A Matter of Faith: Unravelling the role of religion on child survival in sub-Saharan Africa

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SUMMARY

This study has reviewed the role of religion on child mortality in sub-Saharan Africa using searches of electronic Databases. The review found only one study, which investigated the relationship between religion and child mortality in sub-Saharan Africa using religion as the “main” independent variable. In addition the review identified several areas (definition of religion, measurement and types of studies), which should be further addressed towards a better understanding of the role of religion on child health outcomes, especially child mortality.


Introduction

Religion is of great importance in Africa and most people engage in some form of religious practice from time to time, and many profess membership of some formal religious organisational, traditional, Muslim, Christian or otherwise (1,2). Many Africans voluntarily associate themselves with religious networks, which they use for a variety of purposes–social, economic and even political–that go beyond the strictly religious aspect.

There is a suggestion that in the African context most people are religious inasmuch they believe in the existence of an invisible world, distinct but not separate from the visible world, that is inhabited by spiritual beings or forces with which they can communicate and which they perceive to have an influence on their daily lives. Religious ideas typically govern relationships of people with a perceived spiritual world. In effect, this idiom can govern relations both of one person to another, or of one person to a community, but also to the land they cultivate (3). The relationship between religion and health has been of longstanding interest in health, social, and behavioural sciences, spanning a period of more than 100 years (4–7). Despite recognized methodological and analytical issues (8), overall the findings indicate a consistent and salutary influence of religion factors on individual and population health (6, 9).

In the past years, systematic research on religious involvement and physical and mental health has begun to explore the functional mechanisms linking these constructs. However, research regarding the relationship between religion and health sometime faces sceptical resistance due to several factors: First, it is a challenge to understand the complex, multifactorial process through which religion affects individual and population health. In addition, the study of religion and health involves many disciplines. Although this diversity enriches the study of religion and health, it is difficult to appreciate disciplinary
differences in conceptual frameworks, methodological and analytical approaches, relevant contextual issues, and levels of inquiry (e.g. individuals versus populations). Secondly, longstanding scientific and professional perspectives have fostered stereotypes and misconceptions about issues of religion and/or openly antagonistic attitudes that preclude a consideration of these questions (10, 11). Third, researchers and practitioners in the behavioural, social, and health sciences may themselves be less religiously active than the general population (12, 13) and, therefore, may dismiss or deprecate the relevance of religion for human affairs. Finally, the absence of thoughtful and comprehensive discussions of the ethical considerations, practice and policy implications, and professional ramifications of the integration of religion and health has made researchers and practitioners wary of addressing these questions in their work (4).

**Background**

**Definitions and indicators of religion and religions involvement**

One of the most difficult and perplexing issues in the field concerns what is meant by religion and basic conceptual definitions of what constitutes religious involvement. A review of religious and social behavioural science writings on the topic of religion defines it as “a process, the search for significance in ways related to sacred” (14). This definition incorporates the themes of both the substantive content (e.g., beliefs, practices, and feelings directed towards God) and functional aspects (e.g. a process focused on questions of ultimate meaning and concern) of religion. Many agree that religion is a multidimensional construct (4, 14). Unfortunately, different disciplines and fields such as psychiatry, social epidemiology and clinical medicine often emphasize particular dimensions or forms of religious expression (e.g. church attendance or denominational affiliation) which further complicate efforts to define and measure religious involvement, as well as various mechanisms through which religious effects have impact on diverse health outcomes (4).

**Religious effects on health outcomes**

Evidence from epidemiological and clinical studies and medical research from developed countries supports the impact of religious affiliation and involvement on a diverse array of mental and physical health indicators and disease states. This evidence encompasses studies of cancer, hypertension, stroke, other cardiovascular conditions, gastrointestinal diseases, overall and cause-specific mortality, indicators of physical disability, self-ratings of health status, and reports of symptomatology (4, 15, 16). Many investigations indicate that religious involvement is associated with better outcomes for persons who are recovering from physical and mental illness (17–19). On the other hand studies have indicated a positive association between religious involvement and mental health outcomes (4). Studies (primarily epidemiologic) indicate that religious factors have a salutary influence on a diverse set of outcomes, including depression, drug and alcohol abuse, delinquent behaviour, suicide, psychological distress and certain functional psychiatric disorders (4,20). Furthermore, a large body of research indicates that religion is beneficial to a sense of personal well–being and overall adjustment (4, 6).

