

Religiosity and Health Status in Middle Aged Male Muslims in Indonesia

Hayuni Rahmah, Urai Hatthakit, Sopen Chunuan

Abstract: The aims of this descriptive study were to describe the levels of religiosity and health status, and examine relationships among components of religiosity and health status. Using non-probability convenience sampling, 126 middle-aged, Indonesian, Muslim men were recruited through nine mosques in Jakarta. Data were collected via a self-report questionnaire consisting of three parts: the Demographic and Health Information Questionnaire, the Islamic Involvement Questionnaire (measuring religiosity) and the Health Status Questionnaire.

Findings revealed the majority of subjects had both low religious intrinsic orientation (57.9%) and religious behavior (55.6%). Approximately 27% ranked themselves as “high” in overall religiosity, while 40.5 % ranked themselves as “low.” Those who ranked themselves as “high” in religious behavior only accounted for 15% while those who ranked “high” in religious intrinsic orientation only was 17.5%. The majority (69.1%) indicated their level of health status was “good.” However, within the six specific components of health status, the majority ranked themselves at a “moderate” level. Positive correlations were found between religious intrinsic motive and spiritual health ($r = .26, p < .01$), and religious behavior and general health perception ($r = .24, p < .01$) and spiritual health ($r = .37, p < .01$). The relationships among various components of religiosity and health were discussed, and recommendations for further studies were also provided.

Thai J Nurs Res 2008; 12 (3) 220 - 230

Keywords: health status, Indonesia, middle-aged Muslim men, religiosity,

Background

The role of spiritual and religious factors in health has received attention following acceptance of the concept that one’s body works in collaboration with the mind to influence health and disease.¹ Health has been seen as holistic and addresses a person as a bio-psycho-social and spiritual being.²

Hayuni Rahmah, R.N., M.N.S. (Candidate) Faculty of Nursing, Prince of Songkla University, Hat Yai, Songkhla, Thailand
Urai Hatthakit, R.N., Ph.D. Assistant Professor, Faculty of Nursing, Prince of Songkla University, Hat Yai, Songkhla, Thailand
Sopen Chunuan, R.N., Ph.D. Assistant Professor, Faculty of Nursing, Prince of Songkla University, Hat Yai, Songkhla, Thailand

Religious activities have been thought to have a positive effect on health. Levin and Schiller³ concluded, after review of over 250 published articles, that religiosity appears to exert a salutary effect on physical health. Other religious groups, including Mormons and Adventists, are known to live longer with less chronic illness than non-religious groups.¹ Religion also has been found to have a positive effect on mental health. People engaged in public religious activities have lower psychological distress, greater happiness and better self-rated health.⁴ Individuals who, during stressful events, use religious beliefs and prayer are less likely to report anxiety than those who tend not to use prayer or religious beliefs.⁵ On the other hand, some prior studies have found no significant relationship between religiosity and health.^{6,7}

Previous research has revealed levels of religiosity demonstrate patterns in regards to gender and age. Women have been found to be more religious than men,⁴ and older people tend to demonstrate higher levels of religiosity.⁸

Most of the studies regarding religiosity and health have captured samples from Christian or Jewish populations in the United States or Europe.⁷ Limited research has been conducted regarding the religion-health intersection in Muslim populations, particularly within Asia.

Islam, ranked by number of followers, is the second largest world religion and Indonesia has been identified as having the largest Muslim population.⁹ Islam emphasizes and values health, as shown in Islamic principles and teachings, as important for Muslims. The Islamic way of life is a system of divine principles and code of ethics to be practiced in daily.¹⁰ Therefore, Muslims who adhere to the guidance of Islam are more likely to function at their optimal level of health. However, some Muslims underestimate and ignore the principles and teachings of Islam, and value materialism and rationalism more than beliefs and spiritual values,

which are essential to Islam. One has to wonder if varying attachment among Muslims to Islam also might impact their health. Therefore, the purposes of this study of middle-aged, Indonesian, Muslim men were to: (a) describe the levels of religiosity and health, and (b) examine relationships among components of religiosity and health.

