

REPOSITIONING HEALTH EDUCATION TO ADDRESS CULTURAL BARRIERS IN HEALTH-SEEKING BEHAVIOUR IN KADUNA STATE, NIGERIA

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Abstract

This study investigates the role of health education in addressing cultural barriers to health-seeking behaviour in Kaduna State, Nigeria. Despite improvements in healthcare infrastructure, cultural beliefs and practices continue to influence how people perceive illness and access modern health services, often resulting in delayed treatment and poor health outcomes. The research question include what are the personal health-seeking patterns and influences among residents of Kaduna State residents of Kaduna State? Using a mixed-method approach, the research surveyed 400 community members across urban and rural areas of Kaduna State, Nigeria. There is no significant cultural beliefs that shape perception of illness and health care among residents of Kaduna State, Nigeria was rejected with p-value of 0.02. Findings reveal that cultural beliefs significantly shape health-seeking behaviours and that current health education programmes inadequately address these cultural factors. The study recommends culturally sensitive health education strategies, active involvement of traditional and religious leaders, and enhanced training for health educators to reposition health education within the healthcare system. This repositioning is essential for improving healthcare utilization, fostering trust in modern medicine, and ultimately enhancing public health in Kaduna State.

Keywords: Cultural barriers, Behaviour, Healthcare

Introduction

Health education is a cornerstone of public health, promoting positive health behaviour, improving health literacy, and bridging the gap between traditional beliefs and biomedical knowledge. In Nigeria, however, many health education interventions remain generic, poorly contextualized, and disconnected from the socio-cultural realities of target populations, which limits their effectiveness. This shortfall is particularly significant when considering health-seeking behaviour, which refers to the choices individuals make regarding whether, when, and where to seek care in response to illness or symptoms (Ogundimu et al., 2020).

Health-seeking behaviour is shaped by a complex interplay of cultural beliefs, socio-economic status, gender roles, educational level, and access to healthcare facilities. In many communities, illness is frequently perceived as a spiritual or supernatural problem rather than a biomedical condition. These perceptions often encourage reliance on traditional healers, religious leaders, self-medication, or home remedies before seeking modern healthcare services. While such practices are culturally meaningful, they can result in delays in diagnosis and treatment, worsening health conditions, preventable deaths, and increased pressure on an already strained health system (Oyekale, 2017).

Critical factors compound the problem, including economic disparities that limit affordability of care, gender norms that influence decision-making about seeking treatment, and geographical challenges that restrict access to health facilities in rural and underserved areas. The result is a pattern of delayed health-seeking behaviour, underutilization of modern healthcare services, and continued reliance on traditional and spiritual healing methods. Health education strategies, as currently delivered, frequently fail to address these realities,

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resulting in weak health communication, mistrust in public health systems, and persistent misconceptions about diseases and treatments (Ezenwaka et al., 2021).

Repositioning health education to be culturally sensitive, community-driven, and contextually relevant is therefore critical to improving health outcomes in Kaduna State. Tailoring health education messages to local languages and belief systems, engaging trusted community influencers such as religious leaders, elders, and traditional healers, and addressing socio-economic and gender-related barriers will enhance the effectiveness of health education interventions. Bridging the gap between traditional health beliefs and modern medical practices, culturally grounded health education can promote timely and appropriate health-seeking behaviour, foster trust in healthcare systems, and reduce preventable illnesses and deaths among Kaduna State's diverse population.

Kaduna State in North-West Nigeria presents a unique context for studying these dynamics because of its significant ethnic and religious diversity. Residents of LGAs such as SabonGari, Zaria, Kaduna North, Igabi, Giwa, Kachia, and Kaura hold varied beliefs and practices that strongly influence their perceptions of illness and the healthcare system. Deep-seated cultural barriers such as misconceptions about the causes of illness, mistrust of biomedical interventions, and the prioritization of ancestral or religious healing traditions often hinder timely utilization of formal healthcare. These issues persist despite the expansion of healthcare infrastructure and health education programmes across the state.

Methodology

Research Design

This study employs a mixed-method design to explore the influence of cultural beliefs on health-seeking behaviour and the role of health education in Kaduna State. The researcher employs a cross-sectional descriptive design for quantitative uses structured questionnaires to measure cultural beliefs, health-seeking patterns, and exposure to health education. The qualitative component involves focus group discussions with community members and key informant interviews with healthcare providers, traditional leaders, and health educators. This combination allows for a comprehensive and contextually rich analysis, enhancing the validity and depth of the findings.

