



Original Research

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UTILIZATION OF SPEECH-LANGUAGE PATHOLOGY SERVICES AMONG PARENTS OF CHILDREN WITH SPEECH AND LANGUAGE DISORDERS IN IBADAN, NIGERIA

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ABSTRACT

Background: Pediatric speech-language disorders present a global health challenge, yet service utilization remains suboptimal in developing contexts. This study investigated the determinants of Speech-Language Pathology (SLP) service utilization among parents in Ibadan, Nigeria, specifically examining the interplay between healthcare system barriers and socio-cultural factors.

Methods: Using a quantitative, cross-sectional design derived from a larger sequential exploratory mixed-methods study, 211 parents were recruited via multi-stage sampling from 10 urban and rural schools. Data were collected through an interviewer-administered questionnaire (Cronbach's $\alpha = .81$) developed from preliminary qualitative themes. Binary logistic regression was employed to identify sociodemographic predictors of service utilization and perceived barriers.

Results: Only 37.4% ($n = 79$) of parents had utilized SLP services. Logistic regression identified post-secondary education ($OR = 3.16$, $p = .001$) and urban residence ($OR = 2.56$, $p = .003$) as the strongest predictors of service use. Financial constraints (90.0%) and accessibility issues (85.7%) were the most prevalent systemic barriers; rural residents were significantly more likely to report financial hurdles ($OR = 3.06$, $p = .004$) and long hospital wait times ($OR = 2.18$, $p = .018$). Socio-cultural barriers were prominent, with 77.7% of parents citing ignorance and 60.1% reporting psychological denial. While ignorance was linked to rurality ($p = .005$), parental denial was significantly higher among urban residents ($OR = 1.99$, $p = .033$). Gender did not significantly predict utilization or barrier perception ($p > .05$).

Conclusion: Service utilization is driven by educational awareness and geographical proximity, but hindered by a complex paradox: rural parents face structural and financial exclusion, while urban parents are deterred by psychological denial. Interventions must move beyond infrastructure to include targeted public health campaigns that address diagnostic denial and improve community-level awareness.

Keywords: Speech-Language Pathology, Service Utilization, Healthcare Barriers, Socio-cultural Factors, Speech-Language Disorders, Children

INTRODUCTION

Speech and language disorders remain one of the most common disabilities of childhood, affecting approximately 7-10% of children worldwide [1]. These disorders manifest as problems in the acquisition and development of language skills, characterized by difficulties in understanding others or expressing oneself, limited vocabulary, and reduced grammar skills [2]. In Nigeria, speech and language disorders affect up to 16% of children, with prevalence rates varying across regions and communities [3]. The variation in prevalence rates may result from several factors including poor reporting and identification of cases, inadequate funding for research and

treatment, limited availability of trained professionals in speech therapy services, cultural beliefs, and attitudes towards disabilities [4]. Children with speech and language disorders are at an increased risk of poor academic performance, social isolation, and mental health problems [5,6]. Speech-language therapy services have been found effective in treating speech and language disorders [7,8]. Children exposed to speech and language services show significant improvements in their ability to communicate effectively, understand and use language, and develop appropriate social communication skills [8]. However, even though speech-language therapy has demonstrated effectiveness, service availability and access remain limited in Nigeria, particularly in rural areas. The implementation of community-based rehabilitation programs remains insufficient, resulting in significant challenges for families in specific geographic regions [9]. Additionally, the financial burden of out-of-pocket healthcare expenses, extended waiting times at healthcare facilities, and deficiencies in the country's healthcare infrastructure present considerable hindrances for parents seeking speech and language therapy for their children [10]. These systemic issues highlight the need to understand factors affecting the utilization of SLP services within the Nigerian context. Prior studies in sub-Saharan Africa have documented similar challenges, including workforce shortages and geographical maldistribution of speech-language pathologists [9,11]. However, few studies have systematically examined the interplay between systemic barriers and socio-cultural factors in a single framework, particularly in the Nigerian context. Understanding these determinants is essential for developing targeted interventions to improve access and utilization of SLP services. This study investigated the factors influencing the utilization of SLP services among parents of children with speech and language disorders in Ibadan, Nigeria.

