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EXPLORING THE INTERSECTION OF RELIGIOUS EDUCATION AND HEALTHCARE SEEKING BEHAVIOR IN SOUTH-SOUTH NIGERIA

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Abstract
The intersection of religious education and healthcare-seeking behavior highlights the complex ways in which religious beliefs and practices influence health-related decisions and actions. The present paper highlights the role of religious education on healthcare-seeking behavior in South-South Nigeria. Two hundred and forty-one respondents conveniently selected from different religious environments in Edo and Delta States 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 analysis revealed a statistically significant interaction between religious education and HSB, $F(1,239) = 41.38$, $p < 0.05$. The adjusted R^2 indicated that religious education contributed about 12.1% of the variation in HSB. By recognizing and respecting these influences, healthcare providers can offer more holistic and culturally competent care.

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 that is desired to be included in 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;

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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). Moreover, 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 dissolves 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 decisions appear complicated, possibly because behaviors are varied and influenced mainly by several factors, including 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 education and healthcare behavior

Growing insinuation suggests 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, religious education 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 is significant 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.

Most adherents of various religious denominations perceive healing as a supernatural occurrence, attributing the recovery from illnesses to prayer and divine intervention rather than medical treatment or the intervention of physicians. This belief has led to a concerning trend in the proliferation of established faith centers by numerous religious factions, drawing in a multitude of followers seeking spiritual restoration. Essentially, the prevailing notion is that prayers and faith are the primary panaceas for ailments. As a result, the conviction in spiritual healing has become deeply rooted in the psyche of numerous devout individuals, exhibiting variances among different religious affiliations.

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Indeed, diverse religious teachings instill varying perspectives on healthcare, with such inclinations appearing notably prominent during adolescence. This developmental stage represents a critical juncture for fostering good health, yet it is characterized by a burgeoning quest for autonomy and erratic decision-making, fostering a susceptibility to abstract concepts. While the healthcare requirements for most people may be relatively low, cultivating a mindset centered on religious healing during this phase could yield enduring implications on healthcare practices and pose a substantial impediment to health-promoting behaviors. Hence, the objective of this study is to explore healthcare-seeking behavior in light of the diversity in religious instruction.

Hypothesis: *Religious education would determine differences in healthcare-seeking behavior*

Method

The participants in the present paper comprise individuals aged 18 – 59 who reside in Edo and Delta State, South-South Nigeria. The study draws primarily on those who identify as Christians or Muslims.

Procedure

About two hundred and eighty participants were approached in various places of worship, predominantly during mid-week gatherings and partially during Sunday services, based on convenience. Prior consent was acquired from religious authorities before the study commenced. Significantly, the participants were briefed on the study's objectives and encouraged to complete a consent form. Those who agreed to take part in the survey (n=267) were informed that participation was voluntary and they had the liberty to withdraw at any point. They were handed the research questionnaires to fill out on the spot. Additionally, any unclear items were elucidated for them. The participants did not receive any monetary compensation for their involvement in the survey. Specifically, 267 questionnaires were distributed and collected on-site. However, out of the 267 questionnaires given to the respondents, 26 were inaccurately completed and thus deemed invalid. Consequently, only the adequately completed questionnaires (i.e., 241) were included in the statistical analysis. The survey took place between August and October 2024.

Healthcare-seeking behavior was assessed using a questionnaire crafted to gauge the respondent's responses to their health status, particularly in determining the priority placed on medical intervention from professionals in times of illness compared to seeking spiritual assistance. The questionnaire consisted of 15 items utilizing a 5-point Likert scale and underwent preliminary testing in a pilot study. The analysis revealed a Cronbach's alpha coefficient indicating a satisfactory level of internal consistency reliability, surpassing the recommended threshold of .72 for research purposes (Kaplan & Saccuzzo, 2001). A higher score on the questionnaire signifies a greater inclination towards healthcare-seeking behavior. Information on religious affiliations was collected in the demographic segment 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 education and HSB, $F(1,239) = 41.38$, $p < 0.05$. The adjusted R^2 indicated that religious education contributed about 12.1% of the variation in HSB.

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

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

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

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Discussion

The present paper examined the variation in healthcare-seeking behavior in South-South Nigeria based on their religious education. Two hundred and forty-one participants belonging to different religious organizations responded to the study questionnaire. The linear regression model performed on the data showed that religious education 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 religious education 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 that individuals who are highly devoted to their religion commit more to a spiritual solution than to access the healthcare system. At the same time, those with a low pledge to spirituality are more likely to seek professional attention. However, the study could not confirm the mechanisms through which commitment in a particular religious sect could determine the resolve to depend on faith rather than exploit the healthcare system during illness. It, however, provides insight into a possible decline in healthcare utilization due to elevated credence to religious belief. Thus, it undermines the principles of the healthcare system and 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 intersection of religious education and healthcare-seeking behavior is a fascinating area of study that explores how religious beliefs and teachings influence individuals' decisions and actions regarding their health. The study concludes that spiritual discipline is a crucial element of HSB. Indeed, the findings affirmed the central hypothesis of the study. Thus, it is recommended that religious education be considered an aspect of healthcare that is of concern to healthcare providers in order to achieve all-inclusive care for 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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