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The Contributions of Religious Beliefs and Practices on Access to Healthcare Services by the Elderly in Bagamoyo District Pwani Region, Tanzania

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Abstract

Religious beliefs significantly influence healthcare access among elderly individuals in Tanzania, particularly in Bagamoyo District, yet their specific contributions remain inadequately understood in current healthcare delivery systems. With 57% of elderly individuals avoiding health facilities when sick due to various barriers, understanding the religious dimensions becomes crucial. This study examined the contributions of religious beliefs and practices on access to healthcare services by the elderly in Bagamoyo district, anchored in Jean Watson's Theory of Transpersonal Caring (1979), which emphasizes caring as more effective in supporting health than medical treatment alone. The study employed a mixed-method research design, targeting 4,998 elderly individuals aged 60 years and above attending health facilities in Bagamoyo district. Using Krejcie and Morgan's formula, and a proportional formula a sample of 239 respondents was determined, though 237 actually participated. Data was collected through structured questionnaires, key informant interviews with 15 medical officers, and 11 focus group discussions. The instruments' reliability was validated using Cronbach's Alpha, yielding coefficients of 0.7733 for unstandardized items and 0.8086 for standardized items. Data analysis combined descriptive statistics, inferential statistics, and thematic analysis. The study found a statistically significant positive relationship between religious beliefs and healthcare access ($\beta = 0.384$, $p = 0.007$), with 47.3% of respondents demonstrating high religious engagement. Religious beliefs explained 3.1% of variance in healthcare access, while 89.8% of respondents affirmed the positive role of religious institutions in providing psychological healing services. However, 84% reported their religious affiliations lacked formal health programs for the elderly, though 95.8% of religious institutions endorsed regular use of government healthcare facilities. The study concludes that religious beliefs significantly influence elderly healthcare access, though they represent one of several contributing factors. Healthcare providers and religious institutions should establish formal partnerships to enhance elderly healthcare access by leveraging existing religious networks and community trust, while developing dedicated healthcare programs that integrate preventive care with spiritual activities.

Keywords: *Religious Beliefs and Practices, Access to Healthcare Services, Elderly, Bagamoyo District, Pwani Region, Tanzania*

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1.0 Background of the Study

Religious beliefs and practices play a significant role in shaping healthcare access and decision-making among elderly populations worldwide, particularly in developing countries where traditional belief systems remain deeply entrenched. In Tanzania, religious beliefs and practices have historically influenced how individuals, especially the elderly, perceive, seek, and engage with healthcare services. Studies have shown that religious beliefs can act as both facilitators and barriers to healthcare access. For instance, research by Smith, Byles, and Kingston (2016) demonstrates how religious communities often serve as crucial support networks for elderly individuals, providing both emotional support and practical assistance in accessing healthcare services. However, these same religious beliefs may sometimes lead to delays in seeking medical attention when health issues are attributed to spiritual causes rather than medical conditions.

In the African context, traditional religious practices often intersect with healthcare decisions. According to Mutisya et al. (2017), approximately 80% of Africans, particularly in rural areas, consult traditional healers before seeking modern medical care. This practice is especially prevalent among the elderly population, who may have stronger ties to traditional religious beliefs and healing practices. In Tanzania specifically, the interplay between religious beliefs and healthcare access is particularly complex. Frumence et al. (2017) highlight how religious institutions often serve as important community hubs that influence healthcare-seeking behaviour among the elderly. These institutions can either encourage or discourage the use of modern medical facilities, depending on their theological perspectives and community practices.

