

EVIDENCE-BASED ASSESSMENT OF RELIGIOUS LEADERS AND INSTITUTIONS IN COMBATING DRUG AND SUBSTANCE ABUSE IN NIGERIA

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Original Article | Quantitative cross-sectional survey with supplementary qualitative thematic analysis

Abstract

Background. Religious leaders and faith-based institutions are important community channels for prevention, counselling and support related to drug and substance abuse. This study assesses these roles using a general respondent survey and a supplementary set of religious-leader responses.

Methods. The quantitative dataset contained 432 respondent records. Equivalent categorical labels were harmonized before analysis. Frequency distributions and percentages were calculated; selected categorical associations were tested using Pearson's chi-square test and Cramér's V. A nine-item agreement-scale set was examined descriptively for internal consistency. Fourteen religious-leader responses to open-ended questions were analyzed as contextual qualitative evidence using the thematic structure.

Results. Respondents were 63.89% male and 36.11% female; 42.36% were aged 25–34 years. Personal counselling about drug/substance abuse was reported by 55.79%; 60.19% reported an institutional programme; and 50.35% of 431 respondents with a recorded answer reported participation in a faith-based prevention/recovery activity. Lifetime substance use was reported by 30.56%, while 44.21% reported some use in the preceding 12 months. Religious institutions were rated very or somewhat effective by 81.48%. Programme participation, institutional programme availability and sermon frequency were significantly associated with perceived effectiveness, whereas lifetime use and gender were not. The nine-item attitude set had $\alpha \approx 0.755$ among 364 complete cases.

Conclusion. The report indicates substantial community reach and positive perceptions of religious institutions, alongside gaps in structured programming, referral systems, professional collaboration and formal capacity building. The findings support a complementary role for religious institutions alongside professional services. They do not establish causality, national prevalence, or independently verified programme effectiveness.

Keywords

faith-based organizations; religious leaders; substance abuse; drug prevention; Nigeria; community perception; thematic analysis; cross-sector partnership

1. Introduction

The study positions religious leaders and faith-based institutions as accessible community actors who may contribute to prevention, counselling, stigma reduction and referral for people affected by drug and substance abuse.

The study uses two distinct evidence streams: a general respondent survey (N=432) and supplementary religious-leaders views obtained through virtual interview (n=14). The quantitative survey supports descriptive and inferential statistics; the religious-leader responses provide contextual, in-depth accounts of practice, challenges and perceived capacity needs.

The objectives are to describe the respondent profile and religious engagement; summarize self-reported substance-use indicators; assess perceptions of institutional effectiveness and community change; test selected associations with perceived effectiveness; and synthesize religious leaders' accounts.

2. Materials and Methods

2.1 Data source and design

The analysis was conducted using primary data obtained through kobotoolbox online questionnaire within a period of about six months (February-September 2026). The general public response was 432 after cleaning and validation, while religious-leaders interviewed were 14. The design is cross-sectional and the general survey is non-probability; therefore, results describe the observed sample and should not be interpreted as nationally representative estimates.

2.2 Data standardization and quality control

Equivalent labels were harmonized, including capitalization differences and underscore/space formatting. Counts and percentages were calculated from the underlying 432 records.

2.3 Statistical analysis

Descriptive analysis used frequencies and percentages. Pearson's chi-square test assessed selected categorical associations, with Cramér's V used as an effect-size measure. Statistical significance was set at $p < .05$. Because the data are cross-sectional and non-probability based, significant associations are not interpreted as causal effects or population estimates.

The nine-item agreement set was scored from 1 (strongly disagree) to 5 (strongly agree), with “not sure” treated as non-scored for mean calculation.

2.4 Qualitative analysis

The 14 religious-leader responses were analyzed separately using the six-phase reflexive thematic-analysis. Theme counts are descriptive and illustrative, not prevalence estimates.