MATERIALS AND METHODS

Study Design

This study reports the quantitative phase of a larger sequential exploratory mixed-methods research project. The overarching study investigated the management of speech and language disorders among parents in Ibadan, Nigeria. In the initial qualitative phase, semi-structured interviews were conducted to identify key themes, which subsequently informed the development of the quantitative survey instrument. This paper presents the findings from the survey regarding systemic and socio-cultural factors influencing parental utilization of speech-language pathology (SLP) services.

Sample and Sampling Procedure

The target population consisted of parents of children diagnosed with, or exhibiting signs of, speech and language disorders in Ibadan. A total of 211 parents were recruited through a **multi-stage sampling procedure**.

Stage 1 (Selection of LGAs): Four Local Government Areas (LGAs) were stratified into two urban and two rural districts and selected from the 11 LGAs in Ibadan using simple random sampling (balloting without replacement).

Stage 2 (Selection of Schools): Ten schools (five urban, five rural) were randomly selected from within the identified LGAs using simple random sampling. School names were entered into a sampling frame, and random selection was performed using a random number generator.

Stage 3 (Participant Identification and Recruitment): The identification and recruitment of participants followed a school-based referral protocol. Class teachers and school heads acted as key informants to nominate pupils who demonstrated persistent communication difficulties, such as delayed speech onset or limited expressive vocabulary. Following nomination, school heads

acted as liaisons to contact the mothers and fathers of the identified pupils. Research assistants then recruited the parents during scheduled school visits or Parent-Teacher Association (PTA) meetings. This gatekeeper-mediated approach allowed for the identification of a specific, non-clinical population that might otherwise be difficult to reach.

Inclusion Criteria

Participants were required to meet the following criteria: (a) be the biological mother or father of a child with a speech and language disorder as identified by school-based nomination and parental confirmation, and (b) demonstrate voluntary willingness to participate through provision of written informed consent.

Instrumentation

The research tool was an **interviewer-administered questionnaire** designed to accommodate varying literacy levels and ensure data completeness through direct interaction. The instrument was developed based on qualitative findings from the larger exploratory study and comprised three sections:

Section A: Demographic Characteristics: This section established the profile of the study population, collecting data on parental age, educational level, occupation, and the child's age. These variables served as independent variables (IVs) for the inferential analysis.

Section B: Healthcare System Factors Scale: This subscale consisted of five items assessing systemic barriers (e.g., "The distance to the therapy center is a major barrier to my attendance"). Items were rated on a 4-point Likert scale ranging from 1 (*Strongly Disagree*) to 4 (*Strongly Agree*). Total scores ranged from 5 to 20, where higher scores indicated a more favorable perception of the healthcare system. The subscale demonstrated strong internal consistency ($\alpha = .84$).

Section C: Socio-cultural Factors Scale: This section comprised five items exploring cultural and social influences, such as community encouragement and cultural beliefs. Utilizing the same 4-point Likert scale, scores above the midpoint of 12.5 indicated that socio-cultural factors were a facilitating force, while lower scores suggested cultural barriers or stigma. This subscale yielded a Cronbach's alpha of $\alpha = .79$.

Instrument Development: Exploratory Qualitative Phase

The questionnaire items were derived from an initial qualitative phase involving 20 semi-structured interviews with parents of children with speech and language disorders in Ibadan. Interviews explored parents' experiences, perceptions, and barriers to seeking SLP services. Thematic analysis of interview transcripts yielded six major themes: financial constraints, accessibility issues, infrastructural deficits, quality of service, shortage of SLPs, and socio-cultural factors (ignorance, social influence, and parental denial). These themes directly informed the construction of questionnaire items, ensuring content validity and cultural relevance.

