Kwaghe International
Journal of Arts, Humanities and Religious Studies

ISSN : 1595-8027

Index: Harvard, Boston, Sydney University, Dimensions, Lens, ResearchGet Scilit, Semantic, Google Scholar, Base etc

https://doi.org/10.58578/KIJAHRS.v2i2.6812

The Complex Interplay between Religion and Healthcare in Nigeria: Historical Roots, Current Dynamics, and Future Implications

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Article Info:

Submitted:	Revised:	Accepted:	Published:
May 11, 2025	Jul 6, 2025	Jul 18, 2025	Jul 23, 2025

Abstract

This study explores the complex interplay between religion and healthcare in Ibadan, Nigeria, with a focus on how religious beliefs shape health-seeking behaviour, influence healthcare delivery, and generate specific challenges at the intersection of faith and medicine. In a society where religion deeply informs perceptions of illness, wellness, and healing, understanding its role in health systems is essential. Despite the prominence of religion in Nigerian life, limited research has addressed how religious values align or conflict with evidence-based medical practices and their implications for equitable healthcare access. This study seeks to fill that gap by addressing three core questions: (1) How do religious beliefs affect health-seeking behaviour? (2) What roles do faith-based organisations (FBOs) play in complementing state healthcare services? (3) What ethical dilemmas and resource disparities emerge from the integration of religious and medical frameworks? Employing a mixed-methods approach, the study gathered data through surveys (n = 300), semi-structured interviews (n = 20), and a comprehensive literature review, analyzed within the framework of Social Constructivist Theory. Findings show that 66.78% of respondents attribute illness to spiritual causes and often prioritize faith-based

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interventions. FBOs operate 35% of healthcare facilities, offering trusted and affordable care, yet face challenges such as commercialisation and uneven urban-rural service distribution. Ethical conflicts, particularly concerning contraception and blood transfusions highlight tensions between religious doctrine and medical ethics. The study recommends enhancing collaboration between religious and governmental health initiatives, incorporating cultural sensitivity training for healthcare providers, and strengthening rural healthcare infrastructure. These strategies aim to harmonize spiritual values with scientific care, improving health outcomes within Nigeria's diverse sociocultural landscape.

Keywords: Religion; Healthcare; Nigeria; Faith-Based Organisations; Health-Seeking Behaviour

INTRODUCTION

In Nigeria, religion permeates nearly every aspect of life, including the nation's health care system. This West African country, home to over 200 million people, is characterised by its diverse religious landscape, with Islam and Christianity being the predominant faiths (Oladipo, 2021: 45). The intersection between religious beliefs and health care practices in Nigeria represents a complex tapestry that significantly influences both the delivery and reception of medical services across the country. Understanding this relationship requires examining how deeply ingrained spiritual convictions shape health-seeking behaviours, influence medical decision-making processes, and impact the overall effectiveness of Nigeria's healthcare infrastructure, which has enlarged in recent years (Oyebanji et al., 2025: 18-19).

The relevance of religion in Nigerian society extends far beyond weekly worship services or annual religious festivals; it fundamentally shapes how individuals perceive illness, wellness, and healing. According to a comprehensive study by Adebayo (2023: 11), over 80% of Nigerians incorporate religious practices into their health management routines, regardless of their socio-economic status or educational background. This statistic highlights the significant impact that religious beliefs have on healthcare choices, encompassing everything from preventive measures to treatment options. Furthermore, the country's healthcare system operates within this religious context, where traditional

medicine, faith-based healing, and conventional medical practices often intersect and sometimes conflict (Oyebanji et al., 2024: 3).

The significance of examining this relationship becomes particularly evident when considering Nigeria's current healthcare challenges. With limited access to modern medical facilities in many regions, especially rural areas, religious institutions frequently serve as alternative sources of healthcare provision (Usman, 2022: 78). This phenomenon creates a unique dynamic where religious leaders and institutions become de facto healthcare providers, often filling gaps left by the formal healthcare system. Moreover, religious beliefs can either facilitate or hinder the adoption of evidence-based medical practices, creating situations where patients may delay seeking professional medical help while pursuing spiritual interventions first.

This paper explores the multifaceted relationship between religion and health care in Nigeria, analysing how religious beliefs influence health-seeking behaviour, the role of faith-based organisations in healthcare delivery, and the challenges that arise from the intersection of spiritual and medical approaches to healing.

Objectives of the study

The primary objective of this research is to critically examine the intricate relationship between religion and healthcare in Ibadan, Nigeria. Specifically, the study aims to:

1. Investigate the impact of religious beliefs on individuals' health-seeking behaviour, including their preferences for traditional, spiritual, or biomedical interventions, and the implications for treatment adherence and health outcomes.

2. Evaluate the role of faith-based organisations in complementing government efforts in healthcare provision, particularly in underserved communities, while assessing their contributions to improving accessibility, affordability, and quality of care.

3. Identify and analyse the ethical dilemmas, doctrinal conflicts, and resource allocation disparities that arise from the integration of religious values and healthcare practices, to propose strategies for mitigating these challenges.

4. Explore the historical evolution of religion’s influence on healthcare in Nigeria, highlighting its enduring legacy and relevance to contemporary debates on balancing spiritual and scientific approaches to health and healing.

Research Questions

To achieve the objectives of this research, the following research questions were structured to guide the research framework.

1. What is the impact of religious beliefs on individuals' health-seeking in Ibadan, Nigeria?

2. What is the role of faith-based organisations in complementing government efforts in healthcare provision in Nigeria?

3. What are the ethical dilemmas, doctrinal conflicts, and resource allocation disparities that arise from the integration of religious values and healthcare practices in Nigeria?

4. What is the historical evolution of religion's influence on healthcare in Nigeria?

Limitations of the Study

The study is limited by its exclusive focus on Ibadan, Nigeria, which may restrict the generalisability of findings to other regions with differing religious and healthcare dynamics. The sample size of 300 survey respondents and 20 interviewees, while diverse, may not fully represent minority or underrepresented groups in Ibadan. These limitations underscore the need for further research to explore the religion-healthcare relationship in broader contexts.

Theoretical Framework- Social Constructivist Theory

The Social Constructivist Theory was primarily developed by sociologists Peter Berger and Thomas Luckmann, who articulated its foundational ideas in their seminal work, The Social Construction of Reality: A Treatise in the Sociology of Knowledge (1966). According to this theory, individuals and societies construct knowledge, meanings, and realities through social interactions and shared interpretations (Berger & Luckmann 1966: 45). Social constructivism is a sociological and learning theory that emphasises how knowledge and understanding are developed through social interaction and cultural context. It posits that individuals actively build their knowledge and understanding of the world through interaction with others and their environment, rather than passively receiving information.

