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The Role of Traditional Leaders in Enhancing Healthcare Acceptance and Delivery in Shagari Local Government Area, Sokoto State

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ABSTRACT

Healthcare acceptance and delivery in many communities are strongly influenced by sociocultural factors and local leadership structures. Traditional leaders play a crucial role in shaping health behaviors and promoting trust in healthcare services. This study assesses the role of traditional leaders in enhancing healthcare acceptance and delivery in the Shagari Local Government Area of Sokoto State. A descriptive cross-sectional survey design was employed. The population comprised traditional leaders and community household heads in Shagari LGA. A total of 422 respondents were targeted and selected through census and multistage sampling techniques, respectively. Data were collected using two sets of structured questionnaires and analyzed using descriptive statistics. The findings revealed that traditional leaders play a significant role in healthcare acceptance by mobilizing communities, advocating, and leveraging cultural authority to promote health programs. However, they face challenges including inadequate healthcare infrastructure, a shortage of medical personnel, and limited government support. The majority of community members perceived traditional leaders positively and exhibited strong trust in their health-related guidance. The study concludes that traditional leaders serve as effective intermediaries between modern health systems and local communities, with their influence rooted in cultural legitimacy and trust. Strengthening this partnership will enhance healthcare access and delivery in rural areas such as Shagari LGA.

INTRODUCTION

Globally, traditional leadership has been essential to governance, dispute resolution, and community growth, evolving amid ongoing political, economic, and societal transformations. Even though modern governance frameworks have superseded numerous conventional ruling bodies, traditional leaders still influence local decision-making in regions where they retain their perceived legitimacy. In many parts of Asia and Latin America, native leadership structures continue to serve as mediators between governments and rural communities, notably in managing land and social support programs (Bhoyar *et al.,* 2025). In a similar vein, across Africa, traditional leadership remains highly regarded, with local chiefs, kings, and respected council members playing critical roles in both public administration and the preservation of cultural heritage (Malicse, 2024).

In many African nations, traditional leaders play a vital role in administration, conflict resolution, and public health. Frequently, they are the primary guardians of a community's cultural legacy and overall prosperity, serving to bridge the gap between the government and local residents (Eze *et al.,* 2025). In Nigeria, traditional leaders derive their authority from pre-colonial governance systems, and even though they no longer hold official political jurisdiction, their persuasive power remains strong, especially in rural societies. Research indicates that traditional leaders continue to influence healthcare decisions, promote immunization campaigns, and advocate for maternal health services (Belaid *et al.,* 2024). Their capacity to rally communities establishes them as significant participants in public health initiatives focused on addressing disparities in healthcare access in neglected areas.

In northern Nigeria, especially among the Hausa-Fulani ethnic groups, traditional monarchs exercise authority through both cultural norms and religious institutions. They participate in conventional councils and Islamic bodies, where they manage local administration under the guidance of state governments. Their joint role as political figures and religious authorities empowers them to significantly shape attitudes toward healthcare, vaccine acceptance, and reproductive health decisions (Ofurum *et al.,* 2024). This form of leadership is frequently employed by policymakers and healthcare organizations to advance initiatives focused on disease prevention and the promotion of preventive healthcare behaviors. However, the lack of formal medical training among certain traditional leaders occasionally contributes to the spread of inaccurate information, creating difficulties in implementing healthcare practices in less-developed regions.

Similarly, in 2022, the World Bank emphasizes that the vast majority, 70%, of Nigerian medical facilities are clustered in urban locales, thereby restricting accessibility to vital services for rural inhabitants, such as those within Shagari LGA. Further complicating this situation, the National Primary Health Care Development Agency (NPHCDA, 2020) reports that 40% of basic healthcare facilities in rural regions lack fundamental resources such as electricity, potable water, and properly functioning

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equipment, thereby diminishing their capacity to deliver quality healthcare.

The difficulties mentioned above are intensified by cultural obstacles and logistical limitations. For example, the UNICEF Multiple Indicator Cluster Survey (UNICEF MICS, 2021) shows that a substantial proportion, 65%, of rural women identify the distance to healthcare facilities as a crucial impediment to obtaining healthcare, an issue amplified in particular sectors of Shagari LGA because of economic hardship, substandard road conditions, and insufficient transportation options.