Questionnaire Translation and Validation

Translation Procedure: The English version of the questionnaire was translated into Yoruba by two independent bilingual translators fluent in both English and Yoruba. A third bilingual expert reconciled the two translations to produce a single Yoruba version. This version was then back-translated into English by a different bilingual translator who was blind to the original English version. The back-translated version was compared with the original English version by the research team to identify and resolve any discrepancies, ensuring semantic, conceptual, and cultural equivalence.

Validation: The Yoruba version was pilot-tested with 20 parents in a neighboring district to assess comprehensibility and cultural appropriateness. Face and content validity were established

by a panel of three experts in SLP and public health, resulting in a **Content Validity Index (CVI) of .92**. The total 10-item scale yielded a Cronbach's alpha of $\alpha = .81$, and a test-retest procedure performed over a two-week interval resulted in a Pearson correlation coefficient of $r = .85$, suggesting high instrument stability.

Data Collection Procedure

The questionnaire was administered in both English and Yoruba based on participant preference to ensure linguistic accuracy. Trained graduate research assistants managed the informed consent process and conducted the interviews in private school settings after school hours. Assistants followed a standardized protocol to rephrase or clarify questions for participants when necessary, ensuring consistent understanding without introducing interviewer bias. The data collection process spanned three weeks, with each session lasting approximately 20 minutes per participant.

Data Analysis

Data were analyzed using IBM SPSS Statistics version 23.0. Demographic data and barrier prevalence were analyzed using descriptive statistics, including frequencies, percentages, and means. Inferential analysis utilized binary logistic regression to measure and predict associations between sociodemographic independent variables and the specific healthcare and socio-cultural barriers (dependent variables). All statistical tests were conducted at a significance level of $\alpha = .05$.

Ethical Considerations

Ethical approval was granted by the Oyo State Ethical Review Committee. The study adhered to the principles of the Declaration of Helsinki, ensuring participant confidentiality, anonymity, and the right to withdraw at any stage without penalty. Written informed consent was obtained from all participants prior to data collection.

RESULTS

Socio-demographic Characteristics

Table 1 provides an overview of the demographic characteristics of the 211 parents who participated in the study. The majority were female (64.0%), above age 40 (51.2%), lived in urban areas (56.9%), and had post-secondary education (57.9%).

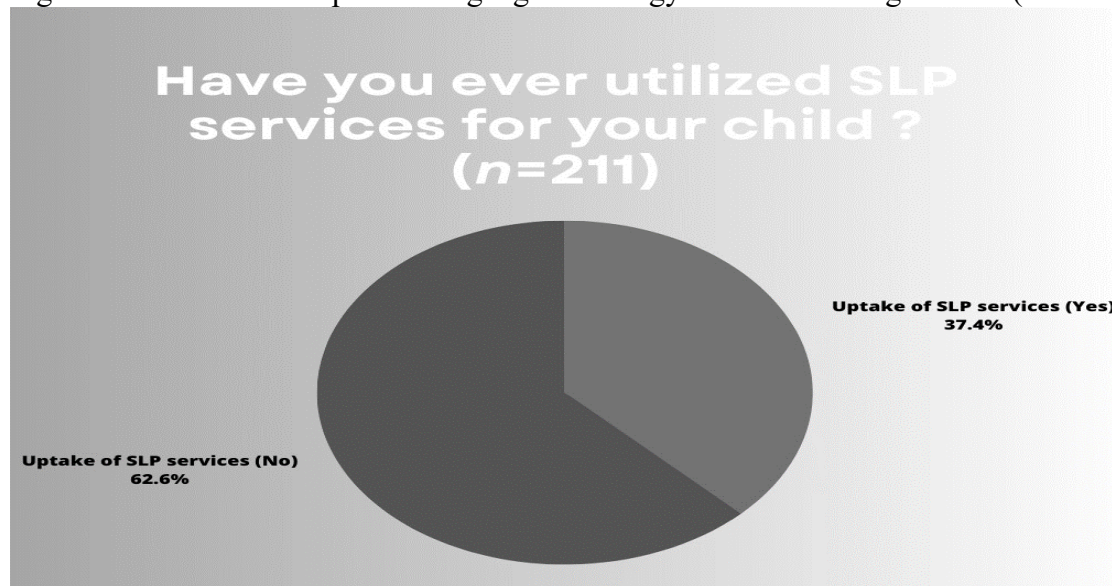
Table 1: Sociodemographic Characteristics of Participants (N = 211)

