CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

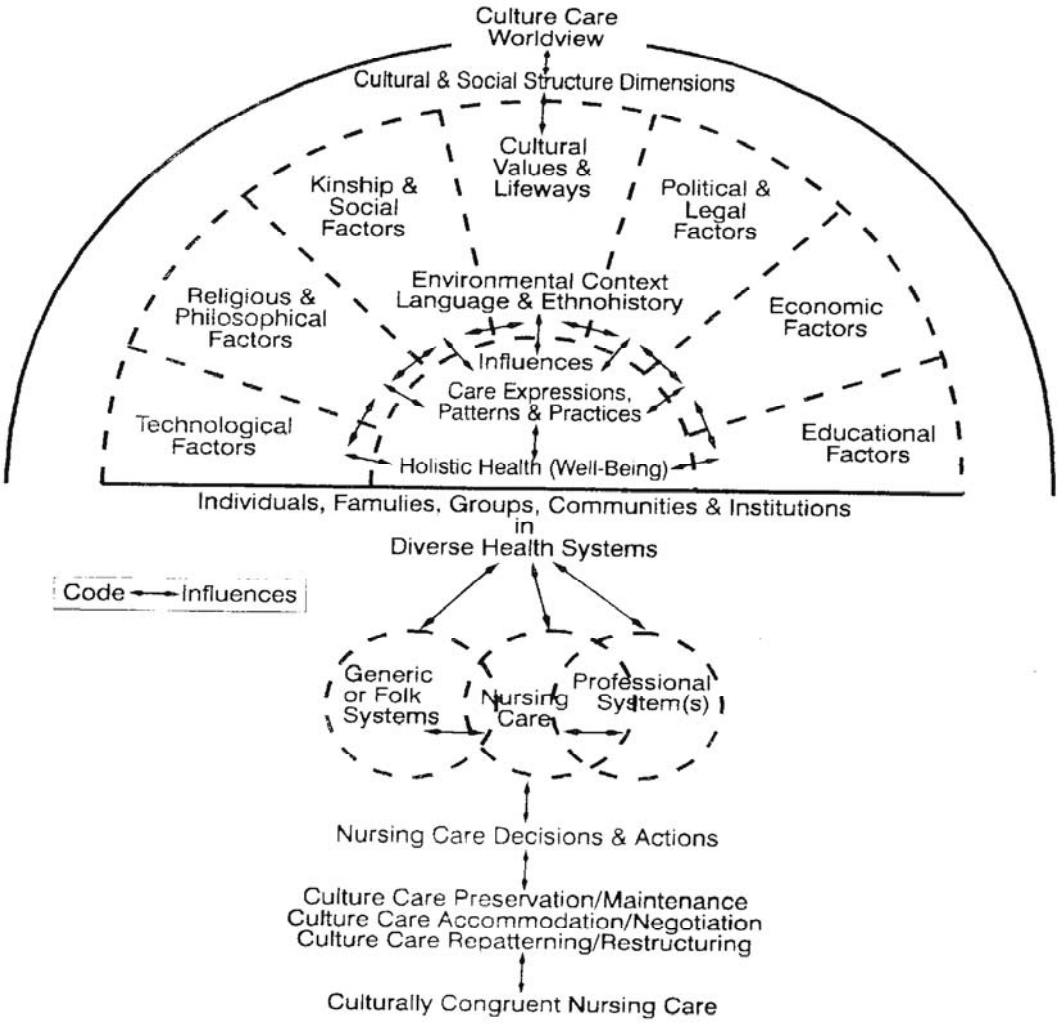
In this chapter Leininger's Theory of Culture Care Diversity and Universality is discussed. The relationship between health, culture and religion is also discussed by examining research reports of various authors. The chapter presents the Culture Care Theory, the Sunrise Model, and the Ethnonursing Method, which were used as the framework for the study and to guide the research design. The literature review also explores the concept of culture and its relationship to health and illness through a discussion of related research studies that were done in Southern Africa and other locations internationally. Explanatory models of health and illness are discussed to serve as a background to understanding the relationship between culture and health seeking behaviour.

