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Constraints to Empowering the Girl Child Through Multicultural Health Education in Delta State

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ABSTRACT

This study investigated the constraints affecting the empowerment of the girl child through multicultural health education in Delta State, Nigeria. Despite growing efforts to promote inclusive education, cultural taboos, religious beliefs, and gender norms continue to hinder effective health education delivery for adolescent girls in multicultural contexts. A descriptive survey research design was adopted, and data were collected from 200 respondents including female students, teachers, and community stakeholders using a structured questionnaire based on five research questions. Mean scores were used to analyze the responses, and a 4-point Likert scale guided the interpretation. Findings revealed that cultural taboos such as the shame associated with menstruation, the perceived immorality of discussing reproductive health, and the belief that female health issues are private matters significantly restrict open dialogue in schools. Additionally, gender expectations and religious ideologies were shown to influence both the content and delivery of health education. The study also found that the current health education curriculum does not reflect the multicultural realities of Delta State, lacking the inclusion of local languages, cultural practices, and community participation. However, respondents strongly supported culturally sensitive strategies such as involving parents, community elders, and religious leaders, as well as adapting content to reflect local traditions and beliefs. The study concludes that empowering the girl child through health education requires culturally responsive approaches that challenge harmful traditions while respecting diversity. It recommends curriculum reform, teacher training, and community engagement as critical steps toward achieving inclusive and transformative health education. The findings contribute to educational policy discussions on gender equity, curriculum development, and culturally sustainable health practices in Nigeria.

Keywords: Girl Child, Multicultural Health Education, Cultural Taboos, Gender Norms, Empowerment

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1. INTRODUCTION

Empowering the girl child is a cornerstone for sustainable development, gender equality, and improved public health outcomes. Globally, investments in girls' education and health have yielded

high returns in economic productivity, social well-being, and intergenerational advancement (UNESCO, 2022). In particular, health education equips girls with essential knowledge to make informed decisions about their bodies, reproductive rights, and overall well-being (World Health Organization (WHO, 2020). In multicultural regions like Delta State, Nigeria, the role of culturally inclusive health education is even more pronounced. Given the state's ethnic diversity and complex sociocultural dynamics, health education that acknowledges and incorporates various cultural beliefs and values is essential to ensure that all girls irrespective of their backgrounds can participate fully and meaningfully in such programs.

Health education, particularly when targeted at adolescents, has been recognised as a powerful tool to reduce teenage pregnancy, improve menstrual hygiene, prevent sexually transmitted infections, and increase health-seeking behavior (Shackleton, Jamal, Viner, Dickson, Patton, & Bonell, 2016). The concept of multicultural health education refers to instructional approaches that are sensitive to the cultural, religious, and linguistic backgrounds of learners (Luquis, & Pérez, 2021). It goes beyond the simple transmission of health facts to integrate local beliefs, practices, and values into health literacy (Banks, 2019). In Delta State, over 25 ethnic groups coexist, including Urhobo, Isoko, Itsekiri, Ijaw, Anioma, and others. Each group possesses distinct cultural norms, especially regarding gender roles, puberty, marriage, and healthcare practices, all of which significantly shape how young girls perceive and respond to health information (Okonofua et al., 2018).

However, despite the growing emphasis on gender-responsive programming in national policies, there remains a disconnect between policy intentions and the lived realities of girls in rural and multicultural areas (UNICEF, 2021). Many interventions are developed using uniform, urban-focused models that overlook the complex and unique experiences of indigenous communities. This limits the effectiveness of programs and often leads to the exclusion of the very populations they aim to serve.

Although multicultural health education has the potential to be transformative, its implementation in Delta State faces numerous constraints. Cultural taboos, patriarchal structures, religious orthodoxy, economic limitations, and lack of culturally sensitive teaching materials hinder the full participation of the girl child in health education initiatives (Opara, Iheanacho, & Petrucka, 2024). In many communities, discussions on menstruation, contraception, reproductive anatomy, or sexually transmitted infections are considered inappropriate, especially for young girls. As a result, even when such information is available, it is censored, avoided, or poorly understood. Furthermore, teachers often lack the training to deliver health education in ways that honor students' cultural contexts, and school curricula are often devoid of content that reflects the lived experiences of girls from various ethnic backgrounds.