3. Results

3.1 Respondent profile

Dimension	Category	n	Percent
Gender	Male	276	63.89
Gender	Female	156	36.11
Age group	18–24	107	24.77
Age group	25–34	183	42.36
Age group	35–44	96	22.22
Age group	45–54	29	6.71
Age group	55 years and above	17	3.94

Age distribution of respondents

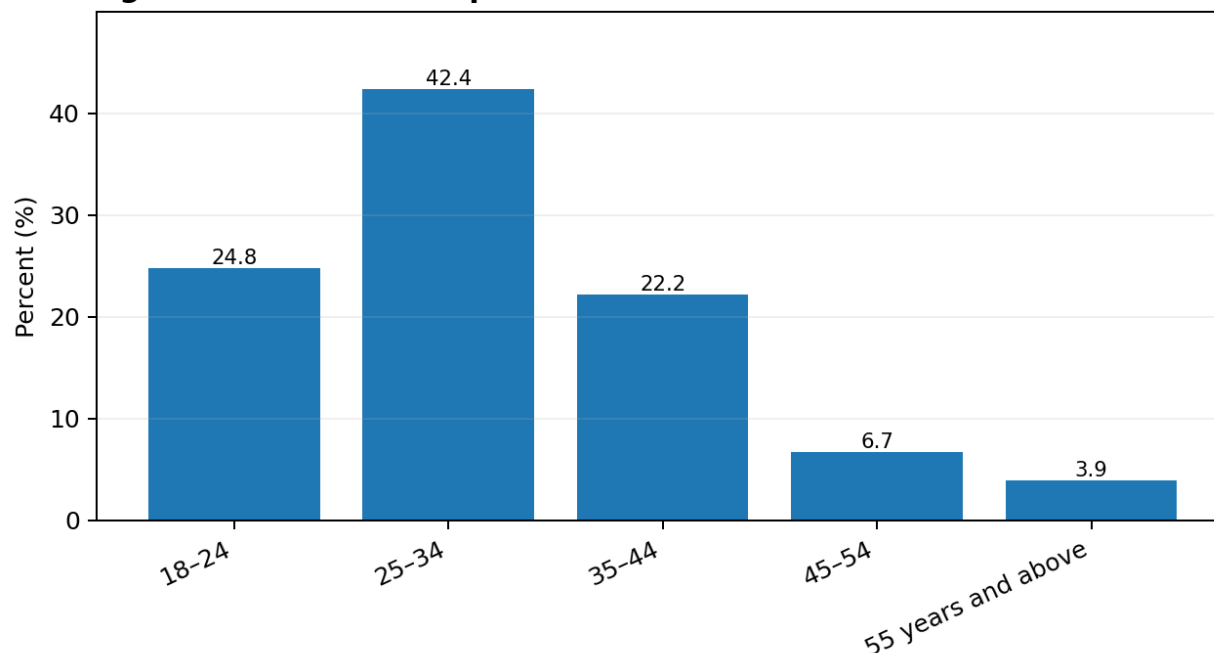


Figure 1. Age distribution of respondents (N=432).

The sample was predominantly male. The largest age group was 25–34 years (42.36%), followed by 18–24 years (24.77%).

3.2 Religious engagement and programme exposure

Indicator	Response	n	Percent
Personal counselling/admonishment	Yes	241	55.79%
Personal counselling/admonishment	No	191	44.21%
Institutional programme	Yes	260	60.19%
Institutional programme	Not sure	165	38.19%
Institutional programme	No	7	1.62%
Faith-based activity participation	Yes	217	50.35%
Faith-based activity participation	No	214	49.65%

Figure 2. Religious engagement and programme exposure.

