

## **Effects of Religious Involvement on the Health Outcomes of Adults in the Sunyani Municipality**

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Date received: November 2, 2022

Date published: January 14, 2023

**Abstract:** In the last 20 years, there has been an increase in interest in the issue of faith and health, which focuses on the connections between social, religious, and health sciences. This study's primary objective was to evaluate the impact of religious affiliation on persons' health-seeking behaviors in the Sunyani municipality. The study's goals were met by using a cross-sectional research approach. The study also used a mixed-methods strategy where both qualitative and quantitative methods of data collection were used. The present study viewed religion and spirituality as multidimensional components and quantified them using a novel measure of religion and spirituality for research on health outcomes. The findings of the study suggest that the inclusion of religious faith did have a significant impact on the lifestyle choices of those who practiced it. It was discovered throughout the interviews that a person's religious affiliation affected many other parts of their lives, not only their health decisions. Diet, sanitation, cleanliness, modesty, clothing and grooming, family planning, blood transfusion, organ transplantation, pregnancy, care of the dying, burial, post-mortems, and festivities/celebrations were among these consequences, but they weren't restricted to these.

**Keywords:** Health, adults, religious involvement, health outcomes, Sunyani Municipality

### **1. INTRODUCTION**

The World Health Organization (WHO) refers to health as a “state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (WHO, 2016). Healthcare exists to help people maintain this optimal state of health. Also, WHO sees health as “a resource for everyday life, not the objective of living? Health is a positive concept emphasizing social and personal resources, as well as physical capacities” (WHO, 2016). This means that health is a resource to support an individual's function in wider society, rather than an end in itself. A healthful lifestyle provides the means to lead a full life with meaning and purpose. The relationship between faith and health is an emerging topic of research in the last 20 years, which focuses on the correlation between religion, social, and health sciences. It has baffled scientists because it is difficult to compare faith and beliefs to human physical and mental conditions. As such, research is limited as a means of evidence. The role of health is related to a system of beliefs, community interaction, and practices. Mental and physical health is probably the two most frequently discussed types of health though spiritual, emotional, and financial health also contributes to overall health. Medical experts have linked lower stress levels and improved mental and physical well-being. People with better financial health, for example, may worry less about finances and have the means to buy fresh food more regularly. Those with good spiritual health may feel a sense of calm and purpose that fuels good mental health (Zimmet, Magliano, Herman & Shaw, 2014).

Biological health represents physical health that can be mitigated by religious practices and abstinences. For example, Elifson, Klein, and Stark (2003) demonstrated that being religious was

a strong predictor of women's sexual practices related to HIV risk, and women that were least religious were reported to have the greatest risk, whereas faith and community correlate with our social interactions and support system. In a study of faith communities of African-American churches in the United States, it was reported that the social and spiritual support of the African-American people was consistent with the reduction of cases of drug and alcohol substance abuse (Watson et al., 2003).

A person who has good physical health is likely to have bodily functions and processes working at their peak (Marinho, de Azeredo Passos, Malta, França, Abreu, Araújo, & Naghavi, 2018). This is not only due to an absence of disease. Regular exercise, balanced nutrition, and adequate rest all contribute to good health (Seyum, Mebrahtu, Usman, Mufunda, Tewolde, Haile, & Negassi, 2010). One aspect of health to consider is mental health. According to the WHO, mental health is "a state of well-being in which the individual realizes his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and can contribute to his or her community" (WHO, 2004). According to Morinho et al. (2018), mental health refers to a person's emotional, social, and psychological well-being. Mental health is as important as physical health as part of a full, active lifestyle.

## **2. MATERIALS AND METHODS**

The first part talks about the study area which deals with the socio-demographic characteristics, physical features and healthcare among others in the Sunyani Municipality. The second part talks about the methods used in achieving the study objectives. These include the research design and strategy, the sample size, sampling technique, and the kind of data analysis that was employed in arriving at the study objectives.