Conceptual Framework

Construction of the conceptual framework was based on a review of the literature regarding religiosity. Religion, in general, can be conceptualized as a multidimensional construct encompassing values and beliefs, personality, search for meaning in life, self-knowledge and development of self-control, and salubrious behaviors.¹¹ Religiosity, or religious involvement, then refers to commitment of an individual to religion; it is the quality of being religious.¹²

Religion has relevance for health by reason of its prescriptions and restrictions in shaping health perceptions and attitudes, as well as affecting one's psychological and personality characteristics. The extent to which religion affects health is based on one's level of religious involvement and adherence to religious practices (religiosity).¹³

Religious involvement, or religiosity, is conceptualized as distinguishing between behavioral and subjective dimensions.¹⁴ The behavioral component pertains to individual characteristics and activities that reflect organizational or public religious expression (e.g. religious-service attendance) and non-organizational practices (e.g. private prayer and reading religious materials).¹⁴ In this study, religious behavior referred to the practice of Islamic teachings in the daily life of Muslims.

Subjective dimensions include attitudes, beliefs, experiences and self-perceptions that involve religious or spiritual content (e.g. feeling of closeness to God).¹⁴ The subjective dimension of religiosity, in

this study, was the attitude component that employs the concept of intrinsic orientation.¹⁵ Intrinsic religiosity (IR) considers religion a master motive in life¹⁶ and the framework which shapes one's goals and decisions.¹⁷ The concept of intrinsic orientation is congruent with core aspects of Islamic religiosity. Islam means complete and peaceful submission to the will of Allah (God) and obedience to His law.¹⁸

Health status was perceived as a multi-dimensional construct. This multi-dimensional construct encompasses aspects of general health perception, physical function, role-physical, role-mental, mental health, social functioning, and spiritual health.

Method

Sample A descriptive correlational design, using convenience sampling, was employed. The sample consisted of 126 subjects. Sample size, was based on a power analysis at an alpha level (α) of 0.05, with an expected power ($1-\beta$) of 0.80¹⁹ and effect size of 0.25.^{20, 21} Selection criteria included Muslim males who were: between 40 and 65 years of age; Jakarta residents; without acute or chronic illnesses; not dependent upon others for care; not recently hospitalized; without cognitive impairment; and able to communicate in the Indonesian language, bahasa. Subjects had a mean age of 50.24 years, were employed ($n = 123$; 97.6%) and earned an annual family income of 500,000 to 1 million Rupiah ($n = 62$; 49.2%), however, they were not satisfied with their income ($n = 79$; 62.7%). Most of them held a senior high school level of education ($n = 58$; 46%). From the investigators' observations and experiences, the subjects appeared representative of middle-aged male Muslims in Jakarta.

Procedure Data were collected in May-June 2007. The researcher provided each mosque manager, where data were to be gathered, with information about the study. After being allowed entry, and prayers were completed, the mosque manager explained the study to the men and told them they could choose whether to participate in the study or not.

Potential subjects were approached, informed their participation was voluntary, that they had the right to withdraw at any time without negative repercussions, and that they would be asked to complete a questionnaire over a 15-20 minute timeframe. Potential subjects primarily were obtained during nighttime prayer (Maghrib to Isya/6-7.30 PM), when more men attended mosque. Those meeting the selection criteria were given questionnaires and pens and told they could complete the questionnaires then or later at home. Those taking questionnaires home were asked to return them to the mosque manager the next time they returned for prayer. All completed questionnaires were reviewed by the researcher.

To ensure anonymity, no code numbers were placed on questionnaires until they were returned to the researcher. Safeguards used to assure confidentiality and minimize risks for subjects, conformed to guidelines established by the researchers' university and the Governor of the district where data were collected.

Instruments The study questionnaire consisted of three parts: Demographic Data Questionnaire, Islamic Involvement Questionnaire (IIQ), and Health Status Questionnaire (HSQ). The Demographic Data Questionnaire was developed by the researchers and requested information on: age, educational background, occupation, family income and level of satisfaction with annual family income.

