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CULTURAL BELIEFS AND HEALTHCARE UTILIZATION IN ANAMBRA STATE, NIGERIA

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ABSTRACT: This study investigated cultural beliefs and healthcare utilization in Anambra State, Nigeria. The study used a mixed-methods research design. This type of research involves the collection and analysis of data via both quantitative and qualitative methods. The quantitative data were gathered via questionnaires, and the qualitative data were collected via an in-depth interview guide (IDI). The quantitative data collected were processed via SPSS (23) and analysed with descriptive statistics, whereas the data from the qualitative interviews were coded into themes that reflected the objectives of this study. Evidence suggests that cultural beliefs affect healthcare utilization. In addition to cultural beliefs, economic factors are other factors that prevent modern healthcare utilization. With the belief that traditional medicine is potent, it presents a viable alternative. The major factor is economic factors. The respondents believed that involving traditional healers in healthcare programs would help increase healthcare utilization. Additionally, reducing the cost of utilizing modern healthcare is a major intervention, among other findings. The results of this study suggest that further studies that are comprehensive enough to breed more data are needed to aid in generalization.

Keywords: Cultural Beliefs, Healthcare Services Utilization, Cultural Beliefs, Healthcare Services Utilization

INTRODUCTION

Much studies on cultural beliefs and healthcare utilization have been conducted across cultures (Kagawa-Singer & Kassim-Lakha, 2013; Betancourt et al., 2013; Smedley et al., 2015; Suarez et al., 2015; Okoronkwo et al., 2019). Some studies argue that cultural impacts affect healthcare consumption and that many civilizations have used traditional or alternative medicine, sometimes alongside Western treatment termed modern healthcare. Additionally, studies such as (Gee et al., 2015) suggest that ethnic and cultural groups utilize healthcare differently. In Anambra, (Sibeudu et al., 2019) found that households in the urban community had a higher level of utilization of routine immunization (95.5%) than those in the rural community (75.3%) and the difference was statistically significant ($p < 0.05$). However, there is a dearth of empirical studies that compared how cultural beliefs affect healthcare utilization within the locality of Anambra State. This study aims to empirically examine the impact of cultural beliefs on healthcare utilization in Anambra State.

LITERATURE REVIEW

Cultural belief is a group's common values, customs, and actions. Cultural beliefs include religion, morality, ethics, and social values. Ogunyemi (2018) noted that many indigenous cultures believe in the interconnectedness of all living things and the need to cohabit

harmoniously with nature. Nikiforova and Voronova (2023) research on cultural belief emphasizes the need to understand how groups and cultures form identities, values, and standards. Cultural belief practices encompass many rituals, conventions, and traditions handed down from generation to generation. These behaviours unite society and shape identity. Religion, art, language, and social interactions saturate everyday life. These activities also reflect a community's faith, history, and worldview (Salmorin and Gepty, 2023). Cultural ideas shape how people see, interpret, act, and comprehend morality, identity, and social duties. Cultural relativists believe that understanding ideas and acts inside a culture is more important than judging them outside (Eche, 2023), challenging the idea of a shared human morality.

Additionally, cultural concepts may impact people's self-image and identity. Several indigenous cultures employ storytelling and oral traditions to preserve and transmit history and knowledge (Bordoloi, 2015). These tales teach life lessons and build a feeling of ancestral connectedness. These practices often promote continuity and affiliation, which may vary by culture. Diwali, the Hindu festival of lights, celebrates virtue over evil (Yu, & Stoet, 2019).

Healthcare utilization refers to how much people utilize healthcare services to stay healthy. This notion matters in public health and healthcare systems. Personal traits, healthcare system issues, and socioeconomic variables affect healthcare service seeking, use, and decision-making. It includes health promotion, maintenance, and repair and is essential to human civilization. Many activities, services, and systems enhance health and fight disease (World Health Organization, 2015). Healthcare is an essential human right that benefits individuals and society.

Davis et al. (2014) reported that many industrialised countries' healthcare systems provide a broad variety of services and innovative technology to the public and private sectors. These systems often incorporate primary care, professional medical services, hospitals, and public health activities to provide universal healthcare access. The healthcare utilisation model, an integral part of healthcare usage, explains what influences people's medical care choices. Ronald Andersen's (1968) behavioural model of healthcare utilisation lists three kinds of characteristics that affect healthcare use: predisposing variables, including demographics and attitudes; enabling aspects, including healthcare access; and need factors, including health conditions. The Abel (2023) model has been frequently used to study demographic healthcare consumption.