2.2 THEORETICAL FRAMEWORK

Leininger's Theory of Culture Care Diversity and Universality provides the framework for this research through the use of the Sunrise Model and the ethnonursing method. The Sunrise Model "is a cognitive map to orient and depict the influencing dimensions, components, facts or major concepts of the theory with an integrated total view of these dimensions" (Leininger 1991:49). The ethnonursing method is a qualitative research method that is used to investigate research participants' life-worlds with a specific focus on health, illness and care, and it has been used in this study as part of the research design (Leininger 1991:79).

2.2.1 Leininger's Theory *Culture Care Diversity and Universality*

The central theme of Leininger's theory is culture care, and care is regarded to be the essence of nursing (Leininger 1991:35). The goal of the Culture Care Theory is to provide culturally congruent care to individuals, families, groups, communities and institutions. Culturally congruent care is defined as " those cognitively based assistive, supportive facilitative, or enabling acts or decisions that are mostly tailor made to fit with an individual's, group's, or institution's cultural values, beliefs, and lifeways in order to provide meaningful, beneficial, satisfying care that leads to health and well-being" (Leininger 1995:75). The structure of the theory is depicted in the Sunrise Model (figure 2.1).



From *Culture Care Diversity and Universality: A Theory for Nursing* by M. Leininger, 1991 New York: National League for Nursing. Reprinted by permission.

Figure 2.1 Leininger's Sunrise Model (Leininger 1991:49)

The theory assists the nurse to learn about the worldview of a group or an individual. From the worldview, a cultural group derives its cultural and social structure dimensions that define their existence. The way in which each cultural and social structure dimension is lived and experienced differs from one cultural group to another. These cultural and social structure dimensions flow from the worldview and are also shaped by the environment and language contexts in which they exist. They, in turn, influence culture

care patterns, practices and expressions. The Culture Care Theory states that there are seven cultural and social structure dimensions,

- *Technological factors,*
- *Religious and philosophical factors,*
- *Kinship and social factors,*
- *Cultural values and lifeways,*
- *Political and legal factors,*
- *Economic factors, and*
- *Educational factors.*

This study specifically focuses on religion and its influence on health seeking behaviour. However, the researcher used the seven cultural and social structure dimensions as an organising framework during data analysis.

In order to provide culturally congruent care, the nurse synthesises aspects from a generic (traditional) and a professional health care system. The care provided would be unique for each individual or group as a result of this synthesis. Three main modalities guide nursing judgement, decision-making and actions, namely:

- *Cultural care preservation / maintenance,*
- *Cultural care accommodation / negotiation,*
- *Cultural care repatterning / restructuring.*

Culture care preservation and maintenance imply that existing behaviour and lifestyles that are good for health should not be changed. For instance, nurses must encourage

cultural practices such as mutual support for the sick by members of the extended family. Nurses ought to incorporate such practices into the care plan.

Culture care accommodation " refers to those assistive, supporting, facilitative, or enabling professional actions and decisions that help people of a designated culture to adapt to, or to negotiate with, others for a beneficial or satisfying health outcome with professional care providers" (Leininger 1991: 48). For example, if a client eats a lot of fatty meat, this may be construed as a possible source of illness and the health professional may negotiate with the client to substitute fatty meat with other sources of protein and to reduce fat in the diet.

Culture care repatterning and restructuring "refers to those assistive, supporting, facilitative, or enabling professional actions and decisions that help a client(s) reorder, change, or greatly modify their lifeways for new, different, and beneficial health care patterns while respecting the client(s) cultural values and beliefs and still providing a beneficial or healthier lifeway than before the changes were co-established with the client(s)" Leininger 1991: 49). A client, who is HIV positive, has multiple sexual partners and abuses alcohol, would be encouraged to restructure his lifestyle and change his/her behaviour radically.