### **Demographic Characteristics of Respondents**

The demographic characteristics in this study include age, gender, Citizenship, Place of interview, Employment status, Marital Status, and Level of education. The estimated number of interviewees was 385. All qualitative and quantitative analyses of the survey data may be summed up to this total. Many individuals were hesitant to participate, permission was withdrawn days after being given, and some questions were avoided, all of which led to differences between the theoretical framework and the actual fieldwork. The differences can be seen when you add up the numbers for the different kinds of questions. The results from the analysis revealed that age group and health insurance status were the only independent demographic predictors of seeking care at government health facilities. As supported by the findings in research question two, respondents from older age groups reported seeking care from government health facilities more often compared to those from younger age groups. Again, this may be attributed to greater health care needs among older respondents due to the higher prevalence of chronic conditions among these groups of individuals for whom chronic long-term care at mainstream health facilities (government health facilities included) is the mainstay of treatment. The findings that the older age group predicts care from government health facilities agree with the findings of Grimsmo and Siem (1984), whose study uncovered increased age as a predictor of regular primary care and was tied to a higher prevalence of chronic disorders among the older age groups.

### **Study Design**

A cross-sectional research design was used in the study to achieve its objectives. This study design was selected due to the following reasons. Firstly, in the collection of data by a cross-sectional design, it makes it possible for more than one case within a single point in time in connection to two or more variables (Bryman, 2012). Also, the researcher does not interfere with or manipulate the study environment with a cross-sectional design (Morse, 1991). The cross-sectional design helps in the examination of relationships between variables and makes finer distinctions between cases. The study used a mixed-method strategy where both qualitative and quantitative methods of data collection were used.

### Data collection

During the data collection, two researchers were assistants who both have backgrounds in engineering with a considerable knowledge base and experience in research. Having such capable assistants makes it ideal and easy for data collection as they have been made resilient through tough calculations in their courses of study. They went in person to the selected communities to conduct face-to-face interviews using audio recordings with the citizens and made real-time observations and documented their responses in handwritten notes. The recommendations made by the responses were later transcribed into a word document.

### Sampling Technique and Sample Size

The purposive sampling technique was used to select four communities within Sunyani Municipality, Bono Region. The administration of the questionnaire was done by using the convenience sampling method. This convenience sampling is used by researchers to collect research data from a conveniently available pool of respondents (people at the faith healing centres and hospitals). It was used due to its credibility, uncomplicated and economical nature. Also, members as respondents are readily approachable to be part of the study sample. In many cases, potential respondents are readily approachable to be a part of the sample.

### Data Analysis

The data collected was processed using a spreadsheet package (Microsoft Excel) and then imported into a statistics software package (SPSS software).

Descriptive statistics, such as frequencies, proportions and logistic regression analysis, were used as a means of data representation.

## 3. RESULTS

### Demographic Characteristics

The response rate for the study was 41%. The researcher observed some respondents could not return or answer the questionnaire because it bothers on faith. People very reserved with regards to their faith believe and sometimes finds it difficult sharing them. The total sample size for the study is 159.

**Table 1: Demographic Characteristics of Respondents**

VARIABLE	CATEGORY	(F)	(%)
Gender	Male	97	61.0
	Female	62	39.0
Age	18-30	88	55.0
	31-40	41	25.0
	41-50	18	11.0
	50+	12	8.0
Citizenship	Ghanaian	154	97.0
	Non-Ghanaian	5	3.0
Place of interview	Abesim	38	24.0
	Sunyani	77	48.4
	Nwanwasua	15	9.4
	Kotokrom	29	18.2
Employment status	Working	68	43.0
	Retired	5	3.0
	Unemployed	86	54.0

