International Journal of Social and Education (INJOSEDU) e-ISSN: 3047-6151
Vol. 2 No. 8 September 2025, hal., 2427-2440

THE ROLE OF SPIRITUALITY AND RELIGION IN PSYCHOLOGICAL AND PHYSICAL HEALTH OF WOMEN IN NIGERIA

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Abstract

For many women in Nigeria, spirituality and religion are part of daily life and well-being. They bring comfort, ease stress, and encourage healthy living. In places where healthcare is not readily available, faith often fills the gap—making it a powerful source of support for both mind and body. This study was therefore framed within the Health Belief Model (HBM) and Pargament's Theory of Religious Coping to explored the role of spirituality and religion in the psychological and physical health of women in Nigeria. A descriptive survey design was used, and data were gathered through a self-developed online questionnaire that focused on four key areas: spirituality, religious involvement, psychological health, and physical health. The instrument was reviewed and validated by three experts in Educational Psychology, Guidance and Counselling, and Measurement and Evaluation to ensure its clarity and relevance. Its reliability was confirmed using Cronbach's alpha, with a reliability coefficient of 0.77, 0.81, 0.92 and 0.88 respectively for spirituality, religious involvement, psychological health, and physical health clusters, indicating a high level of internal consistency. The questionnaire was distributed over a two-week period through women-focused social media groups, and a total of 400 completed responses were received. The data were then analyzed using descriptive statistics and correlation analysis. The findings showed that out of 400 women, most were single (47.3%), married (27.0%), widowed (20.3%), or divorced (5.5%). The mean scores for spirituality (3.17), religious involvement (3.19), psychological health (3.02), and physical health (3.08) were high. Strong positive correlations were found between all variables, especially between religious involvement and physical health (r = 0.822). ANOVA results confirmed that spirituality significantly predicts psychological (F = 122.28) and physical health (F = 316.46), while including religious involvement further strengthened these effects (F = 139.38, 877.78). Regression models showed that both spirituality and religious involvement positively influence women's health outcomes, with religious involvement having a stronger impact on physical health. Based on these results, the study recommended that health and wellness programs aimed at women in Nigeria should take spiritual and religious factors into account, especially within culturally sensitive frameworks.

Keywords: Spirituality, Religion, Psychological Health, Physical Health, Women.

Introduction

Spirituality and religion contribute immensely, irrespective of the differences or similarities involved, to the promotion of psychological as well as physical health. Whereas spirituality is a quest of individuals for their meaning, inner peace, and transcendence, religion is usually more organized belief with communal practice. Taken together, they are coping mechanisms that build resilience, especially when it comes to adversity (Nnoruga,

2025). However, especially women, tend to refer to the faith-based resources to gain emotional support, ability to manage stress, and find a sense of purpose. When it comes to the psychological aspects, religious and spiritual engagement has been linked with reduced likelihoods of anxiety, depression, and suicidal ideation because of the emotional and moral support as well as the hope (Ukeachusim et al, 2024). On a spiritual level, prayer, meditation and the experiencing of religious fellowship make spiritually-inclined individuals better emotionally regulated with improved well-being.

Physically, spirituality and religion encourage healthy practices and offer a social support system that leads to better results. The studies associate regular religious participation with lower blood pressure levels, stronger immune systems and better management of chronic diseases (Dik et al, 2024). The lifestyle structures that are enmeshed in many faith traditions, including dietary instructions, rest and avoidance of harmful substances, contribute even more toward physical wellness. Spirituality and religion go hand-in hand to reveal a holistic system that reinforces the association between mind and body; it demonstrates that health is not merely the lack of disease but a combination of physical energy and internal good. Women, in different cultures and situations, tend to use spirituality and religion as coping mechanisms in dealing with life's stressors specifically in terms of their psychological and physical health. The growing research has focused on the possible contribution of religious and spiritual practices in promoting well-being, especially among women who are more likely to be involved in religious activities and find meaning in them (Noh et al, 2023). However, as there is increased recognition of spirituality in health literature, there remains the gap in synthesis relating to its effects on women mental and physical health outcomes. This void calls for an extensive examination of the cross roads of spirituality, religion and women's health.

