



Ethno-religious Beliefs and Patients' Healthcare-seeking Behavior in Nigeria

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ABSTRACT

This paper examined how ethnic cleavages stimulate the medical choices and decisions of patients in Nigeria. Indeed, how ethno-religious beliefs, push patients into adhering too much to religious faith and doctrines instead of seeking medical help is hardly examined in Nigeria. This gap invariably constitutes not only a high mortality rate but large-scale human insecurity in terms of loss of lives in the country. Drawing on structural-functionalism theory and qualitative methods that were sourced through observations, interviews, and document analysis, this article examined the connection between ethno-religious beliefs and the healthcare choices or behavior of patients. The findings showed that the high level of insecurity in Nigeria includes patients who risk their lives over religious-based healthcare decisions or seeking behavior. The findings also expand the discussion on the dynamics of the influence of ethno-religious sentiments among patients in Nigeria's tertiary health institutions. It further expands knowledge on how the Nigerian government can mitigate reliance on ethno-religious beliefs in ways to promote human security, including that of patients in hospitals.

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INTRODUCTION

Studies on how corruption forces people to seek religious and ethnic help rather than medical solutions, especially in Nigeria are scarce in the literature. Observations have shown that the lives of some patients have ended because they rely more on religious doctrines than medical assistance.¹ This has remained a potential source of human insecurity that has hardly been examined. Indeed, not many studies have considered how corrupt practices in the health sector, are pushing people to resort to religious faith practices, which in turn, leads to their demise. It is a fact that most people, especially uneducated religious worshippers, shun medical treatments and procedures and rely on miracles and religious faith practices, believing that their conditions would improve.

This healthcare-seeking behavior or decision may have arisen as a result of the weakened capacity of public hospitals and the ugly experiences faced by patients in the country. Weakened capacity and negative experiences in public hospitals are symptoms of corrupted institutions tasked with healthcare

¹ A C Gorter and B Bellows, "Do Competitive Voucher Schemes Improve the Provision of Health Care to Underserved and/or Vulnerable Population Groups," *Experiences from Nicaragua, India and Africa*, 2008; T. A. Oyejide, "Corruption and Development: A Nigerian Perspective," in *Paper Presented at ICAN 38th Annual Accountants Conference Held at Abuja, 14th October.*, 2008; Adegboyega Kamorudeen and S A Bidemi, "Corruption in the Nigerian Public Health Care Delivery System," *Sokoto Journal of the Social Sciences* 2, no. 2 (2012): 98–114; I Akinbajo, "The Massive MDG Fraud: How the Health Ministry Steals from the Sick and Dying," *Premium Times* 20 (2012); Daniel H Kress, Yanfang Su, and Hong Wang, "Assessment of Primary Health Care System Performance in Nigeria: Using the Primary Health Care Performance Indicator Conceptual Framework," *Health Systems & Reform* 2, no. 4 (2016): 302–18.

delivery.² Importantly, patients' choice of ethno-religious practices over medical solutions is partly influenced by loss of trust in public healthcare delivery institutions in Nigeria. Loss of public confidence or trust is among the implications of healthcare institutional fraud or corruption.³ As people tend to lose trust in public healthcare institutions due to corruption, they are most likely to be driven to put their trust in ethno-religious beliefs, believing that God will come to cure them of their health challenges. Evidence shows that a huge number of these people, often visit hospitals or make themselves available for medical treatment, very late and at the dying minute, when it is probably too late for medical treatment to save their condition.⁴ Although, biblical or Qur'anic doctrine has been blamed for such behavior, however, corruption can also activate similar behavior in people.⁵ Corruption, which has eaten deep into the fabric of Nigeria, somehow manifests in forms of diversion of public healthcare facilities for private use, looting of public health funds, and inordinate selfish interests of medical experts, who operate their private hospitals with stolen facilities from the government's owned hospital, fake drugs, deplorable condition of facilities in publicly owned hospitals and low commitment of medical experts, among others.⁶ As a result of the high level of corruption in Nigeria's healthcare sector, public hospitals have been less functional in the delivery of healthcare services.⁷ This has had severe implications such as congestion of the hospital facilities, long waiting times, inadequate healthcare services delivery, and shortage of medical experts, among others. It is a fact and true that if public funds meant for the procurement of medical equipment and recruitment of experts are looted, the hospital is likely going to face the above implications.

Most extant studies on the subject of insecurity, rarely show how corrupt practices in the health sector push patients into adhering to ethno-religious beliefs, which in turn, end their lives. Indeed, due to the high level of corruption in Nigeria's health sector, typified by the diversion of public health facilities for private use, deplorable medical facilities, and conditions, many patients are forced to hold on to their religious and ethnic beliefs instead of medical solutions. Although, without any empirical proven evidence, adherence to religious and ethical faith seems to have worked for some patients in some instances, such practice raises concerns for sustainability, acceptability, and human security. Research is scarce on the sustainability and acceptability of health-seeking behavior that is based on ethno-religious beliefs or faith. This article bridges this gap, by investigating how corruption pushes patients in Nigeria into believing or resorting to religious faith instead of seeking medical treatment for their health challenges.

To address this problem, measures have been put into place to create more awareness of the need to embrace medical solutions and shun cultural and religious practices for health-seeking behaviour, yet, people, especially rural uneducated Muslim women, continue to cling to their religious practices. The persistent nature of how corruption and ethno-religious beliefs have collectively led to the untimely death of patients in Nigeria has continually signified a worrisome and precariousness of Nigeria's healthcare system. Untimely death due to corruption and obnoxious cultural and religious practices is a potential source of insecurity that requires attention. It raises the question as to why would people die based on religious beliefs that make them reject medical solutions. The answer to this question brings to the fore

² Monica Ewomazino Akokuwebe and Damilare Michael Adekanbi, "Corruption in the Health Sector and Implications for Service Delivery in Oyo State Public Hospitals," *Ilorin Journal of Sociology* 9, no. 1 (2017): 200–217.

³ Monica Ewomazino Akokuwebe and Erhabor Sunday Idemudia, "Fraud within the Nigerian Health System, a Double Threat for Resilience of a Health System and the Response to the COVID-19 Pandemic: A Review," *Pan African Medical Journal (African Field Epidemiology Network)*, May 1, 2023), <https://doi.org/10.11604/pamj.2023.45.116.36979>.

⁴ Klaus Deininger and Paul Mpuga, "Does Greater Accountability Improve the Quality of Public Service Delivery? Evidence from Uganda," *World Development* 33, no. 1 (2005): 171–91; S. Ouma and M. E. Herselman, "E-Health in Rural Areas: Case of Developing Countries," *International Journal of Biological and Life Sciences* 4, no. 4 (2008): 194–200; Karen Hussmann, "Vulnerabilities to Corruption in the Health Sector: Perspectives from Latin American Sub-Systems for the Poor (with a Special Focus on the Sub-National Level)," *Panama: UNDP Regional Centre for Latin America and the Caribbean*, 2011.

⁵ Akokuwebe and Adekanbi, "Corruption in the Health Sector and Implications for Service Delivery in Oyo State Public Hospitals."

⁶ Akokuwebe and Adekanbi, "Corruption in the Health Sector and Implications for Service Delivery in Oyo State Public Hospitals"; W. Yankins, "Counterfeit Drugs: Coming to a Pharmacy near You," American Council on Science and Health, 2006, www.acsh.org/publications/pubID.1379/pub_detail.asp; D Akunyili, "Counterfeit Medicines: A Serious Crime against Humanity" (Presentation to the European Parliament by Professor Dora Akunyili, Director ..., 2007); T. Vian, W. D. Savedoff, and H. Mathisen, *Anticorruption in the Health Sector: Strategies for Transparency and Accountability* (Sterling, VA: Kumarian Press, 2010).

⁷ Akokuwebe and Idemudia, "Fraud within the Nigerian Health System, a Double Threat for Resilience of a Health System and the Response to the COVID-19 Pandemic: A Review."

the relevance of this research, which examines how corruption that has hindered efficient service delivery in health institutions and religious and cultural practices impact human insecurity in Nigeria.

Research in this direction would expand discussions on the dynamics of corruption and ethno-religious practices and their impact on health-seeking behavior in Nigeria. It will further contribute to knowledge in the general body of works on human insecurity in Nigeria. Importantly, this research has the utility to provide adequate information on how the Nigerian government can mitigate corruption and create awareness to orientate patients on the importance of medical solutions for their health-seeking behavior. This research becomes highly important because if nothing is done to speedily address the untimely deaths arising from adherence to religious and cultural beliefs, many patients will continue to lose their lives and this will aggravate the already existing insecurity in the country.

Studies on the subject of human insecurity in Nigeria are quick to blame poverty, bad governance, unemployment, and lack of education, and even those that blamed corruption and religion, only measured it from the lens of politicians and extremists, not much is known from the lens of health seeking people (patients).⁸ How religion and ethnic cleavages influence health-seeking behavior and how such behavior is steadily leading to the death of many Nigerians is largely unclear and understudied. This research is an approach to bridge the gap in the literature by providing adequate information on how insecurity in Nigeria can also be explained from the lens of patients' health-seeking behavior in public tertiary health institutions.

Drawing on qualitative research design that was sourced through observation, document analysis, and interview of participants, who are mainly patients, hospital clinicians and non-clinicians, consultants, and members of the hospital management team, this article examined the effect of corruption on making patients resort to religious faith or doctrines. It also examined the implications of patients' religious-based health-seeking behavior for human security in Nigeria. Further, it determined possible mitigation strategies against religious health-seeking behavior in Nigeria.

