

The Influence of Religiosity Dimensions on Health Protocols Compliance of Muslim Netizen

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Keywords: Compliance, Health, Muslim, Religiosity.

Abstract: Religion is one of the social determinants that affect health behaviour. This study aims to examine the effect of the religious dimension on health protocols compliance on Muslim netizens in Makassar city. The study was conducted with a cross-sectional design using purposive sampling. The number of research samples is 215 people. The dimensions of religiosity and adherence to health protocols were measured by instruments that had been tested for validity and reliability. Data analysis was performed by linear regression test with a significance value of $p < 0.05$. The results showed that the dimensions of religiosity that affected adherence to the health protocol were the ritual dimension ($p = 0.011$), intellectual ($p = 0.028$), and the consequence dimension ($p = 0.000$). While the dimension that has no effect on health protocol compliance is the ideological dimension ($p = 0.061$). The final model shows that $Y = 22.927 + 0.235X_1 + 0.631X_2 + 2.071X_3$. Ritual, intellectual and consequence dimensions affect adherence to the health protocol of Muslim netizens in Makassar City by 41%, while the rest are influenced by other factors. The dimension of religiosity is important to pay attention for Covid 19 prevention.

1 INTRODUCTION

Coronavirus Disease 2019 (Covid-19) is a new type of virus caused by SARS-CoV-2 (Severe Acute Respiratory Syndrome Coronavirus 2) which is currently shaking the world community (Mona, 2020). Since January 2020, this virus has managed to infect hundreds of millions of people globally, with 104,370,550 confirmed cases and 2,271,180 deaths (WHO, 2021). Even someone who does not show symptoms of being infected with this virus can also spread or become a carrier to others (Kumar & Dwivedi, 2020). The public is encouraged to implement a new healthy lifestyle according to health protocols during this corona virus pandemic to prevent an increase in the spread and number of infections (Pinasti, 2020).

Health protocols are a series of activities aimed at preventing the spread of covid 19 infection. The forms are routinely maintaining hand hygiene, maintaining distance, staying at home and going out only for urgent needs, using masks when outside the

house, covering nose and mouth when sneezing, keeping food intake, physical activity and managing stress

Since it was implemented, public compliance with health protocols has been quite good, but some is still low. Research that shows that community compliance is quite good is a study conducted in Deli Serdang, the study shows that community compliance is in a very positive area (Putra, 2020). Likewise, the results of a survey conducted in the city of Yogyakarta, the compliance of the community to wear masks when leaving the house reached 93.3%, 80.44% always washed their hands with soap and 66.33% always kept their distance (Dinkes, 2020). Similar results were found in the city of Jakarta, showing that 68.96% of people comply with health protocols in places of worship, 50.6% in traditional markets and 80.71% in malls/shopping centres (Simanjuntak, 2020)

However, there are also research results that show community compliance is still low. As the results of a survey conducted in Surabaya showed that 70% of the people did not wear masks in places of worship

and 84% did not keep their distance. While in traditional markets, there are 81.6% of people who do not wear masks and 85.9% who do not keep their distance (Persakmi, 2020). Many factors affect people's adherence to health protocols. These factors include perception, age, education level, gender, knowledge, marital status and health status (Larasati, 2020). Factors that cause public disobedience to health protocols are due to lack of understanding/lack of knowledge, economic motives, indifferent attitude and feeling of low potential for the transmission of covid 19 and distrust of the government (Wiranti, 2020).

One aspect that is often associated with health behaviour is religiosity. Related to adherence to health protocols, religiosity is an interesting aspect that needs to be studied. Because religious gatherings have been one of the points of spread of Covid 19 (Aschwanden, 2020). Research conducted in secular countries, such as America, found that adherence to health protocols tended to be lower in areas with high levels of religiosity (Hill TD, Gonzales K, Burdette AM, 2020). Community movement is higher in more religious areas (Hill, 2020). Religious communities find it more difficult to obey orders to stay at home in an effort to prevent the spread of disease.

Indonesia is a country with the largest Muslim population in the world. In Islam there are guidelines on health protocols contained in the Qur'an and Sunnah. In the Qur'an, Muslims are commanded to stay away from things that can destroy themselves. The Sunnah provides so many guidelines related to this health protocol, such as the order not to cause harm to others, the order to stay away from infectious diseases, the quarantine order, the order to maintain cleanliness, the order to cover the face when sneezing to prevent the spread of droplets and the order to consume food. healthy ones. All of these things should be the basis for Muslims to comply with health protocols.

This study wants to see whether religiosity has an influence on compliance with health protocols. Do Muslims with a high level of religiosity have a better level of compliance?

