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EFFECT OF RELIGIOUS DOMAIN ON HEALTHCARE SEEKING BEHAVIOR AMONG THE ADOLESCENTS IN ENUGU STATE, NIGERIA

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Abstract

Research has emphasized the relevance of good healthcare, and several variables have been identified as constraints to health-promoting behaviors. The present paper highlight the role of the religious domain on healthcare-seeking behavior among adolescents in Enugu state. Two hundred and forty-one respondents conveniently selected from different religious environments in Enugu state participated in the study. The respondents completed a self-report measure of health-seeking behavior. A cross-sectional research design was employed in the study. Data from the questionnaires were analyzed using the statistical package for social sciences (SPSS, Version 23). Linear regression was performed to determine the variation in HSB based on the religion domain. The result of the analysis revealed a statistically significant interaction between religious domain and HSB, $F(1,239) = 41.38$, $p < 0.05$. The adjusted R^2 indicated that the religious domain contributed about 12.1% of the variation in HSB. The finding has implications for policymakers and healthcare providers.

Keywords: RC, HSB, youth, southeast, Nigeria

INTRODUCTION

The World Health Organization described human health as a state of complete mental, physical, and well-being and not simply the nonappearance of disease (WHO, 2016). Although, this classification is defied for failing to include current trends in healthcare systems (Card, 2017; Leonardi, 2018). Therefore, contemporary descriptions entail a dynamic, unceasing, multifaceted, distinct from function, and determined by balance and adaptation (Krahn et al., 2021). Indeed, a holistic understanding of health recommends an extended range of favorable, pleasing health attitudes (Saylor, 2004). Hence, health behavior represents an aspect of human health desired to be accommodated into the definition of health. A modern viewpoint labeled health as a varying quality of living where the mind, body, and spirit are wholly energetic (Bradley et al., 2018). Following the relevance associated with the behavioral aspect of human health, it is essential to explore various underpinning factors of healthcare.

Healthcare describes the totality of actions and activities deployed to ensure good health. Indeed, accessible and quality healthcare is an indispensable factor and fundamental right of every person regardless of race (Abrokwah et al., 2020; Alhanawi et al., 2020; Anjum et al., 2021; Costagliola et al., 2020; Gustafsdottir et al., 2017; Hashemi et al., 2020; Loosli et al., 2021; Maksimović, 2017; Qoronfleh, 2020; Unger et al., 2020). However, growing intimation suggests that healthcare is not adequately accessed in several societies, despite the availability of healthcare facilities.

Healthcare-seeking behavior (HSB) is conceptualized as an individual's action dedicated to averting health-related challenges. So, healthcare behavior describes a person's response to the thought of problematic health (Olenja, 2003). Thus, HSB entails self-instigated procedures evolving through self-recognized health indicators, self-medication, medical consultation, and compliance with expert recommendations (Gupta, 2010). Moreso, Latunji and Akinyemi (2018) stressed that health-seeking behaviors comprised the totality of health conduct. Thus, the concept entails a person's responses toward improving health status, including fighting health-related problems and maintaining overall health awareness (Mackian, 2003). HSB reflects a self-motivated behavior that has enormous implications in healthcare. Particularly, disparate studies have highlighted the variations in HSB in the Nigerian context (Adebiyi et al., 2014; Aham-Onyebuchi & Atulomah, 2020; Aigbokhaode et al., 2015; Ekeh et al., 2021; Falaki & Jega, 2019; Ojifini, 2012; Okojie & Lane, 2020; Oluwole et al., 2020; Onyikwelu, 2019; Owoyemi & Ladi-Akinyemi, 2017; Sinaii et al., 2019; Uguru et al., 2021; Usman et al., 2020). Importantly, there is a compromise in the literature suggesting that people pay less or no attention to healthcare in Nigeria.

The ever-increasing poor health evaluations and inadequate utilization of the available healthcare services have been associated with varying health-related consequences, such as ill-health and death (Budu et al., 2021), including declining global health data (Atuyambe et al., 2009; Mwase, 2015). Nonetheless, demographic variables such as employment status, educational level, gender, and location have been identified as significant correlates of HSB (Atchessi et al., 2018). Moreso, empirical evidence has implicated social support in HSB (Togonu-Bickersteth et al., 2019), thus, meaning that people who receive proper social support are more likely to exhibit HSB. Likewise, Adam and Aigbokhaode (2018) found that most people only access healthcare during health-related emergencies. In essence, the common assumption that sickness always dissolve has been found to restrain HSB (Tanimola & Owoyemi, 2009).

