

Faith-Based Psychoeducation for Stress-Related Conditions in Nigeria: A Critical Narrative Review and the RAHMA-P5 Preventive Medicine Framework

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Abstract

Background: Stress-related conditions contribute to psychological distress, sleep disruption, cardiovascular risk, functional impairment and reduced quality of life. Faith-sensitive psychoeducation may improve acceptability and engagement among Muslim communities, but it can also transmit unsupported claims when programmes lack evidence appraisal and information governance.

Objective: To critically synthesise evidence on psychoeducation, faith-adapted psychological care, Islamic health practices and faith-based health promotion; to examine their relevance to Nigeria; and to develop a five-level RAHMA-P5 framework that incorporates primary, secondary, tertiary, quaternary and quinary prevention.

Methods: A SANRA-informed critical narrative review was conducted. PubMed/MEDLINE, Scopus, Web of Science, PsycINFO and Google Scholar were purposively searched for peer-reviewed reviews, trials and observational studies on stress, psychoeducation, religion-adapted cognitive behavioural therapy, Islamic psychology, Qur'anic recitation, gratitude, prosocial behaviour, mosque-based health promotion, health literacy, health misinformation and the five levels of prevention. Nigerian health-system and mental-health literature was included for contextual analysis. Unpublished presentations, unverifiable citations, conference abstracts without full publications and claims unsupported by retrievable evidence were excluded.

Synthesis: Evidence supports psychoeducation as a low-intensity intervention that can improve knowledge, coping and selected mental-health outcomes. Faith adaptation can enhance cultural fit when it follows the patient's preferences and remains clinically competent. Islamic concepts such as knowledge, gratitude, patient striving, trust, remembrance, goodness and mutual aid can be translated into stress literacy, cognitive reappraisal, behavioural activation, social support and referral. Evidence is less secure for direct disease-specific biological effects. The RAHMA-P5 model adds quinary prevention: coordinated protection against health misinformation, hearsay and misleading digital content through health literacy, source verification, trusted messengers, rapid correction and accountable communication.

Conclusion: Islamic faith-based psychoeducation is best positioned as a measurable adjunct to preventive and clinical care, not as a substitute for assessment, treatment or public-health policy. RAHMA-P5 offers a culturally responsive but plural and rights-based framework for Nigerian mosques, clinics, schools, workplaces, cooperatives and digital platforms. Its effectiveness and cost-effectiveness require prospective evaluation.

Keywords: Islamic psychoeducation, stress-related conditions, preventive medicine, quinary prevention, health misinformation, Nigeria

Introduction

Stress is a dynamic psychobiological process in which perceived demands interact with neuroendocrine, autonomic, immune, cognitive and behavioural systems. Acute stress may support adaptation, whereas persistent or poorly regulated

stress can contribute to depression, anxiety, sleep disruption, cardiometabolic risk, cardiovascular disease and functional impairment [2-6]. These associations do not imply that stress is the sole cause of complex medical conditions. They support a prevention strategy that improves stress literacy,

strengthens coping and identifies people who require clinical assessment.

Psychoeducation is a structured intervention that helps people understand a health problem, recognise warning signs, develop coping and self-management skills, and use services appropriately. Meta-analytic and practice literature indicates that psychoeducation can reduce psychological distress and improve knowledge and self-efficacy, although outcomes depend on intervention quality, facilitator competence, intensity and follow-up [7-9]. Its relatively low resource requirements make it relevant to primary care, schools, workplaces, community organisations and digital delivery in resource-constrained settings.

Faith-based psychoeducation adds a culturally meaningful language of purpose, hope, moral responsibility, compassion and social support. For Muslim participants, concepts including tawhid, sabr, shukr, tawakkul, dhikr, tazkiyah, ihsan and ukhuwwah may support meaning-making and self-regulation. Faith adaptation is clinically defensible only when it reflects the patient's preferences, preserves informed consent and remains within professional competence. Systematic reviews suggest that faith-adapted psychological therapies can improve outcomes for some religious patients, but heterogeneity and risk of bias limit universal conclusions [10,11].