Variable	Frequency (n)	Percentage (%)
Settlement		
Urban	120	56.9
Rural	91	43.1
Age (years)		
Below 40	103	48.8
Above 40	108	51.2
Gender		
Male	76	36.0
Female	135	64.0
Highest Qualification		
Secondary Education and Below	89	42.1
Post-Secondary Education	122	57.9

Parents' Utilization of SLP Service

The study revealed that only 79 out of 211 (37.4%) parents had utilized SLP services, while 132 (62.6%) had not. Figure 1 illustrates this utilization pattern.

Figure 1: Utilization of Speech-Language Pathology Services Among Parents (N = 211)



Predictors of Utilization: Logistic Regression Analysis: Table 2 presents the binary logistic regression analysis predicting SLP service utilization.

Table 2: Binary Logistic Regression Predicting the Odds of SLP Service Utilization (N = 211)

Predictor (IV)	B	SE	Wald	p	OR	95% CI
Residence (Urban)	0.94	0.32	8.61	.003	2.56	[1.36, 4.81]
Education (High)	1.15	0.35	10.81	.001	3.16	[1.59, 6.27]
Age (> 40)	0.21	0.30	0.49	.484	1.23	[0.68, 2.22]
Gender (Female)	0.45	0.31	2.11	.146	1.57	[0.85, 2.89]
Constant	-1.82	0.44	17.13	<.001	0.16	

Note. OR = Odds Ratio; CI = Confidence Interval. Reference groups: Rural, Low Education, Age < 40, Male. Bold p-values indicate significance at < .05.

The logistic regression model was statistically significant, $\chi^2(4) = 38.42$, $p < .001$, explaining approximately 23.4% (Nagelkerke R^2) of the variance in service utilization. Residence and Education emerged as the only significant predictors of service use. Parents residing in urban areas were 2.56 times more likely to utilize SLP services compared to those in rural areas (OR = 2.56, $p = .003$). Education proved to be the strongest predictor; parents with post-secondary education had 3.16 times higher odds of utilizing services than those with below-secondary education (OR = 3.16, $p = .001$). Neither Gender ($p = .146$) nor Age ($p = .484$) were significant independent predictors of utilization.

Healthcare System Barriers

Table 3 presents the prevalence of specific healthcare system obstacles as perceived by the participants (N = 211).

Table 3: Frequency Distribution of Healthcare System Barriers (N = 211)

Healthcare Barrier Variable	Agree/Strongly Agree n (%)	Disagree/Strongly Disagree n (%)
Financial constraints	190 (90.0)	21 (10.0)
Accessibility issues	181 (85.7)	30 (14.3)
Infrastructural deficits	180 (85.3)	31 (14.7)
Quality of service	157 (74.4)	54 (25.6)
Shortage of qualified SLPs	136 (64.4)	75 (35.6)
Hospital wait times	132 (62.5)	79 (37.5)

Systemic barriers were nearly universal in this population. Financial constraints were the most pervasive barrier (90.0%), followed by accessibility issues (85.7%) and infrastructural deficits (85.3%). A substantial majority also expressed concerns regarding quality-of-service delivery (74.4%) and the acute shortage of qualified Speech-Language Pathologists (64.4%), while 62.5% reported that long hospital wait times acted as a deterrent.

