HEALTHCARE SEEKING BEHAVIOUR OF UNDERGRADUATE STUDENTS: A CASE STUDY OF UNIVERSITY OF BENIN

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CERTIFICATION

This is to certify that this research study titled '**HEALTHCARE SEEKING BEHAVIOUR OF UNDERGRADUATE STUDENTS: A CASE STUDY OF UNIVERSITY OF BENIN**' was carried out by **CHIJIOKE SAMUEL UKALIKE** with matriculation number **MED1706288** and **MATILDA ONYEBUCHI UTULU (Miss)** with matriculation number **MED1606147** under supervision in the Department of Community Health, School of medicine, College of Medical sciences, University of Benin as part of the requirements for the award of Bachelor of Medicine, Bachelor of Surgery (MBBS).

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DECLARATION

We hereby declare that this work is original and will be carried out by the under-listed researchers under appropriate supervision.

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DEDICATION

This project is dedicated to God Almighty who made all these possible. This work is also dedicated to our beloved parents, Mr and Mrs M.I Utulu and Mr and Mrs C.P Ukalike and our wonderful lecturers whose impact lives forever in us.

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LIST OF ABBREVIATIONS

TISHIP:	Tertiary Institution Social Health Insurance Program
UNIBEN:	University of Benin
UNN:	University of Nigeria
SDG	Sustainable Development Goal

DEFINITION OF TERMS

Barriers: Challenges or obstacles that hinder undergraduates from accessing or seeking healthcare services.

Behaviour: the way an individual acts or conducts himself especially in response to a stimuli.

Confidentiality: the obligation to keep information secure and private, limiting access to only authorized individuals.

Health: a state of physical, mental and social well-being and not merely the absence of diseases.

Healthcare: Medical services provided to individuals to maintain or improve their health.

Perception: an individual's understanding and belief about an event, shaprd by personal experiences, cultural influences, andavailable information.

Suboptimal: below the best or most effective standard, often lacking in quality or efficiency.

Undergraduates: students who are studying at a university or college to earn their first degree, usually a bachelor's degree.

Utilization: act of using something at a rate at which resources are employed for a specific purpose.

ABSTRACT

BACKGROUND: Healthcare is a vital component of any thriving society.Generally, young people (tertiary students inclusive) tend to demonstrate sub optimal helath seeking behaviour and this may be detrimental to their well being, resulting in increased health expenditure, loss of productive hours and generally poorer health outcomes within this demographic.

OBJECTIVES: We sought to assess the knowledge, attitude and practice of undergraduates in the university of Benin towards optimal and prompt seeking of health services.

METHODOLOGY: A descriptive cross-sectional study design was adopted. Study was carried out among tertiary institution undergraduate students within the University of Benin from duration was from August 2023- September 2023. Sample size was calculated using the Cochran's formula for descriptive studies and a self-administered structured questionnaire was used as the data collection tool. Data was analysedusing IBM SPSS version 27.0 and the level of significance was set at $p< 0.05$. Data was presented using frequency tables, graphs as well as prose. Ethical approval was obtained from the Ethics and Research committee, University of Benin Teaching Hospital

RESULT: A total of 430 respondents participated in this study.The mean age was 21.45 ± 2.89. Majority of respondents had good knowledge of healthcare services including where the heathcenter is located and the meanining of TISHIP. Attitude was positive for most respondents. Despite good knowledge and attitude, practice was poor showing significant association with monthly allowance/income. Lack of time to visit healthcenter was a significant factor that influenced healthcare seeking practices.

CONCLUSION: Knowledge and attitude levels were high while practice was poor among respondents. Time to utilize healthcenter and monthly allowance were significant factors influencing practice.

Keywords: healthcare, undergraduates, vaccination, self medication.

CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND

The world health organization defines health as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.[1] Health plays a pivotal role in the social and economic progress of a nation. However, in numerous developing countries like Nigeria, a significant number of individuals, particularly children and youths, succumb to preventable causes every year. This unfortunate trend can be primarily attributed to the adoption of risky behaviors among young people, leading to various health challenges. Despite these challenges, accessing healthcare when needed remains a concern for the youth.[2]

Health seeking behavior represents an individual's response to health issues, where actions are taken to address illness-related problems.[3] A comprehensive understanding of the health seeking behavior of users becomes imperative, especially for policy makers who aim to tailor healthcare services to the specific requirements of target communities, such as university students.[4]

For individuals dealing with infectious diseases, the delay in seeking medical care can heighten the risk of disease transmission within the community.[5] The actions people take when they experience symptoms of illness bear significant consequences, influencing the morbidity and progression of the illness, and ultimately impacting the overall health of the community.[6] Moreover, hesitating or refusing to seek timely diagnosis and treatment can increase the likelihood of experiencing adverse outcomes.[6]

Recent research into patient behavior has revealed that patients hold expectations for both compassionate and competent interactions with physicians. They value

healthcare professionals who can provide them with accurate information regarding their health conditions.[7]

In the context of university students, their expectations from university health centers encompass a holistic approach to care, ensuring not only their physical well-being but also addressing their mental, psychological, and financial needs.[8]

University students, as a distinct subgroup, typically exhibit lower rates of mortality, morbidity, and healthcare utilization. However, it's important to recognize that they often harbor significant health concerns, which may remain concealed or under-diagnosed. These concerns often stem from various factors, including unhealthy lifestyles, poor dietary choices, elevated stress levels, and engaging in risky behaviors such as drug and alcohol abuse, unsafe sexual practices, smoking, as well as grappling with mental health issues like depression and suicidal thoughts and attempts.[3]

In numerous tropical regions, studies have identified prevalent health issues among university students, with malaria, headaches, colds/flu, and fever being among the most frequently encountered illnesses.[9] What is notable is that many students delay seeking medical attention until their discomfort or pain becomes intolerable.[10]

University students often face challenges in seeking assistance, particularly when it pertains to health-related matters. Barriers to accessing healthcare services within this population encompass a broad spectrum, spanning from socio-cultural factors and the influence of social networks to considerations related to gender and economic status. Additional hurdles include worries about maintaining confidentiality, the discomfort of disclosing personal health concerns, a lack of health insurance documentation or limited financial resources, limited awareness of available services, and a degree of mistrust in healthcare professionals.[3]

Furthermore, both gender and the academic year of study play a relatively minor yet noteworthy role in shaping the health status and health promotion beliefs and activities among undergraduates.[11]

When individuals develop symptoms of minor ailments, their subsequent actions aimed at alleviating these discomforts typically involve seeking medical advice from a doctor or a pharmacist, utilizing home remedies or readily available medications, or simply opting for rest without taking any action.[3] A noteworthy finding is that self-medication is a widespread practice, observed among both medical and non-medical students, but it appears to be more prevalent among medical students.[12]

In the context of improving health seeking behavior, it is vital to recognize that the provision of quality services, affordability of these services, and their proximity to individuals are considered the most critical service characteristics. Consequently, to enhance access to healthcare services, there is a need for policy formulation and Iimplementation geared towards increasing the number of healthcare facilities, particularly in underserved areas.[13]

Achieving optimal health depends on proper health seeking behavior, making it crucial for individuals to seek healthcare effectively.[14] Universities establish health centers to enhance healthcare accessibility, a move that brings both short and long-term benefits.[15]

Despite this, students often favor seeking help from community pharmacies or peers in health-related academic programs due to ease of access, which may expose them to suboptimal care from physicians at the health center.[6] Additionally, students utilize the internet as another avenue for health-related information, where they search for information on illnesses, treatments, and medications.[16] Understanding the health-

seeking behavior of students within the university community is essential for maintaining a healthy community.[6]

Fostering awareness about health education and general symptom recognition for diseases, alongside the importance of accessing on-campus healthcare services, even for minor symptoms, is vital. Additionally, streamlining the registration process can significantly boost healthcare utilization, particularly in a university community where students often seek health information online and prefer alternative sources of care.[15]

1.2 STATEMENT OF THE PROBLEM

Students within tertiary institutions tend to exhibit suboptimal health-seeking behaviors while on campus. This may be evidenced by; delayed diagnosis and treatment of health problems, thus resulting in increased severity of illnesses and higher healthcare costs, as well as a negative impact on academic performance due to loss of productive hours. It is therefore important to investigate the factors contributing to the poor health seeking behavior among these students and to examine the coping strategies employed by students to manage their healthcare needs in the face of these challenges and most importantly propose viable solutions to enhance health seeking behavior on campus.

Despite the widespread availability of health centers on campuses, healthcare utilization within this demographic remains notably low.[17] An extensive study across 23 universities in the United States discovered that merely 32% of enrolled students accessed student health services within a year, with preventive services accounting for only 15.6% of these visits.[18]

Remarkably, even with a knowledge of medical science, achieving desirable health-seeking behavior and practices among students has proven challenging. The prevalence of self-medication further complicates the matter.[19]

A study conducted among undergraduates at the University of Nigeria (UNN), Enugu campus, unveiled distinct triggers for seeking orthodox healthcare services. A small fraction (3.4%) would do so in the absence of any illness, while others (22.8%) would visit a healthcare facility when symptoms manifest, or when discomfort and pain become intolerable. Additionally, some (27.2%) seek medical care when their capacity to fulfill student responsibilities is compromised, and a portion (6.7%) when an illness impacts their appearance. Another group (9.7%) would only seek healthcare when they are aware of someone's death caused by similar symptoms.[2]

In Edo State, Nigeria, a substantial number of deaths and severe illnesses stem from preventable conditions, often manageable through vaccines, sanitation, or straightforward remedies. However, a lack of appropriate healthcare-seeking behavior, including timely and suitable care, coupled with insufficient treatment facilities, heightens the risk of serious complications in the context of minor ailments.[14]

1.3 JUSTIFICATION

This study is relevant given the dire consequences of suboptimal or delayed health seeking; as these may impact negatively the health of university students thus resulting in the occurrence of preventable health complications which may be lifelong as well as diminished productivity in this population eventually.

Hence, it is imperative to assess the health seeking behaviour of students in tertiary institutions with respect to knowledge, attitude and practice; so as to identify any gap in these stated areas and proffer solutions.

The findings of this study will be useful as it would inform policy decisions within Nigeria to enhance healthcare accessibility and address specific health challenges faced by tertiary students.

Additionally, it will be relevant in the promotion of preventive healthcare practices, thus contributing to overall student well-being.

It will also be useful in the development of targeted and strategic health interventions within tertiary institutions in Nigeria.

1.4 RESEARCH QUESTIONS

1. What is the level of knowledge of undergraduate students on available healthcare services?

2. What is the general attitude of undergraduates towards the accessibility, affordability of healthcare services?

3. What are the common healthcare-seeking practices exhibited by undergraduates?

4. What are the factors associated with the practices exhibited by undergraduates towards health services

1.5 OBJECTIVES

GENERAL OBJECTIVE:

To determine the knowledge, attitude and practice of undergraduate students towards optimal and prompt seeking of health care services.

SPECIFIC OBJECTIVES

1. To assess the level of knowledge of undergraduate students on available healthcare services.
2. To assess the general attitude of undergraduate students towards the accessibility, affordability of healthcare services.
3. To identify the healthcare-seeking practices of undergraduate students
4. To identify the factors associated with their health seeking practices

CHAPTER TWO

LITERATURE REVIEW

2.0 BRIEF OVERVIEW

Understanding the level of knowledge, attitude, and health-seeking behaviour exhibited by university students is essential for promoting their overall well-being and ensuring access to appropriate healthcare services. This literature review examines various studies conducted across regions to assess the awareness and utilization of health services among undergraduate populations. It explores factors influencing students' awareness of healthcare facilities and resources, perception of health insurance schemes, and attitudes toward accessing campus health facilities. In addition, the review looks at the challenges and barriers affecting tertiary students' utilization of healthcare services. By analysing findings from different studies, this literature review looks into the current situation of health resources and services awareness and practices of university students and to identify areas for intervention and improvement.

2.1 STUDENTS KNOWLEDGE ON HEALTHCARE SERVICES

A cross-sectional study was done in Kwame Nkrumah University of Science and Technology on the assessment of the level of health literacy of the university students.

