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Cultural and religious factors shaping health-seeking behaviour in a Nigerian tertiary hospital

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Abstract

Background: Healthcare-seeking behaviour significantly impacts health outcomes, particularly in low- and middle-income countries where delays in accessing formal care are common. In Nigeria, cultural and religious beliefs deeply shape how and when individuals seek healthcare, often influencing treatment decisions and timing. Objective: This study explores the cultural and religious factors affecting outpatient healthcare-seeking behaviour at the Irrua Specialist Teaching Hospital (ISTH) in Edo State, Nigeria. Methods: A cross-sectional study was conducted from October 2023 to January 2024 among 70 adult outpatients at ISTH using systematic random sampling. Data were collected via structured interviewer-administered questionnaires covering demographics, religious and cultural affiliations, and healthcare-seeking practices. Data analysis involved descriptive statistics and chi-square tests to assess associations, with significance set at $p < 0.05$. Results: Most respondents were young (54.3% aged 18–25) and single (85.7%). Sixty-four percent reported that culture or religion influenced their health-seeking, with 84.3% having communicated these preferences to providers. Despite positive perceptions of cultural accommodation, 82.9% had previously opted out of care due to religious or cultural reasons. Females reported significantly more positive perceptions of care than males ($p = 0.016$). No significant differences in cultural/religious health practices were observed across demographic groups. Conclusion: Cultural and religious beliefs strongly shape healthcare-seeking behaviour at ISTH, affecting timely access to care. Health systems should integrate culturally sensitive practices and actively engage community and religious leaders to reduce delays and improve outcomes in similar settings.

Keywords: *Cultural factors, religious beliefs, Outpatients, Healthcare-seeking behaviors, Nigeria.*

Introduction

Healthcare-seeking behaviour, the process by which individuals recognize symptoms and decide when, where, and how to seek care, is a major determinant of health outcomes. Globally, the World Health Organization emphasizes that early and appropriate care-seeking is key to preventing disease progression, reducing mortality, and improving health system efficiency.[1] However, in many low- and middle-income countries (LMICs), particularly in sub-Saharan Africa, delays in accessing formal healthcare remain widespread.[2] These delays contribute significantly to the burden of preventable morbidity and mortality.

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Evidence shows that, beyond structural barriers like cost or distance, cultural and religious beliefs play a powerful role in shaping healthcare-seeking behaviour[3,4]. In many societies, illness is not viewed purely through a biomedical lens but is interpreted through spiritual, social, or traditional frameworks. This influences not only how symptoms are understood but also the perceived appropriateness of different forms of treatment. Religious leaders, traditional healers, and community norms often guide health decisions[5].

In the African region, it is estimated that more than 50% of people are estimated to consult traditional or religious healers before seeking care at formal health facilities.[6,7] Illness is frequently attributed to supernatural causes such as spiritual attacks or divine punishment, leading to a reliance on prayers, herbal remedies, or rituals. This

behaviour delays diagnosis, interrupts treatment adherence, and contributes to poor outcomes for both communicable and non-communicable diseases.

Nigeria, with over 220 million people and wide ethno-religious diversity, presents a striking case. Despite improvements in health infrastructure and coverage, health service utilization remains suboptimal. The 2018 Nigeria Demographic and Health Survey (NDHS) reported that nearly 40% of children and adults with symptoms did not seek formal care.[8,9] Cultural prescriptions, gender roles, and religious convictions remain central to healthcare choices.

In Edo State, located in Nigeria's South-South region, the intersection of Pentecostal Christianity, Islam, and traditional beliefs influences local healthcare-seeking patterns. The Irrua Specialist Teaching Hospital (ISTH), a major referral centre in the region, frequently receives patients who present late in the course of illness or only after exhausting traditional or faith-based options. Such delays increase the clinical and economic burden on the health system and jeopardize patient outcomes.

Despite growing attention to healthcare access in Nigeria, there remains limited empirical data on how cultural and religious beliefs shape health-seeking at the point of care. This study investigates the cultural and religious influences on outpatient health-seeking behaviour at ISTH. Findings from this research will inform locally tailored interventions and public health messaging aimed at improving timely utilization of healthcare services.