The IIQ was modified from the Religiosity Orientation Scale (ROS) 15 and Sahin-Francis Scale of Attitudes toward Islam,²² and based on

review of Islamic principles. The measure of the religious attitude dimension contained questions regarding intrinsic orientation and knowledge of Islam. Questions regarding dimensions of religious behavior were developed, by the researchers, based on review of Islamic principles. The IIQ consisted of 26 items, including 12 that assessed religious attitude, and 14 that measured religious behavior. Each item, in the intrinsic orientation component, was measured using a five-point Likert scale ranging from strongly agree = 5 to strongly disagree = 1. Scores were determined by summing all items in the respective subscale. Value of the attitude, intrinsic orientation, was categorized into low and high, using a median score of 56 as the cut-off point. Scores below the median were

considered low, while scores above the median were considered high.²³ Religious behavior was measured by way of 14 items, using a five-point Likert scale, ranging from always = 5 to never = 1. The total score was obtained by summing all items. Higher scores reflected greater religious behavior. Religious behavior, like religious attitude, was categorized as low or high, using a median score²³ of 57 as the cut-off point. Scores above 57 were considered high, while scores below 57 were considered low. Subjects then were ranked into a final category of either low (attitude only or behavior only) or high religiosity. The rankings were based upon subjects' combined ranking within the categories, religious attitude and religious behavior²³ (Table 1).

Table 1 Categorization of the Level of Religiosity²³

Religious Dimension		Attitude Dimension: intrinsic orientation	
		High	Low
Behavior Dimension	High	High Religious	Behavior Only
	Low	Attitude Only	Low Religious

The HSQ consisted of 15 items, that were modified from the HSQ-12²⁴ and Self Assessment²⁵ that assessed health perception (1 item), physical function (3 items), role physical (1 item), mental health (4 items), role mental (1 item), social function (2 items), and spiritual health (3 items). Each subscale employed its own response format and was analyzed independently. Scores were not

summed together to form an overall score. All sub-scales were scored on a five-point Likert scale, with the exception of physical functioning, which was scored on a three-point Likert scale. Determination of the level of each subscale, except for the health perception subscale, had predetermined cut-off points to categorize scores as low, moderate or high (Table 2).

Table 2 Levels of Religiosity (n = 126)

Level of Religiosity	Frequency	Percentage
<i>Attitude Dimension – Intrinsic orientation</i>		
Low	73	57.9
High	53	42.1
<i>Behavior Dimension</i>		
Low	70	55.6
High	56	44.4
<i>Overall Religiosity</i>		
Low (attitude and behavior)	51	40.5
Attitude Only	22	17.5
Behavior Only	19	15.1
High (attitude and behavior)	34	27.0

The instruments' content validity was validated by three experts in religiosity and health status. Alpha coefficients were found to be 0.78 (religious attitude), 0.71 (religious behavior) and 0.71 (health status)

Results

As reflected in **Table 2**, the majority of subjects had a low religious attitude or intrinsic

orientation, low religious behavior and low overall religiosity (both attitude and behavior, attitude only or behavior only). **Table 3** shows that subjects believed their health was basically good. However, in the health status sub-sections, most ranked themselves at a moderate level. **Table 4** shows significant relationships among spiritual health and religious attitude and religious behavior, and between health perception and religious behavior.

Table 3 Level of Health Status (n = 126)

Level of Health Status	Range of Scores	Frequency	Percentage
<i>General Health Perception</i>			
Fair		39	31.0
Good		70	55.6
Very Good		14	11.1
Excellent		3	2.4
<i>Physical Functioning</i>			
Low	16 - 47	16	12.7
Moderate	48 - 89	92	73.0
High	90 - 100	18	14.3
<i>(Mean = 69.71, SD = 21.74)</i>			
<i>Role Physical</i>			
Low	25 - 39	31	24.6
Moderate	40 - 97	45	35.7
High	98 - 100	50	39.7
<i>(Mean = 69.04, SD = 29.5)</i>			
<i>Role Mental</i>			
Low	0 - 49	21	16.7
Moderate	50 - 97	54	42.9
High	8 - 100	51	40.5
<i>(Mean = 74.16, SD = 24.76)</i>			

Table 3 Level of Health Status (n = 126) (cont.)