Within this framework, traditional leaders also play a pivotal role in bridging contemporary medical practices and conventional indigenous healthcare approaches. Their involvement in health awareness initiatives has demonstrated effectiveness in improving societal engagement in maternal healthcare services and immunization efforts (Eze *et al.,* 2025). Studies suggest that medical treatments endorsed by traditional leaders tend to achieve higher acceptance rates, as community members perceive their advice as reliable and attuned to cultural values (Belaid *et al.,* 2024). Nevertheless, despite their valuable input, certain traditional leaders continue to advocate for the use of herbal medicine, including unconventional therapeutic methods, over contemporary healthcare, thereby contributing to delayed medical interventions and reduced rates of healthcare service utilization.

This research investigates how their hidden capabilities could be leveraged to alleviate the ongoing challenges highlighted in national and local health reports. There is a lack of knowledge of the precise methods by which these leaders influence the delivery and reception of healthcare in Shagari LGA.

LITERATURE REVIEW

Previous studies were reviewed to provide an extensive overview of academic literature examining the role of traditional leaders in shaping healthcare adoption and service delivery, with particular attention to rural areas such as the Shagari Local Government Area (LGA) in Nigeria's Sokoto State. A thorough and well-organized investigation of the literature was conducted from January to May in 2025, focusing on academic sources directly relevant to the aims of this research. Research consistently demonstrates that their engagement in efforts such as vaccination drives, advocacy for maternal health, and disease prevention programs boosts community involvement.

An investigation by Adewuyi *et al.,* in 2024, delved into how traditional and religious leaders affect the acceptance of Caesarean Sections (CS) within Nigeria. Data from the 2023 Nigeria Demographic and Health Survey (NDHS) were used to analyze information from 33,924 women across all six of Nigeria's geopolitical zones. Results indicated greater acceptance of CS in communities where traditional leaders actively supported hospital births, whereas resistance was more prominent in communities where leaders favored conventional birthing methods. Women residing in northern Nigerian states (Kano, Sokoto, and Katsina) showed a lower inclination to accept CS than those in southwestern states (Lagos, Oyo, and Ekiti), where traditional leaders worked alongside healthcare experts (NDHS, 2024).

Similarly, Mohammed & Nwaze (2020) explored the contributions of traditional leaders to the campaign to eradicate polio in Nigeria, focusing on Borno, Yobe, and Zamfara states, which initially showed high resistance to vaccines. The research involved conducting structured interviews with 30 traditional rulers and distributing surveys to 600 community participants. Findings revealed that immunization rates rose by 35% in areas where traditional rulers actively promoted vaccination, compared with areas where leaders remained impartial. A related investigation by Oteri & Dip (2022) examined the measles vaccination campaign in Northern Nigeria, particularly in the states of Jigawa, Bauchi, and Niger. Through a case study analysis of government health records and 1,200 household surveys, the research found that measles vaccination rates increased by 40% in areas where traditional rulers participated in health promotion. A study by Adedini *et al.* (2023) examined the difficulties faced by traditional and religious figures in promoting the use of contraception in Nigeria, concentrating on the states of Lagos and Kano. The research involved surveying 800 individuals, including traditional rulers, religious authorities, and women of childbearing age. Results indicated that traditional leaders who supported contraception encountered opposition from conservative community members, which resulted in a 20% decrease in the adoption rate of family planning services compared to regions where leaders remained neutral.

Adeleke (2024) conducted a study on the impact of traditional leaders on the implementation of healthcare policies in Nigeria, specifically in the states of Ekiti, Oyo, and Kaduna. Employing an ethnographic research method involving 50 interviews, the study revealed that many traditional leaders lacked formal health training, resulting in inaccurate information about modern medical treatments.

Akabuike *et al.* (2024) conducted research to understand rural Nigerian communities' views on the impact of traditional leaders in maternal healthcare. The methodology employed focused group discussions and the administration of structured questionnaires to 500 participants in Enugu and Ebonyi states. The research revealed that 78% of those surveyed placed greater trust in traditional leaders compared to government health professionals, although 40% of educated individuals doubted their knowledge of medical science. Also, Okeke *et al.* (2024) conducted an extended study in Nigeria that monitored the use of maternal healthcare services. This study followed 2,000 expectant mothers in Anambra, Ogun, and Plateau states over a two-year period. The data indicated that working with traditional leaders resulted in a 45% rise in the use of healthcare facilities, despite

ongoing worries about incorrect information provided by traditional birth attendants.