This caution is especially important in Nigeria. Religious leaders and institutions are influential sources of health information, yet access to specialist mental-health care, health insurance and

reliable digital information remains uneven. Faith institutions may extend reach and trust, but they may also amplify unverified claims, spiritual blame or delayed referral. A sermon, devotional message or viral WhatsApp recording is not equivalent to structured psychoeducation. The distinction depends on evidence, learning objectives, facilitator training, referral pathways, safeguards and outcome measurement.

The central question of this review is therefore: how can Islamic faith-based psychoeducation support prevention and management of stress-related conditions in Nigeria while protecting patients from under-treatment, overmedicalisation and health misinformation? To answer this question, the review develops RAHMA-P5, an implementation framework spanning primary, secondary, tertiary, quaternary and quinary prevention. Quinary prevention is used here in its emerging misinformation-centred sense: organised action to reduce the creation, transmission and harmful effects of false or misleading health information. Because the term has also been used to describe protection of patients through attention to clinician wellbeing, this manuscript makes the selected definition explicit and does not imply that it is yet a universally accepted fifth tier of preventive medicine [23-26].

Methods

Review design and reporting approach

This study used a critical narrative review design because the research question spans stress science, psychological intervention, Islamic concepts,

health promotion, prevention theory, information governance and Nigerian health-system implementation. Reporting and critical appraisal were informed by the Scale for the Assessment of Narrative Review Articles (SANRA), particularly the need to justify the review, state its aims, describe the literature search, reference key claims, reason scientifically and present relevant evidence [1]. The review was not registered as a systematic review and does not claim exhaustive retrieval or pooled effect estimation.

Search strategy and eligibility

PubMed/MEDLINE, Scopus, Web of Science, PsycINFO and Google Scholar were purposively searched for English-language publications available up to 31 July 2026. Search concepts were combined around: stress and stress-related conditions; psychoeducation; faith-adapted or religion-adapted cognitive behavioural therapy; Islamic psychology and psychotherapy; Qur'anic recitation; gratitude; kindness and prosocial behaviour; mosque- or faith-based health promotion; health literacy; misinformation, disinformation and infodemics; primary, secondary, tertiary, quaternary and quinary prevention; and Nigerian health financing, mental-health law and plural health services.

Priority was given to systematic reviews, meta-analyses, randomised or controlled studies, well-described observational research, peer-reviewed conceptual papers and authoritative health-policy publications. Nigerian and other low- and middle-income country literature was used where available.

Unpublished presentations, conference abstracts without full reports, theses used as outcome evidence, references without stable bibliographic metadata, predatory or unverifiable publications and claims that could not be traced to retrievable sources were excluded. An earlier internal presentation stimulated topic selection but was not treated as evidence and does not appear in the reference list.

Critical synthesis and framework development

Evidence was synthesised in four stages. First, findings were grouped into stress science, psychoeducation, faith adaptation, Islamic practices, gratitude and prosocial behaviour, faith-institution delivery, health literacy and misinformation. Second, the strength and limits of each evidence stream were considered, with preference for replicated findings and higher-level reviews. Third, culturally meaningful mechanisms were separated from direct biomedical claims. Fourth, the mechanisms were mapped across the five prevention levels and Nigerian delivery contexts. RAHMA-P5 is therefore a theory-informed, hypothesis-generating framework; it is not a validated intervention or clinical guideline.

Evidence synthesis

Stress-related conditions and the role of psychoeducation

Chronic stress can influence health through repeated activation of stress-response systems, sleep disturbance, behavioural risk, reduced adherence and social strain [2-6]. Nevertheless,

labels such as "stress-related disease" should be used carefully. Hypertension, diabetes, chronic kidney disease, asthma, peptic ulcer disease and cardiovascular disease are multifactorial. Psychoeducation should not imply that stress reduction alone prevents or cures them. Its defensible role is to improve understanding, support risk-reducing behaviour, strengthen self-management, detect deterioration and facilitate timely care.

