Religion, Health and Turbulence of Healing Craft in the Nigerian Context

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Abstract

One critical and engaging point of religious discourse among social-theorists and thinkers is the healing craft capacity often claimed by religious institutions. This paper explores the structure and dynamics of the nexus between religion and health in the Nigerian context, considering its complexities and pervasiveness. From a review of grey literature and data from online blogs and religious websites, findings show that there is high traffic and patronage to religious centres in Nigeria, mostly for issues ‘bothering the mind’ and terminal diseases, whereas same sources create avenue for assassination and promotion of unhealthy behaviour. Religious factors are essential in health discourse at policy level, to ensure wholesome impacts.

Keywords: healthcare delivery, healing practices, mental health, religious institutions, spirituality
BACKGROUND

Religious beliefs and practices are widespread, and constitute a fundamental part of human societies. Recent reports show that about 84% of the world’s populations have religious affiliations (Pew Research Center, 2017). The new religions (Christianity, 31.2% and Islam, 24.1%) topped the list of the choices. Others are 15.1% Hinduism, 6.9% Buddhism, 6.7% Folk religions, 0.2% Judaism, and 0.8% other religion (Pew Research Center, 2017). In Nigeria, Christianity and Islam also account for the largest followers (Owumi, Raji and Aliyu, 2013). These various religious bodies contribute significantly to cultures and lifestyles of different populations and exert influence on various aspects of people’s social life. Particularly, religion has gained recognition as an inextricable social institution in many societies, mainly as a social determinant of health and an alternative or complementary health service provider (Vanderweele, 2016). In fact, patronage to religious houses is often influenced by their capacity to provide solutions to psychological and health problems that are considered severe or terminal. In line with this, Anderson (2006) observed that many Christians in Africa are converting from Orthodox churches to Pentecostal churches, due to the latter’s emphasis on healing and deliverance from diseases, infections, diseases of the mind and those attributed to supernatural.

Religion and health have an incontrovertible relationship. The relationship dates back to pre-modern societies, when theological accounts were dominant explanations of health and wellbeing (Shaw, Dorling and Mitchell, 2002). With the emergence of modern and scientific medicine in the nineteenth century, there seemed to be an “explicit and intentional disentanglement from religion” (Hufford, 2005: 3). However, the adoption of religious rituals and practices as alternative means of medicine (Vanderweele, 2016), even in more recent times, is still a clear indication of the indispensable connection between religion and health. The affiliation of individuals to different religions also suggests the possibility of exposure to religious beliefs or practices that could shape their health decision-making, health behaviour and health-seeking behaviour (Koenig 2004; Sarri, Higgings and Kafatos, 2006; Padela and Curlin, 2012; Rumun, 2014).

The identification of religion as a major determinant of individual and community health behaviour, through its influence on lifestyles, worldviews and motivations (Benjamins, 2005) is well established. A growing body of scientific research (Dhurkeim 1987; Chiswick and Mirtcheva, 2010; Rumun, 2014; Farrell, Masquelier, Tissot and Bertrand, 2014; Walelign, Mekonen, Netsere and Tarekegn, 2014; Vanderweele, 2016; Blazer 2017) suggests strong connections between religion, spirituality, and health. It is noted that the close
connections between religion and health is due to; the perception of religion as a source of comfort in time of sickness (Owumi, Raji and Aliyu, 2013) and also a coping mechanism (Fadeyi and Oduwole, 2016); the belief in supernatural cures for severe and terminal diseases (Jim, 2015); and reliance on religious associations as means of social support (Rumum, 2014). Religious participation, mostly characterized by service attendance (Vanderwheele, 2017), is associated with better physical and mental health outcomes (Koenig, King and Carson, 2012; Johnson, Tompkins and Webb, 2008); controlled consumption of alcohol (Burdette, Weeks, Hill and Eberstein, 2012) and lower rates of smoking and drug abuse (Hufford, 2005; Koenig, King and Carson, 2012), amongst others. Even the existence of religious bodies, also referred to as ‘Faith-based Organizations’ is noted to contribute greatly to health care provision (Levin, 2016).

Religious beliefs and practices also dominate the social lives of many people in Nigeria as 50.4% of Nigerians practice Islam; 48.2% practice Christianity and the remaining 1.4% are Traditional African Worshippers (Owumi, Raji and Aliyu, 2013). Clearly, religious affiliations permeate the day-to-day activities of people, and also have an overwhelming influence on other socioeconomic, environmental and political outcomes in Nigeria. At the structural level, Faith-based organizations in Nigeria have contributed significantly to the creation of Schools, Banks, Hospitals and other relevant structures for sustainable development in the country (Iwuoha, 2014). In terms of health, religious bodies have also cooperated with public health initiatives during major health crisis in the country (Solanke, Oladosu, Akinlo, and Olanisebe, 2015). For instance, during the incidence of Ebola outbreak in Nigeria in 2014, the Catholic Churches in Nigeria suspended handshaking (which is a dominant custom of the Catholic Church) during Mass (Nairaland, 2014); disengaged from giving communion in the mouth (Huffpost, 2014); and also banned the lying of corpses in church auditorium, to avoid spread of the disease (Solanke, Oladosu, Akinlo, and Olanisebe, 2015). However, in situations where the religious organizations do not support certain health initiatives, there is delayed or withdrawn cooperation (ActionAid, 2008).

