Magna Scientia Advanced Research and Reviews

eISSN: 2582-9394

Cross Ref DOI: 10.30574/msarr

Journal homepage: https://magnascientiapub.com/journals/msarr/

(RESEARCH ARTICLE)

Check for updates

From Pulpit to Clinic: Health-Seeking Behaviours of Clergymen in South-Eastern Nigeria

Chizoba Jessica Diogu [1], Gabriel Chidera Edeh [2,*], Chimdalu Obialunamma Chukwujekwu [1], Chibuikem Emmanuel Okparaeke [1], Bostock Chinecherem Okafor [3], Al-amin Ahmad Adamu [4], , Sandra Olufunmilayo Idris [5] Precious Chinenye Madu [6] and Rukayyah Surajo Karaye [7]

[1] *Department of Medicine and Surgery, Faculty of Medicine, Nnamdi Azikiwe University, Awka, Anambra State, Nigeria.*
[2] *Department of Haematology, Babcock University Teaching Hospital, Ilishan-Remo, Ogun State, Nigeria.*
[3] *Department of Medicine and Surgery, College of Health Sciences, University of Abuja, Abuja, Federal Capital Territory, Nigeria.*
[4] *Department of Medicine, Faculty of Medicine, Elrazi University, Khartoum, Sudan.*
[5] *Department of Internal Medicine, Afe Babalola University, Ado Ekiti, Ekiti State, Nigeria.*
[6] *Department of Medicine and Surgery, College of Medicine and Health Sciences, Abia State University, Uturu, Abia State, Nigeria.*
[7] *Department of Medicine/Surgery, Faculty of Medicine, Misr University for Science and Technology, Egypt.*

Magna Scientia Advanced Research and Reviews, 2025, 14(01), 066-077

Publication history: Received on 08 March 2025; revised on 05 June 2025; accepted on 07 June 2025

Article DOI: https://doi.org/10.30574/msarr.2025.14.1.0067

Abstract

Introduction: Health-seeking behaviour can be defined as any activity that individuals who perceive themselves to have a health problem or to be ill undertake to find an appropriate remedy. This study assessed health-seeking behaviour among clergymen in South-Eastern Nigeria to understand how to better improve their health and care for them.

Methodology: A descriptive cross-sectional study was conducted among 180 clergymen in Nnewi-North, South-Eastern Nigeria. Information was obtained using a semi-structured, interviewer-administered, anonymous, and validated questionnaire. The study population comprised clergymen from the 3 main denominations (Catholic, Anglican, and Pentecostal). A random and simple sampling technique was used to enroll the respondents in the study. The data collected was analyzed using SPSS version 24. Descriptive and inferential statistics were applied where necessary.

Results: The mean age of the respondents was *43.4±10.6* years. The majority of the respondents (97.2%) had a good perception of the different dimensions of health, as well as good practice of health-seeking behaviour (78.9%). It was found that the seriousness of the illness and the availability or quality of services in the health facilities were the major factors that influenced their health-seeking behaviour practices.

Conclusion: This study underscores the centrality of clergies as health influencers in African communities, blending holistic health perceptions with evolving biomedical engagement. While denominational and educational factors shape practices, the rejection of spiritual fatalism signals a promising shift toward integrative care. By aligning interventions with clergy's cultural and theological frameworks, policymakers can harness their pivotal role in advancing public health goals.

Keywords: Health-Seeking Behaviour; Clergy; Practice; Perception; Factors; Nigeria

* Corresponding author: Gabriel Chidera Edeh

1. Introduction

World health Organization (WHO) defined health as a "state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" [1]. There are 5 dimensions of health, which include the physical, emotional, mental, spiritual, and social dimensions of health [2]. Health-seeking behaviour has been defined by Olenja and quoted by Latunji et al as, "any action or inaction undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy" [3]. It is any activity that individuals who perceive themselves to have a health problem or to be ill undertake in order to find an appropriate remedy [3]. Health seeking behaviour could be viewed based on some indicators: routine medical check-up, preference of healthcare facility, admission while having health problem, refusal of health services while ill [4]. Also, factors affecting health seeking behaviour such as illness type/severity, accessibility and availability of health services, socioeconomic status, gender and culture can be used in viewing health seeking behaviour [5].