Table 4: Multivariate Logistic Regression for Predictors of Healthcare Barriers

Dependent Variable (Barrier)	Independent Variable (IV)	B	SE	Wald	p	OR	95% CI
Financial Constraints	Residence (Rural)	1.12	0.38	8.69	.004	3.06	[1.45, 6.47]
	Age (< 40)	0.68	0.34	4.01	.046	1.97	[1.01, 3.84]
	Education (Low)	0.81	0.36	5.06	.025	2.25	[1.11, 4.56]
	Gender (Female)	-0.22	0.31	0.50	.481	0.80	[0.44, 1.47]
Accessibility Issues	Residence (Rural)	0.98	0.36	7.41	.007	2.66	[1.31, 5.41]
	Age (< 40)	0.15	0.31	0.23	.631	1.16	[0.63, 2.13]
	Education (Low)	0.74	0.36	4.22	.039	2.10	[1.04, 4.24]
	Gender (Female)	-0.41	0.32	1.64	.201	0.66	[0.35, 1.25]
Infrastructural Deficits	Residence (Rural)	1.15	0.39	8.70	.003	3.16	[1.47, 6.78]
	Age (< 40)	0.28	0.32	0.77	.380	1.32	[0.70, 2.49]
	Education (High)	0.89	0.35	6.47	.011	2.44	[1.23, 4.82]
	Gender (Female)	0.11	0.33	0.11	.740	1.12	[0.59, 2.12]
Quality of Service	Residence (Urban)	0.76	0.32	5.64	.017	2.14	[1.14, 4.01]
	Age (< 40)	0.31	0.34	0.83	.362	1.36	[0.70, 2.64]
	Education (High)	1.04	0.36	8.35	.004	2.83	[1.40, 5.72]
	Gender (Female)	0.05	0.29	0.03	.862	1.05	[0.60, 1.84]
Shortage of SLPs	Residence (Urban)	0.65	0.30	4.69	.028	1.92	[1.07, 3.44]
	Age (< 40)	0.12	0.29	0.17	.680	1.13	[0.64, 1.99]
	Education (High)	0.21	0.28	0.56	.454	1.23	[0.71, 2.13]
	Gender (Female)	-0.24	0.28	0.73	.393	0.79	[0.46, 1.36]
Hospital Wait Times	Residence (Rural)	0.78	0.33	5.59	.018	2.18	[1.14, 4.17]
	Age (< 40)	0.08	0.29	0.08	.777	1.08	[0.61, 1.92]
	Education (Low)	0.44	0.31	2.02	.155	1.55	[0.84, 2.86]
	Gender (Female)	-0.19	0.28	0.46	.498	0.83	[0.48, 1.43]

Note. Bold *p*-values indicate significance at < .05.

Geographical residence and educational attainment were the most robust predictors of systemic barriers. Rural parents faced significantly higher odds across nearly all structural categories, most notably for infrastructural deficits (OR = 3.16, $p = .003$) and financial constraints (OR = 3.06, $p = .004$). Younger parents (under 40) were nearly twice as likely to cite financial limitations as a deterrent compared to their older counterparts (OR = 1.97, $p = .046$). A distinct trend emerged regarding service quality and workforce availability. Parents with higher levels of education had significantly higher odds of identifying poor service quality (OR = 2.83, $p = .004$) and infrastructural gaps (OR = 2.44, $p = .011$) as barriers. Similarly, urban residents were 2.14 times more likely to report service quality issues ($p = .017$) and 1.92 times more likely to identify the shortage of qualified SLPs ($p = .028$). Across all models, gender remained non-significant ($p > .05$).

Socio-cultural Factors: Table 5 presents the frequency distribution of socio-cultural factors.