Different services or kinds of treatment might be used to measure healthcare utilization. Emergency department utilization is a common study and policy topic. Research may analyze the causes of frequent emergency department visits and ways to minimize them to optimize emergency care. Medical accessibility is crucial to healthcare. Access disparities may affect individual and group health outcomes. Socioeconomic status, geography, and culture might affect healthcare access. Doctors, nurses, and allied health professionals are vital to medical treatment. These professionals can assess patients, identify the best therapy, and offer ongoing care. Doctors diagnose and cure diseases in the medical field (Stephen et al., 2022).

Medical care goes beyond treating diseases and injuries. Healthcare systems emphasise preventive care, health education, and healthy lifestyles worldwide. These efforts aim to promote public health and minimise sickness (Riekert, 2021). Kamgba (2023) claims that healthcare, including activities to preserve good health or prevent disease, is essential to human civilization. Cultural, economic, and societal influences shape this essential human

right. Effective healthcare systems provide universal access, reduce sickness, improve diagnostic and treatment techniques, and promote well-being. Health promotion and prevention are part of healthcare. Disease prevention includes immunisation efforts, health education, and lifestyle interventions that promote healthy diets and exercise.

Additionally, healthcare planning and resource allocation depend on service usage. Healthcare systems may improve resource allocation, planning, and access inequalities with greater utilisation analysis. Researchers and policymakers use data to plan infrastructure, manpower, and budgets. Healthcare regulations and procedures affect medical treatment availability. Systems may differ greatly by country. Canadians with Medicare and other universal healthcare programs are entitled to medical care regardless of income (Koumpouros, 2023).

There are scholarly researches that explored factors affecting healthcare utilization. For instance, Moonpanane et al (2022) conducted a study to understand healthcare service utilization of hill tribe children in underserved communities in Thailand. The study found that barriers to access was the central theme identified. Other themes included distance matters, education and socioeconomic deprivation, lack of cultural sensitivity, communication problems, tradition, beliefs, and differences in cultural practice, lack of child health professionals, and bureaucratic hurdles.

In another study Alwan et al (2020) investigated beliefs, perceptions, and behaviors impacting healthcare utilization of Syrian refugee children. The study identified four salient themes: stressors preclude health seeking behaviors, parents perceive health barriers, parents are dissatisfied with the healthcare system, and parents use resilience behaviors to overcome barriers. Stressors included poor housing and neighborhoods, reliving traumatic experiences, depression and anxiety, and social isolation. Dissatisfaction included emergency room wait times, lack of testing and prescriptions. Health barriers included missed appointments and inadequate transportation, translation services, health literacy and care coordination. Parents reported resilience through faith, by seeking knowledge, use of natural remedies, and utilizing community resources.

Also, Herwansyah et al (2022) in their study on the utilization of maternal health services at primary healthcare settings in Southeast Asian Countries found several themes. These include cultural and socioeconomic factors. Factors associated with the low utilization of ANC, determinants affected place of delivery and delivery assistance choice. Sociocultural barriers and disparities of health services provision are the major factors associated with low utilization of the services.

Mochache et al (2020) in their study found that religious and socio-cultural norms as well as gender stereotypes were important influences on the uptake and utilization of maternal health services, including facility-based delivery and contraception. Key amongst this was the unspoken deference to the counsel of a prominent matriarchal figure in the decision-making process.

Nyande et al. (2022) reported that sub-Saharan Africa accounts for approximately 50% of worldwide infant mortality. When children obtain regular and rapid healthcare, their health improves. However, rural Ghanaians face social and cultural impediments to medical treatment for children. This study revealed that carers' self-medication, language challenges,

and cultural views and behaviours connected to children under five years of age are the primary socio-cultural obstacles to child healthcare services in Nkwanta South Municipality. Many socio-cultural obstacles prevent nurses and carers from providing timely paediatric healthcare or delayed treatment for unwell children. community leaders to overcome cultural and social obstacles and ensure that rural children receive fast and uninterrupted treatment.

Another study by (Kota et al., 2023) revealed that maternal healthcare services significantly affect pregnancy and delivery outcomes. Togo and other sub-Saharan African nations face a public health crisis with high maternal and neonatal mortality. This research examined how 15–49-year-old Togolese women utilise maternal health care. Togo's 2013 Demographic and Health Survey, the third in the country, provided data for the research. Approximately 4,631 women aged 15–49 years were evaluated and studied. Birth at a hospital, proper prenatal care (ANC) visits, and timely ANC beginning were the outcome criteria. The data were examined via Stata 16. Most births occurred in health facilities, with 59.99% occurring during appropriate antenatal care (ANC) visits and 27.53% occurring during timely first ANC visits. The study revealed that women in the highest wealth quintile were more likely than women in the lowest wealth quintile to have their first antenatal care visit at the recommended time, receive adequate prenatal care, and give birth in a health facility (OR = 8.53, 95% CI = 4.06, 17.92). Women with a bachelor's degree or higher are more likely to have timely first antenatal care (ANC) visits (OR = 1.37, 95% CI = 1.11, 1.69) and attend an adequate number of ANC visits (OR = 1.73, 95% CI = 1.42, 2.12). Conversely, rural societies with greater egalitarianism and indigenous values used healthcare less. Togo reported that sociocultural obstacles and socioeconomic disparities affect maternal healthcare usage. However, apart from (Sibeudu et al., 2019) on immunization utilization, there is a dearth of empirical data on how cultural beliefs affect healthcare utilization in Anambra State of South-Eastern Nigeria.

