The Influence of Religion in The Health Behavior of The People in Meghalaya.

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Abstract
Religious participation in individual health research is on the rise in the health sciences, social sciences, and behavioral sciences. Researchers conducted an ethnographic investigation. It was held in Meghalaya, an Indian state in the country's northeastern region. This study work seeks to comprehend the potential origins and consequences of religious participation in people's health behavior.

Keywords: Health, religion, health behavior

BACKGROUND

Understanding the notion of religion and health interrelationship. Patients are extremely likely to incorporate religion into their medical treatment and well-being. The relationship between religion and health, as well as vice versa, has been discussed. Many faiths have had distinct beliefs and worship methods from the beginning of time. Every religion and belief system has health and sickness consequences(Behere, Prakash , Das, & Yadav, 2019).We discussed how Christianity and the Niamtre or Niam - Khasi system of beliefs and rituals may have a role in the development of various diseases. It is also discussed how religion might assist an individual in sustaining his or her life in numerous disciplines. The connection between religion and somatic symptoms is discussed. Religion's impact and outcome on health have been noted.

INTRODUCTION

Dealing with stress can improve not just one's psychological health, but also one's physical wellbeing. The desire for meaning in our lives and the events that occur in them is an important component of coping. Individuals cope with illness and other problems in a variety of ways. Religion is a crucial technique of coping(Koenig, Harold G and McCullough, Michael E and Larson, & David B, 2001). Every religion and belief system has an impact on mental health and sickness. We discussed how the Hindu system of beliefs and rituals may have a role in the development of various mental diseases. It is also discussed how religion might assist an individual in sustaining his or her life in numerous disciplines. The connection between religion and symptomatology is discussed. Religion's influence and consequence on mental health have been addressed(Behere, Das, Yadav, & Behere, 2013).

Meghalaya is one of three Indian states with a Christian majority. Approximately 75% of the population is Christian, with the most prevalent denominations being Presbyterians, Baptists, Church of God, and Catholics. The remaining 25% of the population is non-Christian. Non-Christians celebrate health-related festivals in Meghalaya, such as the "Ka Rongkhli" Festival of Jaintia, which is held

in the months of (January, February, and March) in Nongtalang. Rong means festival and khli means tiger, therefore the Tiger Festival. It is thought that if God is not worshipped, certain tragedies or misfortunes such as pandemic illnesses, famine, and blindness will strike the people(Route, n.d.). Behdeinkhlam is a Non-Christian festival observed in the Jaintia Hills area. Based on the Jaintias' socioeconomic existence and prayers for the people's prosperity and health. The celebration is held to seek the Gods' blessings for a plentiful crop and to protect people from illness and pestilence(Bhatnagar, 2016).

LITERATURE

RELIGION

The primary religions in the area are Christianity and Niamtre or Niam Khasi. There is also a modest Muslim and Hindu minority. Catholicism, Orthodoxy, and Protestantism are the three major Christian denominations.There are several more Christian groups, such as the Church of God, the Church of Christ, Jehovah's Witnesses, and others. Presbyterians and Catholics are now the two most popular Religious denominations in Meghalaya.

It is scarcely surprising that spirituality and religion may have a significant impact on human health and behaviour. Religious resources are significant among the strategies used by people to cope with life stress and disease(Miller, William R, Thoresen, & Carl E, 2003).

CONCEPTUAL MODELS LINKING RELIGION AND HEALTH

Researchers have made several efforts to define the health impacts of religious engagement, providing a comprehensive framework that includes behavioural, psychological, genetic effects, and psychodynamics of belief, ritual, and faith. Many approaches see religion and health as multifaceted entities. There are several structures involved in religion and health that cannot be overlooked. For example, in health, it may encompass a wide range of physical and mental signs and rely on several types of data. As a result, the influence of religion on health can have both direct and indirect impacts via other factors.

Religious participation element can only be comprehended in this study within a context characterised by common group norms, expectations, and meanings. As a result, can be considered as multifactorial and may represent the activity of several potential pathways (i.e. positive self-perception, instrumental support etc.).

There are 5 major categories which propose linkage between religion and health. They are as follows:

POSITIVE ASPECT OF RELIGIOUS INVOLVEMENT:

LIFESTYLE & HEALTH BEHAVIOUR

Religion plays an important influence in developing behaviours that affect physical and mental health. Take, for example, risk-taking and defensive behaviours. It involves explicitly and legally prohibiting particular health-riskingbehaviours as well as encouraging health-promoting behaviours. Religious organisations and clergy serve as gatekeepers for individual assistance-seeking behaviour and health-care usage, particularly among the impoverished and disadvantaged. There is little understanding of the function of clergy in health care delivery and in bridging communities and health and human service organizations.

Religious practitioners may also lessen their likelihood of stressful life situations since religious teachings provide universal behavioural rules that discourage

individual deviation and support interpersonal harmony(Chatters, 2000).