Other studies have examined the associations between religious involvements and health and life style behaviours (4). Much of that research has focused on the health / life styles of persons within identified religious groups and denominations (e.g. Mormons or Seventh Day Adventists), which may, in turn result in lower levels of morbidity for various diseases (4).
Religious strategies may be particularly important for coping with mental and physical illness and disability. Persons who use religious coping appear to handle their conditions more effectively than those who do not (4, 20). It is suggested that religious coping is significant for mental health and physical health outcomes for a variety of life circumstances, especially health problems (17) and bereavement (9). Religious coping also appears to reduce levels of depression and anxiety (14) in connection with bereavement and other loss events (4).

Geriatric outpatients, who report greater spirituality but not greater religiosity, are more likely to appraise their health as good. Spirituality may be an important explanatory factor for subjective health status in older adults (21). A study of the impact of biological and religious correlates on mortality showed a distinct denominational mortality differentials between Roman Catholic, Lutheran, and Reformed Calvinist individuals. Death rates among Catholics were high than those among protestant or Jews (22).

In sub-Saharan Africa, which is the focus of this review, the study of the association of religion and health outcomes has been limited primarily to fertility and these studies have tried to assess the role exerted by religion on fertility choices or behaviour. In many instances religion has been found to be associated with fertility behaviour (23–32). On the other hand an array of studies on child mortality has used religion as a control variable when studying associations between child mortality and a variety of other determinants (33–36). Very few studies have investigated the relationship between religion and child survival and child mortality in particular. Therefore, this literature review is aimed at identifying studies, which used religion as the main independent variable in relation to child mortality in sub-Saharan Africa. In addition the study discusses relevant issues, which should take into account when studying role of religion on child health outcomes in sub-Saharan Africa.

**Methods**

A total of 6 electronic databases where searched during one month (1–30 May 2007): Medline, Google, Dissertation abstracts, Popline, Web of Science and IBSS. Search words included “religion and child mortality in sub-Saharan Africa”, “religion and child mortality in East, West or Southern Africa”. The selection of articles was based on the following criteria: the articles must include data from population-based studies in which analysis was based on “Religion being the main independent variable. First, titles of articles were examined for appropriateness; and titles not meeting the criteria were eliminated. If there was uncertainty, the abstracts were printed from the database and examined, and those who did not meet the criteria were eliminated. If appropriateness of an article was still in question, the entire article was evaluated.

**Results**

In all, the searches yield 10 were potentially relevant documents, which included scientific articles, reports, and policy documents. However, only one article fulfilled the criteria of being a study, which was population-based and used the variable religion as the main independent variable. Details of the study are displayed in Table 1.
Table 1. Results of the literature search regarding studies, which used religion as “the main independent variable” when studying the relationship between religion and child mortality in sub-Saharan Africa.

<table>
<thead>
<tr>
<th>Study Title</th>
<th>Subjects</th>
<th>Methods</th>
<th>Main results</th>
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<tr>
<td>Gymah SO.</td>
<td>Pooled data from 1998 and 2003 Ghana Demographic and health Survey Sample=7142 children born in the 5 years before the survey</td>
<td>Dependent variable: mortality (0–59 months) Exposure was broken into &lt;1month, 1–5 months; 6–11 months, &gt;24 months. Main independent variable: Religion</td>
<td>At the bivariate level results showed that the survival probability for children by age 5 was about 91% for Christians compared to 85–86% for Muslims and traditionalists. However, in the multivariate analysis the religious differences disappeared after controlling for socio–economic status.</td>
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Discussion

This review found only one study, which investigated the relationship between parental (mother in particular) religious affiliation and child mortality in sub-Saharan Africa and in which religion was the main independent variable. The study was carried out in Ghana (37). This is in agreement with the already lack of investigation of the role of religion and health outcomes in the African context. Such an omission is, however, unfortunate given the overwhelming influence of religion on the African social fabric and the general interpretation of diseases and causation within a religious context.