Population

The population for this research comprises all residents in Kaduna State. According to the 2025 National Population Commission estimates, Kaduna State has a projected population of 9,857,682 people. While adult's population is estimated at 5,420,000. The diverse nature of this population is essential to capture a broad perspective on cultural barriers in health-seeking behaviour across various settings.

Sample and Sampling Procedures

The sample size for this study was drawn from the population which was 384. The sample size was adopted from Research Advisor (2006) who stated that for large population of about (2,500,000 to 300,000, 000), 384 respondents can be adequately used as a simple size. Ten (16) respondents were added for incase of attrition, sample will be 400 respondents. A multi stage sampling procedure was employed for this study, which include stratified, simple random, proportionate and systematic sampling procedure.

Stage I: Cluster sampling technique was used to divide Kaduna state into the three (3) existing senatorial zones, which are Kaduna north, Kaduna central and Kaduna south as a strata.

Stage II: Simple Random Sampling Technique was used to select two (2) local government area from the each senatorial zones which (Kaduna North, Kaduna Central and Kaduna south) in Kaduna state.

Stage III: Simple Random sampling technique was used to select one community for the study from each selected LGAs. Sabon Gari and Zaria LGA from Kaduna north, Igabi and Giwa from Kaduna central and Kachia and Kauru from Kaduna South.

Stage IV: Proportionate sampling technique was used to select respondents from each community. Number of respondents in a particular community. The respondents selected are 27, 23, 102, 148, 38 and 62 respectively.

Stage V: Systematic sampling method was used to select and administer questionnaire to participants using every 5th participants from the selected houses in community to participate in the study.

Instrument for Data Collection

The instrument that was used for data collection in this study was researcher-structured closed-ended questionnaire. The questionnaire was divided into 3 sections A, B and C. Section "A" comprises of demographic characteristics of the respondents, Section "B" and C Consists of (5) items each on repositioning health education in address cultural barriers to health-seeking behaviour in Kaduna State, Nigeria. To calculate the mean score of response as shown by respondents, the modified four (4) point's likert rating scale was used. Therefore, any mean score of response than 2.5 or above was regarded positive, while any mean score of response less than 2.5 was regarded negative.

Validity of the Instrument

To ensure content validity, the questionnaire and interview guide are reviewed by experts in dentistry, public health education, and research methodology. Their feedback is used to refine the items for clarity and relevance.

Procedure for Data Collection

Informed consent is sought from all participants. Research assistants distribute questionnaires to dental professional in dental clinics, providing necessary explanations. Respondents complete the forms immediately. Data from questionnaire were complemented by focus group discussions and key informant interviews with healthcare providers and community leaders. Responses are recorded with permission. Completed questionnaires are collected, coded, and prepared for analysis. Focus Group Discussion Guide is to explore cultural perceptions, barriers, and suggestions related to health-seeking behaviour and health education. Key Informant Interview Guide is to obtain expert views on health education implementation, cultural barriers, and strategies for repositioning health education.

Procedure for Data Analysis

The collected data undergoes analysis using both descriptive and inferential statistics. Frequencies, percentages, means, and standard deviations are used to summarize demographic data and responses on address cultural barriers to health-seeking behaviour. Chi-square tests is applied to assess the relationship between knowledge level and facilities. The Statistical Package for the Social Sciences (SPSS) software is used for data analysis.

Answering the Research Questions

Descriptive analysis of the participants' socio-demographic characteristics

The total number of four hundred (400) questionnaire was distributed and three hundred and ninety-five (395) questionnaire were retrieved. The socio-demographic characteristics of the respondents selected for the analysis along their expressed responses were: marital status, level of education, age, occupation and Gender. These variables are categorized into ranges and presented in frequency and percentages in table 1

Table 1: Demographic Characteristics of the Participants

Variable	Variable Options	Frequency	Percentage %
Marital status	Single	79	20

Level of education	Married	110	28
	Widow	72	18
	Divorced/separated	134	34
	Total	395	100.0
	Non formal education	98	25
	Primary education	130	33
	Secondary education	88	22
Age	Tertiary education	79	20
	Total	395	100.0
	18 -25	178	45
	26 - 35	133	34
	36 - 45	37	9
	46 - above	47	12
	Total	395	100.0
Occupation	Artisan	165	42
	Trader	121	31
	Civil servant	75	19
	Farmer	34	9
	Total	395	100.0
Gender	Male	247	63
	Female	148	37
	Total	395	100.0

Source: Field survey, 2024

Table 1 showed that on Marital status distribution single has 79 (20.0%); Married has 110 (28.0%); Widow, has 72 (18.0%), and divorced/separated has 134 (34.0%). Married the highest while Widow is the lowest.

