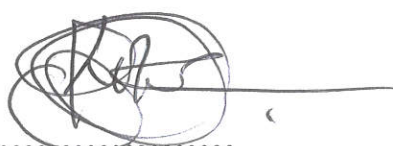

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DEDICATION

I dedicate this work to God Almighty. I also dedicate it to my ever attentive best friend, **Very Rev. Monseignor Anthony Babatunde Erinle** and to my ever caring parents **Mr. and Mrs. Michael Oladosu** for their effort and encouragement towards my education. I love you people so much and I pray that you shall reap the fruit of your labour in good health and wealth. Amen

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ABSTRACT

Social inequality in health care grew dramatically in the 1980s and has remained at a high level ever since. Health inequality is the differences that occurs in health status or in the distribution of health determinates between different population groups, these social inequalities in health are responsible for the dramatic differences that occur in health seeking behavior of people in the society at large. It was on this note that this research examines the effect of social inequality on health seeking behavior in the case of diabetes in Nigeria, most especially in Ile-Ife, Osun state. Simple random sampling techniques were used to select the sample size, while data were collected through the use of questionnaire and in-depth interview. In this study, the data generated was analyzed using the statistical package for social science (SPSS). On the other hand, each result was qualitatively analyzed in relation to the research questions formulated for the study. The study found out that there is a relationship between social inequality and health seeking behavior in the case of diabetes. The findings show that when faced with diabetes the rich will live longer than the poor, as it was confirmed by 66.7% of the respondents. The study also revealed that the age liable to have diabetes is age 36years and above. Education was found to influence how people respond to treatment as study found that 66.7% of those without education do not know how they response while 40% of those with school certificate said they respond slowly and 26.9% of those with school certificate said they respond quickly. The research at the end offered policies and measures towards reducing inequality in both income and health care and response to diabetes in Ile-Ife, Osun state and Nigeria as a whole, among was that government should improve standard of the health sectors so that all citizens could access health care freely and there should be equal and universal access to health. Both governmental and non-governmental organizations should try to encourage the citizens to create a healthy life style by taking part in exercises, create a balanced diet e.t.c and to also look at benefits of these life style changes to health in other to reduce the rate of diabetes in Ile – Ife and Nigeria at large.

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CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Social inequality refers to relational processes in the society that have the effect of limiting or harming a group's social status, social class, and social circle (Science Daily 2018). There are various measures of social inequality but a few of them include; income, power, health, occupation, education, ethnicity, racism, status, and so on. Social inequality and social stratification has been used interchangeably in many fields. Social inequality simply refers to the existence of socially created inequality while social stratification is a particular form of social inequality (Haralambos and Holborn 2013). People have long dreamed of an egalitarian society, a society in which all members are equal, such a society has never existed. All human societies from the simplest to the most complex have some form of social inequality. In particular, power and prestige and unequal distribution between individuals and social groups, and in many societies there are also marked differences in the distribution of wealth (Haralambos and Holborn 2013). Economists and health experts have known for years that people who live in poorer societies live shorter lives. But research also points to an additional factor in explaining life expectancy: a society's level of inequality. People live longer in nations with lower levels of inequality (Rowlingson, 2011)

Health inequalities are systematic differences in the health status of different population groups. These inequalities have significant social and economic cost both in individuals and society (W.H.O.2017). For instance, in low income countries the average life expectancy is 62 years, while in high income countries, it is 81 years. A child born in Sierra Leon can expect to live for 50 years while a child born in Japan can expect to live 84 years (W.H.O. 2017). Health inequality does not only affect people within countries but also between

countries. Biologically male and female have similar diabetes prevalence. Gender differences in the social structure, gender differentials in diagnosis, access to care, access to medications and follow up, adherence to medications, life style modifications and all other self care behaviors are likely to introduce a dramatic contrast in the experiences of women with diabetes. Men and women have different attitudes and behaviors related to health care. Women are more sensitive to illness, more able and likely to rest during illness and more willing to seek medical advice (Kumar, 2010). Women were found to have greater interest and concern for health and were more likely to perceive symptoms than men. In general, women appear to be more knowledgeable and sensitive to and symptoms of illness and seek medical care more frequently than men (Hebbard, 2012). In Nigeria, there is an admixture of the use of both orthodox and traditional medicine in seeking healthcare services (National Open University of Nigeria (N.O.U.N. 2014). It is not yet fully known the exact processes involved in making decision to obtain medical care, however, research findings have revealed some social factors which tend to encourage or discourage a person from seeking medical care (N.O.U.N. 2014). Relevant socio-cultural factors which affect the perception of health and wellbeing include religion, availability of relatives in the hospital or connection with hospital staff, family decision, marital status, position in the family, educational status and also very importantly the nature of the illness (Omosho, 2010).

Diabetes is a public health problem not only in Nigeria but in the world at large (Quinn, 2012). Globally, increasing numbers of chronic patients are in need of treatment and care (Camilla, 2016). Cardiovascular diseases (CVDs) are the main cause of deaths and loss of quality of life due to related disabilities in the world. Even though a decline in mortality rates has been observed in recent decades, the impact of CVDs is still expressive (Enfermagem, 2013). It is fitting to note that diabetes mellitus is one of the many cardiovascular diseases killing people in the world presently. Diabetes mellitus (DM) is a chronic disorder

characterized by elevated blood sugar levels that occur when the pancreas does not produce enough insulin or when the body cannot effectively use the insulin it produces. The first one is called as type 1 diabetes mellitus (T1DM) and later one is called as type 2 diabetes mellitus (T2DM). A National Health and Nutrition Examination Surveys (NHANES) in the USA between 1976 and 2010 showed ethnicity/race, ageing, and obesity as the principal risk factors for type 2 diabetes. The prevalence of diabetes in men rose from 4.7% to 11.2% during this period, and from 5.7% to 8.7% in females (Oputa, 2015). Once diabetes develops, it is a costly disease to manage because of its chronic nature and severity of complications.

Over 70% of diabetes-related cost is attributed to its complications, particularly for macrovascular diseases that most commonly occur in type 2 diabetics (Kishore J et al, 2015). Diabetes mellitus is emerging as an epidemic of the 21st century. About 366 million people around the world have diabetes and it is expected to increase to 552 million by 2030 in which; over 90% of those have type 2 diabetes (T2DM) (International Diabetes Federation [IDF], 2011).

Three out of four people with diabetes live in low and middle-income countries where more than 80% of diabetes deaths occur (Shrestha, 2013). The health of a population is an important element in its ability to progress and develop. To improve the health of the population in the developing world, health services must be capable of delivering effective health care and the members of the population must use these services (Amegbor, 2014). Type 2 diabetes mellitus (DM) has become a global epidemic with significant disability, premature death and enormous medical costs (Herath et al., 2017). Currently, diabetes is expected to be the leading cause of death worldwide (Mathers & Loncar, 2011), with a global prevalence of 552 million (International Diabetes Federation (IDF) 2011). Diabetes mellitus is a major pandemic disease globally with both high morbidity and mortality and a high

health cost, especially in developing countries. Diabetes is currently a very prevalent disease especially in Africa (Bos and Agyemang, 2013).

A campaign for free diabetes screening, and diagnosis with referral services for low income earners in Lagos was launched recently by Novo Nordisk, a Danish company. It is estimated that six (6) out of ten Nigerians that are diabetic are unaware while less than one of ten (10) diabetes patients are on treatment (Ogundipe 2017). According to the vice president for Africa & The Gulf, Novo Nordisk, Mr Mads Larsen, the screening exercise is targeted at Nigerians with poor access to care. The governor of the state of Osun, Ogbeni Rauf Aregbesola, has stated that his administration has developed strategies to get rid of diabetes and some other avoidable diseases among the people of the state (Mohammed 2012). Problems associated with DM can be minimized by early diagnosis and proper management. The primary aim of management of DM is to delay the macro and micro vascular complications by achieving optimal glycaemic control. This involves lifestyle modification, including regular exercise, healthy diet and weight loss, and drug therapy. Therefore, health literacy is an integral part of the diabetes management. Patients with good knowledge on diabetes and its complications seek proper treatment and care, and take charge of their health. There is strong evidence that individuals who are educated and diligent with their diabetes self-care achieve better and durable diabetic control (Herath 2017). The Diabetes Association of Nigeria (DAN) has in the past few years harnessed local and international efforts on diabetes; leading a strong advocacy to the Federal Ministry of Health (FMOH) in Nigeria, to adopt international best practices to stem the tide of the diabetes epidemic in Nigeria (Opata 2015).

1.2 Statement Of The Problem

The global number of people with diabetes was 151 million in 2000, 366 million in 2011, currently affecting 246million people worldwide, and projected to increase to 551 million in 2025 (International Diabetes Federation [IDF], 2011). The influx of diabetes in the society is in great need of help and concern both to government and non governmental bodies worldwide. Complications of Diabetes Mellitus (acute and chronic) can be severe, debilitating and fatal. Some reports have shown that populations of African origin have high prevalence of micro vascular (and low of macro vascular) complications partly due to co-existent Hypertension, inappropriate diabetic control and limited access to care (Oguejiofor et al 2014). Most Governments of the African countries do not recognize the catastrophic potential of the diabetes epidemic and time may be running out for Africa. Akin to HIV/AIDS, by the time Governments wake up, the epidemic may have overwhelmed the continents already meager resources, resulting in avoidable death of millions of Africans. Majority (70% - 90%) of African diabetes is of type 2 and is more prevalent among the wealthy, hence the tag “disease of opulence” (Oguejiofor et al 2014). It is more pronounced in urban areas where people tend to be less physically active, eat diets rich in saturated fat and refined sugars and are more obese. Obesity is a pivotal contributor to increased prevalence of DM in both urban and rural areas, but more so in the former and the terminology reflects the close relationship between both medical conditions. (Oguejiofor et al 2014).

More than 95% of cases of diabetes in Nigeria are type2 diabetes. Many cases of type 1 diabetes may die of acute complications, be misdiagnosed, or may not present to hospital due to poverty and lack of health insurance (Opute 2015). The diabetes pandemic evolved in association with rapid cultural and behavioral changes, aging population and increasing urbanization without preparedness for prevention and/or control, throwing up a myriad of

challenges to diabetes care, especially in developing countries like Nigeria (Oguejiofor et al 2014). In Nigeria and much of the developing economies, poverty, ignorance, attribution of symptoms to other myths, lack of tools and basic infrastructure and inadequate training of health workers are responsible for much of the failure to detect DM. They also increase the risk of misdiagnosis and late diagnosis such that vast majority of patients are diagnosed late, at complication stages of the disease (Oguejiofor et al 2014). Absence of medical insurance implies that patients pay for all aspects of medical care and when there is no money, fatalities may occur. Diabetes is a silent and expensive disease many sufferers became aware that they have diabetes only when they develop one of its life threatening complications. Once diabetes develops, it is a costly disease to manage because of its chronic nature and severity of complications. Over 70% of diabetes related cost is attributed to its complications, particularly for macro vascular diseases that most commonly occur in type 2 diabetics (Kishore et al 2015). Costs result from treating the disease itself, complications of the disease and costs of treating many other diseases where diabetes is an underlying causal factor. Type 2 DM burden is disproportionately borne by people of working age, the same age group profoundly affected by HIV/AIDS (Onwukwe 2014). Over the years from colonial to post-colonial eras, the aim of many governments in the developing world has been to promote modern biomedicine and to increase its accessibility. These attempts have ignored the fact that people in this part of the world have their own set of local beliefs and practices regarding illness and diseases (Amegbor 2014). The diabetes pandemic evolved in association with rapid cultural and behavioral changes, aging population and increasing urbanization without preparedness for prevention and/or control, throwing up a myriad of challenges to diabetes care, especially in developing countries like Nigeria. In Nigeria and much of the developing economies, poverty, ignorance, attribution of symptoms to other myths, lack of tools and basic infrastructure and inadequate training of health workers are responsible for much of the

failure to detect DM. They also increase the risk of misdiagnosis and late diagnosis such that vast majority of patients are diagnosed late, at complication stages of the disease (Oguejiofor et al 2014). Scholars in the academia have conducted research on the health seeking behavior of patients in the developing world.

1.3 Research Questions

1. How knowledgeable are the people about the causes of diabetes in Ile Ife, Osun State?
2. What is the relationship between social inequality and diabetes in Ile Ife, Osun State
3. What is the relationship between these socio-demographic factor (age, education, gender, e.t.c.) and diabetes in Ile Ife, Osun State?
4. What are the socio-demographic factors that affects diabetes in Ile Ife, Osun State
5. What are the general health seeking behaviours of people in Ile Ife,Osun state pertaining to diabetes?