As religious affiliations, beliefs and participations differ among persons in Nigeria, this influences individual and community health behaviour in distinct ways. In other words, as people associate with and/or practice different religions, their health behaviours are determined by the religious group to which they belong. For instance, in a study on the socio-cultural factors, gender roles and religious ideologies’ contribution to Caesarian-section (CS) refusal in Nigeria, Ugwu and De kok (2015) discovered that while some religious denominations support their members to consider CS, some other denominations advised women against CS and encouraged them to turn to
prayers and fasting instead. Another common example is the case of the Jehovah Witnesses, a Christian denomination which discourages its members from partaking in blood transfusion (Solanke, Oladosu, Akinlo, and Olanisebe, 2015) irrespective of whatever condition they find themselves.

Asides the connection between religious participation and health behaviour, the patronage of religion in treatment of ailments is also well established in Nigeria (Owumi, Raji and Aliyu, 2013). Miracle healings and cures from diseases are predominantly noted in religious houses in Nigeria (Amanze, 2013; Diara and Onah, 2014). However, religion has also contributed significantly to violence and strife in Nigeria, as well as in many countries in sub-Saharan Africa. Most are cacophonies! It is on the ground of pervasiveness and divisiveness nature of nexus between religion and health that this paper intends to capture the turbulence of healing craft through religion and realities in Nigeria.

Religion and Health: From Classical thinking to realities

The long standing connection between religion and health from pre-modern times to date has triggered several discussions among social thinkers and theorists. Most writings and discussions are centred on the influence of religious beliefs and participation on health status including suicide and suicidal thoughts/intention, depression, psychological wellbeing and sickness survival. Durkheim (1987), a functionalist, for instance, was one of the foremost Sociologists to link religion to correlates of health. In his classical work on suicide, Durkheim noted that social cohesion and regulation within the Catholic Church accounted for lesser cases of suicides amongst Catholics compared to Protestants. For him, social cohesion provides psychic support to group members, enhances psychological balance and suppresses stress and anxieties tendencies (Wallace and Wolf, 1995). Recent studies (Whitlock, Whyman and Moore, 2014; Cetin, 2015; Mueller and Abrutyn, 2016; Hsieh, 2017), also established that where social cohesion and regulation exists in abnormal rates, there is high tendency of suicide within such environments.

Some other theorists (Francis, 2000; Ardelt, 2013; Borges, Santos, and Pinheiro, 2015; Francis, Jewell and Robbins, 2010) recognize the essential role of religion in shaping how people perceive the meaning of human existence and their purpose in life (Galek, Flannelly, Ellison and Jankowski, 2015). In a study of religious behaviour, health and well-being among Israeli Jews, Levin (2013) observed that while synagogue attendance was associated with only greater happiness, offering prayers was associated with greater happiness and life satisfaction. Karl Marx’s (1818-1884) theoretical stance on religion also contributes to concerns on health matters.
The Marxian perspective, with its core conflict orientation, considers religion as the “opium of the masses, the heart in a heartless world”. This way, religion is perceived as a tool for suppressing the oppression, busy life and coping with the ills experienced by the Proletariat. While the masses are faced with exploitation and alienation orchestrated by the Bourgeois, religion provides solace and comfort such that it would help suppress the attainment of “true consciousness” of the situation (Marx and Engels, 1975). For instance, some religious institutions claim that there exist “eternal life after death” filled with happiness. This then encourages its members to focus on the future gains, thereby quenching any tendency of a revolution. Thus, Marxian views on religion insights that, religion provides temporary psychological comfort and wellbeing for those in distress just as opium drugs provides relief for illness or diseases (McKinnon, 2006).

The writings of Sigmund Freud have featured religion, for the most part, as an “irrational neurotic phenomenon” (VanderWeele, 2016: 1). For Freud, religion is a technique created by men to cope with psychological distress experienced in day-to-day living. These theories have shaped several researches on the relationship between religion and health. Evidences from epidemiological and clinical studies also submit that religious affiliation and involvement impact on mental and physical health in diverse ways (Chatters, 2000).

MATERIALS AND METHODS

Data for this study were sourced from review of grey literature, Nigerian online blogs, religious websites and twitter. Specifically, the study started with familiarization with grey literature and its review on those contemporary issues revolving around religion and health in Nigeria and globally. Relevant ones were downloaded and reviewed. These are online blogs where contemporary issues are discussed. These blogs were analyzed, listed and censored to those addressing religious issues. The blogs were visited to elicit data in discussions that revolve around religion, health, healing and turbulence of daily life. The review and cropping of discussion and data went to as far back as duration of the blogs. Also, religious websites and twitter pages/handles were identified and visited for a review. These were examined critically and consciously to avoid conflict of interest. These were done for two new religions (Christianity and Islam). A couple of sites were also referred to on indigenous religion; these were examined.