METHODOLOGY

Research Design

The study adopted a mixed-methods research design. This type of research involves the collection and analysis of data via quantitative and qualitative methods.

Area of the study and study population

The area of this study is Anambra State. Anambra state comprises twenty-one local government areas, namely, Aguata, Awka North, Awka South, Anambra East, Anambra West, Anaocha, Ayamelum, Dunukofia, Ekwusigo, Idemili North, Idemili South, Ihiala, Njikoka, Nnewi North, Nnewi South, Ogbaru, Onitsha North, Onitsha South, Orumba North, Orumba South, and Oyi. Anambra State is located in the southeastern part of Nigeria. It is among the five states that make up the southeast geopolitical zone of Nigeria. It was created on 21st August 1991. It is bounded in the north by Enugu state, in the east by Imo state, in the south by the Delta state and in the west by Kogi state. The land area of Anambra state is approximately 4,844 square kilometres.

The target populations for this research were males and females in urban and rural areas. The Nigeria Population Census (2019) noted that Anambra state has a human population size of 4,177,828 people, with 2117984 males and 2059844 females (United Nations Human

Settlements Programme UN-HABITAT, 2009). When projected to the current year (i.e., 2024), the area has a population of 7,434,856 (male: 3,768,542; female: 3,666,314).

Sample size and sampling technique

The sample size for this study was 400. First, we clustered the 179 towns into urban and rural groups on the basis of their primary economic activities. From the urban and rural clusters, Awka and Agulu were selected via simple random technique.

Awka comprises seven Igbo groups sharing a common blood lineage divided into two sections. The senior section comprises four groups, namely, Ayom-na-Okpala, Nkwelle, Amachalla, and Ifite-Oka, followed by the Ezinator Section, which consists of three groups, namely, Amikwo, Ezi-Oka and Agulu. Each of these groups has a number of villages. Altogether, Awka comprises 33 villages. Furthermore, Agulu town comprises twenty villages. These are Nwanchi, Nneohia, Okpu, Ama-Ezike, Odidama, Amorji, Isiamaigbo, Ukunu, Uhueme, Obeagu, Obe, Nkitaku, Okpu-Ifite, Umubialla, Amatutu, Umuowelle, Umunnowu, Ifiteani, Umuifite, and Nneogidi.

The villages were selected using simple random selection techniques and the households were selected through systematic sampling techniques. The researchers selected 50% of the respondents (200) from urban households and the remaining 50% (200) from rural households via multistage sampling techniques.

For the qualitative data, the purposive sampling technique was used to select 12 participants, including six (6) from the urban area and the other six (6) from the rural area for the in-depth interview (IDI). The interviewees were selected on the basis of their level of knowledge, experiences and roles in cultural beliefs and healthcare utilization in the communities under study.

Instruments for Data Collection and Administration

A questionnaire and an in-depth interview (IDI) guide were used for the quantitative and qualitative data collection, respectively. The researchers administered the questionnaire and conducted the in-depth interviews. Consent was obtained through a consent letter.

Method of Data Analysis and Presentation

Data collected from the field were processed with the statistical package for social sciences (SPSS) version 23.0, and analysed via descriptive statistics, including frequency counts and simple percentages. The qualitative data gathered were processed manually and analysed thematically.

FINDINGS

This section contains the descriptive analysis and interpretation of quantitative data collected from the field, complemented by the descriptive analysis of qualitative data. The analysis is presented in two distinct sections: section A, which contains the descriptive analysis of the sociodemographic characteristics of the respondents, and B, which contains the descriptive analysis of the research question.

Sociodemographic characteristics of the respondents

This section presents the descriptive analysis of the responses offered by the respondents on their sociodemographic variables, including gender, age, religion, educational qualifications, marital status, occupation, level of income and place of residence. These are presented in Table 1.

The data in Table 1 shows that females outnumbered males in the present study's sample (i.e., 50.5% female respondents and 49.5% male respondents). The minimum age in the present study's sample was 15 years, whereas the maximum age was 105 years. However, 22.3% of the respondents were aged 31–28 years, 19.5% were aged 36–60 years, 20.6% were aged 61–75 years, and 17.8% were aged 76–90 years, while the smallest proportion (8%) of them were older men and women aged 91–105 years.

