Effect of Orthodox and Traditional Health Promotion on Health Decisions of Residents of Offa, Kwara State

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Abstract

This study examined how Orthodox Health Promotion (OHP) and Traditional Health Promotion (THP) messages shape the health decisions of residents in Offa, Kwara State. Using the Health Belief Model (HBM) as a theoretical framework, the study explored how exposure to modern, evidence-based health messages and culturally rooted traditional health messages influenced individual choices about seeking medical care. A quantitative survey design was adopted, allowing systematic measurement of residents' exposure to both types of health messages and the resulting health decision patterns. Results showed that both OHP and THP significantly influenced health decisions, though OHP had a stronger effect. Simple linear regression revealed that OHP explained 99.5% of the variance in health decisions ($R^2 = .995$, $\beta = .997$, $p = .001$), while THP accounted for 97.5% ($R^2 = .975$, $\beta = .987$, $p = .001$). A combined multiple regression model showed that both predictors together explained 99.8% of the variance ($R^2 = .998$, $p = .001$), with OHP ($\beta = .731$) exerting greater influence than THP ($\beta = .272$). The study concluded that both forms of health promotion play complementary and significant roles in shaping the health-seeking behaviours of Offa residents. It highlights the importance of combining evidence-based health communication with culturally relevant traditional practices to improve public health outcomes. The very high R^2 values suggest possible measurement limitations or response bias; future research should therefore, use more diverse sampling methods and examine moderating variables. Studies should also investigate the long-term impact of health promotion messages on actual health outcomes beyond decision-making.

Keywords: Effect, Health Promotion, Orthodox, Residents, Traditional

1. Introduction

The Federal Government of Nigeria's health promotion policy, developed in collaboration with the World Health Organisation (WHO), was designed to address health challenges and promote preventive healthcare across the country. A series of health promotion messages have been disseminated through both orthodox and traditional channels, reflecting growing global attention to the importance of preventive health. However, between 2005 and 2019, little effort was made to systematically evaluate the effectiveness of these policies on Nigerian citizens (Akinyemi et al., 2021; Uzochukwu et al., 2020). This gap exists even as the WHO has formally recognised the integration of traditional medicine into global health care systems. It is estimated that about 80% of the world's population uses traditional medicine in one form or another (WHO, 2023). It is on record that 170 out of 194 WHO member states have reported using traditional medicine, and their governments have formally requested WHO's support in developing credible evidence and data on traditional health practices (WHO, 2019, 2023). Consistent with this, in many developing countries, traditional healers serve as the primary or sole healthcare providers for millions of people living in rural communities. The ratio of traditional health practitioners to citizens in Africa stands at 1:500, compared to 1:40,000 for medical doctors (James et al., 2019; Peltzer & Pengpid, 2019).

According to Klepp et al (2025), health promotion refers to a set of actions aimed at fostering good health and overall wellbeing. Recent years have seen increased attention to preventive health by both state and federal governments, driven by significant demographic changes such as population growth and ageing, as well as lifestyle changes that have contributed

to rising rates of chronic disease (Nugent et al., 2019; Allen et al., 2020). Both orthodox and traditional health promotion remain highly relevant in responding to what has been described as a 'triple burden of diseases', comprising communicable diseases, newly emerging and re-emerging infections, and the rapid rise of non-communicable chronic diseases (Mendenhall et al., 2020; Singer et al., 2021).

Health promotion efforts must target both individual and community levels, strengthen health systems, and foster multi-sectoral partnerships. A settings-based approach targeting schools, hospitals, workplaces, and residential areas has also been recommended (de Leeuw et al., 2020; Tsouros, 2020). When integrated into all relevant policies and implemented effectively, health promotion leads to positive health outcomes. Many nations, including Nigeria, have developed health care policies specifically aimed at maintaining and improving the health status of their populations (Masters et al., 2019; McDaid et al., 2020).

Nigeria's Federal Ministry of Health describes the national health policy as being 'based on the philosophy of social justice and equity', with the goal of preventing, treating, and managing illness while promoting the mental and physical wellbeing of citizens through qualified health personnel (Aregbeshola & Khan, 2018; Oleribe et al., 2020). This policy is broadly consistent with Nigeria's traditional healing system, which predates orthodox medical practice. Before the introduction of Western medicine, traditional healers were entirely responsible for healthcare delivery, and people relied on them based on their knowledge of local environments and remedies (Edet, Bello, & Babajide, 2019).