3.3 Substance-use indicators

Indicator	Response	n	Percent
Lifetime use/misuse	Yes	132	30.56%
Lifetime use/misuse	No	300	69.44%
Use in preceding 12 months	Never	241	55.79%
Use in preceding 12 months	Rarely	83	19.21%
Use in preceding 12 months	Monthly	53	12.27%
Use in preceding 12 months	Weekly	30	6.94%
Use in preceding 12 months	Daily	25	5.79%

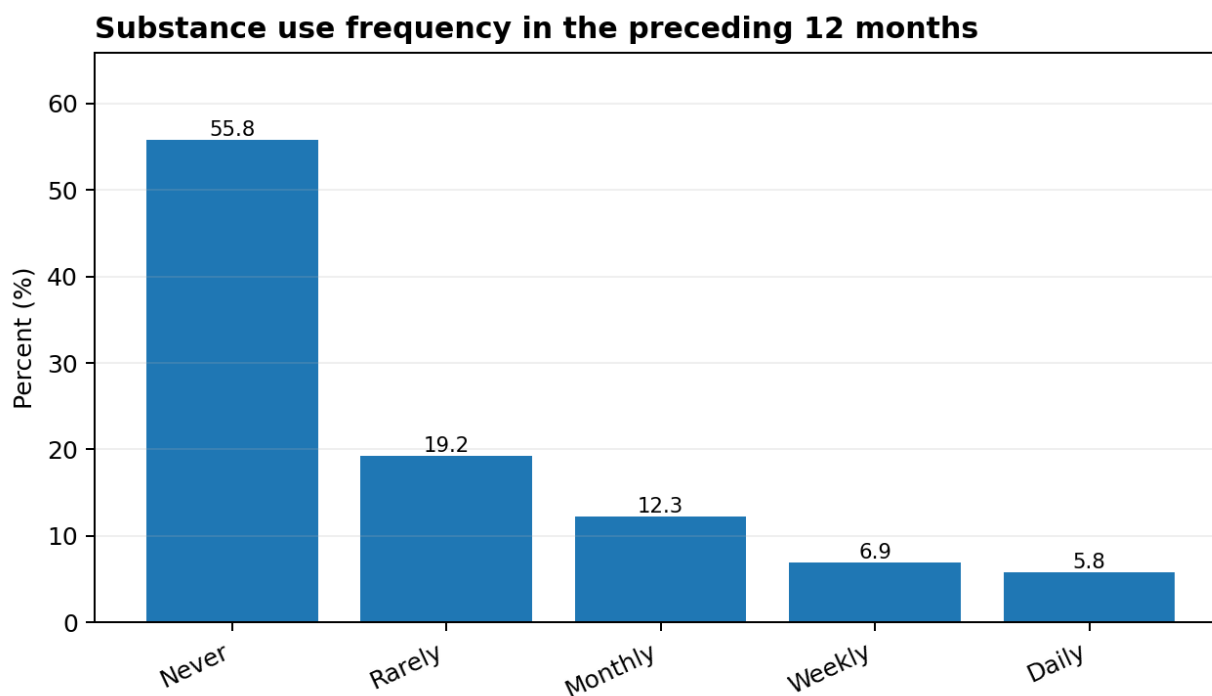


Figure 3. Frequency of reported drug/substance use in the preceding 12 months (N=432).

Lifetime use/misuse was reported by 30.56% of respondents. For the preceding 12 months, 44.21% reported some level of use (rarely, monthly, weekly or daily).

3.4 Perceived effectiveness and community trend

Measure	Response	n	Percent
Perceived effectiveness	Very effective	181	41.90%
Perceived effectiveness	Somewhat effective	171	39.58%
Perceived effectiveness	Not effective	52	12.04%
Perceived effectiveness	Not sure	28	6.48%
Compared with five years ago	Increasing	205	47.45%
Compared with five years ago	About the same	92	21.30%
Compared with five years ago	Decreasing	92	21.30%
Compared with five years ago	Not sure	43	9.95%