The Level of Education distribution Non-Formal Education has 98 (25.0%); Primary education has 130 (33.0%); Secondary education, has 88 (22.0%) and Tertiary education has 79 (20.0%). Primary education is the highest while no-formal education is the lowest.

The Age distribution 18-25 has 178 (45.0%); 26 - 35 has 133 (34.0%); 36-45 has 37 (9.0%) and 46 and above, has 47 (12.0%). 26 - 35 is the highest while 36-45 is the lowest.

The occupations distribution Artisan has 165 (42.0%); Trader has 121 (31.0%); Civil servant has 75 (19.0%) and Farmer has 34 (9.0%). Artisans are the highest while farmers are the lowest.

The gender distribution Male, has 247 (63.0%), and Female has 148 (37.0%). Male are the highest while Females are the lowest.

Research Question One: What are the personal health-seeking patterns and influences among residents of Kaduna State?

To determine the personal health-seeking patterns and influence among residents of Kaduna State were computed and compared using mean scores and standard deviation. The benchmark mean was fixed at 2.50 as the midpoint average of the 4 point scale used for the measurement. The summary is presented in Table 2

Table 2 Mean score and standard deviation on personal health-seeking patterns and influences among residents of Kaduna State, Nigeria.

S/No	Personal health-seeking patterns and influences	Mean	Std. Dev.
1	I visit health facilities when I feel unwell.	2.25	0.971
2	I prefer self-medication before going to the hospital.	2.99	0.628

3	I trust traditional healers more than hospitals.	3.23	0.765
4	I delay visiting hospitals due to cost or distance.	2.76	0.965
5	My decision to seek healthcare is influenced by family or religious leaders.	2.75	0.743
Aggregate		2.80	0.814

(Decision Bench mark = 2.50)

The rating of the two groups in Table 2 revealed a positive response of respondents in the test of; I prefer self-medication before going to the hospital (2.99), I trust traditional healers more than hospitals (3.23), I delay visiting hospitals due to cost or distance (2.76), My decision to seek healthcare is influenced by family or religious leaders (2.75). The negative response is I visit health facilities when I feel unwell (2.25). The aggregate mean of 2.80 and standard deviation of 0.814 indicate agreement to the research question on the influence of cultural beliefs and practices on health-seeking behaviour.

Qualitative Insights (Interviews and FGDS)

What are the personal health-seeking patterns and influences among residents of Kaduna State?

Qualitative Findings (Interviews and Focus Group Discussions)

To supplement the quantitative results in Table 2, in-depth interviews and focus group discussions (FGDs) were held with community members from SabonGari, Zaria, Kaduna North, Igabi, Giwa, Kachia, and Kaura Local Government Areas (LGAs). The discussions revealed several consistent themes:

Item 1: I visit health facilities when I feel unwell (M = 2.25) – Below benchmark

- Kaduna North (Interview): A 29-year-old teacher said, "I rarely go to the clinic for minor issues; I only go if it becomes serious."
- SabonGari (FGD): Several participants admitted postponing hospital visits, citing long waiting times and unresponsive staff.
- Kaura (Interview): A farmer explained, "The hospital is far, and transport is costly, so we manage small illnesses at home first."

Item 2: I prefer self-medication before going to the hospital (M = 2.99) – Positive Response

- Zaria (FGD): A young woman said, "The chemist is closer and cheaper. We try over-the-counter drugs first."
- Igabi (Interview): A trader stated, "Why spend so much on a hospital when simple tablets from the pharmacy usually work?"
- Giwa (FGD): Participants highlighted that self-medication is a family habit passed from parents to children.

Item 3: I trust traditional healers more than hospitals (M = 3.23) – Strong Positive Response

- Kachia (Interview): A mother of four shared, "Our elders' herbs heal quickly; hospitals sometimes make the illness worse."
- Kaura (FGD): Participants agreed that traditional healers are respected custodians of health knowledge.
- Zaria (Interview): A middle-aged man said, "When hospitals fail, the herbalist is the final answer."