SOCIAL RESOURCES:

Involvement in religious groups has a variety of advantages. These advantages include the size of one's social network, the regularity with which one interacts with network members, and a favourable view of support connections. Religious organisations may be unique in the information they convey to members about their value and worth as persons (e.g., a sense of being cared for and loved by others), contributing to positive views of support (support satisfaction and anticipated assistance). Additionally, religious communities give a unique environment within which to analyse challenging life events and provide required aid since members share comparable frames of reference and meaning. Religious institutions actively shape attitudes and ideas about major life responsibilities(Ellison C. , 1994).

RELIGIOUS COPING AND BEHAVIOURS

Religious coping research in its different forms demonstrates a relationship between broad religious inclinations and individual responses to stressful life situations(Ellison C. G., 1994). Religious-coping research takes a variety of methods, ranging from studies that look at the relationship between global religious expression and commitment and health outcomes to studies that look at proximal and localised approaches to religion in response to personal issues(Pargament K. I., 1997). In their investigation, religious coping literature highlighted a few approaches: Approach based on indicators: worldwide religious objects are utilised as markers of religious coping; The overall method assesses the overall degree of religious participation in coping; the general approach uses religious coping items on a general coping scale; Religious coping strategies that examine various religious coping methods; religious coping patterns.

Many key topics for further study have been identified, including how social location, problem kind, and religious orientations may influence the usage of certain religious-coping approaches. Further research is needed to understand the causal relationships (e.g., coping mobilisation mechanisms) that exist between challenges, religious coping, and pertinent health consequences.

POSITIVE ATTITUDE, BELIEF AND EMOTION

Positive perspectives of human nature and the self-emotional state that are related with improved physical and mental health outcomes may be supported by religious teaching. Religious injunctions have the potential to alter interpersonal behaviour towards others in ways that highlight a variety of positive and prosocial goals while reducing the risk of stressful situations.

Religious rituals may be crucial for instilling pleasant emotional states and/or developing more global belief and world perspective, both of which are related with improved health.

The use of religion to promote individual and communal healing has been related with feelings of self-worth, competence, and connection with others(Krause, 1995).

NEGATIVE ASPECT OF RELIGIOUS INVOLVEMENT

LIFESTYLE & HEALTH BEHAVIOUR

Religious teachings may prescribe particular medical procedures and treatments, but in extreme cases, religious

teachings may promote and support societal deviancy and aberrant conduct that is harmful to health and well-being. There has been little study on the impact of religious groups on the effectiveness of health care services. It may have a detrimental impact on self-care patterns, discourage professional help-seeking behaviour, promote inappropriate service usage, and encourage exclusive treatment.

SOCIAL RESOURCES

It can also cause issues in religious groups' social relationships. Because of interpersonal features, religious settings are ideal for support exchange. The sharing of social support is controlled by rules of reciprocity and balance that are implemented through time. Yet, these interpersonal issues might occur when these expectations are not met.

Similarly, complications may emerge if the support giver and the recipient do not have comparable beliefs, support provision, problem perception, and religious group role. Religious institutions ask members to commit substantial amounts of time and money, which can drain financial and other resources(Ellison C. , 1994).

Recent studies have concentrated on these types of social relationships in religious groups and organisations. Individuals may be distressed because they are unexpected, unusual, and inconsistent with religious expectations and traditions.

RELIGIOUS COPING AND BEHAVIOUR

A study on religious coping discovered that people who use negative coping tend to see the world as threatening, have a less secure relationship with God, and experience spiritual struggle. It is linked to sadness and psychiatric disorders, as well as worse life quality and sociability(Pargament, Kenneth I and Smith, Bruce W and Koenig, Harold G and Perez, & Lisa, 1998).

NEGATIVE ATTITUDES, BELIEFS AND EMOTIONS

Some emotional states, attitudes, and ideas that perpetuate negative views of human nature and self may be jeopardised by religious dogma. These emotional states, beliefs, and attitudes may have a detrimental impact on physical and mental health. Religion doctrines and beliefs have the potential to establish and sustain global beliefs and worldviews that impact individual behaviours and interpersonal relationships. It may foster a pessimistic attitude towards the status of human affairs and its members.

Religion predates humanity. Prehistoric man had rudimentary religions and revered natural elements such as the sun, earth, air, cloud, and water. Religions became institutionalised as civilization advanced. All faiths have fundamental traits. There is a strong belief in an unseen governing power. Religion, from the standpoint of mental health, provides much-needed rules that can assist individuals in charting a direction for their life. Believers can cope better with life's stresses and hardships, as well as its uncertainties. Yet, many antiquated rituals and belief systems may stifle constructive progress and contribute to mental illness-health (Behere, Das, Yadav, & Behere, 2013)

Medicine and religion have been inextricably linked since antiquity. Priests were regularly in charge of healing techniques in ancient Mesopotamia, Egypt, India, China, Greece, and the Americas. The Jews had a high regard for medicine, and it was prohibited for them to dwell in communities without a doctor. Throughout

the Middle Ages, medicine was taught at Church-run schools or monasteries, and many hospitals were established throughout Europe, the most of which were affiliated with religious orders (often Catholic or Islamic). In the face of human misery, medicine was considered as proof of God's love. This history of caring for the ill through religious hospitals has been carried on to the present day, with the various faith-based charitable hospitals that now exist across the world(Risse & Guenter B, 1999).