Psychoeducation works through understandable explanations, symptom recognition, coping skills, behavioural planning and collaborative problem-solving. Reviews indicate benefits for depression, anxiety and psychological distress, but effect sizes and durability vary [7-9]. Programmes should therefore specify the target population, number and duration of sessions, facilitator competencies, core content, referral thresholds and intended outcomes. A faith-sensitive programme should meet the same standards as any other health intervention.

Faith adaptation and Islamic psychological integration

Religion-adapted cognitive behavioural therapy commonly incorporates the patient's beliefs into psychoeducation, cognitive restructuring, behavioural activation, motivation, meditation or prayer, and coping exercises [10-13]. Pilot trials of religiously integrated CBT for depression in chronic medical illness have shown feasibility and symptom improvement, but sample size, setting and treatment heterogeneity limit generalisation [12,13]. The clinically important principle is not

that religious content is intrinsically superior; it is that congruent adaptation may improve relevance, trust and adherence for patients who value it.

Islamic adaptations of psychological interventions increasingly describe ways to connect cognitive and behavioural methods with Islamic concepts [14]. Some small studies report reductions in anxiety or depression following Islamic-spiritual mindfulness or related interventions [15]. Systematic review evidence also suggests that listening to Qur'anic recitation may reduce anxiety in selected settings, although study quality, comparators and blinding vary [16]. These practices should be presented as optional adjuncts, not as replacements for evidence-based assessment, psychotherapy, medication or urgent care.

Translating knowledge, gratitude and goodness into measurable mechanisms

Three accessible themes - knowledge, gratitude and goodness - can be translated into intervention components without overstating biological effects. Knowledge becomes health literacy, source appraisal, symptom recognition and informed decision-making. Gratitude becomes attention training and cognitive reappraisal without denying pain. Goodness becomes behavioural activation, prosocial action and social connectedness. Meta-analytic evidence suggests that gratitude interventions can improve some wellbeing and mental-health outcomes, while acts of kindness produce modest benefits for the actor's wellbeing [17,18].

The distinction between a spiritual value and a clinical mechanism is essential. Shukr does not require a person to suppress grief. Sabr is not passive endurance of abuse or untreated illness. Tawakkul should support responsible action rather than fatalism. Tazkiyah should encourage reflective self-correction without intensifying shame. Ihsan can motivate service, but volunteering must not become an additional burden for exhausted or unwell participants.

Table 1. Islamic psychoeducational principles, plausible mechanisms and safeguards

Principle	Plausible mechanism	Practical translation	Safeguards and evaluation
Iqra and knowledge	Stress literacy, symptom recognition, source appraisal and informed choice.	Brief teaching on stress, sleep, blood pressure, substance use, warning signs and service navigation.	Do not imply that reading or religious study alone treats illness; assess knowledge and behaviour change.
Dhikr and Qur'anic reflection	Attention, meaning, grounding, hope and reduced rumination.	Optional guided reflection alongside breathing, grounding, sleep hygiene and treatment plans.	Use only with consent; do not replace emergency care, medication or psychotherapy.
Shukr (gratitude)	Cognitive reappraisal, positive affect and relational appreciation.	Gratitude records, balanced reflection and family appreciation exercises.	Avoid toxic positivity; allow grief, anger, trauma disclosure and ambivalence.
Sabr and tawakkul	Distress tolerance, active coping and tolerance of uncertainty.	Problem-solving, adherence planning, appointments, crisis planning and values-based goals.	Prevent fatalism and endurance of harm; pair trust with practical action.
Ihsan and goodness	Behavioural activation, social contribution, meaning and connectedness.	Feasible kindness, volunteering, family repair and mutual-aid activities.	Avoid moral judgement or overburdening participants with severe symptoms.
Tazkiyah al-nafs	Self-awareness, regulation, accountability and relapse prevention.	Trigger-thought-feeling-behaviour-value worksheets and repair plans.	Monitor shame and self-blame; complex trauma and psychosis require trained clinicians.
Ummah, zakat and sadaqah	Social support, reduced isolation and practical assistance.	Transport vouchers, treatment navigation, support groups and insurance enrolment assistance.	Protect privacy, use transparent eligibility rules and avoid stigmatising recipients.