Level of Health Status	Score of the Level of Health Status	Frequency	Percentage
<i>Mental Health</i>			
Low	35 – 45	25	19.8
Moderate	46 – 75	86	68.3
High	76 – 100	15	11.9
<i>(Mean = 61.15, SD = 14.89)</i>			
<i>Social Functioning</i>			
Low	12.5 – 54	30	23.8
Moderate	55 – 95	54	42.9
High	96 – 100	42	33.3
<i>(Mean = 76.09, SD = 21.27)</i>			
<i>Spiritual Health</i>			
Low	33.33 – 58	15	11.9
Moderate	59 – 92	78	61.9
High	93 – 100	33	26.2
<i>(Mean = 76.87, SD = 17.42)</i>			

Table 4 Correlations among Components of Religiosity and Health Status (n = 126)

Health Status	Religiosity	
	Attitude: intrinsic orientation	Religious Behavior
General Health Perception	0.15	0.24**
Physical Functioning	0.00	0.06
Role Physical	0.01	0.10
Role Mental	0.01	0.16
Mental Health	0.01	0.10
Social Functioning	- 0.08	0.16
Spiritual Health	0.26**	0.37**

** $p < .01$

Discussion

Over half of the subjects had a low religious attitude (intrinsic orientation). Religious attitude entails living one's religious beliefs with intent, purpose and sincerity.²⁶ From an Islamic perspective, intrinsic orientation is the soul of the Islamic spirit and means Muslims have total compliance toward Allah. Surprisingly, these findings suggest the majority of subjects were more individual-centered than Allah-centered. This is further supported when items of the IIQ are examined. A small number were

found to perform sunnah (meritorious deeds), sunnah fasting (8.7%) and sunnah prayer (18.3%). Only 22% indicated studying the Holy Qur'an or reading Islamic literature. These practices may have occurred because of the influence of their iman (faith) and knowledge of Islam.

Socioeconomics may have influenced the low levels of religious attitude (intrinsic orientation).^{8, 27} Dealing with socioeconomic instability, which many Indonesians face as a result of the 1998 economic crisis, may limit access to sources for gaining religious knowledge and recharging religious spirit.

Over one third of the respondents indicated their family income was insufficient. Thus, their focus may have been more toward fulfilling basic physical needs, rather than spiritual ones.

Possibly, because of a low religious attitude (intrinsic orientation), the majority of subjects ranked at the lowest level of religious behavior. This finding is similar to previous findings showing Christians, who are more intrinsically inclined, tend to attend church more frequently, read the Bible more, and give a higher annual offering than those who are not intrinsically inclined.¹³ In addition, it is argued that those who have a deeper intrinsic religious orientation are expected to be more involved in religious practice.¹⁷

Some subjects demonstrated low levels of religiosity, but only in categories of either attitude or behavior. Participants showing low levels of attitude may have had only enough knowledge of Islam to know what is expected of a Muslim. However, they may not actualize religious beliefs through every aspect of their life. They may practice religious teachings, with more concern for ritual practices (fasting {Ramadan} and obligations to pray), and ignore other daily life activities (maintaining healthy habits as parts of their involvement in Islam). Those found to manifest religious behavior may do so only because they practice religious teachings for purposes of self-gain, i.e. self-comfort or social support. By so doing, their practice of religious teachings becomes more for external (extrinsic) purposes than for internal (intrinsic) ones.

Even though subjects were recruited through mosques, only one-quarter ranked high in overall religiosity. As Islam emphasises, religious maturation is affected by knowledge of Islamic principles. These principles encourage Muslims to continue learning and never stop mastering knowledge of Islam. Based on life experiences of the researcher, it appears some Muslims may have a narrow

understanding of Islam and not realize it covers every aspect of life. Being born Muslim is not sufficient when practicing Islam. One must optimize knowledge through learning in order to understand Allah and all aspects of Islam.

