

CULTURAL BARRIERS AND INTERVENTION ON HEALTHCARE UTILIZATION IN ANAMBRA STATE, NIGERIA

By

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Abstract

This study investigates cultural barriers and interventions in healthcare utilization in Anambra State of Nigeria. The study used mixed-methods research design. This kind of research collects and analyses data using quantitative and qualitative methods. Quantitative data were gathered with questionnaire and the qualitative data were collected with in-depth interview guide (IDI). Quantitative data collected were processed by SPSS and analyzed with descriptive statistics, while data from qualitative interview were coded into themes that reflect the objectives of this study. Evidence suggests that traditional medicine is potent. However, traditional belief is not an important factor in utilization of modern healthcare. The major factor is economic. Respondents believe that involving traditional healers in healthcare programs would help to increasing healthcare utilization. Also, reducing cost of utilizing modern healthcare is a major intervention, among other findings. The study recommends a further study that will be comprehensive enough in generating more evidence to aid generalization.

Keywords: Cultural barriers to healthcare utilization, healthcare utilization, interventions on healthcare utilization

Introduction

Across the world, studies have examined the cultural barriers to healthcare utilization (Janz & Becker, 1984; Bentancourt et al., 2003; Nwabueze et al., 2017; Adebawale et al., 2018; Ngo-Metzger et al 2018; Hawley & Haden, 2019; Adogu et al., 2020; Ahmed et al., 2021; Ma et al., 2021; Abel, 2023). In a cross-sectional, study by Nwokoro, et al. (2022) examined the factors of primary healthcare utilisation in rural Enugu State, Nigeria. At least 335 18-year-old inhabitants provided the data. The data comprises socio-demographic parameters, community and primary healthcare (PHC) facility utilisation, and PHC service use. Semi-structured questionnaires were given by pre-tested interviewers. The data were analysed using descriptive and inferential statistics with 5% significance, about 50% of the 335 respondents used primary care during sickness. From the 178 participants who did not use PHC services, 51 (28.7%) cited inadequate medical treatment, 41 (23.0%) cited the lack of accessible doctors, 31 (17.4%) cited long patient wait times, and 25 (14.0%) cited the lack of required pharmaceuticals. Primary health care use was affected by numerous variables. These factors included being female (Adjusted Odds Ratio = 2.3, 95% Confidence Interval 1.3–4.0), treatment cost (2.4, 95% Confidence Interval 1.3–4.6), the scarcity of qualified medical professionals (0.3, 95% Confidence Interval 0.1–0.5), the waiting time to see a doctor (2.2, 95% Confidence Interval 1.2–4.3), and previous treatment satisfaction. Few people used basic healthcare. To improve utilisation, healthcare expenditures, workforce capacity, patient waiting times, and patient satisfaction with primary healthcare must be addressed.

Odishika and Nwabueze (2021) examined how cultural health concepts affect healthcare provider-consumer communication. This research studied how cultural health concepts affect doctor-patient communication in Delta, Nigeria, primary healthcare institutions. The research examined how participants' cultural health attitudes affected healthcare provider-patient communication, medication adherence, and healthcare seeking in the study region. A random sample of 316 participants completed this questionnaire for this study. Focus group discussions (FGDs) included 68 participants, while in-depth interviews (IDQs) had 16. Health Belief Model (HBM) and Theory of Planned Behaviour (TPB) underpinned the research. The research found that patients' cultural health beliefs affected their prescription adherence and healthcare-seeking but not provider-patient communication.

Other studies provided interventions to integrate cultural beliefs and healthcare utilization. For instance, Alkhawaldeh (2017) examined students' university health facility utilisation variables. This research evaluates university students' health facility utilisation over the last six months and the obstacles they experienced. In a cross-sectional study, 240 students completed a self-administered questionnaire. Frequencies helped us discover health issues, student usage patterns, and perceived obstacles. Fewer than 50% of students utilised the health clinic in the last six months. Student visits were caused by influenza (23.5%), headaches (14.7%), and stomach discomfort (11.8%). About 64.6% of students were satisfied with the health clinic. However, students highlighted various elements that they felt were affecting their resource utilisation. These included restricted medication supply (22.5%), inadequate medical staff-student links (17.1%), insufficient medical staff-doctor skills (10%), poor referral services (8.3%), and excessive waiting periods (5%). The research sheds light on Jordanian university students' health-seeking practices, promising to improve their health. At a southern Nigerian university, Obiechina and Ekenedo (2013) examined what influences students' health care utilisation. Most university health services