Faith institutions as health-promotion partners

Mosques can provide trusted venues for education, screening, referral and social support. A recent scoping review identified health-promotion interventions delivered through mosques, while systematic reviews of faith-based cardiovascular and hypertension programmes suggest potential

benefits [19-21]. Most evidence, however, comes from heterogeneous settings and intervention models. Nigerian programmes should not assume transferability. They require local co-design, gender-sensitive access, language adaptation, clinical governance and evaluation.

Faith leaders are best positioned as trusted communicators and referral partners, not substitute clinicians. Imams and Islamic scholars can ensure theological accuracy, reduce stigma and model help-seeking. Health professionals should retain responsibility for clinical screening, diagnosis, treatment and risk management. Co-facilitation can preserve both religious credibility and professional boundaries.

From P4 to P5: the RAHMA-P5 framework

RAHMA components

RAHMA denotes mercy and safeguards the programme from coercive, judgemental or medically unsafe practice. The operational components are: Recognition; Appraisal; Habituation; Mutual aid; and Access, accountability and accurate information. Recognition concerns stressors, symptoms and danger signs. Appraisal supports balanced psychological and Islamic meaning-making. Habituation develops repeated health-protective behaviours. Mutual aid mobilises family and community support. Access, accountability and accurate information connect participants with services, supervision, privacy protections, outcome monitoring and reliable health communication.

The five levels of prevention

Primary, secondary and tertiary prevention remain the conventional core. Quaternary prevention focuses on avoiding unnecessary, excessive or harmful intervention and on protecting patients

from both overmedicalisation and neglect [22]. Quinary prevention is an emerging extension. An earlier published use linked it to preventing patient harm through support for clinicians [23]. Later publications defined it around preventing health-related hearsay, misinformation or inappropriate information and reducing their effects [24-26]. RAHMA-P5 adopts the latter definition because faith-based and digital psychoeducation depends heavily on information quality.

In this model, quinary prevention is not censorship, suppression of legitimate uncertainty or automatic rejection of traditional knowledge. It is a transparent process for distinguishing evidence, interpretation, uncertainty and falsehood; correcting demonstrably misleading claims; helping people verify sources; and reducing harm from advice that delays care or undermines adherence. The approach applies across all stages of the illness trajectory rather than only after tertiary or quaternary prevention.

Quinary prevention in faith-based and digital psychoeducation

Why misinformation is a preventive-medicine concern

Health misinformation may be false, inaccurate, incomplete or misleading regardless of intent; disinformation is deliberately deceptive. Social media has increased the speed, scale and persistence of questionable health claims [27,28].