1.4 Research Objectives

The major objective of this study is to observe social inequality and health seeking behaviours on diabetics in Ile Ife, Osun state Nigeria

1. To examine how knowledgeable people of Ile Ife, Osun State are about diabetes.
2. To ascertain the relationship between social inequality and diabetes in Ile Ife, Osun State.
3. To ascertain the relationship between the socio-demographic factors and diabetes in Ile Ife, Osun State.
4. To determine the socio-demographic factors that affects diabetes in Ile Ife, Osun State.

5. To examine the general health seeking behaviours in Ile Ife, Osun State, pertaining to diabetes.

1.5 Research Hypothesis

H1: There is a relationship between socio-demographic factors and knowledge and causes of diabetics in Ile Ife, Osun state.

H0: There is no relationship between socio-demographic factors and knowledge and causes of diabetes in Ile Ife, Osun state

H1: There is a relationship between socio economic status and health seeking behaviours in diabetes cases in Ile Ife, Osun State.

H0: There is no relationship between socio economic status and health seeking behaviours in diabetes in Ile Ife, Osun State.

1.6 Significance of the study

The exploration of this study would be beneficial to the global world in that it would provide the general government, non-governmental organizations and hospitals with the means to reducing other diseases related to diabetes (obesity, hypertension, e.t.c.) and also make people have a positive attitude toward healthcare seeking behavior. It would also avert the forecast by the W.H.O. of diabetes mellitus increasing by 2025 by providing solutions to the reduction of diabetes.

It would also aid the state governments and its immediate societies or better still the Nigerian government to abort any form of inequality be it social or health, it will help to propel the people to seek help in various illnesses and diseases that may hinder the smooth running of the society, most especially in the case of diabetes. It would correspondingly encourage both

the governmental and non-governmental organization to organize a free medical check for those whom their healthcare seeking behavior is influenced by financial issues and other factors.

This research work would peculiarly help the people of Osun state and the local government of Ile-Ife to be precise, to control diabetes disturbing the state and also help to curtail any form of health inequalities that may arise. The study would likewise encourage individuals to improve their healthcare seeking behavior and to make them understand the long and short term effect of diabetes on eyes, heart, kidney, e.t.c. and to also acknowledge the fact that “health is wealth”.

1.7 Definition of terms

For better understanding of this research work, some terms that would be used continuously as this work unfolds would be defined below:

Social Inequality

Social inequality is a state in the society in which some people in the society have more rights or better opportunities than other people in the same society (Merriam Webster dictionary). Social inequality is also the concentration of resources on certain people and is significantly affecting the opportunities of individuals in poorer and less powerful countries.

Health inequality

The health inequality is the differences that occurs in health status or in the distribution of health determinates between different population groups.

Health status

Health status is simply a person's condition of wellbeing at a particular point in time. It is also the overall condition of someone's body or mind.

Health Seeking Behaviours

Health seeking behaviour is defined as an action undertaken by individuals who perceive themselves as having a health problem or to be ill for the purpose of finding an appropriate remedy. Health seeking behavior is the rate at which people seek medical help to their illnesses and what they attribute mentally and physically to these illnesses.

Diabetes

Diabetes is defined as a serious disease in which the body cannot properly control the amount of sugar in the blood because it does not have enough insulin. It is also any of various abnormal conditions characterized by the secretion and excretion of excessive amount of urine; especially, diabetes mellitus. Diabetes is a group of metabolic diseases whereby a person (or other animals) has high blood sugar due to an inability to metabolize, sufficient quantities of the hormone insulin.

Type 1 diabetes

Type 1 diabetes is a form of diabetes mellitus that usually develops during childhood or adolescence and is characterized by severe deficiency in insulin secretion resulting from atrophy of the islets of Langerhans and causing hyperglycemia and a marked tendency towards ketoacidosis. (Merriam Webster's dictionary)

Type 2 diabetes

It is a form of diabetes mellitus that develops especially in adults and most often in obese individuals and that is characterized by hyperglycemia resulting from impaired insulin utilization coupled with the body's inability to compensate with increased insulin production. (Merriam Webster's dictionary)

Social Status

A social status can be regarded as a person's position or rank when compared to other people in society, organization, group, e.t.c. It is also a socioeconomic category based on differences between groups of individuals that create differences in their life chances and power.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

The case of diabetes and the extent to which people seek help in health care is a topic which should be imperatively studied. Owing to this reason a lot of scholars have carried out various brilliant researches on diabetes and general health seeking behavior of people towards diseases and illness and not on diabetes alone. This chapter tends to portray the related write ups of other scholars which would be appropriately explained to create an applicable theoretical framework for this research. The topics that would be discussed therefore include:

- An understanding of the disease named “diabetes”
- Rate of Diabetes in Nigeria
- Understanding health seeking behavior
- Religion and health seeking behavior
- Gender and health seeking behavior
- Socio-economic status and health seeking behavior
- Health seeking behavior of people with diabetes
- Relationship between social inequality and diabetes
- Socio economic status(income) and diabetes
- Gender, Age and diabetes
- Socio demographic factors and its effects on diabetes

2.1.1 An Understanding of the Disease Named “Diabetes”

Diabetes is when the blood glucose, also called blood sugar, is too high. Blood glucose is the main type of sugar found in the blood and the main source of energy. Glucose comes from the food we eat and is also made in the liver and muscles. Blood carries glucose to all of the body’s cells to use for energy (National Institution of Health (NIH), 2013). Diabetes is simply a disease that occurs when the body cannot absorb the high concentration of glucose taken into the body. A body without the problem of diabetes has the power to transform sugar into glucose and tries to circulate it to the appropriate parts in the body to get energy (NIH, 2013).

There are three major types of diabetes and they include:

Type 1: The body does not make insulin. This is a problem because you need insulin to take the sugar (glucose) from the foods you eat and turn it into energy for your body. There is a need to take insulin every day to live (National Diabetes Education Program (NDEP), 2013). This is a kind of diabetes in which the body does not naturally have insulin in the first place.

Type 2: The body does not make or use insulin well. It may need to take pills or insulin to help control your diabetes. Type 2 is the most common type of diabetes (NDEP, 2013). This is the kind in which the body stops producing insulin to transform glucose to energy, so medications have to be taken in order to survive.

Gestational diabetes: Some women get this kind of diabetes when they are pregnant. Most of the time, it goes away after the baby is born. But even if it goes away, these women and their children have a greater chance of getting diabetes later in life (NDEP, 2013). This kind of diabetes happens only to pregnant women but goes away after delivery.

There are various signs and symptoms of diabetes but the few of them includes:

- Being very thirsty
- Urinating often
- Feeling very hungry

- Feeling very tired
- Weight loss
- Sores that heal slowly
- Dry and itchy skin
- Feelings of pins and needles in the feet
- Losing feeling in the feet
- Blurry eyesight (National Institution of Health (NIH) 2013).

Complications of DM (acute and chronic) can be severe, debilitating and fatal. It is observed that the longer the duration of the illness, the greater the possibility of an end organ complication (Ogueiofor et al, 2014). If this abnormally high sugar level is not treated it can harm different parts of the body. The complications diabetes can cause include damage to:

- The eyes;
- Kidneys;
- Heart;
- Blood vessels; and
- Nerves.

If diabetes is detected early, it can be treated and the risk of developing serious problems can be greatly reduced (Sharp et al, 2015). Despite the complications and illnesses attached to diabetes, it has been noticed that if detected on time can be treated and cured but if not detected on time can be suppressed.

There are appropriate diets for people living with diabetes mellitus. Make a diabetes meal plan with help from the health care team.

- Choose foods that are lower in calories, saturated fat, Trans fat, sugar, and salt.
- Eat foods with more fiber, such as whole grain cereals, breads, crackers, rice, or pasta.

- Choose foods such as fruits, vegetables, whole grains, bread and cereals, and low-fat or skim milk and cheese.
- Drink water instead of juice and regular soda (NDEP, 2015).

Exercise is important to help in managing diabetes. Exercise helps to:

- Lose weight;
- Lower the blood pressure;
- Reduce the blood sugar levels; and
- Allow the insulin and tablets to work more effectively.

It is always useful to increase your level of movement (Sharp et al, 2015). This statement is trying to tell us that exercise is another means of treating or controlling diabetes, as the case may be.

2.1.2 Rates of Diabetes in Nigeria

Nigeria has the largest population in Africa (about 170 million); and of this the adult population (aged 20–79 years), is approximately 79 million (Oputa et al, 2015). In Nigeria, hardly will anybody live a day without taking a part of the starchy food which medical practitioners claim to be a major cause of diabetes and in most cases Nigerians especially those in the lower class (poor People) even spend months depending only on starch. The prevalence of diabetes mellitus in Nigeria has increased from 2.2% as reported by Akinkugbe (1997) from a national survey to 5.0% by 2013 estimates of the International Diabetes Federation (IDF)(Oputa et al, 2015). One third of all the cases of diabetes are in the rural communities, while the rest are in the urban centers. About two million of the cases of diabetes in Nigeria are undiagnosed (Oputa et al, 2015). The global chronic killer status of Diabetes Mellitus emanates not only from its direct systemic complications, but also

indirectly from its linkages, particularly in developing countries, with Communicable Diseases - TB, HIV/AIDS -, other Non-Communicable Diseases – cardiovascular diseases, chronic respiratory diseases, renal diseases, cancer – and other modifiable and non-modifiable risk factors including obesity, hypertension, dyslipidemia, physical inactivity, increasing age, ethnicity, poverty, under nutrition, urbanization etc (Oguejiofor et al, 2014). Nigeria happens to fall under the developing countries indentified by Oguejiofor in his illustration and they as well face these modifiable and non-modifiable risk factors stated by him. In Nigeria, developing economies, poverty, ignorance, attribution of symptoms to other myths, lack of tools and basic infrastructure and inadequate training of health workers are responsible for much of the failure to detect DM. They also increase the risk of misdiagnosis and late diagnosis such that vast majority of patients are diagnosed late, at complication stages of the disease (Odenigbo et al, 2014). More than 95% of cases of diabetes in Nigeria are type 2 diabetes. Many cases of type 1 diabetes may die of acute complications, can be misdiagnosed, or may not be present to hospital due to poverty and lack of health insurance (Oputa et al, 2015). Due to the economic imbalance in Nigeria, lack of adequate health infrastructure and illiteracy on the part of the citizens, it has been realized that people get little or no access to health care facilities and due the high rate of illiteracy-the rate at which people seek help in health care is abysmally low (Oputa et al, 2015). The diabetes pandemic evolved in association with rapid cultural and behavioral changes, aging population and increasing urbanization without preparedness for prevention and/or control, throwing up a myriad of challenges to diabetes care, especially in developing countries like Nigeria (Odenigbo et al, 2014). Like it has been said earlier, that Nigeria lack general health care facilities most especially in the, cure, prevention and suppression of the disease. The culture of the people of Nigeria strongly affects the proper education and the adequate use of drugs on diabetes mellitus. Less than optimal organization in Government involvement in diabetes

care remains the foundation of most of the challenges to diabetes care in Nigeria (Owunkwe et al, 2014). It has been noticed that the government body, including the ministries and agencies, pays little or no attention to the health care of the citizens leading to the unawareness of people to diabetes and the little care people get from the treatment of diabetes.

2.1.3 Understanding Health Seeking Behavior

Health seeking behavior is defined as an action undertaken by individuals who perceive themselves as having a health problem or to be ill for the purpose of finding an appropriate remedy (Kersnik, 2013). According to this definition health seeking behavior is an awareness of an illness or diseases in the body and the positive or negative way in which the individual seek medical care. According to sociology literature, health care seeking behavior will be influenced by the individual's self, diseases, and the availability and accessibility of health services (Sheleaswani, 2016). A substantial body of literature demonstrates health seeking behaviors are directly related to disease incidence, prevalence and complication (Sheleaswani, 2016). This scholar tries to point out the fact that people seek help due to how rampant the disease is or people's cultural perception about the disease. If a kind of disease is treated with little or no importance, then any individual that has the disease would tend not to seek help. Health seeking behavior is not just a one off isolated event. Health seeking behavior is associated with socio demographic factors, such as age, sex, education, socioeconomic status, race and ethnicity, religion and marital status, but also socio-cultural dimensions are important, i.e. social networks, lay advice seeking (lay referral system), country economics, geographic and other dimensions (Kersnik et al, 2013). In other words, health seeking behavior is not just an isolated concept but it is all encompassing and holistic

in nature, it is psychological, sociological, scientific, demographic and a host of others in nature.