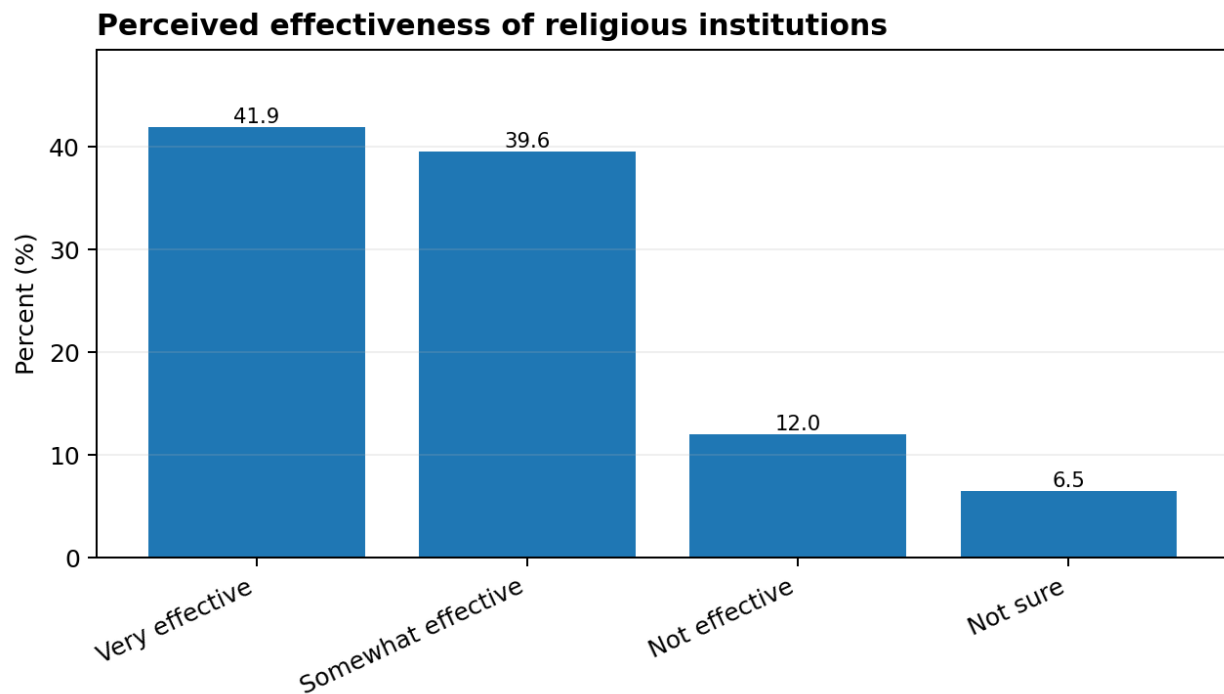


Figure 4. Perceived effectiveness of religious institutions (N=432).