A study conducted by Adebayo & Ahonsi (2020) surveyed 500 individuals in rural Nigeria to assess community confidence in traditional leaders' ability to make healthcare choices. The results indicated that 68% of those surveyed had more confidence in traditional leaders than in government health personnel for guidance on vaccinations and medical treatments. The research determined that cultural impact and well-established community connections were the reasons for trusting traditional leaders. In a related vein, Mugisha & Muyinda (2021) conducted a qualitative study in Uganda, including detailed interviews with 30 individuals. The results indicated that 72% of those involved felt more at ease seeking healthcare advice from village elders rather than healthcare experts. Nevertheless, half of the respondents admitted that this trust occasionally led people to delay seeking contemporary medical attention, particularly when traditional leaders were reluctant to approve certain treatments. Additionally, Makwiza and associates (2021) found in a survey of 350 people in Malawi that 57% recognized traditional leaders as crucial in shaping attitudes toward seeking healthcare. Conversely, 32% of participants noted that some traditional leaders favored herbal treatments over contemporary medicine, resulting in inconsistent health advice within the community.

This study is guided by an integrated conceptual framework that combines the Health Belief Model (HBM) (Rosenstock, 1974) and the Theory of Planned Behavior (TPB) (Ajzen, 1991). The framework explains the pathways through which traditional leaders influence health-seeking behaviour in rural communities, providing a comprehensive model that accounts for both individual perceptions and socio-cultural determinants. The integrated framework positions traditional leaders as a critical exogenous variable. Their influence directly shapes the core constructs of both the HBM and the TPB. As demonstrated in prior research, traditional leaders act as powerful Cues to Action (HBM) and are instrumental in forming Subjective Norms (TPB), defined as a "person's perception of what most people who are important to (them) think" (Fishbein & Ajzen, 1975, p. 302). This is evidenced in contexts where leader endorsement creates strong communal expectations for health behaviours (Adebayo & Ahonsi, 2020; Mugisha & Muyinda, 2021).

Furthermore, traditional leaders shape risk perception by influencing Perceived Susceptibility and Perceived Severity (HBM), thereby elevating the overall perceived threat of a health condition. They also amplify Perceived Benefits and, crucially, help to reduce Perceived Barriers (HBM), such as mistrust or logistical fears, by legitimizing health services (Von Maltitz & Bahta, 2022). This reduction in barriers directly enhances an individual's Perceived Behavioral Control (TPB) "people's perception of the ease or difficulty of performing the behaviour of interest" (Ajzen, 1991, p. 188). These influenced constructs converge to form a stronger Behavioral Intention. According to the TPB, intention is a function of Attitude, Subjective Norm, and Perceived Behavioral Control (Ajzen, 1991). The model posits that a strong intention, when supported by high Perceived Behavioral Control, is the most direct predictor of the actual Health-Seeking Behaviour.

In summary, this integrated HBM-TPB framework provides a robust mechanism for analyzing the multifaceted role of traditional leadership. It elucidates how leaders bridge community structures and individual health decisions by simultaneously operating through the perceptual pathways of the HBM and the social-volitional pathways of the TPB.

MATERIALS AND METHODS

Study Settings and Study Population

This descriptive cross-sectional survey, using a quantitative approach, was conducted in Shagari LGA, Sokoto State, Nigeria, from December 2024 to October 2025. The target population consisted of individuals who play a direct role in healthcare decision-making in Shagari LGA. These are the traditional leaders (twenty-four (24) village heads (representing each major village) and three (3) district heads (higher traditional leaders) with community members (household heads).

Sample Size and Sampling

The sample for this study consisted of two distinct categories: traditional leaders and household heads (community members). Each group required a different sampling approach due to differences in population size and structure.

Traditional Leaders: A census method was used, in which every member of the population was included in the study. This included three district heads (representing Shagari, Dandin Mahe, and Sanyinnawal district) and twenty-four (24) village heads, one from each village in Shagari. The total sample size for traditional leaders was twenty-seven (27)

Household heads (Community Members): The sample size was determined using Taro Yamane's formula (Taro Yamane, 1967)

$n = N/1 + N(e)^2$

Where;

n = Sample size

N = Population size (33,333 household heads)

e = Margin of error (5% or 0.05)

n = 33,333/1 + 33,333(0.05)2

n = 33,333/1 + 33,333(0.0025)

n = 33,333/1 + 83.33

n = 33,333/84.33

n =395.