The situation in Bagamoyo district presents unique challenges due to its rich religious heritage and cultural diversity. As a historical centre of both Islamic and Christian influence along the Tanzanian coast, Bagamoyo's elderly population navigates a complex landscape where traditional religious practices interact with modern healthcare systems. This complexity is further highlighted by the findings of Garcia and Navarro (2018), who emphasize how religious beliefs influence not only individual healthcare decisions but also community support systems that facilitate or hinder healthcare access. The aging population in Tanzania, as noted by Morisset and Wane (2012), faces particular challenges in reconciling traditional religious practices with modern healthcare needs. With life expectancy having increased from 43 years in 1960 to 58 years in 2011, there is a growing need to understand how religious beliefs and practices influence healthcare access among the elderly. This understanding becomes crucial as only a small percentage of elderly Tanzanians are covered by formal healthcare systems, making religious and community support networks increasingly important.

Furthermore, the National Aging Policy of 2003 and its subsequent integration into the National Health Policy of 2017 (URT, 2017) acknowledge the need to consider cultural and religious factors in healthcare delivery. However, there remains a significant gap in understanding how religious beliefs and practices specifically impact healthcare access among the elderly in Bagamoyo district. Despite these policy frameworks, the practical implementation of healthcare services that are sensitive to religious beliefs while ensuring adequate medical care remains a challenge. This gap between policy and practice underscores the need for a deeper understanding of how religious beliefs and practices influence healthcare access among the elderly in Bagamoyo district. This background sets the stage for examining how religious beliefs and practices contribute to healthcare access among the elderly in Bagamoyo district, acknowledging both the supportive and potentially limiting roles that religious factors play in healthcare access.

1.1 Statement of the Problem

Religious beliefs and practices significantly influence healthcare access among elderly individuals in Tanzania, particularly in Bagamoyo District, yet their specific contributions remain inadequately understood and addressed in current healthcare delivery systems. Despite the National Ageing Policy's recognition of cultural factors in healthcare access, there is a notable gap in understanding how religious beliefs and practices affect elderly individuals' decisions to seek and utilize healthcare services. The intersection of religious beliefs with healthcare access presents a complex challenge, as traditional religious practices often compete with modern medical care. While existing literature has extensively explored various determinants of healthcare access, such as geographic accessibility and quality of care (Abdu, 2018), the role of religious beliefs in shaping health-seeking behaviour among the elderly remains underexplored. This gap is particularly concerning given that religious practices can strongly influence decisions related to healthcare utilization, especially in culturally rich areas like Bagamoyo District.

The problem is further complicated by the erosion of intergenerational ties and the marginalization of elderly individuals in accessing essential healthcare services. With 57% of elderly individuals avoiding health facilities when sick due to various barriers (Ntahosanzwe, 2013), understanding the religious dimensions of these barriers becomes crucial. The traditional wisdom and cultural practices held by elderly individuals, often deeply rooted in religious beliefs, may conflict with modern healthcare approaches, potentially contributing to their reluctance to seek medical care. This knowledge gap hinders the development of culturally sensitive and effective healthcare interventions that could better serve the elderly population while respecting their religious beliefs and practices. Without a clear understanding of how religious factors influence healthcare access, policy makers and healthcare providers lack the necessary insights to design and implement interventions that appropriately address these cultural dimensions, potentially perpetuating barriers to healthcare access among elderly individuals in Bagamoyo District.

1.2 Objective of the Study

To examine the contributions of religious beliefs and practices on the access to healthcare services by the elderly in Bagamoyo district, Pwani Region, Tanzania.

1.3 Research Hypothesis

Hypothesis (H): The contributions of religious beliefs and practices on access to healthcare Services by the elderly in Bagamoyo district

Null Hypothesis (H_o): Religious beliefs and practices do not have significant contributions on access to healthcare services by the elderly in Bagamoyo district.

Alternative Hypothesis (H_a): Religious beliefs and practices have significant contributions on access to healthcare services by the elderly in Bagamoyo District.

The hypotheses decision rule was based on whether the regression results support this hypothesis. The indicator was if the regression coefficients of the variables show any contribution on access to healthcare services by the elderly in Bagamoyo district

2.0 Literature Review

This section presents a comprehensive review of literature related to religious beliefs and healthcare access among the elderly, organized into three main subsections. The review begins with a theoretical framework anchored in Watson's Theory of Transpersonal Caring, followed by empirical studies examining religious influences on healthcare access, and concludes with a conceptual framework illustrating the relationship between religious beliefs and healthcare access outcomes.