2.1.4 Religion and Health Seeking Behavior

Few finding agrees that there are differences in health issues as related to different religious organizations (Ihaji, 2014). Having certain beliefs informs the kind of attitude a person will have regarding certain issues and this will in turn affect how the person behaves and even what the person thinks is the right behaviour for every human being. There is a close link between beliefs and religion. One definition of religion is “a personal set or institutionalized system of religious attitudes, beliefs and practices”. Thus, religion is not just what people do in church on Sundays or in the mosque on Fridays but it is a way of life for people in that it determines what they would consider right or wrong (Anarfi, 2016).

It was believed in some places that hospitals can help with physical diseases, but spiritual diseases require spiritual solutions, such as prayer. It is also a general belief that doctors can treat certain conditions, but only God heals (Fiaveh et al, 2016). Religion therefore occupies a central place in the consciousness of people and has affected the way people attempt to understand and relate to the world around them. According to Atiemo, religion is so pervasive in the life of people that we can identify what he termed as “popular religion”, which is the manifestation of religious faith at the informal, unofficial level. It virtually runs through all faiths and religions so that there is no boundary to where people seek spiritual assistance in times of need (Anarfi, 2016). This may explain why religion did not have significant association with seeking treatment from prayer camps. Nonetheless, parents from denominations known to be more spiritually inclined (like the Charismatic/Pentecostals), were more likely to seek treatment from prayer camps than those perceived to be less

spiritually inclined (like the Catholics). It is believed that Roman Catholics engage in more health seeking behaviour than the non-Roman Catholics (Ihaji, 2014).

Some prayer camps combine prayers and the administration of medicine, either orthodox or herbal, in the treatment of their patients. Spiritual intervention on the other hand, can come from any source, including Christian, Islamic, traditional and others. The interventions do not involve any medication and are non-residential. Similarly, herbal treatments are linked to herbalists or fetish priests. These combine herbal preparations with other spiritual activities for the treatment of their patients which may involve residence at a shrine for some days. Herbal medications are just medicines made from herbs. They can be bought from anywhere, including pharmacies, with or without prescription (Anarfi, 2016).

2.1.5 Gender and Health Seeking Behavior

Much of the empirical literature suggests that stereotypical (or “traditional”) gender roles and norms culturally dominant behaviour considered to be essentially “masculine” and “feminine” are an important factor that shapes both men's and women's health help-seeking behaviour” (Galdas et al, 2010). Public narratives concerning men's help seeking for illness have long reinforced beliefs that “rather than seek help, men will be strong, stoical and often silent in matters relating to health” (Robertson, 2013). To some extent, this stereotype has been fuelled by well-known gender differences in use of primary care; analysis of routinely collected data on almost 3.8million patients in the UK, for example, shows higher mean number of visits to the general practitioner in females than males between the ages of 10 and 65 years (Wang et al., 2013). Furthermore, a qualitative synthesis of patients' help-seeking experiences and delays in cancer presentation identified men's “reluctance to seek help”, concludes that “Men viewed help-seeking as not masculine enough and indicated that women found help-seeking easier because of greater contact with health services for themselves and

their family” (MacLean et al, 2017). Such statements reinforce a view that men's (under) use of health care is problematic, consulting for serious symptoms at a later stage, while women are presumed to consult more readily, frequently and with less serious complaints and perhaps by implication to be ‘over-users’ of health service resources (Hunt et al., 2010).

2.1.6 Socio-Economic Status and Health Seeking Behavior

It is widely acknowledged that, exploring the health seeking behavior in different socio-economic levels of any community is crucial for proper planning and implementing of effective health services, particularly for poor community (Mahijabin, 2016). Socioeconomic status is having greater impact on health care utilization especially in developing countries that is documented in many studies. For instance, wealthier families are about twice time take health care service from formal and informal practitioners (Murima et al, 2012). Low socioeconomic status is a common barrier to get health services for people and those direct and indirect factors are- doctor fees, cost of transport, medicine etc (Siddique, 2016).

Educational attainment is the one aspect of socio-economic status which is usually established in early adulthood and stable over life course, and is relatively easily ascertained. Poorly educated, impoverished and minority often have poorer access to and lower quality of medical care. It is well recognized that education has a positive impact on health care utilization. It is argued that educated people are aware of health problem, know more about the availability of health care services, and use this information more effectively to maintain or achieve good health status (Ihaji et al, 2014). People with low educational level had longer time to delay in seeking help when they noticed some symptoms unlike the educated that had a faster response. From the above, it is accepted that education is a factor which influences response to issues patterning to health (Carolyn et al, 2010).

2.1.7 Health Seeking Behavior of People With Diabetes

The phenomenon of health seeking behavior in the developing world has always been of interest to both researchers and policy makers (Amegbor, 2014). Researchers are very much interested in this top most especially in developing areas because of the high rate of self medication one can find in developing countries. Positive health-seeking behavior (i.e., the early recognition of symptoms, presentation to health facilities, and compliance with effective treatment) should improve control of diabetes and thereby reduce the incidence of complications associated with this devastating disease (Dominguez, 2010). When an individual is used to seeking medical help at the slightest symptoms of a disease the person is therefore likely to discover a remedy at an early stage of the disease, because when it gets to the final stage it cannot be cured but sometimes be suppressed. Appropriate health seeking behavior among people with diabetes is defined as seeking modern/conventional treatment either through oral hypoglycemic or insulin injections, from a public or private health facilities (hospital and clinic) (khadijah, 2016). There are various means of reducing the effect of diabetes in the body, most especially from people who seek adequate health care. The methods are oral hypoglycemic injection (an injection which helps to reduce the rate of sugar in the body) and insulin injections (an injection that helps to turn sugar into energy). There are few data about the link between health-seeking behavior and morbidity in people with diabetes, showing that a delay in health-seeking behavior will increase the risk of complications (Dominguez, 2010). Like I said earlier, if people form the habit of seeking medical help it will reduce the risk of a greater disease. It is here that the dictum “a stitch in time saves nine” comes to a fact. This applies to the case of diabetes; if health care is not looked into at a very quick pace then the person is at a risk of dying. The Nigerian rural people demonstrate undesirable health-seeking behavior because of their cosmological and

nosological notions which ascribe etiology of diseases and ill-health to entities far beyond the realm of the stethoscope (Iyalomhe, 2012). The people from rural Nigeria have to notice to seek little or no medical help due to their doctrine and classification of diseases. This simply means that the rural Nigeria believes more on herbs and they have their own classification of diseases in which diabetes is not part and the herb in which they create cannot help cure diabetes, making them be at the risk of the fatality of diabetes. Health seeking behavior exhibited by people in the developing world is complex given the plurality of the health care system in this part of the world. However, these studies on health seeking behavior in the developing world have often ignored the phenomenon of health pluralism and examined patients' behavior from the perspective of a single health system (Amegbor, 2014). Since Traditional African Medicine (TAM) has been with the rural dwellers for generations and also for the fact that orthodox medicine is often in short supply, their approach in times of ill health is first towards TAM. It is when this fails that they result to chemist shops or medicine vendors and then the hospital as a last resort. Majority of the rural dwellers are at variance with reality when it comes to treatment of chronic diseases such as, diabetes mellitus, bronchial asthma, hypertension, congestive heart failure, arthritis, epilepsy and schizophrenia. Because of repeated follow-up treatments and check-ups, they conclude wrongly that orthodox medicine does not have effective remedy for such diseases, and then they opt for TAM (Iyalomhe, 2012). This statement would refer back to when I mentioned that most of the Traditional medicine does not have a cure to what they call this "modern illnesses". The rural dwellers of most developing areas are not pretty used to the queue for hospital cards or queue to see the doctor. All they are used to is just go straight to the herbalist find concoctions and take care of themselves. There is a need to have an information regarding health seeking behaviour among people with diabetes particularly related to utilization of health facilities and consuming modern medicine. The information is crucial in order to

develop strategies for prevention of complication and adaptation to the treatment (Sheleaswani et al, 2013). Certain patient and disease factors can predict appropriate health seeking behaviour. Gender, age, racial group, income, educational level and presence of chronic disorder are some of predictive factors. The present study have demonstrated that age of respondents, educational level, employment status, mean household income, duration of illness, presence of other illness, closed family having history of diabetes mellitus, duration of seeking treatment upon diagnosis, family support and perception severity of disease were determinants of appropriate health seeking behavior (Sheleaswani et al, 2013).

2.1.8 Relationship between Social Inequality and Diabetes

The idea of social inequality refers to differences between groups of people that are hierarchical in nature. At its most basic, it refers to the hierarchical distribution of social, political, economic and cultural resources. A closely related concept is that of stratification, a more specific and technical term that refers to a model of social inequality that specifies the relationship between particular variables, such as wealth and social standing. Stratification refers to a systematic and enduring pattern of inequality that is transmitted across generations, built into institutions and practiced in everyday activities (Oxford press 2013). Resources, material and others, within virtually all human societies are unequally distributed. The ability of an individual to access resources is strongly related to their position within the social hierarchy of that society (Nigel, 2010). As stated in the first chapter (chapter 1) of this work, that there are scarce resources and due to this some people want more than others thereby leading to unequal distribution of these resources. Health inequalities in the prevalence of type 2 diabetes have also been demonstrated (Imkampe et al, 2010). The disease affects all socio-economic groups but is generally more frequent in lower socio-economic groups. Data from the British Women's Heart and Health Study that investigated elderly women aged 60–

79 years showed that area deprivation independently influenced the diagnosis of type 2 diabetes (Imkampe et al, 2010). Low socioeconomic status is associated with higher levels of mortality and morbidity for adults with type 1 diabetes even amongst those with access to a universal healthcare system (Chambers et al, 2017). Self-care is critical to successful outcomes for individuals with type 1 diabetes and good diabetes management has been shown to minimize the risks of long-term and short-term complications. However, it is postulated that inequalities in diabetes care may potentially disadvantage individuals of low socioeconomic status (SES) (Goyder et al, 2017). Economically disadvantaged people are more vulnerable to development of diabetes and more likely to experience inequality of care once diabetes has developed, despite universal health insurance coverage. Similar to our findings, a growing body of studies has shown an association between low SES and increased diabetes incidence, especially in females. Limited resources in food choice, tendency toward obesity and physical inactivity and detrimental psychosocial pressures, such as occupational stress and lack of social support, are often found to be unfavorable intermediate factors inherent in disadvantaged economic situations and serve as a link to the high incidence of diabetes (Chen et al, 2012).

2.1.9 Socio Economic Status (Income) and Diabetes

Modifiable risk factors for diabetes, including obesity, physical inactivity and cigarette smoking, are themselves subject to socio-economic inequalities (Imkampe et al, 2010). Socio-economic disadvantage has been associated with high smoking rates and low levels of leisure time physical activity in both, men and women with higher obesity prevalence has been described for women of low socio-economic position (Imkampe et al, 2010). Reviews of socioeconomic disparities in diabetes have tended to focus predominantly on type 2 diabetes. Since the etiology and treatment of type 1 and type 2 diabetes are different it cannot

be assumed that the impact of socioeconomic circumstances on management and outcomes would be the same in both patient groups (Scott et al, 2017). However, the association of diabetes with socio-economic position is only partly explained by known risk factors for diabetes such as obesity, exercise, alcohol, smoking, ethnicity or family history (Imkampe et al, 2010). Socioeconomic characteristics can be viewed differently depending on the type of diabetes the person has and socioeconomic status as it was said earlier can only be seriously associated with those with type 2 diabetes. In addition, although socioeconomic disparities in type 1 diabetes have been identified in pediatric populations, less research has been conducted about adults with type 1 diabetes. Since self-care is essential to the achievement of successful outcomes in type 1 diabetes, access to good healthcare that facilitates patient adoption of the most effective treatment regimens is also crucial (Scott et al, 2017). Diabetic individuals with complications were twice more likely not to be in the labor force than non diabetic individuals (Kraut et al, 2010). Due to the stress attributed to labor force it is logical to notice that there cannot be patients with diabetes complications and illnesses working in the labor force. This difference was not evident for diabetic individuals without complications. The limitations in the amount of work a diabetic patient can perform puts strain on how he or she can find a job, thereby reducing the adequate sources of income (Kraut et al, 2010). Low socioeconomic status is associated with higher levels of mortality and morbidity for adults with type 1 diabetes even amongst those with access to a universal healthcare system. The association between low socioeconomic status and diabetes management requires further research given the paucity of evidence and the potential for diabetes management to mitigate the adverse effects of low socioeconomic status (Scott et al, 2017). There is a clear link between socio-economic background (such as income or occupation) and health (Rowlingson, 2011). Due to its high burden and economic cost it is imperative that diabetes mellitus is prevented. Towards this end community screening for the

presence of disease, its complications and risk factors, and life style modification programs in the primary health care setting have been introduced. However the alarming increase in the prevalence of this disease and its complications in low income countries/lower middle income countries demonstrate the failure of primary and secondary prevention measures in these settings. Although technical and medical solutions such as disease control and medical care within the health sector are important they alone are not sufficient (De Silva et al, 2018). Early literature from high income countries reported a pattern where the affluent were at high risk of diabetes in comparison, more recent literature from other countries report higher rates of diabetes mellitus and its risk factors in the poorer population groups. This suggests that during economic transitions adverse health behaviors are initially encountered in the higher socioeconomic sector and are later transmitted to the lower socioeconomic groups. It may also be that higher socioeconomic categories modify their risky behavior early while lower socioeconomic categories persist with the adverse health behaviors during the course of a country's economic development (De Silva et al, 2018).