Data generated were subjected to thematic analysis (Braun and Clark, 2006) through framework approach (Spencer, Ritchie and O’Connor, 2003). The framework enabled both deductive and inductive theme identification achieved through two phases comprising five main steps. The first is managing
the data cropped from various outlets, in three steps: familiarization with the data, development of a thematic/coding framework and indexing. The second is data explanation phase including data charting and data mapping. Both phases enhance theory-driven and data-driven analysis (Braun and Clarke, 2006). The analysis derived its strength from the admonition of Braun and Clarke (2006) that thematic analysis is highly recommended when investigating an under-researched area. Analysis of religion, health and healing craft is one core area that is not fully engaged in Nigerian literature. This analysis also benefitted from analytical rigour and guides derived from other experts in religious studies (Cornish, Gillespie and Zittoun, 2014); hence queries were raised and cleared with insights into statements and data with the hope of identifying the patterns within the whole data set. The overall analysis is presented in the results section as follows.

FINDINGS

Religion, Faith and Health Risks

Religious participation in some ways, promote adoption of appropriate health behaviours. Through its multifaceted influences on health behaviour, certain religious practices not only help to discourage risky behaviours that can result in health problems, but also encourage positive and healthy lifestyle choices (Ellison and Levin, 1998). In Nigeria, for instance, Fadeyi and Oduwole (2016) discovered that Christianity and Islam (which are the two prominent religions in Nigeria) play positive roles in reproductive health issues especially in aspects such as birth spacing, safe motherhood, antenatal attendance, premarital sex and abortion. Also, alcohol patronage and consumption is largely preached against as a form of prohibited drinks. Although alcohol plays a prominent role in traditional African religious settings (Olaosebikan, Osarenren and Okoli, 2014), modern religious organizations including Christianity (especially Pentecostal churches) and Islam in Nigeria condemn its consumption (Omonijo, Nwodo, Uche and Ezechukwu, 2016). This is one instance where the orthodox churches in Nigeria differ from the Pentecostal churches, as although some orthodox Christian churches tolerate a level of alcohol consumption, their Pentecostal counterparts out rightly condemn its use. However, Dumbili (2012) observed that many Nigerians, who claim to abstain from alcohol due to religious reasons, still consume it in deception.

In observing the strong influence of religion on positive health behaviours and avoidance of health risks, Ellison and Levin (1998) noted five major factors that contribute to the behaviour:

First, individuals may internalize strong religio-ethical norms; the prospect of violating these internalized religious norms may evoke feelings of
guilt and shame or even fear of divine punishment (“hellfire”). Second, members of religious communities may conform to religious norms because they fear the threat of embarrassment and possible social sanctions, sometimes formal (ridicule from clergy) but more often informal (e.g. gossip, ridicule, ostracism by their fellows. Third, religious persons may alter their lifestyle to make them consistent with those of reference group members- that is, persons (e.g. influential church members) they consider worthy of emulation. In some cases, religious activities or networks may simply reduce exposure to deviant behaviours or unhealthy lifestyles. Others suggest that observed religious variations in lifestyles reflect selection mechanisms: Many persons involved with religious communities may be predisposed toward risk-averse lifestyles and comfortable with social control or be immersed in nuclear families, which have been shown to promote positive health behaviours (Ellison and Levin, 1998, P. 704).

On the other hand, religious beliefs and participation may instigate risky health behaviours and non-adherence to appropriate health action among the people. In Nigeria and other African countries, there are several records of instances where people engage in risky behaviours, to prove the efficacy of their religious beliefs. One of such instances occurred in the ancient city of Ibadan, Southwestern Nigeria in the year 1991. A certain ‘Man of God’ named Prophet Abodunrin Daniel, was reported to have deliberately entered into a Lion’s den, with faith that a miracle would occur such that God would prevent the Lions from hurting him (Dunamis Blog, 2017). It was reported that his goal was to recreate an occurrence recorded in the old testament of the Holy bible, where it was written that a Jewish kid named Daniel who was faithful and submissive to the only Supreme God, and refused to worship smaller gods, attracted the wrath of the king Nebuchadnezzar of Babylon and he was thrown into the lion’s den, but was delivered by the Supreme God (Daniel 6: 8-17). However, this was not the case for prophet Abodunrin, as it was reported that:

“........the red robed prophet with his huge Holy Bible sneaked in (into the Lion’s den),.....so convinced that God would spare his life...moved closer to the animals reciting bible verses and speaking in other tongues....the prophet approached the lions and he continues to chew the scriptures and that led to the end of the journey in the wonder land” (Dunamis Blog, 2017).

Scholars view this as extremist’s attempt to display “faith and spiritual pride by actively tempting God....and an attempt to replicate biblical or other scenarios which may have no relevance to their respective situations” (Abioye, 2004, P. 171)
In some other cases, religious affiliations of people encourage drug refusal and non-adherence to appropriate medical recommendations. For instance, Ogunleye (2013) noted that members of Christ Apostolic Churches in Nigeria believe in the notion of divine healing from the supreme God such that they refuse medical aids. This is similar to the findings of Maguranyanga (2011), who discovered that ultra-conservative Apostolic groups in Zimbabwe, through their religious teachings and doctrines, stress faith healing over modern healthcare seeking. The Jehovah Witness group in Nigeria have also been noted to reject blood transfusion, with the belief that it is against biblical injunctions (Nwadinigwe, Okwesili, Nzekwe, Ogbru and Lekwa, 2014). Although there has not been any conclusive evidence that Jehovah’s Witnesses’ rejection of blood transfusion has led to a higher mortality rate after traumatic injury or surgery (Nwadinigwe, Okwesili, Nzekwe, Ogbru and Lekwa, 2014), this affects medical procedures and creates confusion for physicians in their services.