Marital Status	Single	94	59.1
	Married	52	32.7
	Divorced	6	3.7
	Widowed	4	2.5
	Separated	2	1.3
	Cohabiting	1	0.6
Level of education	No formal education	5	3.1
	Primary	2	1.3
	Middle/JHS	6	3.7
	Secondary	22	13.8
	Vocational/Technical	30	18.8
	Tertiary	94	59.1

**Source: Fieldwork, 2022**

From Table 1 above a total of 159 people chose to disclose their gender identity. 97(61%) were males and 62(39%) were females. With regards to the age disparities of respondents, 88(55%) of them fell within the ages of 18-30years, 41(25.0%) were 31-40years 18 people made up 11% who were in the ages of 41-50years while the remaining 13(8%) were above 50years. The results show that, 68(43%) of them had active work while 86(54%) were unemployed and 3% had no jobs. Many of them were very learned as we had a tertiary level of education having the highest number of respondents 94(59.1%). A third of that number 30(18.8%) had acquired technical/vocational education and the remaining had some primary to tertiary level education. Only 5 (3.1%) respondents had no formal education. This gave confidence that there were people who had some basic reading and understanding skills. In this way, they could read the questionnaires on their own and answer the questions without the need of an interpreter as the document was prepared fully in English with no section featuring the use of the local dialect.

### Descriptive Statistics

**Table 1: Descriptive Statistics of Variables**

Variables	Health Care	Effect	Relationship		
Mean	25.650	3.170	.2460	.1000	.0650
Median	24.350	3.150	.1250	.0900	.0650
Standard deviation	12.1812	1.3191	.23857	.04243	.02068
Minimum	10.9	1.3	.10	.04	.03
Maximum	45.8	5.1	.74	.16	.09

**Source: Field data (2022)**

Table 3.1 above highlights the descriptive statistics (means and standard deviations) for all the variables under consideration. It depicts the averages of both the dependent and independent variables for the period. The summary results of the descriptive statistics show the variables captured in the regression model. These statistics were generated to give an overall description of the data for any suspicious figure. The key descriptive measures are the mean, standard deviation, and the minimum and maximum values of the variables. It tested a number of variables. Table 3.1 demonstrates that all variables have positive average values (mean and median). This is usual considering the arrangement included. Also, the minimum deviation of the variables from their means, as indicated by the standard deviation, gives an indication of the moderate rate of fluctuation of these variables within the period of study. For the study periods, the mean rate for causes was 25.650 with a standard deviation of 12.1812. The period of study of the mean effect was 3.170 with a standard deviation of 1.3191. Again, the mean rate for sub-standard health outcomes (relationship) was 0.2460 with a standard deviation of 0.23857. Also, the mean rate for

health-seeking behaviour (relationship) was 0.1000 with a standard deviation of 0.04243. Lastly, the mean rate for challenges and conditions (relationship) was 0.0650 with a standard deviation of 0.02068.

**Table 2: Quick facts about the selected communities:**

No.	Community Name	Total Population	Male distribution	Female distribution	Households	Number of Houses
1	Abesim	16,441	7,858	8,583	4,156	1,897
2	Kotokrom	1,822	896	926	476	231
3	Nwawansua	844	429	415	152	174
4	Sunyani Township	75,366	37,387	37,979	17,613	6,698

Source: *Ghana Statistical Service, 2014*

The participant selection will be those who are found in some faith healing centres. The selected respondents for the questionnaires were from the faith-healing centres. The participants were ideal as they have first-hand experience with the objective of the research. Questionnaires were administered to individuals of religious bodies such as Christians, Muslims, Traditional, and others.