have substantial healthcare facilities to ensure students get good and fast treatment. The goal was to gauge students' opinions on research variables. This poll asks college students about campus health care and their desire to utilise it. A simple random sample approach selected 540 people, 390 males and 150 females. The research collected data using a structured, self-administered survey and analysed it using frequency count and percentage. The inquiry found the high cost of medications (72.0%), the lack of essential drugs (54.8%), the long waiting time for treatment (67.2%), the inadequate referral services (81.7%), and the level of satisfaction with university health services (60.6%), were reported as factors influencing their use. However, student-medical staff relationship (77.6%) and health facility accessibility (74.3%), which affect university health care use, were not included.

This study therefore, suggest that the government should integrate higher education institutions in the National Health Insurance program to provide free medical treatment to 18-year-olds. This project attempts to lower healthcare costs and boost use. A University of Maiduguri research in Borno State, Nigeria, examined faculty understanding of preventative healthcare services (Sangari et al., 2021). Two concepts underpinned the investigation. The study employed descriptive surveying and simple random sampling. A random sample of 200 college faculty members was selected from seven disciplines. Our questionnaire was self-designed. One component collected demographic data, while the other assessed preventative healthcare knowledge. At a 0.05 significance level, descriptive statistics like percentages and counts were used. Hypotheses were tested using inferential statistics including one-sample and independent t-tests. There was no statistically significant gender difference in understanding preventative healthcare services. To stress the significance of preventive healthcare services in managing avoidable illnesses, measures to improve health and have an immediate effect on workers should be assessed periodically. In the light of the foregoing, this study investigates cultural barriers and interventions in healthcare utilization in Anambra State of Nigeria.

Methodology

Research Design

This section describes the study's methodology and context. The study will involve mixed-methods survey research. This kind of research collects and analyses data using quantitative and qualitative methods. They then combine their results to make community-wide conclusions. For real-time population analysis, this study will employ a research approach known for its flexibility in obtaining trustworthy data while minimizing costs. This involves collecting a variety of important data at a specific moment. The researcher will detail the statistical methods utilized to analyze the data.

Area of Study

Anambra state comprises of 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 southeastern part of Nigeria. It is among the five states that make up southeast geopolitical zone of Nigeria. It was created in 21st August 1991. It is bounded in the north by Enugu state, in the east by Imo state, in the south by Delta state while in the west by Kogi state. The land area of Anambra state is approximately 4,844 square kilometers.

Population of the Study

The target populations for this research are male and female individuals in urban and rural areas. Nigeria Population Census (2019) noted that Anambra state has a human population size of 4,177,828 people with 2117984 males and 2059844 females. 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). However, the target population for this study will include the urban and rural dwellers in Anambra state as at the time of this study. It is from the population that the sample needed for this study will be drawn.

Sample size and sampling technique

The sample size for this study is 400. Study participants were selected using both probability and non-probability sampling techniques. To begin, the study categories the 179 towns into urban and rural groups based on their primary economic activities. From the urban cluster, (Awka) was selected using balloting method. On the other hand, using the balloting method without replacement, one town (Agulu) was selected from the rural cluster. This process ensures that urban and rural dimensions to the subject under study will fully be harnessed.

Awka comprises seven Igbo groups sharing common blood lineage divided into two sections. Ifite Section, the senior section, comprises four groups, Ayom-na-Okpala, Nkwelle, Amachalla, and Ifite-Oka followed by Ezinator Section, which consists of three groups, 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, Isiamagbo, Ukunu, Uhueme, Obeagu, Obe, Nkɪtaku, Okpu-Ifite, Umubialla, Amatutu, Umuowelle, Umunnouwu, Ifiteani, Umuifite, and Nneogidi.

This study selected 50% respondents (i.e 200) from urban households and the remaining 50% (200) from rural households using multistage sampling techniques. For the qualitative aspect of the study, the purposive sampling technique was used to select 12 participants including six (6) from urban household and the other six (6) from rural household for In-Depth Interview (IDI). The interviewees were selected based on their level of knowledge, experiences and roles in cultural beliefs and healthcare utilization in the communities of study.