Sample size was 460 comprising of students aged between 16 - 35 years. A multistage cluster sampling technique was employed and data was obtained using a self-administered questionnaire. The findings of the study revealed that over half (54.6%) of the students demonstrated limited health literacy, with approximately 20% exhibiting inadequate levels. Among these, male students had a higher rate of limited health literacy at 59%, in comparison with female students at 48.6%. The subgroups showing the greatest prevalence of limited health literacy included students from economically disadvantaged backgrounds and those with low self-esteem, at 82.4% and 80% respectively. [3]

In a cross-sectional survey to assess the awareness and perception of college students on the Tertiary Instituition Social health insurance scheme program. First, second, and third-year NCE students from the Federal College of Education Okene in Kogi State and the Federal College of Education Pankshin in Plateau State, Nigeria were selected. The study included a total of 188 students from these institutions and the data was obtained using a Self-administered semi-structured questionnaires were employed. It was observed that 75% of the students had moderate understanding of the objectives and advantages (62.7%) of the Tertiary Institution Social Health Insurance Program (TISHIP), however majority (69.2%) lacked understanding on how to make complaints and seek redress about the TISHIP. The reason behind this was owing to the situation surrounding the enforcement of TISHIP, that is; it was basically seen as a compulsory government initiative, where school administrations implemented enrolment without sufficiently informing students. It appeared the students were not particularly interested in understanding TISHIP's essential guidelines and simply just sought to enrol in a bid to avoid the consequences faced by those who do not enrol.[21]

In a cross-sectional study carried out amongst Nnamdi Azikiwe University students and the staff of the University Medical Centre on the knowledge and implementation of tertiary institution social health insurance programme. The sample size of 396 was selected using the stratified random sampling technique and data was obtained using a self-administered questionnaire. The findings of the research indicated that while virtually all students at Nnamdi Azikiwe University possessed significant knowledge and awareness concerning TISHIP, their attitudes towards it was not in tandem with this level of awareness. However, healthcare professionals at the institution's Medical Centre were observed to have good utilization of this scheme. The reasons behind this poor uptake exhibited by students included dissatisfaction with services provided and shortage of medications at facilities covered by the scheme. The students were also said to have been informed about TSHIP from their peers.[22]

2.2 ATTITUDE OF STUDENTS TOWARDS ASSESSING HEALTH CARE FACILITIES AND RESOURCES

A descriptive cross-sectional study was carried out to assess the attitude of undergraduate students of Obafemi Awolowo University, Ile-Ife toward utilisation of the university's health centre using a sample size of 400. The students were selected across five of the thirteen faculties in the institution, using a multistage sampling technique and a self-administered questionnaire was used to obtain data. The study revealed that 54% of respondents had negative attitude towards utilising the university's health centre evidenced by unwillingness to readily visit the health centre and choosing rather to seek help from chemists when ill, where as another 46% exhibited positive attitude. The implication of this finding is that a higher proportion

of the students had a negative attitude toward the utilisation of the campus health centre.[24]

In a cross-sectional study carried out in the University of Ibadan on the accessibility and utilization of health care services, a sample of 200 was obtained using an accidental sampling technique and the data was collected with the aid of a self-administered questionnaire. The study revealed 53% of the students had positive perception about the activities and general facilities as well as staff at the university's health centre, while another 22.5% perceived the healthcare particularly the nurses the harsh and as such preferred not to have any dealings with them. [30]

In 2022, a cross sectional study was carried out in Sumatera, Indonesia to describe the attitude of university student regarding the utilisation of mental health services. The study focused on the mental aspect of health and the attitude of undergraduates towards seeking for help. The study sample size comprised of 998 students and a questionnaire as well as a mental help attitude seeking scale was used to obtain data. Results showed that most of the participants had a positive attitude, 91.9%, only 8.1% had a negative attitude. From the results of the data analysis, attitude towards mental health services varies based on gender as women have more positive attitudes towards mental health services than men.[25]

2.3 HEALTH SEEKING BEHAVIOUR /PRACTICE OF STUDENTS

A cross sectional mixed design study was done in the Uganda Christian University Kampala on Students' health seeking behaviour and its rationale. A sample size of 424 was used and sample selected using stratified random sampling method. A self-administered questionnaire was employed as the survey tool.The data obtained indicated that 84 respondents, making up 26% of the total, had unmet medical needs.

The primary reasons cited for these unmet needs included: Opting to wait for the issue to resolve itself; accounting for 29% of this group, the service required was not available, as seen in 21% of respondents, excessively long queues at institutions health Centre as highlighted by 16% of participants as well as confusion on how to sign up for the institution's health centre services (8%) and a lack of confidence in the services provided by the institutions' health centre (6%).[4]

A descriptive cross-sectional study done in Babcock University, Nigeria to assess the university students' health-seeking behaviour and perception of healthcare services provided at the Babcock University teaching hospital had a sample size of 425 students. The sample was selected across all levels of students cutting across 7 facilities; Medicine, Physical science, Social science, Arts, Nursing science. A multistage sampling technique was used (Simple random sampling done on 3 occasions). A validated structured questionnaire was used as the survey instrument. The results revealed that 49.4% of the respondents exhibited good health seeking behaviour, whereas 50.6% demonstrated poor behaviour. Regarding barriers to seeking healthcare, a majority of respondents (81.9%) reported that the cost of care was not a hindrance, whereas 27.3% identified waiting time as a barrier. In addition to waiting time and cost, barriers to good health-seeking behaviour included insufficient information (49.9%), the poor attitude of healthcare workers (32.5%), and medicines being out of stock (37.2%).[8]

In 2016, a descriptive study was carried out in the University of Nigeria, Enugu to assess the Health Seeking Behaviour among Undergraduates in the Faculty of Health Sciences and Technology, within the Campus. The sample size was 317, sample was determined using Simple random sampling and a self-administered questionnaire was used. The findings of the study revealed that the health complaints of these students

often included headaches, fever, cough, and catarrh. They rarely had boils, dental issues, waist pains, urinary symptoms as well as sore throat. This study established that a larger number of students (77.2%) in response to these symptoms, would rather choose to rest or do nothing, some would treat themselves using information from the internet or advice from peers, a number of students also used spiritual methods like chaplets and olive oil, take herbs, some others purchased over the counter medications without a prescription to address their symptoms, rather than visiting formal healthcare centers. It also implied that most students only visited the doctor when their illness became severe enough to interfere with their studies significantly or when they noticed the symptoms had severely worsened. Very few students (22.8%) visited hospitals for regular health check-ups without having any specific symptoms. The reasons for this included high cost of health care and the long waiting time.[2]

2.4 FACTORS ASSOCIATED WITH THEIR HEALTH SEEKING PRACTICES

A cross sectional study carried out among four faculties in a Federal institution in South West Nigeria revealed that 76% of the participants registered with the health center leaving 24% unregistered. The major reason of not registering was the clumsiness and tediousness of the registration process rather than the cost of registration. The study also highlighted the fact that registration with the health center affects its utilization by the participants as none of the students who did not register with the health center accessed the service even though they have been ill.[15]

Another study carried out in university South Eastern Nigeria showed that only 22.8% respondents visited orthodox health facilities when they fell ill while the remaining showed poor utilization of health services. According to this study, some of the

reasons for not utilizing health services included: lack of money, belief that the symptoms are self-limiting, shyness to disclose symptoms to anyone, fear of possible complications if treated, and lack of knowledge on where to seek help. Those that fell in the previous listed category resorted to resting and waiting out their symptoms.[2]

In South Africa a cross-sectional study was carried out on the perceived barriers to the uptake of health services among young adults entering the tertiary education system. A sample size of seven hundred and ninety-two was used and the sample was selected using a convenience sampling technique across first-year students aged 18–25 years, registered at one of the three study sites in Johannesburg, South Africa (two public and one private university). A self-administered questionnaire was used and data was collected on general health-seeking behavior Results from the study showed that half of all students had visited a health facility in the last six months, and the most common reason for the visit were because they had been sick or for HIV testing. In the last 6 months, females were more likely than males to visit the health facility. From the study, the most common factors / barriers affecting utilization of health services were long waiting time, attitude of health workers, cost of care, lack of sufficient information (poor health literacy) and the inability to leave studies (miss classes or stay away from school). The large sample size of this study is a major strength while a limitation is the fact that the study focused only on first year undergraduates and as such may not represent the full undergraduate community.[27]

A cross sectional study carried out in Asia among undergraduate students showed that the barriers to the good health seeking practices were as follows; fear of confidentiality, fear of unwanted intervention, and poor knowledge were the most common mental healthcare barriers reported while long waiting hours in healthcare

facilities, fear of side effects, and fear of unwanted interventions were the most common barriers to physical healthcare-seeking.[16]

This review displayed that though students in tertiary institutions generally had impressive knowledge concerning available health services and resources, their attitudes and practices however were often not in tandem with this degree of knowledge. This thus suggests that there remain significant gaps in the pragmatic application of this knowledge, hence the relevance for this study at this time.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 STUDY AREA

This study was conducted at the University of Benin, located in Benin City, the capital of Edo State, Nigeria. Edo State is situated in the South-South geopolitical zone of Nigeria and was established in 1991. It covers an area of 19,743 square kilometers and shares borders with Ondo, Anambra, Kogi, and Delta States. Its geographical coordinates span latitude 60 06'N to 60 30'N and longitude 50 30'E to 50 45'E, relative to the Greenwich meridian. The state is home to various ethnic groups, including the Benin, Esan, Etsako, Owan, and other smaller tribes. Benin City, an ancient urban center, serves as the administrative hub of Edo State and is known for its historical significance. It is home to several higher education institutions, including the University of Benin.[28]

The University of Benin (UNIBEN) was the site of this study. Founded in 1970 as a technology institute, UNIBEN gained full university status in 1971. Accredited by the National University Commission (NUC), UNIBEN offers a wide range of academic programs at diploma, undergraduate, and postgraduate levels. The university contains 15 faculties; 14 of the faculties are located at the Ugbowo Campus while 1 faculty is at the Ekenwan Campus. The current vice chancellor is Prof. Lilian I. Salami. Currently, UNIBEN has an estimated student population of over 70,000, including both full-time and part-time students, and employs about 4,000 academic staff members. The campus has different faculties such as Agriculture, Arts, Education, Engineering, Law, Life Sciences, Management Sciences, Pharmacy, Physical Sciences, Social Sciences, Veterinary Medicine, and the College of Medical Sciences which is composed of the School of Basic Medical Sciences which has seven (7) departments under it, School of Medicine, Dentistry and Institute of Child Health.

3.2 STUDY DESIGN

A descriptive cross-sectional study design was used for this study.

3.3 STUDY POPULATION

The study population comprised of undergraduate students of the University of Benin, Benin City, Edo State, Nigeria.

3.4 SELECTION CRITERIA

3.4.1 Inclusion criteria

All undergraduate students of the University of Benin who were present at the time of data collection.

3.4.2 Exclusion criteria

All 100 level students in the University of Benin as they had not pent enough time in the university to have developed solid opinions and perceptions ion of the health services as at the time of the study

3.5 STUDY DURATION

This study was carried out between September 2023 and August 2024.

3.6 SAMPLE SIZE DETERMINATION

The minimum sample size (n) was calculated using the Cochran's formula for a cross-sectional study.[29]

$$n = \frac{Z^2 pq}{d^2}$$

Where:

n = minimum sample size

Z = standard normal deviation set at 1.96 (at 95% confidence interval)

d = degree of precision set at 0.05

p = prevalence rate of a particular characteristics of the target population

A prevalence rate of 50.6% will be used, as it described the prevalence of poor health-seeking behavior among undergraduates in a 2023 study conducted in Babcock University, Ogun State, Nigeria.[8]

p = 50.6%

= 50.6 / 100

= 0.506

q = 1 - p

= 1 - 0.506

= 0.494

Hence:

$\underline{(1.96)^2 \text{ x } 0.458 \text{ x } 0.542}$

$$(0.05)^2$$

$= 381.45 \approx 381$

To make room for non-response, 10% non-response rate was added to the minimum sample size, utilizing the formula

nf = n / (1 - nr)

where,

n = Minimum sample size = 381

nr = Non-response rate = 10% = 0.10

nf = Final Minimum sample size

nf = 381 / (1- 0.10)

nf = 381 / 0.9

nf = 423.33

A sample size of 430 will be used.

3.7 SAMPLING TECHNIQUE

A multistage technique comprising was used in this study to select respondents

STAGE 1: SELECTION OF DEPARTMENTS

The sampling frame consisted of the fifteen faculties of the University of Benin from which, one-degree programme was selected from each faculty using simple random sampling by balloting.

STAGE 2: SELECTION OF RESPONDENTS

From the selected degree programmes, stratified sampling technique was used to select the respondents based on the population of undergraduate students in each of

the selected degree programmes, and the population at each level will form the basis of each stratum.

3.8 DATA MANAGEMENT

3.8.1 Tools for data collection.

A structured questionnaire was used to collect data for the study, containing both open and closed-ended questions. The questionnaire was adapted from similar studies reviewed in our literature review.[8,10,16.xz]

SECTION A: SOCIODEMOGRAPHIC DATA OF RESPONDENTS

SECTION B: KNOWLEDGE OF UNDERGRADUATE STUDENTS ON AVAILABLE HEALTHCARE SERVICES.

SECTION C: ATTITUDE TOWARDS HEALTH SEEKING SERVICES

SECTION D: UTILIZATION OF HEALTHCARE SERVICES

SECTION E: FACTORS ASSOCIATED WITH IDEAL HEALTH SEEKING BEHAVIOURS

3.8.2 Method of data collection

The questionnaires were self-administered. Informed consent was obtained from the respondents and the respondents before administering the questionnaire.