Delta State presents a unique case for studying the constraints of multicultural health education. Apart from its ethnic plurality, the state is marked by socio-economic disparity between oil-producing and agrarian communities, as well as between urban and rural settlements. In some traditional settings, cultural norms assign health decision-making roles solely to male heads of households, making it difficult for girls to access even the most basic health services without permission. Religious beliefs in both Christian and traditional settings influence the perception of certain health topics as "immoral" or "sinful" for unmarried girls.

These prevailing cultural, religious, and economic factors create a dense web of limitations that impede the empowerment of the girl child through conventional health education channels.

This study therefore seeks to investigate the specific cultural, institutional, and pedagogical constraints that hinder the empowerment of the girl child through multicultural health education in Delta State.

1.1 Statement of Problem

Several previous studies in Nigeria have explored the challenges of girl child education, focusing predominantly on access to schooling, early marriage, and reproductive health risks Sandøy, (2016), (Nkhoma et al., (2020), Udoh, (2024), Adedokun et al (2016), Abera et al (2020). These studies have contributed valuable insights into the socio-economic and gender-based barriers that limit educational attainment among girls. Similarly, research on health education has emphasized the importance of adolescent reproductive health and hygiene, particularly in urban settings (Akwaraet et al., 2023). While these works acknowledge the impact of culture on learning, they often treat culture as a peripheral variable rather than a central determinant of educational outcomes. More importantly, there is a scarcity of research that critically examines how multicultural dynamics such as ethnic plurality, indigenous belief systems, and language diversity that has the capacity to shape the implementation and effectiveness of health education for girls in Delta State.

This knowledge gap is significant because Delta State is one of the most ethnically and culturally diverse regions in Nigeria. The relationship between cultural norms, religious ideologies, and gender expectations creates a uniquely complex environment that requires special educational strategies. Despite the presence of multicultural communities, little is known about how health education is received, negotiated, or resisted in these different cultural contexts. Addressing this gap will contribute to the design of culturally responsive educational interventions that are inclusive, effective, and empowering.

1.2 Research Questions

The following research questions were formulated to guide the study:

1. What are the cultural taboos that often prevent open discussion of health topics with girls in schools in Delta State?
2. What sociocultural factors act as constraints to the implementation of multicultural health education for the girl child in Delta State?
3. How do cultural beliefs, gender expectations, and religious norms affect girls' participation in and understanding of health education?
4. To what extent does the current health education curriculum accommodate the multicultural backgrounds of girls in Delta State?
5. What culturally sensitive strategies can be adopted to improve the delivery and impact of health education on girl child empowerment?

2. METHODOLOGY

This study adopted a **descriptive survey research design.** The design was appropriate because it enabled the researcher to collect, describe, and analyze opinions and perceptions of respondents regarding the sociocultural constraints that hinder the empowerment of the girl child through multicultural health education.

The target population comprised **teachers, female students in junior and senior secondary classes and community stakeholders** such as parents and local education officers across selected multicultural communities in Delta State. These groups were chosen because of their direct involvement in either delivering, receiving, or influencing school-based health education. A sample of 200 respondents was selected from 10 secondary schools across different ethnic and cultural zones of Delta State using a multistage sampling technique. Firstly, three Local Government Areas (LGAs) with significant cultural diversity were purposively selected. Secondly, schools within these LGAs were randomly selected, after which respondents (students and teachers) were chosen through stratified sampling to ensure gender and role representation. Community stakeholders were selected through purposive sampling based on their involvement in school and community health initiatives.

The main instrument for data collection was a structured questionnaire designed by the researcher. The questionnaire was divided into six sections: demographic data and five sections based on the five research questions. Each item was rated on a 4-point Likert scale: Strongly Agree (SA), Agree (A), Disagree (D), and Strongly Disagree (SD). The items were developed based on literature review and expert input to ensure content validity. The instrument underwent face and content validation by experts in Educational Psychology, Measurement and Evaluation, and Health Education. Their suggestions were used to revise and improve the clarity and appropriateness of the items. A pilot study was conducted using 20 respondents from a different but culturally similar area in Delta North Senatorial District. The reliability of the instrument was established using the Cronbach Alpha method, and a reliability coefficient of 0.84 was obtained, indicating high internal consistency.

Data collection was carried out over a period of two weeks with the help of trained research assistants. The questionnaires were administered to respondents during school hours and community education meetings, ensuring informed consent and voluntary participation. Clear instructions were given, and anonymity was maintained to encourage honest responses. The completed questionnaires were coded and analyzed using descriptive statistics. The mean ($\bar{x}$) was calculated for each item to determine the general tendency of responses. A decision rule was applied where a mean score of 2.50 and above was interpreted as "Agree," while a score below 2.50 was interpreted as "Disagree." The results were presented in tables and interpreted according to each research question.