2.2.2 The Ethnonursing Method

The ethnonursing method was developed by Leininger (1995:97-98) to assist her as a researcher to learn from people about their cultural values, beliefs and caring practices. The method is qualitative and naturalistic, and produces data that is grounded in the life-ways of the group under study. "The central purpose of the ethnonursing research method is to establish a naturalistic and largely emic open enquiry discovery method to explicate

and study nursing phenomena especially related to the theory of Culture Care Diversity and Universality" (Leininger 1991:74-75). The method has been designed to "… tease out complex, elusive, and largely unknown nursing dimensions from the people's local viewpoints…"(Leininger 1991:75). The method was specifically developed to study care within the cultural context. It assists in learning about similarities and differences between the traditional / generic and the professional care systems.

As the method is naturalistic, it ensures that the people's views and experiences are recorded and interpreted contextually. Leininger (1991:80), believed that folk methods of caring could only be fully known by studying care while involving the people in their natural environments such as their homes and workplaces. The ethnonursing research method enables a researcher to learn about people's experiences through observation and interaction (Leininger 1991:71). To prevent biasing the results the researcher puts aside his/her personal beliefs during data collection and also avoids being judgemental. The method requires the researcher to live with the people for an extended period so that he/she moves from being a stranger to being a friend whom the informants can confide in. In this research, it was not possible for the researcher to live with the informants during data collection because of work commitments and because the informants were scattered throughout the city. However, the ethnonursing method was still considered suitable for this study as the researcher aimed to learn about the health seeking behaviours of the Africa Gospel Church members, what they do to promote health, prevent illness and care for the sick within the context of their religious beliefs. The researcher found especially the sampling principles and the enablers that Leininger developed, useful.

The research method for this study was developed using Leininger's ethnonursing method and enablers as guidelines (refer to section 3.4).

2.3 CULTURE AND HEALTH

Giddens (1993:31) defines culture as “the ways of life of the members of a society, or of groups within a society”. Leininger (1995:105) defines culture as “the learned, shared, and transmitted values, beliefs, norms, and lifeways of a particular group that guide their thinking, decisions, and actions in patterned ways”. Culture is generally transmitted intergenerationally (Leininger 1995:9).

“Culture determines people’s definition of mental and physical health and their interpretation determines how they deal with the illness” (Gardiner et al 1998:224). Culture dictates people’s behaviours and thoughts to a large extent. It influences the way they view health and illness, causes of illness and how to deal with it (Giddens 1993:31). People’s health seeking behaviours are influenced by their culture through their beliefs attitudes, and values (Shire 2002: 48-54). In East Malaysia, for example, depression is believed to be caused by evil charms cast by jealous relatives, and the affected person may seek assistance from a traditional healer, yet in North America depression is believed to be biological, and may be treated with antidepressants (Gardiner, Mutter and Komitzki 1998:224).

Every culture has its own explanatory model/models of health and illness. Explanatory models of health and illness have a significant impact on health seeking behaviour as explained in sections 1.2.3.2 and 2.3.1. Gardiner et al (1998:225) cites a study by Cook (1994), among the Chinese, Indian and Anglo-Celtic Canadians, which focused on illness beliefs about chronic illnesses and how they should be treated. The findings of that study suggested that these groups had differing views about the causes of chronic illness and how it should be treated. This prompted the researcher to investigate the religious beliefs,

of members of the Africa Gospel Church in Francistown, on health, illness, and health seeking behaviour.

2.3.1 Explanatory models for illness and health seeking behaviour

People's views on the causes of illness influence their decisions on where to seek health care and what remedies to employ in an effort to regain health.

There are three explanatory models that are significant for this study. Andrews and Boyle (1995:22-29) identify the magico-religious, the biomedical and the holistic health paradigms. Traditionally African cultures lean more towards the supernatural and the holistic paradigms.

2.3.1.1 The biomedical paradigm

The biomedical model also referred to as the medical model, attributes illness to germs and biophysiological changes in the body. Health care services are predominantly curative and science based. If a client's definition of health and illness is based on this model he/she is likely to seek professional health care and choose between scientifically developed diagnosis and treatment options (Jones 2000:29-30).

2.3.1.2 The magico-religious paradigm

The magico-religious model is a supernatural explanatory model, which attributes health and illness to God's or the ancestors' pleasure or displeasure. Illness is also attributed to the intervention of an evil force.