In assessing health-seeking practices of the general public, it was shown that people have varying practices. A cross-sectional study done in Jamaica revealed that 52% of participants sought medical attention at the onset of illness, 42.3% sought medical care 2–7 days after the onset of the illness, while only 34.2% took the medication as prescribed by their doctors [6]. Another survey done in Palestine showed that there was a certain delay in seeking professional care when sick, as medical care was only sought for conditions that did not improve with self-medications or those which are perceived to be severe [7]. In a quantitative cross-sectional study done in Cambodia, it was shown that both the poor and the better-offs used home remedy such as herbs as first line care when ill, whereas the second most common action was self-medication and only very few ill people sought care from a hospital [8]. In a cross-sectional study done in Australia among doctors showed that they practiced self-treatment for acute condition as 90% of the specialists and 83% of the general practitioners says they are reluctant to receiving treatment from another doctor [9].

In Africa, a qualitative study done in Mbulu Tanzania showed that most people first stay at home, practice self-medication and if there isn't any recovery, they visit the dispensary [10]. Another qualitative survey on health-seeking behaviour done in Kenya revealed that disease perception or the attributed cause determines the management approach as some believed that illnesses perceived as natural were to be treated by doctors, while those perceived as having spiritual back-up were to be treated by traditional healers [11].

Certain factors affect health-seeking behaviour including age, sex, level of education, denomination and even some belief system. In a cross-sectional study done in Benue State, Nigeria, it was found that participants with higher educational level, female, and those from Catholic denomination had higher mean score of better health-seeking behaviour compared to their counterparts [12].

Beliefs about faith are important to people from African communities. They are more likely than other ethnicities to identify as belonging to a religious denomination [13]. Church-based health promotion have the ability to reduce health disparities and the church is one of the most respected and trustworthy institutions which has the potential to greatly enhance public health work [13]. It was reported that besides the physician or health care provider, clergies are another group of people with significant influence on other people's thoughts, emotions and behaviours [13]. Thus a clergy's concepts about health would influence his own self-care and how he minsters to others [14]. Clergies have been uniquely placed to promote community change but have virtually been ignored by the health system [15]. A qualitative study done in Kenya among 49 male clergies using focused group discussions revealed that some believe that God alone heals, hence it is unnecessary to see the doctor [14]. Some others believe God heals but seeking medical attention is permissible because physicians and others are conduits of God's healing, however some other pastors use herbal medication and sought health from ancient spirits too [14]. This study also revealed that some clergies were afraid to seek health-care when ill because it makes them feel they are without faith or immoral, and they were also worried that the congregation would lose faith in them [14]. Despite the crucial role played by clergymen in the society, there's still paucity of literature in Nigeria and Africa at large assessing health-seeking behaviour among this important population. To our knowledge, no studies have yet examined the health-seeking behaviour of clergymen in Nigeria, hence this study set out to fill this gap. Therefore, this study aimed to determine the perceptions of the clergymen about the different dimensions of health, their practices of health-seeking behaviour, as well as determine the factors influencing such behaviours.

2. Methodology

2.1. Study Area

This study was conducted in churches in Nnewi-North local government area. Nnewi is the second largest city in Anambra State, South-Eastern Nigeria with an estimated projected population of about 1,301,000 people in 2024, and an estimated landmass of about 520km^2 [16]. The people are mainly Christians with different church denominations available, however the predominant denominations include the Roman Catholic, Anglican and Pentecostal Churches.

2.2. Study Population

The study population included all Clergymen in major denominations in Nnewi-North local government area which included the Catholic, Anglican and Pentecostal churches.

2.3. Inclusion Criteria

Clergies who have their churches in Nnewi or who head churches located in Nnewi-North were included in this study.

2.4. Exclusion Criteria

Clergies who met the inclusion criteria but objected to the survey were excluded from this study.

2.5. Study Design

This was a descriptive cross-sectional study among clergymen.