Table 5: Frequency Distribution of Socio-cultural Factors (N = 211)

Healthcare Barrier Variable	Agree/Strongly Agree n (%)	Disagree/Strongly Disagree n (%)
Ignorance/Lack of awareness	164 (77.7)	47 (22.3)
Social influence (Family/Friends)	146 (69.1)	65 (30.9)
Parental denial	127 (60.1)	84 (39.9)

A substantial majority of participants (77.7%) identified ignorance as a primary barrier, acknowledging that a lack of understanding of the nature and benefits of SLP hinders service engagement. Social influence from family, friends, and neighbors was cited by 69.1% of parents as a significant determinant. Furthermore, 60.1% of parents reported that psychological denial served as a major obstacle.

Multivariate Predictors of Socio-cultural Factors: Table 6 presents the multivariate logistic regression analysis for predictors of socio-cultural factors.

Table 6: Multivariate Logistic Regression for Predictors of Socio-cultural Factors

Dependent Variable (Barrier)	Independent Variable (IV)	B	SE	Wald	p	OR	95% CI
Ignorance	Residence (Rural)	1.06	0.38	7.78	.005	2.89	[1.37, 6.08]
	Age (< 40)	0.22	0.34	0.42	.517	1.25	[0.64, 2.44]
	Education (Low)	0.92	0.36	6.52	.011	2.51	[1.24, 5.08]
	Gender (Female)	0.14	0.33	0.18	.671	1.15	[0.60, 2.20]
Social Influence	Residence (Rural)	0.82	0.35	5.59	.018	2.27	[1.15, 4.49]
	Age (< 40)	0.18	0.32	0.32	.572	1.20	[0.64, 2.24]
	Education (Low)	0.33	0.34	0.94	.332	1.39	[0.71, 2.71]
	Gender (Female)	0.58	0.32	3.24	.072	1.79	[0.95, 3.37]
Parental Denial	Residence (Urban)	0.69	0.32	4.55	.033	1.99	[1.05, 3.76]
	Age (< 40)	0.24	0.31	0.60	.438	1.27	[0.69, 2.34]
	Education (High)	0.48	0.33	2.11	.146	1.62	[0.85, 3.11]
	Gender (Male)	0.54	0.30	3.24	.072	1.72	[0.95, 3.11]

Note. Bold p -values indicate significance at $< .05$.

Ignorance was significantly predicted by residence ($p = .005$) and education ($p = .011$), with rural parents and those with lower educational attainment being 2.89 and 2.51 times more likely,

respectively, to report a lack of awareness as a barrier. Social influence was significantly stronger in rural settings (OR = 2.27, $p = .018$). In contrast, **Parental Denial** was more prevalent among urban residents, who had 1.99 times higher odds of citing this as a barrier compared to rural residents ($p = .033$). Gender showed a marginally significant trend across several models ($p = .072$), with female parents 1.79 times more likely to be affected by social influence, while male parents were 1.72 times more likely to exhibit denial.

DISCUSSION

This study provides valuable insights into the factors influencing the utilization of SLP services among parents of children with communication disorders in Ibadan. A key finding was the substantial utilization gap, with only 37.4% of parents having accessed SLP services. This finding is consistent with previous research documenting suboptimal service utilization in resource-limited settings [9,11]. Financial constraints emerged as the most dominant barrier (90.0%), supporting prior research on the role of affordability in accessing SLP services [12]. Given that speech therapy often requires multiple sessions, families with limited financial resources may find it challenging to sustain treatment. Younger parents and rural residents were more likely to encounter financial difficulties, consistent with findings from previous studies [13]. The relationship between parental age and financial constraints presents a novel finding, suggesting that younger parents who may not have achieved financial stability face greater barriers. This underscores the need for government intervention and inclusion of SLP services in health insurance coverage, particularly for younger demographic groups. Long hospital waiting times (62.5%) posed a significant challenge. Extended waiting times may be attributed to insufficient manpower, poor infrastructure, and lengthy assessment procedures [14]. These systemic difficulties may lead to discouragement and loss of hope among parents, ultimately affecting utilization. This finding aligns with previous research demonstrating the negative consequences of treatment delays on both psychological and financial outcomes for families [14].