**Table 3: Determinants of Religious Involvement for Health Outcomes of Adults in the Sunyani Municipality**

VARIABLE	CATEGORY	(F)	(%)
Choice of health care facility	Self-medication	19	11.9
	Health Center	71	44.6
	Pharmacy/Drug Store	10	6.2
	Clinic/Hospital	39	24.5
	Traditional/Herbal medicine	11	6.9
	Spiritualist	9	5.6
Reasons for the choice	No transportation difficulties	32	20.1
	Family/Friend/Acquaintance works there	17	10.6
		5	3.1
	Recommended by someone else	39	24.5
	Accepts NHIS/Other insurance	4	2.5
	Shorter waiting times	47	29.5
	Good quality of service	12	7.5
	Religious or cultural beliefs	3	1.8
Healthcare decision	Self	118	74.2
	Family member	24	15.0
	Parents	13	8.1
	Partner	4	2.5
Affiliation to a religion	Yes	103	65.0
	No	56	35.0
Religions	Christian	55	53.3

	Muslim	30	29.1
	Traditional	15	14.5
	Other	3	2.9
What influence the religious choice	Family history with religion	59	37.1
	Personal	88	55.3
	Friends	3	1.8
	Society	5	3.1
	Higher education	2	1.2
	Marital status	2	1.2
Choice of treatment method	Prayerful healing	28	17.6
	Medical treatment	32	20.1
	Both	99	62.2
Reasons for the choice	Risk escalation	16	10.1
	Religious commitment	48	30.2
	Communal reception	3	1.8
	Personal conviction	92	36.7
Reasons for religious involvement during healthcare	Happiness	62	57.9
	Wellbeing	81	50.9
	Stress coping	5	3.1
	Diseases	4	2.5
	To be assigned more religious responsibilities	1	0.6
	To be accepted by God as an obedient child	1	0.6
	To be well respected in my society for choosing God's will over any other decision	1	0.6

**Source: Fieldwork, 2022**

Table 3 shows the determinants of religious involvement for health outcomes of adults in the Sunyani Municipality. The results show that 71(44.6%) who visit the health centre, and 39(24.5%) respondents opting for clinics/hospitals. The results show that reasons for the choice of place for assessing health care indicated, 39(24.5%) because the facility accepts NHIS or insurance, 45(30.2%) were because the health facility had good quality of service. With regards to taking decision on health care matters, 118(74.2%) owed their healthcare decisions to themselves. The study again showed 103(7.7%) were religiously affiliated while 56(35.0%) were not religiously affiliated. The results again showed out of those who were religiously affiliated 55(53.3%) were Christians, 30(29.1%) were Muslims as 15(14.5%) were traditional oriented. The results again show that 59(37.1%) were largely influenced by their family history in making their choice of religious affiliation, 88 (55.3%) were their personal decisions. Respondents' decision on their choice for medical treatment came out that, 99(62.2%) of respondents prefer both prayerful healing and medical treatment. Reasons for the choice of preference shows that 48(30.2%) of respondents indicated is based on religious commitment, 92(36.7%) also indicated personal conviction as their reason. With regards reasons for religious involvement concerning health, 81(50.9%) indicated wellbeing, 62(57.9%) said happiness.

**Table 4: Model Summary Statistics for Causes of Religious Involvement for health Outcomes**

Model Summary statistics				
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.932 <sup>a</sup>	.868	.802	5.4223

a. Predictors: (Constant), Adults in the Sunyani Municipality

b. Dependent Variable: Health Outcomes (wellbeing, happiness, Stress coping)

Source: *Field data (2022)*

Table 4 shows an "R" (correlation coefficient) of 0.932, indicating that the causes of religious involvement for health outcomes are very strong. The "R Square" of 0.868 shows that every component of the independent variable (adults in the Sunyani Municipality) explains the dependent variable (religious involvement for health outcomes as measured by Health Outcomes) by 86.8%. That is every component of health outcomes for only 86.8% of variations in the dependent variable (religious involvement for health outcomes as measured by Health Outcomes). Other health factors are responsible for the remaining 13.2% variation in religious involvement for health outcomes in Sunyani municipality. The adjusted R Square, which gives the percentage of variation explained by only those independent variables that in reality affect the dependent variable, shows a figure of 0.802 or 80.2%. This means that, according to the adjusted R square, total health accounts for only 80.2% of the variation in religious involvement in health outcomes. The remaining 18.8% is due to other factors. This means that other factors rather than religious involvement in health explain lesser variations in the causes of religious involvement for health outcomes of adults in the Sunyani Municipality.