3.8.3 Pretesting of tool

The questionnaire was pre-tested among students of Benson Idahosa University to determine the comprehensibility, validity, and reliability of data taken as it has students of the same university and shares similarities with the study population. Ten percent (10%) of minimum sample size of the students will be used for pretesting and observed errors will be corrected before being utilized in this study.

3.8.4 Data analysis

Data collected was collated, screened for completeness, numbered serially and entered into IBM Statistical Package for Social Sciences (SPSS) Statistics for Windows, Version 25.0 software.

3.8.5 Scoring

Knowledge was scored using questions under the knowledge section. Positive responses were given a score 1 and negative responses were given 0. The scores were summed up and converted into percentages. Respondents with scores equal to or greater than 50 had good knowledge while those with scores less than 50 had poor knowledge.

Attitude was assessed using a 5-point likert scale from strongly disagree to strongly agree given 1-5. The scores were summed up and converted into percentages. Respondents with scores equal to or greater than 50 had good attitude while those with scores less than 50 had poor attitude.

Practice was scored using questions under the practice section. Positive responses were given a score 1 and negative responses were given 0. The scores were summed up and converted into percentages. Respondents with scores equal to or greater than 50 had good practice while those with scores less than 50 had poor practice.

3.9 ETHICAL CONSIDERATION

Ethical clearance and approval was obtained from the University of Benin Teaching Hospital Ethical Committee. Permission for the study will be sought from the departments chosen for the study. Consent will be obtained from the respondents after they have been educated on the purpose of the study and the confidentiality of the information assured.

3.10 LIMITATION OF STUDY

Data to be collected from the respondents will be self-reported and this may introduce response bias.

CHAPTER 4

RESULTS

A total of 430 respondents participated in this study with a response rate of 100%. The results are presented as follows:

Section A: Socio-demographic characteristics of respondents

Section B: Knowledge of ideal health seeking behaviours

Section C: Attitude of undergraduates towards health seeking

Section D: Factors associated with ideal health seeking behaviors

SECTION A:

SOCIO-DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

TABLE 1: SOCIO-DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

Variables	Frequency (n = 430)	Percent (%)
Age (years)		
16-20	180	41.9
21-25	216	50.2
26-30	33	7.7
>30	1	0.2
Mean(SD) = 21.45±2.89		
Sex		
Male	237	55.1
Female	193	44.9
Marital Status		
Single	426	99.1
Married	4	0.9
Religion		
Christian	413	96.0
Islam	13	3.0
African traditional religion	3	0.7
Atheist	1	0.3
Ethnicity		
Benin	157	36.5
Igbo	83	19.3
Esan	48	11.2
Urhobo	38	8.8
Yoruba	34	7.9
Etsako	17	4.0
Owan	15	3.5
Hausa	10	2.3
Isoko	8	1.9
Ijaw	6	1.4
Efik	5	1.2
Itsekiri	4	0.9
Annang	3	0.7
Ebira	2	0.5

The table above shows the frequency of age, sex, marital status, religion and ethnicity of respondents. The respondents' ages ranged from 16 to over 30 years, with a mean age of 21.45 years (SD = 2.89). The majority of respondents, 216 (50.2%), were between 21 and 25 years old, followed by 180 (41.9%) in the 16 to 20 age group. A small proportion, 33 (7.7%), were between 26 and 30 years old, and only 1 respondent (0.2%) was over 30 years old.

In terms of sex distribution, there were more male respondents, 237 (55.1%), compared to female respondents, 193 (44.9%).

Almost all respondents were single, 426 (99.1%), with only 4 (0.9%) being married.

The majority of respondents were Christians, 413 (96.0%), followed by Muslims, 13 (3.0%), while a small number practiced African traditional religion, 3 (0.7%), and 1 (0.3%) identified as atheist.

Regarding ethnicity, the largest group was Benin, with 157 respondents (36.5%), followed by Igbo, 83 (19.3%), and Esan, 48 (11.2%). Other notable ethnic groups included Urhobo, 38

(8.8%), Yoruba, 34 (7.9%), and Etsako, 17 (4.0%). Smaller ethnic groups represented included Owan, Hausa, Isoko, Ijaw, Efik, Itsekiri, Annang, and Ebira, each making up less than 4% of the respondents.

TABLE 1: SOCIO-DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS CONTINUED

Variables	Frequency (n = 430)	Percent (%)
Degree programmes		
Medicine	48	11.2
Dentistry	8	1.9
Pharmacy	64	14.9
Law	55	12.8
Veterinary Medicine	2	0.5
Computer Engineering	25	5.8
Soil Science	16	3.7
Political Science	25	5.8
Linguistics	39	9.1
Human Kinetics and Sports Science	18	4.2
Architecture	10	2.3
Plant Biology and Biotechnology	30	7.0
Geology	12	2.8
Accounting	51	11.9
Medical Laboratory Science	27	6.3
Level		
200	124	28.8
300	127	29.5
400	110	25.6
500	52	12.1
600	17	4.0

The degree programmes and levels of respondents are represented in the above table. The most represented department is Pharmacy, with 64 respondents (14.9%), followed by Medicine, which accounts for 48 respondents (11.2%). Other departments with significant representation include Law (55 respondents, 12.8%) and Accounting (51 respondents, 11.9%). On the other hand, Veterinary Medicine and Architecture are the least represented, with only 2 (0.5%) and 10 respondents (2.3%), respectively.

Regarding academic level, the largest group of respondents are in 300 Level, with 127 respondents (29.5%), followed closely by those in 200 Level (124 respondents, 28.8%). Meanwhile, the smallest group comes from 600 Level, with only 17

respondents (4.0%). Overall, this distribution highlights the prevalence of respondents in mid-level academic years, particularly in 200 and 300 Levels.

TABLE 1: SOCIO-DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS CONTINUED

Variables	Frequency (n = 430)	Percent (%)
Average monthly income		
< 10,000	47	10.9
10,000 – 30,000	166	38.6
31,000 – 50,000	141	32.8
51,000 – 70,000	45	10.5
> 70,000	31	7.2
Sponsor		
Parents	395	91.9
Self	25	5.8
Both	7	1.6
Others*	3	0.6
Accommodation		
On Campus	264	61.4
Off Campus	166	38.6
Completed health center registration		
Yes	240	55.8
No	190	44.2

*Others – Uncle and aunts

The average monthly income/allowance, sponsor, accommodation and completion of health center registration among respondents are represented in the table above. Regarding the average monthly income, the majority of respondents (38.6%) reported earning between ₦10,000 and ₦30,000, followed by 32.8% who earn between ₦31,000 and ₦50,000. A smaller proportion (7.2%) earns more than ₦70,000, while the lowest income bracket of less than ₦10,000 accounts for 10.9% of the respondents. Most respondents (91.9%) are financially supported by their parents, while 5.8% support themselves. A very small proportion is sponsored by both parents and other means, such as uncles and aunts, accounting for less than 3%.

In terms of accommodation, 61.4% of respondents live on campus, with the remaining 38.6% residing off-campus. Additionally, more than half of the respondents (55.8%) have completed their registration at the health center, while 44.2% have not.

SECTION B:

KNOWLEDGE OF IDEAL HEALTH SEEKING BEHAVIOURS

TABLE 2: AWARENESS OF HEALTHCARE SERVICES AMONG RESPONDENTS

Variables	Frequency (n = 430)	Percent (%)
Aware of the location of the University Health Center		
Yes	367	85.3
Heard of TISHIP		
Yes	179	41.6
Meaning of TISHIP	**n = 179**	
Tertiary Institution Social Health Insurance Programme	124	69.3
Today's Institution Students' Health Insurance Programme	7	3.9
Today's Institution Social Health Insurance Programme	8	4.5
Tertiary Insurance Students' Health Insurance Programme	40	22.3
Source of information about TISHIP		
News	18	97.9
Social media	38	79.2
Family and friends	28	41.7
Health facility	62	31.3
University of Benin kofa page	28	6.3
Lecture	4	4.2
Source of health information*		
Hospital	291	67.7
Government agencies	111	25.8
Social media	210	48.8
Family and Friends	154	35.8

*Multiple responses

The table shows the awareness of respondents on healthcare services including the awareness of the location of the health center, awareness of TISHIP and meaning, as well as source of health related information.

The majority of respondents (85.3%) are aware of the location of the University Health Center, while 41.6% have heard of the Tertiary Institution Social Health

Insurance Programme (TISHIP). Among those aware of TISHIP, 69.3% correctly identified its meaning as the "Tertiary Institution Social Health Insurance Programme," with smaller proportions selecting incorrect options.

The primary sources of information about TISHIP include news (97.9%), social media (79.2%), and health facilities (31.3%). Other sources, such as family and friends (41.7%), the University of Benin kofa page (6.3%), and lectures (4.2%), were less frequently cited.

For general health information, most respondents rely on hospitals (67.7%), followed by social media (48.8%), family and friends (35.8%), and government agencies (25.8%).

TABLE 3: SOCIO-DEMOGRAPHIC CHARACTERISTICS AND KNOWLEDGE OF THE LOCATION OF THE UNIVERSITY HEALTH CENTER

Variables	Knowledge (n = 430)		Fishers Exact	p-value
	Good (%)	Poor (%)		
Age				
16 – 20	142 (78.9)	38 (21.1)	11.003	**0.003**
21 – 25	196 (90.7)	20 (9.3)		
>25	29 (85.3)	5 (14.7)		
Sex				
Male	206 (86.9)	31 (13.1)	1.042	0.338
Female	161 (83.4)	32 (16.6)		
Marital Status				
Single	365 (85.7)	61 (14.3)	4.035	0.104
Married	2 (50.0)	2 (50.0)		
Accommodation				
On campus	234 (88.6)	30 (11.4)	5.911	**0.017**
Off campus	133 (80.1)	33 (19.9)		
Average monthly allowance/income				
< 10,000	40 (85.1)	7 (14.9)	7.533	0.105
10,000 – 30,000	132 (79.5)	34 (20.5)		
31,000 – 50,000	127 (90.1)	14 (9.9)		
51,000 – 70,000	40 (88.9)	5 (11.1)		
>70,000	28 (90.3)	3 (9.7)		
Completed registration at health center				
Yes	231 (96.3)	9 (3.8)	51.618	**<0.001**
No	136 (71.6)	54 (28.4)		
Sponsor of respondent				
Parents	344 (87.1)	51 (12.9)	12.638	**0.004**
Self	15 (60.0)	10 (40.0)		
Others*	8 (85.7)	2 (14.3)		
Level				
200	98 (79.0)	26 (21.0)	13.957	**0.008**
300	107 (84.3)	20 (15.7)		
400	102 (92.7)	8 (7.3)		

500	48 (92.3)	4 (7.7)
600	12 (70.6)	5 (29.4)

* Both Parents and self, Uncle, Aunt

The table shows the association between age, marital status, accommodation, average monthly income/allowance, completion of registration at health center sponsor, and level.

Respondents aged 21–25 had the highest proportion of good knowledge of the location of the university health center, 196 (90.7%), compared to other age groups. The association between age group and knowledge of the health center's location was statistically significant ($\chi2 = 11.003$, $p = 0.003$).

A greater proportion of male respondents, 206 (86.9%), had good knowledge of the health center location compared to female respondents, 161 (83.4%). However, the association between sex and knowledge was not statistically significant ($\chi2 = 1.042$, $p = 0.338$).

The majority of single respondents, 365 (85.7%), had good knowledge of the health center location, while only 2 (50.0%) of married respondents had good knowledge. However, the association between marital status and knowledge was not statistically significant ($\chi2 = 4.035$, $p = 0.104$).

Respondents residing on campus had better knowledge of the health center location, 234 (88.6%), compared to those living off-campus, 133 (80.1%). The association between accommodation and knowledge was statistically significant ($\chi2 = 5.911$, $p = 0.017$).

Those who completed their registration at the health center had significantly better knowledge, 231 (96.3%), compared to those who did not complete their registration, 136 (71.6%). This association was statistically significant ($\chi 2 = 51.618^*$, $p < 0.001$).

Regarding sponsorship, a higher proportion of respondents sponsored by their parents had good knowledge of the health center location, 344 (87.1%), compared to those who were self-sponsored, 15 (60.0%). The association between sponsorship and knowledge was statistically significant ($\chi 2 = 12.638$, $p = 0.004$).

In terms of academic level, respondents in the 400 level had the highest proportion of good knowledge of the health center location, 102 (92.7%), while those in the 200 level had the lowest, 98 (79.0%). The association between academic level and knowledge was statistically significant ($\chi 2 = 13.957$, $p = 0.008$).

The average monthly allowance did not show a statistically significant association with knowledge of the health center location, as indicated by the p-value of 0.105.