The final sample for the study was 422 respondents, comprising 27 traditional leaders and 395 household heads. This study employed a multi-stage (two-stage sampling) technique to ensure proper representation of both traditional leaders and household heads across Shagari Local Government Area.

In the first stage, a census method was used to select the traditional leaders. At the second stage, the selection of household heads (community members) was conducted using stratified and simple random sampling. First, all 24 villages in Shagari LGA were stratified into two categories based on estimated population size: three larger villages and twenty-one smaller villages. The sample was then distributed proportionately (Proportion ÷ Total Population Size × Sample Size) based on the estimated population of each village to ensure balanced and fair representation; simple random sampling was used to select household heads.

Data Collection Instruments

Two structured questionnaires were used as instruments for this study: one for traditional leaders and another for community members (household heads). Both instruments were adapted from validated tools used in similar studies.

Table 1: Breakdown of the sample allocation per village, proportion, and stratification category

SN	District	Village	Proportion	Sample per Village	Traditional Leader (S)
1.	Shagari	Shagari	4200	50	2
2.		Lambara	1300	15	1
3.		Gamgam	900	11	1
4.		Kajji	1700	21	1
5.		Mandera	1500	18	1
6.		Rugga	1100	13	1
7.		Aggur	1000	12	1
8.		G/Dan Gara	1050	12	1
9.		Lungu	1200	14	1
10.		Doruwa	1150	14	1
11.	Dandin Mahe	Dandin Mahe	3800	45	2
12.		Jaredi	1000	12	1
13.		Ginga	1080	13	1
14.		Mabera	1115	13	1
15.		Asarara	1050	12	1
16.		Kambama	1100	13	1
17.		Horo Birni	950	11	1
18.		Ruggar Mallam	860	10	1
19.		Horon Boro	900	11	1
20.		Sullubawa	850	10	1
21.	Sanyinnawal	Sanyinnawal	3000	36	2
22.		Karoga	950	11	1
23.		Bulanyaki	800	9	1
24.		Kalangu	778	9	1
	TOTAL	24 Villages	33,333	395	27 Traditional Leaders

The traditional leaders' questionnaire focused on their role in promoting healthcare acceptance and the challenges they face in healthcare delivery. It was adapted from existing instruments used by Mugisha and Muyinda (2021), who examined the influence of traditional leaders on maternal health services in Uganda, and Adebayo and Ahonsi (2020), who studied the impact of traditional rulers on healthcare acceptance in rural Nigeria. Additional adaptation was drawn from Von Maltitz and Bahta (2022), which highlighted indigenous leadership in public health mobilization. The household heads' questionnaire focused on community members' perception of and trust in traditional leaders as health influencers. It was adapted from studies of Adebayo and Ahonsi (2020) and Escuriet *et al.* (2023), which explored community trust in local leadership and their influence on modern healthcare utilization.

Face and content validity were conducted by presenting the instrument to academic experts in research methodology and public health. The items were reviewed in relation to the study objectives to assess whether the questions appear to measure the intended concept and ensure full coverage of the relevant construct. Recommendations and corrections were made where possible. A reliability analysis was conducted with 10% of the sample size for both questionnaires (40 and 3 questionnaires for community members and traditional leaders, respectively). Cronbach's Alpha was used as the reliability coefficient to assess how closely the set of items functioned as a group. The test was performed

using Statistical Package for the Social Sciences (SPSS) version 25.0. Reliability analysis was conducted for the different sections of the questionnaire corresponding to the study objectives. The overall reliability coefficient was 0.82, indicating a high level of internal consistency across all sections of the instruments. The detailed information and purpose of the research were clearly stated to the respondent, consent was ensured before administering the instrument, and their personal information remained anonymous throughout the process.

Data Analysis

The collected data were analyzed using descriptive statistics (which included frequency, mean, and standard deviation) to summarize the characteristics of respondents and general trends in healthcare acceptance, the role of traditional leaders, and the challenges faced in healthcare delivery. These statistics included frequencies, percentages, mean, and standard deviation, which were presented in a frequency distribution table.

