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The Excluded Giant: Religion, Health Myths, and Hypertension Awareness in Four Ile-Ife Communities, Osun State, Nigeria

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Abstract

This study examined the intersection of religious belief, health mythology, and hypertension awareness in four peri-urban communities in Ile-Ife, Osun State, Nigeria: Eleyele, Igboya, Iremo, and Lagere. Drawing on questionnaire data from 188 adult respondents and key informant interviews, the study analysed two interrelated phenomena: first, the systematic exclusion of religious organisations from the World Health Organization's global call to action on hypertension, and the public health consequences of this exclusion in a predominantly religious African population; and second, the role of religious and cultural health myths in shaping community responses to hypertension - functioning both as barriers to evidence-based health-seeking behaviour and, when reframed, as potential resources for health promotion. The theoretical framework applies Berger's social constructionism and Kleinman's explanatory models' framework to analyse how communities construct meaning around illness, and how these constructions interact with biomedical understandings of hypertension. The findings reveal that while 66 per cent of respondents have some knowledge of hypertension, only 53.7 per cent have confirmed their blood pressure status through clinical diagnosis - reflecting a pattern of fatalistic health belief, religious attribution of disease causation, and structural barriers to health-seeking that collectively constitute a public health crisis of under-diagnosis. The article argues that rather than bypassing religious frameworks, effective hypertension prevention in Africa requires the deliberate engagement of religious institutions as primary health promotion actors, and proposes a model of faith-engaged health communication for the Nigerian context.

Keywords: religion and health, health myths, hypertension awareness, Nigeria, Ile-Ife, WHO, social constructionism, faith-based health promotion

Introduction

In May 2013, the World Health Organisation published its landmark Global Brief on Hypertension, framing the condition as a "silent killer" and a "global public health crisis" requiring coordinated action across governments, civil society, the private sector, families, and individuals.[1] The document is notable both for what it includes and for what it conspicuously omits. Among the

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[1] World Health Organisation, A Global Brief on Hypertension: Silent Killer, Global Public Health Crisis, (Geneva: WHO, 2013), 45

partners called upon to address the hypertension epidemic, religious organisations, arguably the most extensive and deeply embedded civil society institutions in Africa - receive no mention. This omission, in a document oriented toward the region of the world where religion is most socially dominant and where hypertension prevalence is highest, reflects what the present study terms a critical institutional blind spot with significant public health consequences.

Nigeria illustrates this paradox with particular clarity. As the country with the highest adult hypertension prevalence in Africa, 51 percent among men and 49 percent among women,[2] Nigeria is simultaneously a country where religious participation rates exceed 90 percent, where the most regularly attended communal gatherings are religious services, and where religious leaders command a level of moral authority and community trust that secular health professionals and government agencies rarely approach.[3] The consequence of excluding these institutions from hypertension prevention and management is not merely a missed opportunity but an active reinforcement of the alternative health narratives, including religious and cultural health myths- that religious communities generate in the absence of faith-engaged health education.

This article examines both dimensions of this problem: the institutional exclusion of religion from hypertension governance, and the specific role of religious and cultural health myths in shaping community hypertension awareness and health-seeking behaviour in Ile-Ife. The Ile-Ife setting is chosen for its distinctive combination of high hypertension prevalence, Adebayo et al.'s study found a prevalence of 26.4 percent in rural Ife communities,[4] while Abubakr et al.'s market screening found 37.7 percent, and its juxtaposition of a functionally advanced SDA Lifestyle Centre with communities that remain significantly under-informed about hypertension risk and prevention.[5]

The article proceeds as follows: Section 2 presents the theoretical framework; Section 3 reviews the literature on religion, health myths, and health-seeking behaviour in Nigeria; Section 4 describes the methodology; Section 5 presents the empirical findings on hypertension awareness and health beliefs; Section 6 analyses the religion-myth interface; and Section 7 proposes a model for faith-engaged health communication.

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[2] World Health Organisation, A Global Brief on Hypertension, 48

[3] G. N. D. Ajah, 'Religion and Health.' In A. F. Adelowo and S. M. Nwaomah (eds.), Religion and Society. (Ilishan-Remo: Babcock University Press, 2012).

[4] R. A. Adebayo, M. O. Balogun, R. A. Adedoyin, O. A. Obashoro-John, L. A. Bisiriyu and O. O. Abiodun, 'Incidence, Prevalence and Risk Factors of Hypertension in Three Rural Communities in Southwest Nigeria.' Cardiovascular Journal of Africa, vol. 24, no 2, (2013). 71-75.