Belief in God is a cultural universal among Africans, and ancestral spirits play an intercessionary role. Failure to follow cultural or religious prescriptions, or breaching of a taboo, is believed to lead to illness. Taboos are described as "…systems of prohibitions

with regard to certain persons, things, acts, or situations" (Magesa 1997:75). Taboos contribute towards maintenance of morality and order in society. Breaching taboos jeopardises health and well-being in society (Magesa 1997:149). An individual who transgresses a taboo is exposed to danger, which may manifest itself in the form of illness, probably due to an intervention by God or the ancestors.

Within this paradigm, the client is likely to seek healing from God by consulting a faith healer or a traditional healer (ngaka). An individual who attributes illness to God or the ancestors may consult a priest or a faith healer. Help is sought through prayer, or by appeasing the spirit of the offended ancestor. Prayer is often used in the African tradition to restore health and to petition for practical daily needs and protection from illness. These prayers are holistic, encompassing all aspects of life. Prayers may be accompanied by offerings to God or the ancestors (Magesa 1997:195, 203). During illness ancestral spirits may be invoked to seek conciliation. People may seek the services of a diviner to diagnose their ailments. A diviner is a person who is able to identify and reveal causes of illness as well as prescribe appropriate remedies through the use of supernatural power (Magesa 1997:212).

The Manianga of Zaire believe that illness is a form of punishment, that results from disobeying the clan's traditional doctor, or it could occur naturally through the intervention by God or the ancestors. All members of the community participate in seeking an explanation for illness (Mulemfo 1995:342). Bourdillon (1987) cited in Bourdillon (1990:30) states that, in Zimbabwe, rituals are performed to honour spiritual elders when there is a troubling illness.

Sorcery “is the deliberate employment of malevolent magic” (Staugard 1985:95). A malevolent person casts a spell or uses a technical aid to cause illness in an individual. Witchcraft is believed to cause unnatural illnesses through poisoning of food or drink. If a client believes that his/her illness is a result of sorcery or witchcraft, he/she may consult a traditional healer who may use emetics, enemas, inhaling, or steaming to treat the individual (Mashaba 1995:593-596; Selelo-Kupe 1993:1). Evil can be dispelled through prayer which may include shaking the patient vigorously to chase away the evil.

Intrusion by a disease causing spirit may also cause illness. These are malevolent spirits that cause disorder for no apparent reason. These spirits may belong to the dead who were not buried properly or may be of natural objects like sacred trees that have been violated somehow. Health care may be sought from a prophet who will perform an exorcism or cleansing ceremony in order to restore health (Staugard 1985: 73).

An elementary research project was done by sociology students in a nursing college in South Africa to explore health seeking behaviour of an African community in Cape Town. This was a qualitative project, which sought to learn about the meaning people attached to illness and their responses to illness (Haegert 1996:81). Informants were asked to explain what their responses to illness were. Responses varied but interestingly they alluded to the use of traditional methods of care like slaughtering an animal, making beer, visiting a diviner or using herbs (Haegert 1996:82). Their responses were consistent with their beliefs about the nature of illness, which they attributed to witchcraft, evil spirits and failure of the ancestors to protect them.

2.3.1.3 The holistic paradigm

The holistic model attributes illness to an imbalance in the body of people and/or their environment. The universe and the client must be in a state of equilibrium in order for health to be experienced, as health is influenced by "environmental, sociocultural and behavioural determinants" (Andrews & Boyle 1995:27). Health is more than just signs and symptoms. Those who maintain this perspective may seek to live a healthy lifestyle in order to preserve or regain health. Care may be sought from herbalists, aroma therapists, reflexologists, and naturopathists, reflecting the holistic nature of health and illness (Andrews and Boyle 1999:66).