Literature abounds that describes the variations in HSB and the accessibility of available healthcare facilities and self/home care remedies (Abdulraheem & Parakoyi, 2009; Ahmed et al., 2000; Ashenafr et al., 2014; Bapolisi et al., 2021; Fidan & Çelik, 2021; Jain & Agarwal, 2016; Mushtaq et al., 2020; Ogunlesi & Olanrewaju, 2010; Rashidi Fakari et al., 2021; Shaikh & Hatcher, 2005; Webair & Bin-Gouth, 2013). Indeed, there is consensus in the literature suggesting that healthcare-seeking decision appears complicated, possibly because behaviors are varied and influenced mainly by several factors, including the belief systems. Accordingly, religious belief is an essential antecedent of healthcare behavior that has not received much research attention in the HSB literature. Thus, the present paper examined HSB based on the differences in religious attachment.

Religious domains and healthcare behavior

There is growing insinuation suggesting that religious acceptance significantly influences an individual's behavior (Somefun, 2019). Indeed, allegiance to religion is a universal phenomenon that could explain most individuals' responses to healthcare. In particular, the religious domain describes a subjective feeling of faith linked with a specific religious group and activities. It primarily reflects an individual's fundamental value that resonates with self-righteousness and allegiance to religious ideologies and practices. The trend reveals the role of religion in an individual's personal and social life. According to Hardin (2018), allegiance to religious practices exerts a probable script that modifies a person's health beliefs and maintenance. For example, evidence links increased religious-related coping with physical inactivity in adults (Steffen et al., 2001). The religious organization promotes attitudes that could potentiate belief in spiritual healing. Thus, attachment to a religious group might contribute essentially to healthcare-seeking behavior.

Evidence has identified belief in religion as a protective factor in several difficult circumstances (Richardson & Stoneman, 2015). Therefore, belief in religion is a commonly known factor in the lives of numerous young people in most African cultures (Agardh et al., 2011; Gyimah et al., 2013; Odimegwu, 2005). Religion plays a significant role in endorsing youth's closeness to their faith and dynamic religious events. However, most religious units have recommended specific moral norms that influence a more substantial aspect of their followers' lives, especially the young ones, inspiring prayer in place

of medication during illness. Religion in the Enugu State, Nigeria, is predominantly Christian, with the Catholic and Anglican faith dominating. However, there are indications of an increasing number of pentecostalism patronized mainly by young people (Smith, 2004). Equally, the different religious domains have different orientations and expectations for their members.

Most members of different religious sects believe that healing is a supernatural phenomenon and that prayer and divine intervention heal illness rather than medication or the involvement of physicians have potentiated the experience of poor healthcare. Remarkably, there is a growing concern about numerous established faith homes/centers by many religious groups that attract many believers seeking spiritual healings. In other words, prayers and faith are assumed to be the principal remedies to illnesses. Consequently, belief in spiritual healing has been ingrained in the mind of many dedicated members and varies across the different religious groups. Indeed, other religious domains exert different attitudes towards medical care, and the trend seems pervasive in adolescence. This stage is a unique period in human development and a critical phase for building good health. However, adolescence is characterized by an increasing demand for independence and inconsistent decision-making, which potentiate the experience of a conformity to abstract phenomenons. Although the need for healthcare is minimal in adolescents, developing a mindset of religious healing at this stage may have a long-lasting effect on healthcare and pose a significant challenge to health-promoting behaviors. Thus, the present paper aims to investigate healthcare-seeking behavior in adolescents based on differences in religious membership.

Hypothesis: *Religious domain would determine differences in healthcare-seeking behavior among adolescents.*

Method

The participants in the present paper comprise male and female adolescents aged 13 – 19 years and residents in Enugu State, Nigeria. The study draws primarily on adolescents in the state who identified as Christians from different faith backgrounds, including Catholic and non-Catholics. Thus, non-Christians were excluded from the study. The participants were conveniently selected from the churches in various locations in Enugu urban.

Procedure

About two hundred and eighty adolescents were approached in various religious houses, primarily during the mid-week activities and partly during Sunday worships, depending on convenience. Authorization was obtained from religious leaders before the commencement of the study. Most importantly, the participants were informed of the study objective and urged to fill out a consent form. Those who consented to participate in the survey (n=267) were advised that participation is voluntary and could withdraw at any stage of the process. They were given the study questionnaires to complete on the spot. Equally, clarifications were provided on items that seemed ambiguous to them. The participants received no financial compensation for partaking in the survey. In particular, 267 questionnaires were distributed and retrieved on the spot. However, out of the 267 questionnaires given to the respondents, 26 copies were wrongly filled and rejected. Thus, only the satisfactorily filled copies (i.e., 241) were subjected to statistical analysis. The survey lasted between February and April 2022.