The issue resolved in this discourse is the lack of representation of gender-specific views in the study of religion, spirituality, and health. Although, many of the studies are concerned with the general health outcomes, a few students can shed focused attention on the ways different religious and spiritual engagements influence women's health, differently. Women have unique psychosocial stressors like gender-based violence, caregiving burdens, reproductive health challenges, and socioeconomic disparities, which impinge heavily to their mental and physical wellbeing. Spirituality and religion are usually at the center of women's interpretation and reaction to these challenges (Derboghossian et al, 2024). Therefore, the research is to investigate and synthesize the way spirituality and religious involvement add to psychological resilience and physical well-being in women. The value of this research is the possible contribution to holistic health initiatives that take into consideration spiritual and religious dimensions, especially in culturally different environments, in which the life of women is intrinsically connected with religious practices. Comprehension of such dimensions can help to improve the quality of mental health services and minimize stigma regarding the emotional challenges, offering culturally competent care to women (Surzykiewicz et al, 2022).

While being conceptually separate, spirituality and religion often overlap within the lives of women. By and large, spirituality implies a personal search for meaning and reach to what is transcendent but religion pertains to and has structure of beliefs and practices that relate to particular faith tradition (Fry, 2024). Both constructs have been associated with health outcomes particularly in women because of the focus on inner peace, community support, moral direction, and existential hope. Spiritual/religious practices have been empirically associated with positive psychological well-being of women. For instance, various women who practice prayer, meditation, consistent religious practice often report reduced cases of anxiety, depression, and stress (Ukpo et al, 2024). This can be explained through the feeling of meaning, sense of community belonging, and emotional control received from religious involvement. Further, spiritual coping, which includes seeking comfort in God or finding spiritual meaning in suffering, is a popular strategy for women with illness or trauma (Lawrence et al, 2023).

Spirituality also provides protection for the physical health of women. It has also been found that women who are spiritually active have less blood pressure, lower risk of cardiovascular disease and better immune functioning (Racheal et al, 2024). Such outcomes can be brought about by healthier lifestyles that are commonly dictated by religious teachings, including avoiding substance abuse as well as the advocacy of rest and self-care. Also, faith-based communities are known to offer examples of support networks which neutralize negative health effects caused by isolation and stress. Specifically, in cases of chronic illnesses including cancer, HIV/AIDS, or infertility in women, spirituality and religion provide an outline of meaning-making and resilience. Some women take refuge in ideas of divine purpose or healing which could increase their emotional sustainability and compliance to the treatment (Jidong et al, 2021). Situations wherein one needs spiritual support like counseling from religious leaders or a prayer group have also been found to enhance coping efficacy and alleviate feelings of hopelessness.

In Nigeria, spirituality and religion play a significant role in shaping the psychological and physical health of women. Religious participation often provides emotional support, social connection, and a framework for interpreting suffering. For many women, especially in rural areas, faith-based coping mechanisms are essential for managing stress, trauma, and communal conflicts (Mbuba, 2021). Religious communities offer a sense of belonging, which can mitigate loneliness and human trafficking (Mbuba, 2022). Furthermore, spiritual beliefs often promote health-seeking behaviors, such as avoiding harmful substances or adhering to medical advice. Women's involvement in religious groups can also promote self-esteem and resilience, supporting sustainable development (Mbuba, 2016). However, the impact is not limited to psychology; some women report faster physical recovery when spiritual practices are integrated into their healing at home (Ike, Mbuba & Nwot, 2021; Ho, 2025). Government and NGOs can leverage these networks for improved healthcare outreach through effective coverage by broadcasting media in Nigeria (Mbuba, 2018).