2.6. Sample Size Determination

The Cochran's formula below was used to calculate the sample size

$$N = \frac{z^2 PQ}{D^2}$$

where N is the minimum sample size:
Z is the standard normal deviate (1.96) at 95% confidence level.
p = Prevalence taken as 0.12 from a previous study on the topic. [17]

q=1-p = (1- 0.12)

d=Level of precision required, and it's taken as 0.05

N= ((1.96)^2 x 0.12 x(1-0.12)) / (0.05)^2

N= 162. 28

Therefore, anticipating a non-response rate (f) of 10% as used in a previous study, the adjusted sample size (Ns) were

Ns $= \frac{N}{1-f} = \frac{162}{1-0.1} = \frac{162}{0.9}$ =180.29= 180

2.7. Sampling Technique

There were about 141, 131, and 232 clergymen in the Anglican, Catholic, and Pentecostal denominations respectively, making a total of about 504 clergymen in the studied area. These figures were gotten from their respective denominational headquarters. Using proportional allocation, the total number of clergies required from each denomination were;

For Anglican: (141/504) x 180 = 50 clergymen

For Catholic: (131/504) x 180 = 47 clergymen

For Pentecostal: (232/504) x 180 = 83 clergymen.

Nnewi-North comprises of four autonomous quarters – Otolo, Uruagu, Umudim, and Nnewichi, each of which represented a cluster. By random sampling, Nnewichi (a cluster) was selected. Through simple random sampling, the clergies from the three (3) main denominations were recruited until the allocated total number of clergies required for each denomination was reached.

2.8. Study Instrument

Data were collected through a semi-structured interviewer-administered, anonymous and validated questionnaire after seeking verbal informed consent following a proper orientation of the participants of the objectives and the impact of this study to the society. The questionnaire was developed with guidance from several works already done on the subject/related works. [14,18,19,20]

2.9. Training of Research Assistants

Four (4) research assistants were recruited and trained to help with carrying out this research in record time. These research assistants were medical students in their clinical rotation at the Nnamdi Azikiwe University Teaching Hospital. They were trained on the contents of the questionnaire to avoid bias.

3. Data management

3.1. Measurement of Variables

The main outcome/dependent variable for this study was practice of health-seeking behaviour among the clergymen, while the independent variables were the socio-demographics, perceptions about the dimensions of health, and the factors influencing their practices of health-seeking behaviours.

3.2. Assessment of Perception and Practice of Health-Seeking Behaviour

Participants' perception about the dimensions of health were assessed by asking two (2) questions. Similar approach was also applied to assess their practices of health-seeking behaviour by asking them three (3) questions about their practices. Respondents who scored 50% and above were assumed to have "good perception and practices," while those who scored less than 50% were considered to have "poor perception and practices" respectively.

3.3. Statistical Analysis

Data were analysed using SPSS version 24. Descriptive and inferential Statistics was applied where necessary. Numerical variables were reported as mean and standard deviation, while categorical data were reported using proportion and percentages. Chi-square test was used to assess the association between categorical variables. Variables with p-value ≤ 0.05 in the confidence interval of 95% was taken as being significant.

4. Result

This study was carried out to access the health seeking behaviour among clergymen in Nnewi Local Government Area, Anambra State. 180 clergymen in Nnewi Local Government Area were sampled and the result obtained are presented in the tables below:

Table 1 Socio-Demographic Characteristics of the Respondents

Variable	Frequency	Percentage
Age (Years)		
20-29	12	6.7
30-39	62	34.4
40-49	54	30.0
50-59	35	19.4
≥60	17	9.4
Average Age in years	*43.4±10.6 years*	

Marital Status		
Single	69	38.3
Married	108	60.0
Divorced/Separated	1	0.6
Widowed	2	1.1
Denomination		
Anglican	50	27.8
Roman Catholic	47	26.1
Pentecostal	83	46.1
Highest Educational Level		
Primary	3	1.7
Secondary	18	10.0
Tertiary	58	32.2
Post-graduate	101	56.1
Tribe		
Igbo	175	97.2
Yoruba	1	.6
Efik	3	1.7
Ikwerre	1	0.6
How long have you been a clergy?		
<5	61	33.9
5-9	34	18.9
10-14	28	15.6
15-19	23	12.8
20-24	15	8.3
25-29	11	6.1
≥30	8	4.4
Average duration of being a clergy	*11.02±9.32years*	

This table 1 shows that majority of the clergies were within the age ranges 30-39 and 40-49 years, with an average age being 43.4 years. Most of the clergy are married (60) with the rest single (38%), and a very few of them were either divorced or widowed. Anglican denomination represented 27.8%, Roman Catholic (26.1%), and Pentecostal 46.1%). Most of the clergy had postgraduate education (56.1%), with only a few (1.7%) who had primary education as their highest level of education. Almost all participants were Igbos (97.2%), with the rest from other tribes. 33.9% of clergies had <5years experience while a few (4.4%) had >30years experience.