The traditional healthcare system continues to thrive not only in rural areas where more than 70% of the population lives but also in urban centres that have greater access to orthodox medical services (James et al., 2019; Waweru et al., 2020). Traditional healthcare is affordable, accessible, and regarded as effective by its users. Today, Nigeria operates a dual healthcare system: the officially recognised orthodox system and the informally tolerated traditional system (Nwankwo, 2023). Achieving the goal of the national health policy to harness all available resources for healthcare requires collaboration rather than competition between the two systems, and calls for their integration have been growing (WHO, 2019, 2023).

Health promotion involves both individuals and communities in health decision-making, and it recognises the role of policymakers, since people who value their health are more likely to support adequate resource allocation for health (Nutbeam, 2020). The media play a central role in this process. Velasco, Slusser and Coats (2022) argue that health education is essential for helping the public internalise appropriate health information and translate it into behaviour. Health behaviour is largely determined by the information available to individuals. Despite the government's efforts through the National Health Policy, Aliyu, Mustapha and Garun Danga (2024) note that the communication design process for health promotion in Nigeria remained weak.

Against this background, this study set out to: (a) examine residents' exposure to orthodox and traditional health promotion messages in Offa; (b) assess the influence of these messages on residents' health decisions; and (c) identify residents' preferences between orthodox and traditional health promotion and the reasons behind those preferences.

2. Literature Review

The Concept of Health Promotion

According to WHO (2024), health promotion involves individuals and communities in making decisions about their health, and it takes into account the role of policymakers. According to the WHO (1986) in the Ottawa Charter for Health Promotion, health promotion is the process through which people gain greater control over, and improve, their health. Contemporary scholars emphasise that health promotion has continued to evolve in response to complex 21st-century challenges, including rising rates of non-communicable diseases and persistent health inequities (Baum et al., 2019; Golden et al., 2020). To achieve complete physical, mental, and social wellbeing, individuals and groups must be able to identify their aspirations, meet their needs, and either change or adapt to their environment. Health, therefore, is understood not as an end in itself, but as a resource for everyday living. Recent scholarship reinforces the need for health promotion to address the broader social determinants and structural factors that shape health outcomes across different populations (Pelikan et al., 2018; Warwick-Booth et al., 2021).

One of the earliest and most widely cited definitions of health promotion, used by the American Journal of Health Promotion from at least 1986, describes

it as the science and art of helping people change their lifestyles toward a state of optimal health. This definition has since been expanded to incorporate digital health technologies and community-based participatory approaches that now characterise modern health promotion practice (Nutbeam & Muscat, 2021). Digital platforms and social media are increasingly being used to extend the reach and engagement of health promotion efforts (Gabarron et al., 2018; Stellefson et al., 2020).

The 1979 Healthy People report by the United States Surgeon General defined health promotion as efforts directed at developing community and individual measures that help people adopt lifestyles capable of maintaining and enhancing their wellbeing. Building on this, more recent health promotion frameworks place particular emphasis on health literacy, empowerment, and equity as essential conditions for achieving sustainable health outcomes (Sentell et al., 2020; Van den Broucke, 2020).

The WHO and its partners have co-sponsored a series of international conferences on health promotion. The first of these, held in Ottawa in 1986, produced the Ottawa Charter for Health Promotion, which stated that health promotion is not solely the responsibility of the health sector but goes beyond healthy lifestyles to encompass overall wellbeing, and that it involves making political, economic, social, cultural, environmental, behavioural, and biological factors favourable to health through advocacy. Subsequent studies have confirmed that these principles remain foundational to effective health promotion, though implementation strategies have evolved to address contemporary challenges such as climate change, migration, and digital inequality (Tsouros & Green, 2019; McQueen et al., 2021).