2 METHODS

This research is a survey research with a cross-sectional design. Measuring the level of religiosity and compliance with implementing health protocols at the same time. This research was conducted in March-April 2021 in Makassar City. The population of this research is the community of internet users in

Makassar City. Because the population is very large and the exact number is not known, the research sample is calculated by the formula $n = Z^2/4 (Moe)^2$, so the minimum sample size in this study is 171 respondents. The sample selection was carried out purposively with the following criteria: Muslim, living in Makassar City, Age > 15 years and Willing to participate in the study. While the exclusion criteria were not filling out the questionnaire completely and resigning as a respondent. The data in this study were collected using a questionnaire created on a google form, then distributed on the researcher's social media, such as Facebook and WhatsApp. The questionnaire has passed the reliability test and validity test. The test results have been used to improve the questionnaire, so that the final questionnaire is a questionnaire that has good reliability and validity values. Data analysis in this study was carried out in three stages. First, univariate analysis to describe the characteristics of the dependent variable and the independent variable. Second, perform prerequisite test for multiple linear regression test. Third, multivariate analysis with multiple linear regression. The significance value used is $p < 0.05$.

This research was conducted in accordance with applicable ethical standards by applying for an ethical license to the Health Research Ethics Committee, Faculty of Medicine and Health Sciences, Alauddin State Islamic University, Makassar with license number B.065/KEPK/FKIK/III/2021

3 RESULT AND DISCUSSION

This research was conducted in February-May 2021 with a total sample of 215 people. It can be seen that most of the samples are women, aged < 30 years, work as civil servants and are married. (Table 1).

Based on the characteristics, it can be seen that the religiosity score is higher in men, but the adherence score is higher in women. Based on age, religiosity scores and adherence scores were highest in the >40 years age group. Based on occupation, teachers and lecturers have the highest scores of religiosities and obedience. Similarly, respondents who were married had the highest scores of religiosities and obedience (Table 2).

Table 1: Respondents' characteristics

Respondent Characteristic (n=215)	n	%
Gender		
Male	76	35.3
Female	139	64.7
Age		
18-30 years	113	52.6
30-40 years	61	28.4
>40 years	41	19.1
Profession		
Civil Servant	88	40.9
Housewife	15	7.0
Teacher/Lecturer	9	4.2
Student	80	37.2
Entrepreneurs	17	7.9
Jobless	6	2.8
Marital Status		
Married	108	50.2
Not Married	103	47.9
Widow/widower	4	1.9

Table 2: Level of religiosity and adherence to health protocols based on respondent characteristics

Characteristics (n=215)	Religiosity		Adherence	
	mean	Sd	Mean	Sd
Gender				
Male	58.73	±6.85	54.35	±1.00
Female	58.33	±7.07	54.9	±5.54
Age				
18-30 years	57.48	±7.03	53.65	±5.63
30-40 years	58.57	±6.96	55.16	±6.48
>40 years	61.07	±6.34	56.61	±4.32
Profession				
Civil Servant	58.93	±6.82	55.09	±5.79
Housewife	59	±7.22	53.53	±4.78
Teacher/Lecturer	63.11	±6.85	58.44	±5.5
Student	56.56	±6.57	53.15	±5.63
Entrepreneurs	60.82	±7.68	57.29	±4.82
Jobless	62.33	±6.95	57.5	±6.59
Marital Status				
Married	59.49	±6.77	55.59	±5.86
Not Married	57.39	±7.2	53.67	±5.60
Widow/widower	59	±1.82	53.75	±2.63

There is a difference in the score of adherences to the health protocol based on ritual, intellectual and

consequence dimensions ($p < 0.05$), where respondents who have a high score on the religiosity dimension tend to have a high compliance score as well. However, on the ideological dimension, although there was a difference between obedience scores based on the level of religiosity, the difference was not significant ($p = 0.061$, $p > 0.05$) (Table 3).

Table 3: Differences in adherence to health protocols based on the level of religiosity dimensions

Religiosity Dimension	Adherence to health protocol		
	Mean	Sd	P*
Ritual			
Medium	51.69	±5.55	0.000
High	56.89	±4.83	
Ideology			
Medium	52.35	±7.15	0.061
High	54.88	±5.57	
Intellectual			
Medium	49.78	±5.78	0.000
High	55.93	±5.03	
Consequences			
Medium	48.14	±5.10	0.000
High	55.35	±5.38	

Based on the results of the variable prerequisite test, it appears that the variables that meet the ritual, intellectual and consequence dimensions (Table 4).