The sample comprises 90% Christians, 2% Muslims and 8% African traditional religion. This shows that Muslim and African traditional religion is somewhat low among the people of Anambra state.

With respect to educational qualifications, 28.1% of the respondents completed the secondary level of education. Approximately 42.8% of the respondents attended the tertiary level of education, 9% of whom only completed Diploma/NCE level, 26.6% of whom completed the first-degree level, and only a very low proportion (7.2%) of whom completed the postgraduate level. This finding shows that education in the present study area is somewhat impressive, even though approximately half of them could not attend higher education.

The sample comprised 27% single men and women, and 70% of the respondents were married. Approximately 3% of the respondents (1% and 2%) were divorced or separated, respectively. This shows that the divorce and separation rates were somewhat low.

Data analysis revealed that a relatively 91.3% of the respondents were employed, and 8.7% of them were unemployed. Among those who were employed, the data analysis revealed that their occupations varied. Among those employed, 30.3% were employed within the government or private sector. Among those who were informally employed, 52.2% and 3.6% were in the religious sector.

The minimum income level was below ₦30,000, whereas the maximum income level was above ₦91,000 per month. However, 49% of the respondents earned between ₦61,00 and ₦90,000 per month, 32% earned between ₦31,000 and ₦60,000 per month, and the smallest proportion (7%) earned below ₦30,000 per month.

Table 1: Sociodemographic characteristics of the respondents

Socio-Demographic Variables	Frequency	Percentage
Sex		
Male	197	49.5
Female	201	50.5
Total	398	100
Age Categories		
15 – 30	46	11.5
31 – 45	89	22.3
46 – 60	78	19.5
61 – 75	82	20.6
76 – 90	71	17.8
91 – 105	32	8
Total	398	100
Religion		
Christian	358	90
Muslim	8	2
African Traditional Religion	32	8
Total	398	100
Educational Qualification		
No formal education	32	8
FSLC	83	20.8
JSSCE	0	0
SSCE	112	28.1
OND/NCE	36	9
HND/BA/BSc	106	26
MA/MSc	21	5.5
PhD	8	2
Total	398	100
Marital Status		
Single	101	27
Married	282	70
Divorced	7	1
Separated	8	2
Total	398	100
Occupation		
Civil Servant	67	16.8
Public Servant	54	13.5
Trader	122	30.6
Farming	86	21.6
Artisan	21	5.2
Clergy	13	3.6
Unemployed	35	8.7
Total	398	100
Income Level		
Below ₦30,000	28	7
₦31,000 - ₦60,000	129	32
₦61,000 - ₦90,000	193	49
₦91,000 – above	48	12
Total	398	100
Place of Residence		
Urban	200	50.3
Rural	198	49.7
Total	398	100

Research Question: What are the cultural barriers to utilizing healthcare services in Anambra State?

Table 2: Composite data if respondents face cultural barriers in utilizing healthcare services

Variables	Not at all	Rarely	Sometimes	Often	Always	Total
Do cultural beliefs contribute to your hesitation in utilizing healthcare services?	169 (42.4%)	162 (40.7%)	51 (12.8%)	14 (3.5%)	2 (0.6%)	398 (100%)
Do cultural taboos prevent you from seeking medical treatment?	207 (52%)	161 (40.4%)	15 (3.7%)	10 (2.5%)	5 (1.5%)	398 (100%)
Do cultural norms discourage you from accessing healthcare facilities?	241 (60.5%)	127 (32.1%)	10 (2.5%)	15 (3.7%)	5 (1.2%)	398 (100%)
Do superstitions influence your decision to seek preventive healthcare measures?	281 (70.6%)	101 (25.3%)	3 (0.7%)	5 (1.2%)	7 (2.2%)	398 (100%)
Do cultural stigmas surrounding certain illnesses deter you from seeking treatment?	117 (29.3%)	156 (39.1%)	94 (23.6%)	10 (2.5%)	21 (5.5%)	398 (100%)
Do cultural rituals or ceremonies in hinders you from utilization of healthcare services?	126 (31.6%)	171 (42.9%)	87 (21.8%)	4 (1.0%)	10 (2.7%)	398 (100%)

Researcher Data Analysis, 2024

The data presented in Table 2 shows that 42.4% of the respondents said that cultural beliefs do not contribute to their hesitation in utilizing healthcare services. However, 40.7% of the respondents stated that cultural beliefs rarely contribute to their hesitation in utilizing healthcare services.

Furthermore, 52% of the respondents believed that cultural taboos do not prevent them from seeking medical treatment, whereas 40.4% of the respondents believed that cultural taboos rarely prevent them from seeking medical treatment.

