CULTURAL BELIEFS AND HEALTHCARE UTILIZATION AMONG URBAN AND RURAL DWELLERS IN ANAMBRA STATE, SOUTHEAST NIGERIA

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ABSTRACT
This study investigated cultural beliefs and healthcare utilization among urban and rural dwellers in Anambra state, Nigeria. The study used mixed-methods research design. This kind of research collects and analyses data using quantitative and qualitative methods. Quantitative data were gathered with questionnaire and the qualitative data were collected with in-depth interview guide (IDI). Quantitative data collected were processed by SPSS and analyzed with descriptive statistics, while data from qualitative interview were coded into themes that reflect the objectives of this study. Evidence suggests that cultural beliefs influence healthcare utilization, affecting both the accessibility and effectiveness of healthcare services. Many people in the rural area have a strong reliance on traditional medicine, preferring herbal remedies and spiritual interventions over modern medical treatments than urban dwellers, though some of the urban dwellers indicated that they sometimes go for herbal medicine. This preference often leads to delays in seeking professional healthcare, which can result in worsened health outcomes and higher mortality rates. The study recommends a further study that will be comprehensive enough in generating more evidence to aid generalization.
Keywords: Cultural beliefs, cultural beliefs and healthcare utilization, healthcare utilization, healthcare utilization among urban and rural dwellers

INTRODUCTION
The WHO has developed guidelines and strategies to promote cultural competence in healthcare. They emphasize the importance of understanding cultural beliefs and practices and incorporating them into healthcare delivery to improve access and outcomes. These guidelines serve as a global reference point for addressing cultural issues in healthcare (WHO, 2015). Various global health initiatives and partnerships aim to improve healthcare access and utilization while respecting cultural diversity. For example, the United Nations Sustainable Development Goals (SDGs) include targets related to achieving universal healthcare access and reducing health disparities, which inherently involve addressing cultural barriers (UN, 2021).

In many African communities, traditional medicine and healers are highly regarded and are commonly consulted for various health issues. This reliance on traditional medicine may impact the utilization of modern healthcare facilities and formal medical services. Moreover, some cultural beliefs may emphasize the importance of spiritual interventions and prayers for healing, leading to delays in seeking medical attention and potentially compromising health outcomes (Akinwande et al. 2018).

As African countries strive to improve their healthcare systems and achieve better health outcomes for their populations, understanding the complex interplay between cultural beliefs and healthcare utilization becomes paramount. Developing culturally sensitive and relevant healthcare policies and interventions requires a comprehensive understanding of the cultural factors influencing healthcare-seeking behaviors (Okoronkwo, et al. 2019).

Rural residents seem to frequently prefer traditional medicine and spiritual practices to modern treatment. Despite the availability of hospitals and clinics, many sick people seek advice from traditional healers or use religious traditions. Lack of faith in contemporary healthcare and well established cultural practices contribute to this tendency (Okoronkwo, et al. 2019; Ugwu &Okpara, 2024a; Ugwu & Okpara, 2024b)). Due to cultural and infrastructural hurdles, rural populations have a bigger healthcare utilization and accessibility gap than metropolitan ones (Federal Ministry of Health, 2020). These findings highlight the need to study how cultural norms and urban-rural divides impact healthcare utilization in Anambra State.This study therefore, fills this gap by investigating cultural beliefs and healthcare utilization among urban and rural dwellers in Anambra state, Nigeria.

REVIEW OF RELEVANT LITERATURE

Urbanization and Rural Factors Influencing Cultural Beliefs and Healthcare Utilization

Okeke, Okezie, and Uzochukwu (2017) claim that rural-to-urban migrations boost cities and towns. This is called urbanization. This issue typically causes people to abandon rural lives for urban ones, which affect cultural views and healthcare utilization. Due to rural circumstances, urban migration may affect cultural views and healthcare utilization. Cultural attitudes, healthcare utilization, and urbanization/ruralization are strongly correlated. These traits may affect healthcare accessibility, attitudes, and habits. Cultural ideas about healthcare utilization affect many urban and rural factors. This section suggests tackling a subset of the difficulties as it is unlikely to handle them all in one study.

Access to Healthcare Services: Access to medical treatment affects how often people use the system. Remote residents may have to drive farther to reach a hospital or clinic. Okeke et al. (2017) discovered that rural residents use traditional therapeutic methods and home medicines more. Remote residents may turn to traditional healers for help when modern medical treatment is scarce. Urban locations have better hospitals, clinics, and other medical facilities. Due to the convenience of healthcare services, urbanites may seek medical treatment sooner. Rural areas have higher healthcare infrastructure issues such a lack of doctors and facilities. This might cause a shortfall or postpone medical attention. Due to more healthcare facilities, urban India uses more healthcare than rural India (Singh & Singh, 2017).