In a BBC world survey it was found that three–quarters of those questioned in Africa identified religious leaders as the most trusted group, compared with only a third worldwide (38). Furthermore when asked who had the most influence on their decision–making over the past year, a significantly higher proportion of respondents in Africa indicated religious leaders (38). These results suggest that religion play an important role in the life of Africans and may impact significantly on behaviour formation. For instance, according to Pfeifer (39), over the last decade, Central Mozambique has experienced a dramatic proliferation of independent Christian faith–healing churches, whose memberships jumped from 10% in 1998 of poor urban populations to well over 50% in 2000. In addition he argued that the rapid church expansion was largely driven by the intensification of economic social inequality, which was produced by the Structural adjustment policies and privatization, implemented during the same period. Furthermore he stated that growing inequality in the City of Chimoio, central Mozambique generated a widely held perception that social conflict, crime, perceived “moral “ breakdown and distrust within both households and communities have increased during that period. As a result of the growing influence of those Christian Churches, in Chimoio, many women with sick children or suffering from infertility did turn to
the African Independent Churches for treatment because traditional healers were increasingly viewed as dangerous and too expensive. On the other hand in US, a study, which investigated 172 children who died between 1975 and 1995, found that 140 of those deaths were conditions for which survival rates with medical care would have exceeded 90%. The authors of that study suggested that it was faith healing, which was used to exclude those children from medical treatment (40). Many authors argue that sometimes religious beliefs and commitments may also encourage general lifestyles and patterns of behaviour that are harmful to health (4, 41). In addition religious teachings may prescibe specific medical procedures and treatments and, in extreme forms, promote and reinforce social deviancy and aberrant behaviour that is detrimental to health and well being (e.g. cult membership). Religious groups may negatively influence patterns of informal and self care, discourage professional help-seeking behaviours for health care, promote the inappropriate use of services (e.g. delays in the timing of service use), and encourage exclusive treatment by clergy (e.g. for mental and emotional problems) (41). However in both developed and developing countries there is little systematic information that focuses on the mechanisms through which religious groups and clergy influence the use of professional health services.

Theories of the relationship between religion and child survival in sub-Saharan Africa

In developed countries systematic work on religious involvement and health has advanced the quality of research and scholarship in this area; for example, religion is now recognized as a multidimensional construct comprising attitudes, behaviours, beliefs, values, and experiences (4). However, in developing countries and especially sub-Saharan Africa there has been little research on the impact of religion on health outcomes in general and child health outcomes in particular.

Two theoretical paradigms have been forwarded in relation to parental religious affiliation and child survival in sub-Saharan Africa. The first derives from the notion that doctrinal teachings, beliefs and values of the various religious groups themselves may influence child health and survival (37). By prescribing or proscribing certain lifestyles and regulating daily health-related behaviours, religion may negatively or positively impact on health and survival. For instance Hummer et al (42) point out that, one of the key functions of religious communities is to shape the norms of individual member’s through behavioural regulations that are specified in sacred teachings, reinforced through authoritative messages from congregational leaders, and solidified through social interactions in the religious community.

In the African context, many mainstream Christian churches such as Catholic and Protestants tend to prescribe health-enhancing behaviours and other denominations such as Pentecostals and Spiritual churches often stress the importance of divine healing through intercessory prayers and fasting. In many settings, believers who seek modern care are often chastised for having little faith in God (37). For instance in northern Nigeria (Kano, Kaduna and Zamfara States) parents refused to allow their children to be vaccinated against poliomyelitis after an Islamic leader declared the vaccines unsafe (43–45). This somewhat contributed to the rise in numbers of polio cases in that region (43).

The second theory is based on the selectivity hypothesis, which postulates that denominational differences in child mortality mainly reflect differential access to social and human capital rather than religion per sé. It argues that religious affiliation is confounded with and mediated by other putative characteristics that are known to associate with health-related behaviour,
and that these factors need to be controlled statistically to be able to isolate the residual effect of religion. For instance, maternal education, for example can be considered a mediating factor in the way that religion may influence a women’s propensity to seek formal education, which in turn can affect child survival. For instance in Ghana it was found that there were remarkable differences in educational attainment among different religions. They stated that women who professed to be Traditionalists or Muslims had lower education than Christians (46). Furthermore, factors such as place and region of residence may have a confounding effect due to the uneven distribution of religious affiliations along side these characteristics in many sub-Saharan African countries (46,47).