The majority of respondents were in good to excellent health. Most of the health status subscales were scored within the moderate level, with the exception of physical role. These findings are consistent with previous studies, wherein most individuals, during their middle years, enjoy good health.²⁸ Moreover, with rapid physical and intellectual growth completed, middle-aged adults are prepared to enjoy a productive and satisfying life.²⁹ However, studies of middle-aged males have revealed as age increases, physical function tends to decrease.^{30, 31}

Socioeconomic status, as a result of access to health care, plays a significant role in health status.²⁹ Similar to prior research, this study found poor health higher among those who were small business owners and semi-skilled or unskilled workers,³² as well as men who are retired or experiencing economic hardship.³³ Unlike prior findings, this study found the majority of respondents reported they were in good health, including those with socioeconomic and financial problems. This may be because one's perception of health tends to be a personal, internal value³⁰ that is culturally and/or socially defined. For example, a culture may view good health as an indicator of balance in life or of being a "good" person. The participants may have assumed that being healthy was part of their manifestation of sound religiosity, since health, from an Islamic perspective, is considered a blessing Allah has bestowed.¹⁸

A major factor determining health is human behavior.²⁹ Examination of individual items within the IIQ revealed that almost half of the participants reported they "always" followed Islamic teachings

regarding dietary practices, while thirty percent indicated they “often” did not. Islamic teachings regarding healthy dietary practices are congruent with modern approaches to healthy food habits, including eating, in moderation, a balanced diet; consuming only clean and fresh food; and not using harmful food or drink, i.e. pork and alcohol. Nearly half the subjects indicated never having smoked, while about 14% indicated they always smoked. Smoking is common throughout Indonesia, even among Muslims. Islamic scholars, historically, have had mixed views about tobacco, since cigarettes are not explicitly addressed in the Qur’an and Sunnah. With increased evidence regarding the dangers of smoking, Islamic scholars have become more united in proclaiming that tobacco usage is forbidden (haram).³⁴ However, those who always smoke may find it difficult to stop and rely upon unclear Islamic law to justify their use of tobacco.

Consistent with modern health teachings, Islamic teachings encourage exercise, hobbies and recreation. However, exercise, recreational participation, or doing hobbies received the least attention from the participants. Only 11% admitted exercising and slightly over one-third indicated “sometimes” engaging in hobbies or recreation. Those who gave little attention to such activities may have done so because of considering them non-essential and seeing participation as a mere suggestion. In addition, their lack of involvement in them may have been due to their socioeconomic status. Because of having a medium or low socioeconomic income, they may have given more priority to acquiring money for essentials, rather than spending time and resources on exercise and recreation. Lack of exercise and recreational activities, however, could have negatively influenced the subjects’ health.

The findings suggested religious behavior was positively correlated with general health perception

and spiritual health, while spiritual health (a component of health status) was found positively correlated with religious attitude (intrinsic orientation). These results are consistent with prior studies, wherein intrinsic attitude has been found to be positively correlated with spiritual well-being.³⁵ Not surprisingly, religiosity has been found to provide individuals a sense of meaning and purpose, as well as being linked to greater life satisfaction, improved psychological health and higher levels of general health.^{4, 7, 17, 20}

Health optimism, or the reporting of good health, may help explain the interaction between one’s religiosity and perception of health. Those with increased religiosity might share characteristics with health optimists, who appraise health via a transcendental approach that involves incorporation of a broad and inclusive perceptive of health.³⁶

Although previous studies have found mental health related to religiosity,^{4, 13, 37} no significant relationships, between mental health and either component of religiosity, were found in this study. Prior findings have noted mental health to be positively related to intrinsic religious attitude or orientation, and negatively related to extrinsic religious orientation.¹⁷ Intrinsic orientation tends to positively influence religious coping methods, while extrinsic orientation appears to have a negative affect on religious coping methods.³⁷ In addition, religious orientations (extrinsic and intrinsic) have been shown to have a significant effect on psychological distress and/or psychological well-being; whereas religious behavior (church attendance) appears to demonstrate no such effect.¹⁷ Thus, it is unclear why the results of this study were not consistent with prior findings. One explanation may be that the majority of subjects had a low intrinsic orientation. This study possibly failed, because it was conducted only with generally health people, to catch the real picture of the association

between components of religiosity and most of the components of health status. The Holy Qur'an clearly states, when a peaceful life exists (including being healthy), most people tend to ignore the importance of religion and God.