Cultural Beliefs and Health-seeking Behavior: In rural sub-Saharan Africa, cultural attitudes significantly affected healthcare seeking (Sudhinaraset, Ingram, Lofthouse, &Montagu, 2016). Many delayed treatments due to these misunderstandings. Due to the dense population of varied cultural backgrounds in urban areas, healthcare attitudes vary. Urbanites may combine conventional and non-traditional medicine more often. Rural healthcare utilization may differ due to an emphasis on traditional cultural beliefs and practices. Remote residents may initially consult alternative medicine or traditional healers before seeing a doctor. Rural residents' healthcare-seeking behaviour is heavily influenced by culture. Due to cultural beliefs and traditions that inhibit modern treatment, rural people value traditional healing and spiritual remedies. Exposure to various cultures and medical practices in a metropolis may influence these attitudes (Singh, 2015).

Health Education and Awareness: Urban areas have higher educational achievement than rural ones. Health literacy may cascade into healthcare utilization due to limited educational opportunities. Urbanization increases educational options, which may improve health literacy and current healthcare knowledge (Egbe et al., 2019). Metropolitan areas have increased public

awareness and educational efforts supporting healthy lifestyles, including regular checkups and preventative actions. Rural areas may lack health education resources, lowering knowledge of healthcare services and preventative measuresRimal et al. (2015) found that urban Nepalese had greater healthcare usage rates than rural Nepalese, perhaps due to better health education.

Social Support and Stigma: According to Okeke, Okafor, and Ezenyeaku (2019), rural communities may stigmatise certain health issues or medical treatment. Rural communities may stigmatise mental health patients who actively seek care. Due to more relaxed cultural norms, urbanites may be more likely to share their health and utilization of healthcare. Metropolitan residents also have more diverse social networks, which may improve healthcare use. Social network members may motivate and aid with medical treatment. Due to societal stigma, rural residents may be hesitant to seek medical care. Okeke et al. (2019) found that HIV/AIDS stigma affected rural Nigerian healthcare use. Thus, illness identification and treatment were delayed.

Economic Factors: Poverty hinders healthcare access, worsening a rural problem. Urbanization may provide economic opportunity and healthcare access. Economic stability may increase healthcare spending prioritization (Van Minh et al., 2018).

Belief system and healthcare utilization among the rural dwellers

Using the Equality of Opportunity (EOp) theory, Ma, Song, and Zong (2021) examined the healthcare accessibility gap between rural and urban China. Researchers created a method to quantify the fairness gap in healthcare access between urban and rural areas. The study's equity disparity is assessed using 1997–2006 China Health and Nutrition Survey (CHNS) data. A CHNS-based empirical research found that the equity gap to the directly observed average urban-rural healthcare differential was 1.167 between 1997 and 2000. The ratio was 1.744 in 2004–2006. The initial statistics data showed a disparity between urban and rural regions, which may have exaggerated this basic inequity. The analysis suggests that increasing urban-rural reimbursement ratios alone will not address the healthcare access gap between rural and urban people. A more efficient way to promote equitable healthcare access would be to implement a policy that benefits disadvantaged individuals within a social structure that distinguishes between urban and rural areas and addresses the growing economic gap between them.

The research by Arcury, Gesler, Preisser, Sherman, Spencer, and Perin (2005) examined how physical location and spatial behaviour impact rural healthcare access. They considered demography, socioeconomic status, culture, and health. This study surveyed 1,059 rural Appalachian North Carolina residents in 12 counties. This cross-sectional research employed county and ethnicity-stratified three-stage sampling. A preliminary study on health services utilization examined the weighted proportions of recent visits for routine check-ups, chronic care, and acute treatment across geographic, socio-demographic, cultural, and health characteristics. Multivariate logistic regression models revealed health care usage determinants. A standard questionnaire was given to participants. Their health-related and non-health-related activities were tracked using a geographic information system. Bivariate analysis indicated a substantial connection between frequent checkups and chronic care use and numerous regional and spatial behaviour characteristics. Driver's license, given transportation and regular care distance are factors. The multivariate model indicated that several characteristics influence a person's chance of obtaining regular therapy. These include race, gender, age, family income, physical and mental health, number of conditions, treatment distance, and driver's license. Chronic care and frequent checkups correlated with geography,

while acute care did not. Geographic and spatial characteristics influence rural healthcare utilization, as shown by the statistics. Our study also highlights rural healthcare inequality; which governments must address immediately.

Braillon (2020) evaluated urban-rural healthcare access and results. Prospective studies are needed to support the observational-based assumptions in the December 2019 rural health journal. A particular article concludes that "Medicare should address the lack of specialist care for rural beneficiaries," but fails to consider that metropolitan primary care professionals may provide better treatment and send patients to specialists. This may explain rural-urban health differences, not only specialist availability. Migrations restrict cross-sectional research: Young people move from rural to urban regions, whereas pensioners stay in the same cities.

Furthermore, classifying people as urban or rural is oversimplified. The rural poverty rate was 16.7%, the urban rate 13.0%, and the suburban rate 10.8%. Poverty affects health. Rural regions make up 97% of the US while having just 19% of the population, making resource allocation and development difficult. Geoffrey Rose's paradox shows that engaging a bigger number of intermediate-risk people is more effective than targeting a smaller group of high-risk individuals.