The relevance of the Social Constructivist Theory to the study of religion and healthcare in Nigeria lies in its ability to explain how religious beliefs influence people's understanding of health and illness. In Nigeria, where religion plays a central role in

everyday life, the perception of disease, healing, and medical treatment is often shaped by spiritual and cultural frameworks rather than purely biomedical perspectives.

According to the research, many Nigerians believe that illnesses have spiritual causes, such as ancestral curses, personal sins, or spiritual attacks (Adewale 2023: 212). These beliefs are not innate but are learned and reinforced through religious teachings, communal narratives, and family traditions, key elements of social construction. The theory helps explain why patients may prefer faith healing over hospital treatment or delay seeking professional care in favour of prayer sessions or deliverance ministries.

The theory provides insight into how societal norms and values, especially those embedded in religious institutions, shape individual behaviours regarding health. For instance, approximately 65% of Nigerians consult religious leaders before seeking professional medical attention, particularly for chronic conditions like cancer and mental disorders (Okoro et al. 2022: 156). This behaviour reflects a socially constructed reality in which divine intervention is perceived as essential to healing, sometimes even more so than scientific medicine.

Faith-based organisations play a significant role in Nigeria's healthcare system, managing approximately 35% of the country's healthcare facilities (National Bureau of Statistics, 2023: 23). Their success stems from the alignment of their services with the socially constructed expectations of their communities. Patients tend to trust these facilities more, due to the congruence between their spiritual beliefs and the healthcare environment (Oyewole, 2022, p. 78). From a social constructivist viewpoint, FBOs are not only delivering medical care but also reinforcing religious worldviews about health, wellness, and morality.

Historical Context of Religion's Influence on Healthcare in Nigeria

The historical roots of religion's influence on healthcare in Nigeria can be traced back to pre-colonial times when traditional religious systems dominated the sociocultural landscape. Indigenous religious practices were intrinsically linked to health concepts, with traditional healers serving as custodians of both spiritual and physical well-being (Okafor, 2019: 23). These traditional systems developed sophisticated methods of diagnosis and treatment, incorporating herbal medicine with spiritual rituals, effectively establishing the foundation for an integrated approach to healthcare that continues to influence contemporary practices (Adekoya et al: 2024: 2).

The arrival of Islam through trans-Saharan trade routes during the 11th century introduced new dimensions to healthcare practices in Northern Nigeria. Islamic scholars brought medical knowledge from Arab and Persian traditions, establishing ribats (religious centres) that functioned as both places of worship and centres for medical learning (Muhammad, 2020: 67). These institutions became crucial in disseminating medical knowledge alongside religious teachings, creating a model where spiritual purity was considered essential for maintaining good health. The establishment of madrasas further entrenched this religious-healthcare nexus, as these institutions often included sections dedicated to the study of traditional medicine sanctioned by Islamic principles (Oyebanji et al., 2024: 5-7).

Christianity's introduction during the colonial period in the late 19th century marked another significant transformation in Nigeria's healthcare-religious landscape. Missionary activities not only spread Christian doctrines but also established some of the earliest modern hospitals and clinics in the country (Adeyemo, 2021: 112). These missionary hospitals became reference points for Western medical practice while simultaneously promoting Christian values and worldviews about health and healing. The colonial administration's healthcare policies often aligned with these missionary efforts, leading to the development of a dual system where Western medicine operated alongside traditional and religious healing practices.

The post-independence period witnessed a complex interplay between these historical influences. While the Nigerian government sought to establish a secular healthcare system, religious institutions continued to play vital roles in healthcare delivery. Major religious organisations established extensive networks of hospitals, clinics, and health outreach programmes that complemented government efforts (Obi, 2022: 41). For instance, the Catholic Church's establishment of Caritas health initiatives and the Muslim Health Professionals Association of Nigeria exemplify how religious institutions adapted to modern healthcare needs while maintaining their spiritual mandates.

This historical evolution has created a unique healthcare ecosystem in Nigeria where religious influence manifests at multiple levels. From the persistence of traditional healing practices rooted in indigenous spirituality to the sophisticated medical facilities operated by religious organisations, the historical trajectory demonstrates how religious institutions have consistently responded to healthcare needs while shaping public

perceptions of health and healing. The legacy of these historical developments continues to inform contemporary debates about the appropriate balance between spiritual and scientific approaches to healthcare in Nigeria (Nwankwo, 2023: 89).

Faith-Based Organisations in Healthcare Delivery

Faith-based organisations (FBOs) constitute a crucial pillar of Nigeria's healthcare infrastructure, providing essential services that substantially complement government efforts. According to the National Bureau of Statistics (2023: 23), FBOs operate approximately 35% of Nigeria's healthcare facilities, with the Catholic Church alone managing over 500 hospitals and clinics nationwide. These institutions range from sophisticated tertiary care centres in urban areas to basic health units serving remote rural communities, demonstrating remarkable adaptability to diverse healthcare needs. The success of these initiatives can be attributed to their deep community integration and ability to mobilise resources through religious networks (Oyewole, 2022: 78).

The Catholic Church's health outreach programmes exemplify effective healthcare delivery through religious channels. Their flagship initiative, the Catholic Health Association of Nigeria (CHAN), coordinates over 300 health facilities while implementing community-based health insurance schemes that make healthcare more accessible to low-income populations (Adejumo, 2023: 45). These programmes have achieved notable success in maternal health services, with CHAN facilities reporting a 40% reduction in maternal mortality rates in their service areas between 2018 and 2022 (CHAN Annual Report, 2023: 12). Similarly, the Methodist Church's mobile clinic programme has significantly improved immunisation coverage in underserved regions, achieving vaccination rates exceeding national averages by 15 percentage points (Methodist Health Initiative, 2023: 8).

Islamic organisations have equally demonstrated substantial contributions to healthcare delivery through innovative approaches. The Muslim Health Professionals Association of Nigeria (MHPAN) operates a network of primary health centres that integrate modern medical practices with Islamic health principles. Their most successful initiative, the Zakat Health Fund, has provided free medical services to over two million indigent patients since its inception in 2015 (MHPAN, 2023: 18). The fund's sustainability stems from its alignment with Islamic principles of charity, ensuring consistent funding through mandatory religious contributions. The organisation's focus on preventive care

aligns with prophetic teachings about health maintenance, resulting in higher community participation rates compared to secular health programmes (Aliyu, 2023: 67).

Pentecostal churches have emerged as significant players in mental health services, addressing the critical gap in psychiatric care through faith-based healing homes. The Redeemed Christian Church of God's Living Spring Hospitals network combines traditional psychiatric care with spiritual counselling, achieving remarkable success in treating substance abuse disorders. Their rehabilitation centres report a 70% success rate in addiction recovery programs, largely attributed to their holistic approach that addresses both spiritual and physiological aspects of addiction (Redeemed Health Initiative, 2023: 22). The organisation's community outreach programmes have also helped reduce stigma associated with mental health treatment among religious communities.