Limitations of the Study

The lack of correlations among the two components of religiosity and most of the components of health status may have been because of the manner in which health was conceptualized. The concept of health primarily has been proposed and described by Western cultures. In addition, most instruments, such as those used in this study, that measure health and religiosity have been created in the Western world. Thus, a lack of culture sensitivity may exist, in these instruments, causing them to fail to appropriately reflect the Islamic link between religiosity and health.

Generalizability of the study findings is limited, since the sample consisted of middle-aged Muslim men, who were in good to excellent health and recruited from one geographic area within Jakarta. Since they primarily were in good health, the impact illness may have had on their religiosity would not have been detected.

Recommendations

Future studies need to be conducted using longitudinal designs within multiple geographic areas; subjects who are experiencing both good and poor health; and both qualitative and quantitative designs. In addition, the use of culturally sensitive instruments to measure health status and religiosity, within a non-Western world, should be addressed.

References

1. Thoresen C. Spiritual and health: Is there a relationship? **Journal of Health Psychology** 1999; 4: 291–300.
2. Potter PA, Perry AG. **Basic nursing: Essentials for practice** 5th ed. Mosby Company, 2003.
3. Levin JS, Schiller PL. Is there a religious factor in health? **Journal of Religion and Health** 1987; 26: 9–36.
4. Maselko J, Kubzansky LD. Gender differences in religious practices, spiritual experiences and health: Results from the US General Social Survey. **Social Science & Medicine** 2006; 62: 2848–2860.
5. Koenig HG. Religion and death anxiety in later life. **The Hospice Journal** 1988; 4: 3–24.
6. O'Connor DB, Cobb J, O'Connor RC. Religiosity, stress and psychological distress: no evidence for an association among undergraduate students. **Personality and Individual Differences** 2003; 34: 211–217.
7. Yeager DM, Gleib DA, Au M, Lin H, Sloan RP, Weinstein M. Religious involvement and health outcomes among older persons in Taiwan. **Social Science & Medicine** 2006; 63: 2228–2241.
8. Albani C, Bailer H, Blaser G, Braehler E, Geyer M, and Grulke N. Religious and spiritual beliefs – validation of the German version of the System of Belief Inventory (SBI-15R-D). **Psychotherapie, Psychosomatik, Medizinische Psychologie** 2002; 52(7): 306–313.
9. Wikipedia. **Major religious groups**. http://en.wikipedia.org/wiki/Major_world_religions, 2005
10. Arafa MA. **Health, nutrition in Islam**. <http://www.pitt.edu/~super1/lecture/lec5601/001.htm>, n.d.
11. Cacioppo JT, Brandon ME. Religious involvement and health: complex determinism. **Psychological Inquiry** 2002; 13: 204–206.
12. Hixson KA, Gruchow HW, Morgan DW. The relation between religiosity, selected health behaviors, and blood pressure among adult females. **Preventive Medicine** 1998; 27: 545 – 552.
13. Paek E. Religiosity and perceived emotional intelligence among Christians. **Personality and Individual Differences** 2006; 41: 479 – 490.