TABLE 4: SOCIO-DEMOGRAPHIC CHARACTERISTICS AND AWARENESS OF TISHIP AMONG RESPONDENTS

Variables	Knowledge (n = 430)		Fishers Exact	p-value
	Good (%)	Poor (%)		
Age				
16 – 20	68 (37.8)	112 (62.2)	8.380	**0.015**
21 – 25	89 (41.2)	127 (58.8)		
>25	22 (64.7)	12 (35.3)		
Sex				
Male	92 (38.8)	145 (61.2)	1.715	0.202
Female	87 (45.1)	106 (54.9)		
Marital Status				
Single	177 (41.5)	249 (58.5)	0.116	0.553
Married	2 (50.0)	2 (50.0)		
Accommodation				
On campus	113 (42.8)	151 (57.2)	0.389	0.548
Off campus	66 (39.8)	100 (60.2)		
Average monthly allowance/income				
< 10,000	16 (34.0)	31 (66.0)	7.510	0.110
10,000 – 30,000	61 (36.7)	105 (63.3)		
31,000 – 50,000	65 (46.1)	76 (53.9)		
51,000 – 70,000	25 (55.6)	20 (44.4)		
>70,000	12 (38.7)	19 (61.3)		
Completed registration at health center				
Yes	113 (47.1)	127 (52.9)	6.653	**0.011**
No	66 (34.7)	124 (65.3)		
Sponsor of respondent				
Parents	169 (42.8)	226 (57.2)	6.067	0.091
Self	5 (20.0)	20 (80.0)		
Others*	5 (42.9)	5 (57.1)		
Level				

200	45 (36.3)	79 (63.7)	7.223	0.122
300	60 (47.2)	67 (52.8)		
400	39 (39.5)	71 (64.5)		
500	26 (50.0)	26 (50.0)		
600	9 (52.9)	8 (47.1)		

* Both Parents and self, Uncle, Aunt

Respondents aged over 25 had the highest proportion of good knowledge of TISHIP, 22 (64.7%), compared to other age groups. The association between age group and knowledge of TISHIP was statistically significant ($\chi2 = 8.380$, $p = 0.015$).

A greater proportion of female respondents, 87 (45.1%), had good knowledge of TISHIP compared to male respondents, 92 (38.8%). However, the association between sex and knowledge was not statistically significant ($\chi2 = 1.715$*, $p = 0.202$).

Among single respondents, 177 (41.5%) had good knowledge of TISHIP, while 2 (50.0%) of married respondents had good knowledge. However, the association between marital status and knowledge was not statistically significant ($\chi2 = 0.116$*, $p = 0.553$).

Respondents living on campus had slightly better knowledge of TISHIP, 113 (42.8%), compared to those living off-campus, 66 (39.8%). However, the association between accommodation and knowledge was not statistically significant ($\chi2 = 0.389$, $p = 0.548$).

In terms of monthly allowance, respondents with a monthly allowance between ₦51,000 and ₦70,000 had the highest proportion of good knowledge, 25 (55.6%), while those with less than ₦10,000 had the lowest, 16 (34.0%). However, the association between monthly allowance and knowledge was not statistically significant ($\chi2 = 7.510$, $p = 0.110$).

Respondents who had completed their registration at the health center had a significantly higher proportion of good knowledge of TISHIP, 113 (47.1%), compared to those who had not completed their registration, 66 (34.7%). This association was statistically significant ($\chi 2 = 6.653^*$, $p = 0.011$).

Regarding sponsorship, respondents sponsored by their parents had the highest proportion of good knowledge, 169 (42.8%), compared to those who were self-sponsored, 5 (20.0%). However, the association between sponsorship and knowledge was not statistically significant ($\chi 2 = 6.067$, $p = 0.091$).

In terms of academic level, respondents in the 500 level had the highest proportion of good knowledge of TISHIP, 26 (50.0%), while those in the 200 level had the lowest, 45 (36.3%). The association between academic level and knowledge was not statistically significant ($\chi 2 = 7.223$, $p = 0.122$).

TABLE 5: SOCIO-DEMOGRAPHIC CHARACTERISTICS AND KNOWLEDGE OF CORRECT MEANING OF TISHIP AMONG RESPONDENTS*

Variables	Knowledge (n = 430)		Fishers Exact	p-value
	Good (%)	Poor (%)		
Age				
16 – 20	48 (26.7)	132 (73.3)	11.960	**0.003**
21 – 25	57 (26.4)	159 (73.6)		
>25	19 (55.9)	15 (44.1)		
Sex				
Male	66 (27.8)	171 (72.2)	0.252	0.669
Female	58 (30.1)	135 (69.9)		
Marital Status				
Single	122 (28.6)	304 (71.4)	0.881	0.328
Married	2 (50.0)	2 (50.0)		
Accommodation				
On campus	83 (31.4)	181 (68.6)	2.256	0.155
Off campus	41 (24.7)	125 (75.3)		
Average monthly allowance/income				
< 10,000	8 (17.0)	39 (83.0)	14.832	**0.005**
10,000 – 30,000	37 (22.3)	129 (77.7)		
31,000 – 50,000	50 (35.5)	91 (64.5)		
51,000 – 70,000	20 (44.4)	25 (55.6)		
>70,000	9 (29.0)	22 (71.0)		
Completed registration at health center				
Yes	79 (32.9)	161 (67.1)	4.405	**0.042**
No	45 (23.7)	145 (76.3)		
Sponsor of respondent				
Parents	116 (29.4)	279 (70.6)	2.434	0.465
Self	5 (20.0)	20 (80.0)		
Others*	3 (42.9)	7 (57.1)		

Level				
200	33 (26.6)	91 (73.4)	7.094	0.128
300	35 (27.6)	92 (72.4)		
400	27 (24.5)	83 (75.5)		
500	22 (42.3)	30 (57.7)		
600	7 (41.2)	10 (58.8)		

*Others – Uncles and Aunts, * Tertiary Institutions Students Health Insurance Programme

Respondents aged over 25 had the highest proportion of good knowledge of the correct meaning of TISHIP, 19 (55.9%), compared to other age groups. The association between age group and knowledge of the correct meaning of TISHIP was statistically significant ($\chi2 = 11.960$, $p = 0.003$).

A slightly higher proportion of female respondents, 58 (30.1%), had good knowledge of the correct meaning of TISHIP compared to male respondents, 66 (27.8%). However, the association between sex and knowledge was not statistically significant ($\chi2 = 0.252$, $p = 0.669$).

Among single respondents, 122 (28.6%) had good knowledge of the correct meaning of TISHIP, while 2 (50.0%) of married respondents had good knowledge. However, the association between marital status and knowledge was not statistically significant ($\chi2 = 0.881$, $p = 0.328$).

Respondents residing on campus had a higher proportion of good knowledge of TISHIP, 83 (31.4%), compared to those living off-campus, 41 (24.7%). However, the association between accommodation and knowledge was not statistically significant ($\chi2 = 2.256$, $p = 0.155$).

Respondents with a monthly allowance between ₦51,000 and ₦70,000 had the highest proportion of good knowledge, 20 (44.4%), while those with less than ₦10,000 had the lowest, 8 (17.0%). The association between monthly allowance and knowledge was statistically significant ($\chi 2 = 14.832$, $p = 0.005$).

Respondents who completed their registration at the health center had a higher proportion of good knowledge of TISHIP, 79 (32.9%), compared to those who did not complete their registration, 45 (23.7%). The association between registration completion and knowledge was statistically significant ($\chi 2 = 4.405$, $p = 0.042$).

Regarding sponsorship, respondents sponsored by their parents had the highest proportion of good knowledge, 116 (29.4%), while those who were self-sponsored had the lowest, 5 (20.0%). However, the association between sponsorship and knowledge was not statistically significant ($\chi 2 = 2.434$, $p = 0.465$).

In terms of academic level, respondents in the 500 level had the highest proportion of good knowledge of TISHIP, 22 (42.3%), while those in the 400 level had the lowest, 27 (24.5%). The association between academic level and knowledge was not statistically significant ($\chi 2 = 7.094$, $p = 0.128$).

TABLE 6: KNOWLEDGE REGARDING HEALTHCARE SERVICES

Variables	Strongly agree (n = 430) Freq (%)	Agree (n =430) Freq (%)	Undecided (n=430) Freq (%)	Disagree (n=430) Freq (%)	Strongly disagree (n=430) Freq (%)
The hospital/health center is the best place to receive health services	218 (50.7)	137 (31.9)	48 (11.2)	19 (4.4)	8 (1.9)
Doctors are well trained to render healthcare	221 (51.4)	171 (39.8)	27 (6.3)	10 (2.3)	1 (0.2)
Students should primarily rely on self-medication	31 (7.2)	18 (4.2)	40 (9.3)	188 (43.7)	153 (35.6)
It is very important to consult professional help when feeling unwell	220 (51.2)	174 (40.5)	20 (4.7)	13 (3.0)	3 (0.7)
Reputable websites are trustworthy sources of medical information	83 (19.3)	159 (37.0)	121 (28.1)	47 (10.9)	20 (4.7)

The majority of respondents believe that hospitals or health centers are the best places to receive health services, with 218 (50.7%) strongly agreeing and 137 (31.9%) agreeing with this statement. Only a small proportion of respondents, 19 (4.4%), disagreed, and 8 (1.9%) strongly disagreed.

Regarding the training of doctors, 221 (51.4%) strongly agreed that doctors are well trained to render healthcare, and 171 (39.8%) agreed. A minimal number of respondents, 10 (2.3%), disagreed, and only 1 (0.2%) strongly disagreed with the statement.

Thirty-one (7.2%) respondents strongly agreed that students should primarily rely on self-medication, while 18 (4.2%) agreed. A substantial number of respondents, 188 (43.7%), disagreed, and 153 (35.6%) strongly disagreed with this notion.

Two hundred and twenty (51.2%) respondents strongly agreed and 174 (40.5%) agreed that It is very important to consult professional help when feeling unwell. Only 13 (3.0%) disagreed, and 3 (0.7%) strongly disagreed.

While 83 (19.3%) strongly agreed and 159 (37.0%) agreed that reputable websites are trustworthy, 121 (28.1%) were undecided. A smaller number, 47 (10.9%), disagreed, and 20 (4.7%) strongly disagreed with this statement.

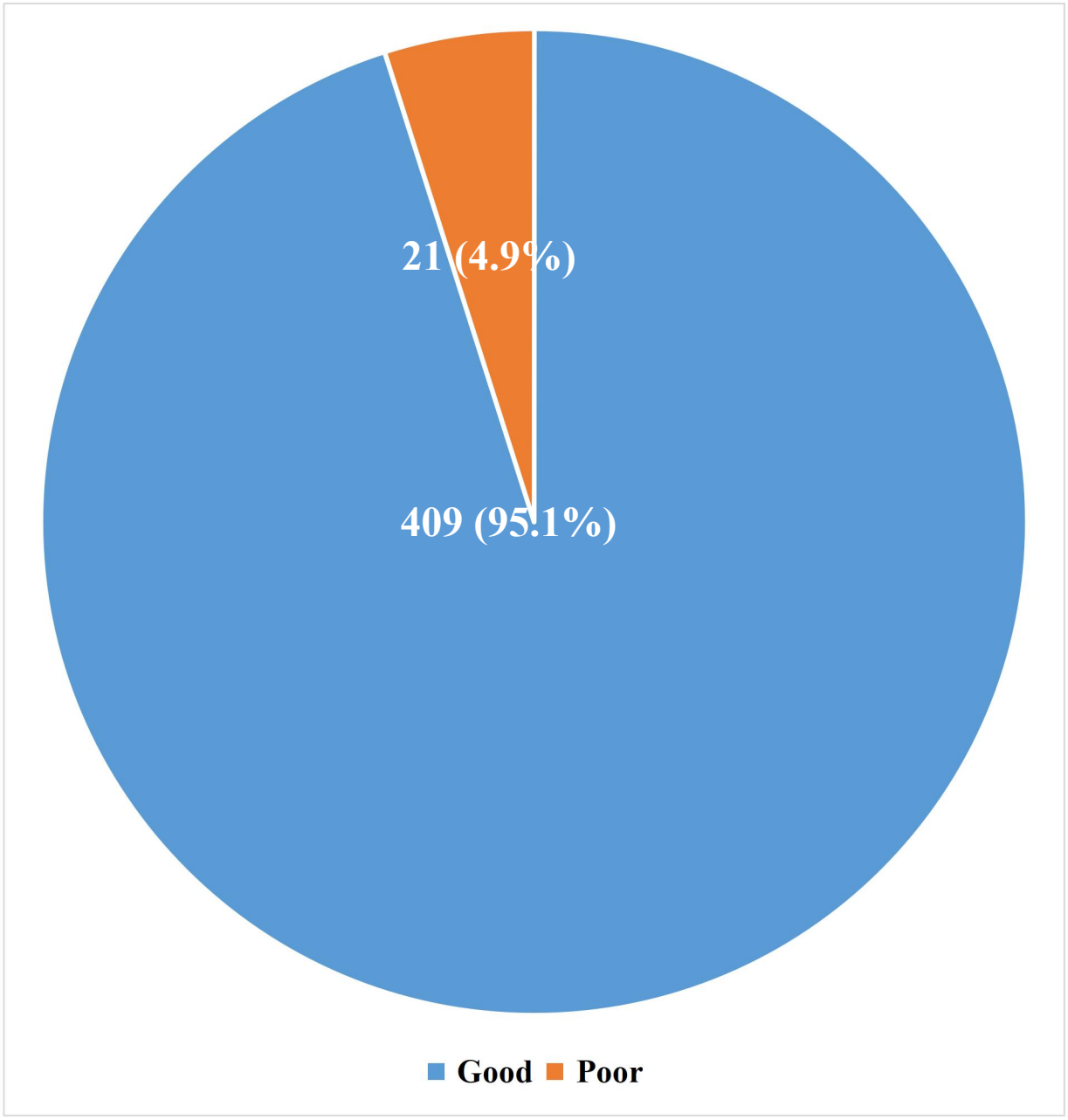

FIGURE 1: showing the knowledge levels of respondents. Majority of respondents, 409 (95.1%) had good knowledge regarding seeking healthcare