Measures:

Healthcare-seeking behavior

Healthcare-seeking behavior was measured with a questionnaire designed to determine the respondent's reactions to their health, including the extent to which they think medical attention from experts during perceived illness is more important than seeking spiritual help. The 15-items, 5-points Linkert type questionnaire was exposed to a pilot study. A Cronbach's alpha coefficient disclosed an acceptable level of internal consistency reliability, which exceeded the cutoff rules-of-the thumb of .72 as recommended for study purposes (Kaplan & Saccuzzo, 2001). A higher score specifies high healthcare-seeking behavior. Religious domains were ascertained in the demographic section of the questionnaire.

Result

A cross-sectional research design was adopted in the paper. Data from the questionnaires were analyzed using the statistical package for social sciences (SPSS, Version 23). Linear regression was conducted to determine the variation in HSB based on the religion domain. The result of the analysis revealed a statistically significant interaction between religious domain and HSB, $F(1,239) = 41.38$, $p < 0.05$. The adjusted R^2 indicated that the religious domain contributed about 12.1% of the variation in HSB.

Table 1: - Table showing the linear regression result on the effect of a religious domain on HSB.

	B	SEB	β	t	Sig
Constant	1.13	.032		34.01	.000
RD	.71	.034	.86	19.38	.000
R^2	.121				

Note. RC = Religious domain; B = Unstandardized regression coefficient; SEB = Standardized error of the coefficient; β = Standardized coefficient; R^2 = Coefficient of determination, Adjusted R^2. *P<.000.

Discussion

The present paper examined the variation in healthcare-seeking behavior in adolescents in Enugu state based on their religious association. Two hundred and forty-one adolescents belonging to different religious organizations responded to the study questionnaire. The linear regression model performed on the data showed that the religious domain statistically significantly predicted healthcare-seeking behavior among the respondents at $F(1, 239) = 41.38$, $p < 0.05$. Most importantly, the R^2 indicated that the religious domain explained about 12.1% of the variation in HSB among the respondents. Thus, the result presupposes that religious attachment positively influences a person's knowledge, belief, and response relating to healthcare. Indeed, the finding suggests that those more committed to their religious faith are more likely to have more confidence in divine intervention when health is compromised. The present result corroborates the findings of previous studies, which implicate religion in health behavior (Coe et al., 2015; Dessio et al., 2004; Figueroa et al., 2006; Gäbler et al., 2017; Garcia et al., 2013; Horton, 2015; Krause et al., 2017; Togonu-Bickersteth et al., 2019; Underwood & Powell, 2006). For instance, Fletcher and Kumar (2014) reported that intrinsic religiosity-self-reported relevance of religion-during adolescence largely contributes to a reduction in substance dependence, thus, affirming the effect of religious commitment on health-promoting behavior. Conversely, the result contradicts Bakhtiari et al. (2019), who found no significant relationship between health behavior and religious orientation. Perhaps, this disparity suggests the chance of other intervening variables. The mechanisms driving HSB are complex and require a multidimensional approach that encompasses every motivation, intention, effectiveness, and availability of the healthcare system.

Similar to the frequent reports of faith-based resilience to health conditions, the present study confirms the effect of perceived religious belief on HSB. Thus, it presupposes those individuals who are highly devoted to their religion commit more to a spiritual solution than accessing the healthcare system. At the same time, those with a low pledge to spirituality are more likely to seek professional attention. Although, the study could not confirm the mechanisms through which commitment in a particular religious sect could determine the resolve to depend on faith than exploit the health care system during illness. It, however, provides insight into possible decline in healthcare utilization due to elevated credence to religious belief. Thus undermining the principles of the healthcare system, which promotes unbiased healthcare-seeking behavior. As religion is one of the psychosocial characteristics of patients, knowing patients' level of attachment to faith can be helpful for healthcare providers (Kang et al., 2020).

Conclusion

The present paper investigated religious domains as an essential correlate of HSB in a sample of adolescents. The investigation concludes that spiritual discipline is a crucial element of HSB. Indeed, the finding affirmed the central hypothesis of the study. Thus, it is recommended that the religious domain be considered an aspect of healthcare concern to healthcare providers to achieve all-inclusive care for the younger people. Also, full enlightenment health-promoting programs are needed, especially among the youth. Thus, it is believed that significant improvements can be recorded in promoting the good health of young people in Nigeria if health education and outreach efforts are presented and promoted through religious, spiritual, and faith-based settings.

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