Nevertheless, one should be aware that not all religious experiences are positive. Women might have spiritual struggles of being deserted by God, or struggling against the

religious doctrines which may aggravate psychological distress (Nnoruga, 2025). Furthermore, conservative or patriarchal readings of religious texts could strengthen the gender inequality and hinders autonomy in health-related decision, made by women. The lack of scholarly focus on gender-specific health outcomes within the faith-based context is the trigger for studying the role of spirituality and religion in the psychological and physical health of women of Nigeria. Notwithstanding, Nigeria is highly spiritual and spirituality permeates the way people live and making generalisations on population outside isolating specifics of the female gender is common most times. Research has stressed the health impacts of religion in general (Alao, 2022) but not many have looked into how such impacts come to differ in women, especially culturally varied and patriarchal as Nigeria. Furthermore, though there are a number of local investigations that emphasize the role of religious coping in Nigerian patients, said coping is quite frequently not referred to in terms of its direct correspondence to the quantifiable health effects in women (Eze et al, 2025). This study is seen in light of filling these gaps by earnestly studying on how spiritual and religious beliefs become conservative or transformative factors of women's mental and physical well-being. The knowledge about this relationship can help inform gender-sensitive health interventions in cultural and spiritual realities.

Research Questions

1. To what extent does spirituality influence the psychological health of women in Nigeria?
2. What is the relationship between religious involvement and the physical health of women in Nigeria?
3. To what extent do spirituality and religious involvement jointly predict psychological and physical health outcomes in women?

Hypotheses

H_1: There is a significant positive relationship between spirituality and psychological health among women in Nigeria.

H_2: Religious involvement has a significant influence on the physical health of women in Nigeria.

H_3: Spirituality and religious involvement jointly have a significant predictive effect on both the psychological and physical health of women in Nigeria.

Method

The design of research of the study was mixed, consisting of descriptive survey research and correlational methodology. This was deemed the most appropriate design because it enabled collection and analysis of data from a vast population of women, the understanding of their experience regarding spirituality, religion and health without disturbing their natural settings. The research was conducted in three significant geopolitical regions of Nigeria – South-East, South-West, and North-Central. These zones were strategically chosen in order to represent diverse religious and cultural background of women in the country, given the impact of religion and culture on health and well-being.

For each of these zones one state was randomly picked and from each picked up state, two local government areas were selected. These were the points around which the data was collected.

Study participants were adult women 18 years and above regardless of the marital status, education level, or religious affiliation. From the general population, a total of 400 women were sampled with a multistage sampling procedure. At this initial stage, there was random selection of states and local government areas. The second stage took form purposive sampling to ensure all religious practices were represented such as Christianity, Islam and African Traditional Religion. In order to gather data a structured questionnaire was formulated with the name being Spirituality, Religion, and Women's Health Questionnaire (SRWHQ). Four core areas were covered by the instrument. background and demographic data, spirituality, religious participation, and markers for both psychological and physical wellbeing. There was a four-point Likert scale response option on the questionnaire ranging from "Strongly Agree" to "Strongly Disagree" to enable the respondents to indicate the level of agreement to each statement.

Prior to the use of the questionnaire on a large scale, the instrument was validated by three experts, one from the fields of health psychology, religious studies, and measurement and evaluation. These professionals went through the questionnaire to ensure that it was clear, relevant and comprehensive. Their feedback improved a number of them, which ensured that the final version is reliable in that it reflected the constructs under study accurately. To check for reliability, a pilot study was carried out with 30 women from a community that was not the main one. Cronbach's alpha was the tool of choice for internal consistency of the four clusters of the questionnaire. The scale showed reliability coefficients as 0.77 for spirituality; 0.81 for religious involvement; 0.92 for psychological health and 0.88 for physical health. Such values held the instrument reliable and suitable for use in the main study.

Data was collected with the help of trained research facilitators who went to the selected local government areas to administer questionnaires directly to the respondents. For the women who were having challenges to read or understand the items, an assistance was given to ensure that any responses made were genuine and representing the true answers. For analysis, the data was processed using Statistical Package for the Social Sciences (SPSS) after data collection. Descriptive statistics (such as mean scores and standard deviations) were employed to summarize the responses while inferential statistics (or t-tests and analysis of variance (ANOVA)) were used to test the significant differences in psychological and physical health consequences depending on levels of spirituality and religious involvement. With a significance level of 0.05, the differences that were identified as statistically significant were determined.