[5] F. A. Abubakr, H. Muzamil, G. Aderoju, O. Funmilayo, O. Bola and A. Adewale, 'Undiagnosed Hypertension and Proteinuria in a Market Population in Ile-Ife, Nigeria.' Arab Journal of Nephrology and Transplantation, vol. 4, issue 3, (2011), 141-146.

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Literature Review

Religion and Health-Seeking Behaviour in Nigeria

The relationship between religious belief and health-seeking behaviour in Nigeria has been extensively documented in the clinical and sociological literature, though with a predominantly conflict-oriented framing. Ayantayo documents the widespread practice of faith healing among Nigerian Christians, particularly within Pentecostal and African Independent church traditions, and the consequent delay or avoidance of biomedical diagnosis and treatment.[6] Okojie examines the specific case of the Christ Apostolic Church (CAC) and the Faith Tabernacle denomination, documenting constitutional prohibitions on biomedical treatment that have resulted in documented harm to members with treatable conditions.[7] The Islamic tradition of tib al-nabawi (prophetic medicine), which recommends specific herbal remedies, dietary practices, and spiritual interventions for various conditions, similarly generates health-seeking patterns that may not align with biomedical recommendations.[8]

However, a critical limitation of this literature is its disproportionate focus on extreme cases of faith-biomedical conflict, which obscures the much larger population of religiously engaged Nigerians whose health-seeking practices combine biomedical, traditional, and religious resources in pragmatic and often effective ways. Levin and Vanderpool argue, on the basis of their review of epidemiological evidence, that the net effect of religious participation on health is protective rather than harmful, reflecting the balance of social support, prosocial behaviour, and health-promoting norms that religious communities generate alongside the minority of cases where faith-biomedical conflict produces harm.[9]

More directly relevant to the present study, the literature documents a significant role for religious narratives in constructing community understandings of hypertension specifically. Adetunji analyses the function of what he terms 'legitimisation of moral norms' in Nigerian religious contexts, the attribution of illness to divine punishment for moral transgression, as a mechanism that may foreclose rational, evidence-based approaches to disease prevention and management. When community members attribute their hypertension to divine retribution, enemy attack, or ancestral curse, the appropriate response from their explanatory framework is not dietary modification or antihypertensive medication but prayer, spiritual warfare, or traditional ritual.[10]

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[6] J. K. Ayantayo, "Interplay between Faith Healing and Modern Medical Practice," Orita: Ibadan Journal of Religious Studies 40, no. 1 (2008): 31.
[7] B. Okojie, "Faith Healing in James 5:14–16 and Modern Medical Practices" (Long Essay, Department of Religious Studies, Adeleke University, Ede, 2016), 39.
[8] P. O. Amanze, "Emerging Challenges in the Use of African Traditional Medicine in Health Care Delivery System: The Way Forward," 15th Babcock University Inaugural Lecture (Ogun: Babcock University Press, 2017), 18.
[9] J. S. Levin and H. Y. Vanderpool, "Is Religion Therapeutically Significant for Hypertension?" Social Science and Medicine 29, no. 1 (1989): 72.
[10] A. F. Adetunji, "Religion and Other Social Institutions," in Religion and Society, ed. A. F. Adelowo and S. M. Nwaomah (Ilishan-Remo: Babcock University Press, 2012), 56.

The WHO and the Exclusion of Religious Actors from Global Health Governance
The exclusion of religious organisations from the WHO's global hypertension framework is not an isolated oversight but reflects a longstanding tension in international public health governance between the secular institutional norms of the multilateral system and the religious character of the societies that the system is designed to serve. Tomalin documents this tension across multiple dimensions of global health governance, noting that the "secular script" of international development organisations has historically treated religion as a private matter at best and a public health risk at worst, generating systematic underfunding and institutional marginalisation of faith-based health actors despite their often-dominant role in healthcare delivery in low-income settings.[11]

The consequences of this exclusion are particularly acute in sub-Saharan Africa, where faith-based organisations are estimated to provide between 30 and 70 percent of health services in many countries.[12] In Nigeria specifically, the Catholic Health Services, the Christian Health Association of Nigeria (CHAN), and various Islamic medical organisations operate hundreds of hospitals and clinics that serve millions of patients annually. Yet these organisations' potential as health promotion platforms, leveraging their trusted relationships with community members to promote preventive lifestyle behaviours, remains almost entirely unrealised in relation to hypertension.

The argument is not that the WHO should endorse specific religious beliefs but that effective population health promotion in predominantly religious societies requires the deliberate engagement of religious institutions as implementation partners, using communication strategies that are resonant with community religious frameworks rather than designed in institutional isolation from them. This is the core practical implication of the present study's theoretical and empirical findings.