This is because persistent cases of corruption, which have weakened the efficiency of most public hospitals, have made many of the end-users (patients), resort to the belief that "only God can rescue the situation." With this mindset, patients are likely to shun medical facilities or assistance, with the belief that nothing good can come out of these corruption-polluted public hospitals, having seen how empty the majority of them are. This behavior has caused many patients to lose their lives, thereby constituting human insecurity.⁹ In this case, corruption, which impoverishes and undermines the efficient delivery of healthcare services in public tertiary healthcare institutions, does not only push patients in these hospitals to their ethno-religious beliefs but also to their deaths.¹⁰ Given the foregoing analysis, the paper hypothesizes that corruption and religious beliefs are potential sources of human insecurity in Nigeria. This hypothesis is hinged on the fact that the likely reason why people resort to their religious faith or belief, is partly because the healthcare institutions look too fragile and incapable of addressing their health conditions, thus making their lives largely unsecured. Human security is one of the critical functions of any government, including that of Nigeria.¹¹ It includes freedom from danger, threats, disasters, ailments, and accidents as well as all forms of health risks.¹²

Occurrences in Nigeria about human security, indicate that corruption is partly the underlying factor responsible for the high level of human insecurity in Nigeria. This is inclusive of the health sector and public healthcare hospitals in particular.¹³ As a result of massive corrupt practices from both

⁸ S. C. Agunyai, "Emerging Governance Crises in Twenty-First Century Nigeria," in *Africa Now: Emerging Issues and Alternative Perspective*, ed. A. Adebunsi and K. Ikutejo (Springer, 2018); S C Agunyai and V Ojajorotu Governance Failure, "Formation of Anti-State Organizations: The Impact of the Amnesty Policy on the Development of Nigeria's Niger-Delta," *Nigeria. African* 10, no. 2 (2021).

⁹ M. O. Muhibbu-Din, "Human Security in Developing Regions: Critical Perspectives of Health Security in Nigeria," *Journal of Human Sciences* 5, no. 17/4 (2020): 1054–68.

¹⁰ Muhibbu-Din, "Human Security in Developing Regions: Critical Perspectives of Health Security in Nigeria."

¹¹ Temitayo Isaac Odeyemi and A Sat Obiyan, "Digital Policing Technologies and Democratic Policing: Will the Internet, Social Media and Mobile Phone Enhance Police Accountability and Police–Citizen Relations in Nigeria?," *International Journal of Police Science & Management* 20, no. 2 (2018): 97–108.

¹² Glender Amantle Mothelesi, Agunyai Samuel Chukwudi, and Phemelo O Marumo, "Prison Administration and Human Insecurity in Nigeria," *Gender and Behaviour* 17, no. 1 (2019): 12352–66.

¹³ Akokuwebe and Adekanbi, "Corruption in the Health Sector and Implications for Service Delivery in Oyo State Public Hospitals"; Muhibbu-Din, "Human Security in Developing Regions: Critical Perspectives of Health Security in Nigeria"; Akokuwebe and Idemudia, "Fraud within the Nigerian Health System, a Double Threat for Resilience of a Health System and the Response to the COVID-19 Pandemic: A Review."

government functionaries, and health experts in public hospitals, the lives of patients have been similar to what Thomas Hobbes described in a state of nature as short, dark, and brutish. Short, in terms of the sudden death of patients due to fake drugs, limited supply of medical resources, delay in service delivery, among others, dark in terms of the murky state of affairs of facilities in Nigeria's public hospitals, brutish, symbolizes the anti-social behavior of some medical experts, which manifests in forms of sudden cut of electricity supply during strike actions, which in turn, affects surgical operations and patients on oxygen.¹⁴ It is a fact that some medical experts divert medical resources from public hospitals to their private hospitals. This may have made Akokuwebe and Idemudia conclude that the public-private partnership initiative is not transparent, as more clinical workers are diverting medical tests, drugs, and other resources to their private clinics.¹⁵

It is no more new news that some pharmacists in public hospitals use their medical insurance scheme to purchase drugs at a subsidized rate and sell them at a higher price to their pharmaceutical vendors. All these, according to Jaiyesimi are limitations weakening the capacity of public healthcare institutions to deliver efficient healthcare services in Nigeria.¹⁶ These limitations do not only reduce citizens' public trust, according to Akokuwebe and Idemudia but somehow have a way of pushing them to believe in their religious faiths or doctrines rather than seeking medical assistance from hospitals.¹⁷ How these beliefs impact human security, especially the effect of ethno-religious beliefs on the safety of patients in public tertiary institutions is also part of the focus of this paper.

To achieve this purpose, the article is structurally organized into six different sections. The first section discusses the introduction. The second section traces the inherent problem of corruption and ethno-religious beliefs in Nigeria's healthcare institutions. The third section reviews the literature, which consists of the theoretical and conceptual reviews of key concepts relating to the subject. This is followed by recommendations and conclusion. The fourth section discusses in detail various methodological approaches adopted in the study. The fifth section looked at the findings of the study, with a specific focus on the study's objectives.

LITERATURE REVIEW

Tracing the problem with Ethno-religious beliefs among patients in Nigeria's Healthcare Institutions

While corruption and ethno-religious sentiments or beliefs are problems in themselves, how they both influence medical choices or decisions made by patients who need healthcare is a bigger problem that has consistently become a potential source of insecurity in Nigeria. This goes to show that there is a connection between three issues corruption, ethno-religious beliefs, and insecurity, but how they connect is rarely examined. This article therefore provides adequate information on how they connect. Across international governance systems, the government is expected to protect lives and control factors that can highlight insecurity.¹⁸ The government as a state actor through an amalgam of institutions, including hospitals can enhance security and protect human lives through affordable medical treatments.¹⁹ In this context, how public hospitals tasked with the responsibility to deliver healthcare services trigger

¹⁴ Akokuwebe and Adekanbi, "Corruption in the Health Sector and Implications for Service Delivery in Oyo State Public Hospitals"; Muhibbu-Din, "Human Security in Developing Regions: Critical Perspectives of Health Security in Nigeria"; Akokuwebe and Idemudia, "Fraud within the Nigerian Health System, a Double Threat for Resilience of a Health System and the Response to the COVID-19 Pandemic: A Review."

¹⁵ Akokuwebe and Idemudia, "Fraud within the Nigerian Health System, a Double Threat for Resilience of a Health System and the Response to the COVID-19 Pandemic: A Review"; Akokuwebe and Adekanbi, "Corruption in the Health Sector and Implications for Service Delivery in Oyo State Public Hospitals"; Yankins, "Counterfeit Drugs: Coming to a Pharmacy near You"; Akunyili, "Counterfeit Medicines: A Serious Crime against Humanity"; Vian, Savedoff, and Mathisen, *Anticorruption in the Health Sector: Strategies for Transparency and Accountability*.

¹⁶ Rotimi Jaiyesimi, "Corruption in Health Sector," *The Nation*, 2015, <https://thenationonline.net/corruption-in-health-sector/>.

¹⁷ Akokuwebe and Idemudia, "Fraud within the Nigerian Health System, a Double Threat for Resilience of a Health System and the Response to the COVID-19 Pandemic: A Review"; Sophia Ahmed Hussien et al., "Spirituality, Social Capital and Service: Factors Promoting Resilience among Expert Patients Living with HIV in Ethiopia," *Global Public Health* 9, no. 3 (March 16, 2014): 286–98, <https://doi.org/10.1080/17441692.2014.880501>.

¹⁸ Odeyemi and Obiyan, "Digital Policing Technologies and Democratic Policing: Will the Internet, Social Media and Mobile Phone Enhance Police Accountability and Police–Citizen Relations in Nigeria?"; Mothelesi, Chukwudi, and Marumo, "Prison Administration and Human Insecurity in Nigeria."

¹⁹ Muhibbu-Din, "Human Security in Developing Regions: Critical Perspectives of Health Security in Nigeria."

insecurity is the focus of this article. Expectedly, with adequate functional healthcare facilities, funding, and highly motivated and committed health workers in public healthcare institutions, human lives, especially ailing citizens could be saved from diseases and other related medical concerns.²⁰ Indeed, through functional healthcare systems, many patients have been treated for their diseases and sicknesses and have regained their health.

This shows that factors, such as diseases and pandemics, which also threaten human security or that can exacerbate the tendency of insecurity in human beings can be checked and put under control by functional healthcare institutions.²¹ However, the reality in Nigeria, shows that public tertiary health institutions suffer from limitations undermining their medical care roles to save dying or ailing patients.²² Corruption has been identified as the greatest limitation threatening the functionality of healthcare institutions across Nigeria.²³ Corrupt practices from parliamentary oversight committee members, government officers in the Ministry of Health, and health workers in public health institutions are partly the reasons why patients experience difficulty in accessing good medical care. Today, many public hospitals owned by the government suffer from diversion of funds, misappropriation of funds, inadequate procurement process to purchase medical equipment, strained clinical and non-clinical workers' relations, low commitment of health workers, deliberate diversion of public hospital resources to fund private hospitals owned by health workers, among others. These are practices working against the sacred goals of public healthcare institutions in Nigeria. They are partly responsible for the deplorable conditions of facilities and the low commitment of medical experts to their work. Bad clinical experiences of patients, which usually manifest in the forms of long waiting times, long queues for surgical operations, congestion of the facilities, shortage of clinical experts to attend to patients, fake drug usage, and hostile relations, are among the consequences of corruption in public health institutions in Nigeria.²⁴

These experiences not only frustrate patients but make them believe that the majority of public hospitals are deficient and cannot deliver efficient healthcare services.²⁵ The failure and underperformance of healthcare institutions, according to Newbrander et al., are likely to contribute to why most patients resort to prayers and other religious beliefs rather than medical solutions.²⁶ The question then is, Why won't patients stick to their religious beliefs, considering the ugly experiences they go through in public hospitals in Nigeria? From this analysis, it is clear and logical to argue that the underperformance and inadequate healthcare delivery, which is partly caused by corruption, is a factor that can also push people to begin to pray their way out of their sickness. Although there have been fewer studies that interrogated the connection between religious beliefs and healthcare decisions or behavior, evidence exists to show that some orthodox Christians prefer to rely on their faith-based practices and spirituality in coping with their illness and health-seeking behavior.²⁷ Having established the fact that religious beliefs and teachings affect medical choices and decisions, the extent to which ethno-religious faith and practices determine health-seeking behaviour differs across continents and countries. In the

²⁰ Akokuwebe and Idemudia, "Fraud within the Nigerian Health System, a Double Threat for Resilience of a Health System and the Response to the COVID-19 Pandemic: A Review"; Jaiyesimi, "Corruption in Health Sector"; Akinbajo, "The Massive MDG Fraud: How the Health Ministry Steals from the Sick and Dying"; Kress, Su, and Wang, "Assessment of Primary Health Care System Performance in Nigeria: Using the Primary Health Care Performance Indicator Conceptual Framework."