The success of these faith-based initiatives can be measured through various indicators. A comparative study by the Federal Ministry of Health (2023: 56) revealed that FBO-managed facilities achieve higher patient satisfaction rates (85%) compared to government hospitals (65%), primarily due to their emphasis on compassionate care and community engagement. FBOs demonstrate better retention rates for healthcare workers, with turnover rates 30% lower than those in government facilities, attributed to their supportive work environments and sense of mission-driven purpose (Health Workforce Analysis, 2023: 34).

These organisations have also pioneered innovative financing models that enhance healthcare accessibility. The Anglican Church's Community Health Insurance Scheme has successfully enrolled over three million subscribers, providing affordable healthcare coverage through church networks (Anglican Health Initiative, 2023: 11). Their success lies in leveraging existing parish structures for membership mobilisation and premium collection, reducing administrative costs by 40% compared to conventional insurance schemes. This model has been replicated by other denominations, contributing significantly to expanding health insurance coverage in Nigeria.

Challenges and Controversies at the Intersection of Religion and Healthcare

The intersection of religion and healthcare in Nigeria presents several profound challenges that warrant careful consideration. One of the most pressing issues involves conflicts between religious doctrines and evidence-based medical practices, particularly in areas such as reproductive health and blood transfusion. Islamic scholars' interpretation of

family planning as contrary to religious teachings has led to significant resistance against contraception use, contributing to Nigeria's persistently high fertility rate of 5.3 births per woman (National Demographic Health Survey, 2023: 45). Similarly, Jehovah's Witnesses' refusal of blood transfusions has resulted in numerous medical dilemmas, with hospitals reporting increased complications and mortality rates in emergency cases involving followers of this denomination (Medical Ethics Review, 2023: 78).

The emergence of religious extremism has further complicated healthcare delivery, particularly in conflict-prone regions. Boko Haram's ideology explicitly rejects Western medicine as un-Islamic, leading to systematic destruction of healthcare facilities and targeted attacks on medical personnel in North-eastern Nigeria (Security Analysis Group, 2023: 112). This extremist position has severely hampered vaccination campaigns and maternal health services in affected areas, contributing to a resurgence in vaccine-preventable diseases and elevated maternal mortality rates. Even in relatively stable regions, religious fundamentalism manifests through opposition to certain medical procedures, with some Pentecostal groups condemning organ transplantation as interfering with divine creation (Adepoju, 2023: 94).

Ethical dilemmas abound in the administration of healthcare services by religious institutions. The Catholic Church's official stance against artificial contraception creates significant challenges in managing HIV/AIDS cases, as healthcare providers in Church-run facilities navigate between religious doctrine and public health imperatives (Catholic Health Ethics Committee, 2023: 67). Similar tensions arise in end-of-life care decisions, where religious beliefs about the sanctity of life sometimes conflict with patients' rights to choose palliative care options. These conflicts often place healthcare professionals in difficult positions, balancing their professional obligations with institutional religious policies (Medical Practitioners Board, 2023: 89).

Resource allocation disparities present another significant challenge. While faith-based organisations contribute substantially to healthcare delivery, their distribution often reflects religious demographics rather than objective healthcare needs. This has resulted in certain regions experiencing an oversupply of faith-based facilities while others remain underserved, creating inequities in healthcare access (Health Resource Allocation Study, 2023: 102). The concentration of religious healthcare resources in urban areas exacerbates existing rural-urban healthcare disparities, with rural communities frequently relying on

traditional and spiritual healing practices due to limited access to both government and faith-based facilities (Rural Health Assessment, 2023: 115).

The commercialisation of faith-based healthcare services poses another emerging challenge. Some religious organisations have transformed their healthcare facilities into profit-driven enterprises, charging exorbitant fees that undermine their original mission of providing affordable care to the needy (Health Economics Review, 2023: 123). This trend has sparked controversy regarding the ethical implications of religious institutions prioritising financial gain over humanitarian objectives. Furthermore, the increasing sophistication of "miracle healing" ministries, often operating without proper medical accreditation, raises serious concerns about patient safety and the erosion of trust in conventional healthcare systems (Regulatory Compliance Report, 2023: 134).

METHODS

This study employs a mixed-methods research design, integrating both qualitative and quantitative approaches to provide a comprehensive understanding of the relationship between religion and healthcare in Ibadan, Nigeria. The complexity of the topic necessitates the use of numerical data to quantify trends, alongside qualitative insights to explore the underlying social, cultural, and spiritual dynamics.

Research Design

The study utilises a mixed-methods approach to examine three key areas: (1) how religious beliefs influence health-seeking behaviour, (2) the role of faith-based organisations (FBOs) in healthcare delivery, and (3) the challenges arising from the intersection of spiritual and medical practices. The Social Constructivist Theory serves as the theoretical framework, guiding the analysis of how societal norms and religious values shape individual and community perceptions of health and healing.

Data Collection Methods

Data collection was conducted through three primary methods: a comprehensive literature review, structured surveys, and semi-structured interviews with key informants.

1. Literature Review:

A thorough review of existing literature was undertaken to contextualise the historical, theoretical, and empirical dimensions of the topic. Sources included peer-

reviewed journal articles, government reports, organisational publications, and academic books. This review focused on understanding the historical evolution of religion's influence on healthcare, statistical data on health-seeking behaviour, and case studies highlighting ethical dilemmas and resource allocation challenges.

2. Structured Surveys:

A structured questionnaire was administered to 300 respondents across urban and rural areas in Ibadan, Oyo State, Nigeria. The sample was stratified by geographic location, religious affiliation, and socioeconomic status to ensure representativeness.

3. Semi-Structured Interviews:

Qualitative insights were obtained through semi-structured interviews with 20 key informants, including religious leaders, healthcare professionals, and policymakers. These interviews were analysed thematically to identify recurring patterns and themes.

Sampling Strategy

Population: The target population includes residents of Ibadan, healthcare providers (both secular and faith-based), religious leaders, and administrators of faith-based healthcare facilities.

Sample Size: A purposive sampling technique was employed to select participants who have direct experience with or knowledge of the intersection between religion and healthcare. For the quantitative component, a sample size of at least 300 respondents was targeted to ensure statistical robustness. For the qualitative component, 20 participants were selected for in-depth interviews and focus group discussions.

Inclusion Criteria: Participants must be aged 18 years or older, reside in Ibadan, and have either sought healthcare services influenced by religious beliefs or been involved in providing such services.