Table 2 Respondents' Perception about the Dimensions of Health

Variable	Frequency	Percentage
How do you define health?		
State of physical, spiritual, mental and social well-being	172	95.6
State of Physical well-being alone	7	3.9
State of spiritual well-being alone	1	0.6
What health-seeking behaviour do you know?		
Going to a hospital	149	82.8
Visiting a pharmacist	106	58.9
Compliance with medication	82	45.6
Visiting a chemist	74	41.1
Using herbal medications	72	40.0
Using medications prescribed by self	66	36.7
Level of perception about the dimensions of health		
Good Perception (≥50.00%)	175	97.2
Poor Perception (<50.00%)	5	2.8
Average perception score	76.32±19.12%	

This table 2 shows that majority of the clergies (95.6%) defined health as state of physical, spiritual, mental and social well-being and going to the hospital being the most known health seeking behaviour with self-medication being the least hence majority had a good perception of the dimensions of health.

Table 3a Respondents' Practices of Health Seeking Behaviour.

Variable	Frequency	Percentage
Which health seeking behaviour do you practice?		
Using medication prescribed by self	43	23.9
Using herbal medication	31	17.2
Visiting a pharmacist	84	46.7
Visiting a chemist	60	33.4
Going to hospital	152	84.5
Compliance with medication	84	46.7
Where do you go to first when you are sick?		
Stay at home	22	12.2
Go to the church or prayer house	70	38.9
Go to the hospital or health centre	135	75.0
Go to the herbalist or native doctors	3	1.7

Visit a pharmacy	62	34.4
Visit a chemist	33	18.3
Go to the laboratory	70	38.9
When do you think going to the hospital or health centre is not necessary?		
When I feel it is a 'normal 'sickness	65	36.1
When I feel it has a spiritual basis	52	28.9
When I feel it is just stress	98	54.4
When I feel it is because of my sins/actions	21	11.7
When prayer can handle the situation	65	36.1
What influences your choice of health seeking behaviour?		
The affordability of treatment	73	40.6
Seriousness of the sickness	108	60.0
The availability/quality of services in the health facilities	103	57.2
Attitude of the staff of the hospital/health facility	60	33.3
Nearness of the health facility to my residence	46	25.6
Level of practice of health seeking behaviour		
Poor practice(I<50.00)	38	21.1
Good practice (≥50.00)	142	78.9
Average practice score	*66.08±23.39%*	

Table 3b Opinion on Some Statements

Variable	**Strongly Agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
I believe God heals, so seeking healthcare in hospitals/ health centres should be discouraged.	8(4.4)	2(1.1)	19(10.6)	57(31.7)	94(52.2)
I believe sickness is a spirit that should be cast out first	21(11.7)	20(11.1)	26(14.4)	42(23.3)	71(39.4)
Seeking health care makes me feel faithless as a clergy	5(2.8)	3(1.7)	9(5.0)	52(28.9)	111(61.7)
Seeking healthcare by the clergy will make the congregation lose faith in him/her.	3(1.7)	4(2.2)	11(6.1)	43(23.9)	119(66.1)
Strong spirit-filled clergy cannot be sick	2(1.1)	5(2.8)	9(5.0)	40(22.2)	124(68.9)

The table 3 shows that going to the hospital is the most practiced health-seeking behaviour (84.5%), as well as where they visit first when sick, it shows that more than half of the clergies (54.4%) think that it is unnecessary to go to the hospital when it's just stress. Most of the clergies strongly disagreed to the statement that seeking health care should be discouraged because God heals. Most also strongly disagreed that sickness is a spirit that should be cast out first and that seeking health care makes them faithless as clergies. They also strongly disagreed to the statement that the congregation would lose faith in them. Finally, most strongly disagreed that strong spirit filled clergy cannot be sick.

Table 4 The Relationship between the Respondents' Socio-Demographics and Perceptions about the Dimensions of Health.