Religious resistance to vaccinations has contributed negatively to health management in Nigeria. One of the popular instances was the boycott of polio vaccination in 2003/2004 in the Northern part of the country (dominated by Muslims) (Jegede, 2007) thereby jeopardizing global efforts to curb prevalence and incidence of polio (Anyene, 2014). It was misconstrued that the polio eradication programme was an attempt by the western governments to reduce Muslim population (IRIN, 2004). Jegede (2007) documented the factors that led to the boycott of the polio vaccination in Northern Nigeria. The most prominent factor is religious influence and religious leaders’ activities. In another case, the Catholics’ resistance to modern contraceptive use may affect the rate of success of family planning and control of sexually transmitted diseases such as HIV/AIDS.

Furthermore, some religious practices may also increase vulnerability to health risks among people. For instance; use of hijab or abaya by Muslim women during heat stress can increase thermal discomfort (Tashkandi, 2014); members of the Celestial Church of Christ (CCC) not putting on footwear with their sutana (Celestial Church of Christ Blog, 2015) may expose them to foot injuries; and prolonged fasting may be hazardous for peptic ulcer patients (Gokakin, Kurt, Atabay, Koyuncu, Topçu, Aydin, Sen and Akgol, 2012; Amine, Kaoutar, Ihssane, Adil and Dadr-Allah, 2012) and duodenal ulcer patients (Kucuk, Censur, Kurt, Ozkan, Kement and Oncel, 2005; Davoodabadi, Akbari, Ghasembandi and Kashi, 2016). As noted that Nigerians are structured by religious affinity, large majority belong to Islamic religion. There may not be an accurate number of women on hijab, an estimate could be possible since it is more mandatory for Muslim women (Quran, 24: 30). Also Celestial Church of Christ has its large adherents in Nigeria. In fact, it has its headquarters located in Imeko-Afon, the
hometown of the founder, Samuel Oshoffa, in Ogun state, Nigeria. The Church annual convention attracts followers from all over Nigeria and neighbouring countries. Body contact is possible during worship, while this has implications for transmission of diseases such as Ebola virus and Lassa virus. Fasting is prescribed in the Holy Books for followers of new religions (Islam and Christianity), yet the consequences of fasting may cost more than the value attached.

**Faith Healing in Religious Centres**

One of the most important attributes of religious centres in Nigeria is their emphasis on faith healing. As such, miracle healing and *deliverance* from diseases and illnesses of ‘mind and body’ are core practices in many religious houses in Nigeria. For Christians, “healing is conceived as a comprehensive restoration of a believer to superabundant health or status accruing to him/her as a result of what Jesus Christ has wrought on the Cross” (Ukah, 2007, P. 14). Many claims have been made by ‘men and women of God’ through various media sources, to have cures for diseases, especially the most severe and medically incurable ones (Falaye, 2015).

There is a history of healing from diseases recorded in the holy book of Christians (Bible) and Muslims (Quran). The Old and New Testament of the Bible have recordings of several healings carried out ‘in the name of God’. In the Old Testament, there are twelve occurrences of individual healings and three occurrences of corporate healings (The Voice of Healing, 2011). In one instance, a devoted woman of God, through her consistent prayers, received healing from barrenness (1 Samuel 1: 9-20). In another instance, King Nebuchadnezzar (who was previously a pagan) received healing from insanity (which had plagued him for seven years) by looking up to heaven (Daniel 4: 34-36). In the new testament of the Holy Bible, more than one-third of the scriptures describe healing from several physical and mental diseases. In one instance, Jesus healed a man from leprosy (which was a common and terminal disease at the time) by simply saying to him “*Be clean*” (Matthew 8: 1-3). In the Holy Quran, it is recorded that Prophet Mohammad healed a man who had a broken leg, by wiping his hand over the sick man’s leg. Right from old times, believers perceived means of faith-healing power as an important asset for human survival (Ebhomienlen and Ogah, 2013).

The origin and proliferation of spiritual healing centres in Nigeria can be traced to the second decade of the 20th century, during the outbreak of influenza (Erinosho, Usman and Mkpume, 1981). Adegoke (2007) observed that many indigenous faith healing churches in Nigeria (including Christ Apostolic Church, Celestial Church of Christ, Cherubim and Seraphim, Christ Apostolic Faith) emerged around this period for the purpose of healing through spiritual means. The spread of these healing centres has continued even in
recent times, especially with increased uncertainties and rise in strange diseases rampaging resource-limited nations. One popular strand of Christian spiritual centres where healing is a core mission is the Aladura churches. The Aladura churches also known as African Instituted Churches- AICs, “reflect the indigenization of Christianity through its use of African symbols, traditional healing modalities and worship styles” (Harvard Divinity School, 2017, no page). The Aladura churches in Nigeria emphasize healing and deliverance from illnesses and diseases through prayers. In these churches, some days of the week, particularly Wednesdays (known as Ojo Aanu – Day of mercy) and Fridays (Ojo iwosan – Day of healing) are mapped out specifically for healing of the sick (Aiyegboyin, 2008). The Aladura movements now account for 10% of Christians in Africa, and a large number of diaspora Africans in Europe and North America (Ukah, 2007), due to their emphasis on prayers and healing practices.