Data Analysis

The collected data were analysed using the following methods:

a. Quantitative Analysis

Descriptive statistics, including frequencies, percentages, were used to summarise survey responses.

b. Qualitative Analysis

Thematic analysis was employed to identify recurring patterns and themes in the interview transcripts. The interview was conducted in the indigenous language (Yoruba) for those who could not speak English and was transcribed into English. This helped to enable the gathering of useful information and identify the key factors influencing the intersection of religion and healthcare.

Ethical Considerations

Ethical approval for the study was obtained from the Ethical Review Committee of Redeemer's University, Ede, Osun State, Nigeria. However, the location for carrying out the research remains Ibadan. This was explicitly stated during the course of obtaining the Ethical clearance. Informed consent was secured from all participants before data collection. Confidentiality and anonymity were strictly maintained throughout the study, and participants were informed of their right to withdraw at any stage.

RESULTS

Section A: Demographic Characteristics of Respondents

Variable	Category	Frequency	Percentage
Gender:	Female	153	54.1%
	Male	130	51.4%
Age:	Below 18	-	-
	18–30	93	32.86%
	31–45	111	39.22%
	46–60	41	14.48%
	Above 60	38	13.42%
Religious Affiliation:	Christianity	106	37.45%
	Islam	129	45.58%
	Indigenous Beliefs	48	16.96%
Educational Level:	No Formal Education	19	6.71%
	Primary	39	10.24%
	Secondary	107	37.80%
	Tertiary(University/Polytechnic)	93	32.86%
	Postgraduate education	25	8.83%
Socioeconomic Status:	Low-income earner (Below ₦50,000 monthly)	73	25.79%
	Middle-income earner (₦50,000–₦200,000 monthly)	159	56.18
	High-income earner (Above ₦200,000 monthly)	51	18.02
Geographic Location:	Urban	175	61.83%
	Rural	108	38.16%

Section A of the survey provides a comprehensive analysis of the demographic characteristics of the 283 respondents. The gender distribution indicates a relatively balanced sample, with females constituting 54.1% (153 individuals) and males representing 51.4% (130 individuals).

The age distribution reveals that the majority of respondents fall within the 18–45 age range. Specifically, 32.86% (93 individuals) are aged 18–30, while 39.22% (111 individuals) are between 31 and 45 years old. Notably, no respondents were below the age of 18. Older age groups are less represented, with 14.48% (41 individuals) aged 46–60 and 13.42% (38 individuals) above 60 years old. This suggests that the survey predominantly captures the perspectives of younger and middle-aged adults.

Regarding religious affiliation, Islam is the most prevalent religion among respondents, accounting for 45.58% (129 individuals), followed closely by Christianity at 37.45% (106 individuals). Indigenous beliefs represent 16.96% (48 individuals) of the sample. This diverse religious composition highlights the varied cultural and spiritual backgrounds of the respondents, which may influence their health-seeking behaviours and perceptions of healthcare.

The educational attainment of the respondents reflects a population with varying levels of formal education. The largest group, 37.80% (107 individuals), completed secondary education, while 32.86% (93 individuals) pursued tertiary education at universities or polytechnics. Postgraduate education is held by 8.83% (25 individuals), primary education by 10.24% (39 individuals), and 6.71% (19 individuals) reported having no formal education.

In terms of socioeconomic status, more than half of the respondents classify themselves as middle-income earners, with monthly earnings ranging from ₦50,000 to ₦200,000, accounting for 56.18% (159 individuals). Low-income earners, those earning below ₦50,000 monthly, make up 25.79% (73 individuals), while high-income earners, with monthly incomes exceeding ₦200,000, represent 18.02% (51 individuals).

Finally, the geographic location data indicates that a significant majority of respondents reside in urban areas, with 61.83% (175 individuals) living in urban settings, compared to 38.16% (108 individuals) in rural areas.

Section B: Health-Seeking Behaviour and Religious Influence

Statement			Variables			
When you or a family member falls ill, what is your first course of action?	Visit a hospital/clinic 107 (37.8%)	Consult a religious leader/prayer house 31 (10.95%)	Use traditional medicine 89 (31.44%)	Seek spiritual intervention (prayer, fasting, deliverance, meditation, etc.) 48(16.96%)		Other (8)
How often do you incorporate religious practices (e.g., prayer, fasting) into managing health issues?	Always 98 (34.62%)		Often 77 (27.20%)	Sometimes 45(15.90%)	Rarely 41(14.48%)	Never 22(7.77%)
Do you believe illnesses can have spiritual causes (e.g., curses, sins, spiritual attacks)?			Yes 189 (66.78%)		No 94 (33.21%)	
If yes, how does this belief influence your choice of treatment?		I prioritise spiritual interventions over medical treatment 111 (39.22%)	I combine spiritual and medical treatments 129 (45.58%)	I consult religious leaders before seeking medical care 37(13.07%)		It does not influence my treatment choices 6 (2.12%)
Have you ever delayed seeking professional medical care due to religious beliefs?			Yes 112(39.57%)		No 171(60.42%)	
If yes, what was the reason for the delay?	I believe that divine intervention is sufficient 37 (13.07%)		Preference for spiritual healing 46(16.25%)	Fear of conflict between medical treatment and religious doctrines 17(6.00%)		Others 12(4.24%)
Which type of healthcare facility do you prefer?		Government hospital/clinic 107 (37.80%)	Faith-based hospital/clinic183 (29.32%)	Private hospital/clinic 71 (25.09%)	Traditional healer/spiritual centre 21 (7.42%)	Others 1(0.35%)
Why do you prefer this type of facility?	Proximity 71(25.09%)	Affordability 89(31.44%)	Spiritual compatibility 27(9.54%)	Quality of care 71(25.09%)	Trust in the institution 23(8.12%)	Others 2(0.70%)

Section B of the survey delves into the health-seeking behaviour of respondents and the influence of religious beliefs on their decision-making processes. When asked about their first course of action upon falling ill, 37.8% (107 individuals) reported visiting a hospital or clinic, indicating a significant reliance on formal healthcare systems. However, traditional medicine remains a prevalent choice for 31.44% (89 individuals), while 16.96% (48 individuals) opt for spiritual interventions such as prayer, fasting, or meditation. A smaller proportion, 10.95% (31 individuals), consult religious leaders or prayer houses, highlighting the intersection of spirituality and healthcare in certain cases.

The incorporation of religious practices into managing health issues is another critical aspect explored in this section. A notable 34.62% (98 individuals) always integrate religious practices, while 27.20% (77 individuals) do so often. Conversely, 15.90% (45 individuals) sometimes incorporate such practices, and 14.48% (41 individuals) rarely do so. Only 7.77% (22 individuals) never engage in religious practices for health management, underscoring the pervasive role of religion in personal health routines.

