Context Matters, Evidence Decides: Building Trustworthy, Person-Centred Health Systems in Nigeria

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Abstract

Background: Nigerian healthcare must respond to patients' cultural, religious, occupational and social realities while maintaining scientific rigour, clinical safety and public accountability. Context improves the relevance and acceptability of care, but culturally attractive explanations may cause harm when they exceed the available evidence or replace appropriate assessment and treatment. The editorial aim to examine how locally grounded health research can inform safe, effective and person-centred care, drawing on the six articles published in this issue of the IMAN Medical Journal.

Methods: The editorial provides a critical synthesis of papers addressing Islamic whole-person health, occupational low back pain, nursing care of older adults, grit and psychological distress among university students, transfusion safety in sickle cell disease, and contamination-related obsessive-compulsive disorder. The papers are considered in relation to evidentiary boundaries, health-system responsibility, primary-care integration, patient safety and the translation of local research into practice.

Results: Cultural and faith-sensitive care should recognise patients' values without medicalising religious practices or delaying evidence-based treatment. Occupational and geriatric challenges should not be attributed solely to individual knowledge, behaviour or resilience, because staffing, workload, equipment, protocols and institutional support shape clinical outcomes. Psychological constructs such as grit should be interpreted cautiously and should not obscure structural adversity. Primary care provides an important platform for early recognition, coordinated management and referral, but effective integration requires clear protocols, multidisciplinary support, medicines, data systems and sustainable financing. Across study designs, conclusions should remain proportionate to the evidence. Transparent methods, complete data, appropriate reporting standards and explicit acknowledgement of uncertainty are essential safeguards against harmful overstatement.

Conclusion: Locally relevant scholarship can strengthen Nigerian healthcare when context, evidence and accountability are considered together. The next stage of national health research should move beyond description towards prospective, interventional, implementation and cost-effectiveness studies that assess equity, acceptability, harms and clinical outcomes. Journals, researchers and health leaders share responsibility for producing knowledge that is culturally intelligible, scientifically credible and capable of improving care.

Keywords: Contextual Evidence, Health-System Quality, Person-Centred Care, Nigeria, Scientific Integrity, Implementation

Health care fails in two opposite directions. It fails when it ignores the meanings, workplaces, families, beliefs and institutions through which people experience illness. It also fails when contextually attractive explanations are accepted without sufficient evidence, measurement or safeguards. The six papers assembled in this issue of the IMAN Medical Journal occupy this productive tension. Their subjects appear diverse - Islamic whole-person health, occupational low back pain, nursing care of older adults, grit and student distress, transfusion safety in sickle cell disease, and contamination-related obsessive-compulsive disorder. Yet they converge on one editorial question: how can locally grounded knowledge be converted into safe, effective and accountable care?

This question matters because health-system quality is not achieved merely by expanding contact with services. Care must also be competent, respectful, equitable and capable of improving outcomes [1]. Nigeria needs evidence that speaks to its own religious pluralism, workforce constraints, epidemiological transitions, insecurity, informal economy and uneven access to specialist services.

However, local relevance cannot lower the evidentiary threshold. On the contrary, findings that may shape clinical decisions, public trust or scarce-resource allocation require especially careful methods and proportionate claims.

Context is indispensable, but it is not self-validating

The review of the Five Pillars of Islam and whole-person health offers a useful test case. Faith may shape meaning, coping, daily routines, social solidarity and health decisions. These effects are clinically important because patients do not enter consulting rooms as decontextualised bodies. Nevertheless, devotional value does not automatically establish therapeutic efficacy. Prayer is not physiotherapy; fasting is not a universal metabolic treatment; charitable giving is not, by itself, a health-financing system; and spiritual reassurance must not delay assessment of serious illness.

The contribution of culturally responsive scholarship is therefore not to medicalise faith, but to define responsible interfaces between faith and healthcare. This requires separating theological meaning, plausible mechanism, empirical evidence and proposed implementation. It also requires voluntary participation, lawful exemptions, professional boundaries and equal respect for people of different faiths or no faith. Muslim biomedical ethics itself contains diverse interpretive approaches, which makes humility and shared decision-making more defensible than categorical claims [2]. Cultural competence is a method of understanding patients; it is not a licence to overstate evidence.

This discipline applies beyond religion. In every paper in this issue, context strengthens interpretation only when the study design and data can support the conclusion. Narrative reviews should disclose how evidence was identified and weighed; SANRA provides a practical quality framework for doing so [3]. Cross-sectional studies should distinguish description and association from prediction or causation, consistent with STROBE principles [4]. Case reports should provide adequate timelines, consent, diagnostic reasoning and outcome documentation in line with CARE guidance [5]. Tier 1 scholarship is not polished language surrounding uncertain inference. It is alignment between the question, design, analysis, claim and clinical implication.

Move from individual blame to system responsibility

Several contributions challenge the tendency to locate complex problems entirely within individuals. The review of low back pain among healthcare workers moves beyond advice about posture. Manual handling, prolonged static work, insufficient lifting equipment, inadequate staffing, high workload and poor recovery are organisational exposures. Workers cannot exercise their way out of unsafe systems. With low back pain affecting hundreds of millions globally and projected to increase further, prevention must combine evidence-based clinical care with ergonomic redesign, safer patient handling, staffing, surveillance and supported return to work [6].