The Nigerian government has demonstrated commitment to improving the health of its citizens and has recognised health promotion as a rapidly growing area of health development. Evidence indicates that health promotion makes a meaningful contribution to improving human health (Velasco, Slusser and Coats, 2022). According to Olanrewaju et al. (2019) and Adebayo et al. (2020), new demographic trends, urbanisation, and changing lifestyles have introduced risk factors with significant health implications. Research from around the world provides compelling evidence that health promotion strategies can effectively address these risk factors and support health equity (Magnusson & Corin, 2019; Ndejjo et al., 2020). Health education is central to health promotion, but legal, fiscal, economic, and environmental measures are equally important (Sriram & Ranganathan, 2019).

According to the WHO (1986) in the Ottawa Charter, the fundamental conditions necessary for health include peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice, and equity. Contemporary research emphasises that these conditions are increasingly threatened by climate change, conflict, and growing inequality, making renewed advocacy and action essential (Haines & Ebi, 2019). Health promotion also strives to achieve equity by reducing disparities in health status and ensuring equal access to opportunities and resources, acknowledging that structural racism, economic inequality, and unequal access to resources underlie many health inequities (Braveman & Gottlieb, 2014; Marmot & Allen, 2020). Based on this, people cannot fully realise their health potential unless they have control over the factors that determine their health (Nutbeam, 2020).

The Nigerian Health Promotion Policy, outlined in Federal Ministry of Health (FMoH) documents from 2005 and 2019, uses the term 'Health Promotion' in its broadest sense. Assessments of Nigeria's health promotion efforts highlight both progress and ongoing challenges, including resource constraints, implementation gaps, and coordination difficulties (Adebayo et al., 2021; Ogundele et al., 2020).

Orthodox and Traditional Health Promotion

Available literature shows that researchers have examined orthodox and traditional health promotion within the broader context of old and modern approaches to human health challenges (Abdullahi, 2021; Idowu, (2025). In Nigeria, mass media are used either independently or in combination in health promotion activities to bring about positive lifestyle changes (Abdullahi, 2022). Abdullahi (2022) further argued that though orthodox and traditional health promotion are rooted in different knowledge systems, they increasingly converge in user-driven health conversations intensified through both old and new media, framing wellbeing within a historical and cultural continuity. Contemporary scholars stress the importance of integrating traditional and complementary medicine into national health systems, while ensuring safety, effectiveness, and quality (James et al., 2019; WHO, 2019, 2023). According to Sutton and Kuhlmann (2021), health media conversations mediate

a biopolitical rationality that allows the discursive co-evolution of both health paradigms.

The WHO's concern about patient access to health services and increased awareness of health promotion and disease prevention (WHO, 2025) created an environment in which both orthodox and traditional approaches delivered through formal and informal channels such as radio, television, newspapers, hospitals, clinics, outreach programmes, and pamphlets became more inclusive and integrated. Recent WHO reports estimate that traditional medicine is now used by approximately 88% of member states, with growing recognition of its role in achieving Universal Health Coverage (WHO, 2023).

According to WHO (2019, 2025), promoting both orthodox and traditional health practices requires a multifaceted approach that integrates modern medical systems with indigenous knowledge. To this regards, Olaoye and Onyenankeya (2023) recommended communication strategies include community engagement, workshops and seminars, cultural events, public health campaigns, social media, radio and television programmes, and podcasts and blogs. Recent evidence confirms the effectiveness of culturally adapted health promotion interventions that incorporate traditional healing practices and community engagement (Napier et al., 2019; Waweru et al., 2020). These strategies are complemented by policy advocacy, institutional support, and training aimed at integrating traditional medicine into public healthcare systems.

Ibrahim and AhmedOlaitan (2022) observed that the traditional healthcare system has long thrived not only in rural areas but also in urban centres with ready access to orthodox healthcare. Recent studies confirm that traditional medicine use remains widespread across both urban and rural settings in Nigeria, influenced by factors such as cultural beliefs, affordability, and physical accessibility (Ezeome & Simon, 2019; Abdullahi et al., 2021). The significant informal synergy between the two healthcare systems highlights the need for their formal integration. The Offa community, which forms the population of this study, has access to both systems, making it an appropriate setting for examining the effects of both orthodox and traditional health promotion.