	Respondents 'perception about the dimensions of health				
		Poor perception	Good perception	Chi-square (x2)	p-value (≤0.05)
Age (Years)	20-29	0(0.0%)	12(100.0%)	7.01	0.13
	30-39	2(3.2%)	60(96.8%)		
	40-49	0(0.0%)	54(100.0%)		
	50-59	1(2.9%)	34(97.1%)		
	≥60	2(11.8%)	15(88.2%)		
Denomination	Anglican	0(0.0%)	50(100.0%)	2.02	0.36
	Roman Catholic	2(4.3%)	45(95.7%)		
	Pentecostal	3(3.6%)	80(96.4%)		
Highest educational level	Primary	0(0.0%)	3(100.0%)	6.38	0.09
	Secondary	2(11.1%)	16(88.9%)		
	Tertiary	0(0.0%)	58(100.0%)		
	Post-graduate	3(3.0%)	98(97.0%)		
Marital status	Single	3(4.3%)	66(95.7%)	1.07	0.79
	Married	2(1.9%)	106(98.1%)		
	Divorced/Separated	0(0.0%)	1(100.0%)		
	Widowed	0(0.0%)	2(100.0%)		
Duration of being a clergy (years)	<5	1(1.6%)	60(98.4%)	5.20	0.63
	5-9	1(2.9%)	33(97.1%)		
	10-14	2(7.1%)	26(92.9%)		
	15-19	0(0.0%)	23(100.0%)		
	20-24	0(0.0%)	15(100.0%)		
	25-29	1(9.1%)	10(90.9%)		
	≥30-34	0(0.0%)	8(100.0%)		

From table 4 above, respondents within the age range of 20-29 years and 40-49 years had better perception about the dimensions of health respectively, however this was not statistically significant (p-value > 0.05). With respect to the relationship between denomination and highest educational level to their level of perception of dimensions of health, respondents from Anglican denomination and also those with primary and tertiary as their highest level of education had better perception, however this was not statistically significant (p-value > 0.05). Those who were divorced/separated and widowed had better perception about the dimensions of health; however this was not statistically significant (p-value > 0.05). Also, clergymen with service duration of ≥15years had better perception about the dimensions of health, however this difference was not statistically significant (p-value > 0.05).

Table 5 The Relationship between the Respondents' Socio-Demographics and Practice of Health Seeking Behaviour.

	Respondents' Practice of Health-Seeking Behaviours				
		Poor Practice	Good Practice	Chi-square (x2)	p-value (≤0.05)
Age (Years)	20-29	4(33.3%)	8(66.7%)	9.24	0.05
	30-39	7(11.3%)	55(88.7%)		
	40-49	11(20.4%)	43(79.6%)		
	50-59	9(25.7%)	26(74.3%)		
	≥60	7(41.2%)	10(58.8%)		
Denomination	Anglican	12(24.0%)	38(76.0%)	6.18	0.04
	Roman Catholic	4(8.5%)	43(91.5%)		
	Pentecostal	22(26.5%)	61(73.5%)		
Highest educational level	Primary	1(33.3%)	2(66.7%)	2.65	0.45
	Secondary	5(27.8%)	13(72.2%)		
	Tertiary	15(25.9%)	43(74.1%)		
	Post-graduate	17(16.8%)	84(83.2%)		
Marital status	Single	10(14.5%)	59(85.5%)	4.07	0.25
	Married	27(25.0%)	81(75.0%)		
	Divorced/ Separated	0(0.0%)	1(100.0%)		
	Widowed	1(50.0%)	1(50.0%)		
Duration of being a clergy	<5	9(14.8%)	52(85.2%)	6.75	0.46
	5-9	9(26.5%)	25(73.5%)		
	10-14	49(14.3%)	24(85.7%)		
	15-19	7(30.4%)	16(69.6%)		
	20-24	5(33.3%)	10(66.7%)		
	25-29	3(27.3%)	8(72.7%)		
	≥30	1(12.5%)	7(87.5%)		

From table 5 above, with respect to the relationship between age(years) and denomination with the respondents practice of health seeking behaviour, respondents within the age range of 30-39 years of age and those from the Roman Catholic denomination had better practice, and this difference was statistically significant (p-value≤0.05)

On the other hand, respondents post-graduate education, those who were divorced/separated and those with clergy duration of ≥30.0 years had better practice of health seeking behaviour, however this difference was not statistically significant (p-value>0.05).