The belief system and healthcare utilization among the urban dwellers

Oladipo (2014) investigates various empirically linked elements that affect rural-urban healthcare consumption. The gap and its effects on healthcare system design and management are examined. The goals of this research are to compare rural and urban locations, identify the primary variables that impact health service utilization, and compare the effects of predisposing, enabling, need, and healthcare factors. A four-stage service consumption model with 31 variables was created using appropriate modeling methods. The data comes from a cross-sectional survey of 1086 people who may require healthcare at neighbouring hospitals and in the community. Data were analyzed using factor analysis and cross tabulation. Rural and aggregate data were evaluated using a 4-stage model, whereas urban data was studied using a 3-stage model. Need, enabling, predisposing, and health services are relevant. Eleven factors are powerful consumption indicators. The utilization rate should lead the strategic development of distinct healthcare facilities in different locations, with effective facility management supporting more frequent medical treatment.

Ma, Song, and Zong (2021) examined healthcare equity between urban and rural populations. Health disparity persists, although more nations are establishing universal health care. The research examines residents' health care and spending demand and equity, taking into account universal health coverage, urban-rural disparities, and socioeconomic groups. China's Fifth Health Service Survey sample data utilized the 'five levels of income categorization' to identify individuals by income. The research assessed equity using descriptive statistics, a concentration index, and a concentration curve. There was a big difference between rural and urban health care utilization. Rural communities spent more on healthcare than urban populations, although demand fell as wealth climbed. Rural people had less equity in health care demand, use, and annual health and hospitalization expenses than urban ones. Rural residents with moderate and lower incomes had to spend more on hospitalizations than those with high and intermediate incomes. Thus, increased accessibility and health policies are needed to address the persistent issue of economic disparities in healthcare use and cost, whether in urban or rural areas.

The 2022 research "Adopting social health insurance in Nepal" by Paneru, Adhikari, Poudel, Neupane, Bajracharya, and Rawal included numerous topics. Researchers in Nepal's Kailali,

Baglung, and Ilam districts used seven healthcare institutions for a cross-sectional, concurrent mixed-methods study. A structured questionnaire was used to obtain quantitative data from 822 beneficiaries during healthcare institution interviews. Probability proportional to size (PPS) determined sample size. Service providers had twelve in-depth interviews (IDIs) and beneficiaries seven pre-set focus group discussions (FGDs). Epitools, SPSS, and MS-Excel were used to analyse Epi-data quantitative data. Pre-established themes were used for manual topic analysis of qualitative data. Inferences were made using Chi-square and binary logistic regression. The variables were described by percentages, frequencies, means, and medians.

Qualitative data from healthcare professionals and beneficiaries was utilized to analyse numerous facets of health insurance systems and contextualize the quantitative results. Of the 822 responses, 370 (45%) were men. Health insurance was available to 404 people and not to 418. The median family income was $65.96 USD (8.30–290.43). Insurance price perceptions were similar for covered and uninsured groups (p = 0.53). People with insurance were more likely to use and access services than those without insurance (OR = 220.4; 95% CI, 123.3-393.9; OR = 74.4; 95%, 42.5-130.6). From qualitative assessments, the service had poor coverage and quality. The program had a 9.1% dropout rate, although enrolment was rising. Communication between providers and recipients, benefit packages, obstacles, and solutions are examined. The paper also suggests alternate health insurance plans and techniques for our situation. High dropout and low renewal rates indicate a lack of commitment despite promising initial enrolment. Insurance education and patient management should be used immediately. Additional methods and techniques should be considered.

THEORETICAL FRAMEWORK

Cultural Evolution Theory (CET) and the Health Belief Model (HBM) were chosen for this research after thorough consideration of numerous pertinent topics. Since cultural belief and healthcare consumption are the study's main focus, a complete framework for understanding how cultural notions affect healthcare utilization may be created by merging Cultural Evolution Theory with the Health Belief Model. Cultural Evolution Theory emphasizes cultural ideas changing, adapting, and spreading throughout time. This theory explains how healthcare utilization transmits, alters, and preserves cultural conceptions. The psychological framework of the Health Belief Model includes perceptions of health threats, rewards and downsides of health-improvement actions, prompts to act, and self-perception of competence. Consider how one's ideas and beliefs affect health decisions.