Instruments of Data Collection and Administration

Questionnaire and In-depth Interview (IDI) were used for quantitative and qualitative method of data collection respectively. The researcher personally administered the questionnaire and carry out the In-depth Interview, with the help of a research assistant. The research assistant was graduate of Sociology who had gained basic knowledge about social science research method. Consent for the interview was sought from the selected interviewees through the 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. However, quantitative data were analyzed using descriptive statistics including frequency count and simple percentage. On the hand, the qualitative data gathered were processed manually and coded thematically in line with the objectives of the study.

Results

The analysis is presented in two distinct sections. Section A contains the descriptive analysis of socio-demographic characteristics of the respondents, and B – contains the descriptive analysis of the research questions.

Socio-Demographic Characteristics of the Respondents

This section presents the descriptive analysis on the responses offered by the respondents on their socio-demographic variables including gender, age, religion, educational qualifications, marital status, and occupation, level of income and place of residence. These are presented in table 4.1.

Data from table 4.1 shows that females outnumbered the males in the present study's sample (i.e females respondents 50.5% while males respondents 49.5%). It was discovered that the minimum age in the present study's sample was 15 years; while the maximum age was 105 years. However, 22.3% of the respondents were aged between 31 – 28years, 19.5% of them aged between 36 – 60, 20.6% aged between 61 – 75, 17.8% aged between 76 -90; while the smallest proportion 8% of them were older men and women aged between 91 – 105years.

The sample comprises of 90% of Christians, 2% of Muslims and 8% of African Traditional Religion. This shows that Muslim and African Traditional Religion somewhat low among the people of Anambra state. With regard to educational qualification, 28.1% of the respondents completed secondary level of education. Approximately 42.8% of the respondents attended up to tertiary level of education, out of which 9% of them only completed Diploma/NCE level, 26.6% of them completed up to the first-degree level and only a very lower proportion 7.2% of them completed up to the post graduate level. This finding shows that education in the present study area is somewhat impressive, even though about half proportion of them could not attend up to the higher education.

The sample comprised of 27% of single men and women, and 70% of the respondents are married. Respondents who were divorced or separated were approximately 3% of the sample (1% and 2%). This shows that divorce and separation rate was somewhat low.

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

It was discovered that the minimum income level was below ₦30,000; while the maximum income level was above ₦91,000per month. However, 49% of the respondents earns between ₦61,00 - ₦90,000per month, 32% earns between ₦31,000 - ₦60,000per month; while the smallest proportion 7% of them earns below ₦30,000per month.

Table 4.1: Socio-Demographic 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
F.S.L.C	83	20.8
J.S.S.C.E	0	0
S.S.C.E	112	28.1
O.N.D/N.C.E	36	9
H.N.D/B.A/B.Sc	106	26
M.A/M.Sc	21	5.5
Ph.D	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 1. What are the consequences of cultural beliefs in healthcare utilization in Anambra state? To answer this research question, the responses offered by the respondents with regards to questionnaire items 34, 35, 36, 37, 38 and 39 were analyzed and interpreted.

Table 4.16: Description of the consequences of cultural beliefs in healthcare utilization in Anambra state

Variables	Strongly agree	Agree	Neutral	Disagree	Strongly disagree	Total
To what extent do you agree that traditional medicine is more trusted than modern medicine in Anambra State?	51 (12.8%)	162 (40.7%)	169 (42.4%)	14 (3.5%)	2 (0.6%)	398 (100%)
Do cultural beliefs prevent individuals in your community from seeking treatment for mental health issues?	5 (1.5%)	98 (24.6%)	109 (29.8%)	171 (40.4%)	15 (3.7%)	398 (100%)
In your experience, do gender roles impact the decision to access healthcare services in Anambra State?	5 (1.2%)	15 (3.7%)	107 (26.8%)	261 (52.5%)	10 (2.5%)	398 (100%)
Is the stigma associated with HIV/AIDS prevent individuals from accessing healthcare facilities in Anambra State?	7 (2.2%)	5 (1.2%)	101 (25.3%)	281 (70.6%)	3 (0.7%)	398 (100%)
Do you agree that economic perceptions and costs deter people from seeking medical care in your community?	156 (39.1%)	117 (29.3%)	94 (23.6%)	21 (5.5%)	10 (2.5%)	398 (100%)
Do cultural norms around modesty and privacy discourage women from seeking healthcare in Anambra State?	10 (2.7%)	4 (1.0%)	171 (42.9%)	126 (31.6%)	87 (21.8%)	398 (100%)

