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Cultural And Religious Practices: A Major Challenge Of Public Health In Nigeria

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Abstract:

This study investigated how cultural and religious practices have become a major challenge of public health. A cross-sectional research design was adopted for the study. The population of the study involved 5,408,756 as published by NPC. The sample size was 400 obtained using both purposive random sampling technique and simple random sampling technique. The instrument for data collection was a researcher-adopted questionnaire. The validity of the instrument was ensured, and the reliability index of 0.85 was obtained using spearman correlation. The data collected were analysed and presented in tables and charts, the research question was analysed using simple percentage method and the hypothesis tested using Spearman Correlation. The IBM-SPSS (v. 21) statistical software was employed in the analyses. 400 copies of questionnaires distributed was collected and analysed, giving a response rate of 100%. The findings revealed that there is positive significant ($p < 0.05$) correlation between cultural and religious practices on health-seeking behaviours. There is a positive significant ($p < 0.05$) relationship between religious beliefs and the prevalence of certain health conditions due to reluctance/refusal of medical treatments. Religion has significant ($p < 0.05$) effect in reproductive health issues. Collaborating with religious leaders and faith-based organizations to help in communicating health messages and promoting health-saving practices, training of healthcare providers to become culturally competent, adaptability and flexibility of Public health policies and interventions and effective communication and education campaigns are the identified ways in which the challenges caused by cultural and religion in public health can be prevented/controlled. Based on these findings the study recommended amongst others that there should be a collaboration with religious leaders to promote health education and services, as they can be influential in shaping health-seeking behaviours within their communities. There should be awareness aimed at informing the patients about the consequences of refusing medical treatment and that they understand the potential risks and benefits involved. There should be development of inclusive policies that consider religious perspectives and ensure access to a full range of reproductive health services.

Key Words: Cultural, Religious Practices, Challenge, Public Health, Nigeria

Introduction

One of the major determinants of the rate at which public health-associated activities is being accepted is the community culture and religion. Culture, religion and traditional knowledge have been investigated by scholars to be significantly correlated with some of the variables, proxies and indicators of public health such as food and nutrition security by shaping a community's diet, food preferences, intra-household food distribution patterns, child feeding practices, food processing and preparation techniques, health and sanitation practices, traditional medicine and the accessibility and use of biomedical public health services [1]

Religion often involves some form of belief in supernatural or transcendent realities, such as gods, spirits, or sacred principles [2]. These beliefs may provide explanations for the origin, purpose, and meaning of existence, as well as guidance for moral and ethical

behavior. Religion involves some form of ritual or ceremonial action that expresses or reinforces the beliefs of the adherents [3] These practices may include prayer, worship, meditation, sacrifice, pilgrimage, initiation, or other forms of devotion. Religion in some cases, involves some form of organized community or social structure that supports and regulates the beliefs and practices of the followers. These institutions may include churches, temples, mosques, synagogues, monasteries, schools, or other associations. Religion often involves some form of personal or collective experience of the sacred or divine, such as visions, revelations, miracles, ecstasy, or enlightenment. These experiences may inspire, transform, or challenge the believers and their worldview.

Religion is one of the most important social institutions with pervasive effects on various aspects of people's lives, attitudes and behaviours. This pervasive influence of religion in people's lives is derived from its social functions [4]. As evidently asserts extensively by scholars, among these functions of religion for individuals and groups include enabling people to cope with and face the problems of life and death, health and ill health, success and failure, integrating the society by upholding and legitimizing the social norms and values, including morality.

Religion is a 'powerful structure that can improve the condition of man and the health system in many ways. The potential for organized religious bodies should contribute constructively to the reduction of many health challenges starting from the inherited biological problems, environmentally contacted diseases, common African health problems such as malaria, fever, stomach problem, spiritual sickness, contaminated diseases, projected attack and other related health challenges etc. Most religious leaders should be able to teach their members to be hygienic in nature, create economy viable enough to make them feel well to avoid malnutrition, keep their environment clean to avoid outbreak of diseases and infirmities. Churches and mosques should always build medical centers and provide enough health services that can take care of their sick members. The religious leaders should also educate their members on how to keep their environment clean. Vote for leaders that will improve their living condition irrespective of their religious, cultural and ethnic affiliation. Religious leaders should highlight to their members the need to go to school in order to improve their living standard and take care of their feeding pattern and health condition. The norms, ethics and values of the society that can improve the health system should be made known by the religious leaders and their organizations

Culture although a ubiquitous concept, means the whole complex of traditional behavior which has been developed by the human race and is successively learned by each generation. It can mean the forms of traditional behavior which are characteristic of a given society, or of a group of societies, or of a certain race, or of certain area, or of a certain period of time.