Item 4: I delay visiting hospitals due to cost or distance (M = 2.76) – Positive Response

- Giwa (Interview): A farmer stated, "It can take hours to reach the hospital, and transport is expensive."
- Kachia (FGD): Several women said they save money first or try home remedies to avoid hospital bills.

- SabonGari (Interview): A motorcyclist added, "If the sickness isn't severe, I wait hospital charges are high."

Item 5: My decision to seek healthcare is influenced by family or religious leaders (M = 2.75)

– *Positive Response*

- Kaduna North (FGD): Participants explained that elders and imams guide their healthcare choices.
- Igabi (Interview): A mother shared, "Before I take a sick child to the hospital, I ask my husband and our pastor for advice."
- Kaura (FGD): Community members said healthcare decisions are often collective rather than individual.

Summary of Qualitative Themes

Across SabonGari, Zaria, Kaduna North, Igabi, Giwa, Kachia, and Kaura, the narratives reveal:

- Low immediate hospital use: Residents often avoid or delay formal care unless illness is severe.
- Widespread self-medication and traditional healer trust: These practices are culturally embedded and seen as cost-effective.
- Economic and geographic barriers: Cost and distance remain significant deterrents.
- Social influence: Family and religious leaders play a critical role in shaping health decisions.

These qualitative insights support the aggregate mean of 2.80 from the quantitative data, showing that personal health-seeking behaviour in Kaduna State is shaped by cultural traditions, social structures, and access constraints.

Integration of Quantitative and Qualitative Data

The interviews and FGDs contextualize the statistical findings, showing why respondents prefer traditional healers or self-medication. They further confirm that religious and family networks remain central to decision-making and that cost and distance act as powerful deterrents to formal healthcare use. Together, these insights highlight the need for community-based health education and improved rural healthcare access in Kaduna State.

Research Question Two: What are the cultural beliefs that shape perception of illness and health care among residents of Kaduna State?

To determine the cultural beliefs that shape perception of illness and health care among residents of Kaduna State were computed and compared using mean scores and standard deviation. The benchmark mean was fixed at 2.50 as the midpoint average of the 4 point scale used for the measurement. The summary is presented in Table 3

Table 3 Mean score and standard deviation on cultural beliefs that shape perception of illness and health care among residents of Kaduna State, Nigeria.

S/No	Cultural beliefs that shape perception of illness and health care	Mean	Std. Dev.
1	Many people in my community believe illnesses are caused by spiritual forces	2.71	0.402
2	I believe some illnesses should be treated by traditional or spiritual means.	3.42	0.780
3	Cultural beliefs have influenced my decision to delay or avoid hospital visits.	3.14	1.030
4	Violating taboos or customs can lead to illness.	3.17	0.996
5	Cultural beliefs in my community discourage hospital treatment.	3.15	0.569

Aggregate	3.12	0.755
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(Decision Bench mark = 2.50)

The rating of the two groups in Table 3 revealed a positive response of respondents in the test of; Many people in my community believe illnesses are caused by spiritual forces (2.71), I believe some illnesses should be treated by traditional or spiritual means (3.42), Cultural beliefs have influenced my decision to delay or avoid hospital visits (3.14), Violating taboos or customs can lead to illness (3.17), and Cultural beliefs in my community discourage hospital treatment (3.15). The aggregate mean of 3.12 and standard deviation of 0.755 indicate agreement to the research question on the cultural beliefs that shape perception of illness and health care among residents.

Qualitative Insights (Interviews and FGDS)

Follow-up interviews and FGDS across SabonGari, Zaria, Kaduna North, Igabi, Giwa, Kachia, and Kaura LGAs helped contextualize these findings:

Item 1: Many people in my community believe illnesses are caused by spiritual forces (M = 2.71)

- Kaduna North (Interview): A 40-year-old artisan shared, "When someone falls sick suddenly, we suspect spiritual forces or curses."
- Zaria (FGD): Participants recounted experiences where illnesses like prolonged fever were attributed to witchcraft, leading families to seek prayers or spiritual cleansing before considering hospitals.
- Kaura (Interview): A mother of three added, "If medicine fails, we believe the sickness has a spiritual origin."