The Pentecostal movements form another religious strand in Nigeria, with huge emphasis on faith healing. The rise in Pentecostalism in Nigeria is closely linked with the search for spiritual solutions to persistent social, political and economic problems in the country. Pentecostal adherents belief that certain practices such as: giving of tithe, total reliance on faith, being “born again”, etc attract material and spiritual blessings such as healing, wealth, abundant life and success. Pentecostal churches are therefore a strong reference point of spiritual healing in Nigeria. However, healing services in Pentecostal churches in Nigeria is structured in different ways. Some churches are known to have cures to particular diseases, while some others claim to have cures to all forms of diseases. For instance, while the Laughter Foundation International Ministry also known as God’s baby factory, specializes on healing barren women and blessing childless couples with children of their own (Vanguard, 2017), the Synagogue Church of All Nations, owned by Pastor T.B. Joshua, claim to heal people from all forms of spiritual attacks, illnesses and even life-threatening diseases, including HIV/AIDS, cancerous wounds and epilepsy (SCOAN, 2010). In another instance, several testimonies of healing from deadly diseases have been recorded in the Lord’s Chosen Charismatic Revival Ministries in Nigeria. The sick believers in these churches often disagree with medical procedures, but rather believe that they can be healed through spiritual means. For instance, a member of the Lord’s Chosen Charismatic Revival Ministries in Nigeria, diagnosed with breast cancer, refused medical advice to cut off the affected breast:

......I was diagnosed of breast cancer five months ago which caused me serious pain. Doctors in the hospital I visited recommended that the affected breast be cut off surgically. I quickly rejected this advice as I told them I am a child of God and my breast cannot be cut off. I was given some
drugs which I have been taking, after initially refusing to use them. Recently I decided to come to this crusade at the headquarters on Friday, because I believed I will get my healing there (Lord’s Chosen Charismatic Revival Ministries in Nigeria: Testimonies, 2017).

Attending crusades and healing services are believed to provide complete restoration of good health and wellbeing. This is often dependent on the sick person’s faith in God to provide healing from his/her sickness. In line with this, the testimony of the member of Lord’s Chosen Charismatic Revival Ministries in Nigeria, diagnosed with breast cancer continues thus:

.....As I stepped unto Chosen ground (Lord’s Chosen Charismatic Revival Ministries prayer ground in Benin, Nigeria) I felt some changes all over my body, the pains began to subside and I decided to stop taking the drugs I carried. During yesterday’s ministrations, the pastor mentioned my case and prayed over it. Since then, I noticed my system has normalized. I am now stronger. I walk normal and I feel healthy, different from the way I was when I came in here, two days ago... (Lord’s Chosen Charismatic Revival Ministries in Nigeria: Testimonies, 2017).

There are several other instances of faith-healing and deliverance in other Pentecostal churches, and this contributes to the large patronage of Pentecostal churches and even conversion of other denominations to Pentecostalism.

However, asides faith-healing within Christendom, there are also records of healing from diseases and infirmities in Islamic centres and other traditional religious centres in Nigeria. In what is described as a “Charismatic form of Islam” (Obadare, 2015), it has been observed that “African clergymen have begun performing miracle healing crusades like their Christian counterparts” (Nairaland, 2014). There is also the Islamic belief that sicknesses can be cured spiritually without the use of modern medicine. For instance, in a study by Tocco (2011) to examine Muslim’s perspectives on HIV treatment, it was discovered while some respondents claim that HIV can be completely cured by the supernatural power of the Quran (Holy book of Islam), others insist that the natural ingredients prescribed in Islamic texts can cure HIV. Healing in traditional religious centres is also common in Nigeria and other countries. This is often achieved through rituals, animal sacrifice, music, dance, possession trance, use of herbs and plants, etc (Wedel, 2004).
A major feature of healing in the religious context is the use of symbolic materials. According to Falaye (2015), “some of the Aladura/ spiritual churches (in Nigeria) allow the use of certain rituals such as bathing in flowing river, use of palm fronds, use of oil and others in curing the sick people. Some of them also make use of local herbs to cure sicknesses such as prostate cancer, stroke and paralysis successfully” (Falaye, 2015; p. 10). Ebhomienlen and Ogah (2013) noted that the use of saliva as a healing method is common in Africa, which is also linked to the miraculous healings by Jesus in the Holy Bible (John 9:6; Mark 7: 33). Rinne (2001) also observed the importance of water in traditional religious healing practices in Ile-Ife, Southwestern Nigeria.

As regards the procedures used in faith healing, scholars identified; binding and casting (Gbule and Odili, 2015); music and sacred dance (Monteiro and Wall, 2011) giving in charity (Sadaqah) and reciting the Quran (Sulaiman and Gabadeen, 2013) and religious rituals such as bathing in flowing water (Falaye, 2015). In a study by Okyerefo and Fiaveh (2016), to explore the conceptions of illnesses and diseases in Accra, Ghana, it was discovered that prayer group members conducted healing services in the forest, as they consider it a ‘serene sacred place’.