Table 2. RAHMA-P5: Islamic psychoeducation across five levels of prevention

Level	Main purpose	RAHMA emphasis	Illustrative activities	Core indicators
Primary	Prevent onset or reduce risk before clinically significant impairment.	Recognition; Habituation; Mutual aid.	Stress literacy, sleep, physical activity, substance-risk reduction, healthy coping and social support.	Reach, knowledge, risk behaviour, wellbeing and uptake of preventive services.
Secondary	Detect early symptoms, risk states and medical or psychiatric deterioration.	Recognition; Appraisal; Access.	Validated screening, blood pressure measurement, brief intervention and timely referral.	Screening yield, referral completion, time to care, confidentiality and false-positive burden.
Tertiary	Reduce disability, recurrence and complications in established illness.	Appraisal; Habituation; Mutual aid; Access.	Adherence support, family psychoeducation, relapse prevention, rehabilitation and coordinated care.	Symptoms, functioning, adherence, relapse, service use and quality of life.
Quaternary	Prevent harm from unnecessary intervention, coercion, overdiagnosis and under-treatment.	Access and accountability across all components.	Evidence grading, shared decisions, boundaries, adverse-event review and protection from "faith-only" advice.	Unnecessary testing or treatment, delayed care, complaints, adverse events and rights violations.
Quinary	Prevent creation, spread and harmful effects of false or misleading health information.	Accurate information integrated across RAHMA.	Myth surveillance, source verification, prebunking, rapid correction, health/media literacy and trusted-messenger communication.	Myth prevalence, correction reach, time to response, trust, knowledge retention, adherence and harmful-information incidents.

Systematic review evidence shows that misinformation is common across vaccines, chronic disease, cancer, diet, drugs and other health topics [29]. Harm can occur through delayed presentation, treatment discontinuation, unsafe remedies, stigma, mistrust, unnecessary fear and diversion of scarce resources.

Faith-based misinformation may be especially persuasive because it can combine health claims with moral authority, testimony, sacred language and trusted relationships. Examples include claims that depression reflects weak faith, that spiritual practices guarantee cure, that prescribed medicines are inherently harmful, or that a circulating voice

note represents a religious or medical consensus.

Quinary prevention does not challenge faith. It protects worshippers from unsupported medical conclusions and protects the credibility of faith institutions.

A quinary information-safety cycle

RAHMA-P5 uses a six-step cycle: listen, triage, verify, respond, refer and evaluate. Listening includes community dialogue, facilitator reports and ethical social-media monitoring. Triage identifies claims with high reach, high plausibility or high potential harm. Verification uses current guidelines, peer-reviewed evidence and appropriate clinical or scholarly expertise. Response combines

clear correction with a practical alternative and respectful language. Referral provides clinical assessment when misinformation has already affected health. Evaluation examines whether correction improved knowledge, trust and behaviour.

Corrections should be prompt, specific and proportionate. Meta-analytic evidence indicates that corrective interventions can reduce belief in health misinformation, although effects are variable and publication bias cannot be excluded [30]. Repeating a myth without context may inadvertently reinforce it. Messages should therefore lead with the accurate recommendation,

briefly explain why the claim is wrong or uncertain, name a trustworthy source and state what action the audience should take.

Health literacy is a central protective factor. In low- and middle-income countries, health-education interventions can improve knowledge, attitudes and behaviour for selected non-communicable diseases [31]. In Nigeria, quinary prevention should include practical skills: checking dates and authorship; distinguishing testimony from evidence; recognising manipulated images; confirming medication advice with a clinician or pharmacist; and resisting urgency, secrecy or guaranteed-cure language.

Table 3. Quinary prevention information-safety cycle for RAHMA-P5

Step	Key question	Responsible actors and action	Suggested indicators
Listen	What claims are circulating, through which channels and among whom?	Imams, women's groups, youth leaders, clinicians, community health workers and moderated digital reporting.	Rumour log, frequency, reach and affected population.
Triage	Could the claim cause delay, toxicity, stigma, non-adherence or panic?	Clinical and communications leads use a simple severity-reach matrix.	Priority score and response deadline.
Verify	What does the best available evidence say, and what remains uncertain?	Clinician review, pharmacist input, public-health guidance and Islamic scholarly review where religious claims are involved.	Source quality, date and documented decision trail.
Respond	What accurate, respectful and actionable message will replace the false claim?	Short text, khutbah insert, radio response, infographic, clinic script or WhatsApp audio.	Time to response, correction reach and comprehension.
Refer	Has the misinformation already harmed a patient or created urgent risk?	Direct referral to PHC, pharmacy, specialist, emergency service or safeguarding pathway.	Referral completion and adverse-event follow-up.
Evaluate	Did the intervention change belief, trust, behaviour or adherence?	Brief pre/post questions, follow-up sampling and incident review.	Knowledge retention, trust, adherence, repeated exposure and unintended effects.