Researcher's Data Analysis, 2024

From table 4.16, 12.8% strongly agree that traditional medicine is more trusted than modern medicine, 40.7% agreed that that traditional medicine is more trusted than modern medicine, 169 respondents representing 42.4% were on a neutral base about the statement, 3.5% disagreed that

that traditional medicine is more trusted than modern medicine and 0.6% strongly disagreed that that traditional medicine is more trusted than modern medicine.

In addition, 1.5% strongly agreed that cultural beliefs prevent individuals in their community from seeking treatment for mental health issues, 24.6% agreed that cultural beliefs prevent individuals in their community from seeking treatment for mental health issues, 29.8% were neutral to the statement, 40.4% disagreed that cultural beliefs prevent individuals in their community from seeking treatment for mental health issues, while 3.7% strongly disagreed that cultural beliefs prevent individuals in their community from seeking treatment for mental health.

Furthermore, 2.2% strongly agreed that stigma associated with HIV/AIDS prevent individuals from accessing healthcare facilities, 1.2% agreed that stigma associated with HIV/AIDS prevent individuals from accessing healthcare facilities, 25.3% were neutral to the statement, 70.6% disagreed that stigma associated with HIV/AIDS prevent individuals from accessing healthcare facilities, while 0.7% strongly disagreed that stigma associated with HIV/AIDS prevent individuals from accessing healthcare facilities.

However, 39.1% strongly agreed that economic perceptions and costs deter people from seeking medical care in their community, 29.3% agreed that economic perceptions and costs deter people from seeking medical care in their community, 23.6% were neutral to the statement, 5.5% disagreed that economic perceptions and costs deter people from seeking medical care in their community, then 2.5% strongly disagreed that economic perceptions and costs deter people from seeking medical care in their community.

Lastly, 2.7% strongly agreed that cultural norms around modesty and privacy discourage women from seeking healthcare services, 1% agreed that cultural norms around modesty and privacy discourage women from seeking healthcare services, 42.9% were neutral to the statement, 31.6% disagreed that cultural norms around modesty and privacy discourage women from seeking healthcare services, while 21.8% strongly disagreed that cultural norms around modesty and privacy discourage women from seeking healthcare services.

From one of the interviewees:

..... the issues of cultural belief depend on how an individual understand it, with the effort of religious confusion. Why did I use this statement? when we talk about how culture influence healthcare, we should also talk about how religion influence healthcare because there are consequences of some of our actions in terms of religious and cultural belief over healthcare utilization, and sometimes it prevents a particular group to quality healthcare services. For instance, there is this church that do advice their members not to accept anything blood transfusion..... Now think on the consequences of not accepting blood transfusion. Some will ask their members to buy anointing oil and water for medical treatment. Please, which hospital in Anambra state do prescribe anointing oil or holy water to their patients. I believe that God can do miracle and someone get healed but not in a state that you need medical attention first. You have to first of all go to the hospital, get diagnosed then take the prescribe drugs and not holy water.

This case of economic factor, hmmm, you that is interviewing me knows how costly things are in the market talk more of healthcare services. Is not that I don't use herbs for treatment. I do use herbal drugs like that of OSSA Herbal drugs, I have some of their products but the cost of purchasing those herbal drugs is high. When you enter inside Eke Awka market, those Yoruba women that sell herbal medicine, I do purchase from them but the problem is the rate of inflation. Looking at this compound is only this small orange tree and two coconut trees, but when you go my village, we have abundant of herbal leaves and roots that one can easily access without paying much or nothing. So those in the village has more advantage over us that are in the city because we have to buy almost everything even the herbs.

Research Question 2. What intervention will integrate cultural beliefs and healthcare utilization in Anambra state? To answer this research question, the responses offered by the respondents with regards to questionnaire items 40, 41, 42, 43, 44 and 45 were analyzed and interpreted.