The reliance on faith-healing among many in Nigeria is linked to the fact that disease causation is attributed to supernatural, mystical and natural factors, including witchcraft attacks, evil machination and repercussion for offenses (Adegoke, 2007); low cost and inaccessibility to modern health facilities. Studies have explored the relationship between socio-economic factors and utilization of faith healing centres. Adegoke (2007) discovered that there is a significant relationship between educational background, income and utilization of faith-healing centres.

Religion and Psychosocial Wellbeing

Religious involvement and practices have been observed to promote psychosocial and mental wellbeing among individuals (Joshi, Kumari and Jain, 2008). Past empirical evidence suggests that there is a “generally protective effect of religious involvement for mental illness and psychological distress” (Levin, 2010). Even in terms of coping with medical illness, religious beliefs and practices are reported to provide psychologically soothing effects including comfort, hope and meaning (Koenig, 2004). As such, religious factors such as religious attendance, faith, religious devotions and/or being part of congregation, functions as “opiate” for the people. For instance, the expression of faith and belief in a Supreme Being, known as God, who has declared that people should “ask and they shall receive, seek and they shall find, knock and the gate shall be opened unto them” (Matthew 7:7), reduces tension and despair in Christians. Also, among the Muslims, religious
involvements dispel thoughts and feelings of hopelessness, despair and ‘giving up’ as Allah assures that:

> For those who fear Allah, He always prepares a way out, and He provides for him from sources he never could imagine. And if anyone puts his trust in Allah, sufficient is Allah for him. For Allah will surely accomplish His purpose: verily, for all things has Allah appointed a due proportion (Quran, 65:2-3).

Thus religious beliefs emphasize ‘faith’ over worry and despair, which are psychological stressors.

In Nigeria, where the level of religious involvement is high, there is a huge reliance on religious factors for the prevention and treatment of psychological or mental issues. Both past (Gureje, Acha and Odejide, 1995; Abiodun, 1995; Agara and Makanjuola, 2006) and recent studies (Jack-Ide, Makoro and Azibiri, 2013; Adeosun, Adegbohun, Adewumi and Jeje, 2013) indicate that religious centres are the first point of call in case of mental illnesses. Also, up to 70% of the mental health services in Nigeria are provided in religious and traditional homes (Adewuya and Makanjuola, 2009). Consequently, there is delay in reporting mental cases in modern healthcare centres (Adeosun, Adegbohun, Adewumi and Jeje, 2013; Ikwuka, Galbraith, Manktelow, Chen-Wilson, Oyebode, Muomah and Igboaka, 2016), as majority of the people consider mental issues untreatable using western medicine (Aneibu and Ekwueme 2009; Gureje and Lasebikan, 2006; Kabir, Abubakar and Aliyu, 2004). Even in western countries, Muslims are hesitant to seek help from the mental health professionals, to avoid being in conflict with their religious beliefs (Sabry and Vohra, 2013).

Thus, issues pertaining to mental and psychological wellbeing are perceived to be closely intertwined with religious and spiritual matters. In corroboration with this line of thought, a popular Nigerian pastor, Sam Adeyemi, of the Daystar Christian Church noted thus:

> The root cause of mental illness is Sin (Romans 6:23) and the foundational solution to mental health is salvation. To maintain mental health, feed your spirit and soul with healthy diet of God’s word. If you don’t get your identity in God’s word you will believe everything the enemy tells you. If you allow Satan and your circumstances define who you are, it will distort the balance in your mental state.- Sam Adeyemi (@sam_adeyemi) October 30, 2016.
The above statement by the Nigerian Clergy, in response to the increasing rates of depression and suicides among Nigerians, reflects the perceived close link between spiritual beliefs, and psychological wellbeing.

Furthermore, provision of psychotherapeutic care in Nigeria is mostly carried out by either religious or traditional leaders (Bojuwoye and Mogaji, 2013). This is achieved through church services, follow-up visits, cell meetings, group visitations among others (Nwoko, 2009). Religious leaders, through inspirational counselling, also help their members deal with a range of disturbing social and emotional issues, which could otherwise constitute psychological distress. Also, belonging to a religious group/association, provides psychosocial support that can promote mental health and wellbeing. The sense of belonging that religious groups provide its members may reduce psychological distress (Behere, Das, Yadav and Behere, 2013) and increase their capacity to cope with ill-health conditions.

Taking Healing Outside of the Place of Worship

Religious organizations, also known as faith-based institutions play a crucial role in the global efforts to promote health and wellbeing, especially in low-resource settings and among the most disadvantaged populations (Widmer, Betran, Meriadi, Requejo and Karpf, 2011). Reports confirm that faith-based organizations contribute up to 70% of modern healthcare services in developing countries (Kagawa, Anglemyer and Montagu, 2012). This is more evident in Africa, where about 30-70% healthcare infrastructure are owned and managed by faith-based organizations (World Health Organization, 2007). In Nigeria, faith-based institutions are instrumental in the provision of health care facilities (Iwuoha, 2014) and support of public health initiatives (Solanke, Oladosu, Akinlo, and Olanisebe, 2015), especially when they perceive such initiatives as beneficial.