3. RESULT

Research Question 1: What are the cultural taboos that often **prevent open discussion of health topics with girls in schools in Delta State?**

Table 1: Response on cultural taboos that often **prevent open discussion of health topics with girls in schools.**

S/N	Statement	$\bar{x}$	Decisions
1	Menstruation is considered a shameful topic and is not openly discussed in my school or community.	3.0	Agree
2	Talking about reproductive organs in class is viewed as culturally inappropriate.	2.8	Agree
3	Discussions on contraception and sexually transmitted infections are seen as promoting immorality among girls.	2.6	Agree
4	Girls are discouraged from speaking openly about bodily changes like puberty.	3.2	Agree
5	Learning about reproductive health is believed to corrupt a girl's purity or innocence.	3.5	Agree
6	Girls are expected not to question elders or teachers about sensitive health topics.	3.0	Agree
7	A girl who talks openly about her body or health issues is seen as immodest or disrespectful.	2.7	Agree
8	Male teachers avoid teaching about female reproductive health due to cultural restrictions.	3.5	Agree
9	Health matters related to girls are considered family secrets and should not be discussed in schools.	3.0	Agree
10	Religious beliefs in my community discourage open conversation about menstruation and reproductive health.	2.8	Agree

The responses reveal a strong consensus that various cultural taboos hinder open discussions of health topics with girls. With high mean scores (ranging from 2.6 to 3.5), items such as the belief that reproductive health corrupts a girl's purity ($\bar{x}$ = 3.5) and male teachers' avoidance of female health topics due to cultural restrictions ($\bar{x}$ = 3.5) highlight the depth of the issue. Other significant taboos include the notion that menstruation is shameful ($\bar{x}$ = 3.0) and the belief that discussing body changes is inappropriate ($\bar{x}$ = 3.2). The consistent agreement across all ten items confirms that cultural and religious ideologies create an atmosphere of silence and shame, discouraging girls from accessing essential health education.

Research Question 2: What sociocultural factors act as constraints to the implementation of multicultural health education for the girl child in Delta State?

Table 2: Response on sociocultural factors act as constraints to the implementation of multicultural health education for the girl child.

S/N	Statement	$\bar{x}$	Decisions
1	Cultural taboos prevent open discussion of health topics with girls in schools.	3.0	Agree
2	Parents discourage participation of girls in health education programs.	2.4	Disagree
3	Community leaders rarely support health education initiatives for girls.	2.5	Agree
4	Local customs limit the time and space allocated for girl-focused health education.	2.8	Agree
5	Teachers avoid discussing sensitive health topics due to cultural pressures.	2.9	Agree

The findings show that sociocultural constraints are significant, though not uniformly accepted across all items. Cultural taboos were reaffirmed as a core issue ($\bar{x}$ = 3.0), and many respondents agreed that local customs ($\bar{x}$ = 2.8), community leader disengagement ($\bar{x}$ = 2.5), and teacher avoidance of sensitive topics ($\bar{x}$ = 2.9) serve as obstacles. However, the item on parental discouragement received a lower score ($\bar{x}$ = 2.4), suggesting that while community structures pose challenges, parents may not be as resistant as presumed. This points to a partial gap in community-level support and an urgent need for broader cultural engagement in policy and program implementation.

Research Question 3: How do cultural beliefs, gender expectations, and religious norms affect girls' participation in and understanding of health education?

Table 3: Response on cultural beliefs, gender expectations, and religious norms affect girls' participation in and understanding of health education

S/N	Statement	$\bar{x}$	Decisions
1	Some cultural beliefs discourage girls from learning about their bodies.	3.0	Agree
2	Religious doctrines in my community oppose reproductive health education for girls.	3.2	Agree
3	Girls are taught that discussing health issues in public is inappropriate.	3.1	Agree
4	Gender roles in my community discourage girls from speaking openly in class.	3.0	Agree
5	Cultural expectations make girls uncomfortable asking questions during health lessons.	2.8	Agree

There is overwhelming agreement that cultural and religious norms negatively influence girls' engagement with health education. High mean scores across all items ($\bar{x}$ ranging from 2.8 to 3.2) demonstrate that girls are affected by beliefs that discourage body awareness ($\bar{x}$ = 3.0), religious opposition to reproductive health ($\bar{x}$ = 3.2), and gender norms that inhibit classroom participation ($\bar{x}$ = 3.0). Girls are also reportedly uncomfortable asking questions in class due to these cultural expectations ($\bar{x}$ = 2.8). Collectively, these findings indicate that restrictive norms and internalized gender roles continue to create learning barriers, even when health education is available.