Results

In **Table 1: Distribution of Respondents by Marital Status**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Single	189	47.3	47.3	47.3
	Married	108	27.0	27.0	74.3
	Widowed	81	20.3	20.3	94.5
	Divorced	22	5.5	5.5	100.0
	Total	400	100.0	100.0	

The data in Table 1 indicated that almost half of the respondents were single: 47.3%, with close to a quarter of them married: 27.0%. A significant proportion (20.3%) of widowed women and a small percentage of women who have had a divorce (5.5%) were present. This spread is indicative of a combination of life experience among the women and can determine the way they seek spirituality or religion in support. For example, other women that are widowed or divorced might rely on faith more for emotional strength, and single and married women may related to spiritual practices differently.

Table 2: Descriptive Statistics of Study Variables (with Bootstrap Estimates)

		Statistic	Std. Error	Bootstrap[a]			
				Bias	Std. Error	95% Confidence Interval	
						Lower	Upper
Spirituality	N	400		0	0	400	400
	Mean	3.1745		.0007	.0250	3.1265	3.2275
	Std. Deviation	.49504		-.00101	.01445	.46338	.52092
	Variance	.245		-.001	.014	.215	.271
	Skewness	-.155	.122	.001	.066	-.280	-.019
	Kurtosis	-.643	.243	.003	.098	-.820	-.433
Religious Involvement	N	400		0	0	400	400
	Mean	3.1890		-.0011	.0260	3.1385	3.2400
	Std. Deviation	.54297		.00000	.01491	.51360	.57122
	Variance	.295		.000	.016	.264	.326
	Skewness	-.328	.122	.002	.080	-.487	-.171
	Kurtosis	-.768	.243	-.001	.136	-1.019	-.485
Psychological Health	N	400		0	0	400	400
	Mean	3.0175		-.0007	.0207	2.9760	3.0600
	Std. Deviation	.42502		-.00013	.01361	.39774	.45227
	Variance	.181		.000	.012	.158	.205
	Skewness	.013	.122	-.001	.080	-.149	.171
	Kurtosis	-.267	.243	-.003	.142	-.534	.051
	N	400		0	0	400	400

Physical Health	Mean	3.0805		-.0012	.0255	3.0285	3.1275
	Std. Deviation	.51835		.00031	.01510	.48868	.54796
	Variance	.269		.001	.016	.239	.300
	Skewness	-.149	.122	-.002	.066	-.285	-.022
	Kurtosis	-.700	.243	-.001	.105	-.897	-.477
Valid N (listwise)	N	400		0	0	400	400

a. Unless otherwise noted, bootstrap results are based on 1000 bootstrap samples

The descriptive statistics presented in Table 2 show a fairly high mean score for all four variables — spirituality, religious involvement, psychological health, and physical health — whose scores vary between 3.02 and 3.19. This implies that on an average, the women reported favorable experiences in all aspects. Spirituality (M = 3.17, SD = 0.50) and religious involvement (M = 3.19, SD = 0.54) were both high, but dictated a strong spiritual engagement. In this line, psychological health (M = 3.02, SD = 0.43) and physical health (M = 3.08, SD = 0.52) were also positively rated. The skewness and kurtosis values fall within acceptable limits, suggesting a relatively normal distribution across all variables, with no significant bias in the bootstrap estimates.

Table 3: Correlations Between Study Variables

		Spirituality	Religious Involvement	Psychological Health	Physical Health
Spirituality	Pearson Correlation	1	.391**	.485**	.666**
	Sig. (2-tailed)		.000	.000	.000
	N	400	400	400	400
Religious Involvement	Pearson Correlation	.391**	1	.577**	.822**
	Sig. (2-tailed)	.000		.000	.000
	N	400	400	400	400
Psychological Health	Pearson Correlation	.485**	.577**	1	.680**
	Sig. (2-tailed)	.000	.000		.000
	N	400	400	400	400
Physical Health	Pearson Correlation	.666**	.822**	.680**	1
	Sig. (2-tailed)	.000	.000	.000	
	N	400	400	400	400

**. Correlation is significant at the 0.01 level (2-tailed).

The associations between the variables Table 3 are all significant at 0.0 level. There is a positive correlation between spirituality and physical health (r = 0.666) which means better physical health is associated with increase spirituality. Likewise, religious involvement has a high correlation with physical health (r = 0.822) whereby more religious involvement correlates positively with physical health. Psychological health is also

positively correlated with spirituality (r = 0.485) and religious involvement (r =0.577) indicating the role of the spiritual and religious factors in promoting psychological well-being. These results indicate that spirituality and religious participation play a central role in psychological and also physical health in women.