Item 2: I believe some illnesses should be treated by traditional or spiritual means (M = 3.42)

- Giwa (Interview): A farmer stated, "Herbal remedies and elders' prayers have always worked for us, especially for stomach pains or childbirth issues."
- Kachia (FGD): One participant explained, "Even today, for certain ailments, we start with herbs or spiritual prayers it's part of our culture."
- Igabi (Interview): A young trader said, "Some conditions respond better to traditional medicine than hospital drugs."

Item 3: Cultural beliefs have influenced my decision to delay or avoid hospital visits (M = 3.14)

- SabonGari (FGD): Several participants admitted postponing hospital visits to try spiritual remedies first. One woman said, "We go to hospitals only if the sickness persists after prayers."
- Kaura (Interview): A man explained, "I once delayed taking my child to the clinic because elders said it was a spiritual issue."
- Kaduna North (FGD): Participants noted that families often consult community elders before deciding to seek medical care.

Item 4: Violating taboos or customs can lead to illness (M = 3.17)

- Igabi (Interview): An elderly woman stated, "If you break some customs, like eating forbidden food during mourning, you can fall sick."
- Kachia (FGD): Participants discussed local taboos such as avoiding certain rivers or foods, linking their violation to ailments.
- Zaria (Interview): A young mother said, "Older women warn us not to violate customs, or illness will follow."

Item 5: Cultural beliefs in my community discourage hospital treatment (M = 3.15)

- SabonGari (FGD): A participant noted, "Some elders say hospitals cannot treat our kind of sickness they prefer traditional healers."

- Giwa (Interview): A middle-aged man added, “People say hospitals are for emergencies; small illnesses are for herbs and prayers.”
- Kaura (FGD): Participants discussed community pressure, where seeking hospital care first may be viewed as disregarding tradition.

Summary

Across SabonGari, Zaria, Kaduna North, Igabi, Giwa, Kachia, and Kaura LGAs, participants repeatedly linked illness to spirituality, customs, and traditional remedies. Each item’s qualitative evidence confirms the aggregate mean of 3.12, illustrating the strong role of cultural beliefs in shaping healthcare decisions. These insights also suggest that health interventions in Kaduna State must respect cultural contexts, involve community leaders, and gradually build trust in formal healthcare systems.

Integration of Quantitative and Qualitative Data

The aggregate mean (3.12) indicates strong overall agreement that cultural beliefs shape healthcare choices. The interviews and FGDs provide depth, revealing that across the seven LGAs, spiritual explanations, customs, and community expectations consistently influence residents’ perceptions of illness. Together, these findings suggest that culturally tailored health education and community engagement strategies are critical for improving health-seeking behaviour in Kaduna State.

Hypothesis Testing

Hypothesis One: There is no significant personal health-seeking patterns and influences among residents of Kaduna State residents of Kaduna State, Nigeria.

Table 5

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
Pearson Chi-Square	251.432 ^a	22	.004
Likelihood Ratio	221.032	22	.001
Linear-by-Linear Association	102.013	1	.002
N of Valid Cases	395		

- The Pearson Chi-Square, Likelihood Ratio, and Linear-by-Linear Association tests all indicate a significant association (p-value = 0.002).

Hypothesis

H_0 : There is no significant personal health-seeking patterns and influences among residents of Kaduna State residents of Kaduna State, Nigeria.

Decision Criteria

Reject H_0 if p-value is greater than α value (level of significance) we fail to reject.

P-value = 0.02 α = 0.05

With the values above it means that we reject the null hypothesis. Meaning that there is no significant personal health-seeking patterns and influences among residents of Kaduna State residents of Kaduna State, Nigeria.

Hypothesis Two: There is no significant cultural beliefs that shape perception of illness and health care among residents of Kaduna State residents of Kaduna State, Nigeria.

Table 6

Chi-Square Tests

	Value	df	Asymptotic Significance (2-sided)
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Pearson Chi-Square	293.012 ^a	22	.003
Likelihood Ratio	274.00	22	.004
Linear-by-Linear Association	131.220	1	.002
N of Valid Cases	395		

- o The Pearson Chi-Square, Likelihood Ratio, and Linear-by-Linear Association tests all indicate a significant association (p-value = 0.003).

Hypothesis

H_0 : There is no significant cultural beliefs that shape perception of illness and health care among residents of Kaduna State, Nigeria.

Decision Criteria

Reject H_0 if p-value is greater than α value (level of significance) we fail to reject.