If the other independent variables are fixed, then every 1% increase in the ritual dimension score, it will increase the adherence score by 0.253. If the other independent variables are fixed, then every 1% increase in the intellectual dimension score, it will increase the compliance score by 0.631. And if the other independent variables are fixed, then every 1% increase in the consequence dimension score, it will increase 2,071 compliance scores. Because the value of R square is 0.410, then the ritual, intellectual and consequence dimension variables affect adherence to the health protocol by 41% while the rest is influenced by other factors. Because the R value is 0.64, it can be concluded that there is a strong relationship between the variables of ritual, intellectual and consequence dimensions on health protocol compliance (Table 5).

Social capital has become one of the key determinants of health according to WHO (Solar, 2010). This concept includes, among others, social organization, such as participation in social activities and voluntary activities, mutual help and mutual trust in society (Rouxel et al, 2015).

Table 4: Summary of variable prerequisite test results

Prerequisite Test	p	Interpretation
Normality*	0.455	Qualify
Linearity		
Ritual	0.843	Qualify
Ideology	0.003	Unqualify
Intellectual	0.454	Qualify
Consequences	0.795	Qualify
Multicollinearity		
Ritual	0.587	Qualify
Ideology	0.794	Qualify
Intellectual	0.473	Qualify
Consequences	1.535	Qualify
Heteroscedasticity**		
Ritual	0.127	Qualify
Ideology	0.786	Qualify
Intellectual	0.612	Qualify
Consequences	0.137	Qualify

*Kolmogorof-Smirnov

**Glejser

Table 5. Summary of multiple linear test results

Variable	Regression Coefficient	t	Sig
Constant	22.927		
X1 (Ritual)	0.235	2.552	0.011
X2 (Intellectual)	0.631	2.211	0.028
X3 (Consequences)	2.071	5.405	0.000
F			30.457
R Square			0.410
R			0.640

Compliance with health protocols (Y)

$$Y=22.927+ 0.235X1+0.631X2+2.071X3 \quad (1)$$

Social interactions without structural ties lead to discussion of issues in the community and help community members move together towards unseen goals and benefits. (Pattusi MP, Marcenes W, Croucher R, Sheiham A, 2001) Participation in religious groups can be one of the social capitals that provides support among participants

Religiosity can be defined as an organizational system of beliefs, practices, rituals and symbols designed to facilitate closeness to the sacred or transcendent (God, a higher power or supreme truth/reality) and to promote understanding of one's relationships and responsibilities with others. in living together in a society (Koenig HG, ing D and Carvon VB, 2012)

Religiosity is associated with protection against chronic disease and death in children and adolescents. Data from NHANES III shows this (Bruce et al,

2017). Religiosity also has an inverse relationship with risky behaviours such as smoking and alcohol consumption in adolescents (Pitel et al, 2012). Adherence to religious practice is also associated with psychological well-being and life satisfaction in young people (Souza, et al, 2012) and is associated with better health status in older people (Reinal, 2004). However, there are some negative relationships between religiosity and health. Religiosity has been reported to be associated with poor health (Kodzi et al, 2011) and obesity risk (Feinsterb et al, 2011)

Religiosity is one of the factors that influence behaviour. There are various variations of religious dimensions that are positively related to emotional health behaviour in adolescents. A positive correlation was found between individual and family factors with emotional and behavioural health in adolescents. Religiosity directly affects emotional health and behaviour in adolescents (Rafi MA, Avval MH, Yazdami AA, 2020). A study found all dimensions of religiosity to be significant predictors of Islamic work behaviour ethics (Aminuddin, 2019).

Family religiosity is related to dental health related to quality of life in school children (Menegazzo, 2018). Religiosity in adolescents is a factor that mediates the influence of parental religiosity on health behaviour in adolescents, such as alcohol and drug use and depression (Barton AI, Snider JB, Vazsonyi AT, Cox JL, 2014). Workers' religiosity has a strong influence on the organizational behaviour of workers in the workplace (Awani M and Zaiden M, 2019)

During a pandemic, people become more religious (Wilson S, Bourstein M, Hernandez A, Rozsul). More than half of Americans are praying for the end of Covid 19 and 24% report feeling an increase in their faith during the pandemic (Gecewicz). Although in many countries, religious gatherings such as the Tablighi Jamaat (India), Oneji Shincheonji (South Korea) and Kyeve Parchersh Lavira (Ukraine) have become places for the spread of the COVID-19 virus (Aschwanden, 2020). Religiosity and spirituality have an important role in healing pain, impacting health status and minimizing the consequences of social isolation (Luchetti G, Goesl G, Amatul SG, et al, 2020). A study found that most of the respondents had high levels of religiosity and mild anxiety levels. There is a significant relationship between religiosity and anxiety levels in students (Wahyuni I, Suharno, Andika R, 2020)