Table 4: Combined ANOVA for Psychological and Physical Health

Dependent Variable	Model	Source	Sum of Squares	df	Mean Square	F	Sig.	Predictors
Psychological Health	1	Regression	16.940	1	16.940	122.276	.000	Spirituality
		Residual	55.138	398	.139			
		Total	72.078	399				
	2	Regression	29.733	2	14.867	139.381	.000	Spirituality, Religious Involvement
		Residual	42.344	397	.107			
		Total	72.078	399				
Physical Health	1	Regression	47.486	1	47.486	316.461	.000	Spirituality
		Residual	59.722	398	.150			
		Total	107.208	399				
	2	Regression	87.435	2	43.718	877.776	.000	Spirituality, Religious Involvement
		Residual	19.773	397	.050			
		Total	107.208	399				

Hypothesis 1 that spirituality has a high positive impact on both psychological and physical health is sustained. For psychological well being, the significant F-value (122.276, $p < 0.001$) in model 1 suggests the strong predicting variable of spirituality. Likewise, regarding physical health, the F-value (316.461, $p < 0.001$) indicates that spirituality determines physical health positively, indicating the positive contribution made by spirituality on both types of well-being. Hypothesis 2 stated that both spirituality and religious involvement have combined positive effects on psychological and physical health is also upheld. In model 2, for psychological health, F-value (139.381, $p < 0.001$) implies that spirituality and religious involvement explain a significant amount of variation in

psychological well-being. Similarly for physical health, F-value (877.776, $p < 0.001$) indicates that these two factors combined have strong influence on physical health. Both hypotheses are established showing the critical role of spirituality and religious involvement in promoting the psychological and physical health of Nigerian women.

Table 5: Combined Coefficients Table for Predicting Psychological and Physical Health Based on Spirituality and Religious Involvement.

Dependent Variable	Model	Predictor	B	Std. Error	Beta	t	Sig.
Psychological Health	1	(Constant)	1.696	.121	—	14.026	.000
		Spirituality	.416	.038	.485	11.058	.000
	2	(Constant)	1.041	.122	—	8.549	.000
		Spirituality	.263	.036	.306	7.318	.000
		Religious Involvement	.358	.033	.458	10.952	.000
Physical Health	1	(Constant)	.868	.126	—	6.899	.000
		Spirituality	.697	.039	.666	17.789	.000
	2	(Constant)	-.289	.083	—	-3.472	.001
		Spirituality	.425	.025	.406	17.348	.000
		Religious Involvement	.633	.022	.663	28.321	.000

The Combined Coefficients Table offers an understanding of the significance of spirituality and religious engagement for predicting physical and psychological health results. For the sake of psychological health the results from Model 1 show that spirituality is a significant predictor with a positive coefficient at 0.416 and beta value at 0.485. This implies that the more spirituality, the better the psychological health. The obtained t-value (11.058) with a p value of (0.000) shows that the relationship is statistically significant. In model 2 when spirituality and religious involvement are both taken into account, spirituality continues to contribute in a positive manner ($B = 0.263$, $\beta = 0.306$, $t = 7.318$, $p = 0.000$), but religious involvement is also found to be effective ($B = 0.35$ As the physical health dimension, Model 1 demonstrates the strong positive impact of spirituality with the coefficient of 0.697 and beta value of 0.666. This alludes to a clear relationship between enhanced spirituality and improved physical health. The t-value of 17.789 and p-value of 0.000 make this finding significant. In Model 2, spirituality ($B = 0.425$, $\beta = 0.406$, $t = 17.348$, $p = 0.000$) and religious involvement ($B = 0.633$, $\beta = 0.663$, $t = 28.321$). The effects confirm spirituality and religious involvement display significant positive effect on psychological and physical health. This underscores the need to examine these factors in programs and interventions for wellness.