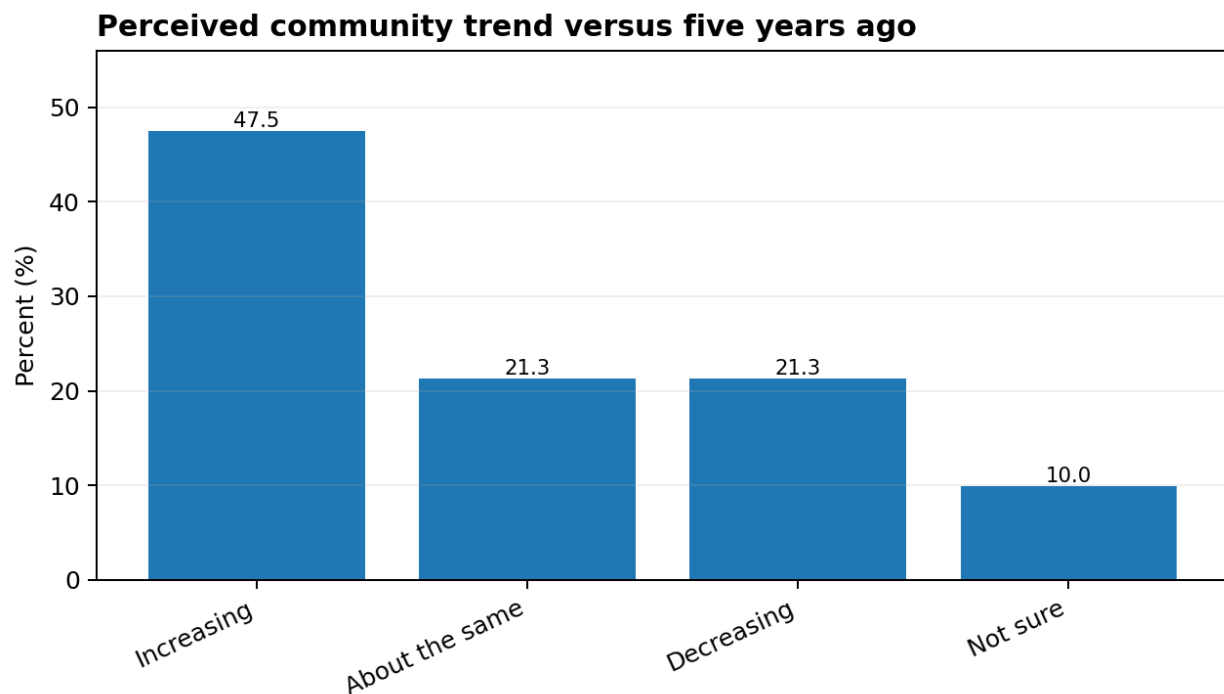


Figure 5. Perceived community trend in substance abuse compared with five years earlier (N=432).

Overall, 81.48% rated religious institutions as very or somewhat effective. At the same time, 47.45% perceived community substance abuse as increasing compared with five years earlier.

3.5 Attitudes toward faith-based intervention

Attitude statement	Mean (1–5)	Agree/strongly agree n	Positive agreement*	Scored responses
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RELIGIOUS LEADERS IN MY COMMUNITY SPEAK CLEARLY AGAINST DRUG USE/SUBSTANCE ABUSE	4.193	358	82.87%	410
ADVICE/COUNSELING/PREACHING FROM RELIGIOUS LEADERS CAN CHANGE PEOPLE'S DRUG USE/SUBSTANCE ABUSE BEHAVIOR	4.313	377	87.27%	412
RELIGIOUS INSTITUTIONS ARE TRUSTED SOURCES OF HELP FOR PEOPLE WITH ADDICTION	4.055	344	79.63%	403
FAITH-BASED PROGRAMS REDUCE STIGMATIZATION TOWARDS PEOPLE SEEKING ADDICTION TREATMENT	4.080	352	81.48%	401
RELIGIOUS TEACHINGS INFLUENCE YOUR PERSONAL DECISIONS ABOUT SUBSTANCE USE	3.938	350	81.02%	432
MOST PEOPLE IN MY COMMUNITY DISAPPROVE SUBSTANCE ABUSE	3.956	356	82.41%	432
PEOPLE STRUGGLING WITH ADDICTION ARE SUPPORTED BY RELIGIOUS INSTITUTIONS	3.384	274	63.43%	432
FEAR OF RELIGIOUS OR MORAL CONSEQUENCES DISCOURAGES DRUG USE	4.069	369	85.42%	432
COLLABORATION BETWEEN RELIGIOUS INSTITUTIONS AND HEALTH SERVICES IS NOT STRONG	4.069	370	85.65%	432

Positive agreement is calculated as agree + strongly agree divided by all 432 records; therefore it can include respondents whose response was “not sure” or missing in the denominator. Means exclude non-scored “not sure” responses.

Figure 6. Mean scores for the nine-item agreement set. Higher scores indicate stronger agreement.

The lowest mean score was for support for people struggling with addiction (3.384), while the highest was for the statement that counselling/advice/preaching can change drug-use behaviour (4.313).