Regions that are more religious show higher population movements. The stay-at-home order had a weak effect on more religious areas (Hill TD,

Gonzales K, Burdette AM, 2020). The high level of religiosity in society triggers an increase in barriers to policies imposed by the government and reduces adherence to Covid 19 mitigation guidelines (DeFranza D, Lindow M, Harrison K, Mishra A, Mishra H, 2020). More religious populations report less trust in science as a social institution and have anti-science (science) behaviour (Evens, 2013). More religious areas report more frequent population movements (Hill TD, Gonzales KE, Upanieli L, 2020)

This study found that men's religiosity was higher than women's. The results of this study are similar to studies conducted on the effect of religiosity on compliance with paying zakat. The study shows that women are less religious than men (Abdulah M, Sapeei NS, 2020). On the other hand, other studies have found that, among Christians, women are more religious than men, both in the United States and in other Christian-majority countries. The study also found that women with higher education were less religious than men. On the other hand, men who were more educated looked more religious (Schnabel, 2017).

The results of this study are similar to previous findings, which found that married women and individuals were more compliant with health protocols (Indrayathi PA, Januraga PP, Pradayani PE, Gesesew HA, Ward PE, 2021). Another study found that compared to men, women wash their hands more often. Men wash their hands less often for various reasons, such as feeling they don't need to do it, don't like to wash their hands or don't have time to do it (Bavel JJV., Baicker, K., Boggio, P.S. et al, 2020). Women are also 12% more likely to use masks and wash their hands than men (Rundle CW, Presley CI, Militello M, et al, 2020). Based on these results, it appears that women are more concerned about maintaining their health than men (Amodan BO, Bulage I, Katana E, et al, 2020). (Cobey KD, Laan F, Stulp G, Bunk AP and Pollet TUJEP, 2013). While men do have high risk behaviour

This study found that the highest adherence was in the group of women, highly educated, married and aged > 40 years. This finding is similar to the results of a study in Italy, that women, most educated, middle age (50-59 years), married/divorced have the highest level of adherence to health protocols. And similar to the results of the study, in this study, the young age group, unmarried and student status, had the lowest level of adherence (Carlucci L, D'Ambrosio I, Balsamo M, 2020). Studies in America, also found that women and older age have better adherence. (Park CL, Russell BS, Fendrich M, et al, 2020). Older

people will try to comply with health protocols because they are a group that is more at risk of fatality due to Covid 19 (Chen CN, Zhou M, Dong X, Qu J, et al, 2020)

Religiosity does not directly predict an individual's intention to worship at home during a pandemic. However, religiosity has a role in raising the intention to change the habit of worshipping at home. Other factors that predict an individual's adaptive behaviour to worship at home are intention, social influence, and trust in the government (Rostiani R, Toyib JS, Khoiriyah S, 2021)

Research in Aceh found that there were differences in the behaviour patterns of respondents when going to public places and when going to mosques. This study found that 68% of respondents rarely visit public places, but they always pray in congregation at the mosque. In addition, it was found that 44% of respondents always use masks when going to public places, but 55.3% of respondents never wear masks when praying in mosques. Respondents tend to adhere more to ethical health protocols going to public places when compared to mosques. This is caused by 3 things. First, the religiosity of respondents has influenced the perception of risk or fear of being infected with Covid 19. They believe that ablution and prayer can prevent someone from being exposed to Covid 19. Second, religiosity has made them feel uncomfortable when leaving worship at the mosque, so they tend to disobey the recommendations for worship at home. Third, they believe that praying in congregation at the mosque is useful for preventing Covid 19. (Nurrahmi F, Masykur T, Harapan H, Masykin T, 2021)

Religiosity in Islam should make a person more obedient in carrying out health protocols. Because Islam teaches to protect others and yourself from harm. In addition, many sources of Islamic teachings are in line with the principles of health protocols. So that a good Muslim should have a good level of compliance with health protocols. Worshipping in the mosque can still be done, but of course when the disease case can still be controlled. Worship at the mosque must still be carried out in accordance with the health protocol, so that the mosque as a place of worship does not become a source of transmission of the Covid 19 outbreak.

4 CONCLUSIONS

Based on the results of the study, it can be concluded that religiosity has an influence on compliance with

health protocols and Muslims with a high level of religiosity have a better level of compliance.

ACKNOWLEDGEMENTS

The researcher would like to thank the respondents who are willing to be involved in this research

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