²¹ Jaiyesimi, "Corruption in Health Sector"; Akinbajo, "The Massive MDG Fraud: How the Health Ministry Steals from the Sick and Dying."

²² Akokuwebe and Idemudia, "Fraud within the Nigerian Health System, a Double Threat for Resilience of a Health System and the Response to the COVID-19 Pandemic: A Review."

²³ Akokuwebe and Adekanbi, "Corruption in the Health Sector and Implications for Service Delivery in Oyo State Public Hospitals"; Muhibbu-Din, "Human Security in Developing Regions: Critical Perspectives of Health Security in Nigeria"; Akokuwebe and Idemudia, "Fraud within the Nigerian Health System, a Double Threat for Resilience of a Health System and the Response to the COVID-19 Pandemic: A Review."

²⁴ Akokuwebe and Adekanbi, "Corruption in the Health Sector and Implications for Service Delivery in Oyo State Public Hospitals."

²⁵ M E Akokuwebe, "Healthy Women, Healthy World": A Theoretical Discourse of General Health Status of Women in Nigeria," *West Afr J Archaeol (Revue Quest Afr Archeol)* 46 (2016): 87–111.

²⁶ William Newbrander et al., "Afghanistan's Basic Package of Health Services: Its Development and Effects on Rebuilding the Health System," *Global Public Health* 9, no. sup1 (July 21, 2014): S6–28, <https://doi.org/10.1080/17441692.2014.916735>.

²⁷ Hussen et al., "Spirituality, Social Capital and Service: Factors Promoting Resilience among Expert Patients Living with HIV in Ethiopia."

North East and North Africa, Muslim women require the assistance of their husbands and male relatives to accompany them outside their homes.²⁸

Women in Afghanistan need the permission of their husbands to visit hospitals, even during emergencies.²⁹ This goes to show the extent to which religion and cultural practices influence health-seeking behavior. Nigeria's northern region is not spared from how religious and cultural beliefs, influence healthcare choices of patients, especially women in the region. Evidence show that majority of the Muslim women often refuse to be attended to by male health workers.³⁰ In some severe cases, their husbands, parents, and religious leaders need to permit them to visit the hospital.³¹ This dynamic has partly remained the cause of the high maternal mortality rate in Nigeria, as more women have lost their lives in the process of strict adherence to ethno-religious practices.³² The more people lose autonomy to make choices or decisions about their healthcare services, the greater their chances of untimely death, which in turn, heightens human insecurity.³³

Studies have indicated that human security is a state of threat, danger, disasters, epidemics, and other related factors, that threaten human survival, peace, and sustainable development.³⁴ These factors can grow exponentially spilling into all facets of people's lives and destroying communities. From this definition, it is clear that anything, including religious and cultural practices that tend to put people in danger or eventual loss of life, can be regarded as one of the triggers of human insecurity. Human insecurity in this context, can be caused by patients' overreliance on cultural and religious practices, which have led to the death of some patients as in the case in Nigeria's northern region and North Africa.³⁵

Conceptual and Theoretical Underpinnings of Corruption, Ethno-Religious Practices and Human Insecurity in Nigeria

Corruption, ethno-religious practices or beliefs, and human insecurity are keywords that are critical to a proper understanding of healthcare behavior in Nigeria. Although studies in social sciences and humanities have advanced knowledge on how corruption and ethno-religious sentiments trigger insecurity, research is very little or scarce on how healthcare choices or decisions, as well as behavior, provoke insecurity. For example, not much attention has been committed to investigating how patients' healthcare behavior or choices trigger their untimely death, which in turn, contributes to the high rate of insecurity in Nigeria. In the context of this paper, how hospital patients' strict adherence to ethnic, cultural, and religious beliefs or practices leads to their avoidable deaths is discussed. To address this, corruption and ethno-religious beliefs are concisely explained.

Corruption is simply an abuse of public office for private gains.³⁶ This is seen in the way public officials who through their positions or offices act in a way contrary to the established laws of the public offices they occupy. This can be in the forms of the collection of bribes to render their statutory duties or the seeking of sexual gratifications from people, needing their services. It is also the process of acting or going contrary to established rules and regulations for personal benefit. It is common in both private and

²⁸ Newbrander et al., "Afghanistan's Basic Package of Health Services: Its Development and Effects on Rebuilding the Health System"; Robert H Remien et al., "Gender and Care: Access to HIV Testing, Care, and Treatment," *JAIDS Journal of Acquired Immune Deficiency Syndromes* 51, no. Supplement 3 (July 2009): S106–10, <https://doi.org/10.1097/QAI.0b013e3181aafd66>.

²⁹ Newbrander et al., "Afghanistan's Basic Package of Health Services: Its Development and Effects on Rebuilding the Health System."

³⁰ Adeniyi Francis Fagbamigbe and Erhabor Sunday Idemudia, "Barriers to Antenatal Care Use in Nigeria: Evidences from Non-Users and Implications for Maternal Health Programming," *BMC Pregnancy and Childbirth* 15, no. 1 (December 17, 2015): 95, <https://doi.org/10.1186/s12884-015-0527-y>; Henry V Doctor et al., "Using Community-Based Research to Shape the Design and Delivery of Maternal Health Services in Northern Nigeria," *Reproductive Health Matters* 20, no. 39 (January 9, 2012): 104–12, [https://doi.org/10.1016/S0968-8080\(12\)39615-8](https://doi.org/10.1016/S0968-8080(12)39615-8).

³¹ Fagbamigbe and Idemudia, "Barriers to Antenatal Care Use in Nigeria: Evidences from Non-Users and Implications for Maternal Health Programming."

³² John Kuumuori Ganle, "Why Muslim Women in Northern Ghana Do Not Use Skilled Maternal Healthcare Services at Health Facilities: A Qualitative Study," *BMC International Health and Human Rights* 15, no. 1 (December 28, 2015): 10, <https://doi.org/10.1186/s12914-015-0048-9>.

³³ Newbrander et al., "Afghanistan's Basic Package of Health Services: Its Development and Effects on Rebuilding the Health System."

³⁴ United Nations Trust Fund for Human Security, "What Is Human Security?," 2018, <https://www.un.org/humansecurity/wp-content/uploads/2018/04/What-is-Human-Security.pdf>.

³⁵ Maryam Al-Mujtaba et al., "Evaluating Religious Influences on the Utilization of Maternal Health Services among Muslim and Christian Women in North-Central Nigeria," *BioMed Research International* 2016 (2016): 1–8, <https://doi.org/10.1155/2016/3645415>.

³⁶ Dahida D Philip and O M Akangbe, "Corruption as a Bane for Under-Development in Nigeria: Issues and Challenges," *International Affairs and Global Strategy* 15 (2013): 76–84.

public sectors; it is an abuse of entrusted power or position for private aggrandizement. It erodes public trust, creates inequality, exacerbates poverty and socio-economic problems, and severely cuts down equitable access to public utilities or services. It limits the dividends of democracy accruing to countries. It entails an abuse of resources either in a private or public capacity. In the context of this paper, the focus is on the abuse of entrusted power and resources in public spheres. For instance, corruption in public utilities like tertiary healthcare institutions. Corruption according to the World Bank was more encompassing and broader including both the private and public sectors of a country. It notes that corruption is that which:

Involves a broad spectrum of human behavior (it is) the abuse of public office for private gain. A public official is said to be abusing their position for personal gain when they accept, solicit, or demand a bribe. Furthermore, it is abused when private agents aggressively offer bribes to go around laws and regulations in order to get an advantage over competitors and make money. Even when there is no bribery, using public office for personal advantage is still possible. The embezzlement of public funds, the use of nepotism and favoritism, or the misappropriation of revenue. Like most prior definitions, it places the public sector at the center of the phenomenon. This is not to say that corruption cannot occur or that it has very little effect on private-sector activity.³⁷

It is clear that the World Bank's definition captured both the private and public spheres, which had been aptly defined by Nwaodu as any unlawful or antisocial behavior that entails coercing or unfairly influencing individuals in public or private to behave against the laws and regulations that are currently in place and often govern a specific procedure. Such anti-social or illegal behavior manifests in forms of diversion of public resources (in the context of this (paper hospital facilities, drugs, mattresses, test centers, medical aids, and insurance, among others), bribes (Payments intended to obtain an advantage or avoid an unfavorable consequence), theft, looting or embezzlement, fraudulent acts.³⁸ Given the different ways corruption manifests, scholars have attempted to classify corruption as political, bureaucratic, and economic.³⁹ Among the three classifications of corruption, political corruption has the highest profound effects on democracy and good governance in any society.⁴⁰ This is so because democracy and good governance are within the purview of politics, thus making them susceptible to the inordinate and corrupt practices of politicians. Politicians are key actors in democracy and good governance and the fact that democratic positions require people to occupy them, there is the likelihood that these people (politicians) seeking power or occupation of democratic offices may resort to fraudulent acts to get to the position of power. This may have influenced one of the reports of the World Bank on corruption, where it was revealed that corruption in public life occurs both in political and bureaucratic realms, with the former, being independent of the latter or both collusively occurring.⁴¹

Corruption can also be systematic or bureaucratic and endemic.⁴² Systematic corruption is the type that normally occurs in the public sector, where public officers systematically divert public resources for their private gains. This kind of corruption usually frustrates access of people to public utilities and those involved in it, often, forget the ideals of good governance which are service, effective performance, accountability, transparency, and upholding of rules and regulations, among others.⁴³ A critical look at both the World Bank and Oviendela's views suggests that corruption in the public realm is both political and systematic or bureaucratic because both can collusively occur.