Figure 1 presents a histogram of regression standardized residuals for the dependent variable *Psychological Health*. The distribution appears approximately normal, with a bell-shaped curve and most residuals clustered around the mean (−3.79E−15), which

is essentially zero. The standard deviation is close to 1 (0.997), and the sample size is 400. The histogram indicates that the assumption of normality in the residuals is reasonably met, supporting the validity of the regression analysis. The residuals are symmetrically distributed with no extreme skewness, suggesting that the model's predictions for psychological health outcomes are relatively unbiased and homoscedastic.

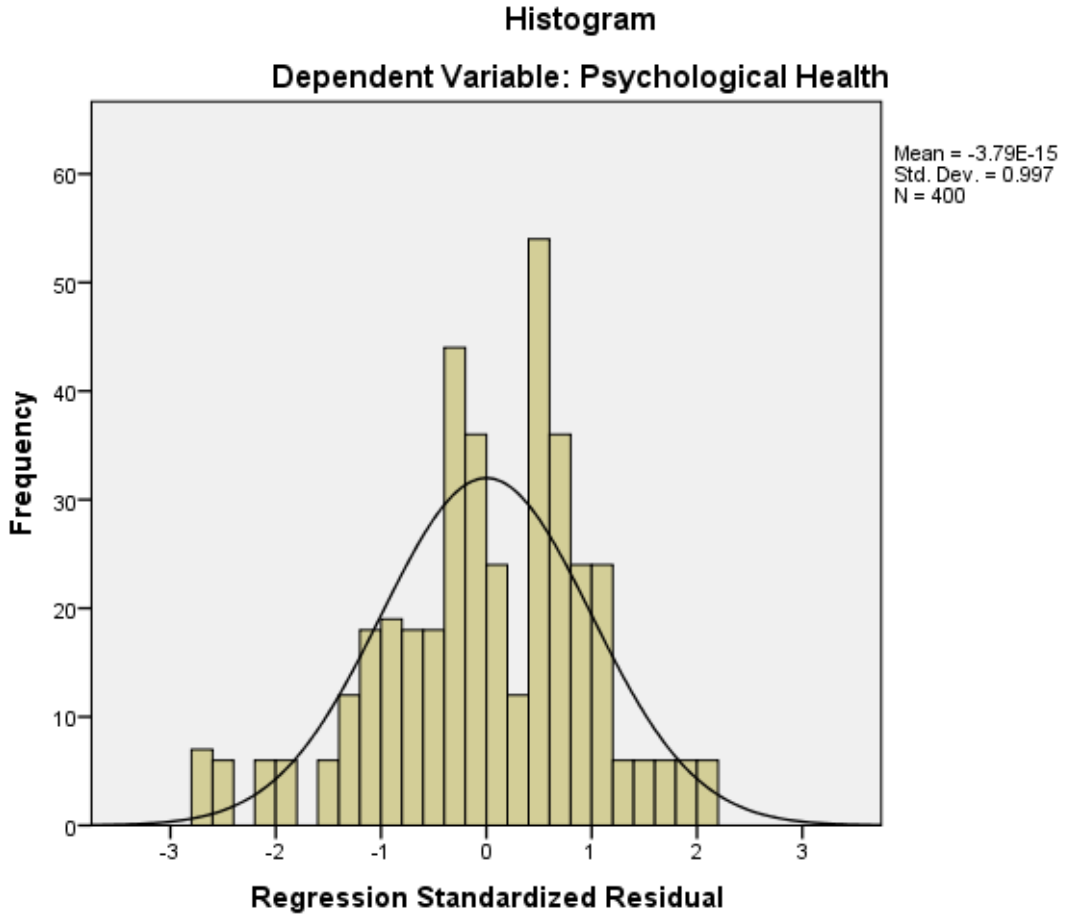

Figure 1: Histogram of regression standardized residuals for the dependent variable Psychological Health.