In addition, 70.6% of the respondents said that superstitions do not influence their decision to seek preventive healthcare measures, whereas 25.3% of them said that superstitions rarely influence their decision to seek preventive healthcare measures.

> …here in Agulu, there is sickness that will happen to someone, the entire community will tell you that the individual committed an abomination, and that person usually faces the consequences. Few months ago, a man in the next village (Ifiteani) was said to carry a married woman with her children without paying dowry to his own house and both of them were living like husband and wife why the original owner of the woman and children (husband) is still alive. The matter was raised at Agulu town hall even at the palace. To summarize the story, the man who took someone else's wife had a heavy swollen stomach (*ọ dalu ibi, tokwa afọ*). His friends who have money, took him to different hospitals even Abuja but there was no remedy, and he died early this year. His

> kinsmen said they won't bury him until the immediate family cleanse the abomination, till today they have not done his funeral. (an interviewee said)
>
> the 72 years old interviewee said ……. Culture is inherent, in the sense that our grandparents passed so many norms, some are still active in this town while some have gone into extinction. For instance, there is what we call "*isọ ebe"* before a young girl is preparing for marriage. That act must be performed, but it is no longer in existence today. The reason for it is to cleanse the girl from youthful life and prepare her for family life so that the suitor will not encounter cultural taboo he knows nothing about and at this point the girl's family history is discussed, like sickness associated history. Then again, there is this family down the road in this village (Nneogidi), their father was popularly known for evil but the man died a long time ago. Nevertheless, the stigma is still living with the children in terms of community association. When they come to community public gatherings, people won't sit close to them. Even in religious activity, in the church if they sit in a particular pew, nobody goes to sit with them and this makes the man go to a neighboring town (Nibo) for Sunday service. And I know it equally affects them in utilizing the community health center in this town because barely you see people associating with them and even small children now usually describe their compound as an evil house. Most times you will hear children saying "my brother is playing football near that evil man's house". These children did not meet the evil man in person but the stigma still follows that particular family till today. So, that family is experiencing societal stigma and also the taboo that their late parents committed.

It is also observed that 39.1% of the respondents believed that cultural stigmas surrounding certain illnesses deter them from seeking treatment, whereas 29.3% of the respondents did not believe that cultural stigmas surrounding certain illnesses deter them from seeking treatment.

However, there is a slight difference of 11.3% from those who do not believe that cultural rituals or ceremonies hinder them from the utilization of healthcare services (31.6%) to those who believe that cultural rituals or ceremonies rarely hinder them from the utilization of healthcare services (42.9%). Moreover, 21.8% believe that cultural rituals or ceremonies sometimes hinder them from the utilization of healthcare services, and 2.7% believe that cultural rituals or ceremonies always hinder them from the utilization of healthcare services.

> … cultural taboo is still existing, there is what we call "*alu or ṅsọ ani".* When committing a taboo, definitely he or she must bear the consequences. Do you think everyone laying in Amaku Teaching hospital is merely sick? Some are spiritual while some are physical. Just like when my wife gave birth and she was combing the baby's hair, that child always falls sick and we keep going to the hospital but no positive result until I related the issue with a church member. He said whether my child is dada (dreadlock) and if he's dada, we should stop combing the hair. And after some months we heed to the advice that my child never fall sick as usual apart from malaria. And we were told that there are some rituals or ceremonies needed to be performed before going to hospital for any further treatment. (Male, 48 years old, Awka Trader).

To describe the cultural beliefs that contribute to respondents' hesitation in utilizing healthcare services, the respondents were first asked to indicate the variables that contribute to their hesitation in utilizing healthcare services. The results of the data analysis are presented in Figure 1.