5. Discussion

This study on health-seeking behaviour among clergymen in Nnewi Local Governmental Area, South-Eastern Nigeria, provides critical insights into the interplay between socio-demographic factors, perceptions of health, and health practices within a religious leadership context.

About 95.6% of the participants defined health as a state of physical, spiritual, mental, and social well-being, reflecting a holistic understanding. This is in agreement with studies from Kenya and Ghana by Walther et al and Asamoah et al, respectively, where clergy emphasized interconnected dimensions of health [14, 21]. For example, Kenyan United Methodist Clergy similarly viewed health through an environmental model, integrating physical, emotional, and spiritual wellness [14]. The Ghanaian study highlighted Pentecostal clergy's belief in spiritual causes of illness but also acknowledged holistic care through prayer, social support, and health education [21]. While the clergy's holistic view mirrors global trends, their strong rejection of purely spiritual explanations for illness, where only 28.9% linked sickness to spiritual causes, diverges from findings in Ghana where Pentecostal clergy prioritized exorcism and diabolical explanations [21]. This discrepancy may stem from denominational differences where there were higher proportion of Anglicans and Catholics in this study compared to Ghana's Pentecostal focus, or probably due to evolving attitudes toward biomedical care in Nigeria.

About 84.5% of clergymen in this study practiced hospital visits, surpassing rates observed in Ghanaian Pentecostal communities, where clergy often combined traditional and biomedical care [21]. About 23.9% practiced self-medication, and 17.2% used herbal treatments, reflecting residual reliance on non-clinical methods. Similar trends were noted in Ghana, where indigenous medicine coexisted with hospital-based care. Only 36.1% deferred hospital visits for prayer-handled situations, contrasting sharply with Kenyan clergy who concealed illnesses to preserve congregational faith [14]. The prioritization of hospitals by the clergymen in this study resonates with studies done in the United States where faith leaders supported medical care as complementary to spiritual practices [22]. However, the persistence of self-medication aligns with systemic barriers such as cost and accessibility noted in African-American and Ghanaian studies by Allen et al and Asamoah et al, respectively [21, 22]. For instance, 40.6% of the participants cited affordability as a key influence, mirroring Ghanaian clergy's financial constraints [21].

Younger clergy (30-39 years) had better health practices, possibly due to greater exposure to health education. Postgraduate education correlated non-significantly with improved practices (83.2%), aligning with other studies where educated clergy were more likely to endorse biomedical care [21, 22]. Roman Catholic clergymen in this study exhibited significantly better health practices (91.5% good practice) compared to Pentecostals (73.5%), a trend echoing findings from a United States survey where denominational doctrines shaped health promotion support [23]. For instance, United States Methodists often integrated health into church missions, whereas Baptists were divided [23]. In this study, Pentecostals' lower adherence to clinical care may reflect stronger spiritual explanatory models, as seen in Ghana [21]. This finding from this study was also similar to a cross-sectional study done by Elvis et al among 448 male and female parishioners in Benue State, where they found that Catholics had slightly higher mean scores compared to non-Catholics in their health-seeking behaviour [12]. Hence, denomination plays a vital role in determining their health-seeking behaviour.

Most clergymen in this study rejected the notion that seeking care undermines faith (61.7% strongly disagreed), contrasting with Kenyan clergies who hid illnesses to avoid congregational doubt [14]. This suggests a cultural shift in Nigeria toward reconciling faith with medical care, possibly influenced by public health campaigns. While 39.4% disagreed that sickness is a 'spirit to be cast out', 11.7% still attributed illness to personal sins/actions. This duality reflects the tension observed in Ghana, where clergy navigated biomedical and spiritual paradigms [21]. The clergymen in this study however leaned more toward biomedical rationality, probably due to higher education levels (56.1% postgraduate).

6. Conclusion

This study underscores the centrality of clergy as health influencers in African communities, blending holistic health perceptions with evolving biomedical engagement. While denominational and educational factors shape practices, the rejection of spiritual fatalism signals a promising shift toward integrative care. By aligning interventions with clergy's cultural and theological frameworks, policymakers can harness their pivotal role in advancing public health goals.