Critical Issues Concerning Health Promotion

Scholars in health and related fields have identified several weaknesses that limit the ability of health systems to carry out health promotion effectively. Systematic reviews have confirmed that implementation challenges persist across low- and middle-income countries, including Nigeria (Amzat & Razum, 2018; Odusanya et al., 2020). Velasco, Slusser and Coats (2022) identify a number of these weaknesses, including poor understanding of health promotion concepts, consumer rights, and the need for multi-sectoral action; inconsistent and largely ad hoc implementation of health education across the three tiers of government; weak communication design; and the rare practice of conducting audience analysis before initiating health communication activities. Contemporary research confirms that these challenges continue, with additional barriers such as inadequate digital infrastructure and the limited integration of traditional medicine into formal health systems (Uzochukwu et al., 2020).

According to the Federal Ministry of Health (FMoH) documents from 2005 and 2019, other weaknesses include the failure to pre-test educational materials, poor communication skills among many health educators, and the absence of programmes designed to build capacity at the community level. Community participation in health talks, meetings, and other health-related events also remains limited. Studies on health communication in Nigeria have revealed gaps in audience segmentation, message framing, and the evaluation of health communication outcomes (Ajayi et al., 2019; Okoro & Odoemelam, 2022). Velasco, Slusser and Coats (2022) further note that many health educators lack the key skills needed to communicate effectively and encourage community participation. Additional problems include the absence of frameworks or guidelines for planning and managing health education interventions, the lack of clear mechanisms for monitoring and evaluating health communication activities, and the mistaken perception that health education and health promotion are the exclusive responsibility of the Ministry of Health, a view that prevents the mobilisation of health promotion resources from other line ministries (Akinyemi et al., 2021). Poor coordination among organisations involved in health promotion, strained relationships between health education units at federal, state, and local government levels and the many NGOs and private sector actors working in health, and insufficient government funding for health promotion activities compound these challenges (Oleribe et al., 2020).

Despite these weaknesses, a number of strengths and opportunities exist that can be built upon to improve the health system's capacity for health promotion. Velasco, Slusser and Coats (2022) identify key

opportunities, including the government's sustained commitment to health sector reform, the development of new health policies and legislation that include health promotion among designated priorities, and growing public concern about the quality of health services and the need to uphold consumer rights in healthcare. Recent developments reinforce these opportunities, including increased investment in primary health care, the expansion of community health insurance schemes, and greater recognition of health promotion's role in achieving Universal Health Coverage (Aregbeshola & Khan, 2018; Uzochukwu et al., 2020). The FMoH also notes that the presence of numerous NGOs in Nigeria strengthens health communication efforts through their skills and expertise. Evidence from Nigeria and other countries demonstrates that well-planned health promotion can bring about positive behaviour change and improve citizens' health outcomes. Velasco, Slusser and Coats (2022) further point to a vibrant press that provides extensive coverage of health issues and the widespread use of national and state-level mass media networks for health promotion. The growing use of mobile technology and social media platforms presents new and significant opportunities for health promotion, though challenges related to misinformation and digital literacy remain (Tagbo et al., 2019). Nigeria's active engagement in international health promotion initiatives, such as the Framework Convention on Tobacco Control and ongoing efforts to strengthen health promotion structures at all levels of government represent additional areas of opportunity.

Approaches to Health Promotion

Several approaches have been identified in the health promotion literature. Abdullahi (2022) describes two broad approaches: individual and collective. Aliyu at al., (2024) further break these down into four: individual, group, general population, and community development approaches. Recent frameworks also emphasise ecological and systems-based approaches, which recognise the complex interplay of individual, interpersonal, organisational, community, and policy factors in shaping health outcomes (Rütten et al., 2019; Golden & Earp, 2020).

The individually focused approach, as described by Velasco et al., (2022) targets the individual, either through authoritative guidance by experts or through negotiated techniques such as education and counselling. Much traditional health education falls within this approach, grounded in the philosophy that individuals bear primary responsibility for their own health. However, this approach has been criticised for failing to account for the structural constraints that shape people's lives (McLaren & McIntyre, 2018; Baum & Fisher, 2019). Aliyu at al., (2024) consider this approach the foundation of health promotion, noting that its one-to-one, face-to-face nature allows for deeper interaction, and that it is generally associated with secondary or tertiary prevention.