Cultural Evolution Theory emphasizes community and intergenerational healthcare views. These ingrained notions influence many people's health practices. The Health Belief Model may help people understand their cultural ideas about health risks and benefits. Cultural concepts may change with changing conditions, another key premise of cultural evolution theory. The Health Belief Model may illuminate how cultural beliefs affect health-related behaviour changes, helping us understand how people respond to health risks. In this context, researchers may examine how a society changes its medical practices to a new illness epidemic. There may be significant cultural differences in health and sickness perceptions. The Health Belief Model may be used to examine how cultures affect health risk perception and medical action. Cultural differences include views on preventative care and sickness severity. Group-level selection may alter cultural ideas, according to evolutionary theory. The Health Belief Model may explain how signals to action from trustworthy community leaders or healthcare practitioners affect healthcare usage across cultures. Integrating these ideas more effectively may improve health promotion efforts. Understanding the development of health beliefs across cultures and following the Health Belief Model are crucial to improving treatment efficacy and

cultural appropriateness. Cultural Evolution Theory and the Health Belief Model may help researchers and healthcare professionals understand cultural attitudes and healthcare use. This helps people navigate the complicated relationship between culture, beliefs, and health. This integrated structure in Anambra State may promote culturally responsive healthcare.

METHODOLOGY

Research design

This section describes the study's methodology and context. The study will involve mixed-methods survey research. This kind of research collects and analyses data using quantitative and qualitative methods (Tashakkori& Creswell, 2007). They then combine their results to make community-wide conclusions. For real-time population analysis, this study will employ a research approach known for its flexibility in obtaining trustworthy data while minimizing costs. This involves collecting a variety of important data at a specific moment. The researcher will detail the statistical methods utilized to analyze the data.

Area of study

Anambra state comprises of twenty-one local government area, namely: Aguata, Awka North, Awka South, Anambra East, Anambra West, Anaocha, Ayamelum, Dunukofia, Ekwusigo, Idemili North, Idemili South, Ihiala, Njikoka, Nnewi North, Nnewi South, Ogbaru, Onitsha North, Onitsha South, Orumba North, Orumba South, and Oyi. Anambra state is located in southeastern part of Nigeria. It is among the five states that makes up southeast geopolitical zone of Nigeria. It was created in 21st August 1991. It is bounded in the north by Enugu state, in the east by Imo state, in the south by Delta state while in the west by Kogi state. The land area of Anambra state is approximately 4,844 square kilometers. INEC (2023) shows that Anambra state has a human population size of 5,953,500 people as of 2023 Nigeria presidential election.

In the aspect of occupation, the people of Anambra are well-known for farming and trading. Other forms of occupation they engage include; public and civil service, hotel catering services, banking business, artisanship, commercial transportation, among others.
Furthermore, as the location of the state, Anambra has succeeded in attracting the presence of the Federal Government through the establishment of a prestigious Federal University (NnamdiAzikiwe University, Awka), CBN, NAFDAC, Agencies, parastatals, and so on.
Anambra State Ministry of Urban Development (2023) reveal that, Anambra has an estimated number of six (6) urban centers out of one hundred and seventy-nine (179) towns that make up Anambra state.

Population of the study

Social research should be conducted in a given social research setting with a given target population in view, and not in a vacuum. The target populations for this research are male and female in urban and rural areas. Nigeria Population Census (2019) noted that Anambra state has a human population size of 4,177,828 people with 2117984 male and 2059844 females (United Nations Human Settlements Programme UN-HABITAT, 2009). When projected to the current year (I.e., 2024), the area has a population of 7,434,856 (Male: 3,768,542, Female: 3,666,314). However, the target population for this study will include the urban and rural dwellers in Anambra state as at the time of this study. It is from the population that the sample needed for this study will be drawn.

Sample size and sampling technique

The sample size for this study is 400. To determine the sample size, Yamane (1967) formula

was be used to calculate sample size for infinite (known) population. The formula provides a simplified way for determining appropriate sample size using 5% margin of error. The formula is given as: n = $\frac{n}{1+ \mathrm{N(e)2}}$

This research used a mix method sampling, which is the combination of cluster, simple random, purposive, systematic, and accidental sampling strategies. Cluster sampling is the appropriate method to use when the population of interest seems uniform from the outside but has internal diversity. However, if the necessary circumstances for using probability sampling techniques are not satisfied, such as when there is a shortage of sample frames, purposive, convenient, and accidental sampling approaches were used. To begin, it is necessary to categories the 179 towns into urban and rural groups based on their primary economic activities. From the urban cluster, (Awka) was selected using balloting method. On the other hand, using the balloting method without replacement, one town (Agulu) was selected from the rural cluster. This process ensures that urban and rural dimensions to the subject under study will fully be harnessed.

Nevertheless, Awka has been identified and classified into streets, churches, avenues and estates despites the villages that make up the town. Awka comprises seven Igbo groups sharing common blood lineage divided into two sections. Ifite Section, the senior section, comprises four groups, Ayom-na-Okpala, Nkwelle, Amachalla, and Ifite-Oka followed by Ezinator Section, which consists of three groups, Amikwo, Ezi-Oka and Agulu. Each of these groups has a number of villages. Altogether, Awka comprises 33 villages (Awka Union, 2023). Furthermore, Agulu town comprises twenty villages. These are: Nwanchi, Nneohia, Okpu, Ama-Ezike, Odidama, Amorji, Isiamaigbo, Ukunu, Uhueme, Obeagu, Obe, Nkitaku, Okpu-Ifite, Umubialla, Amatutu, Umuowelle, Umunnowu, Ifiteani, Umuifite, and Nneogidi.
The researcher will approach the sampling of respondents using the household survey. This implies that the researcher and his team will select 50% respondents (i.e 200) from urban households and the remaining 50% (200) from rural households using multistage sampling techniques.