TABLE 7: SOCIO-DEMOGRAPHIC CHARACTERISTICS AND KNOWLEDGE OF HEALTHCARE SERVICES AMONG RESPONDENTS

Variables	Knowledge (n = 430)		Fishers' Exact	p-value
	Good (%)	Poor (%)		
Age				
16 – 20	167 (92.8)	13 (7.2)	4.512	0.211
21 – 25	208 (96.3)	8 (3.7)		
26 – 30	33 (100.0)	0 (0.0)		
>30	1 (100.0)	0 (0.0)		
Sex				
Male	223 (94.1)	14 (5.9)	1.191	0.275
Female	186 (96.4)	7 (3.6)		
Marital Status				
Single	406 (95.3)	20 (4.7)	3.517	0.061
Married	3 (75.0)	1 (25.0)		
Accommodation				
On campus	254 (96.2)	10 (3.8)	1.768	0.184
Off campus	155 (93.4)	11 (6.6)		
Average monthly allowance/income				
< 10,000	42 (89.4)	5 (10.6)	17.647	**0.002**
10,000 – 30,000	164 (98.8)	2 (1.2)		
31,000 – 50,000	134 (95.0)	7 (5.0)		
51,000 – 70,000	43 (95.6)	2 (4.4)		
>70,000	26 (83.9)	5 (16.1)		
Level				
200	115 (92.7)	9 (7.3)	3.315	0.507
300	123 (96.9)	4 (3.1)		
400	105 (95.5)	5 (4.5)		
500	49 (94.2)	3 (5.8)		
600	17 (100.0)	0 (0.0)		
Completed registration at health center				
Yes	229 (95.4)	11 (4.6)	0.106	0.745
No	180 (94.7)	10 (5.3)		

Respondents aged 26 to 30 had the highest proportion of good knowledge of healthcare, with 33 (100.0%) reporting good knowledge, compared to other age groups. The association between age group and knowledge of healthcare was not statistically significant ($\chi2 = 4.512$; p-value = 0.211).

A higher percentage of female respondents, 186 (96.4%), had good knowledge of healthcare compared to male respondents, 223 (94.1%). However, the association between sex and knowledge of healthcare was not statistically significant ($\chi2 = 1.191$; p-value = 0.275).

Among respondents who were single, 406 (95.3%) had good knowledge of healthcare, compared to 3 (75.0%) of those who were married. The association between marital status and knowledge of healthcare was not statistically significant ($\chi2 = 3.517$; p-value = 0.061).

A greater proportion of respondents living on campus, 254 (96.2%), had good knowledge of healthcare compared to those living off campus, 155 (93.4%). The association between accommodation and knowledge of healthcare was not statistically significant ($\chi2 = 1.768$; p-value = 0.184).

Respondents with a monthly allowance between ₦10,000 and ₦30,000 had the highest proportion of good knowledge of healthcare, 164 (98.8%), compared to other income groups. The association between average monthly allowance and knowledge of healthcare was statistically significant ($\chi2 = 17.647$; p-value = 0.002).

Among respondents in 600 Level, 17 (100.0%) reported good knowledge of healthcare, the highest proportion compared to other levels. The lowest proportion was in 200 Level, with 115 (92.7%) reporting good knowledge. The association between level and knowledge of healthcare was not statistically significant ($\chi2 = 3.315$; p-value = 0.507).

Among respondents who completed registration at a health center, 229 (95.4%) had good knowledge of healthcare, compared to 180 (94.7%) of those who had not completed registration. The association between registration status and knowledge of healthcare was not statistically significant ($\chi 2 = 0.106$; p-value = 0.745).

SECTION C:
ATTITUDE OF UNDERGRADUATES TOWARDS HEALTH SEEKING

TABLE 8: ATTITUDE OF UNDERGRADUATES TOWARDS HEALTH SEEKING

Variables	Strongly agree (n = 430) Freq (%)	Agree (n =430) Freq (%)	Undecided (n=430) Freq (%)	Disagree (n=430) Freq (%)	Strongly disagree (n=430) Freq (%)
I believe it is important to see a healthcare professional for any health concern	220 (51.2)	164 (38.1)	28 (6.5)	17 (4.0)	1 (0.2)
I would prefer to treat a minor illness myself than go to the doctor	41 (9.5)	199 (46.3)	69 (16.0)	87 (20.2)	34 (7.9)
Talking openly about health problems with friends and family is more helpful than seeing a doctor	24 (5.6)	24 (5.6)	84 (19.5)	202 (47.0)	96 (22.3)
I am comfortable discussing personal health issues with a healthcare professional	179 (41.6)	166 (38.6)	54 (12.6)	26 (6.0)	5 (1.2)
I trust the information I find online about health issues	37 (8.6)	63 (14.7)	173 (40.2)	120 (27.9)	37 (8.6)
I need to be pressured before utilizing healthcare services	30 (7.0)	87 (20.2)	72 (16.7)	167 (38.8)	74 (17.2)
Delaying professional care for minor symptoms can cause consequences	157 (36.5)	214 (49.8)	35 (8.1)	20 (4.7)	4 (0.9)

A majority of respondents, 220 (51.2%), strongly agreed that it is important to see a healthcare professional for any health concern, with 164 (38.1%) also agreeing with this statement. Only a small number, 17 (4.0%), disagreed, and 1 (0.2%) strongly disagreed.

When considering treatment preferences for minor illnesses, 41 (9.5%) of respondents strongly agreed and 199 (46.3%) agreed that they would prefer to treat a minor illness themselves rather than visit a doctor. Conversely, 87 (20.2%) disagreed with this approach, and 34 (7.9%) strongly disagreed.

Opinions on discussing health problems openly with friends and family versus seeing a doctor show a clear preference for professional care. Only 24 (5.6%) strongly agreed and another 24 (5.6%) agreed that talking with friends and family is more helpful than consulting a doctor. A significant majority, 202 (47.0%), disagreed with this statement, and 96 (22.3%) strongly disagreed.

Comfort with discussing personal health issues with a healthcare professional is notably high, with 179 (41.6%) strongly agreeing and 166 (38.6%) agreeing. A smaller proportion, 26 (6.0%), disagreed, and 5 (1.2%) strongly disagreed.

Trust in online health information is more divided. Only 37 (8.6%) strongly agreed and 63 (14.7%) agreed that they trust the information found online, while 173 (40.2%) were undecided. A significant number, 120 (27.9%), disagreed, and 37 (8.6%) strongly disagreed.

Regarding the utilization of healthcare services, 30 (7.0%) strongly agreed and 87 (20.2%) agreed that they need to be pressured before seeking healthcare. However, 167 (38.8%) disagreed, and 74 (17.2%) strongly disagreed with this notion.

Finally, a substantial portion of respondents, 157 (36.5%) strongly agreed and 214 (49.8%) agreed that delaying professional care for minor symptoms can lead to consequences. Only a small number, 20 (4.7%), disagreed, and 4 (0.9%) strongly disagreed.

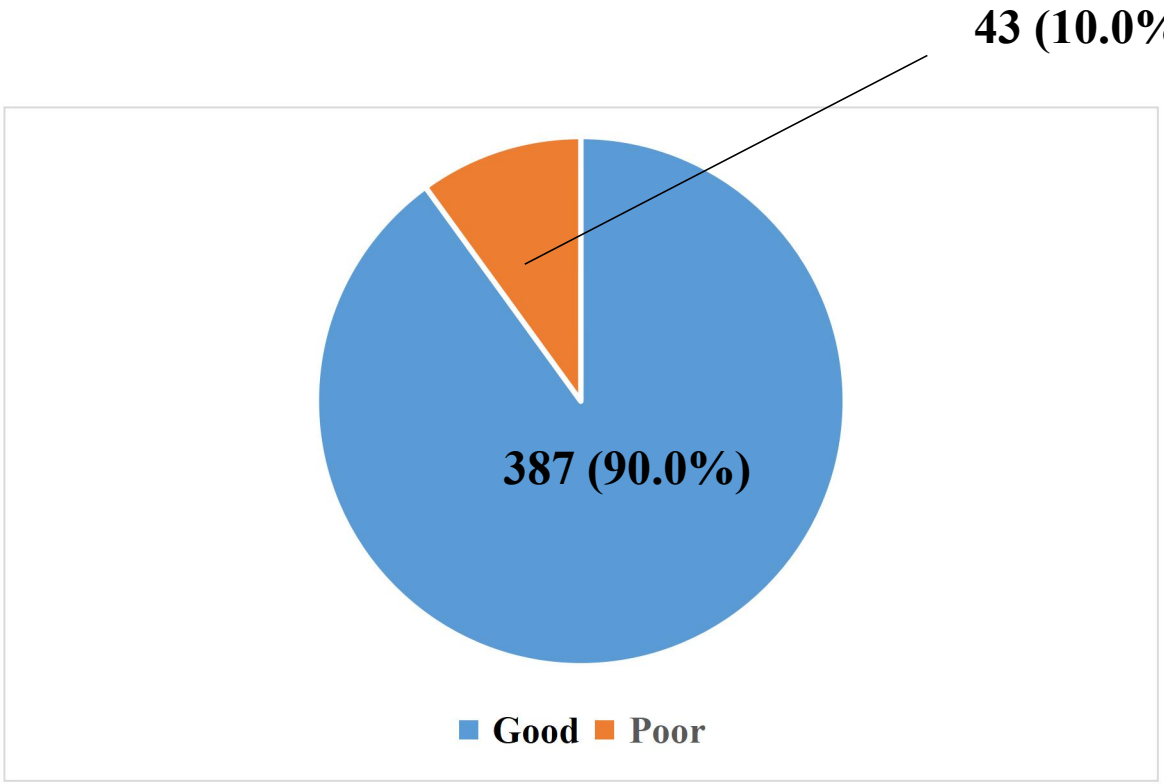

FIGURE 2: showing the attitude of respondents towards seeking healthcare. Majority, 387 (90.0%) had good attitude while 43 (10.0%) had poor attitude

TABLE 9: SOCIO-DEMOGRAPHIC CHARACTERISTICS AND ATTITUDE OF HEALTHCARE AMONG RESPONDENTS

Variables	Attitude (n = 430)		Fishers' Exact	p-value
	Good (%)	Poor (%)		
Age				
16 – 20	166 (92.2)	14 (7.8)	3.654	0.301
21 – 25	193 (89.4)	23 (10.6)		
26 – 30	27 (81.8)	6 (18.2)		
>30	1 (100.0)	0 (0.0)		
Sex				
Male	207 (87.3)	30 (12.7)	4.146	**0.042**
Female	180 (93.3)	13 (6.7)		
Marital Status				
Single	383 (89.9)	43 (10.1)	0.449	0.503
Married	4 (100.0)	0 (0.0)		
Accommodation				
On campus	238 (90.2)	26 (9.8)	0.017	0.895
Off campus	149 (89.8)	17 (10.2)		
Average monthly allowance/income				
< 10,000	43 (91.5)	4 (8.5)	0.256	0.992
10,000 – 30,000	149 (89.8)	17 (10.2)		
31,000 – 50,000	126 (89.4)	15 (10.6)		
51,000 – 70,000	41 (91.1)	4 (8.9)		
>70,000	28 (90.3)	3 (9.7)		
Level				
200	114 (91.9)	10 (8.1)	3.315	0.507
300	113 (89.0)	14 (11.0)		
400	98 (89.1)	12 (10.9)		
500	49 (94.2)	3 (5.8)		
600	13 (76.5)	4 (23.5)		
Completed registration at health center				
Yes	215 (89.6)	25 (10.4)	0.105	0.746
No	172 (90.5)	18 (9.5)		

Respondents aged 16 to 20 had the highest proportion of good attitude toward healthcare, with 166 (92.2%) reporting a good attitude, compared to other age groups. The association between age and attitude was not statistically significant ($\chi2 = 3.654$; p-value = 0.301).