Figure 2 shows a histogram of regression standardized residuals for the dependent variable *Physical Health*. The distribution is roughly normal, with most values clustering around the mean (−5.06E−15), which is effectively zero. The standard deviation (0.997) indicates that the residuals are appropriately standardized. With a sample size of 400, the histogram suggests a slight positive skew, but the residuals generally follow a normal curve. This pattern supports the assumption of normality in regression analysis and indicates that the model predicting physical health outcomes does not exhibit serious bias or heteroscedasticity.

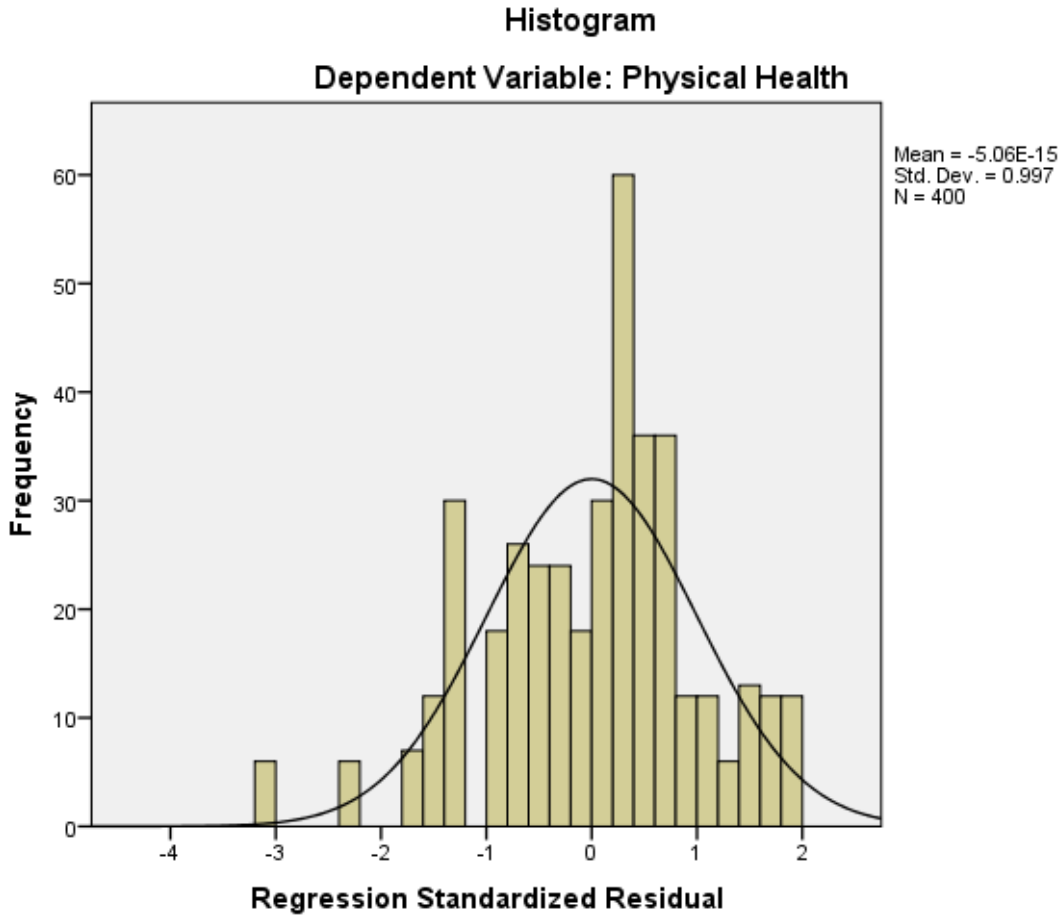

Figure 2: Histogram of regression standardized residuals for the dependent variable *Physical Health*.