Geographic location remained a well-documented barrier to SLP service utilization, particularly in rural areas [9,15]. Our findings confirmed that rural residents faced significantly higher odds across nearly all structural categories, most notably for infrastructural deficits (OR = 3.16) and financial constraints (OR = 3.06). This geographical disparity highlights the need for decentralized service delivery models and mobile health interventions to reach underserved populations. A significant finding was parents' report of poor service delivery. While this issue is not uncommon in health systems in low- and middle-income countries, it is particularly concerning in the SLP context as it may erode parents' confidence in therapy effectiveness. Existing studies suggest that insufficient training, limited supervision of SLPs, and inadequate resources for continuing professional development may be contributing factors [16]. This highlights the need for effective governance and leadership to establish training programs, ensure adequate supervision, and provide ongoing professional development opportunities. The need for infrastructural improvements was also evident, as poor infrastructure was another factor influencing utilization. Poor availability of speech-language assessment tools and inadequate technology contribute significantly to barriers [9]. This further highlights the need for increased funding and support for the SLP sector to improve infrastructure and enhance service delivery. The shortage of qualified speech-language pathologists poses a significant barrier, consistent with

global reports of SLP shortages in countries such as Canada and Australia [17,18]. The increased demand for rehabilitative care, coupled with declining numbers of trained professionals due to brain drain in Nigeria [10], necessitates urgent investment in training more SLPs and implementing strategies to incentivize the workforce for sustainability and balanced distribution. The strong influence of social and contextual determinants of health on SLP service utilization cannot be overlooked. Family, neighbors, and immediate society play pivotal roles, particularly in resource-limited settings [19]. Social influence may manifest as denial of the existence and severity of speech and language disorders among parents, resulting in delays or lack of interest in seeking necessary services. This observation was more common among rural parents compared to those in urban areas, highlighting the need for improved education and awareness campaigns targeted at such demographic groups [20]. Notably, parental denial was more prevalent among urban residents (OR = 1.99), a counterintuitive finding that may reflect higher expectations, increased exposure to information that creates cognitive dissonance, or greater social stigma associated with disability in urban settings. The finding that gender did not significantly predict utilization or barrier perception suggests that barriers are perceived uniformly by both mothers and fathers. However, the marginal significance of gender in social influence and denial warrants further investigation.

CONCLUSION

This study demonstrates that service utilization among parents of children with speech and language disorders in Ibadan is primarily driven by educational awareness and geographical proximity, but hindered by a complex interplay of systemic and socio-cultural barriers. The utilization gap reflects both structural exclusion affecting rural parents and psychological denial affecting urban parents. Enhancing SLP service utilization requires a multi-pronged approach: (1) investments in adequate infrastructure and deployment of qualified professionals to underserved regions; (2) targeted review and redesign of healthcare financing frameworks, including inclusion of continuous therapeutic services in health insurance schemes; (3) public awareness campaigns tailored to parents and caregivers, particularly in rural areas, focusing on early intervention and available resources; and (4) psychological support interventions to address diagnostic denial, particularly in urban populations.

Study Limitations

This study reports the quantitative portion of a larger sequential mixed-methods study conducted in Ibadan. Therefore, its findings are context-specific and may not be generalizable to other regions. The study's focus on parental perspectives may limit comprehensiveness; including perspectives of speech-language pathologists, pediatricians, and policymakers could provide a more holistic understanding. Future research should include broader geographic scope and more diverse stakeholders to enhance applicability. Nevertheless, this study provides valuable insights into factors influencing speech-language therapy service utilization in Ibadan.

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Conflict of Interest

The authors declare no conflicts of interest.

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