A higher percentage of female respondents, 180 (93.3%), had a good attitude toward healthcare compared to male respondents, 207 (87.3%). The association between sex and attitude was statistically significant ($\chi2 = 4.146$; p-value = 0.042).

Among single respondents, 383 (89.9%) had a good attitude toward healthcare, compared to 4 (100.0%) of those who were married. The association between marital status and attitude was not statistically significant ($\chi2 = 0.449$; p-value = 0.503).

A greater proportion of respondents living on campus, 238 (90.2%), had a good attitude toward healthcare compared to those living off campus, 149 (89.8%). The association between accommodation and attitude was not statistically significant ($\chi2 = 0.017$; p-value = 0.895).

Respondents with a monthly allowance of less than ₦10,000 had the highest proportion of good attitude toward healthcare, with 43 (91.5%) reporting a good attitude. However, the association between monthly allowance and attitude was not statistically significant ($\chi2 = 0.256$; p-value = 0.992).

Among respondents in 500 Level, 49 (94.2%) reported a good attitude toward healthcare, the highest proportion compared to other levels. The lowest proportion of good attitude was observed in 600 Level, with 13 (76.5%) reporting a good attitude. The association between level and attitude was not statistically significant ($\chi2 = 3.315$; p-value = 0.507).

Among respondents who had completed registration at a health center, 215 (89.6%) had a good attitude toward healthcare, compared to 172 (90.5%) of those who had not completed registration. The association between registration status and attitude was not statistically significant ($\chi 2 = 0.105$; p-value = 0.746).

SECTION D:

PRACTICES REGARDING UTILIZATION OF HEALTH CARE FACILITIES

TABLE 10: PRACTICES REGARDING UTILIZATION OF HEALTH CARE FACILITIES

Variables	Frequency (n = 430)	Percent (%)
Experienced symptoms of illness over the past year		
Yes	377	87.7
Experienced symptoms*	**n = 377**	
Headache	240	55.8
Fever	241	56.0
Abdominal pain	99	23.0
Cough and catarrh	160	37.0
Toothache	37	8.6
Diarrhea	2	0.5
Action taken after noticing symptom	**n = 377**	
Did nothing/rest	91	21.2
Use spiritual methods	15	3.5
Took herbs	12	2.8
Visited patent medical store	152	35.3
Went to the hospital or health center	93	21.6
Treatment from the internet/colleague	14	3.3
When you utilize hospital/healthcare services		
Occasionally, even without symptoms	24	5.6
When symptoms appear	165	38.4
When symptoms become unbearable	213	49.5
When it affects my facial appearance	21	4.9
When someone I know just died from such symptom	7	1.6
Self-medication		
Yes	217	50.5
Reason for self-medication	**n = 217**	
Cheaper	53	24.4
Minor illness	59	27.2
Easy and convenient	52	24.0
Complex hospital procedure	10	4.6
Knowledge of medications	43	19.8
Vaccination		
Yes	83	19.3

*Multiple responses

Out of 430 respondents, 377 (87.7%) reported experiencing symptoms of illness over the past year. Among those who experienced symptoms, the most common issues were fever (56.0%) and headache (55.8%). Other symptoms reported include cough and catarrh (37.0%), abdominal pain (23.0%), toothache (8.6%), and diarrhea (0.5%).

In response to these symptoms, 91 (21.2%) respondents did nothing or simply rested. The most common action taken was visiting a patent medicine store, reported by 152 (35.3%) respondents. A significant number, 93 (21.6%), went to the hospital or health center, while smaller percentages opted for spiritual methods (3.5%), took herbs (2.8%), or sought treatment from the internet or colleagues (3.3%).

Regarding healthcare utilization, 213 (49.5%) respondents reported seeking healthcare services only when symptoms became unbearable. A smaller proportion, 165 (38.4%), utilized healthcare when symptoms appeared, while 24 (5.6%) visited healthcare facilities occasionally, even without symptoms. A minority of respondents sought healthcare based on external factors, such as when symptoms affected their facial appearance (4.9%) or after hearing about a death due to a similar symptom (1.6%).

Self-medication was practiced by 217 (50.5%) of respondents. The most common reasons for self-medication were the perception that the illness was minor (27.2%), the ease and convenience of self-medicating (24.0%), and cost considerations (24.4%). Additionally, 19.8% of respondents attributed their self-medication to their knowledge of medications, while 4.6% cited the complexity of hospital procedures as a reason for avoiding formal healthcare.

In terms of vaccination, only 83 (19.3%) of respondents reported receiving any vaccinations, indicating a low rate of vaccination uptake among the group.

TABLE 11: SOCIO-DEMOGRAPHIC CHARACTERISTICS AND SELF-MEDICATION PRACTICE AMONG RESPONDENTS

Variables	Self-medication (n = 430)		Fishers Exact	p-value
	Yes (%)	No (%)		
Age				
16 – 20	79 (43.9)	101 (56.1)	5.563	0.061
21 – 25	118 (54.6)	98 (45.4)		
>25	20 (58.8)	14 (41.2)		
Sex				
Male	116 (48.9)	121 (51.1)	0.488	0.499
Female	101 (52.3)	92 (47.7)		
Marital Status				
Single	217 (50.9)	209 (49.1)	4.113	0.059
Married	0 (0.0)	4 (100.0)		
Accommodation				
On campus	129 (48.9)	135 (51.1)	0.702	0.429
Off campus	88 (53.0)	78 (47.0)		
Average monthly allowance/income				
< 10,000	21 (44.7)	26 (55.3)	10.182	**0.037**
10,000 – 30,000	73 (44.0)	93 (56.0)		
31,000 – 50,000	84 (59.6)	57 (40.4)		
51,000 – 70,000	20 (44.4)	25 (55.6)		
>70,000	19 (61.3)	12 (38.7)		
Completed registration at health center				
Yes	124 (51.7)	116 (48.3)	0.314	0.627
No	93 (48.9)	97 (51.1)		
Sponsor of respondent				
Parents	200 (50.6)	195 (49.4)	10.943	**0.005**
Self	8 (32.0)	17 (68.0)		
Both	7 (100.0)	0 (0.0)		
Uncle	2 (66.7)	1 (33.3)		
Level				
200	49 (39.5)	75 (60.5)	17.032	**0.002**
300	58 (45.7)	69 (54.3)		
400	71 (64.5)	39 (35.5)		
500	30 (57.7)	22 (42.3)		
600	9 (52.9)	8 (47.1)		

Among the respondents, the age group over 25 years had the highest proportion of self-medication practice, with 20 (58.8%) participants reporting self-medication. The association between age and self-medication practice was not statistically significant ($\chi2 = 5.563$, $p = 0.061$).

A slightly higher proportion of female respondents, 101 (52.3%), engaged in self-medication compared to male respondents, 116 (48.9%). However, the association between sex and self-medication was not statistically significant ($\chi2 = 0.488$, $p = 0.499$).

Single respondents reported a higher prevalence of self-medication, 217 (50.9%), compared to married respondents, where none reported self-medication. The association between marital status and self-medication approached statistical significance ($\chi2 = 4.113$, $p = 0.059$).

Respondents living off-campus had a higher proportion of self-medication practice, 88 (53.0%), compared to those living on campus, 129 (48.9%). However, the association between accommodation and self-medication was not statistically significant ($\chi2 = 0.702$, $p = 0.429$).

In terms of average monthly allowance, respondents earning more than ₦70,000 had the highest prevalence of self-medication, 19 (61.3%), followed closely by those earning ₦31,000 – ₦50,000, 84 (59.6%). The association between monthly allowance and self-medication was statistically significant ($\chi2 = 10.182$, $p = 0.037$).

Respondents who completed registration at the health center had a slightly higher proportion of self-medication, 124 (51.7%), compared to those who did not, 93

(48.9%). However, the association between health center registration and self-medication was not statistically significant ($\chi2 = 0.314$, $p = 0.627$).

In terms of sponsorship, respondents sponsored by their parents had the highest proportion of self-medication, 200 (50.6%), while self-sponsored respondents had the lowest, 8 (32.0%). The association between sponsorship and self-medication was statistically significant ($\chi2 = 10.943$, $p = 0.005$).

Regarding academic level, respondents in the 400 level had the highest proportion of self-medication practice, 71 (64.5%), while those in the 200 level had the lowest, 49 (39.5%). The association between academic level and self-medication was statistically significant ($\chi2 = 17.032$, $p = 0.002$).

TABLE 12: SOCIO-DEMOGRAPHIC CHARACTERISTICS AND VACCINATION PRACTICE AMONG RESPONDENTS*

Variables	Vaccination (n = 430)		Fishers Exact	p-value
	Yes (%)	No (%)		
Age				
16 – 20	18 (10.0)	162 (90.0)	19.137	**<0.001**
21 – 25	54 (25.0)	162 (75.0)		
>25	11 (32.4)	23 (67.6)		
Sex				
Male	48 (20.3)	189 (79.7)	0.306	0.624
Female	35 (18.1)	158 (81.9)		
Marital Status				
Single	82 (19.2)	344 (80.8)	0.084	0.577
Married	1 (25.0)	3 (75.0)		
Accommodation				
On campus	51 (19.3)	213 (80.7)	0.001	0.548
Off campus	32 (19.3)	134 (80.7)		
Average monthly allowance/income				
< 10,000	5 (10.6)	42 (89.4)	24.913	**<0.001**
10,000 – 30,000	20 (12.0)	146 (88.0)		
31,000 – 50,000	30 (21.3)	111 (78.7)		
51,000 – 70,000	13 (28.9)	32 (71.1)		
>70,000	15 (48.4)	16 (51.6)		
Completed registration at health center				
Yes	60 (25.0)	180 (75.0)	11.320	**0.001**
No	23 (12.1)	167 (87.9)		
Sponsor of respondent				
Parents	75 (19.0)	320 (81.0)	6.925	**0.049**
Self	3 (12.0)	22 (88.0)		
Both	4 (57.1)	3 (42.9)		
Uncle	1 (33.3)	2 (66.7)		
Level				
200	11 (8.9)	113 (91.1)	26.788	**<0.001**
300	21 (16.5)	106 (83.5)		
400	25 (22.7)	85 (77.3)		
500	17 (32.7)	35 (67.3)		
600	9 (52.9)	8 (47.1)		

*Vaccines such as Hepatitis B, Covid-19, Tetanus and Yellow fever

Among the age groups, respondents over 25 years had the highest proportion of vaccination, with 11 (32.4%) reporting having been vaccinated, followed by those aged 21-25 years at 54 (25.0%). The age group 16-20 years had the lowest vaccination rate, with only 18 (10.0%) reporting vaccination. The association between age and vaccination practice was statistically significant ($\chi2 = 19.137$, $p < 0.001$).

In terms of sex, a slightly higher proportion of male respondents, 48 (20.3%), reported vaccination compared to female respondents, 35 (18.1%). However, the association between sex and vaccination practice was not statistically significant ($\chi2 = 0.306$*, $p = 0.624$).

Single respondents had a vaccination rate of 82 (19.2%), while married respondents had a slightly higher rate of 1 (25.0%). This difference was not statistically significant ($\chi2 = 0.084$*, $p = 0.577$).

Regarding accommodation, respondents living on campus and off-campus had equal vaccination rates of 19.3%. The association between accommodation and vaccination practice was not statistically significant ($\chi2 = 0.001$*, $p = 0.548$).

In terms of average monthly allowance, respondents earning more than ₦70,000 had the highest vaccination rate, 15 (48.4%), while those earning less than ₦10,000 had the lowest rate, 5 (10.6%). The association between monthly allowance and vaccination practice was statistically significant ($\chi2 = 24.913$, $p < 0.001$).

Respondents who had completed registration at the health center had a higher vaccination rate, 60 (25.0%), compared to those who had not completed registration, 23 (12.1%). This association was statistically significant ($\chi 2 = 11.320^*$, $p = 0.001$).

Regarding sponsorship, respondents sponsored by their parents had a vaccination rate of 75 (19.0%), while self-sponsored respondents had a lower rate of 3 (12.0%). Respondents sponsored by both parents and another relative had the highest vaccination rate, 4 (57.1%). The association between sponsorship and vaccination was statistically significant ($\chi 2 = 6.925$, $p = 0.049$).

In terms of academic level, respondents in the 600 level had the highest vaccination rate, 9 (52.9%), followed by those in the 500 level, 17 (32.7%). The 200-level respondents had the lowest vaccination rate, 11 (8.9%). The association between academic level and vaccination practice was statistically significant ($\chi 2 = 26.788$, $p < 0.001$).