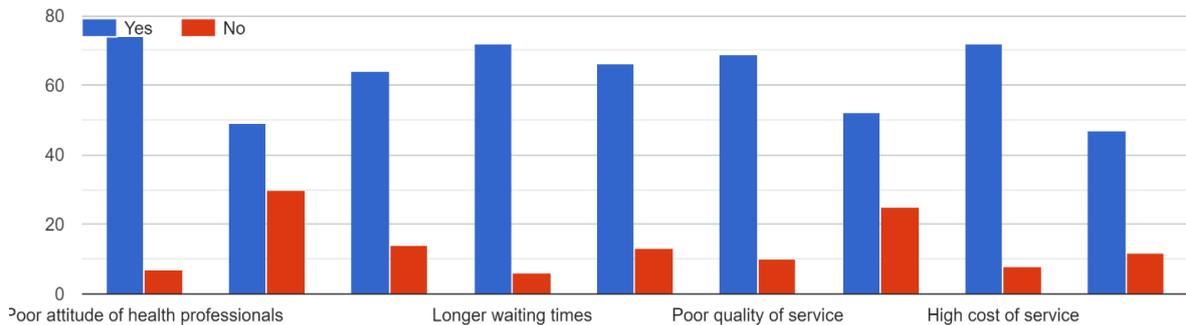
**Table 5: Binary logistic model results: Effects/Consequences of Religious Involvement on Health Outcomes in the Sunyani Municipality**

Variables	B	Sig.	Exp(B)
Self-medication with herbal drug when disease mild	1.489	.126	4.432
Possibility of self-medication in future by use of herbal drugs	2.158	.011	8.654
Notwithstanding the availability of all health care options, self-medication with herbal drugs is preferred.	2.079	.012	7.997
Preferred prayerful healing or medical treatment	2.276	.005	9.740
Reason for the choice	1.527	.043	4.603
Reasons for religious involvement concerning health	1.725	.044	5.615
Self-medicate with herbal drugs when am sick	.206	.810	1.228
self-medication with herbal drugs	1.93	.052	6.24
Constant	-5.414	.000	.004

Source: *Field data (2022)*

The chi-square ( $\chi^2$ ) statistic for the model was 57.23 and statistically significant indicating that the model was significant for predicting the likeliness of performing satisfactorily in Religious Involvement on Health Outcomes in the Sunyani Municipality. The Cox & Snell  $R^2$  statistic was

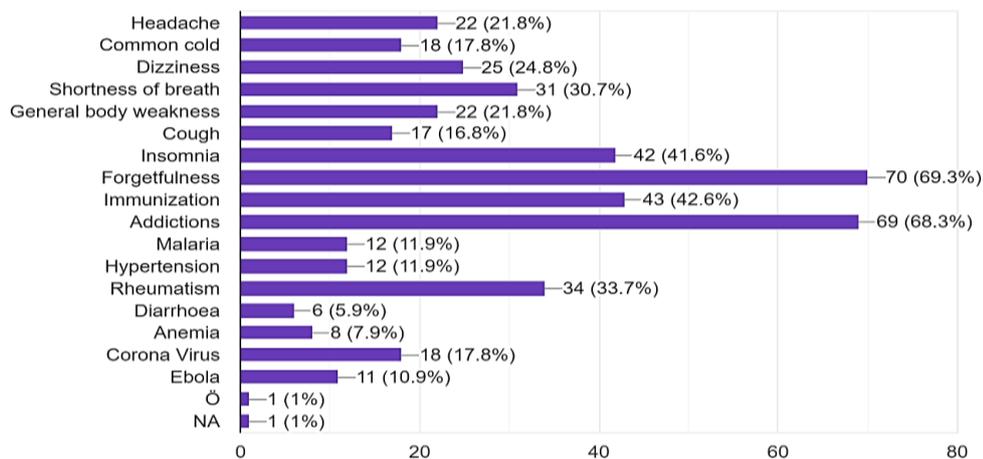
0.61 indicating that the variables in the model explained up to 61% of the difference in Religious Involvement in Health Outcomes in the Sunyani Municipality. The specific variables that significantly influenced Health Outcomes were obtained based on the significance of the odds ratios. The variables show positive and statistically significant ( $p < 0.00$ ). This implied that as hypothesized, these factors significantly influenced Sunyani Municipality.