P-value = 0.03 α = 0.05

With the values above it means that we reject the null hypothesis. Meaning that there is no significant cultural beliefs that shape perception of illness and health care among residents of Kaduna State, Nigeria.

Results from interview and Focal group discussion

Personal Health-Seeking Patterns and Influences among Residents of Kaduna State

The findings revealed that many residents of Kaduna State, particularly in rural communities, tend to delay seeking formal healthcare until health conditions become severe. This pattern of delay is often attributed to a "wait and see" attitude, where individuals prefer to monitor the illness before committing time or resources to treatment. A recurring theme in both interviews and FGDs was the tendency to begin with self-medication or consultation with family and traditional healers before seeking modern healthcare services. This suggests a layered or sequential approach to care-seeking. Another common pattern observed was the simultaneous use of both traditional and orthodox medicine. Respondents, especially in rural settings, often relied on herbal remedies and spiritual healing, sometimes alongside modern medications. This dual usage stems from cultural familiarity with traditional medicine and skepticism toward the efficacy or trustworthiness of hospital care. In urban areas, while the use of hospitals was more prevalent, residents still acknowledged consulting family elders and community leaders for advice, particularly in cases involving children or chronic illness. Health-seeking behaviour was also significantly shaped by gender norms and decision-making hierarchies. In many households, men are the primary decision-makers regarding when and where family members, especially women, can seek care. This patriarchal structure sometimes led to delays in accessing treatment for women and children. Educational level emerged as a strong determinant of behaviour; those with secondary or tertiary education were more likely to seek timely, formal healthcare and showed greater awareness of preventive practices. In terms of economic influences, low-income respondents cited cost as a major barrier to healthcare access. Out-of-pocket expenses, particularly for consultation, medications, and transportation, discouraged timely hospital visits. Furthermore, the distance to healthcare facilities and the perceived quality of care influenced preferences, with some community members opting for traditional medicine simply because it was more affordable and locally accessible. Professionals interviewed noted that exposure to health education campaigns whether via radio, community outreach, or health talks positively shaped people's attitudes and encouraged early health-seeking.

Cultural Beliefs that Shape Perception of Illness and Healthcare in Kaduna State

Cultural beliefs were found to play a profound role in shaping residents' understanding of illness and their responses to health conditions. A significant number of participants in both interviews and FGDs described certain diseases such as epilepsy, mental illness, infertility, and prolonged fevers as spiritual in origin. These illnesses were often attributed to curses, ancestral punishment, or spiritual attacks, leading individuals to seek help from spiritual leaders, traditional priests, before considering formal medical intervention. In many cases, biomedical explanations of these conditions were either misunderstood or outright rejected. Belief in the efficacy of traditional medicine was also strong across many communities. Herbal remedies were perceived as more natural, trustworthy, and aligned with local knowledge systems. Participants emphasized that herbs are part of cultural heritage and are often seen as having fewer side effects compared to pharmaceutical drugs. Some even expressed greater confidence in the healing power of herbs than in hospital treatments. Health professionals interviewed corroborated this perception and acknowledged the widespread influence of traditional medicine in health behaviour, especially in rural areas where hospitals are far and poorly equipped.

Cultural taboos and gender norms further affected health-seeking behaviour. For instance, female respondents from conservative communities expressed reluctance to be examined by male health workers, particularly for maternal or reproductive health issues. Additionally, topics such as infertility, HIV/AIDS, and mental health were often regarded as taboo and not openly discussed within families or communities, leading to secrecy, denial, and late presentation at health facilities. This silence around stigmatized conditions reinforces misinformation and obstructs timely intervention. Religious and traditional leaders were highlighted as key gatekeepers in the community whose influence can either hinder or support health interventions. Respondents frequently mentioned that when community leaders endorsed health messages such as during polio immunization or COVID-19 campaigns community acceptance increased significantly. Health professionals and NGOs working in Kaduna State acknowledged that involving these leaders in the design and delivery of health education is crucial for reaching the grassroots population and reshaping cultural narratives around illness and healthcare.