For the qualitative aspect of the study, the purposive sampling technique was used to select 12 participants including six (6) from urban household survey and the other six (6) from rural household survey for In-Depth Interview (IDI). The interviewees were selected based on their level of knowledge, experiences and roles in cultural beliefs and healthcare utilization in the communities of study.

Instruments of data collection and administration
Questionnaire and In-depth Interview (IDI) were used for quantitative and qualitative method of data collection respectively. The researcher personally administered the questionnaire and carry out the In-depth Interview, with the assistance of a research assistant. The research assistant was graduate of Sociology who have gained basic knowledge about social science research method. Consent for the interview was sought from the selected interviewees through the consent letter.

Method of data analysis and presentation
Data collected from the field, were processed with the statistical package for social sciences (SPSS) version 23.0. However, quantitative data were analyzed using descriptive statistics including frequency count and simple percentage. On the hand, the qualitative data gathered were processed using the Qualitative Data Analysis (QDA) miner software. This involved first the development of initial codes analyzed using the theme-based method of content analysis processed using Max QDA. Themes, thoughts catchphrase and expressions that are similar will

be thematically grouped and coded to underscore findings from the quantitative data. Therefore, emerging themes that are similar will be grouped with major objective theme of the study.

RESULTS/FINDINGS

This section contains the descriptive analysis and interpretation of quantitative data collected from the field, complemented by the descriptive analysis of qualitative data. The analysis is presented in two distinct sections comprising of section A – which contains the descriptive analysis of socio-demographic characteristics of the respondents, and B – which contains the descriptive analysis of the research question.

Socio-demographic characteristics of the respondents

This section presents the descriptive analysis on the responses offered by the respondents on their socio-demographic variables including gender, age, religion, educational qualifications, marital status, and occupation, level of income and place of residence. These are presented in table 1. Data from table 1 shows that females outnumbered the males in the present study's sample (ie females respondents 50.5% while males respondents 49.5%). It was discovered that the minimum age in the present study's sample was 15 years; while the maximum age was 105 years. However, 22.3% of the respondents were aged between 31 – 28years, 19.5% of them aged between 36 – 60, 20.6% aged between 61 – 75, 17.8% aged between 76 -90; while the smallest proportion 8% of them were older men and women aged between 91 – 105years.
The sample comprises of 90% of Christians, 2% of Muslims and 8% of African Traditional Religion. This shows that Muslim and African Traditional Religion somewhat low among the people of Anambra state.

With regard to educational qualification, 28.1% of the respondents completed secondary level of education. Approximately 42.8% of the respondents attended up to tertiary level of education, out of which 9% of them only completed Diploma/NCE level, 26.6% of them completed up to the first-degree level and only a very lower proportion 7.2% of them completed up to the post graduate level. This finding shows that education in the present study area is somewhat impressive, even though about half proportion of them could not attend up to the higher education.

The sample comprised of 27% of single men and women, and 70% of the respondents are married. Respondents who were divorced or separated were approximately 3% of the sample (1% and 2%). This shows that divorce and separation rate was somewhat low.
Data analysis shows that a relatively 91.3% of the respondents were employed, 8.7% of them were unemployed. Among those who were employed, data analysis shows that they varied in their occupations. Among those were employed, 30.3% of them were employed within the government/private sector. Those who were informally employed were 52.2% and those in religious sector were 3.6%

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

Table 1: Socio-demographic characteristics of the respondents

Socio-Demographic Variables	Frequency	Percentage
Sex		
Male	197	49.5
Female	201	50.5
Total	398	100
Age Categories		
15 – 30	46	11.5
31 – 45	89	22.3
46 – 60	78	19.5
61 – 75	82	20.6
76 – 90	71	17.8
91 – 105	32	8
Total	398	100
Religion		
Christian	358	90
Muslim	8	2
African Traditional Religion	32	8
Total	398	100
Educational Qualification		
No formal education	32	8
F.S.L.C	8320.8	
J.S.S.C.E	0	0
S.S.C.E	112	28.1
O.N.D/N.C.E	36	9
H.N.D/B.A/B.Sc	106	26
M.A/M.Sc	21	5.5
Ph.D	8	2
Total	398	100
Marital Status		
Single	101	27
Married	282	70
Divorced	7	1
Separated	8	2
Total	398	100
Occupation		
Civil servant	67	16.8
Public servant	54	13.5
Trader	122	30.6
Farming	86	21.6
Artisan	21	5.2
Clergy 13	3.6	
Unemployed	35	8.7
Total	398	100
Income Level		
Below ₦30,000	28	7
₦31,000 - ₦60,000	129	32
₦61,000 - ₦90,000	193	49
₦91,000 – above	48	12
Total	398	100
Place of Residence		
Urban	200	50.3
Rural	198	49.7
Total	398	100

Research Question 1: How do beliefs systems affect healthcare utilization among the urban in Anambra State? To answer this research question, the responses offered by the respondents with regards to questionnaire items 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19 and 20 were analyzed and interpreted.