2.1 Theoretical Review

This study is anchored in Jean Watson's Theory of Transpersonal Caring (1979), which emphasizes caring as more effective in supporting health than medical treatment alone. The theory presents seven core assumptions: interpersonal relations form the context for care, caring fulfils human needs, active caring positively impacts health and growth, caring addresses current and future patient needs, a caring atmosphere enables patient autonomy in treatment choices, caring sciences complement curative sciences, and nursing fundamentally centres on caring (Watson, 1979). These principles establish a holistic approach encompassing the human being, health, society, and nursing (Gonzalo & Rene, 2016), highlighting how healthcare providers can deliver care that promotes better outcomes beyond mere medical treatment.

The theory's relevance to elderly healthcare in Bagamoyo District lies in its emphasis on holistic care that addresses both medical and psychosocial needs. In rural settings where elderly individuals often face isolation and social neglect (Smith et al., 2016), Watson's framework supports integrating medical treatment with emotional and spiritual care. This approach is particularly significant as it recognizes that patient satisfaction and treatment adherence improve when healthcare providers establish trusting relationships and create supportive environments. However, the theory has limitations in addressing structural barriers prevalent in resource-poor settings, such as financial constraints, transportation challenges, and inadequate healthcare infrastructure that often impede elderly access to care regardless of provider-patient relationships (Mwangi et al., 2021).

While Watson's theory provides valuable insights into the importance of empathetic care in healthcare delivery, it requires adaptation to address broader socioeconomic factors affecting elderly healthcare access in Bagamoyo. The framework must be expanded to consider elements such as income levels, healthcare literacy, and religious beliefs that significantly influence healthcare-seeking behaviours in traditional societies (Mbwambo & Nkingwa, 2020). Furthermore, the theory needs to align with broader development goals, including social protection systems and universal healthcare coverage (URT, 2020), to effectively address the comprehensive well-being of elderly populations. This suggests that while emotional and relational care remains crucial, practical interventions such as financial subsidies and transportation support are equally essential for sustainable healthcare access (Jones & Thompson, 2018).

2.2 Empirical Review of Literature

Religious beliefs play a pivotal role in shaping healthcare behaviours and access among elderly populations, though research varies in its depth of cultural inclusivity and consideration of broader socioeconomic factors. According to Koenig (2013), religion serves as a cornerstone for understanding health behaviours, where adherence to religious doctrines significantly impacts healthcare decisions and practices, including dietary choices and attitudes towards medical interventions. Scholars like Caplan (2019) emphasize the cultural specificity of religious beliefs, highlighting how different religious practices and interpretations shape health

behaviours across societies. For instance, religious fasting may be viewed as a spiritually cleansing practice that positively impacts health in some cultures, while in others, it may present challenges in managing chronic conditions among the elderly. Despite these insights, there remains a significant gap in empirical studies measuring the direct impact of religious practices on healthcare utilization among the elderly, particularly in rural settings.

Balboni et al. (2019) underscore the increasing significance of spirituality as individuals age, particularly in addressing existential concerns and end-of-life issues. As people grow older, they often become more inclined towards religion, seeking comfort and meaning in their spiritual beliefs. This spiritual dimension integrates with Maslow's hierarchy of needs, where elderly individuals may prioritize spiritual fulfilment over purely physical health concerns. The authors explain that some elderly individuals may prefer palliative care that emphasizes comfort and quality of life over aggressive treatments that might compromise their spiritual peace. Additionally, the communal aspects of religion, such as attending services and participating in religious groups, offer social support that can improve mental health and overall well-being.