RESULTS AND DISCUSSION

Results

This study presented an analysis of data collected through two sets of structured questionnaires administered to community members and traditional leaders in the Shagari local government area. Of the 27 traditional leaders identified in the sample, 20 questionnaires were administered, representing a response rate of 74.1%. Similarly, from a sample of 395 community members drawn from the 24 villages across the research settings, 316 (80%) valid responses were retrieved.

Table 2 above shows that the majority of respondents (88.6%) were aged 30 and above, with very few aged 21–

Table 2: Distribution of socio-demographic characteristics of the respondent (Community Members n= 316)

Variables	Frequency	Percentage (%)
Age		
15-20	0	0
21-26	6	1.9
26-30	30	9.5
30 and Above	280	88.6
Total	316	100
Tribe		
Hausa/Fulani	316	100
Igbo	0	0
Yoruba	0	0
Others	0	0
Total	316	100
Religion		
Islam	316	100
Christianity	0	0
Others	0	0
Total	316	100
Marital Status		
Single	0	0
Married	316	100
Others	0	0
Total	316	100
Educational Level		
No formal Education	175	55.4
Primary Education	54	17
Secondary Education	62	19.6
Tertiary Education	25	7.9
Total	316	100
Occupation		
Civil Servant	49	15.5
Business Man	97	30.7
Others	170	53.8

Total	316	100
Have used a health facility in the last 12 months		
Yes	278	87.9
No	38	12
Total	316	100

Source: Field Survey

30. All the respondents (100%) were of Hausa/Fulani ethnicity and practiced Islam. Every respondent was married, indicating a culturally uniform sample. More than half (55.4%) had no formal education, while only 7.9% had tertiary education. In terms of occupation, 53.8% fell into the "others" category, followed by business people (30.7%) and civil servants (15.5%). A large percentage (87.9%) had used a health facility in the last 12 months, indicating high recent healthcare utilization.

Table 3 above shows that all traditional leaders surveyed (100%) were over 30 years old, were Hausa/Fulani, were Muslim, and were married. Educational attainment

Table 3: Distribution of socio-demographic characteristics of the respondent (Traditional Leaders; n= 20)

Variables	**Frequency**	**Percentage (%)**
Age		
15-20	0	0
21-26	0	0
26-30	0	0
30 and Above	20	100
Total	20	100
Tribe		
Hausa/Fulani	20	100
Igbo	0	0
Yoruba	0	0
Others	0	0
Total	20	100
Religion		
Islam	20	20
Christianity	0	0
Others	0	0
Total	20	100
Marital Status		
Single	0	0
Married	20	100
Others	0	0
Total	20	100
Educational Level		
No formal Education	4	20
Primary Education	3	15
Secondary Education	8	40
Tertiary Education	5	25
Total	20	100
Occupation		
Civil Servant	4	20
Business Man	2	10
Farmer	14	70
Self Employed	0	0

Total	20	100
Position		
District Head	3	15
Village Head	17	85
Total	20	100
Years in Leadership		
Below 2 years	0	0
3-9	0	0
10-16	0	0
Above 16	20	100
Total	20	100

Source: Field Survey

varied, with the highest number having secondary education (40%), followed by tertiary education (25%). Most traditional leaders were farmers (70%), while a few were civil servants (20%) or businessmen (10%). Regarding their positions, 85% were village heads, and 15% were district heads. Notably, all had held leadership positions for more than 16 years, suggesting deep-rooted experience and authority in their communities.

Table 4 above indicates that traditional leaders play a significant role in healthcare promotion. Almost all respondents agreed with statements about their involvement. The highest mean score (4.80) was for

Table 4: Showing distribution of respondents on the specific role of traditional leaders in promoting healthcare acceptance (n=20)

S/N	Variables	SA	A	N	DA	SD	X	Sd (Std. Dev.)	Remark
1	I encourage residents to use health centers when they are ill.	16 (80%)	4 (20%)	0	0	0	4.80	0.41	Strongly Agree
2	I help spread government health messages in my community	15 (75%)	5 (25%)	0	0	0	4.75	0.44	Strongly Agree
3	I have supported immunization and antenatal care campaigns.	15 (75%)	5 (25%)	0	0	0	4.75	0.44	Strongly Agree
4	I attend health outreach events in my village	9 (45%)	6 (30%)	5 (25%)	0	0	4.20	0.83	Agree
5	Health workers always involve me in program planning.	10 (50%)	6 (30%)	4 (20%)	0	0	4.30	0.80	Agree
6	Always receive requests from villagers for health-related guidance.	6 (30%)	8 (40%)	5 (25%)	1 (5%)	0	3.95	0.91	Agree
	Aggregate Mean score						**4.46**		