³⁷ World Bank, "The Fight against Corruption: A World Bank Perspective," *Workshop on Transparency and Governance, Organized as Part of the Consultative Group Meeting for the Reconstruction and Transformation of Central America, May 25-28* (Stockholm, Sweden, 1999).

³⁸ N Nwaodu, "Corruption: Development Crises and Political Instability in Nigeria," *Owerri, Mega Atlas Ltd*, 2012.

³⁹ Dhikru Adewale Yagboyaju, "Corruption, Democracy and Good Governance," *Democracy and Democratic Practise in Nigeria: Issues, Challenges and Prospects*, 2011, 142-54.

⁴⁰ Olu Awofeso and Temitayo Isaac Odeyemi, "The Impact of Political Leadership and Corruption on Nigeria's Development since Independence," *Journal of Sustainable Development* 7, no. 5 (2014): 240-53.

⁴¹ World Bank, "The Fight against Corruption: A World Bank Perspective."

⁴² A. A. Oviendela, *The Weeping Child* (New York: Primus International Network for Education and Developments, 2007).

⁴³ Awofeso and Odeyemi, "The Impact of Political Leadership and Corruption on Nigeria's Development since Independence."

This can be interpreted to mean that corruption in the public sector, like the tertiary healthcare institutions (in the context of this paper, OAUTHC), takes the form of both political and bureaucratic. Political in the sense that observations of legislative probe panels and legislative oversight on tertiary healthcare institutions by Nigeria's parliamentary members have always shown how committee members are prime suspects in the diversion of Ministry of Health revenue. Evidence abounds on how politicians collude with heads of ministries, parastatals, and agencies to illicitly manipulate their budgetary allocations, including the health sector.⁴⁴ This is likened to the view of the World Bank, which opined that bureaucratic and political corruption can occur collusively. On their separate realm, political corruption in public tertiary healthcare institutions like OAUTHC manifests in forms of illegal and unlawful diversion and mismanagement of budgetary allocations accruing to OAUTHC by politicians (consisting of parliamentary committee members, board members, legislative representatives, government special assistants on health matters, among others), the systematic or bureaucratic type manifests in forms of official stealing and looting of hospital resources. This involves mainly officers in various parastatals, including OAUTHC, that use their official positions to divert medical facilities (drugs, treatment, medical tests, mattresses, computers, medical equipment, lab coats, refrigerators, incubators, scanners, and others), for their private gains. It also manifests in taking advantage of the healthcare workforce for personal gain, fraud, embezzlement, mishandling of funds, exploitation, and a lack of openness in policymaking.⁴⁵

These manifestations may have also made Akokuwebe and Idemudia classify corruption in healthcare institutions in Nigeria as systemic fraud, which is the deliberate deception or misleading portrayal of material health facts, either for one's benefit or in part for the benefit of others, leaves the health system vulnerable to fraud.⁴⁶ A critical review of the above definition shows that corruption in healthcare institutions can be regarded as institutional fraud, which is an intentional attempt to undermine the healthcare goals of these institutions to render them ineffective and erode public confidence in them.⁴⁷ In Nigeria, evidence has shown several ways health workers have intentionally undermined the effective performance of the public healthcare system for their gains. For example, some of the ways include untransparent public-private partnership initiatives (as observation has shown that the majority of the private hospitals or centers, where medical tests are conducted, and medical treatment are offered are owned by consultants and other medical practitioners, who work in public tertiary institutions).⁴⁸ It also manifests in forms of diversion of drugs purposively meant for the public for private use or gains. Any of the health workers could deceptively use their National Health Insurance Scheme to divert drugs to their private clinics or drug-selling centers (popularly known as chemists in Nigeria). In addition, how fake drugs get entrance into some public tertiary healthcare institutions is another worrisome trigger of human insecurity. This may have informed the report of the World Health Organization stated in 2002 that 70% of drugs in Nigeria were counterfeit or of inferior quality; the National Agency for Food and Drug Administration and Control (NAFDAC), also claimed that 41% of drugs were counterfeit.⁴⁹

From the foregoing reviews, it is obvious that corruption is the bane of the poor performance of public tertiary healthcare institutions in Nigeria. Its nature includes both political, systematic and bureaucratic. Although both forms of corruption can occur independently of the other, they can also occur collusively, as the case may be during ministerial budget defense at the country's parliamentary houses. Both politicians and bureaucrats have been found culpable of corrupt practices in healthcare institutions.

⁴⁴ Mothelesi, Chukwudi, and Marumo, "Prison Administration and Human Insecurity in Nigeria."

⁴⁵ Akokuwebe and Idemudia, "Fraud within the Nigerian Health System, a Double Threat for Resilience of a Health System and the Response to the COVID-19 Pandemic: A Review."

⁴⁶ Akokuwebe and Idemudia, "Fraud within the Nigerian Health System, a Double Threat for Resilience of a Health System and the Response to the COVID-19 Pandemic: A Review."

⁴⁷ Muhibbu-Din, "Human Security in Developing Regions: Critical Perspectives of Health Security in Nigeria"; Aduragbemi Banke-Thomas et al., "Cost of Utilising Maternal Health Services in Low-and Middle-Income Countries: A Systematic Review," *International Journal of Health Policy and Management* 10, no. 9 (2020): 564.

⁴⁸ Akokuwebe and Idemudia, "Fraud within the Nigerian Health System, a Double Threat for Resilience of a Health System and the Response to the COVID-19 Pandemic: A Review"; Muhibbu-Din, "Human Security in Developing Regions: Critical Perspectives of Health Security in Nigeria."; Jillian Clare Kohler and Tom Wright, "The Urgent Need for Transparent and Accountable Procurement of Medicine and Medical Supplies in Times of COVID-19 Pandemic," *Journal of Pharmaceutical Policy and Practice* 13, no. 1 (December 11, 2020): 58, <https://doi.org/10.1186/s40545-020-00256-w>.

⁴⁹ Yankins, "Counterfeit Drugs: Coming to a Pharmacy near You"; Akunyili, "Counterfeit Medicines: A Serious Crime against Humanity"; Vian, Savedoff, and Mathisen, *Anticorruption in the Health Sector: Strategies for Transparency and Accountability*.

The effects of corruption have been multi-faceted, ranging from weakened healthcare delivery capacity to ethno-religious practices in healthcare-seeking behavior, and in some severe cases untimely death of patients, whose trust in Nigeria's healthcare systems has been eroded.

On ethno-religious beliefs, MacKay suggested that they are ideologies, principles, and practices that are culturally, ethnically, and religiously based.⁵⁰ They are identities with which to recognize certain groups of people or communities, especially in the way they think, behave, and make choices. In Nigeria, the majority of adherents are also found in Christianity and Islam.⁵¹ Numerous individuals in Nigeria lead social lives that are dominated by their religious beliefs and practices. Of Nigerians, 51.1% practice Islam, 46.9% practice Christianity, and the other 2% are Traditional African Worshippers.⁵² Ethno-religious beliefs could be *priori* and *circumstantial*.⁵³ *Priori*, in the sense that both (ethnicity and religion) can be earned by birth. And *circumstantial* because both can change and be affected by certain occurrences in the community. As circumstances change, so do religion and ethnic identity, they are not static or fixed. For instance, the borders between ethnic groups are dynamic processes that are not fixed, so also religion is part of a social system.⁵⁴

From the analysis of Mackay's view, it is clear that ethno-religious beliefs are practices and behaviors that people tend to follow or exhibit based on their reasoning that such practices or behaviors have been in existence over time. They are practices and beliefs earned by birth. For example, a child who grew up to become a Muslim or Christian, on the reasoning and deduction that his or her parents are either Muslim or Christian, is operating under the influence of ethno-religious beliefs. Ethno-religious beliefs could also be a result of changes in the social system, that is, *circumstantial* changes could also influence ethno-religious beliefs. A good example of this was the period of COVID-19, which made lots of religious worshippers (Muslims, Christians, and others), turn to their God for protection against the pandemic. This according to Ossai led to Christian-Muslim cooperation as worshippers from both religions cooperated in their faith and prayers against COVID-19.⁵⁵ Indeed, the healthcare-seeking behavior or medical choices of patients in Nigeria have been influenced by ethno-religious practices and beliefs. Studies carried out in the northern part of Nigeria have produced evidence that women rarely go to hospitals for medical checkups because of their fervent Islamic beliefs. Certain Muslim husbands have a well-known preference for female doctors to care for their wives over male doctors. These husbands show no regard for their wives' lives; they would rather have their wives stay at home than receive care from male physicians, even if the only hospital in the area lacks female physicians with the necessary training.