The integration of religious beliefs into healthcare support programs has shown promising results in enhancing patient-centred care, as evidenced by Koenig's (2013) research in the United Kingdom, where healthcare services have adapted to accommodate diverse religious needs. However, Malone and Dadswell (2018) caution that while spirituality can promote resilience and coping mechanisms, its role in healthcare outcomes may vary depending on individual interpretations and community practices. This tension extends to debates over religious exemptions from medical procedures, where proponents argue for religious freedom in healthcare decisions (Sulmasy, 2006), while opponents warn about potential public health risks (Caplan, 2019). Puchalski et al. (2014) advocate for an integrative approach that respects and incorporates cultural and spiritual beliefs into healthcare processes, arguing that this leads to more holistic and effective patient care.

Socioeconomic factors significantly intersect with religious beliefs to shape healthcare disparities among elderly populations. Mariana (2017) discusses how income inequalities influence health outcomes, suggesting that economic status can mediate the impact of religious beliefs on healthcare access. For example, elderly individuals with higher socioeconomic status may have better access to private healthcare services that align with their religious preferences, while those with lower income levels may rely more on public healthcare systems that may not adequately accommodate diverse religious needs. This intersection becomes particularly relevant in developing countries like Tanzania, where indigenous beliefs and practices significantly influence health behaviours but are underrepresented in mainstream literature. Noblin and Ashley (2017) further emphasize that elderly individuals with higher health literacy levels and stronger social support networks are more adept at navigating healthcare systems and adhering to treatment regimens, regardless of their religious beliefs.

2.3 Conceptual Framework

The conceptual framework illustrates the relationship between religious beliefs and practices and access to healthcare services among the elderly in Bagamoyo district. The framework depicts how religiosity, influence of religion on health, and trust in religious institutions for healthcare guidance interact with healthcare access outcomes including service adequacy, satisfaction, and utilization patterns.