Materials and Method

Study Area

The study was conducted at the outpatient department of Irrua Specialist Teaching Hospital (ISTH), located in Irrua, Edo State, Nigeria. Established in 1993, ISTH serves as a major tertiary referral centre for Edo Central and surrounding regions, including parts of Delta, Kogi, and Ondo States. It is affiliated with Ambrose Alli University, Ekpoma, for clinical training and research. With a 422-bed capacity and a large clinical workforce, ISTH provides both outpatient and inpatient services to a diverse patient population.

Study Population

The study population consisted of adult patients attending the General Outpatient Department (GOPD) and Consultant Outpatient Department (COPD) of ISTH during the study period. The inclusion criteria were adults aged 18 years and above who identified with a religious or cultural belief system and accessed conventional healthcare services. Patients who were not present during the study period or who did not give informed consent were excluded.

Data Collection

Data were collected over a four-month period from October 2023 to January 2024 using a structured, interviewer-administered questionnaire. A systematic random sampling technique was adopted, where every third eligible outpatient was invited to participate until the desired sample size was reached. The questionnaire collected information on demographic characteristics, religious and cultural affiliations, and patterns of health-seeking behaviour. Trained research assistants conducted face-to-face interviews in English or local dialects with interpretation when needed, ensuring accuracy and completeness of responses.

Data Analysis

Data were entered, cleaned, and analyzed using IBM SPSS Statistics version 25.0. Descriptive statistics, including frequencies and percentages, were used to summarize participant characteristics and response patterns. Associations between cultural or religious variables and health-seeking behaviour were examined using the chi-square test. A p-value of less than 0.05 was considered statistically significant.

Ethical Considerations

Ethical approval for this study was obtained from the Ethics and Research Committee of the Irrua Specialist Teaching Hospital (ISTH). Written informed consent was obtained from all participants after they were provided with a clear explanation of the study objectives and procedures. Participation was voluntary, and confidentiality was maintained by anonymizing responses and securing all data.

Limitations

This study was limited to patients who accessed outpatient services at ISTH and may not represent the experiences of individuals who rely exclusively on traditional or religious healing systems, or those in other regions of Nigeria. To mitigate this, patients were sampled across both general and consultant outpatient units to reflect a wide range of experiences. Additionally, the use of self-reported data posed risks of recall and social desirability bias. These were minimized through interviewer training, private administration of questionnaires, and reassurance of confidentiality and neutrality throughout the data collection process.

Results

Sociodemographic Characteristics of Respondents (Table 1)

Among the 70 respondents, 37 (52.9%) were male and 33 (47.1%) were female. The most common age group was 18–25 years, accounting for 38 (54.3%) of participants, followed by 26–35 years with 20 (28.6%) and >35 years with 12 (16.1%). The majority identified as Bini 39 (55.7%), while 28 (40.0%) were Esan and 3 (4.3%) belonged to other ethnic groups. In terms of religion, 22 (31.4%) were Christians, 19 (27.1%) Muslims, 17 (24.3%) traditionalists, and 12 (17.1%) identified as atheist or agnostic. Most respondents were single 60 (85.7%), while 10 (14.3%) were married.

Table 1: Sociodemographic Characteristics of Respondents

Variable	Frequency (n=70)	Percentage (%)
Sex		
Male	37	52.9
Female	33	47.1
Age range (years)		
18-25	38	54.3
26-35	20	28.6
>35	12	16.1
Ethnic group		
Bini	39	55.7
Esan	28	40.0
Others	3	4.3
Religion		
Christian	22	31.4
Muslim	19	27.1
Traditional	17	24.3
Atheist/Agnostic	12	17.1
Marital Status		
Single	60	85.7
Married	10	14.3

Cultural and Religious Influences on Health-Seeking Behaviour (Table 2)

Cultural and religious beliefs influenced health-seeking behaviour for 45 (64.3%) respondents. However, 51 (72.9%) did not support teaching cultural practices in healthcare. A majority, 59 (84.3%), had suggested their religious or cultural preference to providers, and 27 (38.6%) had requested the presence of a religious leader during care. About 25 (35.7%) sought religious affirmation before visiting the hospital. Most respondents, 54 (77.1%), preferred combining religion or culture with care, and 31 (44.3%) had recommended this to others. Notably, 53 (75.7%) indicated that religion influenced their medical decisions, and the same number were open to options that challenged their beliefs.