Source: Field Survey

encouraging residents to use health centers. Other key roles included spreading government health messages (4.75), supporting immunization and antenatal care campaigns (4.75), and attending health outreach events (4.20). Although slightly lower, they also reported being involved in program planning (4.30) and receiving health-related requests from villagers (3.95), and with aggregate mean score of 4.46 indicating active engagement in health matters

Table 5 above shows that traditional leaders face several challenges in promoting healthcare. All respondents (100%) reported resistance from some community

Table 5: Showing the distribution of data on the challenges faced by traditional leaders in enhancing healthcare delivery (n=20)

SN	Variables	Frequency	Percentage (%)
1	Do you face resistance from some community members when promoting healthcare?		
	Yes	20	20
	No	0	0
	Total	**20**	**100**

2	Is there poor collaboration with health officers?		
	Yes	2	10
	No	18	90
	Total	**20**	**100**
3	Do cultural or religious values sometimes oppose medical recommendations?		
	Yes	12	60
	No	8	40
	Total	**20**	**100**
4	Are your health-related suggestions often ignored by authorities?		
	Yes	4	20
	No	16	80
	Total	**20**	**100**
5.	Do you receive any support or incentives for health promotion?		
	Yes	7	35
	No	13	65
	Total	**20**	**100**

Source: Field Survey

members. Cultural or religious values were seen as opposing medical recommendations by 60% of the respondents. However, most leaders did not experience poor collaboration with health officers (90%) or feel ignored by authorities (80%). Only 35% reported receiving any support or incentives for health promotion, showing a lack of motivation or structural backing.

Table 6 above shows that the community members generally have positive perceptions of traditional leaders' roles in healthcare. Mean scores for all items ranged from

Table 6: Showing the percentage, mean, and frequency distribution on the perception of community members in Shagari regarding the role of traditional leaders (SA=strongly agree, A=agree, N= neutral, DA= disagree, SD= strongly disagree, X= Mean and Sd= Standard Deviation) n=316

S/N	Variables	SA	A	N	DA	SD	X	Sd (Std. Dev.)	Remark
1	My traditional leader encourages people to visit health facilities.	80 (25.3%)	201 (63.6%)	30 (9.5%)	5 (1.6%)	0	4.13	0.63	Agree
2	I feel more confident attending clinics when encouraged by traditional leaders.	68 (21.5%)	186 (58.9%)	36 (11.4%)	26 (8.2%)	0	3.94	0.87	Agree
3	Traditional leaders support child immunization and maternal health	66 (20.9%)	230 (72.8%)	20 (6.3%)	0	0	4.14	0.52	Agree
4	Health programs endorsed by traditional leaders are well accepted.	61 (19.3%)	245 (77.5%)	10 (3.2%)	0	0	4.16	0.48	Agree
5	I believe traditional leaders understand local health challenges.	85 (26.9%)	211 (66.8%)	20 (6.3%)	0	0	4.21	0.53	Agree
6	My traditional leader's voice influences health decisions in the community.	128 (40.5%)	170 (53.8%)	18 (5.7)	0	0	4.35	0.59	Agree
	Aggregate Mean Score						**4.16**		**Agree**

Source: Field Survey

3.94 to 4.35, indicating agreement with the statements. Most respondents agreed that traditional leaders encouraged the use of health facilities (4.13), supported maternal health and immunization (4.14), and enhanced program acceptance (4.16). Notably, a high mean score of (4.35) and aggregate mean score of (4.16) showed

that many believed traditional leaders' voices influence health decisions, reflecting a high level of trust and respect.

Table 7 above shows that trust in traditional leaders was overwhelmingly high among community members. Almost all respondents (98.7%) trusted their leaders' health advice, and 94.3% would go to the hospital if advised to do so. Furthermore, 93.7% considered their traditional leaders more trustworthy than some health workers. The majority (90.5%) reported following traditional leaders' instructions, and all agreed (100%) that traditional leaders should be more involved in healthcare programs. Lastly, 87.9% stated that their trust in traditional leaders motivated them to use modern healthcare services.