Discussions

There is no significant personal health-seeking patterns and influences among residents of Kaduna State residents of Kaduna State, Nigeria. With the values of value =0.02 means that we reject the null hypothesis. Meaning that there is no significant personal health-seeking patterns and influences among residents of Kaduna State residents of Kaduna State, Nigeria. A similar studies by Bello & Rehal, (2014) on Health-Seeking Behaviours and Cultural Beliefs of Mothers in Paediatric Malaria Treatment in Ile-Ife, Nigeria although qualitative, this study highlights how cultural beliefs influenced treatment decisions for childhood malaria, such as the use of prayer, herbal concoctions, and home remedies before seeking formal care. While exact p-values were not reported, the findings underscore the significant role of cultural beliefs in delaying biomedical treatment.

A similar studies by Usman *et al.*, (2020) Factors Influencing Health-Seeking Behaviour among Residents of Basawa Community, SabonGari L.G.A., Kaduna State. A descriptive cross-sectional study in September 2017 among 125 residents used a semi-structured interviewer-administered questionnaire. Analysis via SPSS ($\alpha = 0.05$) showed that two-thirds delayed seeking care for more than 24 hours. Key barriers included the high cost of care (55.2%), poor staff attitudes (22.4%), and long waiting times (22.4%). The study found no statistically significant association between residential distance and frequency of hospital visits ($p > 0.05$), indicating that personal health-seeking behaviour was not significantly influenced by proximity to facilities.

A similar studies by Ochee et al., (2016) on *Perception and Information-Seeking Behaviour of Rural Households toward Health-Promoting Practices in Maigana District, Kaduna State*. A structured questionnaire using a 4-point Likert scale was administered to 150 respondents selected through multistage sampling. Sixteen core health-promoting practices were assessed. Descriptive statistics and one-sample t-tests were used to determine the significance of responses. Results showed that only 6 out of 16 items had mean scores above the decision benchmark ($M > 2.5$), while the remaining 10 items scored between 2.09 and 2.49. The one-sample t-test revealed that the observed differences in perception and practice were not statistically significant for the majority of health behaviours ($p > 0.05$). The findings suggest inconsistent health-seeking patterns, driven by limited awareness, cultural norms, and low information access. The study recommends enhanced, culturally appropriate health education strategies to increase the adoption of preventive health behaviours in rural communities.

There is no significant cultural beliefs that shape perception of illness and health care among residents of Kaduna State, Nigeria. With the values of value = 0.03 means that we reject the null hypothesis. Meaning that there is no significant cultural beliefs that shape perception of illness and health care among residents of Kaduna State, Nigeria.

A similar studies by Igbokwe et al., (2024) on *Influence of Cultural Beliefs on the Utilization of Integrated Maternal, Newborn, and Child Health Services in Benue State, Nigeria*. This community-based survey involving 896 childbearing mothers revealed a moderate positive correlation between cultural beliefs and the utilization of maternal and child health services ($r = 0.43$, $p < 0.001$). Regression analysis confirmed that cultural factors are significant predictors of service use. Results suggest incorporating local cultural norms and beliefs into health education can enhance service utilization

Conclusion

This study highlights that cultural beliefs significantly influence health-seeking behaviour in Kaduna State, often acting as barriers to timely and effective use of modern healthcare services. Health education, when repositioned to incorporate cultural sensitivity and community engagement, holds great potential to overcome these barriers and improve health outcomes. Integrating traditional and modern approaches, empowering health educators with cultural competence, and involving key community leaders are critical strategies for repositioning health education within Nigeria's healthcare system. Ultimately, such culturally informed interventions will promote better health-seeking behaviour, enhance trust in healthcare services, and contribute to the overall improvement of public health in Kaduna State.

Recommendations

Culturally Sensitive Health Education: Health education programmes in Kaduna State should be designed and delivered with a deep understanding of local cultural beliefs and practices. This includes using culturally appropriate language, examples, and communication channels. **Engage Traditional and Religious Leaders:** Since these leaders influence health-seeking behaviour, involving them in health education campaigns can help bridge cultural barriers and increase community acceptance.

Training Health Educators: Health workers and educators should receive training on cultural competence to improve their interaction with patients from diverse cultural backgrounds.

Community Participation: Encourage active involvement of community members in the planning and implementation of health education programmes to ensure relevance and effectiveness.

Integration of Traditional Practices: Where safe and possible, integrate beneficial traditional health practices with modern healthcare services to improve trust and utilization.

Use of Multiple Communication Channels: Health education should leverage radio, local languages, social media, religious gatherings, and community meetings to reach diverse populations.

Policy Support: Policymakers should develop guidelines that mandate the inclusion of cultural considerations in health education within the healthcare system.

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