Limitations of the study

Causality cannot be inferred as this was a cross-sectional study, therefore longitudinal studies could track health behaviour changes over time. The Igbo-denominated sample limits generalizability. Future studies should include diverse ethnic and regional groups.

Recommendations

- Government and non-governmental organizations should organise outreaches, seminars and symposiums to better educate the clergies on better health-seeking behaviour, encouraging them on better practices to help improve their life as well as encourage them to translate same as they preach on their pulpits.
- Subsidizing care or church-funded health schemes could mitigate affordability issues, particularly for older clergy and those in rural areas.
- Leveraging clergy's trusted role could enhance community health outreach. Training clergy in basic health advocacy (e.g stress management, chronic disease prevention, etc) may bridge gaps in low-resource settings.
- Interventions should consider denominational doctrines. For example, Pentecostals may benefit from programs integrating prayer with clinical referrals, while Catholics could adopt structured parish-based health initiatives.

Compliance with ethical standards

Disclosure of conflict of interest

The authors declare that they have no competing interests.

Statement of ethical approval

This research work was done with approval from the Nnamdi Azikiwe University Teaching Hospital Health Research Ethics Committee (NAUTHHREC), with ethical approval number NAUTH/CS/66/VOL.16/VER.3/198/2022/085. Participants were well oriented on the objectives of the study; verbal consent was sought prior to administration of the questionnaire which emphasized the right to non-participation. Data confidentiality was preserved according to the Helsinki declaration of bioethics.

Statement of informed consent

Informed consent was obtained from all individual participants included in the study.

Financial support/ sponsorship

The authors declared that this study has received no financial support.

Authors' contributions

This work was carried out in collaboration among all authors. All authors read and approved the final manuscript.

References

[1] Health. World Health Organization; 1948. Available from http://en.m.wikipedia.org/wiki/health (Accessed 22 March 2025)

[2] Dimensions of health – HSC PDHPE. Available from: https://www.pdhpe.net/better-health-for-individuals/what-does-health-mean-to-individuals/meanings-of-health/dimensions-of-health (Accessed 17th March 2025)

[3] Latunji OO, Akinyemi OO. Factors Influencing Health-Seeking Behaviour Among Civil Servants In Ibadan, Nigeria. Ann Ib Postgrad Med. 2018 Jun;16(1):52-60. PMID: 30254559; PMCID: PMC6143883.

[4] Abuduxike G, Aşut Ö, Vaizoğlu SA, Cali S. Health-Seeking Behaviors and its Determinants: A Facility-Based Cross-Sectional Study in the Turkish Republic of Northern Cyprus. Int J Health Policy Manag. 2020 Jun 1;9(6):240-249. doi: 10.15171/ijhpm.2019.106. PMID: 32613792; PMCID: PMC7382910.

[5] Health Seeking Behaviour - The University of British Columbia. Available from: http://wiki.ubc.ca/Health_Seeking_Behaviour (Accessed 23rd March 2025).

[6] Bourne PA, Morris C, Charles CA, Eldemire-Shearer D, Kerr-Campbell MD, Crawford TV. Health literacy and health seeking behavior among older men in a middle-income nation. Patient Relat Outcome Meas. 2010 Jul;1:39-49. doi: 10.2147/prom.s11141. Epub 2010 May 26. PMID: 22915951; PMCID: PMC3417896.

[7] Majaj L, Nassar M, De Allegri M. "It's not easy to acknowledge that I'm ill": A qualitative investigation into the health seeking behavior of rural Palestinian women. BMC Women's Health. 2013;13(26).).https://doi.org/10.1186/1472-6874-13-26

[8] Yanagisawa S, Mey V, Wakai S. Comparison of health-seeking behaviour between poor and better-off people after health sector reform in Cambodia. Public Health. 2004 Jan;118(1):21-30. doi: 10.1016/S0033-3506(03)00140-9. PMID: 14643624.

[9] Davidson SK, Schattner PL. Doctors' health-seeking behaviour: a questionnaire survey. Med J Aust. 2003 Sep 15;179(6):302-5. doi: 10.5694/j.1326-5377.2003.tb05552.x. PMID: 12964913.