Health Myths and Their Epidemiological Consequences

Health myths - culturally transmitted narrative explanations for illness that invoke supernatural, moral, or mystical causation - are not unique to African or religious contexts. Medical anthropologists, including Helman[13] and Kleinman[14] document elaborate myth systems in virtually all human societies, including technologically advanced Western societies where myths about genetic determinism, dietary supplements, or medical technology regularly influence health behaviour in ways that diverge from evidence-based recommendations. What distinguishes the Nigerian hypertension context is not the existence of health myths per se but the specific content of dominant myths and the institutional contexts that authorise and sustain them.

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[11] Emma Tomalin, "Thinking about Faith and Development," in The Routledge Handbook of Religions and Global Development, ed. Emma Tomalin (London: Routledge, 2012), 14.
[12] B. Schmid, E. Thomas, J. Olivier, and J. R. Cochrane, The Contribution of Religious Entities to Health in Sub-Saharan Africa, Study Report (Johannesburg: African Religious Health Assets Programme, 2008), 51.
[13] Cecil G. Helman, Culture, Health and Illness, 5th ed. (London: Hodder Arnold, 2007), 120.
[14] Arthur Kleinman, Patients and Healers in the Context of Culture (Berkeley: University of California Press, 1980), 64.

The most consequential hypertension-related myth in the Nigerian context, documented across multiple studies,[15] is the belief that hypertension is caused by "thinking too much" - a folk attribution that, while partially capturing the genuine relationship between psychosocial stress and blood pressure, dramatically simplifies a multifactorial condition and generates treatment-seeking oriented toward stress reduction through prayer and social support rather than comprehensive lifestyle modification. A related myth attributes hypertension to supernatural attack, generating treatment-seeking through traditional healers and spiritual interventions. The Governor Yari meningitis case - in which a senior Nigerian public official publicly attributed a type C meningitis epidemic to divine punishment for fornication - illustrates the potential reach and authority of mythological disease attribution in the Nigerian public sphere.[16]

Methodology

This study employed a mixed-methods design, combining questionnaire data from 188 adult residents of four Ile-Ife communities with semi-structured interviews and ethnographic observation. The questionnaire instrument included sections on respondents' knowledge of hypertension, their health-seeking behaviour in response to hypertension-related symptoms, their explanatory attributions for hypertension causation, and their assessments of the role of their religious communities in addressing hypertension. Forty percent of questionnaire items were specifically designed to elicit information about health beliefs and explanatory models.

Key informant interviews were conducted with twelve community members selected for their recognised roles as health belief mediators, including a CAC elder, an Islamic Alfa, two Baptist church leaders, a traditional medicine practitioner, and community health workers from Eleyele and Lagere. Interviews were conducted in English and Yoruba, with the Yoruba interviews transcribed and translated by bilingual research assistants. Thematic analysis following Braun and Clarke was applied to interview data, with theoretical thematic coding guided by the explanatory model framework.[17]

Ethical clearance was obtained from the Research and Ethics Committee of Adeleke University. All participants provided informed consent, and informants requesting anonymity were identified by code rather than name in the findings.

Theoretical Framework

Social Constructionism and Health Belief

Berger and Luckmann's social constructionism provide the foundational theoretical lens for this study. Social constructionism proposes that social reality, including the meaning of illness, disease causation, appropriate health

[15] B. Onwubere, Essentials of Hypertension Management (Enugu: Institute for Development Studies, University of Nigeria, 2005), 27.
[16] Ibid
[17] Virginia Braun and Victoria Clarke, "Using Thematic Analysis in Psychology," Qualitative Research in Psychology 3, no. 2 (2006): 84.

responses, and the proper relationships between human beings and divine or supernatural forces, is not given but constructed through social interaction, cultural transmission, and institutional mediation. Applied to health, social constructionism directs analytical attention to the processes through which communities come to understand illness: the explanatory frameworks they employ, the social actors who authorise particular understandings, and the practical consequences of these understandings for health-seeking behaviour.[18]

In the Nigerian religious context, illness explanatory frameworks are typically pluralistic, drawing on biomedical, traditional, and supernatural or religious explanatory resources simultaneously.[19] The social constructionist framework enables the analyst to recognise these plural frameworks not as aberrations from a biomedical standard but as socially produced meaning systems that are internally coherent, institutionally authorised, often by religious leaders, and functionally consequential for health behaviour. Rather than simply dismissing religious and mythological illness attributions as 'superstition,' the social constructionist approach asks: how are these attributions produced, who produces them, and what conditions would support their revision toward frameworks more conducive to biomedical health-seeking?