Cultural beliefs and practices have a considerable influence on the health behaviour of Nigerians in spite of the numerous campaigns; awareness etc. carried out by government and other public and private organizations.

There is also a perceived relationship between culture and religion. Religion and culture cannot exist apart from one another. No culture has appeared or developed except together with a religio [5]. According to the point of view of the author, the culture will appear to be the product of the religion": culture is "the incarnation of the religion of a people [6].Since culture is a shared phenomenon, however, its underlying religion is not monolithic the contributions of the multiplied religions of individuals from the whole community converge to create it. As such, the idea of culture is enormously complex. Its practices, patterns, and habits are always formed by a collage of religious worldviews.

The impact of cultural and religious practices on public health in Nigeria is a complex and multifaceted topic. Some of these practices may have positive or negative effects on the health of individuals and communities, depending on the context, interpretation, and implementation of such practices.

Some cultural and religious practices may promote health or prevent disease by encouraging healthy behaviors, providing social support, enhancing psychological well-being, or fostering a sense of identity and belonging. Some of the beneficial cultural practices in Nigeria include the extended family system, which provides child care and emotional support; the respect for elders, which promotes intergenerational solidarity and wisdom; the use of traditional medicine, which may complement modern medicine and offer alternative remedies; and the celebration of festivals, which may enhance social cohesion and happiness [7].

Moreover, some cultural and religious practices may harm health or increase disease risk by discouraging preventive measures, exposing people to infections or injuries, creating stigma or discrimination, or violating human rights. The harmful cultural practices in Nigeria include female genital mutilation, which may cause bleeding, infections, or complications during childbirth; child marriage, which may deprive girls of education, autonomy, and reproductive health; the refusal of blood transfusion, which may endanger the lives of patients who need it for medical reasons; and the belief in witchcraft, which may lead to violence, abuse, or ostracism of accused persons.

Some cultural and religious practices may have mixed or uncertain effects on health, depending on how they are understood, applied, or modified over time. For example, some of the ambiguous cultural and religious practices in Nigeria include the practice of polygamy, which may have positive or negative implications for the health of wives and children, depending on the economic, social, and emotional conditions of the family; the observance of fasting, which may have beneficial or detrimental effects on the physical and mental health of the practitioners, depending on the duration, frequency, and intensity of the fast; and the adherence to dietary laws, which may have advantages or disadvantages for the nutritional status and health outcomes of the followers, depending on the availability, quality, and diversity of food sources. These are some of the ways that cultural and religious practices may impact public health in Nigeria,but they are not exhaustive or definitive. The actual effects of these practices may vary depending on the individual, community, and environmental factors that shape the health of the population. Therefore, it is important to recognize the diversity and dynamism of cultural and religious practices in Nigeria, and to engage with them in a respectful, sensitive, and evidence-based manner [8]

Nigeria is a country with diverse ethnic, cultural, and religious groups, each with its own beliefs and practices that influence health behaviours and outcomes. Some of these practices, such as female genital mutilation, child marriage, refusal of blood transfusion, and vaccine hesitancy, have negative effects on the health and well-being of individuals and communities. These practices are often rooted in tradition, superstition, or misinformation, and are sometimes reinforced by political, social, or economic factors. Public health interventions that aim to prevent or treat diseases, promote healthy

lifestyles, and improve access to health services, face challenges in addressing the cultural and religious barriers that hinder the acceptance and adoption of such interventions [9]. Therefore, there is a need to understand the impact of cultural and religious practices on public health in Nigeria, and to develop strategies that are culturally sensitive, respectful, and effective in improving health outcomes. Some studies have been carried out on this topic by so many researchers. However, there is need for further investigation on and research so as to add to he existing knowledge and available resources. Hence, this study seek to determine how cultural and religious practices have become a major challenge of public health.

Materials And Methods

Research Design

A cross-sectional research design was used for this study. This design allowed for the collection of data, providing a snapshot of the knowledge, perception, attitude and practices of solid waste disposal practices among residents in Owerri Municipal. The cross-sectional design enabled the assessment of various factors related to solid waste disposal practices.