The collectively focused approach targets communities and includes both authoritative and negotiated strategies (Velasco et al., 2022). It encompasses services such as immunisation and screening, as well as broader social policy initiatives ranging from tobacco control to housing provision. Recent applications include policy interventions targeting food environments, active transportation, and climate change mitigation (Frieden, 2018; Swinburn et al., 2019). In both cases, authority rests with experts, such as doctors and policymakers who are seen as possessing specialised knowledge.

The group approach, as explained by Aliyu at al., (2024) offers a middle ground between one-to-one and mass media approaches. Groups vary widely in size and composition and can employ didactic methods such as lectures and seminars, or experiential methods such as skills training and simulation. Recent innovations include peer-led interventions and digital support groups that leverage group dynamics for behaviour change (Maher et al., 2020; Penedo et al., 2020). Health educators use group methods to empower individuals and communities by building health-related attitudes, providing support for shared goals, and facilitating community organisation and social change.

The general population approach is strongly linked to the effects of mass media, advertising, and marketing. Mass media can raise awareness of health issues, position health on the public agenda, convey straightforward information, and together with other enabling factors facilitate behaviour change. This approach works best as part of an integrated campaign that includes one-to-one components (Naugle & Hornik, 2018; Wakefield et al., 2020). However, as Abdullahi (2022) notes, media alone cannot effectively convey complex information, teach skills, or change deeply held attitudes. If messages challenge core beliefs, they are likely to be ignored or reinterpreted (Southwell et al., 2018; Niederdeppe, 2019). Mass media are therefore, most effective when the goal is to reach a wide audience, raise awareness,

stimulate public discussion, or support already ongoing community activities.

The Health Belief Model (HBM)

The Health Belief Model (HBM) provides an appropriate theoretical framework for understanding how residents of Offa make health decisions in response to orthodox and traditional health promotion messages. The model was developed by Becker (1984) and proposes that health behaviour is shaped by individuals' perceptions of health threats and the benefits of taking action (Carpenter, 2020; Jones et al., 2021). It comprises six core constructs:

Perceived Susceptibility: An individual's assessment of their personal risk of developing a health problem.

Perceived Severity: Beliefs about how serious the health condition is and what consequences it could have.

Perceived Benefits: Beliefs about the effectiveness of taking a particular health action.

Perceived Barriers: Perceived obstacles to taking the recommended health action.

Cues to Action: Triggers that prompt individuals to adopt health behaviours, such as media messages or advice from health workers.

Self-Efficacy: Confidence in one's own ability to take the recommended health action.

Applied to this study, exposure to both orthodox and traditional health promotion messages function as a cue to action, raising awareness and motivating residents to adopt preventive behaviours or seek treatment. Orthodox health messages tend to heighten perceived susceptibility and severity by drawing on scientific evidence and statistical risk data, while traditional health messages appeal to cultural values, community trust, and accessibility, thereby enhancing perceived benefits and reducing perceived barriers. The HBM thus provides a useful lens for understanding how psychological and cultural factors interact to influence health decisions in the Offa community.

3. Material and Method

This cross-sectional study was conducted in the Offa community of Kwara State to examine the effects of orthodox and traditional health promotion on residents' health decisions. A quantitative research approach was adopted, using a structured questionnaire developed on a Likert scale to measure exposure to orthodox and traditional health promotion messages, trust in these messages, and their influence on health decisions. The questionnaire also captured demographic information, including age, gender, educational level, and occupation. A total of 370 respondents participated in the study. Responses were numerically coded and entered into a structured dataset. The data were analysed using regression analysis to determine the strength and significance of the relationship between exposure to health messages and health decision-making.

4. Result and Discussion

This study analysed the impact of both traditional and orthodox health promotion messages on the health decisions of residents in the Offa community of Kwara State, taking into account Nigeria's 2005 and 2019 health promotion policies developed in collaboration with the WHO. Within less than two decades of policy implementation, a significant proportion of Offa residents reported benefiting from health promotion initiatives, with a stronger emphasis on orthodox medicine. The WHO's formal recognition of traditional healthcare systems supports their integration into health policy, a position that has been shown to be effective (WHO, 2019, 2023). This aligns with WHO's recent strategic framework emphasising the integration of traditional and complementary medicine into universal health coverage, noting that 88% of member states now utilise such practices (WHO, 2023). The findings in this study demonstrate that residents of the Offa community were both exposed to and engaged with health promotion messages.