**Figure 1: Difficulties in Using Health-care Facilities**  
**Source: Fieldwork, 2022**

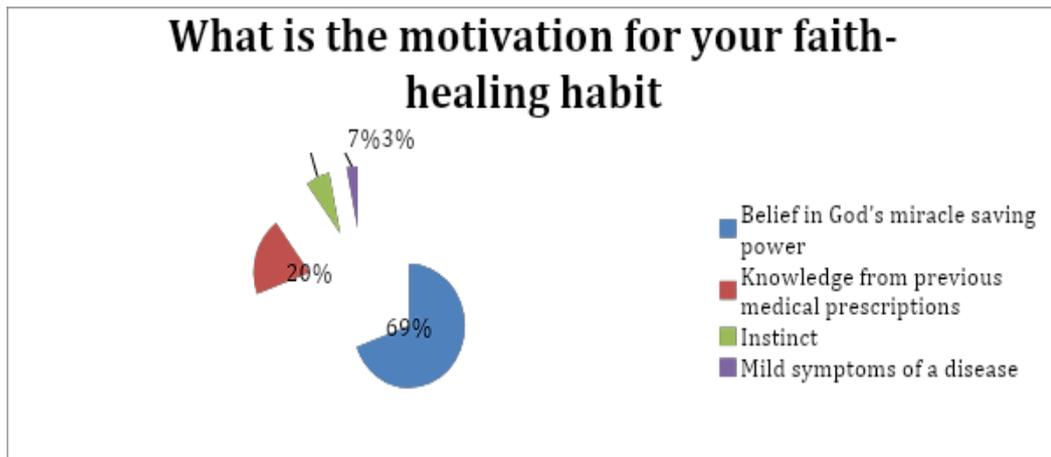
Due to their religious affiliation, many respondents did not seek medical attention for some common health conditions/sicknesses because their religion prohibited them in favour of prayer. Select five common health conditions your religions prohibit members from getting medical treatment in favour of prayer.

**101 Responses**



**Figure 2: Common Health Conditions left in Favour of Prayer**  
**Source: Fieldwork, 2022**

The figure above is a representation of several health conditions including communicable diseases. Disease such as headache, common cold, dizziness, shortness of breath, general body weakness, cough, malaria etc. are common religions that the respondents identify that their religion prohibits medical treatment in favour of prayers.



**Figure 3: What is the Motivation for your Faith-Healing Habit**  
**Source: Fieldwork, 2022**

Respondents in figure 5 above agree 70% to the question what is the Motivation for your Faith-Healing Habit in the case of belief in God’s miracle saving power (70%), while the statement on knowledge from previous medical prescriptions (20%), while the statement on instinct was (7%), and Mild symptoms of the disease were (3%). The highest dominance of the question on what is the Motivation for your Faith-Healing Habit was 70% (belief in God’s miracle saving power).