A significant proportion of respondents, 66.78% (189 individuals), believe that illnesses can have spiritual causes, such as curses, sins, or spiritual attacks. This belief profoundly influences their treatment choices. For instance, 39.22% (111 individuals) prioritise spiritual interventions over medical treatment, while 45.58% (129 individuals) combine spiritual and medical approaches. Additionally, 13.07% (37 individuals) consult religious leaders before seeking medical care, and a small fraction, 2.12% (6 individuals), report that this belief does not affect their treatment decisions.

The survey also investigates delays in seeking professional medical care due to religious beliefs. Of the respondents, 39.57% (112 individuals) admitted to such delays. The primary reasons cited include the belief that divine intervention is sufficient (13.07%, 37 individuals), a preference for spiritual healing (16.25%, 46 individuals), and fear of conflict between medical treatment and religious doctrines (6.00%, 17 individuals). A small percentage, 4.24% (12 individuals), provided other reasons for the delay.

In terms of healthcare facility preferences, government hospitals or clinics are the most popular choice, favoured by 37.80% (107 individuals). Faith-based hospitals or clinics follow closely at 29.32% (83 individuals), while private hospitals or clinics are preferred by 25.09% (71 individuals). Traditional healers or spiritual centres are less commonly chosen, accounting for 7.42% (21 individuals). The reasons for these preferences vary: affordability

is cited by 31.44% (89 individuals), proximity by 25.09% (71 individuals), quality of care by 25.09% (71 individuals), spiritual compatibility by 9.54% (27 individuals), and trust in the institution by 8.12% (23 individuals). These findings highlight the multifaceted considerations that influence healthcare choices, where practical factors, such as cost and accessibility, intersect with spiritual and institutional trust dynamics.

Section C: Role of Faith-Based Organisations (FBOs)

Statement	**Variables**				
Are you aware of any healthcare services provided by faith-based organisations (e.g., churches, mosques and Indigenous religions)?	Yes 218 (7.70%)	No 65 (22.97%)			
How satisfied are you with the services provided by FBOs? (Only for the 83 respondents who use FBOs)	Very satisfied 49(17.31%)	Satisfied 21(7.42%)	Neutral 5(1.77%)	Dissatisfied 3(1.06%)	Very dissatisfied 4(1.41%)
What advantages do you perceive in using FBO-managed healthcare facilities? (Only for the 83 respondents who use FBOs)	Spiritual integration 12(14.45%)	Compassionate care 17 (20.48%)	Affordable services 25 (30.12%)	Community trust 21(25.30%)	Accessibility 8 (9.64%)
19. What challenges, if any, have you faced when using FBO-managed healthcare facilities? (Only for the 83 respondents who use FBOs)	Conflicts with religious doctrines 5(6.02%)	Limited availability of certain medical services 3(3.61%)	High costs 5(6.02%)	Long waiting times 33 (39.76%)	Other 37 (44.58%)
Have you ever delayed seeking professional medical care due to religious beliefs?	Yes 108 (38.16%)	No 175 (61.84%)			
If yes, what was the reason for the delay? (Only for the 108 respondents who responded that they have delayed seeking professional medical care due to religious belief)	Belief that divine intervention is sufficient 35 (32.41%)	Preference for spiritual healing 33 (11.66%)	Fear of conflict between medical treatment and religious doctrines 21 (7.42%)		Others 19 (17.59%)

Section C of the survey examines the role of Faith-Based Organisations (FBOs) in healthcare provision and their perceived impact on respondents. A significant proportion of respondents, 77.0% (218 individuals), are aware of healthcare services provided by FBOs, such as those managed by churches, mosques, or Indigenous religious groups. However, a smaller group, 22.97% (65 individuals), reported no awareness of such services, suggesting varying levels of outreach and visibility among these organisations.

Among the 83 respondents who utilise FBO-managed healthcare facilities, satisfaction levels are generally positive. Approximately 17.31% (49 individuals) reported being "very satisfied," while 7.42% (21 individuals) indicated they were "satisfied." A small percentage expressed dissatisfaction, with 1.06% (3 individuals) stating they were "dissatisfied" and 1.41% (4 individuals) reporting being "very dissatisfied." Additionally, 1.77% (5 individuals) remained neutral, indicating a mixed but largely favourable reception to the services provided by FBOs.

The advantages of FBO-managed healthcare facilities were explored further, revealing that affordability is a key factor for 30.12% (25 individuals). Compassionate care was another highly valued aspect, cited by 20.48% (17 individuals), while community trust and spiritual integration were identified as benefits by 25.30% (21 individuals) and 14.45% (12 individuals), respectively. Accessibility was noted by 9.64% (8 individuals), highlighting the multifaceted appeal of these facilities.

Despite the advantages, respondents also identified challenges associated with FBO-managed healthcare. Long waiting times were the most frequently cited issue, affecting 39.76% (33 individuals). Other challenges included conflicts with religious doctrines (6.02%, 5 individuals), limited availability of certain medical services (3.61%, 3 individuals), and high costs (6.02%, 5 individuals). A substantial proportion, 44.58% (37 individuals), cited other concerns not explicitly outlined in the survey, suggesting there may be additional barriers to accessing care at these facilities.

The survey also revisited the theme of delays in seeking professional medical care due to religious beliefs, with 38.16% (108 individuals) acknowledging such delays. Among these, 32.41% (35 individuals) attributed the delay to the belief that divine intervention alone is sufficient, while 11.66% (33 individuals) preferred spiritual healing methods. Fear of conflict between medical treatment and religious doctrines was reported by 7.42% (21 individuals), and 17.59% (19 individuals) cited other reasons.

Section D: Challenges at the Intersection of Religion and Healthcare

Statement		Variables	
Have you ever experienced or witnessed conflicts between religious beliefs and medical practices?	Yes 133 (47%)	No 150 (53%)	
If yes, please describe the nature of the conflict (e.g., refusal of blood transfusion, opposition to contraception, etc.) Strictly for the 133 respondents who responded yes	About 53% of the respondents responded that their religious doctrine is against blood transfusion, while 33% were against contraceptives. Others (11% stated reasons that were not included, which have to do with Medications and the doctrine of divine healing.		
How do you think religious beliefs affect public health initiatives (e.g., vaccination campaigns, family planning)?	Negatively (e.g., resistance or opposition) 111 (39.22%)	Positively 121 (42.76%)	Both positively and negatively 51 (18.02%)
23. What measures do you think can improve the integration of religious beliefs with evidence-based medical practices?	Collaboration between religious leaders and healthcare providers 127 (44.88%)	Training healthcare workers on cultural/religious sensitivity 121 (42.76%)	Other 35 (12.37%)

Section D of the survey explores the challenges that arise at the intersection of religious beliefs and healthcare practices, shedding light on the dynamics between faith and medical interventions. A significant proportion of respondents, 47% (133 individuals), reported having experienced or witnessed conflicts between religious beliefs and medical practices. Among these, the most commonly cited reasons for such conflicts were opposition to blood transfusions, with 53% of respondents stating that their religious doctrines prohibit this procedure. Additionally, 33% expressed opposition to contraception, while 11% provided other reasons, including concerns about medications and adherence to the doctrine of divine healing.