Table 4.17: Respondents view on interventions that will integrate cultural beliefs healthcare utilization in Anambra state

Variables	Agree	Neutral	Disagree	Strongly disagree	Total	Strongly agree
Do you believe involving traditional healers in healthcare programs would be increasing healthcare utilization	127 (31.9%)	54 (13.5%)	25 (6.4%)	0 (0%)	389 (100%)	192 (48.2%)
Will culturally sensitive health education campaigns improve healthcare utilization in your community?	97 (24.3%)	18 (4.5%)	7 (1.7%)	5 (1.5%)	389 (100%)	271 (68%)
Will it be beneficial to have healthcare providers trained in local languages and cultural practices?	162 (40.7%)	31 (7.7%)	10 (2.5%)	11 (2.7%)	389 (100%)	184 (46.2%)
Do you agree to incorporate family and community leaders in healthcare decision-making processes?	133 (33.4%)	56 (14%)	73 (18.3%)	34 (8.7%)	389 (100%)	102 (25.6%)
How much do you agree that reducing the cost of healthcare services would address cultural barriers to healthcare utilization?	107 (26.8%)	9 (2.6%)	78 (19.5%)	78 (19.5%)	389 (100%)	126 (31.6%)
Will creating separate, private spaces in healthcare facilities for gender-specific consultations improve healthcare access for women?	81 (20.3%)	73 (18.3%)	126 (31.6%)	32 (8.2%)	389 (100%)	86 (21.6%)

Researcher's Data Analysis, 2024

Data analyzed from table 4.17, 48.2% strongly agree that involving traditional healers in healthcare programs would be in increasing healthcare utilization, 31.9% agreed that involving traditional healers in healthcare programs would be in increasing healthcare utilization, 13.5% were on a neutral base about the statement, 6.4% disagreed that involving traditional healers in healthcare programs would be in increasing healthcare utilization and there was no response from strongly disagreed.

Information states that, 68% strongly agreed that culturally sensitive health education campaigns improve healthcare utilization in their community, 24.3% agreed that culturally sensitive health

education campaigns improve healthcare utilization in their community, 4.5% were neutral to the statement, 1.7% disagreed that culturally sensitive health education campaigns improve healthcare utilization in their community, while 1.5% strongly disagreed that culturally sensitive health education campaigns improve healthcare utilization in their community.

.... I must commend government of Anambra state on health sector, because most of our government hospitals are well equipped. But I must add that there should be more hospitals outlet to help comb accessibility. Can you imagine the whole of Isiagu town don't have a single hospital, not even a private one. Imagine what happens to the people living in that area, how do they access healthcare, you may say that they are close to Awka but then again, the cost of transportation, and it does not end there because when they get to the hospital then we talk about the cost of medication. So, I'm seriously calling on government to help comb the situation. Then again campaigns and radio publicity to help create awareness. Just like that of CPHA by Chief Dr. Mrs. Ilonzo, she usually air on ABS (Anambra Broadcasting Service) and teaches the public on the importance of some of the herbal/root medicine, and she goes on to teach how to use some of these herbs. But we need more of that to help integrate traditional medicine and patent medicine. Like I said before that I do take OSSA herbal products, but some persons have not come across such herbal drugs.

Another interviewee suggested that there should be a unit in the hospital that should handle herbal related cases. "If you ask me, I would say that government under the ministry of health should create a unit that sees to herbal medicine and diagnosing" (rural respondent).

Another interviewee also suggested that,

...community and religious leaders should involve be in awareness and there should be uniform integration and not when ministry of health says a thing then the religious leader will counter it because this affect the people's perception towards healthcare utilization in Anambra" (urban dweller)

To continue, 46.2% strongly agreed that it will be beneficial to have healthcare providers trained in local languages and cultural practices, 40.7% agreed that it will be beneficial to have healthcare providers trained in local languages and cultural practices, 7.7% were neutral to the statement, 2.5% disagreed that it will be beneficial to have healthcare providers trained in local languages and cultural practices, while 2.7% strongly disagreed that it will be beneficial to have healthcare providers trained in local languages and cultural practices.