Nigerian implementation architecture

Primary prevention: population stress literacy

At primary prevention level, programmes should address stress science, sleep, physical activity, nutrition, substance avoidance, digital overuse, family communication, financial strain and help-seeking. Faith language can improve relevance: care of the body can be framed as stewardship, while seeking skilled care can be framed as responsible action. Messages should be scripted, reviewed and linked to local services rather than left entirely to individual speakers.

Delivery channels may include Jumu'ah health inserts, madrasah-linked health clubs, women's circles, workplaces, markets, universities, radio and WhatsApp. In Muslim-majority rural settings, local languages and female facilitators are essential. In mixed and plural settings, core clinical content should use inclusive public-health language, with optional faith-specific components for participants who choose them.

Secondary prevention: screening and early intervention

Secondary prevention requires voluntary, confidential screening linked to action. Depending on population and setting, tools may include the Perceived Stress Scale, PHQ-9, GAD-7, brief insomnia assessment, AUDIT-C or other substance-use screening, suicide-risk questions, blood pressure measurement and clinically indicated glucose testing. Screening should not be conducted merely to create publicity. Programmes

need consent procedures, secure data handling, defined thresholds, same-day escalation for urgent risk and documented referral completion.

Community volunteers may provide education and navigation, but clinical decisions require trained health professionals. A mosque or cooperative health desk should not become an unregulated clinic. Supervision, referral agreements and periodic audit are necessary.

Tertiary prevention: chronic illness, mental health and relapse prevention

For people living with depression, anxiety, post-traumatic stress, substance-use disorders, hypertension, diabetes, asthma or other chronic conditions, faith-sensitive psychoeducation can support adherence, coping, family communication, rehabilitation and relapse prevention. A feasible group programme might include six sessions: stress and the body; thoughts, meanings and tawakkul; sleep, breathing and grounding; gratitude and balanced appraisal; goodness and behavioural activation; and relapse prevention, medication adherence and family support. Such a programme requires a manual, competency assessment, supervision and referral pathways.

Quaternary prevention: proportional and non-coercive care

Quaternary prevention protects participants from exaggerated biological claims, unnecessary tests, indiscriminate medication, exploitative spiritual services and coercive religious advice. It also protects against under-medicalisation. Depression, psychosis, suicidal thoughts, domestic violence or

serious physical symptoms should not be dismissed as weak faith or insufficient worship. Facilitators should distinguish ordinary distress from disorder without normalising danger signs.

Quinary prevention: information governance

Every RAHMA-P5 programme should maintain an approved content library, citation dates, version control and a process for urgent corrections. Clinical content should be reviewed by relevant health professionals; explicit theological claims should be reviewed by qualified Islamic scholars. This dual review should not blur roles: scholarly

approval cannot establish medical efficacy, and clinical approval cannot establish theological authority.

Digital records should collect only the minimum necessary information. Sensitive mental-health, religious and referral data require clear purpose, consent, access control and retention rules. The World Health organisation's digital-health strategy emphasises governance, equity, privacy and appropriate use of digital systems [37]. Quinary prevention should also protect people with low literacy, limited data access or minority-language needs from being excluded by digital-first delivery.