Discussion and Conclusion

The results have demonstrated that in Nigeria the role of spirituality and religious involvement in shaping women' psychological and physical health has been a topic of discussion particularly with regard to well-being in a cultural background where women face many challenges. The results always favour the notion that spirituality and religious practices can be important sources of psychological support and physical well-being. While it may be easy to think of spirituality as purely private or individual, connecting people to something larger than them, it can be communal. In Nigeria, numerous women find the strength in their spiritual beliefs which significantly contribute to improving their psychological health. For example, the results of the current study show that spirituality is positively associated with psychological well-being (r = 0.485). This attunes with earlier work (like e.g., Surzykiewicz et al, 2022), which reported that spiritual beliefs play a significant role in mental resilience and cope mechanisms, especially in women living in distressing socio-cultural settings. On the other hand, western studies have proposed that spirituality might not be as inherent into the ordinary as it is in India, and hence apparently limiting its psychological benefits (Dik et al, 2024). Nevertheless, this finding matches

recent studies (Eteachusim et al 2024) which highlighted that Nigerian women who practice spiritualism appear to have less anxiety and depression.

The connection between physical health and religious involvement is equally strong. As is confirmed by the current study, religious involvement is highly correlated with physical health (r = 0.822). This observation is in line with research by Noh et al, (2023), which determined that active involvement in religious activities is also connected to physical wellness via communal support systems and frequent participation in health-themed teachings in religious practices. Religious activities like prayer, meditation and fasting can promote physical well-being by minimizing stress and clarity of mind, which also impacts one's bodily health. In another study, considered related, Derboghossian et al. (2024) observed that women who actively participate in religious activities reported better physical health outcomes – lower blood pressure, better immune system function – compared to those who do not participate as actively.

The findings of the study further indicate that that spirituality and religious involvement mutually predict psychological and physical health outcomes for Nigerian women. The interaction of these two factors seems to have synergistic effect on health as both dimensions contribute to the better well-being. Following this, a study by Ukpo et al, (2024) found that if one looked at spiritual practices and religious involvement at once, there was an increased likelihood of having less mental health problems and even better physical health. This contrasts with findings from other areas of the world, for example, a study in the UK (Fry, 2024), where a religious involvement alone had minimal direct effects on the physical health without such strong spiritual practices. In Nigeria, where spirituality and religion tend to be intertwined, both are elements that are necessary in promoting total health.

The study shows that independent of spirituality, the influence on physical health is significant (r = 0.666). This supplements the previous study by Lawrence et al (2023), which discovered that Nigerian women who described themselves as spiritually active reported less health problems and were more physically well than the others. Spirituality can produce health gains through mechanisms like stress, improvements in emotional regulation, and sense of purpose in life, aspects that are critical for maintaining one's physical health. This is in agreement with a study by Racheal et al, (2024), where the spiritually active women in Nigeria reported better sleep patterns, lower levels of cortisol (stress hormone) and fewer chronic diseases like hypertension and diabetes.

In an aggregate analysis, spirituality and religious engagement are both significant predictors of important differences in psychological and physical health outcomes. The results of ANOVA from the conducted study show that these two factors accounted for a large proportion of the variance in both health outcomes (F-values of 122.276 and 316.461 for psychological and physical health, respectively). This finding lends support to the hypothesis that these factors jointly produce health outcomes, and this suggests findings from other African contexts. For instance, research conducted by Jidong et al, (2021)

obtained similar findings, where spirituality and religious participation was found to have complementary effects on both mental and physical well-being.

This research has demonstrated that the role of spirituality and religion is quite meaningful in sustaining the psychological and physical health of the women in Nigeria. For many women, strength, comfort and a sense of purpose will be found through their spiritual belief and religious practices, which in turn helps them to better endure stress, anxiety and other issues related to health. The results imply that spirituality is not only an individual belief but also a pot of emotional strength and physical health. In the same way, participation in religious communities provides social support, encouragement, and feeling of belonging, all of which have a positive impact on women's health in general. Through focusing people's attention on these connections, the study emphasizes the necessity of acknowledging the existence of spirituality and religion as the essential components of a woman's health journey. Health practitioners, community leaders and policymakers are in a better position to make programs or care when they have the understanding and respect for these influences. Essentially, the well and good of women in Nigeria are intimately connected with their spiritual and religious lives. It may pave new, culturally appropriate ways of promoting healthier lives and better communities with the support of these aspects.

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