According to the Catholic News Agency (2010), the Catholic Church administers 26% of global healthcare services, with 117 000 facilities including hospitals, clinics, and orphanages. According to a World Health Organization (WHO) research, faith-based organisations presently hold between 30 and 70% of Africa's health infrastructure. Yet, there is frequently minimal collaboration between these organisations and conventional public health programmes. Christian hospitals and health centres, for example, offer almost 40% of HIV care and treatment services in Lesotho and nearly one-third of HIV/AIDS treatment facilities in Zambia(Karpf & Ted, 2007).

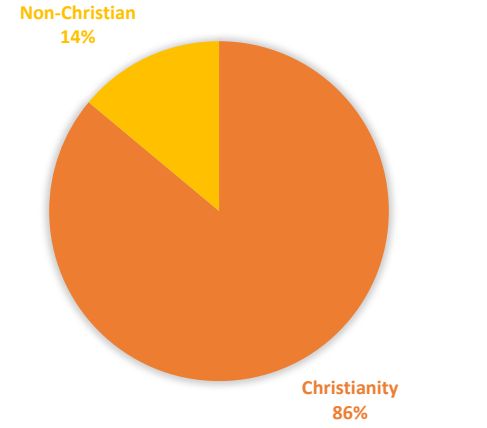
For thousands of years, India has been connected with spiritual traditions; it has been the home of some of the world's biggest faiths, including Hinduism, Buddhism, Jainism, Sikhism, Christianity, and Zoroastrianism. It is a nation where spirituality is nearly a way of life; where even the most uneducated farmer or housewife would wow you with their philosophical life dilemmas(Wig & Narendra N, 1999)

When people are unwell or in stressful situations, they may pray more. Turning to religion while you're unwell may result in a false positive link between religion and poor health. A low health state, on the other hand, may limit one's ability to attend a religious gathering, generating still another bias in the relationship between religiousness and health. Lastly, religious commitment is a crucial aspect of religiosity because it reveals the effect that religious beliefs have on a person's actions and lifestyle. A person's religious inclination might be inherent or extrinsic, according to Harvard psychologist Gordon Allport(Moreira-Almeida, Alexander and Lotufo Neto, Francisco and Koenig, & Harold G, 2006)

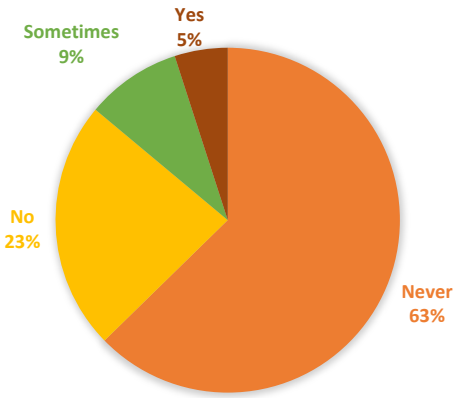
Gartner, Larson, and Allen conducted a literature study and discovered various factors that showed favourable associations with religiousness. Religiousness was associated with lower smoking and alcohol intake, as well as a good influence on heart disease and blood pressure. A perplexing finding was that, at least in the elderly, physical health aided religious activity rather than the other way around. Religious devotion and engagement appeared to influence longevity as well, particularly in men(Bailey & Cathy M, 1997).

RESULT

Religion	**Participants**
Christianity	173
Non-Christian	28
Grand Total	**201**



Does your religion affects your decision-making in seeking healthcare?	
Response	**Participants**
Never	126
No	47
Sometimes	18
Yes	10
Grand Total	**201**



DISCUSSION

Religion and health have a complicated link that varies based on the environment and demographic being investigated. Nonetheless, the evidence implies that religion and health have a favourable relationship. This might be related to the sense of purpose and meaning that religion gives, as well as the health practises that religious societies frequently support.

CONCLUSION

Considering these findings, and despite the overall scarcity of research on the issue, it is evident that faith-based health organisations are pertinent to any discussion of global public health, particularly in low-income nations. There is minimal but consistent evidence that they improve health-related outcome indicators. However, additional information regarding the nature and objectives of these organisations is required, as is a more detailed assessment

of their influence on healthcare service and public health.

Although there are occasional cases of misunderstanding between religious communities and health services, the research given above suggests that fostering this collaboration for health promotion would be quite beneficial. More research in this critical topic is consequently required, as faith-based healthcare is a significant source of health care globally.

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