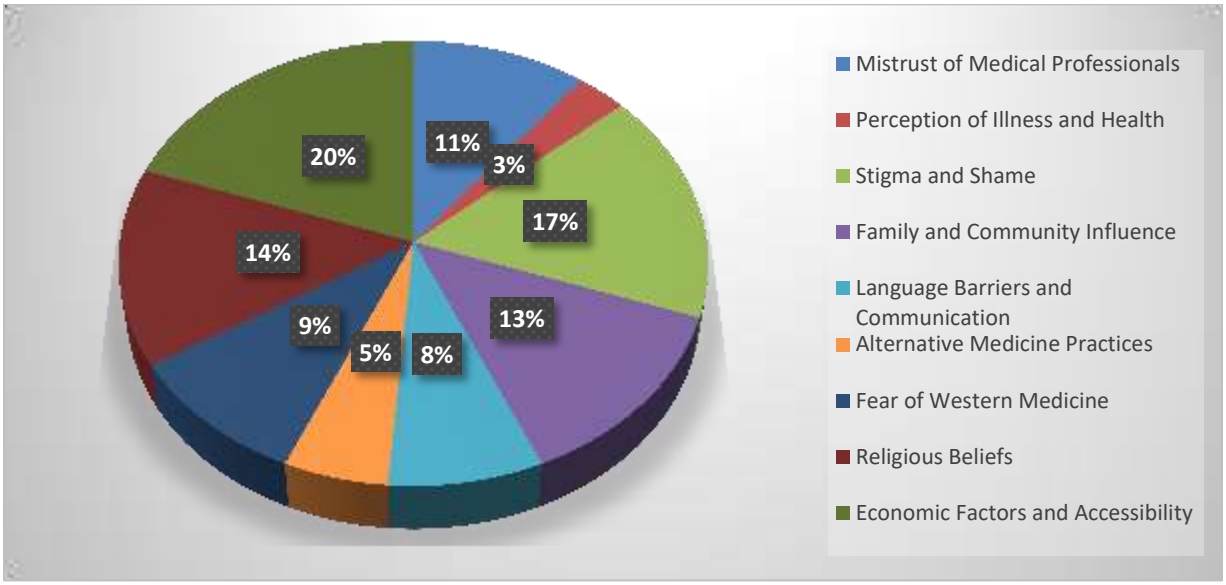

Fig. 1: Cultural beliefs that contribute to respondents' hesitation in utilizing healthcare services

As shown in Figure 1, 20% of the respondents indicated that economic factors and accessibility contribute to their hesitation in utilizing healthcare services, whereas a 17%, 14%, 13% & 11% of the respondents indicated that stigma and shame, religious belief, family and community, and mistrust of medical professionals, respectively, contribute to their hesitation in utilizing healthcare services. It was also observed that 9%, 8%, 5% & 3% of the respondents indicated that fear of Western medicine, language/communication barriers, alternative medicine practices and perceptions of illness and health, respectively, contributed to their hesitation in utilizing healthcare services.

> …there was an announcement our priest said at one Sunday mass here in Awka, he said that there is a particular vaccine that they are giving to females and warn that that vaccine has a particular effect of damaging the uterus (womb) and any parishioner that takes the vaccine is at their own risk. After that announcement, there is a public school nearby so I saw some of the health workers entering the school. After some minutes the health workers came out of the school and were laughing and I asked them "this one you people are laughing what happened". The health worker said that the principal refused them to give the female student that vaccine, and that their parish priest warned against it. After much deliberation the principal asked the health workers to address the students and the students told the health workers that they were told not to take the vaccine, the health workers told them the benefit of the vaccine "is to prevent cancer" but the female students echoed No!..... our parents said we should not take it. This made the health workers not to achieve their aim because of what a religious leader said.

Another respondent gave an impression that religious faith affects healthcare utilization.

> …there is slight conflict between religious leaders here and the followers because the villagers will argue some of the facts. Notwithstanding, they do influence their followers' perception most especially when their ideas work out, you'll begin to hear, "our pastor said it or priest said it". There are sicknesses that the religious leaders cannot influence in our town like I said earlier that some sicknesses in this village are spiritual and it is through spiritual (herbal/root means) these sicknesses are being tackled, so most Christians do not even listen to their pastors when it comes to such sicknesses like that, rather they prefer after getting healed they'll go to the church to thank God. The people in this village still have that perception that not all sicknesses that western medicine nor mere prayers work for (like pin, poison, swollen belly etc). They believe that some of these sicknesses can be handled by some traditional healers. Then why people also result in the traditional healers is because it is affordable in terms of monetary aspect. Some of the herbs and roots can easily be accessed without spending much money but when it comes to western drugs, one must be financially stable to tackle a particular sickness. Even when some individual in the community decided to go for lab test after the result and tabulation of cost of drugs, some of them end up not purchasing those drugs, when ask, they will tell you that the cost is on a higher rate and these makes them to go for herbs and roots which they can easily access in their garden.

To describe cultural norms that discourage respondents from seeking medical treatment, the respondents were first asked to indicate the variable that prevents them from seeking medical treatment. The results of the data analysis are presented in Figure 2.