14. Chatters LM. Religion and health: Public health research and practice. **Annual Reviews Public Health** 2000; 21: 335-67.
15. Allport GW, Ross JM. Personal religious orientation and prejudice. **Journal of Personality & Social Psychology** 1967; 5: 432 - 443.
16. McCormick J, Hoekman K, Smith D. **Religious orientation and locus of control in an Australian open enrolment Christian school.** <http://www.aare.edu.au/00pap/mcc00072.htm>, 2000.
17. Dezutter J, Soenens B, Hutsebaut D. Religiosity and mental health: A further exploration of the relative importance of religious behaviors vs religious attitudes. **Personality and Individual Differences** 2006; 40: 807-818.
18. Maulana AO. **Health promotion: an Islamic perspective.** <http://www.pitt.edu/~super1/lecture/lec6531/001.htm>, 2002.
19. Polit DF, Hungler BP. **Nursing research: Principles and methods** 6th ed. Lippincott, 1999.
20. Francis LJ, Robbins M, Lewis CA, Quigley CF, Wheeler C. Religiosity and general health among undergraduate students: a response to O'Connor, Cobb, and O'Connor (2003). **Personality and Individual Differences** 2004; 37: 485-494.
21. McNamara P, Andresen J, Gellard J. Relation of religiosity and scores on fluency tests to subjective reports of health in older individuals. **International Journal for Psychology of Religion** 2003; 13(4): 259 - 271.
22. Sahin A, Francis LJ. Assessing attitude toward Islam among Muslim adolescents: the psychometric properties of the Sahin-Francis scale. **Muslim Education Quarterly** 2002; 19(4): 35-47.
23. Holt CL, Haire-Joshu DL, Lukwago SN, Lewellyn LA, Kreuter MW. The role of religiosity in dietary beliefs and behaviors among urban African American women. **Cancer Control** 2005; November.
24. Health Status Questionnaire-12. **Health Outcomes Institutes** 1995; 2001 Killebrew Drive, Suite 122, Bloomington, MN 55425, USA.
25. Dossey BM, Keegan L, Guzzetta CE. **Holistic nursing: A handbook for practice** 4th ed. Jones and Bartlett Publishers, 2005.
26. Cohen AB, Pierce JD, Chambers J, Meade R, Gorvine BJ, Koenig HG. Intrinsic and extrinsic religiosity, belief in the afterlife, death anxiety, and life satisfaction in young Catholics and Protestants. **Journal of Research in Personality** 2005; 39: 307-324.
27. Glenn C. **Relationship of mental health to religiosity.** <http://www.medicine.mcgill.ca/mjm/issues/v03n02/v03p086/v03p086fs.htm>, n.d
28. Christensen BL, Kockrow EO. **Foundations of nursing** 4th ed. Mosby, 2003.
29. Craven RF, Hirnle CJ. **Fundamentals of nursing: Human health and function** 4th ed. Lippincott, 2003.
30. Case A, Fertig A, Paxson C. **The lasting impact of childhood health and circumstance.** <http://weblamp.princeton.edu/chw/research/papers.php>, 2004.
31. Naoshima J, Fukunaga I, Takeda N, Kitamado T, Jitsunari F. Association between life events, subjective health status and health practices in a rural population. **Nippon Eiseigaku Zasshi** 2001; 56: 514-22.
32. Borrell C, Muntaner C, Benach J, Artazcoz L. Social class and self-reported health status among men and women: what is the role of work organisation, household material standards and household labour? **Soc Sci Med** 2004; 58: 1869-87.
33. Molarius A, Berglund K, Eriksson C, Lambe M, Nordström E, Eriksson HG, Feldman I. Socioeconomic conditions, lifestyle factors, and self-rated health among men and women in Sweden. **The European Journal of Public Health** 2007; 17: 125-133.
34. Syed IB. **Smoking is haraam in Islam: powerful arguments based on the Quran and Sunnah.** <http://www.islamfortoday.com/syed08.htm>, 2003.
35. Rippentrop A, Altmaier E, Burns C. The relationship of religiosity and spirituality to quality of life among cancer patients. **Journal of Clinical Psychology in Medical Settings** 2006 13: 29-35.
36. Daaleman TP, Perera S, Studenski SA. Religion, spirituality, and health status in geriatric outpatients. **Ann Fam Med** 2004; 2: 49-53. (Abstract).
37. Ake GS, Horne SG. The Influence of religious orientation and coping on the psychological distress of Christian domestic violence victims. **Journal of Religion & Abuse: Advocacy, Pastoral Care, and Prevention** 2004; 5: 5-28.