2.1.10 Gender, Age and diabetes

Globally, the greatest numbers of people with diabetes are aged between 40 and 59 years, as observed (Ekpenyong et al, 2011). The worsening of insulin resistance with age, increased inactivity and longevity of diabetes patients due to improved care were the reasons given for the rising prevalence of type 2 diabetes mellitus with age (Ekpenyong et al, 2011). When people grow older their body system begin to get tired hence reducing the amount of activity in which they take part in. this tends to have a bad effect on the body because the sugar content taken into the body needs to be broken down in order for the body to be able to absorb this sugar content, so lack of activities makes or put the individual at the danger of type 2 diabetes mellitus as illustrated by Ekpenyong (2011). Gender differences in the social

structure bring differences in life style modifications and all other self care behaviors in type 2 diabetes. Several studies in the developed countries have shown that women have worse survival, higher risk of cardiac, renal complications and blindness compared to men (Shrestha et al, 2014). Limited studies have been conducted to explore gender differences in diabetes treatment and the situation is worse in developing countries. (Shrestha et al, 2014). The worldwide diabetes prevalence is similar in men and women, but it is slightly higher in men greater than 60 years of age and women of older ages. Overall, diabetes prevalence is higher in men, but there are more women with diabetes than men (Ekpenyong et al, 2011). Marked gender differences in glucose control have been observed in several studies, and these differences may influence treatment in women with type 2 diabetes (T2DM) (Seghieri et al, 2018). When compared with men, women with normal glucose tolerance have been found to be more insulin-sensitive and have better β -cell function; however, greater postmenopausal metabolic deterioration has been observed. Gender-related differences have been measured using oral glucose tolerance testing, showing that in prediabetic states, women have higher rates of impaired glucose tolerance, whereas the rates of impaired fasting glucose are higher in men. The causes of these differences in glucose control are not clearly understood, although gender-related differences in body fat distribution and hormones, as well as slower glucose absorption in women, may contribute to the observed gender dimorphism (Kautzky-Willer et al, 2014). Due to the monthly menstrual cycle in women it has been noticed that women at their early age have lesser risks than men in having type 2 diabetes due to the waste product they release monthly (menstruation) but in their menopause they (women) are at a very high risk of having diabetes due to stoppage in menstrual cycle and inactivity. It is also believed that men at their young age (because of the various manly activities they engage in) are at lesser risk in having diabetes unlike when they grow old (Kautzky-Willer et al, 2014). Men perceived their lack of gender-specific skills, such as cooking, as a challenge to diabetes

management. Single men noted that not having a spouse to assist them in food preparation was especially problematic. Men also felt that they lacked healthy diet knowledge. They felt that these issues limited their ability to manage their diabetes (Burner et al, 2013). However, it is worth noting that age related increase in insulin resistance is not a universal finding, and the reasons for the discrepant results probably include general health, physical activity, changes in liver size and delay in carbohydrate absorption. When confounding factors, particularly physical activity, are taken into account there appears to be little or no change in insulin action with age. In this study, men were more physically active than women and this probably could have enhanced the improved insulin sensitivity in men than women of the same age group, despite the “female insulin advantage”. Physical inactivity was significantly associated with the incidence of diabetes in this study. This could explain why more women than men were Diabetics (Ekpenyong et al, 2012).

2.1.11 Socio Demographic Factors and Its Effects On Diabetes

Age, education, the area of residence (urban and rural), physical activity and co-morbid diseases were significantly correlated with type 2 diabetes mellitus in Bangladesh (Rabiul, 2017). Different elements of the environment have been posited to influence type 2 diabetes mellitus (T2DM). Prior reviews also suggest a link between the environment and health outcomes closely related to T2DM such as obesity, cardiovascular diseases, and hypertension, metabolic syndrome and physical activity. Environmental characteristics are hypothesized to increase exposure to risk factors of T2DM by enhancing or constraining behavioral, psychosocial and physical stressors. The physical and social environment can influence choices and behaviors. Availability and/or proximity to recreational resources, green spaces, open spaces, walkable destinations, sidewalks, and well-designed and connected public places, higher land use mix can encourage physical activity and social

interaction. Individuals living in a highly walkable environment are likely to walk more, thereby reducing the risk of obesity (Dendup et al, 2018). White Caucasian Americans have a lower risk for developing T2DM than Latino and African Americans. Sleep disorder is linked with blood sugar control in African Americans with T2DM. Habitual Chinese dietary pattern is shifting such as high intake of pork, rice, and vegetables are replacing with high intake of edible oil and meats but low consumption of vegetables and cereals. Smoking, breakfast omitting and high intake of sugar-sweetened beverages become very trendy (Islam, 2017). Inadequate physical activity, sleep duration, and sleep quality are also familiar for Chinese residents; all these are correlated with glucose levels of T2DM. Sitting idle decreases the work performance of large skeletal muscles in legs and back. Over the time course of a single day, physical inactivity may induce negative effects on relatively fast acting cellular processes in the skeletal muscles or other tissues. This may have chronic effects on the propensity to become overweight. The present study also showed that age, education, residential area, physical exercise, and other co-morbid diseases significantly correlated with type 2diabetes (Islam, 2017).

2.2.0 REVIEW OF RELEVANT THEORIES

2.2.1 Conflict Theory

Marxism

Conflict theory is based on the assumption that society is composed of various groups struggling for advantage that inequality is a basic feature of social life, and conflict is the major cause of social change. Conflict theorists seek to determine who benefits at the expense of others in a given situation. Marx's perspective in conflict theory is seen in the rejection of the view expressed by structural functionalism that society is held together by shared norms

and values. Conflict theory claims that true consensus does not exist; rather, society's norms and values are those of the dominant elite and imposed by them on the less privileged to maintain their advantaged position. Since all social systems contain such inequality, conflict inevitably results, and conflict, in turn, is responsible for social change. Whereas the Marxian-oriented features of conflict theory have emphasized class struggle, other theorists have moved toward emphasizing conflicts that occur between interest groups and the unequal distribution of political power. According to B. Turner, modern societies are the best understood as having a conflict between the principles of democratic politics (emphasizing equality and universal rights) and the organization of their economic systems (involving the production, exchange, and consumption of goods and services, about which there is considerable inequality). Therefore, while people have political equality, they lack social equality. This unresolved contradiction is relatively permanent and remains a major source of conflict. Ideologies of fairness are constantly challenged by the realities of inequalities, and they influence governments to try to resolve the situation through politics and welfare benefits. This situation represents one of conflict theory's most important assets for medical sociology; namely, the capacity to explain the politics associated with health reform. Conflict theory allows us to chart the maneuvers of various entities, like the medical profession, insurance companies, drug companies, the business community, and the public, as they struggle to acquire, protect, or expand their interests against existing government regulations and programs and those under consideration. While a major focus of conflict theory in medical sociology is on the role of competing interests in health care delivery and policy, other interests concern the sources of illness and disability.

2.2.2 Structural Functionalism

Significant contributors of Structural Functionalism include Emile Durkheim, Herbert Spencer and A.R. Radcliffe Brown. Structural functionalism looks at the role the sick person plays in society. The focus is on how being ill is given a specific form in human societies so that the social system's stability and cohesion can be maintained. Talcott Parsons is often considered the father of Medical Sociology because of his description of the "Sick Role." This describes the difference between the role of a sick person as opposed to the "Social Role" of a healthy person. He defines the sick role as defining the motivation of the patient. Curiously enough, T. Parsons makes no mention of the role of the doctor or other medical institutions. The sick role comprises four aspects:

1. Exemption from normal social role responsibilities,
2. The privilege of not being held responsible for being sick,
3. The desire to get better, and
4. The obligation to find proper help and follow that advice.

A pivotal event occurred in 1951 that oriented medical sociology towards theoretical concerns and initiated the establishment of its academic credentials. This was the publication of T. Parsons' long-anticipated book "The Social System," which established the author at the time as the dominant figure in American sociology. T. Parsons was interested in the different roles of professionals in capitalistic and socialist societies and decided to include physicians and their relationship with their clients/patients in his analysis, because this topic was an area of long-standing interest and one in which he felt he had familiarity.

T. Parsons' concept of the sick role is a clear and straightforward statement of four basic propositions outlining the normative pattern of physician utilization by the sick and their respective social roles. T. Parsons not only constructed the first theoretical concept directly applicable to medical sociology, but by utilizing the work of E. Durkheim and M. Weber, he

did so within the parameters of classical sociological theory. His formulation was recognized as “a penetrating and apt analysis of sickness from a distinctly sociological point of view,” which indeed it was. T. Parsons also influenced the study of professions by using the medical profession as the model for professions based on expertise and a service orientation. E. Durkheim’s only work that had a direct application to medical sociology was his theory of suicide in which the act of taking one’s life was determined by the individual’s ties to his or her community or society. This is seen in his typology of three major types of suicide:

- 1) Egoistic (social detachment);
- 2) Anomic (state of normlessness); and
- 3) Altruistic (a normative demand for suicide).

The merit of his concept is that it shows the capability of the larger society to create stressful situations where people are forced to respond to conditions not of their own choice. Thus, E. Durkheim helps us to not only understand the social facets of suicide, but to recognize that macro-level social events (like economic recessions) can affect health in a variety of ways through stress and that the effects of stress can be mitigated through social support.

Structural functionalism, with its emphasis on value consensus, social order, stability, and functional processes at the macro-level of society, had a short-lived period as the leading theoretical paradigm in medical sociology.

2.2.3 The Health Seeking Model:

Andersen Newman and Kroeger are the both strong proponents of health seeking model in 1973 and 1983 respectively. There are lots of theories under health, seeking behavior model one of which is Health Utility Model.

Health Utility Model

The model was specifically developed to investigate the use of biomedical health services. The example of the factors organized in the categories of the health care utilization model are; age, gender, religion, global health assessment, prior experiences with illness, formal education, general attitudes towards health services, knowledge about the illness etc. This model has been used extensively in both developing and developed countries to understand health services utilization. The model classifies factors that affect health services utilization into three groups: predisposing, enabling and need factors.

Predisposing Factors: The demographic characteristics (age, gender, marital status) reflect the propensity of individuals to use services. Social structure (education, occupation, and race/ethnicity) measures the ability of the individual to cope with the problem, the resources available in the community and the state of physical environment. Health beliefs are values and knowledge about health and the health care system that influence utilization and these include general attitudes towards medical care, physicians and disease.

Enabling Factors: In this factor, both personal and organizational, must be present for service utilization and these represent the actual ability of the individual to obtain health services. Personal enabling factors include income, health insurance, regular source of care, and travel and waiting times; organizational enabling factors include the availability of health care providers and their spatial distribution.

Need Factor: The most immediate cause of health services utilization is need. This judgment about need can be made by the individual himself or family caregivers (perceived need) and can be estimated by a self-assessment of health status, symptoms experienced during a period of time, or number of symptoms during a period of time. Needs can also be defined through a

professional evaluation (evaluated need); for e.g. physician severity ratings for an episode of illness.