Therefore, 25.6% strongly agreed to incorporate family and community leaders in healthcare decision-making processes, 33.4% agreed to incorporate family and community leaders in healthcare decision-making processes, 14% were neutral to the statement, 18.3% disagreed to incorporate family and community leaders in healthcare decision-making processes, then 8.7% strongly disagreed to incorporate family and community leaders in healthcare decision-making processes.

Family is important in everything, because some severe sicknesses need family intervention, sometimes even the community people do bring their ideas which influence that person initial decision. (From rural respondent).

An urban interviewee added

.... yes, it is very important to involve family in health issues, even our co-tenants are seen as family because there are some sicknesses you will encounter they will refer you to the best hands, but if you keep it to yourself, you may run out options and probably die if mismanaged.

However, 25.6% strongly agreed that reducing the cost of healthcare services would address cultural barriers to healthcare utilization, 26.8% agreed that reducing the cost of healthcare services would address cultural barriers to healthcare utilization, 2.6% were neutral to the statement, 19.5% disagreed that reducing the cost of healthcare services would address cultural barriers to healthcare utilization, while 19.5% strongly disagreed that reducing the cost of healthcare services would address cultural barriers to healthcare utilization.

On the last variable, 21.6% strongly agreed that creating separate, private spaces in healthcare facilities for gender-specific consultations improve healthcare access for women, 20.5%% agreed that creating separate, private spaces in healthcare facilities for gender-specific consultations improve healthcare access for women, 18.3% were neutral to the statement, 31.4% disagreed that creating separate, private spaces in healthcare facilities for gender-specific consultations improve healthcare access for women, while 8.2% strongly disagreed that creating separate, private spaces in healthcare facilities for gender-specific consultations improve healthcare access for women. One of the rural respondents suggested that the government needs to pay adequate attention to healthcare:

...government has a work to do, for instance, I gave birth to all my children at a local midwife who handles pregnancy very well. Even though I use to register at health Centre but I usually prefer the local midwife, after my delivery I'll then go back to health Centre for my child immunization. Even pregnant women who live in Lagos travel all the way to Ukunu village Agulu once they feel their delivery is near. She has different herbal drugs that women take at different stages of their pregnancy. My mom told me that that was the place she gave birth to me when the midwife grandmother was handling pregnant women. After the death of the grandmother, she took over. Even her children who are grown adults now, assist her with delivery. She handles complicated issues very well. So, it's important that government look into some of these local midwives that did not have complete education in medical field and assist them and also incorporating them with modern healthcare. Then again, we have health centers in some villages, but when you go there, they might not have that particular drugs for treatment and some of the workers complain that they do bring drugs late with near expiring date. So, I beg the government to assist us with good facilities and drugs because why some of us subject to traditional medicine is because of lack of trust with level of attention given to us.

What these finding brings to the fore is that majority of the respondents (40.2%) strongly agreed that intervention will be necessary to integrate cultural beliefs and healthcare utilization in Anambra state with a very low respondent (6.7%) who opposed the integration. However, it was noted that cultural beliefs and healthcare utilization can be influenced through various approaches ranging from awareness campaigns, through radios, television, social media etc. with government involvement.

Discussion of findings

One of the objectives of this study was to find out the consequences of cultural beliefs and healthcare utilization in Anambra state. In as much that the dwellers disagreed that cultural belief does not stop them in utilizing healthcare service, they were of the opinion that economic perception and cost of healthcare services deter them from utilizing healthcare services.