Study Area

Nigeria officially the Federal Republic of Nigeria, is a country in West Africa. It is situated between the Sahel to the north and the Gulf of Guinea to the south in the Atlantic Ocean. It covers an area of 923,769 square kilometres (356,669 sq mi), and with a population of over 230 million, it is the most populous country in Africa, and the world's sixth-most populous country. Nigeria borders Niger in the north, Chad in the northeast, Cameroon in the east, and Benin in the west. Nigeria is a federal republic comprising 36 states and the Federal Capital Territory, where the capital, Abuja, is located. The largest city in Nigeria is Lagos, one of the largest metropolitan areas in the world and the largest in Africa.

Study Population

Thus, the population for this study involved a Imo state as selected part of Nigeria. The total population used in this study was 5,408,756

Sampling Technique

Purposive sampling and simple random sampling technique was employed in this study. The study purposively selected based sampled out the three local government under Owerri zone which are Isiala Mbano, Owerri Municipal and Ikeduru L.G.A. The respondents were then randomly selected from these local governments The subjects for this study were randomly selected based on their willingness to participate within the duration of the study and must have attained the age of 18 years and above.

Instrument for Data Collection

The instruments used in data collection for this study was a structured researcher-developed questionnaire. The questionnaire was distributed to the respondents. This enabled the researcher collect different opinion that enabled to give a balanced judgment on the research problem.

Method of Data Collection

In this study, both primary and secondary data sources were utilized. Primary data for this study was collected from survey, key informant interviews and field observations and field measurement. In addition to these, secondary data were also collected from different sources such as journals, articles, statistical abstracts, books, policy briefs, study reports, theses and dissertations were among others as secondary data sources. These sources of secondary information were obtained from the internet, university libraries, institutions and organizations.

Method of Data Analysis

Descriptive statistics, such as simple percentage method was used to analyse the respondents' demographic characteristics and the responses to each item in the questionnaire. Spearman Correlation Coefficient was employed in the test of hypothesis so as to determine the strength and direction of the relationship between the variables. All data were presented using tables and charts. IBM-SPSS (v. 21) statistical software was employed in the analyses.

Results

Table 4.1 shows that 47.5% of the respondents were male while 52.5% were female. 37.5% of the respondents were between the age of 18-35 and 36-45 years respectively, while 25% were above 46 years. Majority (74.2%) were Christians, 0.8% were Muslim while 25% were traditionalists. 12.5% had no formal education, 20% ad FSLC, 50% had SSCE while 17.5% had B.Sc/HND and above.

Table 4.1: Demographic Characteristics of the Respondents

Variables	Frequency	Percentage (%)
Gender		
Male	190	47.5
Female	210	52.5
Total	**400**	**100**
Age		
18-35	150	37.5
36-45	150	37.5
46>	100	25
Total	**400**	**100**
Religion		
Christianity	297	74.2
Islam	3	0.8
Traditional	100	25
Total	**400**	**100**
Educational Level		
No formal education	50	12.5
FSLC	80	20
SSCE	200	50
B.Sc/HND and above	70	17.5
Total	**400**	**100**

4.1.2 Impact of cultural and religious practices on

health-seeking behaviours

The result on the impact of cultural and religious practices on health seeking behaviour of respondents were presented in table 4.2. 75% positively indicated that cultural and religious beliefs influences their daily life while 25% said no. 77.5% indicated that cultural or religious beliefs influences their decision regarding medical treatments. 8.8% uses traditional remedies instead of or along with modern medicine. 87.5 uses it sometimes while 3.75 never used it.

Table 4.2: Impact of cultural and religious practices on health-seeking behaviours

Variables	Frequency	Percentage (%)
Influence of cultural or religious beliefs on daily life		
Yes	**300**	**75**
No	**100**	**25**
Total	**400**	**100**
Influence of cultural or religious beliefs on decision regarding medical treatments		
Yes	**310**	**77.5**
No	**90**	**22.5**
Total	**400**	**100**
Preference on certain types of health services or practitioners due to your cultural or religious beliefs		
Yes	**290**	**72.5**
No	**110**	**27.5**
Total	**400**	**100**
Used traditional remedies instead of or along with modern medicine		
Always	**35**	**8.8**
Sometimes	**350**	**87.5**
Never	**15**	**3.75**
Total	**400**	**100**

4.1.3 Relationship between religious beliefs and the prevalence of certain health conditions due to reluctance/refusal of medical treatments

Table 4.3 shows that majority (70%) positively indicated that there are specific health treatments or interventions that their culture or religious community typically refuses or discourages. 110 27.5% respondents indicated that their culture or religious community typically refuses or discourages blood transfusion and organ donation, 300 (75%) refuses abortion, 130 (35.7%) refuses artificial insemination, 80 (20%) believes on divine healing only and 200 (50%) refuses artificial birth control.