Table 7: Showing the percentage and frequency distribution on the extent to which community members trust their traditional leaders regarding healthcare acceptance (n=316)

SN	Variables	Frequency	Percentage (%)
1.	Do you trust my traditional leader's health advice?		
	Yes	312	98.7
	No	4	1.3
	Total	**316**	**100**
2	Would you go to the hospital if your traditional leader advises you?		
	Yes	298	94.3
	No	18	5.7
	Total	**316**	**100**
3	Do you consider your traditional leaders more trustworthy than some health workers?		
	Yes	296	93.7
	No	20	6.3
	Total	**316**	**100**
4	I follow traditional leaders' instructions even in health matters.		
	Yes	286	90.5
	No	30	9.5
	Total	**316**	**100**
5	Traditional leaders should be more involved in healthcare programs.		
	Yes	316	100
	No	0	0
	Total	**316**	**100**
6	My trust in traditional leaders motivates me to use modern healthcare.		
	Yes	278	87.9
	No	38	12
	Total	**316**	**100**

Source: Field Survey

Discussion

This study revealed that traditional leaders play a critical role in promoting healthcare acceptance through community mobilization, advocacy, and the use of cultural authority to encourage participation in health programs, including immunization, maternal care, and hygiene practices. This is consistent with Adewuyi *et al.* (2024), who reported that acceptance of Caesarean Sections was significantly higher in communities where traditional leaders actively endorsed hospital-based childbirth. Similarly, Mohammed & Nwaze (2020) and Oteri & Dip (2022) found that immunization rates improved when traditional rulers publicly supported vaccination campaigns, particularly in northern Nigeria. These parallels suggest that the Shagari context aligns with broader national evidence, where traditional leaders serve as trusted gatekeepers who bridge the gap between modern health systems and culturally rooted communities.

The study found that traditional leaders encounter significant challenges, including inadequate healthcare infrastructure, a shortage of medical personnel, a lack of essential drugs, poor road networks, insecurity, and limited government support. These systemic barriers mirror findings by Adedini *et al.* (2023), who observed that traditional leaders advocating for family planning in Nigeria faced backlash from conservative community members and limited collaboration with health institutions. Adeleke (2024) similarly reported that many traditional rulers lacked adequate health training, making it difficult for them to effectively champion modern medical

interventions. Additionally, Conteh *et al.* (2025) noted that weak collaboration between traditional authorities and government health officials often undermines healthcare delivery in rural Nigeria. In Shagari, these challenges are compounded by cultural resistance and the persistence of traditional healing practices, reinforcing that traditional leaders operate in a space of both opportunity and constraint.

The results indicated that the majority of community members hold positive perceptions of traditional leaders, acknowledging them as trusted figures who significantly influence health-related decisions. This finding aligns with Akabuike *et al.* (2024), who found that 78% of rural respondents in southeastern Nigeria trusted traditional leaders more than government health officials regarding maternal healthcare. Similarly, Okeke *et al.* (2024) demonstrated that collaboration with traditional rulers increased maternal healthcare facility utilization by 45%. These findings reinforce the Shagari evidence that community members view traditional leaders not only as cultural authorities but also as reliable intermediaries between health systems and the people.

The findings showed that community members strongly trust traditional leaders to guide them in healthcare matters, with a majority expressing high confidence in their advice and directives. This resonates with Adebayo & Ahonsi (2020), who found that 68% of respondents trusted traditional rulers more than government officials for healthcare advice, and with Mugisha & Muyinda (2021), who reported similar trust patterns in Uganda. Furthermore, Makwiza *et al.* (2021) observed that traditional leaders significantly shaped healthcare-seeking behaviors, even though some promoted herbal remedies over modern medicine. In Shagari, the high trust in traditional rulers underscores their pivotal role in sustaining health campaigns, echoing lessons from Nigeria's polio eradication programs, where traditional rulers were instrumental in overcoming vaccine resistance (Mohammed & Nwaze, 2020).

CONCLUSION

The study concluded that traditional leaders play a vital role in promoting healthcare acceptance and delivery in Shagari LGA. Their influence is rooted in cultural authority and trust, which enables them to act as effective intermediaries between modern health systems and local communities. However, systemic challenges such as infrastructural deficits and cultural barriers limit the effectiveness of their efforts. Strengthening collaboration among traditional leaders, healthcare providers, and policymakers is essential to improving healthcare access and outcomes in rural Nigeria.

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