Table 2: Respondent's view on extent which traditional beliefs influence respondents' decision to seek medical care

Variable	**Frequency**	**Percentage** %
Not at all	84	42
To a small extent	52	26
To a moderate extent	37	18.5
To a great extent	27	13.5

Researcher's Data Analysis, 2024

With respect to the respondents' response if traditional believe influence their decision to seek medical care, data analysis shows that a significant proportion (42%) of the respondents indicated that traditional belief does not influence their decision to seek medical care. Also, about large proportion (58%) of the respondents was of different opinion that traditional belief influences their decision to seek medical care.

An interviewee however maintained that traditional beliefs and decision to seek medical care is a personal choice. According to the interviewee, "from my own experience, the issue of belief is a personal thing which does not in all time influence one to seek medical care".

Table 3: Respondent's view on how often respondents prioritize traditional medicine over modern healthcare services

Response	Frequency	Percentage %
Never	51	25.1
Rarely	50	25
Sometimes	55	27.5
Often	29	14.4

Researcher's Data Analysis, 2024

Analysis shows that 25.1% of the respondents never prioritize traditional medicine over modern healthcare services, while major proportion (74.9%) of the respondent indicated at different rate that they do prioritize traditional medicine.

From one of the interviewees

> …There is a level where my children will get sick, I'll be force to go to the village and use traditional means, that does not stop me from going to hospital. Again, there is this sickness called pin (*ṅtụtụ),* after Christmas celebration, before we come back to Awka we'll first of all go to traditional healer to check if that pin has entered any member of my family because that type is sickness is not treated in modern hospital. And anyone that goes for patent medicine usually die. So, I usually use traditional medicine in some health issues.

Table 4: Respondent's view on how significant is the role of religious beliefs in your choice of healthcare provider.

Response	Frequency	Percentage %
Not significant at all	51	45
Slightly significant	50	31
Very significant	29	3
Extremely significant	3	2

Researcher's Data Analysis, 2024

To further assess respondents, believe influence, 45% of the respondents said there is no significant role of religious beliefs in their choice of healthcare provider. While majority of the respondents (31%) said slightly significant is role of religious beliefs in their choice of healthcare provider. Another significant proportion (24%) equally indicated that there is significant role of religious beliefs in your choice of healthcare provider.

Table 5: Respondent's view on what degree do family beliefs about healthcare affect personal healthcare decisions.

Response	Frequency	Percentage %
Not at all	10	5
To a small degree	74	37
To a moderate degree	69	32
To a high degree	44	22
To a very high degree	4	3

Researcher's Data Analysis, 2024

Data analyzed in table 5 indicated that as low as 5% respondents were of the opinion that family beliefs about healthcare do not affect their personal healthcare decisions. 37% majority indicated that family beliefs about healthcare affect their personal healthcare decisions to a small degree.

This in line with one of the interviewees,

> …sometimes when I am sick and I relate it to my siblings, they will inquire to know the type of sickness, level of the sickness and all that. with this they make suggestions of either hospital or type of medication I should take not considering my own personal decision. Therefore, I can say that family has influence my personal decision.

However, 32% of the respondents indicate that family beliefs about healthcare affect their personal healthcare decisions moderately, as well as 22% respondents said to a high degree, while 3% respondents said to a very high degree.

Table 6: Respondent's view on how much does fear of spiritual repercussions influence decision to visit a hospital

Response	Frequency	Percentage %
Not at all	102	51
Slightly	39	19.5
Moderately	48	24
Very much	5	2.5
Extremely	6	3

Researcher's Data Analysis, 2024

In the analysis, 51% of the respondents said that the fear of spiritual repercussions does not influence their decision to visit a hospital at all. While 19.5% of the respondents said that fear of spiritual repercussions slightly influences their decision to visit a hospital.
However, approximately 24% of the respondents said that fear of spiritual repercussions moderately influences their decision to visit a hospital, while some it extremely influences their decision to visit a hospital

> …spiritual repercussions do not influence me to visit hospital, I have to go to the hospital first and know what is wrong with me, if the sickness persist then I can ask my friends on what to do, at that point in time, I know I have ran out of option. I have no other choice than to heed to people's advices concerning that particular sickness. I believe to save life first not minding the means" from urban interviewee

Table 7: Respondent's view on frequency of consultation with traditional healers before seeking modern medical treatment.