This is likened to what MacKay had described as ethno-religious beliefs derived from deductive reasoning, with no empirical evidence (*priori*).⁵⁶ While religious worshippers in Nigeria's north seem to be highly influenced by *priori*-influenced ethno-religious practices, their counterparts in Nigeria's south seem to move by *circumstantial* changes. Although some of them still hold the belief arising from *priori* consideration, the religious belief of a huge proportion of them is still largely influenced by social changes. For example, natural disasters and climatic changes such as erosion, drought, lack of rainfall, and other social changes, have made lots of people resort to prayers, faith or belief in God, rather than holding the government accountable for good governance and service delivery. COVID-19 penetration in Nigeria, made lots of Muslims and Christians revert to their faith and pray as a means to protect them from the spread of the disease.⁵⁷ The case is the same with routine medical or health conditions or diseases, evidences have shown that people quickly revert to their religious faith and prayers in critical health conditions, rather than accessing medical solutions. Changes in health conditions are part of

⁵⁰ D.B. MacKay, "Ethnicity," in *Guide to the Study of Religion*, ed. W. Braun and R.T. McCutcheon (London: Cassell, 2000), 96–109.

⁵¹ B. Owumi, S. O. Raji, and T. K. Aliyu, "Religious Beliefs and the Utilization of Traditional Medicine among Members of Pentecostal Churches in Emurin, Ogun State, Nigeria," *African Journal of Social Sciences* 3, no. 4 (2013): 23–24.

⁵² Pew Research Center, "Christians Remain World's Largest Religious Group, but They Are Declining in Europe," 2017, <http://www.pewresearch.org/facttalk/2017/04/05/christians-remain-worlds-largest-religious-group-but-they-are-declining-in-europe>.

⁵³ MacKay, "Ethnicity."

⁵⁴ MacKay, "Ethnicity."

⁵⁵ Emmanuel Chiwetalu Ossai, "The Social Dynamics of Peaceful Christian–Muslim Relations in Nigeria," *Religion Compass* 18, no. 9 (September 4, 2024), <https://doi.org/10.1111/rec3.70001>.

⁵⁶ MacKay, "Ethnicity."

⁵⁷ Ossai, "The Social Dynamics of Peaceful Christian–Muslim Relations in Nigeria."

circumstantial changes, that could make people, including patients stick to their ethno-religious beliefs.⁵⁸ The implications of this healthcare-seeking behavior are numerous, some of them include untimely deaths, permanent physical damage, and feelings of insecurity.

Human (in)security, simply refers to a situation whereby human beings are in danger, under threat and fear.⁵⁹ It is a state of threats that endanger human beings, their communities, and properties. Human insecurity has no singular cause, it occurs due to multiple factors, including health challenges and healthcare-seeking behavior. For instance, strict adherence to religious practices over medical help is a healthcare-seeking behavior that could threaten the lives of people. In addition, the religion or ethical practice forbidding women from being treated by male doctors may endanger the lives of women and could lead to their untimely deaths. Furthermore, cultural practice stipulating women must be granted permission by their husbands before they visit the hospital may also endanger their lives, especially when their husbands are not around to give such orders. This goes to show that patients' healthcare-seeking behavior can partly trigger insecurities (dangers, threats, and fears) that affect them. The health implications of people's insecurity include injuries, pandemics, diseases (hypertension, diabetes, tuberculosis among others), war-related sexual violence, and sexually transmitted infections like HIV/AIDs.⁶⁰ Patients' behavior or decision about how to tackle these diseases, is critical to their survival. While evidences abound on how strict adherence to medical treatment, drugs, and approaches have cured some of these diseases, there has not been any proven scientific empirical evidence on how cultural, ethnical, or religious beliefs and practices have cured the diseases, yet people, still rely on religious faith and practices during health challenges.

Theoretically, structural-functionalism popularized by Talcott Parson was utilized to explain how unfunctional healthcare institutions force people, especially patients to revert to ethno-religious beliefs and practices.⁶¹ This holds the view that four functional requirements are essential to the effective functioning of all systems, including the health system. It includes adaptation, goal attainment, integration, and latency.⁶² Known as the AGIL scheme, a system needs to put these four functional imperatives into practice. Through a collection of interactions between persons (social actors), Talcott Parson clarifies the pragmatic basis for the frame of reference. From this perspective, social actors have certain objectives that they want to accomplish and to do so, they need to seize opportunities (means) that present themselves under specific circumstances (situations).⁶³ In this context, social actors include the government, health workers, patients, and suppliers of medical equipment among others. They interact or relate based on the objective each of the social actors wants to attain.⁶⁴ The entire system of the health institution, in this case, OAUTHC, can only be functional if each of the social actors (health workers, government, suppliers of medical facilities, patients, community members, external actors, and others), effectively perform their function, as any functional-gap, could distort the entire system of OAUTHC. OAUTHC is a structure or system with inter-related parts, specifically designed to meet the health needs of people. Inter-related parts in OAUTHC consist of clinical and non-clinical workers, suppliers/contractors, government, patients, and external actors or donors. The aggregation of these interrelated parts forms the whole system of OAUTHC. The theory stipulates that the greater the performance of the interrelated parts in terms of their functions, the better the stability and functionality of the whole system. Thus, OAUTHC's ultimate performance in terms of the delivery of healthcare services is largely dependent on the effective performance of statutory functions or duties by each of the parties, which can be through mutual collaboration, interaction, supervision, or monitoring.

The theory sees social facts as one of the ways to control and monitor interrelated parts or social actors within the system. Social facts are religious beliefs, customs, fashions, rituals, laws, morals, values,

⁵⁸ MacKay, "Ethnicity."

⁵⁹ I C Achumba, O S Ighomereho, and M O M Akpor-Robaro, "Security Challenges in Nigeria and the Implications for Business Activities and Sustainable Development," *Journal of Economics and Sustainable Development* 4, no. 2 (2013).

⁶⁰ Suzanne Maman et al., "Efficacy of Enhanced HIV Counseling for Risk Reduction during Pregnancy and in the Postpartum Period: A Randomized Controlled Trial," *PLoS ONE* 9, no. 5 (May 13, 2014): e97092, <https://doi.org/10.1371/journal.pone.0097092>.

⁶¹ Talcott Parsons, *The Structure of Social Action* (New York: McGraw Hill, 1937).

⁶² Parsons, *The Structure of Social Action*.

⁶³ H. Spencer, *The Principles of Sociology* (New York: D. Appleton and Company, 1938).

⁶⁴ Akokuwebe and Adekanbi, "Corruption in the Health Sector and Implications for Service Delivery in Oyo State Public Hospitals."

and all of the cultural rules that govern social actors within the system.⁶⁵ Each of these social facts performs one or more functions within a system. For example, one function of a system’s laws may be to protect the system from collapsing, while another is to punish criminal behavior, while another is to protect people. In the context of OAUTHC, some laws or regulations serve more than one function. For example, the hospital law can help to check the excesses of health workers, protection of patients, and adequate supervision of workers for functional hospitals that can deliver on their mandate of healthcare delivery.

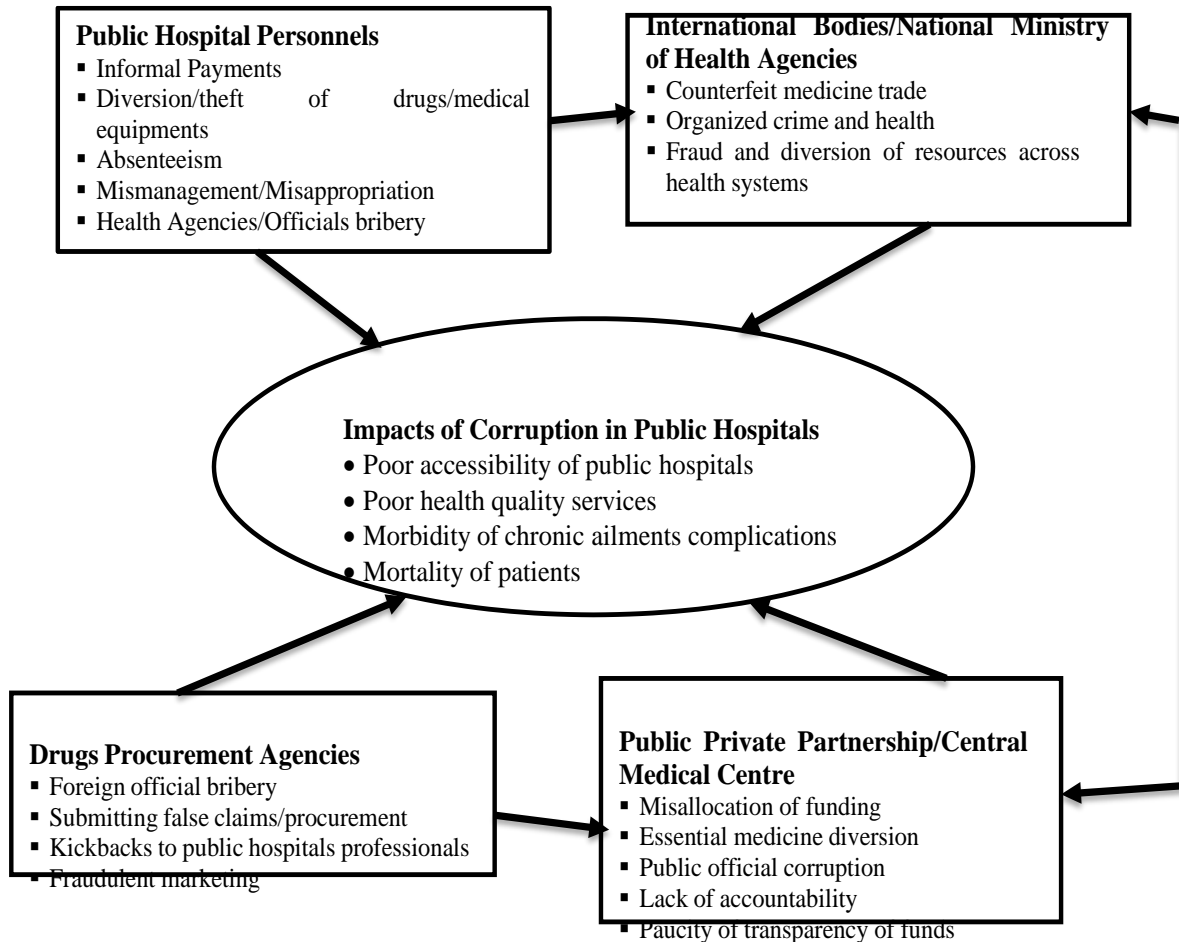


Figure 1: The impact of corruption in Public Hospitals
Source: Adapted from the research work.⁶⁶