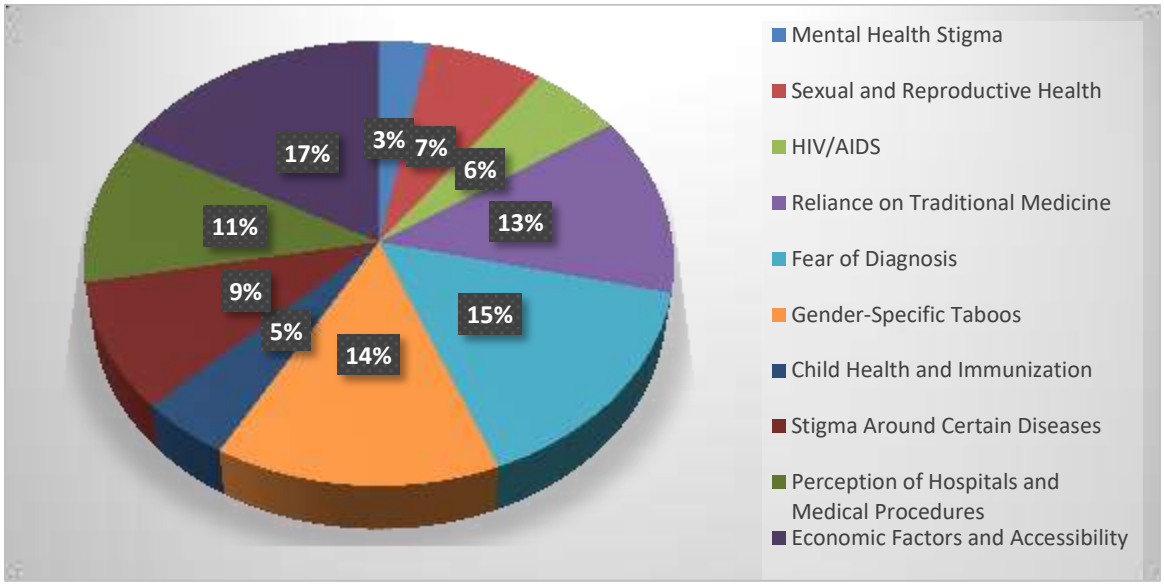

Fig. 2: Cultural norms that discourage individuals from seeking medical treatment

As shown in Figure 2, 17% & 15% of the respondents indicated that economic factors, accessibility, and fear of diagnosis respectively, prevent them from seeking medical treatment, whereas 14%, 13% & 11% of the respondents indicated that gender-specific taboos, traditional beliefs and practices, and perceptions of hospitals and medical practices respectively, prevent them from seeking medical treatment. It was further observed that 9%, 7%, 6%, 5% & 3% of the respondents indicated that stigma around certain diseases, sexual and reproductive health, HIV/AIDS, child health immunization and mental health stigma respectively, prevent them from seeking medical treatment.

Hypothesis

Compared with urban dwellers, rural dwellers are more likely to be affected by cultural beliefs in the use of modern healthcare facilities. The results of the statistical tests are presented in Table 3.

Table 3: Summary of chi-square tests showing the relationships between respondents' place of residence and cultural beliefs, which prevent individuals in Anambra state from seeking treatment for mental health issues.\

Residency	Strongly agreed	Agreed	Neutral	Disagreed	Strongly disagreed	Total	X^2	df	Sig.
Rural	4	83	26	82	4	198			
	2.49	48.75	54.23	85.07	7.46	198.0			
	0.92%	22.67%	14.69%	0.11%	1.61%	100			
Urban	1	16	83	89	11	200	79.6015	4	0.00001
	2.51	49.25	49.77	85.93	7.54	200.0			
	0.91%	22.44%	14.55%	0.11%	1.59%	100%			
Total	5	98	109	171	15	398			
	5.0	98.0	109.0	171.0	15.0	398.0			
	1.83%	45.11%	29.24%	0.22	3.2%	100%			

Researcher's Data Analysis, 2024 (Chi-square)

The chi-square test was run to test the assumption that cultural beliefs prevent individuals in Anambra state from seeking treatment for mental health issues within the place of residency. On the basis of the test conducted, this assumption was upheld, (x^2 (4) = 79. 6015, . This implies that the stated alternative hypothesis is retained. In other words, the propensity to opt that rural dwellers are more likely to be affected by cultural beliefs in the utilization of modern healthcare facilities than urban dwellers are.

DISCUSSION OF FINDINGS

Having analysed the various aspects of the data collected in this study, articulating the findings in a comprehensive and flexible way is pertinent. The first and second objectives of this study were to examine how the belief system affects healthcare utilization among dwellers in Anambra State. Findings from the data analysis performed on the numbers of questions raised in line with the research question actually support the initial motivation of this study, cultural belief and healthcare utilization. Unlike Alwan et al (2020), the findings of this study corroborate (Moonpanane et al., 2022; Mochache et al., 2020; Herwansyah et al., 2022) which suggest that approximately 70.7% of the dwellers in Anambra state believed that traditional beliefs influence their decision to seek medical care at different levels, with

34.4% rarely, 21.1% moderately and 15% to a great extent. This does not negate the fact that some dwellers indicated that traditional beliefs do not influence their decision to seek medical care; however, family beliefs about healthcare affect dwellers' personal healthcare decisions on the basis of their marital status, as it was statistically significant. These findings imply that although (29.3%) a relatively fair proportion of dwellers indicated that traditional belief does not influence their decision to seek medical care.