Table 1. Exposure to Health Messages

	Frequency	Percentage
Yes	370	100
No	0	0
Total	370	100

Table 1 shows that all 370 respondents (100%) had been exposed to health messages or promotions, with none reporting no exposure. This universal exposure reflects the wide reach of health communication in contemporary Nigerian society, consistent with findings by Aliyu, Mustapha and Garun Danga (2024) demonstrating widespread access to health messages through multiple media channels.

Table 2. Types of Health Promotion

Variable (N=370)	Frequency	Percentage
Traditional	27	7
Orthodox	55	15
Both	288	78
Total	370	100

Table 2 shows that most respondents were exposed to both types of health messages. Specifically, 7% (n=27) were exposed to traditional health messages only, 15% (n=55) were exposed to orthodox messages only, and 78% (n=288) were exposed to both. This pattern of dual exposure supports recent scholarship on medical pluralism in Nigeria, which shows that individuals frequently navigate between traditional and biomedical systems based on accessibility, affordability, and cultural familiarity (Peltzer & Pengpid, 2019; Waweru et al., 2020).

Table 3. Frequency of Exposure

Variable (N=370)	Frequency	Percentage
Everyday	55	15
Twice in a Week	88	24
Weekly	176	48
Anytime	51	14
Total	370	100

Table 3 shows that 48% of respondents accessed health promotion messages weekly and 24% did so twice a week, indicating regular and systematic engagement with health information. This is consistent with research by Tagbo et al. (2019) and Stellefson et al. (2020), which found that structured health programming through radio and community channels supports sustained exposure and message reinforcement. Such consistent exposure is critical for behaviour change, as health communication theories stress that repeated message exposure is necessary for knowledge acquisition, attitude formation, and behavioural adoption (Southwell et al., 2018; Wakefield et al., 2020).

Table 4. Effect of Health Promotion on Health Decisions

Variable (N=370)	Frequency	Percentage
Yes	370	100
No	0	0
Indifferent	0	0
Total	370	100

The finding that all 370 respondents (100%) acknowledged that health promotion influenced their health decisions (Table 4) provides compelling evidence that both orthodox and traditional health messages effectively serve as cues to action, a central construct of the HBM. The model proposes that individuals are more likely to adopt health behaviours when they perceive themselves as susceptible to health risks, believe the consequences are serious, recognise the benefits of taking action, and receive clear triggers that prompt behavioural change. The universal agreement among respondents suggests that health messages disseminated through radio, hospitals, and community channels successfully heighten perceived susceptibility, reinforce perceived severity, and strengthen perceived benefits of preventive behaviour. This is consistent with contemporary studies showing that well-designed health messages enhance self-efficacy and motivate informed health decisions when cues to action are consistently available (Abdullahi, 2022).

Table 5. Medium through Which Health Promotion Messages Were Received

Variable (N=370)	Frequency	Percentage
Radio	205	55
Television	15	4
Newspaper/Magazine	6	2
Hospital	80	22
Schools	18	5
Workplace	10	3
Family/Friends	30	8
All of the above	6	2
Total	370	100

Radio was the most frequently cited medium (55%), confirming its continued relevance in Nigerian communities, particularly where literacy levels vary and access to digital technologies is uneven. Studies confirm radio's effectiveness for health promotion in similar contexts, attributed to its accessibility, low cost, and cultural appropriateness (Naugle & Hornik, 2018; Okoro & Odoemelam, 2022). Hospitals were the second most common channel (22%), reflecting the importance of healthcare settings for health education, consistent with research on settings-based health promotion approaches (de Leeuw et al., 2020; Tsouros, 2020).