Table 4. Nigeria-specific implementation pathways for RAHMA-P5

Setting	Priority population	Delivery pathway	Major risks	Safeguards
Muslim-majority rural or semi-urban communities	Farmers, traders, women, youth, older adults, displaced persons and people with chronic illness.	Mosque-linked sessions, PHC outreach, female study circles and local-language radio.	Low literacy, gender barriers, insecurity, delayed referral and rumour networks.	Local-language manuals, female facilitators, referral slips, myth logs and follow-up.
Mixed religious states and towns	Muslim and non-Muslim users of shared public services.	Interfaith health promotion with optional faith-specific modules.	Suspicion, politicisation and perceived religious competition.	Joint governance, patient choice, neutral clinical core and inclusion audit.
Urban plural settings	Workers, students, professionals, transport workers and online communities.	Hybrid sessions, workplaces, universities, clinics, mosques and tele-psychoeducation.	Digital misinformation, privacy breaches and influencer-led overclaiming.	Clinician-reviewed content, data protection, rapid correction and incident reporting.
Informal-sector cooperatives	Market associations, artisans, drivers and self-employed workers.	Association meetings, cooperative enrolment and care-navigation support.	Irregular contributions, adverse selection and fund misuse.	Transparent accounts, broad pooling, NHIA/SHIA linkage and grievance systems.
Hospitals and specialist clinics	Patients with chronic medical or mental-health conditions.	Clinician-led, faith-sensitive psychoeducation integrated into routine care.	Over-spiritualisation, overmedicalisation and weak continuity.	Stepped care, outcome measures, medication review and shared documentation.

Governance, workforce and financing

Provider competencies and supervision

A tiered workforce can extend reach while preserving safety. Tier 1 volunteers may deliver scripted stress literacy and referral information. Tier 2 trained lay counsellors, nurses, community health extension workers and social workers may deliver structured group psychoeducation under supervision. Tier 3 clinicians manage moderate to severe symptoms, diagnostic uncertainty, suicide risk, psychosis, substance dependence, trauma complexity and medical comorbidity. Faith leaders contribute theological guidance, stigma reduction and trusted communication but should not diagnose outside their competence.

Training should cover basic stress science, communication, boundaries, confidentiality, gender sensitivity, domestic violence, suicide risk, substance use, psychosis, referral, documentation, evidence appraisal and misinformation response. Competence requires observed practice and continuing supervision, not attendance at a brief certificate course alone.

Health-system and financing alignment

Nigeria's health-financing reforms create opportunities for community enrolment and vulnerable-group support, but insurance uptake, implementation and financial protection remain uneven [32-34]. Faith and cooperative networks can assist with enrolment, transport and treatment navigation. Zakat and sadaqah may subsidise access for eligible people, but charitable funds

should complement rather than replace statutory financing. Transparent eligibility, broad risk pooling, provider contracts, anti-fraud controls and outcome reporting are required.

Mental-health implementation must also align with the Nigerian Mental Health Act and professional standards. Published commentary identifies a substantial policy advance alongside implementation challenges [35]. RAHMA-P5 should therefore be embedded within recognised referral networks, patient-rights protections and clinical governance rather than established as a parallel, unregulated mental-health system.

Pluralism, gender and equity

Nigeria's religious diversity requires voluntary participation and non-discrimination. Public facilities should not impose Islamic content on non-Muslim patients. A universal core may address meaning, gratitude, compassion, self-control, social support and evidence appraisal, while faith-specific material is offered by informed choice. Research from North-Central Nigeria illustrates that religious affiliation and community norms can influence service utilisation, supporting the need for context-sensitive rather than uniform implementation [36].

Women, adolescents, displaced populations, people with disabilities and people with low literacy require deliberate inclusion. Female facilitators and confidential pathways are important for maternal stress, intimate partner violence and adolescent concerns. Digital delivery should not replace face-to-face options for people without smartphones, data or privacy.

Evaluation and research agenda

The framework should progress through staged evaluation rather than immediate national scale-up. First, co-design and feasibility studies should test acceptability, language, safety and delivery fidelity. Second, pilot controlled studies should estimate changes in stress, mood, sleep, health literacy, adherence and referral. Third, pragmatic cluster-randomised or stepped-wedge trials should evaluate effectiveness across diverse Nigerian settings. Fourth, implementation and economic studies should examine reach, equity, cost per participant, cost per successful referral and sustainability.