Response	Frequency	Percentage %
Never	86	43
Rarely	48	24
Sometimes	47	23.5
Often	12	6
Always	7	3.5

Researcher's Data Analysis, 2024

Information from the data stated that, 43% of the respondents never consulted traditional healers before seeking modern medical treatment. Whereas 24% rarely consult traditional healers before seeking modern medical treatment, as well as 23.5% of respondents, sometimes consult traditional healers before seeking modern medical treatment. Then 6% often consult traditional healers before seeking modern medical treatment, while 3.5% always consult traditional healers before seeking modern medical treatment

> …. it is not a bad thing to consult traditional healers before seeking modern medical treatment because sometimes there are sickness that doesn't need modern medical care, like poison (*ụreụkwụ*), stroke, pin (*ṅtụtụ*), goiter (*ṅgbapiaakpili)* and so on. These sicknesses are treated

by professional traditional healer in my village. Going to hospital is a waste of money, only what lab test reads, that is what they will treat. Like I said earlier, that each time we spent a holiday in the village before coming back to Awka, we will first of all visit the traditional healer before traveling. Not that here we don't go to hospital, we do go to hospital but not all sickness is hospital base. Sometimes when a neighbor or a friend is affected with any of the sicknesses listed, I do direct them to my village and they do get better". One of the urban interviewee narrated

Research Question 2: How do beliefs systems affect healthcare utilization among the rural in Anambra State? To answer this research question, the responses offered by the respondents with regards to questionnaire items 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19 and 20 were analyzed and interpreted.

Table 8: Respondents' views on the extent which traditional beliefs influence respondents' decision to seek medical care.

Response	Frequency	Percentage %
Not at all	33	16.7
To a small extent	85	42.9
To a moderate extent	47	23.7
To a great extent	33	16.7
To a very great extent	0	0

Researcher's Data Analysis, 2024

With respect to the respondents' response if traditional believe influence their decision to seek medical care, data analysis shows that a significant proportion (16.7%) of the respondents indicated that traditional belief does not influence their decision to seek medical care. Also, about large proportion (83.3%) of the respondents was of different opinion that traditional belief influences their decision to seek medical care.

Table 9: Respondents' views on how often they prioritize traditional medicine over modern healthcare services

Response	Frequency	Percentage %
Never	26	13.1
Rarely	87	43.9
Sometimes	42	21.2
Often	22	11.1
Always	21	10.6

Researcher's Data Analysis, 2024

Analysis shows that 25.1% of the respondents never prioritize traditional medicine over modern healthcare services, while major proportion (74.9%) of the respondent indicated at different rate that they do prioritize traditional medicine

Table 10: Respondents' views on how significant the role of religious beliefs in the choice of healthcare provider.

Response	Frequency	Percentage %
Not significant at all	34	17.1
Slightly significant	85	42.9
Moderately significant	61	30.8
Very significant	11	5.5
Extremely significant	7	3.7

Researcher's Data Analysis, 2024

To further assess respondents, believe influence, 17.1% of the respondents said there is no significant role of religious beliefs in their choice of healthcare provider. While majority of the respondents (42.9%) said slightly significant is role of religious beliefs in their choice of healthcare provider.

Table 11: Respondents' view on what degree do family beliefs about healthcare affect personal healthcare decisions.

Response	Frequency	Percentage %
Not at all	0	0
To a small degree	60	30.3
To a moderate degree	78	39.3
To a high degree	52	26.2
To a very high degree	8	4.2

Researcher's Data Analysis, 2024

Data analyzed in table 11 there was no indication of respondents about the opinion that family beliefs affect personal healthcare decisions. 39.3% majority indicated that family beliefs about healthcare affect their personal healthcare decisions moderately.

> …Well, I can say that in this village we are seen as families because we are live among our kinsmen, so when it comes to sickness, even from greetings, you can say aahh! … I don't know how my body is doing me. From that moment the person will go further to ask you what and what have you done about it, after much words he or will advise you to go for a particular drug or to boil some leaves and drink at that point the person has influence your personal decision" said one of the interviewees

However, 26.2% of the respondents indicate that family beliefs about healthcare affect their personal healthcare decisions to a high degree, as well as 4.2% respondents said to a very high degree, while 30.3% respondents said to a small degree.

Table 12: Respondents' view on how much does fear of spiritual repercussions influence decision to visit a hospital

	Frequency	Percent
Not at all	25	12.6
Slightly	108	54.5
Moderately	49	24.7
Very much	9	4.5
Extremely	7	3.7
Total	198	100

Researcher's Data Analysis, 2024

In the analysis, 12.6% of the respondents said that the fear of spiritual repercussions does not influence their decision to visit a hospital at all. While 54.5% of the respondents said that fear of spiritual repercussions slightly influences their decision to visit a hospital.
In line with this, one of the interviewee of the age of 97years said "

> …the reasons why there is increase in death rate if because people no longer have fear of spiritual repercussions. I remember when we were growing up, if anyone is sick, they must first of all enquire what is the cause of the sickness before embarking on treatment. The issue of "osụ cast" is still relevant today because our young girls and boys mix up in the school and have sexual activities without knowing the implication of their action. Some of them have affairs with osụ people without knowing what it will result to, because there is spiritual repercussion behind it and can bring different kinds of sicknesses.