Nevertheless, it was found that integrating traditional healers into healthcare programs would boost healthcare usage. Cultural attitudes may delay medical treatment if people value alternative therapies or traditional medicine above modern medicine. This delay may advance illnesses, making treatment less effective and harder. Some people visit spiritual leaders or traditional healers before obtaining medical care. In situations of life-threatening diseases like malaria, high blood pressure, or delivery problems, this might postpone treatment (Okeke & Okafor, 2008). The preference for traditional medicines and distrust of contemporary healthcare systems are connected to higher mortality and disease rates. Anambra's cultural norms around parenting and postnatal care may discourage women from getting adequate medical treatment during pregnancy and delivery, resulting in worse mother and child health. Nnebue et al. (2014) found that this might cause unnecessary complications such infections, obstructed labour, and haemorrhage, which increase mother and baby mortality. Vaccinations, prenatal care, and family planning may be underused due to cultural beliefs. Even though vaccines can prevent measles and polio outbreaks, Ezeonwu (2014) suggests that cultural resistance to family planning may increase unintended births, putting women and children at risk. Traditional medicine patients in Anambra may pressure the healthcare system by seeking treatment for complicated, expensive ailments. Thus, already underfunded healthcare providers and groups may take on more. In addition, resources that may be better utilised for early and preventative treatments are being diverted to coping with the consequences of delayed or improperly implemented conventional therapy (Oguonu et al., 2017). Due to cultural stigma, mental illness and HIV/AIDS patients may experience social isolation, discrimination, and emotional misery. Anambra residents are ashamed to seek medical care or follow treatment regimens. This practice harms their health and spreads infections (Uwakwe & Otakpor, 2014). Gender stereotypes may worsen the health gap between men and women. Cultural impediments to treatment, like as the necessity for male consent to enter a clinic in Anambra, may leave women with untreated ailments and poorer health consequences. Due to the societal expectation that women should prioritise family above self-care, women's health is commonly neglected (Iwelunmor et al., 2010). Cultural values that conflict with medical recommendations might cause healthcare disillusionment. Many people delay medical treatment because they distrust the healthcare system, which is often formed by bias or negligence. Uzochukwu et al. (2009) think this might lead to reduced healthcare utilisation and poor health outcomes in Anambra.

In addition, the research sought actionable therapies that may change cultural beliefs and healthcare utilisation. A more integrated strategy is recommended, according to this research. Public knowledge of cultural beliefs and healthcare use, family influence on healthcare decisions, rural education, and the need for more healthcare facilities were the main variables that urban and rural residents in this study considered important. Individualised health education initiatives may help people understand contemporary healthcare while honouring traditional beliefs. These efforts should incorporate recognised religious leaders, traditional healers, and community leaders to provide accurate health information. Uzochukwu et al. (2009) believe that bridging the gap between traditional methods and cutting-edge technologies with these prominent persons will

increase villagers' receptivity to contemporary therapy. Traditional healers and contemporary healthcare experts may collaborate to increase healthcare use. The healthcare system may develop confidence in the community and ensure individuals get the treatment they need by training traditional healers' basic health care and encouraging them to collaborate on hospital referrals. This partnership may include traditional and contemporary healthcare organisations sharing a location to send patients (Adebowale et al., 2018). Health promotion initiatives for Anambra must reflect their culture. Indigenous languages, traditional proverbs, and culturally significant symbols may make health messaging more approachable and effective. Clearing up misunderstandings about modern medicine and demonstrating how it can coexist with traditional therapies may help increase acceptability (Nnebue et al., 2014). Outreach initiatives and mobile healthcare facilities may be used in rural communities where cultural beliefs strongly impact healthcare decisions. These clinics treat patients, educate the public about contemporary healthcare, and offer preventative and curative treatments. Decentralising and culturally relevant programmes may reduce healthcare access obstacles (Ezeonwu, 2014). Medical practitioners should undergo cultural competency seminars to better understand their patients' origins and habits and treat them with respect. This communication skills training will help healthcare personnel connect with patients and reduce their aversion to current medical treatments. Onwujekwe et al. (2012) found that culturally competent physicians that show empathy and respect to patients had better healthcare results. Promoting and supporting certain healthcare methods with cultural and religious leaders may increase their acceptability. Religious leaders may be financially rewarded for promoting vaccination, maternity health, and regular exams. Such endorsements may inspire more individuals to seek medical treatment and decrease the stigma of contemporary healthcare. Policymakers should consider Anambra culture while creating health initiatives. Policies that promote the integration of traditional and modern healthcare practices, offer financial incentives for healthcare use, and protect cultural practices that can ensure that local residents have access to culturally appropriate healthcare (Obasi, 2013).

Conclusion

This study examined cultural barriers and healthcare utilization in Anambra state of southeastern Nigeria. While there is a pointer that cultural barriers may affect healthcare utilization, economic factor seems to be the major factor. Whereas the present study is not an attempt to generalize this for further study, which would examine how culturally relevant health education and communication tactics change health-related attitudes and behaviours. Assessing healthcare marketing initiatives such that local languages, narrative, and culturally appropriate symbols may help find the most successful ways to influence healthcare use, the policy implications of cultural notions in healthcare delivery require more study.

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