Table 2: Cultural and Religious Influences on Health-Seeking Behaviour

Variable	Frequency (n=70)	Percentage (%)
Religion/culture influence health-seeking		
Yes	45	64.3
No	25	35.7
Cultural practices should be taught in healthcare		
Yes	19	27.1
No	51	72.9
Suggested religion/culture to provider		
Yes	59	84.3
No	11	15.7
Requested religious leader during care		
Yes	27	38.6
No	43	61.4
Seeks religious affirmation before hospital visit		
Yes	25	35.7
No	45	64.3
Prefers combining religion/culture with care		
Yes	54	77.1
No	16	22.9
Recommends religion/culture to others		
Yes	31	44.3
No	39	55.7
Religion influences medical decisions		
Yes	53	75.7
No	17	24.3
Open to options that challenge beliefs		
Yes	53	75.7
No	17	24.3

Personal Experiences with Religion/Culture and Medical Care (Table 3)

Nearly one-third, 24 (34.3%), reported missing appointments due to religious or cultural obligations. A substantial majority, 57 (81.4%), stated that their religious or cultural practices influenced their health-seeking behaviour. Similarly, 58 (82.9%) had opted out

of medical care for religious or cultural reasons. When asked about institutional responsiveness, 41 (58.6%) believed that ISTH addressed religious and cultural healthcare needs well, while 29 (41.4%) disagreed.

Table 3: Experiences with Religion/Culture and Medical Care

Variable	Frequency (n=70)	Percentage (%)
Have you ever missed an appointment due to religious or cultural obligations?		
Yes	24	34.3
No	46	65.7
Have your religious or cultural practices influenced your health-seeking behaviour?		
Yes	57	81.4
No	13	18.6
Have you ever opted out of medical care because of religion or culture?		
Yes	58	82.9
No	12	17.1
Do you think ISTH addresses religious/cultural healthcare needs well?		
Yes	41	58.6
No	29	41.4

Sociodemographic Factors and Perception of Care (Table 4)

Perception of care varied by sex, with all 33 females reporting a positive perception, compared to 31 (83.8%) of the 37 males; this difference was statistically significant ($\chi^2 = 5.853$, $p = 0.016$). There were no significant associations between perception and age group ($\chi^2 = 4.989$, $p = 0.288$), ethnic group ($\chi^2 = 2.073$, $p = 0.355$), religion ($\chi^2 = 2.332$, $p = 0.506$), or marital status ($\chi^2 = 1.094$, $p = 0.296$).

Sociodemographic Factors and Cultural/Religious Health Practices (Table 5)

There was no statistically significant association between sociodemographic factors and cultural/religious health practices. Although all 37 males reported good practices compared to 30 (90.9%) of the 33 females, the difference did not reach significance ($\chi^2 = 3.514$, $p = 0.061$). Age ($\chi^2 = 0.651$, $p = 0.957$), ethnic group ($\chi^2 = 0.973$, $p = 0.615$), religion ($\chi^2 = 1.614$, $p = 0.656$), and marital status ($\chi^2 = 0.522$, $p = 0.470$) showed no meaningful differences in practice scores.

Table 4: Sociodemographic Factors and Perception of Care

Variable	Perception		X^2	P value
	Negative	Positive		
Sex				
Male	6 (16.2)	31 (83.8)	5.853	0.016
Female	0 (0.0)	33(100.0)		
Age range (years)				
18-25	2 (5.3)	36 (94.7)	4.989	0.288
26-35	4 (20.0)	16 (80.0)		
>35	0 (0.0)	7 (100.0)		
Ethnic group				
Esan	1 (3.6)	27 (96.4)	2.073	0.355
Bini	5 (12.8)	34 (87.2)		
Others	0 (0.0)	3 (100.0)		
Religion				
Christian	3 (13.6)	19(86.4)	2.332	0.506
Muslim	1 (5.3)	18(94.7)		
Traditional	2 (11.8)	15(88.2)		
Agnostic/Atheist	0 (0.0)	12(100.0)		
Marital Status				
Single	6 (10.0)	54 (90.0)	1.094	0.296
Married	0 (0.0)	10(100.0)		

Table 5: Sociodemographic Factors and Cultural/ Religious Health Practices.