However, approximately 24.7% of the respondents said that fear of spiritual repercussions moderately influences their decision to visit a hospital; while some it extremely influences their decision to visit a hospital.

Table 13: Respondents' view on how frequently respondents consult with traditional healers before seeking modern medical treatment.

	Frequency	Percent
Never	15	7.7
Rarely	89	44.9
Sometimes	87	43.9
Often	5	2.5
Always	2	1
Total	198	100

Researcher's Data Analysis, 2024

Information from the data stated that, 7.7% of the respondents never consulted traditional healers before seeking modern medical treatment. Whereas 44.9% rarely consult traditional healers before seeking modern medical treatment, as well as 43.9% of respondents, sometimes consult traditional healers before seeking modern medical treatment. Then 2.5% often consult traditional healers before seeking modern medical treatment, while 1% always consults traditional healers before seeking modern medical treatment

TEST OF HYPOTHESES

The study hypotheses were tested in this section at 0.05significant level using chi-square as deemed appropriate in view of statistical requirements

Hypothesis 1: Urban dwellers are most likely to utilize modern healthcare facilities than the rural dwellers.

In testing this hypothesis, the nineteen (19) item measuring if Urban dwellers are most likely to utilize modern healthcare facilities than the rural dwellers which were computed together in order to have a summed data regardingurban dwellers to utilize modern healthcare.facilities than the rural dwellers, which was then used in cross tabulation with the data on respondents' place of resident. Results of the hypothesis testing are presented in table 4.18.

Table 14: Summary of Chi-square Testing showing respondents inurban dwellers are most likely to utilize modern healthcare facilities than the rural dwellers.

Residency	Yes	No	Total	X^2	DfSig.
Urban	28	172	198		
	47.24	152.76	198.0		
	7.83%	2.42%	100%		
Rural	66	132	200	20.6153	10.00001
	46.76	151.24	200.0		
	7.91%	2.45%	100%		
Total	94	304	398		
	94.0	304.0	398.0		
	15.74%	4,87%	100%		

Researcher's Data Analysis, 2024 (Chi-square)

The chi-square test was run to determine ifurban dwellers are most likely to utilize modern healthcare facilities than the rural dwellers. Based on the conducted test, there is an evidence to accept the state alternative hypothesis (x^2 (1) = 20.6153, $\rho = 0.00001$.

DISCUSSION OF FINDINGS

Having analysed the data collected in this study, it is pertinent to articulate the findings in a comprehensive and flexible way. The first and second objective of this study was to examine how beliefs systems affect healthcare utilization among the dwellers in Anambra State. Finding from data analysis performed on the numbers of questions raised in line with the research question actually support the initial motivation of this study, cultural believe and healthcare utilization. This was evidently shown in the findings obtained through the quantitative and qualitative data, which suggest that about 70.7% of dwellers in Anambra state believed that traditional belief influence their decision to seek medical care at different levels of 34.4% rarely, 21.1% moderately and 15% to a great extent respectively. This does not negate the fact that some dwellers indicated that traditional belief do not influence their decision to seek medical care; but family beliefs about healthcare affect dwellers personal healthcare decisions based on their marital status, as it was statistically significant. These findings imply that although (29.3%) a relatively fair proportion of dwellers indicated that traditional belief does not influence their decision to seek medical care. Beliefs affect urban and rural residents' attitudes, access to, and engagement in healthcare. This affects their healthcare use. Traditional cultural practices and beliefs may affect rural healthcare. Rural residents may choose traditional healers or herbal medicines due to cultural beliefs or a lack of faith in contemporary therapy. Due to this dependency, people may postpone getting medical help, which might harm their

health. Afolabi (2020) found that rural communities choose traditional medicine owing to its accessibility, cheaper cost, and cultural congruence. Modern healthcare is more accessible and used by urbanites. The worldview remains important. Socioeconomic position and religion may affect healthcare utilization even in densely populated places. Urban people may refuse necessary medical treatments owing to religious beliefs or social shame (Smith, 2022). Urbanites are more likely to utilize healthcare facilities because they trust contemporary therapy (Johnson et al., 2021). These beliefs also shape sickness perceptions and healthcare practitioners' roles. In both cases, those who believe their health outcomes are predestined may seek less preventive treatment (Garcia, 2019). This may worsen the health disparity between urban and rural communities due to rural residents' restricted healthcare access. Healthcare utilization is heavily influenced by beliefs. They affect health outcomes, medical intervention, and medical attention.

CONCLUSION

This study investigated cultural beliefs and health care utilization among the urban and rural dwellers in Anambra State, southeastern Nigeria. While findings have shown that cultural beliefs and place of residence may affect health care utilization, there is evidence that variables like education, income, etc, may not predict relatively health care utilization among the rural and urban dwellers in Anambra State, southeastern Nigeria. There is, therefore the need for more comprehensive broad study to enable generalization in this area of study.

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