Historically, the advent of modern healthcare facilities to Nigeria was facilitated by church missionaries in colonial times (Scott-Emuakpor, 2010). The first health dispensary in Nigeria was opened by the Church Missionary Society in parts of Nigeria, while the first hospital (Sacred Heart Hospital, Abeokuta) was built by the Roman Catholic Church in 1885 (Scott-Emuakpor, 2010). Currently, many hospitals located in several parts of the country, including Ahmadiyya Muslim hospital, Seventh Day Adventist hospital, Faith Clinic Foundation in Nsukka, Queen Elizabeth hospital in Umuahia, K and P hospital in Nassarawa, Shendam hospital in Gombe and countless other hospitals are owned and managed by religious bodies (Ikechi-Ekpendu, Adu and Ekpendu, 2010). Traditional religious organizations in Nigeria also own indigenous healing centres, where four categories of health services are provided: nature healing (such as bone setting and hydrotherapy), natural healing (such as telepathy prayers, hypnotism), herbal healing and Spiritual
healing (Adefolaju, 2014). However, the advent of Christianity and Islam in Nigeria has led to relegation of African traditional medicine (Chima, 2015).

Asides the creation and management of hospitals and health centres, religious organizations in Nigeria also provide social services and rehabilitative programmes to the sick outside the ‘congregation’. Burgess (2012) observed that Pentecostal churches in Nigeria were at the forefront of providing rehabilitative programmes for children in Lagos State, Nigeria. He identified two rehabilitation centres: Habitation of Hope, run by the Redeemed Christian Church of God (RCCG), the largest Pentecostal denomination in Nigeria; and the Freedom Foundation, a NGO founded by This Present House, a congregation situated in downtown Lagos (Burgess, 2012). Some other faith-based rehabilitation centres in Nigeria including Wellspring rehabilitation centre, Christ Against Drug Abuse Ministry (CADAM), House of joy, New life Drugs Addicts Rehabilitation Centre, all located in different areas in Lagos State, Nigeria, are involved in welfare services and rehabilitation for persons who are drug-dependent (Cherry and Ebaugh, 2014).

Through hospital and clinic visitations, religious persons extend the ‘healing hands of God’ to sick in-patients. Oluwabamide and Umoh (2011) in a study on the relevance of religion to health care delivery in Akwa Ibom State in Nigeria, discovered that patients often requested for ministers of God to intercede for them in relation to their ill health, while others desired for the ministers of God to stay permanently with them in the hospital. As explained by Oluwabamide and Umoh (2011), “when Christian priest visited hospitals to pray for patients, most of them found succour in the priests’ exhortations, encouragements and prayers” (Oluwabamide and Umoh, 2011 P. 49). Thus hospital visitations is a method through which religious leaders show pastoral care to their sick members and it also provides psychological comfort to members.

Religious Identity, Religious Diversity, Conflict and Health Threatening Outcomes

Nigeria is not only a multi-ethnic State but also a multi-religious State, with over 350 ethnic groups practicing different religions, either Islam, Christianity, Traditional African Religion or others (Ntamu, Eneji, Asor and Ochiche, 2017). Although the country does not have a State religion, it allows freedom of choice of religious affiliation. Such religious freedom, although advantageous in terms of ensuring human rights, often leads to conflict, disorder and violence, especially when issues are often from different religious worldview (Iruonagbe, 2009). In fact, “over the past few decades, it would appear that there has been consistently more religious strife in Nigeria than in other countries in sub-Saharan Africa largely because the country is divided between Christians and Muslims” (Dowd, 2014, P. 154). Religious intolerance among Christians and Muslims, has led to conflict, injuries, and even loss of
life and property. As explained by Iruonagbe (2009): “Such religious intolerance can be attributed to some misconceived favoritism and competition for scarce resources amongst adherents of the two contending religions, Christianity and Islam” (Iruonagbe, 2009. P. 153-154).

As a result, there have been several crises and clashes between and among religious groups in Nigeria. Salawu (2010) listed some of the major crises in Nigeria: the maitatsine religious disturbances in parts of Kano and Maiduguri in the early 1980s, Jimeta-Yola religious disturbances (1984), and Zango-Kataf crises in Kaduna State (1992), Kafanchan College of Education Muslim-Christian riots, Kaduna Polytechnic Muslim-Christian skirmishes (1981-1982), the cross vs the crescent conflict at the University of Ibadan (1981-1985), Bulumkutu Christian-Muslim riots (1982), Usman Danfodio University Sokoto (1982), and the Muslim-Christian Clash during a Christian procession at Easter in Ilorin, Kwara State (1986), amongst several others. These riots and clashes have had devastating effect on the rate of morbidities and mortalities. For instance, the Muslim-Christian violence in Jos in the year 2011, claimed more than four hundred and twenty-six lives in 2011. In Kano, and the same was the case since 2009, 2010, 2011-2013 (Ojo, 2007; Ostien, 2009). In more recent times, the emergence of the Boko Haram Islamic terrorist group in Northern Nigeria, has had severe detrimental effects on the social, economic, and environmental condition of the region and the whole country (Ajaegbu, 2012). Part of the nefarious activities include bombing of churches, mosques and schools, abduction of school children, attacking of government and international organizations’ installations, etc (Blanchard, 2016). These activities have jeopardized the health and wellbeing of people in the region and also increased vulnerabilities to morbidity and death. For instance, Onuegbu and Salami (2017) noted that a large number of adolescent girls in the areas affected by the Boko Haram operations are internally displaced and their sexual and reproductive health is negatively affected.