2.3.0 THEORETICAL FRAMEWORK

2.3.1 Conflict Theory

Maxian conflict theory opines that the capitalist society is made up two major conflicting parts; the bourgeoisie (rich) and the proletariat (poor). The conflict approach emphasizes inequality of health and health care delivery (Wietz, 2013). Society's inequalities along social class, race and ethnicity, and gender lines are reproduced in our health and health care. The poor people or disadvantaged are at a very high risk of becoming sick or ill, and once they become ill, lack of access to adequate health care makes it more difficult for them to become well. Other conflict approaches are connected more directly to classical Marxism by relying on class struggle to explain health policy outcomes and the disadvantages of the lower and working classes in capitalist medical systems where the emphasis is on profit. This can be applied in the case of social inequality in health. In the case of diabetes for instance starting from the incurrence of the disease (balanced diet) to the purchase of drugs, it has been a bottle neck for the poor. In most developing and underdeveloped society like Nigeria (Osun state as an example), the wealthy among them travel out of the country to seek expert health care, the middle class manage to afford the few private hospitals available while the lower class (poor) are left at the mercy of the ill equipped health centers and less dedicated workers. The poor are seen to die by their thousands while the rich are noticed to be able to manage their health properly. Out-of-pocket payments for health care services lead to decrease use of health services and catastrophic health expenditures. Out-of-pocket payment means something paid for with your own money rather than with money from other sources (Merriam-Webster Dictionary). Many advanced countries have tried to reduce this kind of

payment in the area of health by introducing Community Based Health Insurance (CBHI) scheme in their health policy, but this not included in the Nigerian policy which therefore hinders the poor from having a positive health seeking behavior, especially in the case of diabetes – which is a very expensive disease to treat. CBHI is an effective and flexible payment plan where the poor can pay in installment, subsidized premiums for the poor. (Umeh et al 2013)

2.3.2 Health Seeking Model

This explains the use of health care facilities by both the poor and the rich however; due to social inequality among patients health care services might be unavailable to the poor. The poor people or disadvantaged who are at a very high risk of becoming sick or ill, lacks access to adequate health care due to absence of personal enabling factors such as income, health insurance, regular source of care the availability of health care providers and their spatial distribution which makes it more difficult for them to become well.

The health utilization model explains that patients need for health care goes a long way in determining the use of health services since illness is basically the feeling of being unwell, and this judgment about need can be made by the individual himself or family caregivers (perceived need) and can be estimated by a self-assessment of health status, symptoms experienced during a period. According to the model, usage of health services (including in patient care, physician visits, dental care, e.t.c.) is determined by three dynamics: predisposing factors, enabling factors and need. Predisposing factors is what we would use to explain health seeking behavior. Predisposing factors can be characteristics such as race, age, and health beliefs. For instance, an individual who believes health services are an effective treatment for an ailment is more likely to seek care. According to the theory the effective

utility of a hospital system in the society ensures the citizens to want to seek medical help but when the opposite is the case, the members of the society would be discouraged to seek help because of lack of trust on the health care system.

CHAPTER 3

METHODOLOGY

This chapter discusses the research design, population, sample size, sample techniques, research instrument and data analysis to be used for the study. This part of the project cannot be brushed aside because the methodology gave an exposure to the detailed insight of the methods and instrument used for data collection and it also explained how data collected is analyzed and interpreted.

3.1 Research Design

The research design employed in this study is a descriptive and explorative design of the survey design. This research design becomes imperative due to the explorative and descriptive nature of the phenomenon under investigation. This was employed due to the fact that data will be collected from a large number of people to determine the relationship between social inequality and health seeking behavior in the case of diabetes in Ile Ife, Osun State.

3.2 Study Area

The study location is Ile Ife, one of the prestigious states in Osun State which is located in the South West part of Nigeria and lies between the latitude 4.30-4.50° East and the longitude of 7.30-7.500° North. Ile Ife has a population of 755,260 (According to 2006 National Census) and land area of about 1,791 square kilometers. Ile Ife was purposely chosen for the study based on the knowledge of prevailing situations of social inequality and health seeking behavior can be destructive and dysfunctional on the health of patients with diabetes in Ile Ife, Osun State and Nigeria as a whole.

Vastly cultural, justifiably traditional, and fairly cosmopolitan, Ile Ife in Osun state, Southwest Nigeria is like an egg that is always accorded respect by all and sundry. The greatness attributed to Ile Ife is well-deserved because it is the cradle of an important Nigerian race; Yoruba. This is part of the reason why the Ooni of Ife, the custodian of Ife norms and traditions, is revered at home and abroad. Adding to the cultural fascination of Ile Ife is an aesthetic tourist destination that is known for giving visitors an indelible treat. One thing the city is recognized for globally is its age-long art history depicted by bronze heads of the kings of Ile-Ife which is dated as far back as the 1300 BC. Unfortunately, many of these heads have been looted. In Ile Ife, there are lots of infrastructural facilities including health facilities not only created by the State or Local Government but also people from outside the state (Tourists). This town is not in isolation but has surrounding towns like Ipetumodu, Edunabon, Yakoyo, Moro, Akinlalu and Ife Tedo. The major ethnic group in the study area is Yoruba ethnic group, but there are other ethnic groups which came about through migration but are not indigenous members of the state or town. The people believed to have come from “Olodumare” Supreme God through one of their ancestral fathers called “Obatala”. In terms of religion, residents of Ile Ife engage in three (3) major religion, that is, Christianity, Islam, and traditional religion.

Ile Ife housed the popularly known Ooni of Ife from the beginning of time till date. The town is popularly known as orisun – the source of Yoruba. Ile Ife is known for her craftsmanship and cloth weaving. In the modern times now, Ife has a few open markets called Oja-Titun or Odo-gbe with about 1,500 shops. In Ile Ife, there are many treatments outlets where health care facilities can be found. There are sixteen (16) hospitals in Ile Ife and one of them is Obafemi Awolowo Teaching Hospital (OAUTH).

3.3 Study Population

Population refers to a collection of humans. Population studies are broadly defined as the scientific study of human populations. The population of study consists of residents in Ile Ife, Osun state that are of age, 18 years and above. The characteristics of the population of the study comprise sex, age, ethnic group, religion, educational qualification, income level, and occupation.

3.4 Sample Size

Using 10 percent of the quarter of the study population and confidence interval of 95% within an estimated 2.0 percentage error margin, sample size of 397.54 was calculated. However, for even distribution among four (4) local governments the calculated sample size is being approximated and rounded up to 400 residents of Ile-Ife from 18 years and above.

3.5 Sample Procedure and Technique

The sampling technique for this study is random sampling technique. The target population for the study was randomly selected from the general population of people living in Ile –Ife, Osun State. Two hundred (200) people are randomly selected among the residence of Ile Ife and questionnaires were distributed to them while five (5) interviews were conducted for those with diabetes on the subject matter. Every respondent have equal chances of being selected of being part of the population.

3.6 Instrument of Data Collection

Questionnaire (quantitative) and In-depth interview guide (qualitative) was used in collecting relevant information as regards the objectives of the study to know the socio-economic status of respondents, socio-demographic determinants, health status and other variables for analyzing social inequality and health seeking behavior in the case of diabetes in Ile Ife. The

questionnaire was both structured and unstructured. They are generally made to seek information necessary for answering the research questions generated. For the primary data, both quantitative and qualitative data was generated using questionnaire survey and in-depth interviews.

3.7 Data Analysis

In this study, the data generated was analyzed using the statistical package for social science (SPSS). The researcher adopted both quantitative and qualitative methods of analysis. The Quantitative analysis employed the use of tables where data are quantified in frequencies and simple percentages. On the other hand, each result in the in-depth interview was qualitatively analyzed in relation to the research questions formulated for the study.

3.8 Ethical Consideration

The identity of respondents was confidential. The researcher was aware of the emotional and social needs of the respondents. The respondents were viewed as experts and their intellectual capacities were not insulted. Confidentiality, the anonymity of respondents was highly upheld. The information gathered was used strictly for the purpose of the research.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND INTERPRETATION

4.0. Introduction

This section presents the data analysis for this study. It includes descriptive statistics of some variables. Also, inferential statistics such as Chi-Square test for association was also employed to test the hypothesis of the study.

Table 1: Social Demographic Characteristics of Sampled respondents

Social /Demographic Factors	Frequency	Percentage
Male	60	40.8
Female	87	59.2
Total	147	100.0
Age in Group		
18-30yrs	99	67.3
31-40yrs	21	14.3
41-50yrs	14	9.5
50+years	13	8.8
Total	147	98.9
Ethnicity		
Yoruba	114	77.6
Igbo	16	10.9
Hausa	8	5.4

Others	8	5.4
Total	146	89.3
Highest Level of Education		
No formal schooling	11	7.5
School Certificate	51	34.7
OND\NCE	26	17.7
HND\Bsc	54	36.7
Msc PhD	5	3.4
Total	147	100
Monthly Income		
No Income	54	36.7
<18,000	25	14.0
18,000-35,000	21	14.3
35,001-52,000	30	20.4
52,001-75,000	11	7.5
above 75,000	6	4.1
Total	147	97
Religion		
Christianity	107	72.8
Muslim	33	22.4
Traditional	7	4.8
Total	147	100
Occupational Status		
Unemployed	16	10.9

Civil servant	26	17.7
Self-Employed	30	20.4
Students	75	51.0
Total	147	100

The table 1 above revealed the socio-demographic characteristics of the respondents in the study location. The sample demographic characteristics revealed that female was 87 (59.2%) while the male 60 (40.8%). This was not because female are liable to diabetes but they were found to be more available than men in Ile-Ife as most of them were either in their shop or at home with their children.

Majority were within ages 20-30yrs (67.3%) followed by age 31-40yrs (14.3%) while respondents' ages 50+yrs were the least (8.8%). Yoruba ethnic group predominated the sample population as Yoruba took (77.6%), Igbo (10.9%) while Hausa (5.4%)

The level of education of sampled respondents disclosed that majority (36.7%) of sampled respondents had BSc/HND while those with OND/NCE were 17.7% and School Certificate 34.7%. This characterized an improvement in level of literacy in the sample area, this helped to supply some key insight to this study because the non-educated were just 7.5%. The percentage distribution of sample respondents by monthly income revealed that most of them earned no tangible income while those that earned 18,000 or less were 14.% between N18,001-35,000 and N35,000 –N52,000 took 14.3% and 20.4% of each respectively. This implies that some of the sample respondents were fully engaged in economy activities, this could help them meet any financial demand of diabetes.

The distribution of occupational status respondents revealed that most of them were students 51.0% while self-employed 20.4%, Civil servants 17.7% and unemployed were just 10.9%. This was not because students were more liable to diabetes but this group happen to be available during the course of survey.

The percentage distribution of religion of sample respondents revealed that majority (72.8%) of them were Christians while traditional religion were 4.8% and Muslim 22.4%. This could be because most of the people in Ile-Ife were Christians.

4.2: Knowledge, Attitude and Perception toward Diabetes

Table 2: Distribution of the Respondents on the Knowledge and Perception Towards Diabetes

Have You Heard about Diabetes	Frequency	Percentage
Yes	145	98.6
No	2	1.4
Total	147	100
if Yes, How		
Through the Internet	17	11.6
Through family and friends	51	34.7
Through health talk\medical practitioners	55	37.4
Through the media	14	9.5
Others	10	6.8
Total	147	100
What are the likely causes of diabetes		

Excessive Sugar	123	83.7
Stress	1	0.6
Hereditary	16	10.9
Curse	4	2.7
Others	3	2.1
Total	147	100
What are the symptoms of diabetes		
Excessive Sweating	12	8.2
Constant Urine	81	55.1
Purging	2	1.4
Sores that heal slowly	21	14.3
Vomiting	5	3.4
All of the above	21	14.3
Others e.g purging	5	3.4
Toal	147	100
In your language, what is the local name for diabetes		
Atosi	3	2.2
Ito Sugar	108	78.8
Oyammamiri (Igbo)	3	2.2
Oriaiheotoriri	3	2.2
Don't know	20	13.9
Total	147	100

Table 2 above showed that the knowledge of diabetes was very high in the society and almost 100% of the people were aware of the disease, the source of the knowledge was

mostly through family and friends with 37.4% and 34.7% respectively. Knowledge through internet was 11.6%, social media 9.5%. The causes of diabetes was found to be excessive sugar in-take as majority 83.7% confirmed that, others said it could be hereditary 10.9% or through curse 2.7% whichever way, the fact remains that this disease has put many into social dilemma if not properly handle. The symptoms of diabetes was found to be constant urine as majority (55.1%) reported that diabetes gave symptoms of constant urine, 14.3% said it gives sores that heal slowly and excessive sweating while 14.4% said it can be all of sweating, constant urine, purging, vomiting, sore that heal slowly. The local name of diabetes is called **Ito-Sugar**(Yoruba) and **Oyammamiri (Igbo)** while some people did not know. Some of the IDI responses are captured below by diabetic patients to corroborate this analysis

In the IDI session respondents has this to say about what caused their diabetes:

“The doctor said it was excess’s sugar” (IDI, MALE, 60 years)

Another respondent

“I don’t know what caused it precisely but I think it is excess in sugar due to my excessive consumption of beer.”(IDI, MALE, 55 years)

Another respondent

“The doctors said I used a particular drug, that is, steroid drugs. I was using the drugs due to ease the pain in my leg which I had surgery on a long time ago when I had accident. The doctors then made me understand that I had used the drugs to much (the drugs contained high sugar content) and that was what caused the diabetes for me.”(IDI, FEMALE, 48 years)

Another respondent

“The doctors said my sugar level was high, and I think it is due to my drinking habit.”(IDI, MALE, 52 years)