Table 4.3Relationship between religious beliefs and the prevalence of certain health conditions due to reluctance/refusal of medical treatments

Variables	Frequency	Percentage (%)
Specific health treatments or interventions that your culture or religious community typically refuses or discourages		
Yes	280	70.0
No	120	30.0
Total	**400**	**100**
List of health treatments or interventions that your culture or religious community typically refuses or discourages		
Refusal of blood transfusion and organ donation	110	27.5
Discouragement of abortion	300	75.0
Refusal of artificial insemination	130	35.7
Believe on divine healing only	80	20.0
Refusal of artificial birth control	200	50.0
Opinion on how the refusal of certain medical treatments influenced the prevalence of health conditions within community		
Increased significantly	200	50
Increased Slightly	100	25
No change	40	10
Decreased	60	15
Total	**400**	**100**

4.1.4 Effect of religion in reproductive health issues

table 4.4 indicates that 77.5% of the respondents positively indicated that religious background has influenced their views on reproductive health (e.g., contraception, family planning, abortion). Majority (80.0%) believe that religious institutions should play a role in providing reproductive health education, while 20.0% do not believe.

Table 4.4 Effect of religion in reproductive health issues

Variables	Frequency	Percentage (%)
If religious background has ever influenced views on reproductive health (e.g., contraception, family planning, abortion)		
Yes	310	77.5
No	90	22.5
Total	**400**	**100**

Believe that religious institutions should play a role in providing reproductive health education		
Yes	320	80
No	80	20
Total	**400**	**100**

4.1.5 Ways of controlling the challenges caused by cultural and religion in public health

The result of this study showed that about 200 (50%) of the respondents suggested that their should be **co**llaborating with religious leaders and faith-based organizations to help in communicating health messages and promoting health-saving practices. About 300 (75%) suggested that training of healthcare providers to become culturally competent. Adaptability and flexibility of Public health policies and interventions was suggested by 150 (37.5%) while 180 (45%) suggested effective communication and education campaigns.

Table 4.5 Ways of controlling the challenges caused by cultural and religion in public health

Variables	Frequency	Percentage (%)
Collaborating with religious leaders and faith-based organizations to help in communicating health messages and promoting health-saving practices	200	50
Training of Healthcare providers to become culturally competent	300	75
Adaptability and flexibility of Public health policies and interventions	150	37.5
Effective communication and education campaigns	180	45

4.2 Test of Hypothesis

The hypothesis formulated in chapter on of this study are re-stated and tested as follows;

Ho1: There is no significant correlation betweencultural and religious practices on health-seeking behaviours.

Decision on this hypothesis is based on the result presented in table 4.6. There is a positive significant correlation (rs = 0.875; p 0.011) between cultural and religious practices on health-seeking behaviours. Based on these, the null hypothesis was rejected and the alternative which states that there is significant correlation between cultural and religious practices on health-seeking behaviours was accepted

Table 4.6 Correlations between cultural and religious practices on health-seeking behaviours

			CRP	HSB
Spearman's rho	CRP	Correlation Coefficient	1.000	.875**
		Sig. (2-tailed)	.	.011
		N	400	400
	HSB	Correlation Coefficient	.875**	1.000
		Sig. (2-tailed)	.011	.
		N	400	400

**. Correlation is significant at the 0.05 level (2-tailed); CRP cultural and religious practice; HSB health-seeking behaviours

Ho_2: There is no relationship between religious beliefs and the prevalence of certain health conditions due to reluctance/refusal of medical treatments.