Bad hospital leadership, weak hospital managerial skills, and underfunded and poorly managed systems, inadequate record-keeping, and insufficient monitoring and accounting procedures are the main causes of corruption in OAUTHC, related to drug distribution and medical supply misappropriation. As seen in Figure 1, the widespread corruption in public hospitals such as OAUTHC, may have been caused by inadequate evaluation and oversight of the OAUTHC management board and health official personnel. According to Parson, the action system that manages adaptation functions by modifying and adapting to the outside environment is the behavioral organism. By establishing system goals and allocating resources to achieve them, the personality system carries out the goal-attainment function. By maintaining control over its constituent elements, the social structure manages the integration function. Lastly, by giving actors the standards and values that spur them to action, the cultural system fulfills the latency function. However, there can be serious repercussions from corruption in the health system for equality, effectiveness, and accessibility to medical care, particularly for the underprivileged and vulnerable in Nigerian communities. While a pharmaceutical product may be approved for use in

⁶⁵ Emile Durkheim, *The Rules of Sociological Method* (Beverly Hills, CA : Sage Publications, Inc., 1895).

⁶⁶ Akokuwebe and Adekanbi, "Corruption in the Health Sector and Implications for Service Delivery in Oyo State Public Hospitals."

medicine selection, the majority of insurance plans and public procurement systems have controls in place to restrict the purchase or reimbursement of pharmaceuticals. Any pharmaceutical business on this list will see a rise in market shares; additionally, if the selection process is opaque, "special interest groups" may bribe committee members to include their products on the list. A committee that determines whether products are covered by government social insurance programmes may potentially be bought off by interested companies.⁶⁷

METHODOLOGY

The Obafemi Awolowo Teaching Hospital Complex in Ile-Ife, South West Nigeria, was the study's site. The three levels of the healthcare system that make up OAUTHC are distinguished by the strong operational foundation that exists in Ile-Ife. For the study, primary and secondary data were acquired. Several (empirical) research on corruption and how people in Africa, and Nigeria in particular, seek treatment due to religious beliefs are included in the secondary data. Information from fifteen in-depth interview informants and four key informants chosen using a combination of purposive and chain referral sampling techniques made up the primary data. Four key informants—high-ranking health management officials who oversee hospital operations—from the group of clinicians and non-clinicians were contacted for interviews using a chain referral sampling technique. They were asked to link other key members within their respective departments to these informants.

The participants in KII consist of two hospital consultants and two resident physicians. In keeping with the primary goal of the study, key informant interviews were used to extract information from the participants. Additionally, 15 participants were interviewed in-depth to obtain information: three were ward patients who were admitted, three were pharmacists, three were accountants, three were nurses, and three were storekeepers who were chosen from different departments. Separate interviews with each of the participants were conducted throughout the hospital. The goal of the study was explained to the participants to get their consent and assent, under ethical guidelines for social science research. To gain an insider's perspective on the subject under inquiry, two research assistants were hired from among the students affiliated with the hospital. Participants were more accepting and encouraged to voice their ideas openly when they were aware of the OAUTHC management board's hierarchy and structure.

The interviewees spoke candidly about their experiences and goals because the environment was so laid back. Depending on the participants' choices, all 19 of the participants actively participated in the key informant semi-structured interview that took place in various hospital offices. Following a semi-structured interviewing technique, interview protocols were created, however, they were mostly utilized as a guide while adhering to each participant's story and asking questions that were pertinent to the study's goal.⁶⁸ Seven of the interviews had longer durations than an hour, although the majority lasted between 45 and an hour. The primary data were gathered between June 6 and September 6, 2024. All of the interviews were done in Yoruba (for the patients) or English. The information was verbatim translated, transcribed, and content-analyzed.

Ethical consideration was followed in the conduct of this study, as participants were told of their rights of participation, which includes the right to pull out of the study at any time, the right to determine where to interview them, the right to ask for clarification, the right to an interpreter in the Yoruba language, among others. An informed consent form was distributed to participants, to obtain from each of the participants their consent to participate in the study before the interview. Participants were duly informed of the purpose of the study, which was purely for academic purposes. Approval to conduct the study was granted by the management of the hospital where the study was conducted. All participants were also assured of the confidentiality of their responses, which was highly protected.

PRESENTATION OF FINDINGS

In keeping with the main objective of this article, the findings are systematically presented by utilizing opinions that essentially represent the majority of others on a given question to prevent repetitions.

⁶⁷ A. J. Oluwabamide, "Health Sector and the Transformation Agenda of the Federal Government in Nigeria," *Mediterranean Journal of Social Sciences* 5, no. 10 (2014): 580–86.

⁶⁸ John M Johnson, "5 In-Depth Interviewing," in *Handbook of Interview Research* (SAGE Publications, Inc., 2001), 103–19.

The Impact of Corruption in Public Tertiary Healthcare Institutions on Patients' Ethno-religious Beliefs/Practices

By this research aim or objective, how corruption stimulates adherence or reversion to ethno-religious beliefs and practices is expected to be established or identified. Although, how corruption affects and weakens the effective performance or delivery of healthcare services by public healthcare institutions like OAUTHC is well-articulated and documented in the literature, the same cannot be said about how corruption stimulates people to believe in their religious faith or cultural practices. This gap in the literature was the main reason for the use of primary data, which seeks information on how corruption compels people to rely on religious faiths and beliefs. To achieve this objective, respondents were asked to explain if, or how corruption has influenced ethno-religious beliefs. All the respondents, who opined that corruption, just like in the political realm also exists in public healthcare institutions, expressed different means through which corruption had impacted ethno-religious beliefs. In the views of one doctor:

During ward rounds, patients admitted often pray and recite certain religious doctrines and quotations, and when you ask them why, they would tell you that since their health predicament seems not to be improving by available healthcare services, they rather seek help from God than rely on deplorable health facilities. In some cases, because of congestion and shortage of facilities to cater for the teeming sick patients, the fear of losing their lives due to poor functional healthcare delivery, makes majority of patients revert to their religious practices.⁶⁹

In a bid to ascertain what exactly was responsible for congestion, shortage of facilities, and deplorable healthcare delivery, the doctor continued by saying that:

Corruption in the procurement of medical equipment and other hospital consumables is the main reason why the hospital lacks the capacity in terms of facilities to meet the health needs of patients. Even the distribution of these facilities by store officers in the hospital across various clinical wards and departments is corrupt-laden. Some hospital staff in the department of store have been punished and others have been fired for diverting these facilities for private gains. Cases of bribes have been established against store-keepers, especially those on night duties, who often, divert medical facilities and other consumables for their private benefits.

The aforementioned perspective was supported by an IDI, which also brought attention to concerns over the harmful practice of looting hospital supplies and equipment intended for the general public to benefit oneself. She said as follows:

Corruption is when a public officer in a hospital like this, diverts publicly owned medical resources for personal use. The effect of this is that it renders every segment, especially clinical units, that require medical supplies, too weak to perform their function of protecting or meeting the health needs of ailing patients. Another effect is that it subjects the hospital to mockery by patients, who feel threatened by the deplorable conditions of the hospital. As a pharmacist, our ears hear a lot of negative comments and feedback from admitted patients, who could not find prescribed drugs to purchase within the hospital pharmaceutical complex. This precarious state of affairs is partly the strategy behind patients' reliance on religious beliefs and practices.⁷⁰

⁶⁹ KII Participant, Doctor/ Ilesa/ Male/ male surgical theatre/ September, 2024.

⁷⁰ IDI Respondent, Pharmacist/Yoruba/Female/internal medicine department/September 2024.