Another respondent

“My drinking habit and my life style. I hardly exercise.”(IDI, FEMALE, 46 years)

Table 3: Attitude and Health Seeking Behaviour toward Diabetes

How do you think people respond to treatment of diabetes	Frequency	Percentage
Quickly	38	25.9
Slowly	50	34.0
Don't Know	59	40.1
Total	147	100.0
where do you think people go to when they are diagnosed with diabetes		
Hospital	102	69.4
Medical stores/ pharmacist	18	12.2
Prayer House	9	6.1
Traditional Healer	18	12.2
Total	147	100.0
What do you think people take first when they discover they have diabetes		
Modern drugs	82	55.8
Herbs	57	38.8
Prayer Home	8	5.5
Total	147	100.0

Do people with diabetes have adequate access to health facilities		
Yes	81	55.1
No	66	44.9
Total	147	95.9
if Yes, what are the available health facilities		
The hospital	72	49.0
The Pharmacist	4	2.7
The Herbal Homes	18	12.2
Others	53	36.1
Total	147	100.0
Should people who have diabetes seek health care?		
Yes	144	98.0
No	3	2.0
Total	147	100.0

Table 3 above showed that health seeking behaviour of people with diabetes in Ile-Ife, Osun State revealed dynamics health seeking behaviour. It reported from the general respondent that responds to treatment of diabetes was slowly 34% while 25.9% said they respond quickly and 40.1% reported unknown to how they think they respond to treatment. It was reported that majority 49.1% of diabetes patient visit hospitals while 12.2% of same visit medical stores/pharmacist and 12.2% also visit traditional healers while only 6.1% seek treatment from prayer house. Thus most of the respondents reported that people take modern drugs first before seeking other means of treatments as majority 55.8% said they take “modern

drugs” first while some 38.8% said they take “Herbs” and others 5.5% said they visit prayer house and use prayer water first. This so implies that the use of traditional medication is really competing with modern drugs among sample respondents. This study further deduced that people with diabetes had adequate access to the health facilities in the study area as majority 55.1% said Yes while others 44.9% said no. The available health facilities in the study area were Hospital 49%, Pharmacist 2.7%, Herbs Home 12.2% and others like prayer house, drug vendor, etc 36.1%. Some of the IDI responses are captured below by diabetic patients to corroborate this analysis

In the IDI session respondents has this to say about what they took first when they realized they had diabetes:

“I took the medicine prescribed to me by the doctor.” (IDI, MALE, 60 years)

Another respondent

“I went straight to the hospital because I knew it was a sickness for the hospital.” (IDI, MALE, 55 years)

Another respondent

“I used medicine that the doctors prescribed for me and I did not use any form of herbs.”
(IDI, FEMALE, 48 years)

Another respondent

“Well as a born and brought up Yoruba man, I resorted to the use of herbs first.” (IDI, MALE, 52 years)

Another respondent

“For the injuries I had, I had to visit the church cause I taught it was spiritual first then I later taught deep and has this second thought of it being diabetes, I then visited the hospital.”

(IDI, FEMALE, 46 years)

In the IDI session respondents also has this to say about the symptoms they experienced when they had diabetes:

“I noticed that whenever I urinate, termite would be much on my urine so I went to the hospital for help.” (IDI, MALE, 60 years)

Another respondent

“There was no obvious symptom but I had malaria one time and it was serious and life threatening so I went to the hospital. The doctor then discovered that my sugar level was high and that I should stay away from beer.” (IDI, MALE, 55 years)

Another respondent

“I did not notice any symptoms at all even if I had symptoms I would have noticed it because I am a nurse.” (IDI, FEMALE, 48 years)

Another respondent

“The early symptom of diabetes that I had is that I urinated constantly and it was uncomfortably uncontrollable.” (IDI, MALE, 52 years)

Another respondent

“One symptom I discovered that made me admitted in the hospital is that I had this sour this would not heal and I would always feel sick, so I had to come to seek help to know what was really wrong with me. But I suspected that I had diabetes.”(IDI, FEMALE, 46 years)

4.3 Social Inequalities and Perception towards Diabetes

Table 4 Social Inequalities and Perception toward Diabetes

What sex do you think is more prone to diabetes?	Frequency	Percent
Male	68	46.3

Female	79	53.8
Total	147	100.0
What social class do you think in more prone to diabetes	Frequency	Percent
the poor	10	6.8
the rich	53	36.1
the rich and the poor	78	53.1
none of the the above	6	4
Total	147	100
What do you think is the rate of diabetes among the rich people in Osun state	Frequency	Percent
very low	28	19.1
Low	14	9.6
Moderate	44	30.1
High	29	19.9
Very high	31	21.3
Total	146	100
what do you think is the rate of diabetes among the poor people in Osun state	Percent	Valid Percent
very low	31	21.3
Low	28	19.1
Moderate	36	24.3
High	25	16.9
Very high	27	18.4

Total	147	100
when faced with diabetes, who may likely live long?	Frequency	Percent
the poor people	11	7.5
the rich	98	66.7
both the rich and the poor	25	17.0
none of the the above	13	8.9
Total	147	100.0

Table 4 above shows that the responses of people on the relationship of socio-demographic factors and social inequalities on diabetes people and its effect shows level of consistency among the sampled respondents. Majority 53.8% of the sample respondents reported those females are the one prone to diabetes than their male counterpart while others 46.3% said it is male who are prone to diabetes (DB). It was also reported that both poor and rich are prone to this disease as more than halve 53.1% said both poor/ rich have it, 36% of the sample said the rich are more prone to DB, while only 6.8% said the poor are prone to having it. The **rate of diabetes the rich** was found to be moderate in the sample area, 30% of the sample said it is moderate, 21.3% said it is very high, 19.9% said it is high while same 19.1% again said it is very low. The **rate of diabetes the poor** was reported by 24.3% to be moderate in the sample area, 21.3% said it is very low among the poor, 16.9% said it is high while same 19.1% again said it is low. When faced with diabetes majority of the sampled respondents said the rich will live longer than the poor, 66.7% confirmed that while 17% said both while only 7.5% oppose that the poor can live longer.

4.4 Social Inequalities and Perception toward Diabetes

Table 5: Distribution of the Respondents on the influence of Age and income on incidence of Diabetes.

What is the age liable to have diabetes	Frequency	Percentage
Below 18yrs	9	6.1
18-35	28	19.0
36+	69	46.9
No specific age	41	27.9
Total	147	100.0
Does income play any role in the health seeking behaviour of people with Diabetes in Osun State		
Yes	119	81.0
No	28	19.0
Total	147	100.0

The table 5 above shows that the study also found that the age liable to have diabetes is age 36years and above 46% of the respondents reported this while 19% said the liable age was 15-35yrs and 27% of others said it is not by age. The respondents was of the opinion that income play an important role in health seeking behaviour of people with Diabetes in Osun State, this was supported by 81% of the sampled respondents while only 19% disagreed with the opinion.

4.5 Socio Demographic and socio cultural Factors and its Effects on the perception of Diabetes

Table 6: Distribution of the Respondents on Residence and level of Education on incidence of Diabetes

Do you think the place of residence has effect on diabetes	Frequency	Percent
Yes	38	25.9
No	109	74.1
Total	147	100.0'
Does education have effect on the health seeking behaviour of people with Diabetes in Osun State	Frequency	Percent
Yes	105	71.4
No	42	28.6
Total	147	100.0

In table 6 above, when asked whether the place of residence has effect on diabetes, majority of the respondents was of the opinion that it doesn't have effect since 74.1% said No and only 25.9% said Yes. When also asked if education has any effect on the health seeking behavior of people with diabetes, majority of the opinion shows that education has an effect on health seeking behavior because 71.4% of the population said Yes while 28.6% said No.

Table 7: Distribution of the Respondents on Socio-cultural Perception of Diabetes

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
Diabetes is dominant among the	31(21.1)	73(49.7)	16(10.9)	19(12.9)	8(5.4)

.poor people)	
Diabetes is dominant among the rich people	16(10.9)	42(28.6)	15(10.2)	46(31.3)	28(19.0)
Diabetes is cause by excess sugar	5(3.4)	12(8.2)	4(2.7)	52(35.4)	74(50.3)
women have diabetes than men	12(8.2)	41(27.9)	33(22.4)	40(27.2)	21(14.3)
Old people have diabetes than young	14(9.5)	31(21.1)	16(10.9)	62(42.2)	24(16.3)
Diabetes can be best treated traditionalist	15(10.2)	35(23.8)	24(16.3%)	54(36.7)	19(12.9)
Diabetes is a spell cast on somebody	76(51.7)	38(25.9)	5(3.4)	23(15.6)	5(3.4)
Daily Exercise prevents diabetes	7(4.8)	31(21.1)	34(23.1)	50(23.1)	25(17.0)
Diabetes is curable	6(4.1)	23(15.6)	19(12.9)	60(40.8)	39(26.5)
Diabetes can be properly cured in the hospital	8(5.4)	27(18.4)	11(7.5)	42(42.2)	39(26.5)
Diabetes is hereditary	14(9.5)	15(10.2)	24(16.3)	69(47.0)	25(17.0)
I can leave with a diabetes patient	4(2.7)	10(6.8)	9(6.1)	72(49.0)	52(35.4)

Table 7 above further showed the opinion of respondents on their perception and attitude towards diabetes. Majority (70%) of the respondents disagreed that diabetes is dominant among the poor while 17.4% agree that it is dominant among the poor leaving only (10.9%) who were undecided. On the other way round the opinion that diabetes is dominant among the rich was found to be favourable among the respondents as more than 50% agreed while less than 40% disagree with the opinion leaving only 10.2% who were not certain. The opinion on whether DB is caused by excess sugar was unanimously agreed among the sample respondents, 50% strongly agree, 35.4% agree while only 2.7% were undecided and less than 15% remaining disagree that it is not excess sugar. It was also agreed by majority of the sample respondents that old people have diabetes than the young, 42.2% Agree, also 16.3% strongly agree while 21.1% disagree and 10.9% were undecided. Some of the IDI responses are captured below by diabetic patients to corroborate this analysis

In the IDI session respondents has this to say about what their opinion was about diabetes before you became diabetic?

"I was indifferent" (IDI, MALE, 60 years)

Another respondent

"I felt diabetes was a devilish sickness and a sickness that when you have it, it would take away your money."(IDI, MALE, 55 years)

Another respondent

"I knew that diabetes is not good and it can affect the body system." (IDI, FEMALE, 48 years)

Another respondent

"My opinion about diabetes before now is that diabetes is a sickness for careless people."(IDI, MALE, 52 years)

Another respondent

"My opinion about diabetes is that it a very deadly disease." (IDI, FEMALE, 46 years)

Diabetes was seen by less than 20% of the respondents as a spell while more than 75% disagree with the opinion and only 3.4% were undecided. More than 66% of the sampled respondents agree that diabetes can be cure while about 20% disagree and only 12.9% were not sure. 47.0% of the respondents agreed that diabetes is Hereditary even 17% strongly agreed while 10.2% disagree and 9.2% strongly disagree that DB is hereditary. Majority of the respondents agreed that they can live with diabetes patients, 49% Agree, 35% Strongly Agree while 6.8% Disagree, 2.7% Strongly Disagree leaving only 6.1% as undecided. Some of the IDI responses are captured below by diabetic patients to corroborate this analysis

In the IDI session respondents has this to say about the lifestyle they engaged in to remedy and prevent diabetes

"I do nothing in particular but continue to take my drugs" (IDI, MALE, 60 years)

Another respondent

"I exercise and reduce my sugar intake." (IDI, MALE, 55 years)

Another respondent

"What I did is to reduce some starchy food like rice, eba, fufu, pounded yam, garri, and so on." (IDI, FEMALE, 48 years)

Another respondent

"I reduced my drinking habit and watch what I eat as well."(IDI, MALE, 52 years)

Another respondent

"I am still on drugs so I have not started any personal exercises or diet."(IDI, FEMALE, 46 years)

4.6 Testing of Research Hypothesis

The bivariate analysis in table below, shows the results of hypothesis raised in this study to test for relationship between selected factors (Social inequalities) and how it affect the health

seeking behaviour on diabetes patients. The research hypothesis generated in the study was tested using a Pearson Chi-Square Statistical Techniques at 0.05 level of significance.

HYPOTHESIS ONE

Hi: There is a relationship between socio-demographic factors knowledge and causes of diabetics in Ile Ife, Osun state.

Ho: There is no relationship between socio-demographic factors and diabetes in Ile Ife, Osun state

HYPOTHESIS TWO

Hi: There is a relationship between socio economic status and health seeking behaviours in diabetes cases in Ile Ife, Osun State.