Chavunduka's (1978) research, cited in Cavender (1991:363), examined a process by which patients made choices between consulting traditional healers or medical practitioners. His findings indicate that some illnesses are considered natural and others unnatural. Some illnesses like the flu and diarrhoea are considered to be natural and may be treated with herbs. Natural illnesses occur from time to time, like headaches, coughs, and colds, but if they linger on and do not respond to traditional medicines or professional medical treatment, they become unnatural. This implies that the explanatory model of health and illness is dynamic and would be determined by the symptoms present and the progression of the disease. An individual may administer self-treatment for natural illnesses by taking over-the-counter medicines or herbs before consulting a traditional healer or medical practitioner.

This research was aimed at determining what actions members of the Africa Gospel Church would take when they are ill, and the explanatory model or models behind their decisions.

2.4 RELIGION AND CULTURE

Religion is a cultural universal but its substance may differ across cultures. It is an integral part of culture, and culture can be determined by or revolve around it. People may plan their daily lives to the dictates of their religion. Religion forms the basis of some people's lives thus becoming a way of life, often referred to as a paradigm" (Nyatanga 1997:203). Rey (1997:161) shares this view and states, "… religion is not only an element of culture, but can be a culture in itself".

The members of the Africa Gospel Church display this phenomenon in that their lifestyle is determined by religion. Their religion dictates their actions in daily living. Religion prescribes form of dress. The women's dress code is distinctive. They wear long white gowns and headscarves, and the men wear beards and their heads are shaven. The economic lifestyle of members of the Africa Gospel Church is characterised by being self-supporting. They make their living by selling craft (Isichei 1995:256). Education is only important as far as it enables people to write and read the Bible (Tshambani, 1979:23). Beer drinking, smoking, divorce, consubinage, witchcraft, racial segregation, birth control, family planning, gambling and going to discos are discouraged (Amanze 1994:167). This is consistent with Mashaba's (1995:593) view that "for an African, health and healthy living is interwoven with religion which is a way of life and of daily living".

Rey (1997:163-167) presents a family study that shows the extent to which religion can influence the lives of people. She relates how a Jehovah's Witnesses couple struggled to get a divorce despite their having long acknowledged their incompatibility. As plans were being made about the children's future, it became obvious that higher education was not an option, because the children were to finish high school and be trained for a trade

before going on to do mission work for their church. The parents made this decision on behalf of their children who were below the age of eighteen. At that time, the United States Supreme Court would have supported the decision, based on parental religious beliefs. This course of action would probably limit the children's potential, which would cause them misery in later life. The Government of Botswana mandates that all children must attend primary and secondary. Lately, some children within the Africa Gospel Church are encouraged to pursue higher education. A low level of education may have a negative influence on their health seeking behaviour, as it has been documented "that illiteracy prevents a person from reading, understanding, and following health instructions" (Shire 2002: 48-54).

This research explored how the religion or culture of the Africa Gospel Church influences its members' beliefs on health, illness and care, and their health seeking behaviour. For instance, if religion and culture prohibit beer drinking and smoking, the physical health of the group could benefit. Prohibiting divorce could provide family stability resulting in social well-being or it could lead to conflict. On the other hand, if family planning and birth control are not allowed, women's health may be adversely affected.

2.5 RELIGION AND HEALTH: A POSITIVE RELATIONSHIP

Levin (1994:1475-1482) examined previous research that investigated religion and its relationship to health. His literature review was directed at finding out whether there was an association between religion and health, whether the association was valid and whether it was causal. A comparison of religious groups showed that there appeared to be a relatively lower risk of developing cardiovascular disease, hypertension, uterine and cervical cancers, and enteritis in more behaviourally strict religions or denominations, compared to less behaviourally strict religions.

Another finding was that levels of morbidity and mortality tended to be less where religiosity was high compared to low religiosity, when the religious indicator used was frequency of attendance. Twenty-two (22) out of twenty-seven (27) studies reviewed by Levin (1994:1476) “revealed a positive and statistically significant relationship” between religion and health.