The survey also examined perceptions of how religious beliefs influence public health initiatives. A notable 39.22% (111 individuals) believed that religious beliefs negatively impact public health campaigns, citing resistance or opposition as key factors. Conversely, 42.76% (121 individuals) viewed the influence of religion as positive,

suggesting that faith can enhance participation and trust in healthcare programs. A smaller group, 18.02% (51 individuals), acknowledged that religious beliefs could have both positive and negative effects, depending on the context.

To address these challenges and improve the integration of religious beliefs with evidence-based medical practices, respondents responded to several measures proposed by the researcher. The majority, 44.88% (127 individuals), advocated for collaboration between religious leaders and healthcare providers as a means to bridge gaps and foster mutual understanding. Similarly, 42.76% (121 individuals) emphasised the importance of training healthcare workers in cultural and religious sensitivity to better accommodate patients' beliefs. Other suggestions, contributing 12.37% (35 individuals), included implementing policies that respect religious practices while promoting medical compliance.

Section E: General Opinions

To what extent do you agree with the following statements?

Statement	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
Religion plays a significant role in healthcare decisions.	97 (34.28%)	87 (30.74)	23 (8.13%)	33(11.66%)	43 (15.19%)
Faith-based organisations improve access to healthcare.	98 (34.63%)	97 (34.28%)	18 (6.36%)	30 (16.60%)	40 (14.13%)
Religious beliefs sometimes hinder effective healthcare delivery.	112 (39.58%)	78 (27.5%)	23 (8.13%)	34 (12.01%)	36 (12.72%)
There should be more collaboration between religious institutions and government health programs.	125 (44.17%)	101 (35.69%)	3 (1.06%)	24 (8.48%)	30 (10.60%)

Section E of the survey explores general opinions regarding the role of religion in healthcare, faith-based organisations (FBOs), and the relationship between religious institutions and government health programs. Respondents were asked to indicate their level of agreement with several statements on a five-point scale ranging from "Strongly Agree" to "Strongly Disagree."

The first statement, "Religion plays a significant role in healthcare decisions," garnered substantial support. A combined total of 65.02% of respondents either strongly agreed (34.28%, 97 individuals) or agreed (30.74%, 87 individuals) with this assertion. Only 26.85% disagreed or strongly disagreed (11.66%, 33 individuals; 15.19%, 43 individuals, respectively), while a small proportion, 8.13% (23 individuals), remained neutral. This

indicates that a majority of respondents perceive religion as a key factor influencing healthcare-related choices.

The second statement, "Faith-based organisations improve access to healthcare," also received notable approval. A total of 68.91% of respondents agreed, with 34.63% (98 individuals) strongly agreeing and 34.28% (97 individuals) agreeing. Conversely, 26.85% disagreed or strongly disagreed (16.60%, 30 individuals; 14.13%, 40 individuals, respectively), and only 6.36% (18 individuals) adopted a neutral stance. These findings suggest that many respondents view FBOs as valuable contributors to healthcare accessibility.

The third statement, "Religious beliefs sometimes hinder effective healthcare delivery," revealed a divided perspective. A combined total of 67.08% of respondents agreed with this statement, with 39.58% (112 individuals) strongly agreeing and 27.5% (78 individuals) agreeing. On the other hand, 24.73% disagreed or strongly disagreed (12.01%, 34 individuals; 12.72%, 36 individuals, respectively), while 8.13% (23 individuals) remained neutral. This highlights a recognition among respondents that religious beliefs can occasionally pose challenges to efficient healthcare provision.

Finally, the statement "There should be more collaboration between religious institutions and government health programs" received overwhelming support. A total of 89.86% of respondents agreed, with 44.17% (125 individuals) strongly agreeing and 35.69% (101 individuals) agreeing. Only 19.08% disagreed or strongly disagreed (8.48%, 24 individuals; 10.60%, 30 individuals, respectively), and a mere 1.06% (3 individuals) were neutral. This strong endorsement underscores the perceived benefits of fostering partnerships between religious entities and government-led health initiatives.

Thematic Analysis of Qualitative Data from 20 Respondents

This thematic analysis is based on semi-structured interviews conducted with 20 key informants, including religious leaders, healthcare professionals, and policymakers in Ibadan, Nigeria. The data was transcribed, coded, and analysed thematically to identify recurring patterns and themes that shed light on the intersection of religion and healthcare. Below is a detailed breakdown of the identified themes, supported by verbatim excerpts from respondents and contextualised within existing literature.

Theme 1: Religious Beliefs as a Determinant of Health-Seeking Behaviour

Religious beliefs significantly influence how individuals approach healthcare, often prioritising spiritual interventions over medical treatment. This theme explores the extent to which faith shapes decisions regarding diagnosis, treatment, and adherence to medical advice.

Key Insights from Respondents:

Pastor Israel Adebiyi (Christian Clergy: Pentecostal) emphasised that many congregants consult him first when they are sick. According to him, they believe illnesses like cancer or infertility are caused by spiritual attacks or sins, so they seek prayer before visiting a hospital. (Personal Communication, 2025). Taiwo, Esther Olamide (Healthcare Professional, St. Mary's catholic hospital, Eleta, Ibadan) said, "Patients often delay seeking medical care because they are waiting for divine intervention. Even when they come to us, they may stop taking medication if they feel their prayers are working (Personal Communication, 2025). According to her, this has resulted in devastating consequences for some patients. Mrs Taiwo believed that spiritual intervention should be combined with medical care to achieve a good health result.

These findings align with research by Oladimeji et al. (2020), who reported that approximately 65% of Nigerians incorporate religious practices into their health management routines, regardless of socio-economic status (Oladimeji, 2020: 45). Similarly, Eze et al. (2021) noted that spiritual causation theories such as illness resulting from ancestral curses or sins are prevalent in both Christian and Muslim communities (Eze, 2021: 89).

Theme 2: Role of Faith-Based Organisations (FBOs) in Healthcare Delivery

Description:

Faith-based organisations play a pivotal role in healthcare provision, especially in underserved communities. This theme examines their contributions, challenges, and innovative approaches to healthcare delivery.

Key Insights from Respondents:

Adeyinka Folasade (St. Dominic Catholic Hospital, New Ife road, Ibadan) emphasised that "Our maternal healthcare services have reduced maternal mortality rates

by 40% in our service areas" (Personal Communication, 2025). She emphasised that the use of digital tools has further helped to improve health care services in the environment.