3.6 Inferential analysis

Association	χ^2	df	p	Cramér's V	Interpretation
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Faith-based programme participation × perceived effectiveness	29.251	3	<.001	0.261	Significant; small-to-moderate association
Institutional programme availability × perceived effectiveness	26.505	6	<.001	0.175	Significant; modest association
Sermon frequency × perceived effectiveness	72.807	12	<.001	0.237	Significant; small-to-moderate association
Lifetime substance use × perceived effectiveness	0.219	3	.974	0.023	Not significant
Gender × lifetime substance use	0.001	1	.971	0.002	Not significant

The strongest of the three statistically significant associations was between programme participation and perceived effectiveness ($V=0.261$), followed by sermon frequency ($V=0.237$). These effect sizes indicate association rather than causation. No evidence of association was observed between lifetime substance use and perceived effectiveness, or between gender and lifetime substance use, in this sample.

4. Religious-Leader Perspectives: Thematic Analysis

The supplementary dataset contains 14 religious-leader responses. Their perspectives are presented as contextual qualitative evidence.

Theme	Analytical meaning	Descriptive count
1. Preaching-centred but largely unstructured outreach	Sermons and religious teaching are the principal channel; dedicated, monitored curricula appear less common.	14 of 14, to varying degrees
2. Compassionate, confidentiality-based counselling	Leaders emphasize privacy, compassion, non-condemnation and encouragement toward help.	About 11 of 14
3. Fragile, mostly informal referral pathways	Referral to professional care is often personal or informal; a smaller group reports stronger links.	About 10 of 14 describe weak/informal referral; about 4 of 14 describe stronger links
4. Recognition of limits of purely spiritual framing	Some leaders explicitly recognize that substance-related problems may require psychological, psychiatric or medical intervention.	About 4 of 14 explicit
5. Weak or ad hoc government/health collaboration	Most accounts describe collaboration as limited, informal or insufficiently systematic.	About 9 of 14 describe weak links; about 4 of 14 describe satisfactory/improving links
6. Demand for formal training	Leaders consistently express a need for structured training in addiction science and mental health.	14 of 14
Cross-cutting: resources and root causes	Some leaders identify funding constraints and socioeconomic reintegration needs, including education, employment and family/community support.	About 5 of 14

4.1 Integrated interpretation

The quantitative and qualitative strands converge on several operational findings. The survey shows that institutional programme availability exceeds personal participation, while leaders describe outreach that is present but often unstructured. The survey's lower agreement on support for people already struggling with addiction is consistent with leaders' descriptions of fragile referral pathways and uneven collaboration with professional services.

The leaders' responses also reinforce an important boundary: faith-based support may contribute to prevention, counselling, encouragement and stigma reduction, but the respondents themselves describe circumstances in which professional medical, psychological or rehabilitation services are needed. The qualitative data therefore supports a complementary rather than replacement role for religious institutions.

The 14 leaders' near-universal request for formal training is a clear capacity-building signal within this qualitative sample.

5. Discussion

The findings indicate substantial engagement between respondents and religious institutions. More than half reported personal counselling, 60.19% reported that their institution runs a relevant programme, and approximately half of those answering the participation item reported personal participation. Perceived institutional effectiveness was also high, with 81.48% selecting very or somewhat effective.

The association tests suggest that respondents who reported programme participation, institutional programme availability, or more frequent sermons tended to report more favorable perceptions of institutional effectiveness. Because the study is cross-sectional, it cannot determine whether greater engagement improves effectiveness, whether more effective institutions generate greater engagement, or whether other factors explain both.

The perceived increase in community substance abuse reported by 47.45% of respondents should be interpreted separately from perceived institutional effectiveness. One describes a community trend perception; the other describes an assessment of institutions. The two indicators are not inherently contradictory, and neither independently measures actual programme impact.

The qualitative evidence adds operational detail: leaders report strengths in access, counselling and compassionate engagement, but also identify gaps in structured programming, formal referral systems, collaboration and technical training. These observations are consistent with the quantitative pattern, while remaining limited by the small, self-selected qualitative sample.