Research Question 4: To what extent does the current health education curriculum accommodate the multicultural backgrounds of girls in Delta State?

Table 4: Response on extent the current health education curriculum accommodate the multicultural backgrounds of girls in Delta State.

S/N	Statement	$\bar{x}$	Decisions
1	The health education curriculum reflects the cultural values of my community.	2.3	Disagree
2	Instructional materials include local languages or culturally relevant examples.	2.0	Disagree
3	Teachers incorporate traditional practices when teaching health topics.	2.4	Disagree
4	Health education in my school addresses beliefs common to different ethnic groups.	1.5	Disagree
5	The curriculum is designed with input from local communities and stakeholders.	2.0	Disagree

The responses clearly indicate dissatisfaction with the curriculum's cultural inclusiveness. All items were rated below 2.5, with the lowest being the failure to address diverse ethnic beliefs ($\bar{x}$ = 1.5). Respondents disagreed that local languages are used ($\bar{x}$ = 2.0), or that traditional practices are incorporated ($\bar{x}$ = 2.4). The curriculum also lacks input from local communities ($\bar{x}$ = 2.0) and does not reflect community values ($\bar{x}$ = 2.3). This suggests a significant mismatch between curriculum content and the cultural realities of the learners, thereby undermining the goals of multicultural health education.

Research Question 5: What culturally sensitive strategies can be adopted to improve the delivery and impact of health education on girl child empowerment?

Table 5: Response on culturally sensitive strategies can be adopted to improve the delivery and impact of health education on girl child empowerment.

S/N	Statement	$\bar{x}$	Decisions
1	Health education should involve community elders and religious leaders.	3.2	Agree
2	Teachers should be trained on culturally responsive teaching strategies.	2.8	Agree
3	Schools should adapt health education to fit local traditions and customs.	3.5	Agree
4	Use of local languages in teaching health topics will improve understanding.	3.1	Agree
5	Involving parents in health education programs will increase girls' participation.	3.5	Agree

The findings point toward strong support for adopting culturally sensitive strategies to improve health education. High mean scores ($\bar{x}$ = 2.8 to 3.5) suggest broad agreement on the need to involve community elders and religious leaders ($\bar{x}$ = 3.2), train teachers in cultural responsiveness ($\bar{x}$ = 2.8), and adapt school programs to local traditions ($\bar{x}$ = 3.5). Respondents also emphasized the importance of using local languages ($\bar{x}$ = 3.1) and involving parents ($\bar{x}$ = 3.5). These results highlight a clear path forward: integrating community values and structures into the delivery of health education to ensure it is both culturally acceptable and effective for girls in Delta State.

4. DISCUSSION

In line with research question 1, which seeks to investigate the cultural taboos that prevent open discussion of health topics with girls in schools in Delta State, the findings reveal widespread agreement among respondents that sociocultural taboos significantly hinder open health communication. Items such as menstruation being considered shameful, the avoidance of reproductive topics, and the belief that such discussions corrupt purity all received high mean scores, suggesting deep-rooted cultural discomfort around female health matters.

These findings align with Okonofua et al. (2018), who observed that cultural silence around menstruation and sexual health in Nigerian communities leads to misinformation and health risks for girls. Similarly, Tohit, & Haque (2024) emphasized that cultural expectations of modesty and silence discourage girls from engaging in health conversations in both school and family settings. However, some studies argue that cultural taboos are gradually weakening due to increased exposure to global health advocacy. For instance, Iwelunmor et al. (2021) found that in communities where NGO-led interventions have been sustained, openness about menstrual and reproductive health is increasing, indicating a possible shift in norms under the right conditions.