Table 6. Reaction to Health Promotion Messages

Variable (N=370)	Frequency	Percentage
Positively	326	88
Negatively	14	4
Mixed Feeling	30	8
Total	370	100

The majority of respondents (88%) reacted positively to health messages (Table 6), suggesting that the messages were well-designed and appropriately framed, consistent with health communication principles that stress culturally relevant, actionable messaging (Southwell et al., 2018; Stellefson et al., 2020). This high acceptance rate reflects the perceived credibility and relevance of both orthodox and traditional health promotion approaches, suggesting that integrated strategies drawing on both paradigms can achieve wide acceptance (Napier et al., 2019; WHO, 2023).

Table 7. Perception of Orthodox Health Messages as More Educative

Variable (N=370)	No of Respondents	Percentage (%)
Yes	355	96
No	15	4
Total	370	100

The finding that 96% of respondents perceived orthodox health messages as more educative than traditional ones (Table 7) reflects the credibility and authority associated with biomedical knowledge systems, consistent with research on the persuasive power of scientific framing and institutional endorsement in health communication (Hendriks et al., 2020; Nutbeam & Muscat, 2021). This perception may be linked to the structured, evidence-based nature of orthodox health promotion, which typically draws on scientific explanations, statistical data, and professional endorsements (Robinson et al., 2020). Importantly, however, this does not diminish the continued relevance of traditional health promotion, as evidenced by the high utilisation rates and positive responses reported above.

Table 8. Reasons for Preferring Orthodox Health Promotion

Variable (N=370)	Frequency	Percentage
Professionalism	24	6
Accessibility	56	15
Reliability	60	16
All of the above	230	62
Total	370	100

The preference for orthodox health promotion based on professionalism, accessibility, and reliability (Table 8) aligns with contemporary research demonstrating that perceived source credibility significantly influences message acceptance and intention to act (Robinson et al., 2020; Sorensen, 2025). The emphasis on professionalism reflects the growing standardisation and regulation of healthcare, while accessibility may relate to recent expansions in primary healthcare infrastructure (Aregbeshola & Khan, 2018; Uzochukwu et al., 2020).

Simple and Multiple Linear Regression Results

Table 9. Impact of Orthodox Health Promotion on Health Decisions

Variables	B	SE	β	T	P
Constant	-.342	.131	-	-2.599	.010*
HDs	.532	.002	.997	263.456	.001*

F (1, 368) = 69409.092, R^2 = .995, Adj.R^2 = .995, P = .001. Dependent Variable: Health Decisions (HDs). OHP = Orthodox Health Promotion.

Table 9 shows that orthodox health promotion has a very strong and statistically significant influence on health decisions ($R^2 = .995$, $\beta = .997$, $p = .001$). Within the HBM framework, this indicates that orthodox messages effectively shape residents' perceived susceptibility, perceived severity, and perceived benefits of health action. The high coefficient suggests that professionally delivered, evidence-based messages build trust and increase self-efficacy, making individuals more confident in adopting recommended behaviours. This strong effect reflects how orthodox health promotion serves as a powerful cue to action that motivates Offa residents to make informed health decisions (Abdullahi, 2022).

Table 10. Impact of Traditional Health Promotion on Health Decisions

Variables	B	SE	β	T	P
Constant	-5.46	0.171	-	-32.025	.001*
THP	0.314	0.003	0.987	119.801	.001*

F (1, 368) = 14352.248, R^2 = .975, Adj.R^2 = .975, P = .001. Dependent Variable: Health Decisions (HDs). THP = Traditional Health Promotion.

A simple linear regression was also conducted to test the impact of traditional health promotion (THP) on health decisions (Table 10). The results show that THP explains 97.5% of the variance in health decisions (R^2 = .975, p = .001), with a strong positive standardised coefficient (β = .987, t = 119.801, p = .001). These findings confirm that THP significantly and positively influences health decisions, indicating that increasing traditional health promotion is associated with improved health decision-making. The strength of this finding challenges any assumption that traditional health messaging is ineffective, and instead provides empirical support for the continued relevance of culturally embedded health practices in contemporary Nigerian communities (James et al., 2019; Napier et al., 2019; Firenzuoli et al., 2021). The strong effect of THP reflects the deep cultural roots and community trust associated with traditional healing, which the WHO (2023) recognises as an essential component of person-centred, integrated health services.