**Table 6: Pearson Chi-squared Correlation Analysis Results for Effects/Consequences of Religious Involvement on Health outcomes in the Sunyani Municipality**

Variable	Effects/Consequences		Religious Involvement		Health Outcomes	
	Coefficient	P-value	Coefficient	P-value	Coefficient	P-value
Nearest health facility	.706**	.001				
Challenges getting health facility	.687**	.001	.911**	.000		
Challenges	.599**	.005	.572**	.008	.688**	.001
Difficulty in using facility	.329	.157	.247	.294	.437	.054
Some of the challenges	.015	.948	.084	.725	.211	.373
Five common health conditions your religion prohibits in favor of prayers	.312	.180	.425	.062	.421	.064
Healed from any sickness through prayers	.000	1.000	.120	.585	.000	1.000
Healed of any mental problem	.187	.431	.161	.499	.425	.062
Penalized for accepting banned medical treatment	.175	.631	.061	.479	.42594	.071

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Motivation for your faith healing	.168	.431	.089	.489	.42794	.070
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\* indicate significant at 95% level and \*\* indicate significant at 99%

From table above the statement what kind of health facility is nearest to you had a Coefficient of (.706\*\*), and a P-value of (.001), Do you face any challenges in getting to this health facility had a Coefficient of (.687\*\*) and a P-value of (.001). If yes, what are some of the challenges had a Coefficient of (.599\*\*) and a P-value of (.005), Do you face any difficulty this facility had a Coefficient of (.329) and a P-value of (.157), If yes, what are some of the challenges had a Coefficient of (.015) and a P-value of (.948), Select five common health conditions your religion prohibits medical treatment in favour of prayer had a Coefficient of (.312) and a P-value of (.180), Have you ever been healed of any sickness through prayer had a Coefficient of (.000) and a P-value of (1.000), Have you ever been healed of mental health problems had a Coefficient of (.187) and a P-value of (.431), Are you penalized in your religion for accepting any of the banned medical procedures had a Coefficient of (.175) and a P-value of (.631), and What is the motivation for your faith-healing habit had a Coefficient of (.168) and a P-value of (.431). The p-values in respect to the correlation coefficients for Effects/Consequences, Religious Involvement, and Health Outcomes were positive and statically significant ( $p < 0.005$ ) indicating a significant relationship between these variables. Involvement in religious practices and a spiritual outlook have been shown in the vast majority of studies to be associated with improved health outcomes. These results include longer life spans, better coping skills, and a better quality of life in terms of health (even for people with terminal illnesses), as well as less anxiety, depression, and suicidal thoughts.

#### 4. DISCUSSIONS

The finding on Causes of Religious Involvement in Health Outcomes of Adults in the Sunyani Municipality supported (Taylor and Chatters, 1986) study on Origins of Religious Involvement in Health Consequences. It was shown that the present study viewed religion and spirituality as a multidimensional component and quantified it using a novel measure of religion and spirituality for research on health outcomes. This measure was developed specifically for this study. and shows a deep relationship with that of what (Taylor and Chatters, 1986) stated. It seems that the religious and spiritual beliefs of those who suffer from pain are distinct from those of the general community (e.g., pain patients feel less desire to reduce pain in the world and feel abandoned by God). The use of hierarchical multiple regression allowed for the discovery of substantial relationships between aspects of spirituality and religion and both physical and mental health. This suggests that individuals who were experiencing worse physical health were more likely to participate in private religious activities, possibly as a way to cope with their poor health. It was shown that self-rankings of religious or spiritual intensity, forgiveness, negative religious coping, everyday spiritual experiences, and religious support were significant predictors of mental health status. There was no correlation found between religion or spirituality and the degree to which pain interfered with daily living. This research demonstrates correlations between religion/spirituality and health in a population of people with chronic pain. It also shows that spirituality and religion may have both good and bad effects on the health of people with chronic pain.

Religion has a very deep ancestral root in the Bono region according to the interviews conducted during the research work. Many people have stuck to the religion practised by their forefathers or family lineage. It is only a question of a deeply ingrained custom that even some adults will allow their pastors to choose what medical practice they should consider for their condition.