ความสัมพันธ์ระหว่างการนับถือศาสนาและภาวะสุขภาพของชายอิสลามวัยกลางคนในอินโดนีเซีย

ฮายูนี รามา, อุไร หักกิจ, โสเพ็ญ ชุนวล

บทคัดย่อ: การศึกษาเชิงบรรยายครั้งนี้มีวัตถุประสงค์เพื่อศึกษาระดับการนับถือศาสนา (ทัศนคติและแรงจูงใจภายในต่อศาสนาและการปฏิบัติศาสนกิจ) ภาวะสุขภาพ และศึกษาความสัมพันธ์ระหว่างองค์ประกอบของการนับถือศาสนากับภาวะสุขภาพ กลุ่มตัวอย่างเป็นชายวัยกลางคนจำนวน 126 ราย จากมัสยิดจำนวน 9 แห่งในกรุงจาการ์ตา เก็บรวบรวมข้อมูลโดยสุ่มกลุ่มตัวอย่างตามความสะดวกโดยให้กลุ่มตัวอย่างตอบแบบสอบถามด้วยตนเอง เครื่องมือวิจัยประกอบด้วย 3 ส่วน คือข้อมูลทั่วไปของกลุ่มตัวอย่าง แบบสอบถามเกี่ยวกับทัศนคติและแรงจูงใจภายในต่อศาสนาและการปฏิบัติศาสนกิจ และ แบบสอบถามภาวะสุขภาพ

ผลการศึกษาพบว่ากลุ่มตัวอย่างส่วนใหญ่มีทัศนคติและแรงจูงใจภายในต่อศาสนาในระดับต่ำ (ร้อยละ 57.9) และมีพฤติกรรมในการปฏิบัติศาสนกิจในระดับต่ำ (ร้อยละ 55.6) เมื่อพิจารณาถึงระดับการนับถือศาสนาโดยรวม พบว่าประมาณร้อยละ 27 ของกลุ่มตัวอย่างมีการนับถือศาสนาในระดับสูง ในขณะที่ร้อยละ 40 มีการนับถือศาสนาโดยรวมในระดับต่ำ กลุ่มตัวอย่างที่มีพฤติกรรมในการปฏิบัติศาสนกิจสูงเพียงอย่างเดียวประมาณร้อยละ 15 และมีทัศนคติและแรงจูงใจภายในต่อศาสนาสูงเพียงอย่างเดียวร้อยละ 17.5 กลุ่มตัวอย่างส่วนใหญ่มีภาวะสุขภาพในระดับดีร้อยละ 69.1 และเมื่อพิจารณาภาวะสุขภาพเป็นรายด้าน พบว่ากลุ่มตัวอย่างส่วนใหญ่มีสุขภาพระดับปานกลางในทุกด้าน ผลการศึกษาความสัมพันธ์ระหว่างการนับถือศาสนาและภาวะสุขภาพ พบว่าทัศนคติและแรงจูงใจภายในต่อศาสนา มีความสัมพันธ์ในระดับต่ำกับภาวะสุขภาพด้านจิตวิญญาณ ($r = .26, p < .01$) และพฤติกรรมในการปฏิบัติศาสนกิจมีความสัมพันธ์ในระดับต่ำกับการรับรู้ภาวะสุขภาพโดยทั่วไป ($r = .24, p < .01$) และภาวะสุขภาพด้านจิตวิญญาณ ($r = .37, p < .01$) ความสัมพันธ์ระหว่างองค์ประกอบต่าง ๆ ของการนับถือศาสนา และภาวะสุขภาพได้มีการอภิปราย พร้อมทั้งให้ข้อเสนอแนะในการศึกษาวิจัยต่อไป

วารสารวิจัยทางการแพทย์บาล 2008; 12(3) 220 - 230

คำสำคัญ: ภาวะสุขภาพ อินโดนีเซีย ชายวัยกลางคนอิสลาม การนับถือศาสนา

ฮายูนี รามา R.N. นักศึกษาปริญญาโท คณะพยาบาลศาสตร์ มหาวิทยาลัยสงขลานครินทร์ จังหวัดสงขลา ประเทศไทย
อุไร หักกิจ R.N., Ph.D. ผู้ช่วยศาสตราจารย์ คณะพยาบาลศาสตร์ มหาวิทยาลัยสงขลานครินทร์ จังหวัดสงขลา ประเทศไทย
โสเพ็ญ ชุนวล R.N., Ph.D. ผู้ช่วยศาสตราจารย์ คณะพยาบาลศาสตร์ มหาวิทยาลัยสงขลานครินทร์ จังหวัดสงขลา ประเทศไทย