Table 11. Combined Effect of Orthodox and Traditional Health Promotion on Health Decisions

Variables	B	SE	β	T	P
(Constant)	5.275	.238	-	22.141	.001*
OHP	1.369	.022	.731	63.386	.001*
THP	.856	.036	.272	23.622	.001*

F (1, 368) = 87513.837, R^2 = .998, Adj.R^2 = .998, P = .001. Dependent Variable: Health Decisions (HDs). OHP = Orthodox Health Promotion, THP = Traditional Health Promotion.

Table 11 presents the results of a multiple linear regression testing the combined effect of OHP and THP on health decisions. Together, the two variables account for 99.8% of the variance in health decisions (R^2 = .998, p = .001), with both predictors making statistically significant and positive contributions. OHP showed a stronger standardised effect (β = .731, t = 63.386, p = .001) compared to THP (β = .272, t = 23.622, p = .001). These findings demonstrate that OHP and THP are complementary rather than competing, supporting recent scholarship advocating for integrative approaches that draw on the strengths of both systems (Peltzer & Pengpid, 2019; WHO, 2019, 2023). The greater influence of OHP is consistent with research on the persuasive power of evidence-based, scientifically framed health messages across diverse cultural settings (Hendriks et al., 2020; Sorensen, 2025). However, the significant independent contribution of THP underscores the importance of culturally relevant messaging and the value of incorporating traditional knowledge systems into comprehensive health promotion strategies (McElfish et al., 2018; Wallerstein et al., 2020).

Across all regression models, the exceptionally high R^2 values (ranging from .975 to .998) indicate that both OHP and THP are highly predictive of health decisions, suggesting that health choices are deeply influenced by health promotion strategies, whether orthodox or traditional. While OHP has a slightly stronger influence, particularly when both are considered together THP makes a meaningful additional contribution, particularly through its cultural relevance and community reach. The combined results confirm that OHP and THP are not mutually exclusive but rather work together in shaping health decisions, with OHP providing structured, scientific guidance and THP enhancing reach and cultural acceptability, especially in communities with strong traditional ties.

5. Conclusion and Recommendation

The study provides clear empirical evidence that both Orthodox Health Promotion (OHP) and Traditional Health Promotion (THP) significantly influence health decisions among residents of Offa, Kwara State, with OHP having a slightly stronger effect. Regression analyses show that OHP explains 99.5% of the variance in health decisions (R^2 = .995, β = .997, p = .001), while THP accounts for 97.5% (R^2 = .975, β = .987, p = .001). When combined, both predictors jointly explain 99.8% of the variance (R^2 = .998, p = .001), with OHP (β = .731) exerting greater influence than THP (β = .272). These findings affirm the Health Belief Model's proposition that individuals are more likely to adopt health behaviours when messages effectively shape their perceived susceptibility, perceived severity, perceived benefits, and self-efficacy, reinforced by clear cues to action. The universal

exposure to health messages (100%), widespread dual exposure to both types (78%), and overwhelmingly positive reception (88%) demonstrate that health promotion has deeply reached the Offa community. The study concludes that integrating evidence-based orthodox communication with culturally grounded traditional practices offers the most effective pathway for improving public health outcomes, in line with WHO's call for strengthened collaboration between conventional and traditional health systems (WHO, 2023).

Based on the study's findings, the following recommendations are proposed: Government at all levels, health policymakers, and public health practitioners should adopt integrated health promotion strategies that combine orthodox and traditional health messaging to maximise population reach and impact. Given that radio was the most widely used medium for health promotion (55%), followed by hospitals (22%), government and health communication agencies should invest in sustained radio-based health programming and develop multi-channel, integrated communication strategies. To address persistent weaknesses in health promotion implementation, including inadequate formative research, lack of pre-tested materials, insufficient training for health educators, and weak evaluation systems, government, academic institutions, and development partners should invest in comprehensive capacity building at all levels.

While this study offers valuable insights, the exceptionally high R^2 values call for further investigation using more refined methodologies. Future studies should employ longitudinal or experimental designs to establish causal directionality between health promotion exposure and actual health outcomes beyond self-reported decision-making. They should also use more diverse sampling techniques across multiple communities to improve generalisability, and examine moderating variables such as socioeconomic status, educational level, and health literacy.

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