Ho: There is no relationship between socio economic status and health seeking behaviours in diabetes in Ile Ife, Osun State.

Decision Rule:

Reject H_0 if the calculated p-value through statistical software is less than 0.05 level of significant, otherwise we do not reject.

In table 10 to 14 below, the study proceeded to explain the social inequalities among the sample respondent towards their health seeking behaviour, such as their knowledge about diabetes, their opinion on the gender inequalities.

Table 8: Distribution of the Respondents on the Knowledge of Diabetes and Gender of Respondents

GENDER	Have You Heard about Diabetes		Chi-Square
	Yes	No	
Male	59	1	X ² =.071, p=0.792
	98.30%	1.70%	
Female	86	1	
	98.90%	1.10%	
Total	145	2	
	98.60%	1.40%	

In table 8 above, it was found that there is no gender different in the knowledge of diabetes with (X² =0.071,P=, 0.79) as (98.3%) of male and (98.9%) of female already had of the diseases.

Table 9: Distribution of the Respondent to treatment to Treatment of Diabetes

and Gender

	how do you think people respond to treatment of diabetes			
	Quickly	Slowly	Don't Know	
Male	8	19	33	X ² =12.621, p=0.002
	13.30%	31.70%	55.00%	
Female	30	32	25	
	34.50%	36.80%	28.70%	
Total	38	51	58	
	25.90%	34.70%	39.50%	

In table 9 above, majority of sampled female respondents was of the opinion that people were responding to treatment of diabetes *slowly* (36.8%) while majority of the male counterpart did not give any certain response *don't know* (55%) while 34.5% of female reported that people respond to treatment is quick. This was found to be significantly associated with ($X^2= 12.62$, $P= 0.000$) which implies we reject null hypothesis.

Table 10: Distribution of the Respondents of Where People go to When Diagnosed with Diabetes by Gender

Gender	where do you think people go to when they are diagnosed with diabetes			
	Hospital	Medical	Prayer	Traditional

		stores/ pharmacist	House	Healer	
Male	36	6	5	13	
	60.00%	10.00%	8.30%	21.70%	$X^2=9.864, p=0.02$
Female	66	12	4	5	
	75.90%	13.80%	4.60%	5.70%	
Total	102	18	9	18	
	69.40%	12.20%	6.10%	12.20%	

In table 10 above, it shows that where people go to when they are diagnosed with diabetes show a significant associated with gender as majority among 60% and 75.9% of female were of the opinion diabetic patients go to Hospital, with ($X^2= 9.86, p= 0.02$).

Table 11: Distribution of the Respondents on What People Take When they have Diabetes by Gender

	What do you think people take first when they discover they have diabetes			
	Modern drugs	Herbs	Prayer Home	
Male	26	30	4	
	43.30%	50.00%	6.70%	$X^2=6.864, p=0.032$
Female	56	27	3	
	65.10%	31.40%	3.50%	

Total	82	57	7	
	56.20%	39.00%	4.80%	

Table 11 above shows that there was also gender difference on the type of medication people take for treatment of diabetes as 50% of males said they took “HERBS” while 65.1% of females said “**Modern Drug**” This was significant at 5% level of confidence with $X^2= 6.86, P= 0,032$.

Table 12: The Social Class that will Live Long when Faced with Diabetes

GENDER	When faced with diabetes, which may likely live long?				Chi-square
	the poor people	the rich	both the rich and the poor	None of the the above	
Male	5	41	11	2	X ² =0.328, p=0.955
	8.50%	69.50%	18.60%	3.40%	
Female	9	58	15	4	
	10.50%	67.40%	17.40%	4.70%	
Total	14	99	26	6	
	9.70%	68.30%	17.90%	4.10%	

On the other hand, in table 12, when the respondents were asked who may likely live longer among the rich and the poor, there was no gender different as majority of both sex reported that the rich may likely live long when faced with diabetes with ($X^2= 0.32, P> 0.05$)

TABLE 13: Distribution of the Respondents on Age And Health Seeking Behaviour

Health Seeking Behaviour		Age in Group								Chi-Square
		20-30yrs	%	31-40yrs	%	41-50yrs	%	50+y ears	%	
Have You Heard about Diabetes	Yes	99	100.0%	20	95.2%	13	92.9%	13	100.0%	X ² =6.843, p=0.077
	No	0	0.0%	1	4.8%	1	7.1%	0	0.0%	
	Total	99	100.0%	21	100.0%	14	100.0%	13	100.0%	
how do you think people respond to treatment of diabetes	Quickly	29	29.3%	3	14.3%	2	14.3%	4	30.8%	X ² =9.081, p=0.169
	Slowly	37	37.4%	7	33.3%	6	42.9%	1	7.7%	
	Don't Know	33	33.3%	11	52.4%	6	42.9%	8	61.5%	
	Total	99	100.0%	21	100.0%	14	100.0%	13	100.0%	
where do you think	Hospital	75	75.8%	12	57.1%	7	50.0%	8	61.5%	X ² =25.837, p=0.002
	Medical stores/ pharmacist	14	14.1%	1	4.8%	3	21.4%	0	0.0%	
	Prayer House	3	3.0%	1	4.8%	3	21.4%	2	15.4%	

people go to when they are diagnosed with diabetes	Traditional Healer	7	7.1 %	7	33.3 %	1	7.1 %	3	23.1 %	
	Modern drugs	61	62.2 %	11	52.4 %	4	28.6 %	6	46.2 %	
What do you think people take first when they discover they have diabetes	Herbs	35	35.7 %	7	33.3 %	8	57.1 %	7	53.8 %	X ² =13.936, p=0.03
	Prayer Home	2	2.0 %	3	14.3 %	2	14.3 %	0	0.0 %	
when faced with diabetes, who may likely live	the poor people	10	10.2 %	3	14.3 %	1	7.7 %	0	0.0 %	
	the rich	67	68.4 %	13	61.9 %	11	84.6 %	8	61.5 %	X ² =7.811, p=0.553
	both the rich and the poor	16	16.3 %	4	19.0 %	1	7.7 %	5	38.5 %	
	none of the above	5	5.1 %	1	4.8 %	0	0.0 %	0	0.0 %	

long?									
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Table 13 above shows that the age of respondents was found to be not statistically associated with knowledge of diabetes (DB) as most of them had full knowledge of the ailment age 20 - 30yrs (100%), 31- 40yrs (95.2%), 41- 50yrs (92.9%) with ($X^2=6.84$, $P> 0.05$). Also there was no age difference in the opinion of respondent to how DB patient response to treatment as majority within 61.5% age 50+yrs said they don't know,(52.4%) of those within ages 31- 40yrs said "Don't know, while 29.3% of those in ages 20 - 30 said they responded quickly to treatment with ($X^2 =9.081$, $1P>0.05$).But age was found to be associated with where people seek treated for diabetes as 75.8% in age 20- 30 said HOSPITAL while 33.3% in age 31- 40yrs said Traditional healer and (61.5%) of those in age 50yrs + reported that they go to hospital with ($X^2= 25.83$, $P= 0.002$) we say there is significant relationship at 5% level of confidence and we reject H_0 . Age was also found to be related to types of medication diabetic patients uses as (62.2%) of those in age 20 - 30yrs said they take modern drugs while (33.3%) those in ages 31 - 40yrs takes HERBS,(57.1%) of those in age 41- 50 yrs. uses herbs with ($X^2= 13.93$, $P= 0.003$) we say there is significance relationship at 5% level of confidence. When faced with diabetes ailment, there was no significant age different in opinion of respondents on who live long among the poor and the rich with ($X^2 =7.81$, $P>0.05$).

TABLE 14: Distribution of the Respondents on Health Seeking Behaviour And Level Of Education

	Highest Level of Education										Chi-Square
	no formal schooling		School Certificate		OND\NCE		HN D\Bsc		Ms c\PhD		
How do you think people respond to treatment of diabetes											X ² =11.589, p=0.017
Quickly	2	16.7%	13	26.00%	7	26.9%	16	29.6%	0	0.0%	
Slowly	2	16.7%	20	40.0%	6	23.1%	19	35.2%	4	80.0%	
Don't Know	8	66.7%	17	34.0%	13	50.0%	19	35.2%	1	20.0%	
where do you think people go to when they are diagnosed with diabetes											X ² =36.993, 0.000
Hospital	3	25.0%	34	68.0%	20	76.9%	41	75.9%	4	80.0%	
Medical stores/ pharmacist	1	8.3%	11	22.0%	3	11.5%	2	3.7%	1	20.0%	
Prayer House	1	8.3%	3	6.0%	1	3.8%	4	7.4%	0	0.0%	
Traditional Healer	7	58.3%	2	4.0%	2	7.7%	7	13.0%	0	0.0%	
Total	12	100.0%	50	100.0%	26	100.0%	54	100.0%	5	100.0%	
What do you think people take first when they discover they have diabetes											X ² =11.257, p=0.188
Modern drugs	4	33.3%	28	56.0%	13	52.0%	33	61.1%	4	80.0%	
Herbs	6	50.0%	21	42.0%	9	36.0%	20	37.0%	1	20.0%	
Prayer Home	2	16.7%	1	2.0%	3	12.0%	1	1.9%	0	0.0%	
when faced with diabetes, who may likely live long?											X ² =12.347, p=0.418
the poor people	2	16.7%	7	14.3%	4	15.4%	0	0.0%	1	20.0%	
the rich	6	50.0%	34	69.4%	15	57.7%	41	77.4%	3	60.0%	

both the rich and the poor	3	25.0%	6	12.2%	6	23.1%	10	18.9%	1	20.0%
none of the the above	1	8.3%	2	4.1%	1	3.8%	2	3.8%	0	0.0%

In table 14 above, it shows that there was no significant education influence different on the knowledge of diabetes across different level of education as majority with no education (91.7%), school certificate (100%) HND\BSC 100% were having full knowledge of the ailment. Thus chi-square $X^2 = 7.05, P > 0.05$ we conclude there is no educational influence on knowledge of diabetes. Also, Education was found to influence how people respond to treatment as study found that (66.7%) of those without education do not know how they response while (40%) of those with school certificate said they respond slowly and 26.9% with ($X^2 = 11.58, p < 0.05$). significance relationship was found between level of education and where people go when diagnosed with diabetes, (80%) of those with higher degree e.g.M.Sc\PhD go to Hospital when faced with diabetes, HND\BSC (75.9%), OND\NCE (76.9%) and School certificate (68%) also visit hospitals but almost (60%) of those with no education go to traditional Healers. Thus, $X^2 = 36.99, p = 0.000$ implies that access to basic education can influence the health seeking behaviour of diabetes patients in the study area. Use of modern drugs was found to be the major treatment for diabetes since this gain higher prevalence in different level of education School Certificate (56%), OND\NCE (52.0%), HND\BSC (61.1%) and MSC\PHD (61.1%) take modern drugs while 50% of those with no education used "Herbs" for treatment of diabetes. The chi-square ($X^2 = 11.26, p > 0.05$) implies there is no significance association between education and treatments adopted by diabetes patients. Most of the sampled respondents in different level of education supported the opinion that the rich will live longer than the poor when faced with diabetes ailment, no education (50%), School Certificate (69.4%), OND\NCE (57.7%), HND\BSC (60.0%) reported that the rich will live longer than the poor with ($X^2 = 12.34, p > 0.05$), Which was found to be non-statistically significance.

Table 15: Distribution of Respondents on Health Seeking Behaviour and Socio Economic Status.