6. Limitations

- The general survey is a non-probability sample, data collected online at random due to limited resources
- The cross-sectional design does not establish causality or programme impact.
- The sample contains more male than female respondents due to limited reach of the survey.
- The survey does not measure verified treatment completion, relapse, referral completion as it is not specific to drug users alone or independently measured community trends.
- The religious-leader sample is small (n=14) due to unavailability of some leaders to participate, self-selected and through referrals by fellow religious leaders.

7. Conclusion

Within the observed sample, religious institutions are widely engaged with and positively perceived as potential partners in addressing drug and substance abuse. The principal empirical signals are substantial counselling exposure, reported programme availability, approximately half of respondents participating in faith-based activities, high perceived effectiveness, and statistically significant associations between engagement variables and perceived effectiveness.

The supplementary religious-leader accounts provide a practical explanation for the remaining gaps: outreach is often preaching-centred and insufficiently structured; referral pathways can be informal; collaboration with health and government systems is uneven; and leaders express a strong need for formal training. Taken together, the data support strengthening structured prevention, confidential referral, professional collaboration and capacity building while maintaining clear boundaries between faith-based support and specialist treatment.

8. Recommendations

8.1 For religious institutions

- Establish regular, structured substance-abuse education within sermons and community programmes, with simple monitoring of frequency and reach.
- Develop confidential referral procedures and maintain updated directories of relevant health, mental-health, rehabilitation and social-support services.
- Strengthen recovery-support and family-support activities and continue stigma-reduction approaches that avoid condemnation.
- Record basic service indicators such as counselling contacts, referrals made, referral completion where feasible, and follow-up.
- Promote clear escalation pathways for cases requiring professional medical, psychological, psychiatric or rehabilitation services.

8.2 For government and health agencies

- Develop sustained partnerships with faith-based institutions rather than relying only on ad hoc consultation.
- Provide standardized training in addiction science, mental health, safeguarding, confidentiality and referral procedures.
- Establish referral and feedback mechanisms between faith-based institutions and professional treatment providers.
- Support pilot initiatives that measure service reach, referral completion and other observable outcomes rather than relying only on perceptions.
- Provide culturally appropriate prevention and referral materials for different faith and interfaith settings.

8.3 For future research

- Probability-based or clearly defined stratified sampling where population-level inference is intended.
- Increase the number and diversity of religious-leader respondents and consider multiple coders for future research.
- Use longitudinal designs and directly measure referral completion, treatment engagement, retention and other observable outcomes.

Authors' Contributions

I.B.L. conceived and designed the study, developed the survey instrument, cleaned the data, conducted the virtual interview, statistical and thematic analysis, interpreted the results, and wrote the manuscript.

Declaration of Interest

The author declares no personal, professional or financial conflicts of interest that could influence, or be seen to influence, the integrity of this work.

Ethical Approval

The author affirms that appropriate ethical safeguards for human-subject protection, including informed consent and confidentiality of respondent data, were applied during data collection.

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- Pastor Justina Mike Ngwobia — Presbyterian Church of Nigeria.
- Imam Barr. Muhammad Harun Eze —Deputy Imam, National Mosque, Abuja.
- Rev. James Movel Wuye — Assemblies of God Church; Secretary, Christian Association of Nigeria, Northwest Nigeria.
- Ustazh Yunus Salaudeen — Abuja Muslim Forum; Muslim Rights Concern, Abuja.
- Rev. Prof. Atta Barkindo — Kukah Centre, Abuja.
- The remaining two religious-leader respondents preferred not to disclose their identities.
- Survey assistants: Usman Abdullahi Musa — Undergraduate student of Chemical Engineering, Federal University Dutsin-Ma, Katsina; and Musa Ibrahim Gobir — Postgraduate student of Agriculture, Bayero University, Kano.

Disclaimer: The views expressed by the religious leaders named reflect their individual professional opinions, based on their own knowledge and experience, and do not necessarily represent the official stance of the institutions with which they are affiliated.

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