Like (Thomaus & Kumar, 2016) finding of this study suggests that beliefs affect urban and rural residents' attitudes, access to healthcare, and engagement in healthcare. Rural residents may choose traditional healers or herbal medicines on the basis of cultural beliefs or a lack of faith in contemporary therapy. Owing to this dependency, people may postpone receiving medical help, which might harm their health. The study revealed that rural communities choose traditional medicine owing to its accessibility, lower cost, and cultural congruence. Modern healthcare is more accessible and used by urbanites. The worldview remains important. The present study corroborates other findings, as indicated below. Socioeconomic position and religion may affect healthcare utilisation even in densely populated places. Urban people may refuse necessary medical treatment owing to religious beliefs or social shame. Urbanites are more likely to utilise healthcare facilities because they trust contemporary therapy (Thomaus & Kumar, 2016). These beliefs also shape sickness perceptions and healthcare practitioners' roles. In both cases, those who believe that their health outcomes are predestined may seek less preventive treatment. This may worsen the health disparity between urban and rural communities due to rural residents' restricted healthcare access. Healthcare utilisation is heavily influenced by beliefs. They affect health outcomes, medical intervention, and medical attention.

The research objective was to identify Anambra state cultural attitudes that prevent healthcare use. More than 40% were worried about medical condition stigma as a cultural barrier to treatment. Cultural barriers may also limit healthcare access, regardless of financial status. Cultural norms in Nigeria hinder healthcare access and use. Owing to their significant faith in traditional healers and herbal cures, many Nigerians, especially rural individuals, use them. Owing to their cultural relevance, simplicity, and availability, these approaches are typically favoured over contemporary medical procedures. Delaying professional treatment due to reliance may harm health. Health ideas in certain civilizations affect people's conduct. Some people choose prayers and spirituality above medical therapy because they believe in supernatural healing. Some people delay or refuse conventional medical treatment because they believe that their ailment is a spiritual assault or religious challenge (Okronkwo et al., 2019). Cultural gender roles may prevent women from receiving healthcare. Medical treatment may require male family consent for conservative or rural Nigerian women. Owing to social pressure to put their families first, women may postpone obtaining medical treatment (Abel, 2023). Owing to cultural stigma, some people avoid medical treatment for mental health issues, STIs, and HIV/AIDS. Many individuals avoid healthcare because of shame or humiliation. Several Nigerian cultures attribute illness to curses or witchcraft rather than medical emergencies. Because of this, some people avoid doctors and seek help from alternative or spiritual healers. Owing to misconceptions, misinformation, or poor past experiences, some people are hesitant to use healthcare services. Hospitals may be associated with death or anxiety related to medical treatments, making some people dislike them. A lack of medical knowledge and prompt treatment are other obstacles. Misunderstandings regarding illnesses and treatments and cultural beliefs that undervalue preventative care may contribute to healthcare underutilization (Eche 2023).

Conclusion

This study investigated the impact of cultural beliefs on healthcare utilization in Anambra State of South-eastern Nigeria. The study found a connection between cultural beliefs and healthcare utilization, often leading to delayed treatment, reduced access to preventive services, and poorer health outcomes. The reliance on traditional medicine, coupled with religious practices and gender norms, creates significant barriers to the effective use of modern healthcare services. On the basis of the various analyses conducted in line with the specific objectives set out in this study, the researcher therefore concludes that cultural beliefs and healthcare utilization in the present area remain suboptimal and that these findings could be associated with the perceived cost of health services, healthcare accessibility, mistrust of healthcare services, and stigma, among other factors. These cultural factors not only impact individual health but also strain the healthcare system, thus leading to the accumulation of drugs. To improve healthcare utilization and outcomes in Anambra, it is essential to develop culturally sensitive interventions that respect local traditions while promoting the benefits of modern healthcare. Collaborative efforts between healthcare providers, traditional healers, and community leaders are crucial in bridging the gap between cultural beliefs and modern medical practices, ultimately leading to better health outcomes for all.

Recommendations

One of the proposed strategies to solve the limitations of the research is to include local traditions when implementing community health education initiatives. To advance modern healthcare and reliable health information, it is crucial to organise these events in the local vernacular and include influential community figures like religious leaders and traditional healers.

Another important aspect is enhancing contact between traditional medical experts and practitioners of alternative medicine. Providing training to traditional healers on how to recommend patients to hospitals might be advantageous. To enhance communication and ensure prompt and suitable treatment for patients, it is advisable for both conventional and alternative healthcare providers to create formal referral networks.

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