Health Seeking Behaviour	Monthly Income in Naira												Chi-Square
	no Inc ome	<N 18 00 0	18,0 01- 35,0 00	35,0 01- 52,0 00	52,0 01- 75,0 00	abov e 75,0 00							
how do you think people respond to treatment of diabetes													
Quickly	14	23.70 %	3	15.00 %	6	28.60 %	12	40.00 %	3	27.30 %	0	0.00 %	X ² =10.376, p=0.408
Slowly	21	35.60 %	9	45.00 %	8	38.10 %	7	23.30 %	2	18.20 %	4	66.70 %	
Don't Know	24	40.70 %	8	40.00 %	7	33.30 %	11	36.70 %	6	54.50 %	2	33.30 %	
where do you think people go to when they are diagnosed with diabetes													
Hospital	49	83.10 %	11	55.00 %	15	71.40 %	16	53.30 %	6	54.50 %	5	83.30 %	χ ² =34.190, p=0.003
Medical stores/ pharmacist	4	6.80 %	5	25.00 %	0	0.00 %	7	23.30 %	1	9.10 %	1	16.70 %	
Prayer House	1	1.70 %	1	5.00 %	0	0.00 %	4	13.30 %	3	27.30 %	0	0.00 %	
Traditional Healer	5	8.50 %	3	15.00 %	6	28.60 %	3	10.00 %	1	9.10 %	0	0.00 %	
Total	59	100.00 %	20	100.00 %	21	100.00 %	30	100.00 %	11	100.00 %	6	100.00 %	

				%		%							
What do you think people take first when they discover they have diabetes													
Modern drugs	36	61.00%	10	50.00%	10	50.00%	17	56.70%	5	45.50%	4	66.70%	X ² =5.133, P=0.882
Herbs	21	35.60%	8	40.00%	10	50.00%	11	36.70%	5	45.50%	2	33.30%	
Prayer Home	2	3.40%	2	10.00%	0	0.00%	2	6.70%	1	9.10%	0	0.00%	
Total	59	100.00%	20	100.00%	20	100.00%	30	100.00%	11	100.00%	6	100.00%	

In table 15 above, the study further deduced a significance relationship between knowledge of diabetes and income as all levels of recognized income such as no income, those earning less than 18,000, 18,000-35,000 and 52,000-75,000 have heard of the disease before and have seen someone with the ailments while 83.3% of those who earn above N75,000 had previous knowledge of the disease as $X^2=12.87$, $p=0.025$. Also further analysis on how people respond to treatment has no significance relationship with income as 40.7% of those who reported no income said they don't know how they respond to treatments of DB, those earning less than 18,000, 45% said they respond slowly, 38.1% of earning 18,000-35,000 said slowly and 40% of those earning 35,000-52,000 said the medication make them respond quickly to treatment as $X^2=10.37$, $p>0.05$. Where people seek treatment took a significant relationship with income of respondents as 83.1% with no income said they go to hospitals, 55% of those earning

less than 18,000, visit hospital, 71.4% of those earning 18,000-35,000 said Hospital and 23.3% of those earning 35,000-52,000 said they visit pharmacy, and 27.3% those earning 52,000-75,000 said they visit "Prayer Center" with $X^2=34.19$, $p<0.05$ which implies there is significance relationship. Most of the people with diabetes uses modern drugs across different level of income as 61% of those with no income said they took modern drugs, those earning less than 18,000, 45% said they took modern drugs while 40% said they took "herbs", 50% of 18,000-35,000 said "Herbs" and 66.7% of those earning 75,000 above said the medication they use is modern with $X^2=5.133$, $p>0.05$ implies there is no significant relationship. In conclusion, level of income do not influence the opinion of respondent on who live long when faced with diabetes among rich and poor, every level of income support that the rich live long and this make no statistical difference with $X^2=15.50$, $p>0.05$.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION

5.1 Summary

The major objective of this study is to observe social inequality and health seeking behaviours on diabetics in Ile Ife, Osun state Nigeria. This project has been classified into five (5) chapters. Chapter one of the project thesis talks about the introduction of the research topic. Chapter two of this research deals with the literature review and theoretical framework. The third chapter deals with the research methodology, sampling technique, method of data collection, and most importantly how the results were analyzed. Chapter four shows the presentation and interpretation of results pertaining of the analysis of primary data gathered through the administering of the questionnaire. The result and interpretation of the research hypothesis were also presented. Finally, the fifth chapter presents the summary of the study, conclusions, and recommendation. Also this chapter also deals with the discussion of research findings as they relate to the objectives of the study and providing answers to the research questions formulated in this study.

5.2 Discussion of Findings

This section of this chapter provides the discussion of research findings as they relate to the objectives of the study and answers to the research questions. These results of the above are discussed below;

The result in the analysis in Table 2 revealed that the knowledge of diabetes among the inhabitants of Ile-Ife, Osun state was very high and almost 100% of the people were aware of the

disease, the source of the knowledge were mostly family and friends and a little from the internet and social media.

Table 4 in the analysis section made us to understand the response of people on the relationship between social inequality and diabetes in Ile Ife, Osun State. It was reported in Ile Ife that majority of the respondents were of the opinion that females are more prone to diabetes than their male counterpart while few others rejected the claim. It was also reported that both poor and rich are prone to this disease as more than half (53.1%) said both poor/ rich have it, 36% of the sample said the rich are more prone to diabetes, while only 6.8% said the poor are prone to having it. It was discovered in this work that social inequalities such as gender and socio economic status have a significant relationship with diabetes. The socio demographic factor examined is if place of residence has an effect on diabetes. The result gotten from the research identifies that majority of the people of Ile Ife said the place of residence does that affect diabetes.

The research hypothesis testing section of 4.6 of the study proceeded to also explain the social inequalities among the sample respondent towards their health seeking behaviour, such as their knowledge about diabetes. On the issue of gender inequality, it was found that there is no gender difference in the knowledge of diabetes as both male and female already heard of the disease. The age of respondents was found to be not statistically associated with knowledge of diabetes as most of them had full knowledge of the ailment. But age was found to be associated with where people seek treated for diabetes. When faced with diabetes ailment, there was no significant age different in opinion of respondents on who live long among the poor and the rich with diabetes. Education was found to influence how people respond to treatment. The individual's level of education according to the research is seen to have something to do with where people go when

diagnosed with diabetes as illustrated in table 14 above, it also implies that access to basic education can influence the health seeking behaviour of diabetes patients in the study area. In the case of socio-economic status, most of the sampled respondents in different level of education supported the opinion that the rich will live longer than the poor when faced with diabetes ailment. The study deduced that an individual's incomes, just like education, affect where they go to seek medical help.

5.3 Conclusion

From the result of the empirical findings in chapter four of this study, the researcher concludes therefore that the knowledge of diabetes was very high in the society and almost 100% of the people were aware of the disease. Health seeking behaviour of people with diabetes in Ile-Ife, Osun State revealed the dynamics in health seeking behaviour. It was also reported that both poor and rich are prone to diabetes and the fact that income play an important role in health seeking behaviour of people with Diabetes in Osun State was also revealed. It also affects where people go to when they want to seek health care. This study further deduced a significance relationship between knowledge of diabetes and income.

Place of residence and gender difference has no effect on the knowledge of diabetes in Ile Ife, Osun state. The age of respondents was found to be not statistically associated with knowledge of diabetes but age was found to be associated with where people seek treated for diabetes. Significance relationship was found between level of education and where people go when diagnosed with diabetes; it thus implies that access to basic education can influence the health seeking behaviour of diabetes patients in the study area. The study however comes to the

conclusion that there is a significant relationship between few of the social inequalities (education and income) and health seeking behavior of diabetic patients in Ile Ife, Osun state

5.4 Recommendation

Based on the findings of this research, the following recommendations are made:

1. The main recommendation here is that government and government agencies need to help reduce both income and health inequality. This can be done by creating affordable health care services would improve the health seeking behavior of the poor individuals, help reduce and health inequality, and improve average population health seeking behavior of diabetic patients.
2. Not only diabetes should be look into but also other chronic diseases (like cardiovascular diseases); awareness, treatment and control should be on the increase in Nigeria as in most developed countries, individuals should be more educated about the risk factor of the disease on health and on how it can be eradicated or reduced in the society.
3. Government should review their policies by creating laws that would help reduce medical cost for diabetic patients (most especially) and other diseases for affordability.
4. The government should improve standard of the health sectors so that all citizens could access health care freely and there should be equal and universal access to health.
5. The governmental and non-governmental organizations should try to encourage the citizens to create a healthy life style by taking part in exercises, create a balanced diet and so on and to also look at benefits of these life style changes to health.

6. The government should enforce legislative and administrative measures regulating terms and conditions for admission of diabetic patients in both public and private hospitals not mindful of their socio-economic status.
7. Medical facilities should be provided by able body members of the society which will prevent and protect people from economic and health exploitation which is harmful to their health.
8. Government should improve the economy of the country by creating jobs so that it's citizen will have resources or the capabilities to access health facilities as they desire
9. Employers which can afford to pay the medical bills of its employee should make provision for health insurance for their employees, this will go a long way in helping cope with their health issues.
10. Government should make laws that include the various health sectors from exploiting the members of the society on the issue of health so as to improve the health seeking behavior of the population.
11. Both the government and the non-governmental agencies should enlighten the public on the positive effects of seeking medical care and the negative outcomes of not seeking medical care.
12. The study recommends further research into the effects of social inequalities looking at other forms of inequalities in the society as they affect health seeking behavior and health in general of citizens, this will to a great extent help improve the health awareness and health seeking behavior of citizens.

5.5 Suggested Areas For Further Studies

Social inequality and health seeking behavior of diabetic patients has a lot to cover in most cases of obesity and other cardiovascular diseases because they work hand in hand, I am therefore suggesting that further research should be done based on the following;

1. Socio cultural beliefs and health seeking behavior in the case of obesity.
2. Social determinant of health seeking behavior.
3. Social inequality and health outcome of hypertension.
4. Socio demographic determinants of herbal use among hypertensive and diabetic patients.
5. Rural and urban differentials in social inequality and health seeking behavior.

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APPENDIX
QUESTIONNAIRE

**PUBLIC PERCEPTION ON SOCIAL INEQUALITY AND HEALTH
SEEKING BEHAVIOUR: A STUDY OF DIABETIC IN ILE IFE, OSUN
STATE**

INTRODUCTION: I am Oladosu Mary Folashade, a final year student of the department of Sociology, Federal University Oye Ekiti, Ekiti state. This is a part of my Bs.c research thesis and this is a questionnaire designed to obtain information from you for the prime purpose of conducting a research aimed at investigating the social inequality and health seeking behavior of diabetic patients.

You are kindly requested to answer the questions below by selecting the appropriate answer in your own humble opinion. Be rest assured that all the information required are for research purpose only and will be kept absolutely confidential. Thanks for your co-operation.

Yours faithfully,

Oladosu Mary Folashade

SECTION A: QUESTION ON THE SOCIO-DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS.

- (1) Gender (a) Male () (b) Female ()
- (2) Age group (a) 20-30 () (b) 31-40 () (c) 41-50 () (d) 51 and above ()
- (3) Ethnic group (a) Yoruba () (b) Igbo () (c) Hausa () (d) others Specify.....
- (4) What is your highest level of education?
(a) No formal education () (b) School certificate () (c) OND/NCE () (d) HND/BSC ()
(e) Above BSC ()
- (5) What is your estimate monthly salary (a) No income () (b) below ₦18,000 () (c) ₦18,000 - ₦35,000 () (d) ₦35,001 - ₦52,000 () (e) ₦52,001 - ₦75,000 () (f) above ₦75,000 ()
- (6) Religion (a) Christianity () (b) Islam () (c) traditional () (d) others Specify.....

- (7) What is your occupation? (a) Unemployed () (b) Civil servant () (c) Self-employed ()
(d) Student () (e) others specify.....

SECTION B: QUESTIONS ON THE GENERAL KNOWLEDGE OF PEOPLE ABOUT DIABETES IN ILE IFE, OSUN STATE

- (9) Have you heard about diabetes? (a) Yes () (b) No ()
- (10) If Yes, How? (a) Through the internet () (b) Through family and friends () (c) Through health talks or medical practitioners () (d) Through the media () (e) Others specify.....
- (11) What are the likely causes of diabetes? (a) Excessive sugar () (b) Stress () (c) Hereditary () (d) Cause () (e) Others specify.....
- (12) What are the symptoms of diabetes? (a) Excessive sweating () (b) Constant urine () (c) Purging () (d) Sores that heal slowly () (e) Vomiting () (f) All of the above () (g) Others specify.....
- (13) In your language, what is the local name for diabetes?
- (14) Do you think diabetes is a common ailment? (a) Yes () (b) No ()
- (15) Have you ever seen anybody with diabetes before? (a) Yes () (b) No ()
- (16) What is your opinion about diabetes? (a) It is a common disease () (b) It is an uncommon disease () (c) It is a disease for the poor () (d) It is a disease for the rich () (e) It is a disease for the uneducated () (f) Others specify.....

SECTION C: QUESTIONS ON THE HEALTH SEEKING BEHAVIOR OF PEOPLE WITH DIABETES IN ILE IFE, OSUN STATE

- (17) How do you think people respond to treatment of diabetes? (a) Quickly () (b) Slowly () (c) I don't know ()
- (18) Where do you think people go to when they are diagnosed with diabetes? (a) Hospital () (b) Medical store/ pharmacist () (c) Prayer house () (d) Traditional healers () (e) Others specify.....
- (19) What do you think people take first when they discover they have diabetes (a) Modern drugs () (b) Herbs () (c) Prayer water () (d) Others specify.....
- (20) Do people with diabetes have adequate access to health facilities? (a) Yes () (b) No ()
- (21) If Yes, what are the available facilities? (a) The hospitals () (b) The pharmacist () (c) The herbal homes () (d) Others please specify.....
- (22) Should people who have diabetes seek health care? (a) Yes () (b) No ()