The study of nurses' care of older adults carries a similar message. Misconceptions about cognitive decline, inconsistent comprehensive assessment and

limited use of geriatric protocols are important, but they do not arise in a vacuum. Staff shortages, high workload, limited specialised training and absent protocols constrain practice. Education remains necessary, yet education without workflow redesign, supervision, multidisciplinary pathways and adequate staffing will produce limited change. As Nigeria's population ages, health services must prepare for multimorbidity, frailty, cognitive impairment, polypharmacy, functional decline and caregiver burden rather than treating geriatric competence as an optional subspecialty interest.

The exploratory study of grit among university students offers a third corrective. Grit can describe persistence, but it should not become a moral label for students facing insecurity, financial hardship, poor learning conditions, psychological distress or competing family responsibilities. Associations with mindfulness, resilience, anxiety, depressive symptoms and terrorism catastrophising are informative, but they do not show that low perseverance caused distress or that increasing grit will improve attainment. The study's cautious interpretation is therefore a strength. Psychological constructs should illuminate experience, not obscure structural adversity or shift institutional responsibility onto students.

Primary care should become the integrating platform

The case report of contamination-related obsessive-compulsive disorder demonstrates what is possible when primary care recognises a condition that may otherwise remain concealed. Direct questions about intrusive thoughts, rituals, time consumption and functional impairment can reveal OCD behind repeated washing, lateness or family conflict. Evidence-based care then depends on coordinated exposure and response prevention, appropriate serotonin reuptake inhibitor treatment, measurement-based follow-up and family involvement that respects consent and does not reinforce compulsions [7].

This model - recognise, assess, begin appropriate care, and coordinate referral - extends beyond OCD. Primary care can connect faith-sensitive discussion with clinical boundaries, identify stress and student distress, detect frailty and cognitive change, support occupational-health referral, and coordinate chronic transfusion histories. It is also the natural point for health literacy, early detection and continuity. Yet integration cannot mean asking already overstretched clinicians to absorb unlimited tasks. It requires clear protocols, multidisciplinary support, referral feedback, access to essential medicines, data systems and financing.

The sickle cell transfusion paper reinforces the importance of connected systems. Repeated transfusion may be lifesaving, but it also increases the need for accurate transfusion histories, antibody investigation, antigen profiling, compatible blood and haemovigilance. Current guidance supports prophylactic matching for clinically important antigens and careful transfusion support [8]. Local studies can guide implementation, but only when recipient exposure, reaction definitions, laboratory methods, donor data and statistical models are transparent. Where laboratory results or variable coding are incomplete, the scientifically responsible

conclusion is to narrow the claim, correct the analysis and obtain the missing evidence. Restraint protects patients and strengthens, rather than weakens, the credibility of local research.

Scientific restraint is a form of patient safety

A recurring strength across the revised papers is attention to evidentiary boundaries. The faith-health review avoids turning worship into treatment. The low-back-pain review warns against informal pooling of heterogeneous prevalence estimates. The geriatric study distinguishes item-level self-report from objective competence. The grit study rejects causal interpretation and questions the use of unvalidated cut-offs. The transfusion study does not claim molecular findings that were not available. The OCD case acknowledges that improvement cannot be attributed to a single treatment component.

These are not editorial inconveniences. They are patient-safety practices. Overstatement can lead to unnecessary testing, inappropriate treatment, misplaced funding, stigma or delayed care. Quaternary prevention explicitly addresses harm arising from excessive, disproportionate or poorly justified medical intervention [9]. Its logic should also guide scientific publishing: journals should prevent harm from exaggerated certainty, weakly supported recommendations and the uncritical translation of association into action.

For IMAN Medical Journal, this implies five commitments. First, preserve cultural and clinical relevance while keeping claims proportional to evidence. Second, require transparent methods, complete data and appropriate reporting standards. Third, move beyond prevalence and knowledge surveys towards longitudinal, interventional, implementation and cost-effectiveness research. Fourth, evaluate equity, acceptability, harms and unintended consequences alongside efficacy. Fifth, treat limitations, null findings and uncertainty as useful scientific information rather than defects to conceal.

From locally relevant studies to learning health systems

The next stage for Nigerian health scholarship is not simply to produce more studies. It is to create a learning cycle in which locally generated evidence changes practice and practice generates better questions. Occupational-health research should lead to monitored ergonomic interventions. Geriatric nursing surveys should inform competency-based training and protocol evaluation. Student mental-health studies should test multi-level support rather than individual resilience alone. Faith-sensitive frameworks should undergo co-design, feasibility testing and equity audit. Transfusion research should connect laboratory quality, donor systems, haemovigilance and clinical outcomes. Primary-care case recognition should mature into measurable shared-care pathways.

This transition demands partnerships among patients, communities, clinicians, faith leaders, universities, professional bodies, health managers and policymakers. It also requires journals to act as more than repositories. Editorial and peer-review processes should improve question formulation, statistical interpretation, reporting completeness, ethical transparency and practical relevance. The goal is neither to imitate high-income research

agendas nor to celebrate local context without scrutiny. It is to produce knowledge that is locally intelligible, internationally credible and capable of improving care.

The articles in this issue demonstrate that transformative scholarship often begins with disciplined reframing. Worship becomes a potential entry point for care, not a medical product. Back pain becomes an organisational challenge, not merely an individual weakness. Geriatric knowledge gaps become a workforce and protocol question. Grit becomes one feature of student adaptation, not a verdict on character. Transfusion history becomes a haemovigilance priority. Repetitive washing becomes a recognisable and treatable disorder rather than an eccentric habit.

Nigeria's health challenges require such reframing, but they also require follow-through. Context matters because it determines whether care is trusted, accessible and meaningful. Evidence decides whether that care is likely to be effective and safe. Accountability determines whether promising ideas become equitable services. The task before authors, reviewers, editors and health leaders is to hold all three together.

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