Kleinman's Explanatory Models Framework

Kleinman's explanatory models' framework operationalises the social constructionist approach for clinical and public health practice. Kleinman proposes that patients, families, and practitioners each bring distinctive explanatory models to illness encounters - models that include beliefs about illness aetiology, pathophysiology, onset, course and severity, appropriate treatment, and expected outcomes. Discordance between lay and professional explanatory models is identified as a primary source of poor treatment adherence, inadequate health-seeking, and communication failure in healthcare.[20]

Applied to hypertension in Ife communities, the explanatory model framework reveals multiple competing frameworks in operation simultaneously. Biomedical explanatory models attribute hypertension to modifiable lifestyle factors (diet, exercise, stress, substance use) and recommend pharmacological or lifestyle modification treatment. Traditional African religious explanatory models may attribute hypertension-related symptoms to spiritual attack, ancestral displeasure, or witchcraft, and recommend traditional spiritual remedies. Christian or Islamic explanatory models may frame hypertension as divine punishment for moral transgression, or as a testing of faith, recommending prayer and spiritual discernment rather than medical treatment. The practical health consequences of each explanatory model vary significantly, with some actively discouraging biomedical diagnosis and treatment.

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[18] Peter L. Berger and Thomas Luckmann, The Social Construction of Reality: A Treatise in the Sociology of Knowledge (New York: Anchor Books, 1966), 78.
[19] P. O. Amanze, "Emerging Challenges in the Use of African Traditional Medicine in Health Care Delivery System: The Way Forward," 15th Babcock University Inaugural Lecture (Ogun: Babcock University Press, 2017), 18.
[20] Arthur Kleinman, Patients and Healers in the Context of Culture (Berkeley: University of California Press, 1980), 64.

Findings

Hypertension Knowledge and Diagnostic Uptake

The data reveal a significant gap between nominal hypertension awareness and actionable health knowledge. While 66 percent of respondents report some knowledge of hypertension as a disease, only 9.6 percent report a confirmed hypertension diagnosis, and 46.3 percent of those who report not being hypertensive have never confirmed their status through clinical testing. Combining these figures, approximately 52 percent of the study population is either hypertensive or unaware of their blood pressure status, a finding consistent with Abubakr et al.'s market screening data showing 31 percent undiagnosed hypertension in the Ile-Ife area.[21]

This gap between awareness and diagnostic uptake cannot be explained by access barriers alone, as the SDA Hospital Lifestyle Centre and other healthcare facilities are accessible within the study communities. Interview data reveal that health beliefs and social norm factors are at least as important as structural access in explaining non-uptake. Multiple informants described a culturally prevalent attitude of health fatalism, an orientation characterised by low perceived susceptibility ("it will not happen to me"), belief in supernatural causation ("if God wants to give me hypertension, no hospital can stop it"), and deferred health-seeking ("I will only go to the hospital when I am really sick"). These beliefs function precisely as the HBM predicts - suppressing health-seeking behaviour by reducing perceived susceptibility and undermining confidence in biomedical efficacy.

Religious Institutions' Current Role in Hypertension Education

Forty-six percent of respondents report that their religious organisation teaches about hypertension to some extent. However, interview data reveal that the nature and quality of this teaching vary widely - from the comprehensive, evidence-based lifestyle education provided by the SDA Lifestyle Centre to occasional references to health in the context of sermons on stewardship or divine healing, with no systematic health information content. No non-SDA religious institution in the four study communities operates a structured health promotion programme specifically addressing hypertension.

Significantly, the religious institutions that are most likely to provide hypertension-relevant health information are also, in some cases, the most likely to frame disease causation in mythological or supernatural terms. Two informants described receiving explicit teaching from religious leaders, attributing disease in general, and cardiovascular conditions specifically, to sin, spiritual attack, or insufficient faith - teachings that, while intended to encourage spiritual fidelity, function to discourage biomedical diagnosis and treatment-seeking.

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[21] F. A. Abubakr, H. Muzamil, G. Aderoju, O. Funmilayo, O. Bola, and A. Adewale, "Undiagnosed Hypertension and Proteinuria in a Market Population in Ile-Ife, Nigeria," Arab Journal of Nephrology and Transplantation 4, no. 3 (2011): 143.