From the above comments, it is very clear that corruption could also stimulate people to cling to their religious beliefs and practices. This seems to be logical and correct in the face of unfunctional healthcare delivery institutions. Patients' adherence to their ethno-religious identity or faith, may have been a result of fear and total emptiness of public hospitals in the country. There is a high likelihood that ugly experiences faced by patients during medical attention at the hospital could drive them into adopting their religious beliefs as an alternative approach to their ailment. This is the same with the views of almost all the patients interviewed. The majority of them opined that some of the ugly experiences (sudden removal of life-supporting devices due to strike action, lack of prescribed drugs, rush or hasty medical checks due to overcrowding, wrong diagnosis and injection administration, long waiting hours to see doctors, dilapidated or obsolete medical equipment) they face when they come for routine medical checks and treatment have made many resorted to their faith in religious practices and doctrines. An elderly patient from the Igbo ethnic group expressed some of the hospital experiences and their effects as follows:

If you visit accredited drug vendors within the hospital, hardly can you find any drugs prescribed by doctors, but if you go to the ones owned by the same hospital staff, who attended to you, those drugs will be available, then, you begin to wonder what is the purpose of coming to the hospital in the first place. Besides, experiences such as lack of equipment to conduct medical tests, which are available in the public-private partnership initiative, also make you wonder if private individuals are greater than the government. Corruption is the reason for all these experiences, which manifests in forms of mismanagement of public hospital resources. This has negative implications for pushing patients to show a high level of distrust in public hospitals. This lack of trust is gradually making lots of patients stick to their religious beliefs and practices. There are some of us on admission, who believe more in religious faith than the corrupted medical facilities in this place.⁷¹

The views above are the same as those of a female patient in the casualty unit of the hospital. She opined that:

In this place, there were no beds for admission, when I was rushed to this unit last week. We all struggled to get the attention of doctors through shouting and crying, yet, hardly could any of them attend to you because of overcrowding and shortage of medical amenities. This situation has turned most of us to God for healing. In fact, some patients, who do not know how to pray before, are forced to do so because of the precarious state of the hospital. What could have made a big public hospital like this, have no beds and functional equipment, if not for corruption? We see how rich patients pay their way into having beds and timely medical attention, whereas, their poor counterparts suffer greatly because they cannot afford to bribe health workers on duty.⁷²

From the comment above, it is clear that the inability of some patients to bribe health workers on duty schedule, which is the reason why they face ugly experiences, often pushed them into upholding their religious faith or beliefs as an alternative approach that can give them succor while on admission in healthcare delivery.

Furthermore, findings across all the categories of respondents interviewed identified that corruption is critical to patients' healthcare-seeking behavior. Some patients who come to the hospital with hopes of receiving the needed healthcare often resort to prayers and their religious faith, having seen how human lives are cut short by corrupt practices in the hospital. The case in point is the instant withdrawal of service by health workers during strike action against the government's inability to adequately fund the country's

⁷¹ IDI, /patient/Igbo man/Male surgical ward, September, 2024.

⁷² IDI, /patient/Yoruba woman/casualty ward, September 2024.

healthcare systems. For instance, the non-functioning of life-supporting equipment due to a cut in electricity by striking health workers or the delay or the inability to perform surgical operations as a result of the cut in power supply are potential experiences that could likely drive patients into sticking to their religious beliefs or faith. The view of one senior hospital consultant was more revealing as she expressed as follows:

Our hospitals in Nigeria are fast becoming death zones due to corruption from the government, health workers, and other actors. This manifests in forms of government officials seeking bribes to conduct their oversight functions on healthcare institutions, such oversight functions, which could have assisted in the discovery of needs assessment of the hospital are either delayed or not performed because legislative committee members on health, have not been mobilized by bribes by concern agencies. Similarly, greedy health workers, especially those at the managerial level, are not accountable and majority of their in-hospital policies are shrouded in secrecy. All of these inordinate practices erode public trust and in some severe cases, they tend to push patients into superstitiously believing religious practices as solutions to their health challenges.⁷³

From the comment above, it can logically and reasonably be inferred that corruption stimulates ethno-religious beliefs and practices. This is likely correct because, in Africa, people tend to rely on prayers for almost everything, including relying on prayers for a change of government instead of holding the government accountable. In the face of corrupt practices by government officials, people on the continent, especially in Nigeria, still resort to ethnic identity and religious sentiments. For instance, in Nigeria, despite the high level of governance failure in every sector, including health, some citizens still support the government on the grounds of ethnic and religious affiliations.

The Impact of Corruption and Ethno-Religious Beliefs on Hospital Patients' Insecurity in Nigeria

Having found from the interviews with respondents that corruption influences ethno-religious thinking and beliefs among patients, the impact of this on the safety or security of patients in the hospital must be ascertained. Logically, this section is interested in identifying if corruption and ethno-religious beliefs threaten the security of patients. With this, the article expands knowledge on how corruption and ethno-religious beliefs trigger human insecurity in Nigeria. To achieve this objective, respondents were specifically asked to provide their views on the impact of corruption and ethnic-religious beliefs on patients (in)security. Almost all the respondents, especially the clinical experts (doctors) opined that corruption and ethno-religious beliefs affect the safety and health security of patients in Nigeria. Some of the views of participants are expressed as follows:

Corruption is the underlying problem which not only makes some patients replace medical solutions with their religious and ethnic practices but also subjects them to unending fear and anxiety. They are pushed to believe in their religious doctrines on miracles because their trust in medical solutions has been eroded. A patient on admission, who has not been attended to for one week by any doctor due to overcrowding of the scarce facilities, is likely to see a miracle as an alternative and way out of the health challenges. The effect of this fear, danger, and perpetual threats arising from the thinking that they may soon die from the diseases affecting them.⁷⁴

Buttressing the above view was a junior resident doctor in the radiology department, he opined that:

Although, corruption by government officials in charge of health and in-hospital health workers, has long been established as partly causing the

⁷³ IDI, /consultant/Yoruba/Male surgical ward, September 2024.

⁷⁴ IDI/Senior Resident doctor/Yoruba/Histopathology and Forensic Medicine/September, 2024.

untimely death of our patients, ethno-religious beliefs, which affect patients' healthcare-seeking behavior is another fairly-known factor that is killing patients in this country. Today, we continue to lose our patients because of their wrong healthcare-seeking behavior that is largely influenced by religion and ethnic identity. Patients' strong attachment to their religious beliefs, of not taking drugs given to them, on the belief that they will be healed miraculously has led to the death of some patients.⁷⁵

The above is the same with the view of a patient who has been admitted to the hospital since the previous year after a major surgery. He stated that:

Examining the aforementioned remark critically reveals that both religious beliefs and corruption can trigger human insecurity because they have both contributed to the premature deaths of patients in Nigeria. Based on observations, there appears to be a correlation between doctor-government industrial strike movements in Nigeria and corruption. This is probably the case given that lawmakers in the health committee and other government employees have been charged with various forms of corruption, which has been the main cause of the majority of Nigeria's public hospitals' poor performance.

For many of the patients, there is no way religion or its practices can be eradicated from healthcare institutions or systems because some religious practices entail caring, calming, and the use of positive Godly words and parables to pacify sick people in the hospital. Still on how ethno-religious beliefs have impacted patients' security, the view of a patient in a male surgical ward was particularly more revealing as he opined that:

During the visitation period, religious organizations have consistently sent us food and other humanitarian aid in large numbers. In the process of providing services that the hospital does not or is unable to provide, some of these religious organizations help us become more like them in terms of beliefs and practices. If the hospital could have provided for our medical requirements, the situation might have been different because patients are more likely to become attached to their religious beliefs in the absence of such care.⁷⁶

It is clear from the comment above that religion and health are so closely related. Indeed, religious bodies flock around the hospital during visitation hours to attend to some patients, some of whom may not necessarily be their members. Brotherly love and care for the poor are religious doctrines that have tended to drive religious bodies into hospitals to offer welfare packages that could aid the quick recovery of patients. While they offer care to sick patients, they tend to preach their doctrinal ideology, beliefs, and practices and in the process, more patients seem to be attracted to those beliefs and practices, which in the long run, has implications for their healthcare-seeking behavior or choices. It has been observed that religious organizations, often known as "Faith-based Organizations," play a significant role in the delivery of healthcare.⁷⁷

DISCUSSION

Having found that corruption and ethno-religious can trigger the feeling of insecurity in patients, which by extension, partly contribute to human insecurity in Nigeria. This article, through these findings, established that besides corruption, ethno-religious beliefs and practices, can be classified among factors that provoke human insecurity in Nigeria. As shown in the findings, the impact of corruption on ethno-

⁷⁵ IDI/junior resident doctor/female/Igbo/ September, 2024.

⁷⁶ IDI/patient/female/Yoruba/ ante-natal ward/September, 2024.

⁷⁷ Jeff Levin, "Partnerships between the Faith-Based and Medical Sectors: Implications for Preventive Medicine and Public Health," *Preventive Medicine Reports* 4 (2016): 344–50.

religious beliefs is real, while the effect of ethno-religious beliefs on patients' insecurity can be severe and fatal. Corruption in the health sector, which manifests in forms of poor funding, demands for bribes to conduct oversight functions, mismanagement, drug pilfering, diversion of free vaccines, making the targeted population for such drugs and vaccines not getting it, can lead to deteriorating health, or eventual death of patients and this has often pushed surviving patients into believing their religious faith and practices.