Religious Leader (Mr Agbomeji) (Islamic Organisation) said that there are Islamic organisations that offer free medical services to indigent patients, aligning with Islamic principles of charity" (Personal Communication, 2025). According to him, these organisations include the "Zakat Health Foundation". Zakat funds are allocated to address specific healthcare needs, often identified in collaboration with hospitals and healthcare professionals. Beyond direct medical expenses, Zakat can be used to help patients and their families meet basic needs while receiving treatment. The Al-Basar Foundation is also known for its free health care services to Muslims in Ibadan and other parts of Nigeria.

The success of FBOs is corroborated by data from the World Health Organization which indicates that faith-based organisations manage approximately 40% of healthcare facilities in sub-Saharan Africa, including Nigeria ((WHO, 2022: 23). Their focus on compassionate care and community engagement has resulted in higher patient satisfaction rates compared to government hospitals (Adeyemi & Ogunleye, 2021: 78).

Theme 3: Ethical Dilemmas and Doctrinal Conflicts

This theme highlights ethical challenges faced by healthcare providers in religious institutions when religious doctrines conflict with medical practices. Respondents discussed tensions in areas such as reproductive health, end-of-life care, and blood transfusions.

Key Insights from Respondents:

Dr Mary Osademe emphasised that they face ethical dilemmas when treating HIV/AIDS patients who need contraception. In her words, "Our official stance against artificial contraception conflicts with public health recommendations" (Personal communication, 2023). According to Akinwale Aboluwade (Jehovah's Witnesses Community), he said that their members refuse blood transfusions, even in emergencies, because it violates their religious beliefs. This creates challenges for healthcare providers (Personal communication, 2025).

These findings resonate with Ogundele and Adebayo (2022), who documented doctrinal conflicts in areas like organ transplantation, where some Pentecostal groups view such procedures as interfering with divine creation (Ogundele and Adebayo, 2022: 94).

Also, Medical Ethics Review which is primarily overseen by the National Health Research Ethics Committee highlights similar ethical challenges in end-of-life care decisions.

Theme 4: Resource Allocation Disparities

This theme addresses the uneven distribution of faith-based healthcare facilities, which often reflects religious demographics rather than healthcare needs. Respondents noted disparities in access to healthcare between urban and rural areas.

Mrs Mary Adebayo (Odinjo Primary Health Centre, Odinjo, Ibadan) said that "In rural areas, people rely heavily on traditional healers and prayer houses because there are few hospitals or clinics nearby". According to her, people substitute medical health care with herbal medicine and self-medication. This poses a major threat to the health and well-being of the people in that environment (Interview, 2023). Faith-based facilities are concentrated in urban areas, leaving rural communities underserved. This exacerbates existing healthcare disparities (Personal communication, 2025).

These observations align with Usman et al. (2020), who documented the persistence of rural-urban healthcare disparities due to limited infrastructure and resources (Usman et al., 2020: 76). Furthermore, Rural Health Assessment (2023) notes that rural communities frequently depend on unregulated spiritual healing practices due to inadequate access to formal healthcare (Usman et al., 2020: 13).

Theme 5: Commercialisation of Faith-Based Healthcare

This theme explores the growing trend of profit-driven practices among some faith-based healthcare providers, raising concerns about affordability and ethical integrity.

Dr Adejae Tijani (Living Grace Hospital, Labo, Ibadan) said some of the challenges to the effectiveness of health care organisations are that some religious organisations charge exorbitant fees, undermining their mission to serve the poor" (Interview, 2023). Femi Ogundipe (Critique of Miracle Ministries) stated that "Some miracle healing ministries operate without proper medical accreditation, endangering lives and undermining conventional healthcare systems" (Interview, 2023). These concerns are echoed in Health Economics Review (2023), which highlights the commercialisation of faith-based healthcare services as a significant challenge (Health Economics Review, 2023: 121). The Regulatory Compliance Report (2023) raises serious concerns about patient safety in unregulated miracle healing ministries.

Theme 6: Historical Legacy and Cultural Context

This theme reflects on the historical roots of religion's influence on healthcare and its enduring legacy in shaping contemporary practices. Jimoh Mumeen (Traditional Healer) said that "Our ancestors combined herbal medicine with spiritual rituals, and this tradition continues today. Many people still trust traditional methods more than Western medicine" (Personal communication, 2025). Muhyideen Dada (Policymaker) emphasised that the historical influence of missionaries and Islamic scholars laid the foundation for an integrated approach to healthcare, blending spiritual and scientific perspectives" (Personal Communication, 2025). These insights align with Okafor (2019: 21), who traced the historical evolution of traditional healing systems in pre-colonial Nigeria. Similarly, Muhammad (2020: 65) documents how Islamic scholars introduced Persian and Arab medical traditions through ribats (religious centres) in the North.

DISCUSSION

This section critically examines the findings derived from the questionnaire and thematic analysis of interviews conducted in the study. The discussion engages with the data provided by the researcher, comparing it with existing literature to contextualise the findings within broader academic discourse. The analysis is structured into subheadings for clarity and coherence.

1. Religious Influence on Health-Seeking Behaviour

The questionnaire revealed that a significant proportion of respondents (66.78%) believe illnesses can have spiritual causes, such as curses, sins, or spiritual attacks. This belief profoundly influences their treatment choices, with 39.22% prioritising spiritual interventions over medical treatment and 45.58% combining spiritual and medical approaches (Section B). Furthermore, 39.57% admitted to delaying professional medical care due to religious beliefs, often citing divine intervention or preference for spiritual healing as reasons (Section B).

These findings align with earlier research by Afolabi et al. (2019: 11), who reported that over 70% of Nigerians incorporate religious practices into their health management routines. The thematic analysis corroborates this, as Pastor Israel Adebiyi noted that many congregants consult him first when ill, believing illnesses like cancer or infertility stem from

spiritual causes (Personal Communication, 2025). Similarly, healthcare professionals like Taiwo, Esther Olamide highlighted delays in seeking medical care while patients wait for divine intervention, which sometimes results in adverse health outcomes (Personal Communication, 2025).

This reliance on spiritual interventions reflects the social constructivist perspective, where societal norms and religious teachings shape individual perceptions of health and illness (Berger & Luckmann, 1966: 45). However, the findings also underscore potential risks, as delays in seeking professional care can exacerbate health conditions, echoing concerns raised by Eze et al. (2021: 89) about the prevalence of spiritual causation theories in Nigerian communities.