Measuring the effects of religion on child health and child mortality

Unfortunately, research on religion and health continues to grapple with a number of measurement issues, despite sustained attention to these concerns. This is due to several factors. First, health researchers are often unfamiliar with measurement strategies from social and behavioural sciences that have produces brief, reliable, and content–valid instruments for measuring religious involvement (4, 48). Second, perhaps because of administration ease and established practices, there is a tendency to rely on objective and behavioural reports of religious involvement (e.g. church attendance and denomination) and to ignore other aspects of religion that reflect functional relationships with health outcomes. Behavioural reports of religious involvement are essentially proxies for a whole range of phenomena (e.g. lifestyles, attitudes, and social support) that are not directly assessed but potentially bear a strong relationship to health and well being (48). The situation is exceedingly complex, because these multiple components of religious involvement demonstrate divergent relationships to health outcomes. However, the thorough investigation of the proximal factors and functional mechanisms linking religion and health will advance our understanding of how these constructs are related.

Many studies, which investigate the religious effects and health outcomes, use cross-sectional study designs to investigate effects on health. This is true for developing countries especially those using data originated from Demographic and Health Surveys. In these surveys mothers in particular are asked about their religious denominations (if whether there are Christians, Muslim, traditional beliefs or other denominations). However, the consideration of alternative relationships among religion, mediating factors, and health indicates that religious effects may be exerted through a variety of pathways, and different types of study design are required for their investigation. Therefore the use of prospective designs may be particularly helpful in understanding the nature and role(s) of religious factors for individual health status and well being over time (4, 48, 49).

Conclusions

This review found only one study, which investigated the relationship between religion and child mortality in sub-Saharan Africa using religion as the “main” independent variable. This result highlight the need for more studies assessing the importance of religion on child mortality differentials as well as potential inequalities in child mortality. In addition the review identified several issues, which should be addressed further towards a better understanding the role of religion on child health outcomes, especially child mortality. One area of research that warrants further attention in sub-Saharan Africa is the investigation of the role of social resources and specifically social support as a major construct for understanding religion’s effects on health. Work along side these
lines suggest that religion actively shapes the nature, type, and extent social support relationships in ways that benefit health. Another important aspect that needs attention in sub-Saharan Africa is encouragement of qualitative studies.

Qualitative studies of religion and health are important for understanding the culture of religion and the specific ways that individuals link these two constructs. Given the discontinuity between religious and scientific perspectives, qualitative studies could be useful for collecting primary information on individual’s perceptions of the links between religion and child health as well as for exploring several of the hypothesized mechanisms for religions effects on child health outcomes.

In addition another important aspect, which would be useful in the investigation of religion and health, is the investigation of the vocabulary of “religion”. This is due to the fact that researchers and others often make a mistaken assumption that the meanings of religious terms like redemption, faith, salvation, healing, and grace are self evident and shared across different religious groups. This is not the case however, and failure to inquire directly about the types and meanings of core religious terms runs the risk of imposing one’s own understandings on the experiences of another and misinterpreting the meaning of these concepts. In addition research attention should focus on the specific role that religion plays in the development of health attitudes and behaviours. In this respect some proposed a socialization model that incorporates parental (primary) and religious (secondary) factors in understanding the development of health-compromising and health-enhancing behaviours among adolescents.

The model proposes that religion’s influence on adolescent morbidity and mortality is indirect via several mechanisms (e.g. social support, social control, individual and group identity, and values), with an emphasis on how religion actively promotes and prescribes health behaviours (49). Adaptations of this model may be useful for researchers investigating the role of religion in child health (mortality and morbidity) in sub-Saharan Africa. However, most important is that child health researchers in the region should through sound methodologies investigate linkages among spirituality, religion and health. It can be useful in health research to distinguish spirituality from religion, since much more research has been on the latter than on the former.

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