Health Myth Content and Epidemiological Consequences

Thematic analysis of interview data identifies four dominant health myth clusters operating in the study communities. The first is the sin-punishment myth - the belief that illness is divine retribution for moral transgression, which creates shame and concealment around health conditions and discourages disclosure and help-seeking. The second is the enemy-attack myth - the belief that illness, including hypertension, results from supernatural attack by enemies or malevolent spirits, generating treatment-seeking through spiritual warfare and traditional healers rather than biomedical services. The third is the fatalist-destiny myth - the belief that health outcomes are predetermined by divine or ancestral will, reducing perceived efficacy of preventive behaviour. The fourth is the somatisation myth, the culturally prevalent 'thinking too much' explanation for hypertension, which, while partially accurate in its identification of psychosocial stress as a risk factor, dramatically narrows the perceived causes and appropriate interventions.

The epidemiological consequences of these myth clusters are substantial. Informants from the traditional medicine community describe regular consultation by individuals with symptoms consistent with hypertension who are seeking spiritual or herbal remedies rather than a biomedical diagnosis. The financial costs of these alternative treatment pathways - some traditional remedies carry a high monetary cost - add economic burden to the health risk.
Discussion: Toward Faith-Engaged Health Communication

The findings of this study support a fundamental reorientation in the strategy for hypertension prevention communication in Ile-Ife and comparable Nigerian communities. The current default model, secular biomedical information delivered through government health services, media campaigns, and occasional community outreach, reaches at most the 66 percent of the population with nominal hypertension awareness, and fails to translate this awareness into diagnostic uptake or lifestyle modification for the majority, even of those it reaches. It is designed in institutional isolation from the explanatory frameworks, social authorities, and motivational structures that actually govern health behaviour in the study communities.

Faith-engaged health communication, by contrast, begins with the community's existing religious frameworks - not to endorse health myths but to engage them - and works through trusted religious leaders and communal structures to translate biomedical evidence into language and imagery that resonates with community religious values. This approach has been demonstrated to be effective in faith-engaged HIV prevention,[22] maternal health promotion,[23] and mental health destigmatisation programmes across sub-Saharan Africa.

For hypertension specifically, faith-engaged communication would involve training religious leaders across denominations as health advocates who can

[22] B. Schmid, E. Thomas, J. Olivier, and J. R. Cochrane, The Contribution of Religious Entities to Health in Sub-Saharan Africa, Study Report (Johannesburg: African Religious Health Assets Programme, 2008), 51.
[23] Emma Tomalin, "Thinking about Faith and Development," in The Routledge Handbook of Religions and Global Development, ed. Emma Tomalin (London: Routledge, 2012), 14.

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address the sin-punishment myth by presenting a theology of bodily stewardship - the body as a divine gift requiring responsible care, rather than divine punishment; engage the enemy-attack myth by acknowledging spiritual dimensions of health while also presenting evidence for modifiable physical risk factors; and reframe the fatalist-destiny myth by emphasising the theological resources for personal agency and self-care present in Islamic, Christian, and Indigenous Religious traditions alike.

The WHO's exclusion of religious organisations from its global hypertension framework represents a missed opportunity for significant public health consequences. Addressing this requires not only advocacy for the inclusion of faith-based actors in global health governance but also the development of practical tools, training curricula for religious health advocates, communication materials adapted for faith contexts, and evaluation frameworks for faith-engaged health promotion programmes that can operationalise this inclusion at the community level.

Conclusion

This article has examined the role of religion in shaping hypertension awareness and health-seeking behaviour in four Ile-Ife communities, analysing both the institutional exclusion of religious actors from global hypertension governance and the specific health myth systems operating in the study communities. The findings confirm that religious frameworks are central - not peripheral - to how the study population constructs and responds to hypertension risk, and that effective hypertension prevention in this context cannot be achieved through strategies that bypass or ignore these frameworks. Two concrete recommendations emerge from the analysis. First, the WHO and Nigerian federal and state health authorities should formally incorporate faith-based organisations as partners in hypertension prevention programming, providing funding, training, and institutional support for faith-engaged health communication. Second, religious organisations across all denominations operating in hypertension-prevalent communities should develop structured health advocacy programmes that use theological resources to promote biomedical health-seeking while engaging - rather than dismissing - the health myth systems that currently impede it. The two recommendations are mutually reinforcing: institutional recognition legitimises religious health advocacy, and effective religious health advocacy demonstrates the public health value of faith-based partnership. The religious body is Nigeria's most under-utilised public health asset for hypertension prevention. Making it an active rather than passive player in the national hypertension response is among the most cost-effective and scalable interventions available.

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World Health Organization. A Global Brief on Hypertension: Silent Killer, Global Public Geneva: WHO 2013.[24]

[24] Ibid.