The observational findings of the study suggest that the inclusion of religious faith did have a significant impact on the lifestyle choices of those who practised them. The literature reviewed in chapter two stated that better mental health was associated with social support (Chatters, Taylor, Woodward, & Nicklett, 2015). The religious people who practised the above-mentioned lifestyle did not feel guilty as they had a whole community of associates who supported them by living

similar lifestyles. They had the help they needed in the terms of recommendations and defense in times of incapacitation from fellow believers. This made them have better mental health that it wasn't them alone practising any lifestyle out of the ordinary.

It is well known that some psychotic and less seriously disturbed people put their symptoms down to the influence of the devil. The findings were similar to that of (Pfeifer, 1999), on the consequences of religious involvement on health in rural and urban development. Top choice among many respondents was a mental illness that resulted in forgetfulness or a person's lack of willpower to fight or overcome addictions. This was the case because these symptoms are believed to be the results of the works of demonic possession on a person. Among modern evangelical Christians, demonic possession is thought to be one probable cause of mental illness. Those who demonstrate indications of possession are susceptible to deliverance in order to rid themselves of the possession (Kanu, Baker, & Brownson, 2008)

During the interviews, it was realized that religious involvement not only had outcomes on an individual's health decisions but many aspects of their lives. These outcomes included but were not limited to; diet, hygiene, cleanliness, modesty, dressing and grooming, family planning, blood transfusion, organ transplantation, pregnancy, care of the dying, burial, post-mortems, and festivities/celebrations. There are two main dominant religious practices in the Sunyani municipality namely; Christianity and Islamic religion. A review of attendees was made and practitioners of these religions came to the following conclusions on the impact it had on their lives in the aforementioned areas.

This study's overarching goal is to examine the interplay between religious beliefs and medical practice in order to provide guidance for practitioners who find themselves at odds with their patients' religiously informed treatment preferences. Both the patient and the practitioner need to see things from the other's perspective; the patient is aware that the doctor wants what's best for them but is sceptical that "the doctor knows best" in this case. It's something only God can accomplish. The patient has full confidence in the doctor's diagnosis and treatment plan since the doctor has provided a thorough explanation of the patient's symptoms, test findings, and medication.

The coefficients reported was significantly positively correlated with all the complementary and alternative forms of treatment, namely self-medication with herbal drugs, self-medication with pharmaceutical drugs, care from traditional/herbal practitioners and care from faith healers. The present research observed that sufferers of chronic diseases, such as diabetes and hypertension for whom lifelong treatment is indicated, tend to explore complementary and alternative forms of treatment such as traditional/herbal care and faith healing for cures to their conditions that are not only elusive, but frequently result in complications of their primary conditions.

## **5. CONCLUSION**

The discussion follows the major themes of the study which incorporates how the Causes of Religious Involvement in Health Outcomes of Adults in the Sunyani Municipality choose their healthcare services and the Effects/consequences of Religious Involvement on Health Outcomes in the Sunyani Municipality. Discussions are also provided on the Relationship between Religion and Health-Seeking Belief Outcomes in the Sunyani Municipality. Although these discussions are provided separately, they are not mutually exclusive. References were made to other studies that either conform or contradict the study's findings as well in this chapter. With respect to the first objective that looked at Causes of Religious Involvement in Health Outcomes of Adults in the Sunyani Municipality, the study revealed that there are variations in terms of which causes affect choice in what health situations (chronic or acute) and with respect to which individuals in the communities (adults). It was shown that the present study viewed religion and spirituality as a multidimensional component and quantified it using a novel measure of religion and spirituality for research on health outcomes. The Effects/consequences of Religious Involvement on Health Outcomes in the Sunyani Municipality, it was reveal that religious involvement not only had outcomes on an individual's health decisions but many aspects of their lives. These outcomes

included but were not limited to; diet, hygiene, cleanliness, modesty, dressing and grooming, family planning, blood transfusion, organ transplantation, pregnancy, care of the dying, burial, post-mortems, and festivities/celebrations.

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