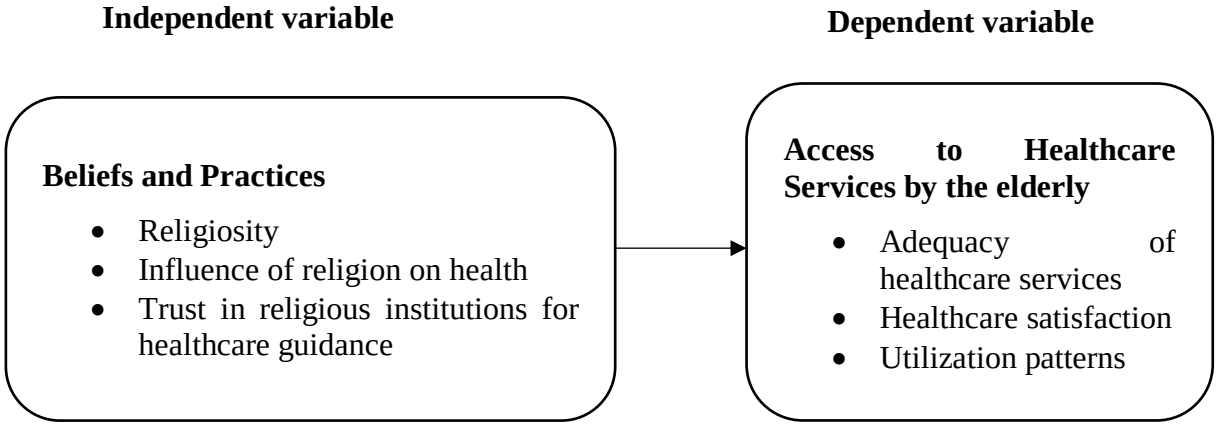

Figure 1: Conceptual Framework

3.0 Research Methodology

This study employed a mixed-method research design combining both qualitative and quantitative approaches under a pragmatic research philosophy. The research was conducted in Bagamoyo district, Pwani Region, Tanzania, targeting elderly individuals aged 60 years and above who were attending health facilities during data collection. The target population consisted of 4,998 elderly individuals (2,441 males and 2,557 females) with a total annual attendance of 1,570 according to 2022 Bagamoyo District health records. Using Krejcie and Morgan's formula, and a proportional formula a sample size of 239 respondents was determined, though the actual number of primary respondents who participated was 237. The study utilized multistage sampling to select 14 health facilities across 10 wards, followed by random sampling to select elderly respondents from health facility records, and purposive sampling to select 15 key informants (14 facility medical officers and 1 district medical officer) and 11 participants for focus group discussions. Data collection instruments included structured questionnaires for quantitative data and key informant interviews (KIIs) and focus group discussions (FGDs) for qualitative data. The reliability of the instruments was tested through a pilot study conducted with 20 respondents across seven healthcare facilities and validated using Cronbach's Alpha, which yielded coefficients of 0.7733 for unstandardized items and 0.8086 for standardized items. Data collection proceeded after obtaining necessary ethical approvals from various authorities including SPUL Board of Postgraduate Studies, SPU-ISERC, NIMR, NatHREC, and COSTECH. The quantitative data was analysed using both descriptive statistics (means, standard deviations, frequencies) and inferential statistics (Pearson's correlation, simple and multiple linear regression) to assess relationships between variables, while qualitative data underwent thematic analysis through a process of transcription, coding, and theme identification, with SPSS software being used for the statistical analyses.

4.0 Finding and Discussions

The specific research objective was examining the contributions of religious beliefs on the access to healthcare services by the elderly in Bagamoyo district, Pwani Region, Tanzania. The study question was; what are the effects of religious beliefs on the access to healthcare services by the elderly in Bagamoyo district of Pwani Region Tanzania? At this section the study dwelt on the questions concerning the religious practices and the elderly access to healthcare services, as well as, the respondents' perceptions on the available religious healthcare services. Furthermore, the study computed the inferential analysis on the contributions of religious

beliefs and practices on the access to healthcare services by the elderly in Bagamoyo district of Pwani region in Tanzania.

4.1 Religious Participations and Access to Healthcare Services by the Elderly

The study measured the religiosity of the respondents or the extent to which they participate to their religious activities. It was anticipated that individuals who have greater extent to religious activities have greater religious influences to their lives including their health behaviours. Also, those who had greater involvements to religious related activities were more likely to have an empirical information concerning the contributions of religious beliefs and practices to their access to healthcare services.

Table 1: Attending to Religious Activities

Religious attendance		Frequency	Percent (%)
	Once	57	24.1
	Twice	14	5.9
	Three	6	2.5
	Five	76	32.1
	More than five	36	15.2
	Total	189	79.7
Missing	System	48	20.3
Total		**237**	**100.0**

Table 1 reveal a high level of religious engagement among Bagamoyo District's elderly population, with significant attendance patterns: 57 respondents (24.1%) attend once weekly, 76 respondents (32.1%) attend five times weekly, and 36 respondents (15.2%) attend more than five times weekly. This strong religious participation suggests religion's central role in shaping elderly residents' health-seeking behaviours and well-being, with religious gatherings providing both spiritual fulfilment and community engagement opportunities. The study found distinct patterns across different faiths: Christian participants reported access to health education and basic services like blood pressure checks through their churches, Muslim respondents indicated that mosque attendance reinforced health-seeking behaviours through religious teachings about self-care, and practitioners of Traditional African Religions integrated their spiritual practices with traditional healing methods. While earlier research by Idler et al. (2017) and Koenig et al. (2012) established general connections between religious attendance and health outcomes, this study uniquely demonstrates how specific religious traditions in the African context influence health-seeking behaviours, suggesting that public health strategies should partner with religious institutions to develop culturally-aligned interventions that can improve healthcare access and outcomes for elderly populations.

4.2 Religious Healthcare Programmes for the Elderly

The study asked the respondents whether their affiliated religion had healthcare programs. Table 2 presents the findings regarding religious institutions' views on how frequently elderly members should access government healthcare facilities. This data is crucial for understanding how religious beliefs influence healthcare-seeking behaviour recommendations within these communities.

Table 2. Religious' Stance about the Frequency the Elderly Should Access Different Healthcare Facilities

		Frequency	Percent
Valid	Often	172	72.6
	All the time	55	23.2
	Total	227	95.8
Missing	System	10	4.2
Total		237	100.0

The findings reveal a strong consensus among religious institutions in supporting regular access to government healthcare facilities for the elderly. A significant majority of respondents (72.6%) indicated that the elderly should "often" seek treatment from government facilities, while an additional 23.2% believed these services should be accessed "all the time," totaling 95.8% in favour of regular healthcare facility utilization. Only a small portion (4.2%) of responses were missing from the system. This overwhelming support suggests that religious institutions in Bagamoyo district generally encourage their elderly members to utilize government healthcare services regularly, aligning with findings by Liana and Kamuzora (2019) that indicate a preference for government healthcare facilities among lower-income populations due to affordability and accessibility. The high level of consensus also reflects religious institutions' recognition of the importance of formal medical care, despite their own spiritual and traditional healing practices.

4.3 Respondents Perceptions on Religious Healthcare Services

The study examined elderly respondents' perceptions of religious healthcare services, specifically focusing on psychological healing services and the influence of religious beliefs on addressing health issues. The following tables present the findings regarding these two key aspects.

Tables 3: Psychological Healing Services and Perceived Influence of Religious Beliefs on Healthcare

Psychological Healing Services	Frequency	Percent (%)
Disagree	9	3.8
Undecided	10	4.2
Agree	188	79.3
Strongly agree	25	10.5
Total	232	97.9
Missing System	5	2.1
Total	237	100
Perceived Influence of Beliefs	**Frequency**	**Percent (%)**
Strongly disagree	32	13.5
Disagree	22	9.3
Undecided	12	5
Agree	141	59.5
Strongly agree	25	10.5
Total	232	97.9
Missing System	5	2.1
Total	237	100

The findings reveal strong positive perceptions of religious healthcare services among the elderly in Bagamoyo District. Regarding psychological healing services, an overwhelming majority of respondents (89.8%) either agreed (79.3%) or strongly agreed (10.5%) that religious programs provide adequate psychological healing through fellowship, visitation, and prayers. Only a small percentage disagreed (3.8%) or were undecided (4.2%). Similarly, when asked about the influence of religious beliefs on addressing health issues, 70% of respondents acknowledged their impact, with 59.5% agreeing and 10.5% strongly agreeing. However, a notable minority (22.8%) either disagreed or strongly disagreed, suggesting some variation in how religious beliefs shape health-related decision-making. These findings align with research by Green et al. (2010) and Katz, Kinde and Muthiani (2012), who found positive associations between religious involvement and health outcomes, particularly in psychological well-being and healthcare decision-making processes.

4.4 Regression Analysis and Hypothesis Testing Results

To examine the contributions of religious beliefs and practices on healthcare access among the elderly in Bagamoyo district, a linear regression analysis was conducted. The religious belief variable was constructed through a multifaceted approach that captured various dimensions including perceptions of religious influence on healthcare seeking, ratings of healthcare services, fellowship experiences, and frequency of religious attendance. The analysis tested the hypothesis that religious beliefs significantly contribute to healthcare access among the elderly.

Table 4: Linear Regression Results

AccessHCservice_eq~1	Coef.	St.Err.	t-value	p-value	[95% Conf	Interval]	Sig
ReligiousBelief_1	.384	.14	2.74	.007	.108	.66	***
Constant	13.674	.677	20.18	0	12.34	15.009	***

Mean dependent var	15.290	SD dependent var	5.235
R-squared	0.031	Number of obs	237
F-test	7.531	Prob > F	0.007
Akaike crit. (AIC)	1452.740	Bayesian crit. (BIC)	1459.676

The regression analysis revealed a statistically significant positive relationship between religious beliefs and healthcare access ($\beta = 0.384$, $p = 0.007$), leading to the rejection of the null hypothesis that religious beliefs do not have significant contributions to access to healthcare services by the elderly in Bagamoyo district. The coefficient indicates that for every one-unit increase in religious belief, there is a corresponding increase of 0.384 units in healthcare access, suggesting that stronger religious beliefs are associated with greater healthcare access among the elderly in Bagamoyo district. The model's constant term (13.674) was also significant ($p < 0.001$), indicating a baseline level of healthcare access independent of religious beliefs. While the R-squared value of 0.031 suggests that religious beliefs explain 3.1% of the variance in healthcare access, the model's overall significance ($F = 7.531$, $p = 0.007$) confirms its validity. These findings align with previous research by Koenig (2013) and Puchalski et al. (2014), who found positive associations between religious involvement and healthcare outcomes through social support networks. The results also support Levin's (2014) and Idler and Kasl's (2019) findings that religious teachings often promote health-seeking behaviours and better healthcare utilization. This relationship can be understood through the lens of Social Exchange Theory, where religious institutions provide both spiritual and practical support, including health education and assistance with healthcare access. Furthermore, the findings extend Jean Watson's Theory of Caring by demonstrating how religious beliefs contribute to a holistic approach to healthcare that encompasses physical, emotional, and spiritual dimensions, particularly relevant for elderly populations who may prioritize spiritual well-being alongside physical health. In the context of access to healthcare, religious institutions and faith-based communities provide not only spiritual but also practical support, such as health education, emotional care, and even direct financial or logistical assistance. The theory suggests that religious individuals are motivated to seek healthcare, trusting in the support networks established within their religious communities. By validating this theory in the context of elderly healthcare, particularly in rural Tanzania, the findings underscore the role of religious institutions as critical social capital for vulnerable populations.

5.0 Conclusions

Based on the comprehensive analysis of religious beliefs' contributions to healthcare access among the elderly in Bagamoyo district, several key conclusions emerge. The study found a

statistically significant relationship between religious beliefs and healthcare access ($\beta = 0.384$, $p = 0.007$), with nearly half of respondents (47.3%) demonstrating high religious engagement through frequent participation in religious activities. This engagement translated into tangible healthcare outcomes, with 89.8% of respondents affirming the positive role of religious institutions in providing psychological healing services, and 70% acknowledging the influence of religious beliefs on their health-related decisions. However, the study also revealed important institutional gaps, as 84% of respondents reported their religious affiliations lacked formal health programs for the elderly, though the existing programs showed promising results in areas such as medical consultancy and health education. Notably, religious institutions strongly endorsed the use of government healthcare facilities, with 95.8% of respondents supporting regular access. While religious beliefs demonstrated a meaningful impact on healthcare access, explaining 3.1% of the variance in the regression model, the significant baseline level of access (constant = 13.674, $p < 0.001$) indicates that religious beliefs represent one of several factors influencing elderly healthcare access in Bagamoyo district. These findings underscore the complex interplay between religious beliefs, institutional support, and healthcare access, suggesting the need for integrated approaches that leverage both religious and secular healthcare resources to improve elderly healthcare outcomes.

6.0 Recommendations

The study recommends that healthcare providers and religious institutions establish formal partnerships to enhance elderly healthcare access in Bagamoyo district by leveraging existing religious networks and community trust. Religious institutions should develop dedicated healthcare programs targeting elderly members, integrating preventive care, health education, and mental health support with spiritual activities, while training religious leaders as health advocates to promote timely medical consultations. Given that religious beliefs represent one of several factors influencing healthcare access, further research should examine additional determinants such as economic conditions, social support networks, and healthcare literacy to provide policymakers with comprehensive insights for improving elderly healthcare systems in the district.

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