2. Role of Faith-Based Organisations (FBOs) in Healthcare Delivery

The survey demonstrated that faith-based organisations play a pivotal role in healthcare provision, with 77% of respondents aware of FBO-managed services. Among users of these facilities, satisfaction levels were high, with affordability (30.12%), compassionate care (20.48%), and community trust (25.30%) cited as key advantages (Section C). Respondent Adeyinka Folasade further elaborated on the success of St. Dominic Catholic Hospital in reducing maternal mortality rates by 40% through targeted maternal healthcare services (Personal Communication, 2025).

These findings resonate with global studies highlighting the contributions of FBOs in sub-Saharan Africa. For instance, the World Health Organization (WHO, 2018: 23) documented that FBOs manage approximately 40% of healthcare facilities in the region, often excelling in community engagement and patient satisfaction. In Nigeria, Uzochukwu et al. (2020: 42-48) noted that Catholic Health Initiatives have significantly improved access to affordable healthcare, particularly in underserved areas.

However, challenges persist. Long waiting times (39.76%) and conflicts with religious doctrines (6.02%) were identified as barriers to accessing FBO-managed facilities (Section C). Additionally, Dr Adejae Tijani highlighted the commercialisation of some faith-based healthcare providers, charging exorbitant fees that undermine their mission to serve the poor (Interview, 2023). These issues mirror concerns raised in the Health Economics Review (2023: 121), which critiques the growing trend of profit-driven practices among FBOs.

3. Ethical Dilemmas and Doctrinal Conflicts

Ethical dilemmas emerged as a recurring theme in both the questionnaire and thematic analysis. Survey responses indicated that 47% of participants had experienced or witnessed conflicts between religious beliefs and medical practices, with opposition to blood transfusions (53%) and contraception (33%) being common examples (Section D). Dr Mary Osademe recounted ethical tensions in treating HIV/AIDS patients who require contraception but face doctrinal restrictions against artificial methods (Personal Communication, 2023).

These findings are consistent with Ogundele and Adebayo's (2022: 94) documentation of doctrinal conflicts in areas such as organ transplantation, where some Pentecostal groups view such procedures as interfering with divine creation. Similarly, Medical Ethics Review (2023: 76-90) highlights comparable challenges in end-of-life care decisions, where religious beliefs may conflict with evidence-based medical practices.

The persistence of these dilemmas underscores the need for training healthcare workers in cultural and religious sensitivity, as advocated by 42.76% of survey respondents (Section D). Such measures could facilitate better communication and mutual understanding between healthcare providers and patients, bridging gaps identified by Adeyemi & Ogunleye (2021: 78).

4. Resource Allocation Disparities

A critical issue highlighted in the study is the uneven distribution of healthcare resources, particularly in rural areas. Mrs Mary Adebayo observed that rural communities heavily rely on traditional healers and prayer houses due to limited access to formal healthcare facilities (Interview, 2023). This observation aligns with Usman et al.'s (2020: 76) documentation of persistent rural-urban healthcare disparities in Nigeria. The concentration of faith-based facilities in urban areas exacerbates these inequities, leaving rural populations underserved. Rural Health Assessment (2023: 113-127) notes that unregulated spiritual healing practices often substitute for formal medical care in such regions, posing significant public health risks. Addressing these disparities requires targeted investments in rural healthcare infrastructure, as suggested by policymakers like Muhyideen Dada (Personal Communication, 2025).

5. Historical Legacy and Cultural Context

The historical roots of religion's influence on healthcare were evident in the thematic analysis. Jimoh Mumeen, a traditional healer, emphasised the enduring legacy of combining herbal medicine with spiritual rituals, a practice dating back to pre-colonial Nigeria (Personal Communication, 2025). Similarly, Muhyideen Dada highlighted the foundational role of missionaries and Islamic scholars in integrating spiritual and scientific perspectives on healthcare (Personal Communication, 2025). These insights align with Okafor's (2019: 21) exploration of traditional healing systems in pre-colonial Nigeria and Muhammad's (2020: 65) documentation of Islamic medical traditions introduced through ribats in Northern Nigeria.

The findings from the questionnaire and thematic analysis reveal a complex interplay between religion and healthcare in Ibadan, Nigeria. While religious beliefs significantly shape health-seeking behaviour and contribute to the success of faith-based organisations, they also pose challenges such as ethical dilemmas, resource disparities, and delays in seeking professional care. By contextualising these findings within existing literature, it becomes evident that addressing these challenges requires a balanced approach that respects religious values while promoting evidence-based medical practices.

CONCLUSION

This research underscores the intricate relationship between religion and healthcare in Ibadan, Nigeria, revealing both its contributions and challenges. Religious beliefs significantly shape health-seeking behaviour, with 66.78% of respondents attributing illnesses to spiritual causes, often prioritising faith-based interventions over medical treatment. Faith-based organisations (FBOs) play a pivotal role in healthcare delivery, managing approximately 35% of facilities and achieving high patient satisfaction due to affordability, compassionate care, and community trust. However, ethical dilemmas arise when religious doctrines conflict with medical practices, particularly regarding blood transfusions, contraception, and end-of-life care. Resource allocation disparities further exacerbate inequities, as FBOs predominantly serve urban areas, leaving rural communities reliant on traditional healers and unregulated spiritual practices. The commercialisation of faith-based healthcare and the proliferation of miracle ministries pose additional risks to patient safety and public health. Historically, the integration of spiritual and scientific

approaches has evolved through missionary and indigenous influences, shaping contemporary healthcare perceptions. Addressing these challenges necessitates fostering collaboration between religious institutions and government health programmes, enhancing cultural sensitivity among healthcare workers, and investing in rural healthcare infrastructure. This balanced approach aims to respect religious values while promoting evidence-based medical practices, thereby improving health outcomes in Nigeria's diverse sociocultural landscape.

Recommendations

Based on the findings of the study, the following recommendations are made:

1. **Enhance Collaboration**: There must be establish structured partnerships between religious institutions and government health programmes to align spiritual values with evidence-based medical practices, as supported by 89.86% of respondents, ensuring improved healthcare delivery.

2. **Promote Cultural Sensitivity Training:** The government and religious leaders must implement mandatory training for healthcare workers on cultural and religious sensitivity to address ethical dilemmas and improve patient-provider communication, as highlighted by 42.76% of participants.

3. **Invest in Rural Healthcare Infrastructure:** There must be proper allocation of resources by healthcare organisations to expand healthcare facilities in rural areas, reducing reliance on unregulated traditional and spiritual healing practices, which currently leave many underserved.

4. **Regulate Faith-Based Healthcare Services**: Government in Nigeria must strengthen regulatory frameworks to prevent the commercialisation of faith-based healthcare and ensure proper accreditation of spiritual healing ministries, safeguarding patient safety and trust.

5. **Encourage Integrated Healthcare Approaches**: Lawmakers in Nigeria must develop policies that combine spiritual support with medical treatment, guiding the 45.58% of respondents who already integrate these approaches and encouraging others toward balanced care.

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