Religious segregation even among same religious groups also affects health care delivery in negative ways. It is true religious intolerance exist not only between members of diverse religions but also among people of different sects within the same religion (Ajaegbu, 2012). Within Christianity and Islam, there are several subgroups. For instance, among Christians, there are many denominations including Catholics, Protestants, Seventh Day Adventists, Jehovah Witnesses, White garment churches, among others, while among the Muslims, there are different sects including the Ahmadiyya, Sanusiyya, Tijanniyya and Quadriyya, among which there have been conflicts (Ajaegbu, 2012). In cases whereby people of a particular sect refuse to patronise health services care from clinics that are owned by other religious organizations, this could affect health care delivery.
In more recent times, religious houses in Nigeria have become soft targets for attacks and assassinations. An example was the attack on the St Philip’s Catholic Church in Ozobulu, Anambra state, where more than 30 lives were lost, and many others were injured (Vanguard, 2017). On occurrence, there are not enough facilities to respond to emergencies. The essence of religion is to maintain order yet the institution sometimes contribute more havocs than order, while the same institution claims to offer succour to peoples’ lives.

**Religion and Health: Recommendations for Better Outcomes**

Religious beliefs and practices affect all aspects of health including health behaviour, physical and psychological wellbeing, health-seeking behaviour, health service delivery, and healthcare utilization. In other words, religion is a powerful social determinant of health, at individual, community and societal levels as is race, gender and income (Vanderweele, 2016). While this has implications for the clinical management of diseases, it also affects overall healthcare provision and utilization. In Nigeria, where large majority of the population have religious affiliations, there are clear connections between religious involvements and various dimensions of health. Therefore, it is imperative to consider religious factors in health discourse, in order to have wholesome and realizable impacts. Clearly, issues bothering the mind and terminal diseases are the most common health issues that people often take to religious institutions.

As research confirms that large majority of mental illnesses are attributed to supernatural factors and are treated either in religious centres or traditional houses in Nigeria (Adewuya and Makanjuola, 2009; Kabir, Iliyasu and Abubakar, 2004; Uwakwe, 2007), there is a need to integrate religious centres into objective ways of managing mental health. An initial step towards this, is the recognition of religious centres as “relevant referral point and as a rehabilitative and support network” (Jack-Ide, Makoro, Bip-Bari and Azibiri, 2013 P. 28) in mental health policy. Next, it is important to educate spiritual and religious leaders on socio-biological causes of mental illness and also encourage them to incorporate religious centres into mental health management. Furthermore, mental health professionals should be assigned to religious houses to educate people, train religious leaders and community members, attend to mental related issues and also encourage referrals to mental health clinics, if need be. Religious organizations need to play a crucial role in reducing stigmatization of people with mental health issues. Even more, religious organizations can help to organize stress-relief programmes such as sports, family hangouts, and regular counselling sessions to help check the psychological states of its members. In terms of health promotion programmes
and projects, there is a need for the Federal Ministry of Health in Nigeria to recognize and collaborate with religious centres given their popularity. As such, regular health awareness campaigns and counselling services should be carried out in religious houses, in other to increase overall awareness.

Religious organizations have crucial roles to play in the provision of healthcare services in Nigeria. Religious organizations need to go beyond building hospitals and clinics, to ensuring that the hospitals have an open system and are functioning without religious bias. Those religious bodies involved in charity works such as visits to Internally Displaced Persons (IDPs) camps and visit to the sick in government-owned hospitals, should carry out such activities without religious bias. Furthermore, religious bodies need to increase efforts towards contributing to development programmes such as donating clean water, free treatment, vaccinations and checks in poor communities, engaging in sanitation programmes in slums, rehabilitation for youths who engage in substance abuse or other risky behaviours.

In cognisance of the role religious beliefs and participation plays in aspects of medical procedures including coping, recovery, medical decisions, willingness to receive treatment, disease detection, and treatment compliance (Koenig, 2004), it is crucial for physicians to seek information on the patients’ religious orientation, prior to treatment. This is important to improve doctor-patient relationship and medical care provided by physicians (Koenig, 2002). Also, this approach may help physicians recognize when patients have spiritual needs and requires pastoral care (Lo, Ruston and Kates, 2002). However, incorporating pastoral care into health care provisions is an aspect that has been largely neglected. In line with this assertion, Agbiji and Agbiji (2016), noted that “one of the resources that is under utilised is the religious and spiritual resource of pastoral care, which constitutes a potentially unique social capital resource for health and healthcare for many people in the world” (no page number). However, this has to be done with caution. Finally, given the increase in the number of attacks targeted towards religious houses in Nigeria, there is a need for the government to intensify efforts to provide security for worshippers.
REFERENCES