Addressing research question 2, which explored the sociocultural factors that constrain the implementation of multicultural health education, the study found that while cultural taboos, local customs, and teacher discomfort were perceived as major barriers, parental discouragement received a relatively low agreement score. This finding adds nuance to the popular narrative that families are the primary impediment to girls' health education. Whereas earlier studies like those by Aventin (2020) strongly emphasized the role of parents in limiting girls' participation in reproductive health programs, this study suggests that the broader community—particularly teachers and local leaders—may play a more significant role in perpetuating resistance to health education. This partially supports the findings of Giroux (2004), who argued that educational institutions must share responsibility in shaping cultural attitudes toward learning. The contrast in views implies that interventions must go beyond targeting families alone to include institutional reform and broader cultural engagement.

Turning to research question 3, which examined how cultural beliefs, gender expectations, and religious norms affect girls' participation in and understanding of health education, the results confirm that these sociocultural forces negatively influence engagement. Respondents agreed that girls are made to feel ashamed of learning about their bodies and are often silenced by both gender norms and religious restrictions.

This is consistent with the findings of Upadhyaya, Kolås, & Connolly (2024), who argued that girls in conservative communities are discouraged from public engagement with reproductive health topics, leading to poor health literacy. In a similar vein, UNESCO (2022) reported that cultural conditioning contributes to a cycle of ignorance, embarrassment, and fear among adolescent girls. With respect to research question 4, which focused on whether the current health education curriculum accommodates the multicultural backgrounds of girls in Delta State, the findings indicate a strong consensus that the curriculum lacks cultural relevance. Respondents disagreed that the curriculum reflects local values, uses indigenous languages, or incorporates traditional health practices. This supports the observations of Igwe & Obeagu (2024) who emphasized the importance of localization of culturally grounded health communication models for diverse populations.

Finally, in relation to research question 5, which sought to identify culturally sensitive strategies to enhance the delivery and impact of health education on girl child empowerment, the results show strong support for community-based and culturally inclusive approaches. High mean scores were recorded for strategies such as involving parents, religious leaders, and elders, as well as using local languages and adapting content to fit traditions. These findings echo those of Iwelunmor et al. (2021), who advocated for community-embedded health interventions that reflect cultural beliefs while correcting harmful practices. Okonofua et al. (2018) also emphasized the need for bottom-up approaches that prioritize local participation in curriculum design and delivery.

5. CONCLUSION

This study investigated how cultural taboos, gender norms, and religious beliefs affect the effectiveness of multicultural health education in empowering the girl child in Delta State. The findings revealed widespread agreement that discussions around menstruation, reproductive health, and puberty are often restricted due to deep-rooted cultural and religious sensitivities. These restrictions create a climate of silence and discomfort, preventing girls from asking questions or participating fully in health education. Although health education is meant to empower, its impact is limited when cultural expectations discourage open dialogue and when teachers lack the training or confidence to navigate sensitive topics within the bounds of community values.

Additionally, the study showed that the current health education curriculum falls short in addressing the cultural diversity of Delta State. Instructional materials often ignore local languages and traditional health knowledge, making the curriculum feel disconnected from the students' lived experiences. However, respondents supported strategies such as involving community leaders, using local languages, and adapting content to reflect cultural values. These findings highlight the need for an inclusive, culturally responsive approach that balances respect for tradition with the goal of promoting health and empowerment. Effective multicultural health education must not only inform but also engage communities to ensure that girls receive the knowledge and support necessary for healthier, more empowered lives.

6. RECOMMENDATIONS

This study recommends that:

1. The Ministry of Education, in collaboration with local communities, should organize community-based awareness campaigns to demystify cultural taboos surrounding menstruation, puberty, and reproductive health. These campaigns should involve parents, religious leaders, and traditional authorities to gradually shift perceptions and normalize open discussions on girls' health issues.
2. Stakeholder engagement platforms should be established at the community and school levels, where educators, health professionals, parents, and cultural leaders can co-develop guidelines for health education delivery that respect cultural sensitivities while ensuring girls receive essential health knowledge.
3. Gender-sensitive teacher training programs should be introduced to equip educators with the skills to manage culturally complex classroom dynamics and address gender biases. This would empower girls to participate freely and confidently in health-related discussions without fear of stigma or shame.
4. The State Ministry of Education should initiate a curriculum review process that integrates culturally relevant content, examples, and local languages into health education. This review should involve curriculum developers, cultural experts, and female students from diverse ethnic backgrounds to ensure inclusivity and relevance.
5. Parent-inclusive school health programs should be adopted, where schools invite parents to participate in health education sessions and workshops. This would foster trust, reduce resistance to sensitive topics, and strengthen support systems around girls' health and well-being within their homes and communities.

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