A minimum evaluation set should include: participant characteristics; intervention dose; facilitator fidelity; adverse events; PSS-10 or an equivalent stress measure; PHQ-9 and GAD-7 when indicated; sleep, functioning and wellbeing; blood pressure or disease-specific measures for clinical populations; medication and appointment adherence; referral completion; and patient-reported cultural and spiritual fit. Quinary outcomes should include misinformation recognition, source-checking skill, myth prevalence, correction reach, time to response, trust, information-related non-adherence and incidents of harm.

Research should also test mechanisms. It should determine whether outcomes are mediated by health literacy, cognitive reappraisal, behavioural activation, social support, spiritual coping or improved access. Studies must report intervention

manuals and fidelity methods so that "faith-based" does not remain an undefined label.

Strengths and limitations

This review strengthens the field in four ways. It removes unpublished material from the evidence base, distinguishes culturally plausible mechanisms from biomedical claims, integrates quaternary and quinary safeguards, and links faith-based psychoeducation with Nigerian implementation realities. The RAHMA-P5 model also specifies measurable activities and outcomes rather than relying on devotional assertion alone.

Several limitations remain. The review is narrative and purposive, so selection bias is possible despite a transparent search approach. The evidence on Islamic adaptations is smaller and methodologically less mature than the wider psychoeducation and CBT literature. Much faith-institution research comes from non-Nigerian settings. Quinary prevention is an emerging and terminologically contested concept rather than a universally established stage. Finally, RAHMA-P5 has not yet undergone Delphi consensus, psychometric operationalisation or prospective evaluation. It should therefore be treated as a framework for testing, not proof of effectiveness.

Policy and practice priorities

Develop a standard, modular RAHMA-P5 manual with facilitator scripts, competencies, referral thresholds, quaternary safeguards and a quinary misinformation-response protocol.

Pilot the programme in at least three contrasting settings: a Muslim-majority state, a mixed North-Central state and a large urban plural setting.

Use co-facilitation between trained health workers and faith or community partners, with documented supervision and clear professional boundaries.

Create an approved, version-controlled content library for sermons, radio, WhatsApp and clinic teaching; publish corrections when content changes.

Link all screening to confidential referral, including same-day pathways for suicidal risk, psychosis, severe depression, domestic violence and acute medical danger.

Measure clinical, implementation, equity, economic and misinformation-related outcomes before considering scale-up.

Align community funds and insurance enrolment with statutory health-financing structures, transparent governance and grievance mechanisms.

Conclusion

Faith-based psychoeducation can provide a culturally resonant route to stress literacy, coping, social support and appropriate help-seeking in Nigeria. Its strongest contribution is not a claim that Islamic practices directly cure complex stress-related diseases. It is the disciplined translation of valued concepts into understandable education, cognitive and behavioural skills, mutual aid and timely access to care.

RAHMA-P5 expands the earlier four-level architecture by adding quinary prevention. Primary

prevention builds literacy and healthy coping; secondary prevention identifies early risk; tertiary prevention supports treatment, rehabilitation and relapse prevention; quaternary prevention protects against excessive, coercive or inadequate care; and quinary prevention protects individuals and communities from misinformation, hearsay and misleading digital content. The model remains plural, voluntary and accountable to evidence-based medicine.

The next scholarly step is empirical validation. A tier-1 contribution will depend less on the attractiveness of the framework than on transparent methods, reproducible intervention content, independently verified references, robust outcome measurement, adverse-event reporting, equity analysis and cost-effectiveness. Used with these safeguards, Islamic psychoeducation can collaborate with Nigeria's health system without competing with it, and can inspire without exaggerating, comfort without blaming and inform without misleading.

Ethical approval: Not applicable to this literature review.

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