Corruption and ethno-religious beliefs not only affect patients' healthcare-seeking behavior, as they tend to place a higher value on their religious practices and faith than medical solutions, but somehow lead to their deaths. This is in line with the findings of Lewis, Crape et al. and Oluwabamide when they explained that the impact of corruption on maternal and infant mortality is high most especially in developing countries such as Nigeria.⁷⁸ Similarly, a growing body of scientific research suggests strong connections between religion, spirituality, and health.⁷⁹ The belief in supernatural cures for severe and terminal diseases;⁸⁰ dependence on religious associations as a means of social support;⁸¹ and the perception of religion as a source of comfort in times of sickness⁸² as well as a coping mechanism are noted as the reasons for the close relationships between religion and health.⁸³

However, despite this relation, evidence has shown that because of different religious beliefs and practices, lots of patients have been subjected to insecurity. For instance, while some religious beliefs permit women to go for a Caesarian section (CS), others frown at it.⁸⁴ Similarly, the Jehovah's Witnesses is a Christian faith religious body in Nigeria that prevents its members from blood transfusion, irrespective of any condition they find themselves in.⁸⁵ These beliefs and practices may not have been induced by corruption, but they collectively threaten the safety and security of patients in the hospital. Also, beliefs and practices such as miracles, healings, and cures from diseases based on faith as they affect patients' healthcare-seeking behavior and medical choices or decisions have been well-documented.⁸⁶ Religious affiliations and practices have made many patients take wrong and risky health decisions, which somehow, have caused permanent damage to their system or eventual death. The case of prophet Abodunrin, who dared a lion at the University of Ibadan Zoo, but eventually was used as a meal by the lion, was an action taken to emulate a religious practice in the book of Daniel chapter 6: 8-17.⁸⁷ Scholars such as Hall et. Al., and Hordern have critiqued this practice on the grounds that it has no

⁷⁸ M. Lewis, "Tackling Healthcare Corruption and Governance Woes in Developing Countries" (Washington, DC, 2006); B. +rape et al., "Evaluation of the Child Health State Certificate Program," *Center for Health Services Research and Development, American University of Armenia. Yerevan, Armenia*, 2011; Oluwabamide, "Health Sector and the Transformation Agenda of the Federal Government in Nigeria."

⁷⁹ Barry R Chiswick and Paul W Miller, "International Migration and the Economics of Language," in *Handbook of the Economics of International Migration*, vol. 1 (Elsevier, 2015), 211–69; A. J. Rumun, "Influence of Religious Beliefs on the Healthcare Practices," *International Journal of Education and Research* 2, no. 4 (2014): 37–48; Margaret Farrell et al., "Islam, Polygyny and Modern Contraceptive Use in Francophone Sub-Saharan Africa," *African Population Studies* 28, no. 3 (2014): 1389–98; D. Walelign et al., "Modern Contraceptive Use among Orthodox Christian and Muslim Women of Reproductive Age Groups in Bahir Dar City, North West Ethiopia: Comparative Cross Sectional Study," *Open Journal of Epidemiology* 4 (2014): 235–42; T. J. Vanderweele, "Religion and Health: A Synthesis," in *Spirituality and Religion within the Culture of Medicine: From Evidence to Practice*, ed. J.R. Peteet and M.J. Balboni (New York, NY: : Oxford University Press, 2016); D G Blazer, "The Empirical Study of Religion/Spirituality and Psychiatric Disorders: Implications for Clinical Practice" (*Spirituality and Religion within the Culture of Medicine: From Evidence to ...*, 2017).

⁸⁰ Jim R Sibley, "Has the Church Put Israel on the Shelf? The Evidence from Romans 11: 15," *Journal of the Evangelical Theological Society* 58, no. 3 (2015): 571.

⁸¹ Rumun, "Influence of Religious Beliefs on the Healthcare Practices."

⁸² Owumi, Raji, and Aliyu, "Religious Beliefs and the Utilization of Traditional Medicine among Members of Pentecostal Churches in Emurin, Ogun State, Nigeria."

⁸³ A O Fadeyi and T A Oduwale, "Effect of Religion on Reproductive Health Issues in Nigeria," *International Journal of Innovative Healthcare Research* 4, no. 1 (2016): 17–33.

⁸⁴ Nnanna U. Ugwu and Bregje de Kok, "Socio-Cultural Factors, Gender Roles and Religious Ideologies Contributing to Caesarian-Section Refusal in Nigeria," *Reproductive Health* 12, no. 1 (December 12, 2015): 70, <https://doi.org/10.1186/s12978-015-0050-7>.

⁸⁵ B. L. Solanke et al., "Religion as a Social Determinant of Maternal Health Care Service Utilisation in Nigeria," *African Population Studies* 29, no. 2 (2015): 1868–81.

⁸⁶ Owumi, Raji, and Aliyu, "Religious Beliefs and the Utilization of Traditional Medicine among Members of Pentecostal Churches in Emurin, Ogun State, Nigeria"; James N Amanze, "The Role of Prophecy in the Growth and Expansion of the Synagogue Church of All Nations," *Scriptura: Journal for Contextual Hermeneutics in Southern Africa* 112, no. 1 (2013): 1–14; Benjamin C D Diara and Nkechinyere G Onah, "The Phenomenal Growth of Pentecostalism in the Contemporary Nigerian Society: A Challenge to Mainline Churches," *Mediterranean Journal of Social Sciences* 5, no. 6 (2014): 395–402.

⁸⁷ Dunamis Blog, "Touching Story of How Prophet Abodunrin Daniel Was Killed and Eaten by Lions at the Ibadan Zoo.," 2017, http://www.dunamisblog.com/touching_story_of_how_prophet_abodunrin_daniel_was_killed_andeaten_.

relevance to Abodunrin's respective situation.⁸⁸ Similarly, in some severe cases, religious beliefs and affiliations have prevented patients from the use of prescribed drugs and medications, as evidence showed that religious-based organizations like Christ Apostolic Church (CAC), Winners, Deeper Life, and a few others, still preach divine healing from the supreme God and this more often, has been misinterpreted by members as they tend to refuse or non-adhere to appropriate medical recommendations.⁸⁹ This is the same with the findings in Maguranyanga, where it was discovered that through their theological teachings and ideologies, ultra-conservative Apostolic groups in Zimbabwe prioritize faith healing over obtaining contemporary healthcare.⁹⁰ This goes to show that ethno-religious beliefs and practices as well as corruption are potential sources that can trigger human insecurity in Nigeria. This is because, corruption and ethno-religious beliefs and practices, which affect patients' healthcare-seeking behavior, also pose danger, threats, and fear in patients. This collectively amounts to human insecurity in Nigeria.

Dicussion Summary

Evidence from previous studies and findings in this article provided similar valid answers and adequate information on the connection between corruption and ethno-religious beliefs on the one hand, and between ethno-religious beliefs and human (patients) insecurity on the other hand. It was established that the higher the corrupt practices, which tend to weaken and limit the capacity of healthcare institutions to deliver healthcare services, the greater the attachment of patients to ethno-religious beliefs. This attachment may have risen due to welfare outreach and care-for-the-sick/poor initiatives of most of the religious bodies in Nigeria. It is a fact that some of the health needs required by patients in public hospitals are provided by religious bodies. In the process of delivering these humanitarian provisions, some religious bodies share their faith, practices, and beliefs with beneficiaries (patients). These practices, which are directly or indirectly imbibed by patients, often affect their healthcare-seeking behavior, as some patients refuse to follow medical solutions. The refusal to take prescribed drugs and medications, surgical procedures, and blood transfusion has severe implications for dangerous health risks such as deteriorating health, permanent damage to the body system, and untimely deaths. With this, it is reasonable to infer that corruption and ethno-religious beliefs, which disproportionately influence dangerous healthcare-seeking behavior among patients, are triggers of human insecurity in Nigeria.

RECOMMENDATIONS

Just as religious sermons have the power to change people's attitudes toward alcohol, smoking, having multiple sexual partners, and unsafe abortions, among other behaviors that can help with health issues, they can also draw attention to more dangerous ones (such as refusing to take prescribed medication and drugs or having a strong preference for miraculous healings over medical treatments) that can take lives, including that of hospital patients. The weight of the negative influence of corruption and the resulting stress of ethno-religious beliefs and practices on patients will be lessened by sincere soul-searching and reforms on the part of the Nigerian government to renovate and sanitize public hospitals of corrupt practices. Additionally, public openness and awareness of the idea that religious beliefs are mere and unproven sentiments that could only cause more harm to human health will activate the potential inherent in medical solutions for safer human lives that can guarantee human security in Nigeria.

CONCLUSION

The study was aimed at investigating the effect of corruption on the clingy of patients on ethno-religious beliefs as a possible way out of their health challenges. In this study, corrupt practices (diversion of hospital materials, hijacking of drugs, long or delayed waiting hours, bribing, shortage of facilities, looting of funds, mismanagement, abuse of public-private partnership, among others) in tertiary

⁸⁸ Daniel E. Hall, Keith G. Meador, and Harold G. Koenig, "Measuring Religiousness in Health Research: Review and Critique," *Journal of Religion and Health* 47, no. 2 (June 6, 2008): 134–63, <https://doi.org/10.1007/s10943-008-9165-2>; Joshua Hordern, "Accommodating Religion and Belief in Healthcare: Political Threats, Agonistic Democracy and Established Religion," *Bioethics* 37, no. 1 (January 18, 2023): 15–27, <https://doi.org/10.1111/bioe.13112>.

⁸⁹ A. R. Ogunleye, "Elimination by Substitution: Christ Apostolic Church and Indigenous Faith Interplay in Nigeria," *European Scientific Journal* 9, no. 11 (2013): 181–89.

⁹⁰ B. Maguranyanga, "Apostolic Religion, Health and Utilization of Maternal and Child Health Services in Zimbabwe" (Harare, Zimbabwe, 2011).

healthcare institutions in Nigeria push patients into displaying religious-based health seeking behavior and how such health seeking behavior impacts on human security in Nigeria were investigated. It was discovered that due to ugly incidences of high levels of corruption in Nigerian tertiary healthcare institutions, most patients, who could not afford bribes and related corrupt practices, often, cling to their religious faith. This, according to this study has led many patients to their early graves and has also threatened human security. This is true because, life is hardly safe and secure, when patients, who need medical care, prefer to stick to their ethno-religious beliefs, instead of medical treatment that can save lives and enhance human security. This can be interpreted to mean that a high level of corruption, which denies patients access to basic healthcare facilities, is a potential factor that, often, pushes people into replacing medical care with religious faith. It can therefore be concluded that health-seeking behavior which is largely influenced by ethno-religious beliefs, is among the factors that heighten human security in Nigeria.

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