Variable	Practice		X^2	P value
	Poor	Good		
Sex				
Male	0 (0.0)	37(100.0)	3.514	0.061
Female	3 (9.1)	30 (90.9)		
Age (years)				
18-25	2 (5.3)	36 (94.7)	0.651	0.957
26-35	1 (5.0)	19 (95.0)		
>35	0 (0.0)	7 (100.0)		
Ethnic group				
Esan	2 (7.1)	26 (92.9)	0.973	0.615
Bini	1 (2.5)	38 (97.5)		
Others	0 (0.0)	3 (100.0)		
Religion				
Christian	0 (0.0)	22 (100.0)	1.614	0.656
Muslim	1 (5.3)	18 (94.7)		
Traditional	1 (5.9)	16 (94.1)		
Atheist/Agnostic	1 (8.3)	11 (91.7)		
Marital Status				
Single	3 (5.0)	57 (95.0)	0.522	0.470
Married	0 (0.0)	10(100.0)		

Discussion

Religious and cultural beliefs were shown to have a strong influence on healthcare behaviours, with over half of respondents acknowledging such influence and more than four-fifths having previously communicated their religious or cultural preferences to healthcare providers. Similar trends have been reported by Agunayi et al.[10] (2025) in Kogi, where patients' cultural identity and religious values often shaped their choice of facility and acceptance of interventions. These findings reflect the integral role of culture and faith in the patient experience, particularly in African contexts where spirituality is deeply embedded in community life. The preference to combine religious/cultural beliefs with care further illustrates the need for integrative, culturally aware healthcare models. Health systems must therefore train providers in cultural competence and foster policies that accommodate non-biomedical belief systems without compromising evidence-based care.

Despite the generally positive perception of cultural inclusion, a concerning pattern persists: a significant number of respondents have previously opted out of medical care or missed appointments due to religious or cultural obligations. This trend mirrors findings by Jellason et al. (2023) in Taraba State, who documented delays in maternal and emergency care due to traditional ceremonies or faith-based prohibitions. The recurrent impact of such practices on timely care-seeking is problematic, particularly in low-resource settings where delays can significantly worsen outcomes. These findings highlight a critical gap in service accessibility—one that is not necessarily logistical, but ideological. Public health campaigns must engage with community and religious leaders to advocate for early and uninterrupted access to healthcare, dispelling myths and offering culturally appropriate alternatives that do not compromise health.

The perception of accommodating cultural and religious beliefs within the health system was overwhelmingly positive, and a statistically significant association observed with sex, with higher levels in females. All female respondents reported a positive perception compared to about four-fifths of males. This sex-based difference in perception is consistent with findings by Daniel[10] (2020), who reported that women were more likely to appreciate culturally sensitive services, particularly in areas such as reproductive and maternal health. The heightened awareness and appreciation among women may stem from their more frequent contact with the health system and their higher vulnerability to culturally mediated care experiences. This suggests that gender-sensitive strategies should be an integral part of institutional efforts to enhance cultural responsiveness. Female patients, in particular, should be continuously engaged in evaluating and co-developing patient-centred models that acknowledge faith and culture.

When cultural/religious health practices were analysed against sociodemographic variables, no statistically significant differences emerged. Although males had slightly higher reported good practice levels, the difference was not significant. Similar non-significant trends were seen across age, ethnic group, religion, and marital status, showing that cultural behaviours are often deeply internalized and upheld regardless of individual characteristics. While such homogeneity may streamline health messaging, it also demands that cultural engagement strategies be broad-based rather than overly segmented by age or sex. Interventions must therefore be community-wide, addressing the collective values and beliefs that shape health behaviour across all groups

Conclusion

Religious and cultural beliefs strongly influence health-seeking behaviour, with most respondents favouring their integration into care. Despite positive perceptions of cultural accommodation, many delay or avoid care due to these beliefs, highlighting a significant barrier. These values are deeply shared across demographics, emphasizing their importance.

Healthcare systems must actively implement culturally responsive practices by training providers and engaging community leaders. Policymakers should prioritize integrating cultural and religious considerations into care to improve trust, reduce delays, and enhance health outcomes.

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