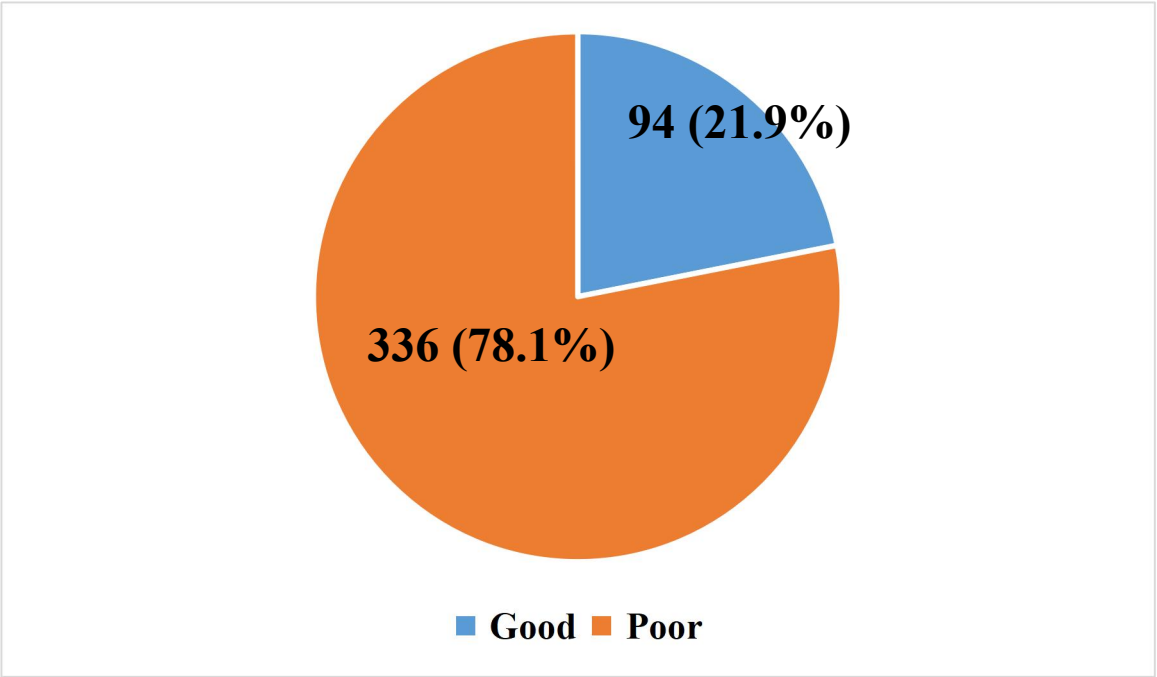

FIGURE 3: showing the practice. Majority of respondents, 336 (78.1%) had poor practice while 94 (21.95%) had good practice

TABLE 13: SOCIO-DEMOGRAPHIC CHARACTERISTICS AND PRACTICE OF HEALTHCARE AMONG RESPONDENTS

Variables	Practice (n = 430)		Fishers' Exact	p-value
	Good (%)	Poor (%)		
Age				
16 – 20	33 (18.3)	147 (81.7)	5.779	0.122
21 – 25	53 (24.5)	163 (75.5)		
26 – 30	7 (21.2)	26 (78.8)		
>30	1 (100.0)	0 (0.0)		
Sex				
Male	54 (22.8)	183 (77.2)	0.264	0.607
Female	40 (20.7)	153 (79.3)		
Marital Status				
Single	92 (21.6)	334 (78.4)	1.872	0.171
Married	2 (50.0)	2 (50.0)		
Accommodation				
On campus	61 (23.1)	203 (76.9)	0.621	0.431
Off campus	33 (19.9)	133 (80.1)		
Average monthly allowance/income				
< 10,000	5 (10.6)	42 (89.4)	11.826	**0.019**
10,000 – 30,000	42 (25.3)	124 (74.7)		
31,000 – 50,000	23 (16.3)	118 (83.7)		
51,000 – 70,000	13 (28.9)	32 (71.1)		
>70,000	11 (35.5)	20 (64.5)		
Level				
200	28 (22.6)	96 (77.4)	1.960	0.743
300	25 (19.7)	102 (80.3)		
400	22 (20.0)	88 (80.0)		
500	14 (26.9)	38 (73.1)		
600	5 (29.4)	12 (70.6)		
Completed registration at health center				
Yes	64 (26.7)	176 (73.3)	7.345	**0.007**
No	30 (15.8)	160 (84.2)		

Among respondents aged 16 to 20 years, 33 (18.3%) had good practice toward healthcare compared to 147 (81.7%) with poor practice. Respondents aged 21 to 25 years had a slightly higher proportion of good practice, 53 (24.5%), compared to those with poor practice, 163 (75.5%). The association between age and practice was not statistically significant ($\chi2 = 5.779$; $p = 0.122$).

In terms of sex, a higher proportion of male respondents, 54 (22.8%), had good practice compared to female respondents, 40 (20.7%). However, the association between sex and practice was not statistically significant ($\chi2 = 0.264$; $p = 0.607$).

For marital status, 92 (21.6%) of single respondents had good practice compared to 334 (78.4%) with poor practice, while 2 (50.0%) of married respondents had good practice. The association between marital status and practice was not statistically significant ($\chi2 = 1.872$; $p = 0.171$).

Respondents residing on campus had a higher proportion of good practice, 61 (23.1%), compared to those living off campus, 33 (19.9%). The association between accommodation and practice was not statistically significant ($\chi2 = 0.621$; $p = 0.431$).

A significant association was observed between average monthly allowance and practice. Respondents with a monthly allowance of less than ₦10,000 had the lowest proportion of good practice, 5 (10.6%), while those earning over ₦70,000 had the highest, 11 (35.5%) ($\chi2 = 11.826$; $p = 0.019$).

In terms of academic level, 600 Level respondents had the highest proportion of good practice, with 5 (29.4%) reporting good practice, followed by 500 Level with 14 (26.9%) showing good practice. However, 300 Level respondents had a lower proportion of good practice, with 25 (19.7%) demonstrating good practice. The association between level and practice was also not statistically significant ($\chi2 = 1.960$; $p = 0.743$).

A greater proportion of respondents who had completed registration at the health center, 64 (26.7%), had good practice compared to those who had not, 30 (15.8%). The association between health center registration and practice was statistically significant ($\chi 2 = 7.345$; $p = 0.007$).

SECTION E:

FACTORS ASSOCIATED WITH IDEAL HEALTH SEEKING BEHAVIORS

TABLE 14: FACTORS ASSOCIATED WITH IDEAL HEALTH SEEKING BEHAVIORS AMONG RESPONDENTS

Variables	Frequency (n = 430)	Percent (%)
Specific healthcare upkeep		
Yes	98	22.8
Adequate healthcare upkeep	**n = 98**	
Yes	61	62.2
Time to utilize healthcare services		
Yes	234	54.4
Unfavorable hospital environment	168	39.1
Yes		
Delays and long procedures at health facility		
Yes	379	88.1
Health Insurance Policy		
Yes	85	19.8
When you utilize hospital/healthcare services		
Caregivers	285	66.3
Self	96	22.3
Friends	22	5.1
Expensive healthcare		
Yes	369	85.8
Minor illness		
Yes	302	70.2
Transit time to health center		
<15 minutes	60	14.0
15-30 minutes	263	61.2
31-45 minutes	47	10.9
46-60 minutes	41	9.5
>60 minutes	19	4.4
Perception of distance		
Too far to walk	308	54.7
Not too far to walk	122	44.9
Encouragement to seek healthcare		
Yes	308	71.6

Out of 430 respondents, 98 (22.8%) reported maintaining specific healthcare upkeep. Among those, 61 (62.2%) indicated their healthcare upkeep was adequate. A majority of respondents, 234 (54.4%), indicated that they had time to utilize healthcare services. Additionally, 168 respondents (39.1%) reported an unfavorable hospital environment. A significant proportion of respondents, 379 (88.1%), experienced delays and long procedures at health facilities. Health insurance coverage was reported by 85 respondents (19.8%).

When utilizing hospital or healthcare services, the majority, 285 (66.3%), relied on caregivers, while 96 (22.3%) handled it themselves. A smaller group, 22 respondents (5.1%), relied on friends. Furthermore, 369 respondents (85.8%) believed that healthcare services were expensive, while 302 (70.2%) sought healthcare even for minor illnesses.

Regarding proximity to health centers, most respondents, 263 (61.2%), lived 15–30 minutes away, followed by 60 (14.0%) who lived within 15 minutes. A smaller number, 19 respondents (4.4%), lived more than 60 minutes away. Additionally, 308 respondents (54.7%) reported that the distance to the health center was too far to walk, while 122 (44.9%) felt it was manageable.

Finally, the majority of respondents, 308 (71.6%), indicated they were encouraged to seek healthcare.

TABLE 15: FACTORS ASSOCIATED WITH THE HEALTH SEEKING PRACTICES OF RESPONDENTS

Variables	Practice (n = 430)	Fishers'	p-value

	Good (%)	Poor (%)	Exact	
Specific upkeep for healthcare				
Yes	73 (22.3)	259 (28.0)	0.014	0.906
No	21 (21.4)	77 (78.6)		
Time to utilize healthcare				
Yes	67 (28.6)	167 (71.4)	13.783	**<0.001**
No	27 (13.8)	169 (86.2)		
Unfavorable hospital environment				
Yes	29 (17.3)	139 (82.7)	3.413	0.065
No	65 (24.8)	197 (75.2)		
Delays and long procedures at health facility	61 (23.1)	203 (76.9)	0.621	0.431
Yes	83 (21.9)	296 (78.1)	0.003	0.957
No	11 (21.6)	40 (78.4)		
Health insurance				
Yes	18 (22.2)	63 (77.8)	0.008	0.930
No	76 (21.8)	273 (78.2)		
Transit time to health center				
<15 minutes	16 (26.7)	44 (73.3)	2.625	0.622
15-30 minutes	59 (22.4)	204 (77.6)		
31-45 minutes	9 (19.1)	38 (80.9)		
46-60 minutes	8 (19.5)	33 (80.5)		
>60 minutes	2 (10.5)	17 (89.5)		
Perception of distance				
Too far to walk	47 (20.0)	188 (80.0)	1.171	0.279
Not too far to walk	59 (75.6)	47 (24.4)		

Respondents who maintained specific upkeep for healthcare had a slightly higher proportion of good practice, 73 (22.3%), compared to those who did not, 21 (21.4%). However, the association between specific upkeep for healthcare and practice was not

statistically significant ($\chi 2 = 0.014$; p-value = 0.906). A higher proportion of respondents who had time to utilize healthcare, 67 (28.6%), reported good practice compared to those who did not, 27 (13.8%). The association between time to utilize healthcare and practice was statistically significant ($\chi 2 = 13.783$; p-value < 0.001). Among respondents who reported an unfavorable hospital environment, 29 (17.3%) had good practice compared to 65 (24.8%) of those who did not. However, the association between hospital environment and practice was not statistically significant ($\chi 2 = 3.413$; p-value = 0.065).

For respondents who experienced delays and long procedures at the health facility, 61 (23.1%) had good practice compared to 11 (21.6%) of those who did not. The association between delays at health facilities and practice was not statistically significant ($\chi 2 = 0.621$; p-value = 0.431).

Among those with health insurance, 18 (22.2%) had good practice compared to 76 (21.8%) of those without insurance. The association between health insurance and practice was not statistically significant ($\chi 2 = 0.008$; p-value = 0.930).

Respondents who lived within 15 minutes of a health center had a higher proportion of good practice, 16 (26.7%), compared to those who lived more than 60 minutes away, 2 (10.5%). However, the association between distance to the health center and practice was not statistically significant ($\chi 2 = 2.625$; p-value = 0.622).

CHAPTER FIVE
DISCUSSION

The health seeking behavior of undergraduate students plays a pivotal role in determining their overall well-being, academic output and productivity, hence the need for this discourse at this time.

Majority of the respondents in this study fell within the age range of 21-25 years. This is similar to a study conducted in southwestern Nigeria which revealed same findings[1]. The predominant ethnic group was Benin, given that the university is located within Benin city, Edo state. A significant majority of the respondents were Christians and were single.

The study also revealed that over half of the respondents resided within the campus and a significant majority (over nine-tenth) were supported financially by their parents.

A significant majority (over four fifths) knew the location of the health center. This could be owing to the fact that a good majority of them resided within the campus and as such were familiar with the facilities within the campus. This is similar to a study done in South Western Nigeria which revealed that majority of the students knew the location and were registered at the health center.[2] Awareness of the location of nearby health facilities is essential as it may encourage uptake of services rendered by the facility thus preventing delay in presentation and fostering quick recovery from illnesses.

Majority of the respondents were not aware of TSHIP. This could be attributed to a reduced public awareness efforts of the health care facilities within the state as it concerns TSHIP as a good majority of respondents relied on health facilities for sourcing healthcare information. This is in contrast to a study conducted in Nnamdi

Azikuwe University which revealed that virtually all the students were aware of the TISHIP.[3] Awareness of available health care services such as TISHIP plays a significant role in uptake of health services as it reduces out of pocket payment thus, making healthcare more financially accessible.