Koenig (1997:83) reports on a study in Georgia, United States of America, on the impact of religion on men’s blood pressure, by involving a sample of 407 men. The results indicated that those who frequently attended church and who also reported that religion was important to them, had lower systolic and diastolic blood pressures than those who were not involved in religious activities. A review of various studies investigating the effects of religion on hypertension showed that practicing Jews, Mormons and Adventists had relatively lower levels of blood pressure with high religiosity, regardless of how religiosity was operationalised (e.g. religious attendance, church membership, subjective ratings of religiosity, father’s years of Yeshiva), compared to religions with lower levels of religiosity (Levin 1994:1477). To support the validity of his conclusion Levin (1994) eliminated the possibility of the association between religion and health being due to chance and bias because the hundreds of research studies reported “statistically significant positive religion-health associations or health differences across religious groups” (Levin 1994:1477). He suggested that bias could be ruled out because the studies he reviewed were carried out in diverse populations such as black and white Protestants in the US, Catholics in Europe, Indian Parsis, South African Zulus and others. Some of the studies were randomised while others used population censuses. The settings and sampling frames were also different hence supporting the validity of the findings.

To eliminate confounding and to support the validity of the association, he examined the functions of religion and how they would relate to health. He also acknowledged that confounding might still be a possible explanation for the association.

Confounding relates to extraneous variables that do not represent functions or characteristic of religion but may have a positive influence on the relationship between religion and health. As to whether the association between health and religion was causal, his conclusion was “maybe” (Levin 1994:1477-1480).

Troyer (1988:1014) believes that religious groups “which provide strong directives for the personal lives of their adherents, provide complex sets of disease related factors embodied in what we generally call lifestyle”. He reviewed research that had been done among the Seventh Day Adventists, the Amish, the Hutterites and the Mormons. These studies were performed in Canada and the United States. His conclusion was that “all four religious groups experience an overall reduced rate of cancer when compared with the respective control groups” (Troyer, 1988:1009). The four religious groups had strong prohibitions related to what they eat, alcohol consumption, tobacco use and reproduction. His findings were similar to those of Levin (1994) about the association between religion and health being positive. The studies examined by Troyer (1988) were on the mortality and morbidity rates of cancers of the stomach, lung, cervix, breast, colon, ovary and leukaemia and their occurrence within the four religious groups and the control groups. Koenig (1997:7) examined studies performed over a period of fifteen years in America’s Duke University, on how religious beliefs and activities influence health. The studies indicated that religious beliefs and activities promote health through early diagnosis and treatment of physical disease and by reducing behaviours that may cause disease, like smoking, drinking and unsafe sexual practices.

It was found that religious beliefs and activities also indirectly promote physical health because an enhanced social system is associated with a reduction of stress (Koenig 1997:80).

Similar research has yet to be done in Botswana but it can be assumed that religious groups that have strong prohibitions about unhealthy lifestyles may be experiencing illness less frequently compared to those with less stringent prohibitions. This may be a result of the prohibitions serving the purposes of promoting health and preventing illness.

Although this present research was not aimed at studying morbidity and mortality, it, however, explored the nature of religious prohibitions and beliefs and how they influence health-seeking behaviour among Africa Gospel Church members. The present study was therefore consistent with Levin's (1994) conclusion that there is a valid association between religion and health, which may or may not be casual.

2.6 RELIGION: HARMFUL TO HEALTH?

The answer to the question whether religion is harmful to health lies in an individual's philosophical perspective. What some may see as harmful may be acceptable to others. Fasting for thirty days is a Muslim practice. According to Nyatanga (1997:205), it is practiced religiously and taken seriously. However, religious groups who do not practice fasting may see it as a threat to physical well-being. Furthermore, nurses' views on the effect of religious practices on health may differ from those of their clients. These differences in religious beliefs and practices need to be respected by nurses and they must refrain from offending persons from religions other than their own. Beit-Hallahmi and Argyle (1997:189) believe that when "violent exorcisms are engaged in, and when medical help is withheld (for reasons of faith) from the sick" then harm may result. This is an

understandable stance from the point of view of the non-believer or the nurse. However, it is biased in the sense that judgement is made which is based on different philosophical beliefs.

This research aims to enable nurses, and other health professionals, to refrain from being judgemental and ethnocentric when they are faced with philosophical beliefs that are different from their own. However, some religious practices of the Africa Gospel Church may be harmful to health. This research aims to identify harmful practices in order to assist nurses in negotiating for changed for the benefit of members of the Africa Gospel Church.