[10] Våga BB. The search for care and cure: exploring health seeking behaviour in Mbulu District, Tanzania [Cand. San. thesis]. Bergen: University of Bergen; 2004. (GeGCA-NUFU Publications; vol 8). ISBN-13: 978-82-7815-119-9.

[11] Abubakar A, Van Baar A, Fischer R, Bomu G, Gona JK, Newton CR. Socio-cultural determinants of health-seeking behaviour on the Kenyan coast: a qualitative study. PLoS One. 2013 Nov 18;8(11):e71998. doi: 10.1371/journal.pone.0071998. PMID: 24260094; PMCID: PMC3832523.

[12] Ihaji E, Gerald EU, Helen C, Ogwuche E. Educational Level, Sex and Church Affiliation on Health Seeking Behaviour among Parishioners in Makurdi Metropolis of Benue State [Internet]. Vol. 1, Journal of Educational Policy and Entrepreneurial Research (JEPER) 2014. 311–316

[13] Heward-Mills NL, Atuhaire C, Spoors C, Pemunta NV, Priebe G, Cumber SN. The role of faith leaders in influencing health behaviour: a qualitative exploration on the views of Black African Christians in Leeds, United Kingdom. Pan Afr Med J. 2018 Jul 6;30:199. doi: 10.11604/pamj.2018.30.199.15656. PMID: 30574218; PMCID: PMC6294965.

[14] Walther NG, Proeschold-Bell RJ, Benjamin-Neelon S, Adipo S, Kamaara E. "We Hide Under the Scriptures": Conceptualization of Health Among United Methodist Church Clergy in Kenya. J Relig Health. 2015;54(3):999-1013. DOI: 10.1007/s10943-014-9947-7.

[15] Anshel MH, Smith M. The role of religious leaders in promoting healthy habits in religious institutions. J Relig Health. 2014 Aug;53(4):1046-59. doi: 10.1007/s10943-013-9702-5. PMID: 23516019.

[16] Nnewi. Wikipedia. Available from https://en.wikipedia.org/wiki/Nnewi (Accessed 24th March, 2025).

[17] Akinpelu AO, Oyewole OO, Odole AC, Olukoya RO. Prevalence of Musculoskeletal Pain and Health seeking Behaviour among Occupational Drivers in Ibadan, Nigeria. Afr J Biomed Res. 2011 May;14(2):89-94. Available from: www.ajbrut.net

[18] Onwujekwe O, Chukwuogo O, Ezeoke U, Uzochukwu B, Eze S. Asking people directly about preferred health-seeking behaviour yields invalid response: an experiment in south-east Nigeria. J Public Health (Oxf). 2011 Mar;33(1):93-100. doi: 10.1093/pubmed/fdq065. Epub 2010 Aug 25. PMID: 20739332.

[19] Abubakar A, Van Baar A, Fischer R, Bomu G, Gona JK, Newton CR. Socio-cultural determinants of health-seeking behaviour on the Kenyan coast: a qualitative study. PLoS One. 2013 Nov 18;8(11):e71998. doi: 10.1371/journal.pone.0071998. PMID: 24260094; PMCID: PMC3832523.

[20] Ajibade BL, Amoo PO, Adeleke MA, Oyadiran GO, Kolade OA, Olagunju RO. Determinants of Mothers Health Seeking Behaviour for Their Children in a Nigerian Teaching Hospital. IOSR J Nurs Health Sci. 2013 Jul-Aug;1(6):09-16. Available from: www.iosrjournals.org

[21] Asamoah MK, Osafo J, Agyapong I. The role of Pentecostal clergy in mental health-care delivery in Ghana. Ment Health Relig Cult. 2014;17(6):601-14. DOI: 10.1080/13674676.2013.871628.

[22] Allen AJ, Davey MP, Davey A. Being Examples to the Flock: The Role of Church Leaders and African American Families Seeking Mental Health Care Services. Contemp Fam Ther. 2010;32(2):117-34. DOI: 10.1007/s10591-009-9108-4.

[23] Webb B, Bopp M, Fallon EA. A Qualitative Study of Faith Leaders' Perceptions of Health and Wellness. J Relig Health. 2011;51(2):269-80. DOI: 10.1007/s10943-011-9476-6.