Decision on this hypothesis is based on the result presented in table 4.7. The r_s value was given at r_s 0.403 while the associated p value of 0.001 which is less than 0.05 level of significance. The implicationof this is that there is positive significant relationship betweenreligious beliefs and the prevalence of certain health conditions due to reluctance/refusal of medical treatments. Hence, the null hypothesis was rejected and the alternative was accepted

Table 4.8: Relationship between religious beliefs and the prevalence of certain health conditions due to reluctance/refusal of medical treatments

			RB	PCHC
Spearman's rho	RB	Correlation Coefficient	1.000	.403**
		Sig. (2-tailed)	.	.001
		N	400	400
	PCHC	Correlation Coefficient	.403**	1.000
		Sig. (2-tailed)	.001	.
		N	400	620

**. Correlation is significant at the 0.05 level (2-tailed); RB religious believe; PCHC prevalence of certain health conditions

Ho_3: Religion has no significant effect on reproductive health issues.

Decision on this hypothesis is based on the result presented on table 4.8. There was a strong, positive significant relationship between religion and reproductive health issues.

Hence, the null hypothesis was rejected and alternative accepted. This is because the calculated r statistics which was given at 0.928 with an associated p value of 0.002 is < 0.05 level of significance.

Table 4.8: Relationship between religion and reproductive health issues.

			ReB	ReH
Spearman's rho	ReB	Correlation Coefficient	1.000	.928**
		Sig. (2-tailed)	.	.002
		N	400	400
	ReH	Correlation Coefficient	.928**	1.000
		Sig. (2-tailed)	.002	.
		N	400	400
**. Correlation is significant at the 0.01 level (2-tailed);ReB religious believe; ReH reproductive health issues				

Discussion

In this study, that 47.5% of the respondents were male while 52.5% were female. 37.5% of the respondents were between the age of 18-35 and 36-45 years respectively, while 25% were above 46 years. Majority (74.2%) were Christians, 0.8% were Muslim while 25% were traditionalists. The possible cause of this might be due to the fact that Christianity is the major religion in the south-eastern Nigeria. 12.5% had no formal education, 20% ad FSLC, 50% had SSCE while 17.5% had B.Sc/HND and above. It is crystal clear that the educational status of a given population is solely dependent on the level of income of such population. In line with this, it was discovered that income level and educational level or qualifications are not the same in a population [10]. In the study of [11], women were higher in number.

In this study, a positive significant correlation was found between cultural and religious practices on health-seeking behaviours. This finding suggests that there is a statistically meaningful relationship where cultural and religious practices are associated with the way individuals seek health services. This means that as the adherence to cultural and religious practices increases, so does the likelihood of engaging in certain health-seeking behaviours. this is in line with the findings of [12] Who discovered that the inclusion of religious faith did have a significant impact on the lifestyle choices of those who practised them.

There is a positive relationship between religious beliefs and the prevalence of certain health conditions due to reluctance/refusal of medical treatments. The findings of this study suggests that in some cases, strong religious beliefs may lead to higher instances of certain health conditions[13]. This is attributed to the fact that some individuals or communities may be hesitant or refuse medical treatments based on their religious convictions. In line with this, it was found out that there was a relationship between religious beliefs and the prevalence of certain health conditions [14,15].

Also, religion has significant effect on reproductive health issues. Argueably, the overall effect of religion on reproductive health issues is multifaceted and can be both positive and negative, depending on the context and the specific religious teachings involved. It's important for public health professionals to understand and respect these religious perspectives when designing and implementing health interventions. Therefore, it is important to recognize the complex interplay between religious beliefs, cultural contexts, and health policies to understand their collective impact on reproductive health issues [16].

Furthermore, the ways identified in controlling the challenges caused by culture and religion on public health was collaboration with religious leaders and faith-based organizations to help in communicating health messages and promoting health-saving practices, training of healthcare providers to become culturally competent, adaptability and flexibility of Public health policies and interventions and effective communication and education campaigns are the identified ways in which the challenges caused by cultural and religion in public health can be prevented/controlled [17].

Conclusion

The present study was carried out in Nigeria precisely Imo state and assessed how culture and religious believe has been a challenge to public health. There was positive significant correlation between cultural and religious practices on health-seeking behaviours. Furthermore, there was a positive relationship between religious beliefs and the prevalence of certain health conditions due to reluctance/refusal of medical treatments. At the same time, religion has significant effect in reproductive health issues. Collaborating with religious leaders and faith-based organizations to help in communicating health messages and promoting health-saving practices, training of healthcare providers to become culturally competent, adaptability and flexibility of Public health policies and interventions and effective communication and education campaigns are the identified ways in which the challenges caused by cultural and religion in public health can be prevented controlled.

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