Majority of the students had good knowledge of the ideal utilization of healthcare services and older age categories demonstrated better level of knowledge. This could be due to the fact that older individuals are likely to be more cautious about their health than the younger ones. This is similar to a study done in India which revealed that students were generally more aware about their health and the need to seek help when necessary.[30] Good knowledge on the ideal utilization of health services is vital as it may eventually result in appropriate in health seeking practices.

As it concerns attitude, a higher proportion of females had good health seeking attitudes compared to the males. This may be because females find it easier to open up about health concerns. This is similar to a study done in Canada which revealed indeed that females had better health seeking practices than males.[31] Majority of respondents generally had good attitude towards health seeking. This could be as a result of their established good knowledge and perception of health care. generally.This is in contrast with a study done in Obafemi Awolowo University which revealed that a majority of the respondents had poor attitude towards health seeking. Developing a good attitude to health seeking is crucial in the establishment of a healthy and productive society.

A significant majority had poor health seeking practices, and low allowance was associated with poorer health seeking practices. This could be as a result of the fact that majority of respondents had less than 50,000 assigned for monthly upkeep and over four fifth did not have health insurance. This is similar to a study conducted in

southwestern Nigeria which revealed also that about half of the students had poor health seeking practices as well. [1]Poor health seeking practices can be detrimental to the well-being and productivity of students as it would result in delayed resolution of symptoms and possible complications thus leading to loss of productive hours. Furthermore, the respondents who had completed registration at the health center had a higher vaccination rate compared to those who had not completed. This may be due to the fact that those who completed their health clearance are more likely to utilize the health centre than those who did not. This is similar with a study conducted in South Western Nigeria, which revealed that those who completed their health clearance generally utilized the health centres sevices more . Vaccination services against commonly endemic diseases is relevant as it prevents onset of these diseases, thus reducing healthcare expenditure and time lost during illness episode.

Concerning the factors associated with their health seeking practices, a higher proportion of students who usually had time to visit the health center had good health care practices compared to the proportion of those who claimed they didn't usually have the time to visit the health facility. This is tandem with a study done in South Eastern Nigeria which revealed similar findings. The importance of students prioritizing and dedicating time to cater for their health needs cannot be over emphasized as students would generally be better efficient in their studies when their health is optimal.

Additionally, the proportion of respondents with good health seeking practices who resided much closer to the facility was higher than those who stayed afar off. This is similar to a study done in Bangladesh, which revealed that the further the distance respondents stays away from the health facilities, the lesser the uptake.[32] This highlights the importance of careful and strategic siting of health facilities with

respect to proximity to residential areas as it potends to increase the utilization of facilities.

Utilization of health services was higher in those that had health insurance compared to those who did not. A study conducted in Iran revealed similar findings, as respondents who had health insurance coverage used health services more.[33] Availability of accessible health insurance schemes is pivotal to increasing uptake of health services when needed, thus fulfilling the overarching goal of SDG.[3]

Moreover, it was observed as well that the proportion of students who perceived the health facilities as unfavorable had poorer health seeking practices compared with those who had a favorable perception. This is similar to a study conducted in South Western Nigeria.[8] It is vital for health care facilities to improve their service delivery processes so as to encourage utilization of these facilities

CONCLUSION

The study revealed that the majority of undergraduate students generally possessed a solid understanding of the available healthcare services, indicating a high level of awareness, however their knowledge of TSHIP was low.

Most undergraduate students expressed a generally positive attitude toward the accessibility, affordability, and of healthcare services, reflecting favorable perceptions.

Despite their good knowledge and positive attitudes, a significant proportion of students demonstrated poor healthcare-seeking practices, highlighting a gap between knowledge and practice.

Key factors such as time constraints and limited monthly allowances were found to significantly impact students' healthcare-seeking behaviors, despite their overall good knowledge and attitude.

RECOMMENDATIONS

To the Federal Government

1. Allocate more resources to improve the accessibility, affordability, and quality of healthcare services, especially for students.
2. Implement and enhance affordable student health insurance schemes to reduce the financial burden of seeking healthcare.
3. They should upgrade healthcare facilities across universities to ensure students have access to quality services.

To the State Government

1. They should invest in improving primary healthcare centers near universities to enhance their capacity to meet student needs.
2. Work closely with universities to integrate healthcare awareness and preventive health measures into the educational system.

To the University authorities

1. Offer mental health services to address the stress and time-management issues affecting students' healthcare-seeking practices.
2. Universities should invest in expanding and upgrading on-campus health centers to ensure students have easy access to quality healthcare.
3. They should Incorporate regular health education programs, seminars, or workshops to promote better healthcare knowledge and proactive attitudes among students.

To undergraduates

1. Develop better budgeting strategies to ensure that monthly allowances can cover essential healthcare needs.

2. Adopt preventive healthcare practices such as regular screenings, vaccinations, and healthy lifestyle choices to reduce the need for urgent medical care.
3. Make better use of campus healthcare facilities and services that are often designed to be more affordable and accessible.

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APPENDIX

APPENDIX: QUESTIONNAIRE

HEALTH SEEKING BEHAVIOR

Dear respondent, I am a 600 level student at the School of Medicine, University of Benin, Benin City. I am researching to assess the health seeking behaviors of undergraduates of University of Benin, Edo State, Nigeria. This questionnaire will aid as a tool for data collection in this research. Your sincere response will be appreciated.

SECTION A: SOCIODEMOGRAPHIC CHARACTERISTICS

1. Age in years as at last birthday _____
2. Sex: Male [ ] Female [ ]
3. Religion: Christian[ ] Islam [ ] ATR [ ] Others [ ]
4. Ethnicity: _____
5. Faculty: _____
6. Department _____
7. Level: _____
8. Marital status: _____
9. Who is your sponsor? Parents [ ] Self [ ] Others specify _____
10. How much is your average monthly allowance/income? < N10,000[ ] N10,000 - N30,000[ ] N31,000 – N50,000[ ] N 51,000 - N 70,000[ ] > N 70, 000[ ]
11. Accommodation: On campus [ ] Off campus [ ]

12. Have you completed your registration at the health centre? Yes [ ] No [ ]

SECTION B: KNOWLEDGE OF IDEAL HEALTH SEEKING BEHAVIOURS

13. Do you know where the university health centre is located? Yes [ ] No [ ]
14. Have you heard of TISHIP before now? Yes [ ] No [ ]
15. What is the meaning of TISHIP? Tertiary Institution Social Health Insurance Programme [ ] Today's Institution Students' Health Insurance Programme [ ] Today's Institutions Social Health Insurance Programme [ ] Tertiary Insurance Students' Health Institution Programme [ ]
16. How did you know about TISHIP? News [ ] Social media [ ] Family and friends [ ] Health facility [ ] Others specify _____
17. What are the sources of health care information you know? Hospitals/ health centre [ ] Government agencies [ ] Social media [ ] Family and friend [ ]

The questions below will assess your knowledge towards health seeking ranging from how strongly you agree with a statement to how strongly you disagree. Tick a single option that is most applicable to you.

S/N	KNOWLEDGE	Strongly Agree	Agree	Undecided	Disagree	Strongly disagree
17.	The hospital/health care is the best place to receive health services?					
18.	Doctors are well trained to render the best health care?					
19.	Students should primarily rely on self-medication for treatment of illnesses					
20.	It is very important to consult professional help when feeling unwell?					

21.	Reputable medical websites are trustworthy sources of medical information					

SECTION C: ATTITUDE OF UNDERGRADUATES TOWARDS HEALTH SEEKING

The questions below will assess your attitude towards health seeking ranging from how strongly you agree with a statement to how strongly you disagree. Tick a single option that is most applicable to you.

S/N	ATTITUDE	Strongly Agree	Agree	Undecided	Disagree	Strongly disagree
22.	I believe it is important to see a healthcare professional for any health concern					
23.	I would prefer to treat a minor illness myself than go to the doctor					
24.	Talking openly about health problems with friends and family is more helpful than seeing a doctor					
25.	I am comfortable discussing personal health issues with a healthcare professional					
26.	I trust the information I find online about health issues					
27.	I need to be pressured before utilizing healthcare services					
28.	Delaying professional care for a minor symptom can cause consequences					

SECTION D: UTILIZATION OF HEALTH CARE FACILITIES

29. Have you ever experienced symptoms of illnesses in the last one year? Yes [ ] No [ ]
30. If yes, what symptom have you experienced? Headache [ ] Fever [ ] Abdominal pain [ ] Cough and catarrh [ ] Tooth ache [ ] Others specify _____
31. What did you do when you noticed the symptom(s)? Did nothing/rest [ ] Use spiritual methods [ ] Took herbs [ ] Visited patent medical store [ ] Went to the hospital or Health Centre [ ] Treatment from the internet/colleague [ ]
32. When do you utilize Hospital/ Health Centre services? Occasionally, even without symptoms [ ] When symptoms appear [ ] When symptom becomes unbearable [ ] When it affects my facial appearance [ ] When someone I know just died from such symptom [ ]
33. Do you self-medicate?
34. If yes, why? _____
35. Have you received any vaccines since your commencement of your study at the university?
36. If yes, which vaccines _____
37. If yes to 35, where did you receive the vaccine

SECTION E: FACTORS ASSOCIATED WITH HEALTH SEEKING BEHAVIOUR OF UNDERGRADUATES

SECTION E1: Factors that hinder formal healthcare-seeking behavior

38. Do you have a specific upkeep for healthcare? Yes [ ] No [ ]
39. If yes, do you think it is adequate?

40. Do you usually have the time to utilize healthcare facilities when ill? Yes [ ] No [ ]
41. Do you consider the hospital/health centre environment unfavorable? Yes [ ] No [ ]
42. Are there delays and long procedures at health facilities? Yes [ ] No [ ]
43. Do you have any health insurance policy? Yes [ ] No [ ]
44. If no, how do you fund your health needs? Caregiver/sponsor [ ] Self [ ] Friends [ ] Others specify _____
45. Do you consider the cost of healthcare expensive? Yes [ ] No [ ]
46. Do you consider your illnesses as minor? Yes [ ] No [ ]

SECTION E2: Factors that promote formal healthcare-seeking behaviour

47. How long does it take to walk down to the nearest health facility?
48. How do you consider the distance to be? Too far to walk [ ] Not too far to walk [ ]
49. Has anyone ever encouraged you to visit the hospital / health centre when ill? Yes [ ] No [ ]
50. If yes, who? _____

INFORMED CONSENT FORM

TITLE OF STUDY: Healthcare seeking behaviour of undergraduate students: a case study of University of Benin

INSTITUTION: School of Medicine, College of Medical Sciences, University of Benin, Benin City, Edo State.

PRINCIPAL INVESTIGATORS: Chijioke Samuel Ukalike and Matilda Onyebuchi Utulu

PARTICIPATION: Participation in this study is voluntary. Refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. You may discontinue your participation at any time without penalty or loss of benefits. The principal investigators may decide to withdraw you from the study if we are unable to obtain the necessary information.

INTRODUCTION: We are interested in assessing the health seeking behavior of undergraduates We will only ask questions on knowledge, attitude and practice regarding healthcare seeking practices.

PROCEDURES TO BE FOLLOWED

QUESTIONNAIRE: If you agree to participate, I will ask you questions about your socio-demographic data, knowledge of healthcare services, attitude towards health care and practices regarding healthcare service utilization.

BENEFITS: You will be enlightened on proper health seeking practices.

COMPENSATION: There is no compensation to volunteers for their participation.

DURATION OF PARTICIPATION: This study only requires the questionnaire. There is no follow-up or further information needed.

WHO CAN PARTICIPATE IN THIS STUDY: the study focuses on the effect of nutrition on healthcare seeking behavior among undergraduates in the University of Benin. The participants will be selected from all the 15 faculties within the university.

ASSURANCE OF CONFIDENTIALITY OF VOLUNTEER'S IDENTITY: Records relating to your participation in the study will remain confidential. Your name will not be used in any report resulting this study. All questionnaires, computerized records, and analysis of data will contain only a unique study number, not your name.

PERSONS AND PLACES FOR ANSWERS REGARDING YOUR RIGHTS AS A RESEARCH SUBJECT: If during the course of this study you have questions concerning the nature of the research or you believe you have sustained a research-related injury or assault; you should contact;

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Ethics and Research Committee,

Email: ubthresearchethics@gmail.com

IF THERE IS ANY PORTION OF THIS CONSENT AGREEMENT THAT YOU DO NOT UNDERSTAND, ASK THE FIELD WORKER OR INVESTIGATOR BEFORE SIGNING.

Please, sign below if you have agreed to participate in the study.

CERTIFICATION OF CONSENT

I, ……. having full capacity to consent for myself do thereby to my participation in the research study.

The methods and means by which the study will be conducted and the risks which may be reasonably expected have been explained to me by Ethical Committee. I have been given the opportunity to ask question concerning

this investigational study, and any such questions have been answered to my full and complete satisfaction.

I understand that I may at any time during the course of this study revoke this consent and withdraw myself from the study without prejudice.

Subject's Signature: _____ Date: