

Religiosity and Health

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Introduction

There are studies showing linkages between religious beliefs and health. The importance of religion on health has been examined by studies (Vaux 1976), the dietary beliefs in health and illness (Chan Ho 1985), the role of religion in morbidity and mortality (Jarvis and North Cott 1987), the Religion and other factors influencing health status (Idler and Kasl 1992).

In India studies showing the role of caste and religion in terms of specific behaviour of individual groups in the power structure and related this to their healthculture (Banerji 1982), and the role of magic and other beliefs among a south Indian caste in health (Dumont 1986). Based on the concurrency in the issue the present paper focuses its attention on the various aspects of religiosity and health

It is observed by various researches that the rural population of India, is very much influenced by religious beliefs. For example cultural formation of individuals closely inter linked with performance of individual's daily routine. Therefore, let us first examine the impact of religious practices and rituals as aspects of religiosity on health with specific reference to rural individuals of India

Research Methodology

The rural population of Tamil Nadu is selected as universe of the present study because of its spectacular achievements in the health administration. Since this study is of health-culture of rural population, two villages were chosen for making a comparative research design. The total population of both the villages were interviewed for collection of desired information.

Data Collection

For data collection, a set of interview schedule was used. It was concerning with the health factors which was administered on the heads of the households who are the major respondents of the study. Some of them were close ended and some were open ended. Totally 207 the heads of the house holds were interviewed. The total period of data collection was spread into 7 months i.e. between November 1992 and January 1993, and between April 1993 to July 1994. The spell of field study was not very smooth. For example, many respondents were initially reluctant to answer some of the questions. However, such cases were overcome by persuasion through personal contacts and rapport.

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Objectivity

Considerable care has been taken to ensure that the data collected for this study were as objective as possible, and they have been collected they formed the basis for interpretation of phenomena observed and for drawing conclusions. There are three types of scales developed. One is Socio Economic Status scale(SES). The second type of scale which is used is on Ritualism.

And the third type of scale is on Health. The Socio Economic Scale was developed with caste, income, occupation, education and age. A set of judges who are familiar with the area were asked to rank the caste and occupation, based on the rank given, and respondents are categorized into three categories i.e. Low, Middle, and High.

Age was made into three-point scale. In case of age, the respondents below the age group of 30 are categorized as Lower(1), the respondents between the age group of 30 and 45 are middle age(2) and 45 and above are higher age(3).

Income scale was mad based on the following criteria. Income ranges from Re.0 to Rs.300 per month placed in Low(1), from Rs. 601 to Rs.2000 placed in middle(2), and 2000 and above placed in higher income(3).

Education the respondents who are in the category of no education and Primary level of education(i.e. Five years of schooling), are categorized as Less educated; the respondents in the secondary level (i.e. above five years of schooling and up to twelve years of schooling) are categorized as middle level of education and the respondents who are educated the University level of education and above are higher level of education.

Religiosity was measured by performance of various kinds of ritualistic actions. On the basis of the observations during the field work, the following items as indicators to measure the levels of religiosity and levels of health were developed.

To determine the degree or extent of the respondent's religiosity the following four indicators were selected:

- (i) Visit to place of worship
- (ii) Celebrating religious ceremonies
- (iii) Performance of rituals
- (iv) Restriction on dietary practices.

Respondents who visited to the places of worship daily were assigned 3 points, the respondents who visited to places of worship once in a week were assigned 2 points, and the respondents who visited to places of worship once in a month or occasionally were assigned 1 point. For the questions on religious ceremonies and rituals, 1 point to each positive response and zero value for negative responses were given. For the respondents

who kept fast and maintained restriction on diet at least once in a week were assigned 3 points, the respondents who kept fast once in a month and some restrictions on diet were assigned 2 points, and who kept fast once in a year or occasionally and who maintained occasional restriction on diet on some specific days were assigned 1 point. The total score ranged from 2 to 8. Those who secured 2 points were placed in 'Less religious' category, those who scored 3 to 5 points were placed in 'Moderately religious' and those who secured 6 to 8 points were placed in 'highly religious' category. Thus, the scale was divided into three major categories: less religious, moderately religious, and highly religious.

Likewise, to assess the extent of 'good health' the following five indicators were used:

- (i) Incidence of sickness,
- (ii) use of physical health measures,
- (iii) paying attention towards personal hygiene,
- (iv) consumption pattern, and
- (v) sanitation

For all questions 1 point to each positive response and zero point to each negative response were assigned. The aspect of sickness was inclusive of frequency, type and duration.

The total score ranged from 0 to 5. Those who secured up to 1 were placed in 'less healthy' category, those who scored between 2 and 3 points were placed in 'moderately healthy' category, and those who secured 4 and 5 points were placed in 'highly healthy' category. Thus, the scale of health-status was divided into three major categories: less healthy, moderately healthy and highly healthy.

Some studies have already pointed out some relationship between moral conduct of individuals and health (Cartstairs, 1965, Hasan, 1967). The studies reported that the roots of illness extend into realm of human conduct and cosmic purposes. Further, these studies have mentioned that villagers did not pay attention on their health care but they do care to follow certain practices in a very rigid manner. For example, the villagers are in habit of taking early morning walk either for a dip in the holy rivers or toilet purposes, following of certain kind of restrictive diet on certain days; keeping fast on certain specified days etc. All of these hygienic and health practices are linked with the aspects of religiosity. Likewise, the habit of bare-footed trekking and of smoking from the same hobble-bubble are some of the in unhygienic traditional practices directly affecting the health (Carstairs, 1965, Hasan, 1967) These habits are known as religious practice; and they have roots in the frame-work of religion.

Definition

In sociological tradition, religion is considered as an institutionalized system of symbols, belief values, and practices. Thus, beliefs and rituals are the main components of any religion. Sociological definitions of religion take two main forms: substantive and

functional. Substantive definition defines religion as a belief and institution directed towards deities or other super human beings such as ancestors or nature - spirits (Tylor, 1871). Functional definition of religion arose principally from Durkheim's rejection of the Tylorian approach. According to Durkheim religion is a binding force and this balances the growth of a society.

In history of society religion is based on the functional requirement of individuals. Functional requirement is to have faith in something for ones own reassurance and confidence. Evolutionists such as Tylor and Muller attempted to explain religion in terms of human needs. Tylor saw it as a response to man's intellectual needs, Muller saw it as a means for satisfying man's emotional needs. (Harlambo).

The religion has two forms. They are animism and naturalism. Animism is the belief in spirits. Edward B Tylor believed this as the earliest form of religion. He argued that animism derives from man's attempt to answer questions on the relationship between life and death. Tylor suggested that religion, in the form of animism originated to satisfy man's intellectual nature to meet his need to understand the events of death, dreams and visions (Tylor, 1970). On the other hand, proponents of naturalism believed that the forces of nature have some supernatural power. Contradicting Tylor's arguments, Malinowski put forward that naturalism was the earliest form of religion. According to him, naturalism arose from man's experience of nature, in particular the effect of nature upon man's emotions. Nature contained surprises, terrors, marvels and miracles such as volcanoes, thunder and lightning. Awed by the power and wonder of nature, the primitive man transformed abstract forces into personal agents. The force of the wind became the spirit of the wind, the power of the sun became the spirit of the sun (Malinowski, 1954) Animism seeks the origin of religion in man's intellectual needs, while naturalism seeks it in fulfillment of man's emotional needs. In the context with the rural masses of India, one finds the peculiar blend of animism as well as naturalism

To some extent Durkheim in his book 'The Elementary Forms of Religion' has supported the blend of natural power and the supernatural beliefs. He said, that all societies divided the religious acts in to "the sacred" and the "the profane". Sacred things are considered to be superior in dignity and power to profane (non-sacred) things. According to Durkheim, religious beliefs are neither to fulfil intellectual needs nor emotional as suggested by Tylor and Malinoski but religious beliefs and practices are needed for the survival of a man. Religion in all forms and types has functional use in a man's life and therefore they were always present.

Rituals

The Latin 'Ritus' from which the term ritual is derived means 'custom', a notion which has misled certain sociologists to believe that ritual was the routine of an organized religion. There is, however, no denying that without ritual there cannot be an organized religion, but this does not necessarily mean that all rituals are religious. There are many rituals which exclusively have social character, not to speak of the magical and what we would like to call the metaphysical rites, none of which can be confused with the religious ones. Certain rites are as much a part of the daily routine of the individual and hence as much as eating, drinking and the other odd chores of domestic life. Unless the necessitous is defined strictly in physiological terms without any sociological admixture, rites cannot be placed in the category of the extra-necessitous. And if the term is defined in this manner, not only rites but several other practices too, will have to be included in the other category. The

popular distinction between the sacred and the profane, again does not seem to be a sound basis for distinguishing rituals from ordinary practices. It is in fact the ritual 'touch' which makes certain practices sacred, not that an act becomes ritual because it happens to possess a sacred character. The objects and beliefs treated as sacred are sacred only because they are endowed with a ritual-value.

Rituals are often understood as a form of symbolic action. Sometimes symbolic actions differ from the ordinary ones. However, the distinctive characteristic of symbolic actions is that they are not governed by the laws of logic which normally govern the other ordinary action.

All human beings believe in supernatural power That is there is a power beyond human-power and knowledge. It is true even in the case of health and illness. People believe that one is healthy and other is not because of the effect of some supernatural forces. There are instances among the rural masses where illnesses are associated with God. Diseases like small pox, chicken pox, measles and cholera are generally associated with a particular God or Goddess or deities as well as the power of natural elements like certain kind of wind pressure, sun light and Neem tree. In rural India, people believe that the health problems arise due to the sins committed in last birth. They generally associate the outbreak of epidemics with the non performance of certain rituals by the population. Likewise, respondents of the study believed certain diseases can never be cured with any amount of medical aids and they can only be cured through the help of divine power which can be aroused by offering, prayers, chanting of mantras' etc. they did mention to the investigator that dreaded diseases like small-pox, plague, cholera have cures in divine offerings and religious rituals.

In the back-drop of the above discussion, one can appreciate the importance of ritualistic action with in the frame-reference of religion.

Using the above two measurements, we arrived at three levels of health-status (high, moderate and low) and three levels of religiosity as presented in Table 1.

TABLE 1 LEVELS OF HEALTH STATUS AND RELIGIOSITY OF RESPONDENTS

CATEGORIES OF RELIGIOSITY	HEALTH CATEGORIES			TOTAL
	LOW	MIDDLE	HIGH	
LESS	11 (42.3)	28 (50.9)	0 (0)	39
MODERATELY	15 (57.6)	24 (43.6)	57 (45.2)	96
HIGHLY	0 (0)	3 (5.4)	69 (54.7)	72
TOTAL	26 (100)	55 (100)	126 (100)	207

X =99.306, df= 4,
p<0.01
Pearson's=0.6117

The Table 1 suggests the frequency distribution of respondents into various categories of health status and religiosity. The table shows that religiosity and health-status are in correspondence with each other. It means highly healthy respondents are the highly religious persons. It shows, that the majority of respondents who are having good health (ie. 69 out of 126) are termed as highly religious persons too. Likewise, those who have scored low on scale of religiosity, have scored low on health scale too (i.e., 11/26). However, it is worth noting that a very low percentage of the total respondents fall in the category of low health status (i.e., only 26 respondents). Out of these 26 cases, only 11 are in the category of low health status. This finding suggests that most of the respondents were very religious and therefore, they were following the traditional practices. Some of the statistical results confirm the above finding. For example, the Chi Square test score shows that, there is a significant relationship between ($p < 0.01$).

Religiosity and Health Status.

In addition to the above results, the coefficient of correlation also confirms ($r = 0.6117$) a significant relationship. The respondents who are placed into the category of highly religious are visiting the places of worship once in a day. They used to perform certain daily routine practices as sacred functions or rituals, such as taking bath before going to a temple, use of sandal mark on forehead, smearing of sacred ashes (made of burnt cow dung cakes) on the fore head, carrying flowers and camphor sticks etc. Most often highly religious respondents kept fast for a day once in a week along with certain kind of restrictive diets on rest of the days. They normally consume vegetarian diet consisting of items like card, fresh vegetables, unpolished rice, seasonal fruits, coconut, etc. Generally, their food was served on banana-leaves Their practices suggested inoculation of certain amount of discipline and regularity in their way of living which in turn was able to provide a mechanism of maintaining good health. To some extent this assumption got confirmed through the answer pattern of respondents. After having a discussion on ritualistic practices as routine action, it would be useful if we can have a look at the offerings performed by the respondents Each respondent was asked whether they are offering. On response to the question, all respondent excepting two respondents performed offerings

Table 2 Religious Rituals for common cure

Kinds of Offering	Number
Goat	192
Pongal	193
Money	115
Hair	4

Table 2 shows 205 respondents perform offerings in the form of animals, pongal, hair etc. for common cures. It is interesting to observe that almost all the respondents performed either for common cure or tangible benefits excepting 2 respondents who mentioned that they did not believe in offerings. 83 Normally these offerings were made in the form of promises at the time of sicknesses and as soon as the sick persons became healthy - the promises of offering were fulfilled in front of the deities

Table 3 Socio Economic Statuses and Religiosity

SOCIO ECONOMIC STATUS	RELIGIOSITY			
	LESS	MODERATE	HIGH	TOTAL
LOW	2	3		5 (2.4)
MIDDLE	23	44	74	141 (68.1)
HIGH	1	8	52	61 (29.5)
TOTAL (percent)	26 (12.6)	55 (26.6)	126 (60.9)	207 (100)

Table 3 shows that there exists a positive relationship between socio economic status and religiosity. A majority of respondents belonged to the middle SES Category. Among the middle SES Category members a majority of the respondents are placed into highly religious group. It is the same in the High SES Category. From Table 3 it is clear that the religiosity is increasing with the socio economic status. The statistical analysis also confirms it (contingency coefficient = 0.34). Table 3 suggests that the respondents who belonged to high SES categories are highly religious and low SES respondents are less religious. It shows that the religiosity increase with SES. It is interesting to suggest that some meaningful relationship have been observed among the socio economic status of respondents and the various forms of ritualistic practices of the respondents The variables influencing the health behavior are caste affiliation, age, income, educational achievements, and the practices etc. and health

TABLE 4 CASTE AFFILIATION AND RESPONDENTS' RELIGIOSITY N= 207

CATEGORIES OF RELIGIOSITY	CASTE CATEGORIES			TOTAL
	LOW	Middle	High	
Less	39 (67.2)	0 (0)	0 (0)	39
Moderate	19 (32.7)	40 (93.02)	37 (34.9)	96
High	0 (0)	3 (6.9)	69 (65.09)	72
Total	58 (100)	43 (100)	106 (100)	207

X = 183.42, df= 4,
 p<0.01 p<0.01
 Pearson's
 r=0.7892

Table 4 shows a positive relationship between caste status and the religious status. It means that the respondents coming from low caste hierarchy have scored low in ritualistic performances. Likewise, the higher caste respondents have shown high kind of religiosity in ritual performance.

Respondents were categorized into three major categories of religiosity based on their religious activities such as diet, fasting, offering etc. Likewise, the respondents were composed of various caste groups based on their status placement in caste hierarchy such as high caste, middle caste and low caste. In the Low Caste Category there were 39 respondents who were also placed into the less ritualistic category (see Col. 1 of 5.1) because they scored low 83 on the composite scale of ritualistic behavior. It suggests that there was complete congruity among the respondents of low category Respondents coming from low caste groups did not believe in rigidity of ritualistic action. Hence, they scored low on ritualistic scale While 19 respondents were placed into "moderately religious" category Table 4 further suggests that respondents belonging to low caste category either have been placed into low religious or moderately religious groups. It is interesting to point out that none of the respondents of the low caste category were placed in 'highly religious' category. Table 4 further denotes that almost all the high caste respondents were placed into highly religions or moderately religious groups. (See Col. 3 and row 3) while none of the high caste respondents were found in the less religious category (see Col.3). The statistical results i.e. the Chi square test score also confirms the above hypothesis by showing significant relationship between different caste categories and the level of religiosity (Chi Square = 183.42 p <0.01). The differences are in the expected direction. The coefficient of correlation result (=0.789) also confirm of the hypothesis. After some probing, we learnt that many rituals were commonly followed in a very religious manner for some tangible benefits. For example, once Muthu a respondent from Mannadiyar caste was needed five thousand rupees for purchasing a pair of cows For this he promised for offering his hairs to Lord Murugan of Palani, in case of getting the money. After a week or so, has sent who was working in another form had sent him the required amount. This kind of offerings were common among the higher caste respondents As soon as Muthu got the money, he want and offered his hair.

Table 5 Religiosity and Health among different Age Groups

RELIGIOSITY	AGE CATEGORIES											
	YOUNG				MIDDLE				OLD			
	L	M	H	I (%)	L	M	H	T (%)	L	M	H	T(%)
HEALTH	3	4		7 (152)	6	17		23 (26,1)	2	7		9 112,3)
LESS												
MODERATE	3	7	14	24 (52.2)	8	8	22	38 (43.2)	4	9	21	34 (46 6)
HIGH		1	14	15 (326)			27	27 (307)		2	28	30 (41)
TOTAL (%)	6 (13)	12 (26)	28 (60)	46 (100)	14 (16)	25 (28)	49 (56)	88 (100)	6 (8,2)	18 (24,7)	49 (67)	73 (100)

The Table 5 denotes that the' health status of different age categories of the respondents. It shows some kind of uniform distribution in different levels of health status. However, it is interesting to note that the respondents belonging to young age categories are also keeping the health status matching to the old age categories. One would assume that young persons would be healthier than the old persons. However, this assumption is completely believed with the findings. Further, it is observed that the older respondents were having more disciplined life than younger respondents. It is quite possible that the differences in health status may be taking place because of the disciplined routine life.

Table 6 Religiosity and Health Among Different Educational Categories

RELIGIOSITY	EDUCATIONAL CATEGORIES											
	LOW				MIDDLE				HIGH			
	L	M	H	T	L	M	H	T	L	M	H	T
HEALTH	7	20		27 (17.9)	4	8		12 (22.6)				
LESS												
MODERATE	10	18	44	72 (47.7)	5	6	11	22 (41.5)			2	2 (66.7)
HIGH		1	51	52 (34.4)		2	17	19 (35.8)			1	1 (33.5)
TOTAL (percent)	17 (11.2)	39 (25.8)	95 (63)	151 (100)	9 (17)	16 (30)	28 (52.8)	53 (100)			3 (100)	3 (100)

Table 6 denotes the health status of different educational categories of the respondents. It shows some kind of uniform distribution in different levels of health status however; it is interesting to note that the respondents belonging to lower level of education categories were also keeping the health matching to the highly educated respondents. One would assume that highly educated persons should be healthier than the less educated respondents. However, this assumption is not found true. Further, it is observed that the less educated respondents were having more disciplined life than highly educated respondents. The highly educated respondents migrate to urban areas due to unemployment, because of that they pick up bad habits such as smoking, consuming liquors etc. Therefore, the highly educated respondents could not follow the routines regularly. Hence, the relationship between health and religiosity among different educational categories is clearly seen.

Based on respondents' description of ritual practices, some characteristic of rituals has been observed. They are:

(i) Rituals performed for tangible gains: Attainment of tangible objects like wealth success, physical, power political gains etc. were the major motives related with certain kind of distribution of money/gift etc. Once Murugan appeared in the Secondary School Examination, he prayed to Lord Murugan that if he passes the examination, he would offer a coconut. When he succeeded in the examination he offered it. Likewise, rituals are performed for tangible benefits.

(ii) Supernatural ritual performances are part of the religious system for attaining salvation in some form. Sometimes their effectiveness is presumed to depend upon the "will" of a supernatural being; thus, when respondents speak of prayer or supplication, they imply that the supernatural being who is addressed may fulfil the wishes of the petitioner. In some rituals, however, the performance is automatically effective provided that it is carried out according to certain prescriptions. For example, in case of spread epidemic diseases like smallpox, measles (a variety of viral disease). In the study villages, it was observed that, whenever a child is ill of chicken pox the members of the family worshipping the child by saying The Goddess has gone into the child.

(iii) Rituals as moral conduct: According to Durkheim in all modes of life, relating to serious acts such as happiness, grief, sufferings, etc one is suppose to perform certain prescribed rituals.

For example, thanks giving celebrations, death rites, funeral-procession etc. These rituals are brought in practice form to inculcate some moral order and discipline. Among the respondents of the study it was a common practice that whenever there was a happy occasion like the birth of a child, or a marriage, they performed some rituals to celebrate the happiness as a symbol of thanks giving Similarly, when a person died, the villagers performed rituals on the second day which they call 'Paal Uthuthal' (milk giving ceremony) This ceremony was performed to show certain amount of respect towards the departed soul.

(iv) Transcendental aspect of rituals: Ritual imposes a transcendental obligation - an obligation which does not stand or sanctions but enforces itself spontaneously Its impact on human mind may be characterized in metaphysical terms as awesome, faith or devotion in contradiction to the psychological 'appeal' of dynamic morality. Love, compassion, charity and loyalty, the tenets of the dynamic morality are the universal principles of human existence. In conforming to these, man simply obeys the law of his nature; he will cease to be a human being if he refuses to abide by them.

An overview of some of the above it can be suggested that health is as much a socio-cultural phenomenon as it is a biological explanation. Religious values such as deeds of the past, attributing to sins committed by people and consequent of wraths of gods and goddesses and treatment sought through magico- religious practices, are indicators of the influence of our tradition and cultural life. With the spread of education, exposure to mass media, urbanizing and industrializing influences resulting in occupational and spatial mobility and economic well being, choice of people to accept modern medicine over folk medicine has increased. Even villagers or tribal folks look forward to modern medicine for relief from pain, sufferings or physical ailments. Medicine, whether folk or modern has a dual nature. Irrespective of the technological level of a society, people still would lend support to the physicians efforts with their prayers and propitiation of gods and goddesses. This mix of scientific temper and faith healing in medicine needs to be understood in the context and situation in which it operates. It may be only making tall claims that modern medicine has stalked death. It has only postponed death but at the same time, the scientific development has increased the "at risk factor" for the health of man. In other words, the life span of man has increased but his rate of becoming unhealthy has increased many fold. Indian villagers in this modern world still wants to try out various systems of medicine and

when they feel dissatisfied with one, they are inclined to try their hand on another, till they are forced to entrust themselves to the folk medicine which is close to their cultural milieu.

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