2.7 RELIGIOUS BELIEFS AND UTILISATION OF HEALTH CARE SERVICES

Staugard (1985:126) did field surveys in Botswana during the period between 1978-1984. The aim of the surveys was to provide knowledge that would be used to facilitate the implementation of a policy of cooperation between the traditional and modern health care systems. The study showed that members of the African Independent Churches use the *moporofiti* (prophet) more than they consult *ngaka* or medical professionals (Staugard 1985:159). These findings would suggest that the Africa Gospel Church members are more likely to consult their own prophets within the church than to seek professional medical care.

The European churches do not believe that illness may be caused by witchcraft. Oosthuizen (1989:79) states that, while the “historic churches in general have no rituals to counteract the effect of witchcraft and sorcery. The African Independent Churches give specific attention to these issues”. This may explain why the independent churches have a large following among the African population.

The African traditional philosophy on health and illness is entrenched in their culture, hence the phenomenon of people gravitating towards the independent churches which will recognise witchcraft and perform rituals to heal afflictions that have been linked to witchcraft.

Stauguard (1985:160) conducted research in Botswana on the relationship between church affiliation and the type of utilisation of health care services. He involved a sample of 945 consisting of 373 persons with no church affiliation, 263 members of an European church and 309 members of an African independent church. The study suggested that 55.3% of members of an African independent church utilised care from the m*oporofiti* (prophet) on more than one occasion compared to 11.3% among those with no church affiliation, and 14.1% among members of an European church. The research findings further suggest that 46.9% members of an African independent church utilised professional health services compared to 71% of the group with no church affiliation, and 78.3% members of a European church. These findings suggest that members of the Africa Gospel Church are likely to utilise the *moprofiti* more than they would utilise professional health services.

What is known about the Africa Gospel Church is that they believe in God. It is likely that its members subscribe to the magico-religious belief system but it is not known how, and to what extent, they utilise the traditional and professional health systems. It was the intention of the researcher to investigate this issue, especially considering the time lapse between the studies cited in this section and the present research.

2.8 RELIGION, HEALTH SEEKING BEHAVIOUR AND HEALTH

Faith healing is widely used in some religions particularly among the Independent Churches of Africa. Members of the Holy Apostolic Church of Zion, Africa Gospel Church and many others pray for the sick and as a result, they attract many people (Amanze 1994:6,138).

Religious beliefs can be very strong and people may refuse treatment of a medical nature in favour of faith healing. The Bible (James 5:16) itself states, “Confess your faults one to another, and pray one for another, that ye may be healed. The effectual prayer of a righteous man availeth much”. There are three types of prayer: meditative, intercessory, and liturgical. Intercessory prayer applies to this study. Intercessory prayer involves seeking help or assistance in solving a problem or it may be a petition for the relief of suffering. This is commonly used when praying for the sick and it may include the laying of hands (Aldridge 2000:144).

It is important at this point to discuss the differences between priests and prophets, as these persons are consulted by the sick when seeking health care. According to Max Weber, the well-known sociologist, priests are religious officials who owe their authority to the status of their position and are officially and duly authorised to officiate at ritual actions. Because priests derive their authority for the religious organisation, they usually defend the religious institution and its affirmation of the status quo. Prophets, on the other hand, have the authority by reason of their personal charismatic qualities. The prophet is not affiliated to an official religious institution. The possibility that the prophet will criticise both religious institutions and the social structure in general is much greater than in the case of the priest. Naturally, conflict often occurs between the priestly and the prophet functions in the leadership of a religious tradition at a given time.

According to Weber, the contrast between these two orientations extends beyond the leadership and can affect the entire organisation of a religion. He regards the contrast between the denomination and the sect, as the direct extension of this contrast. The former, with its systematised and formalised ritual acts, he regards as typical of the priestly environment. The sect, on the other hand, is characterised by the dominant role of the prophetic view because far less rigidity is present there than in the highly structured denomination (Goodman & Marx 1976:382-383).

A study involving the Zionist Churches in South Africa indicated that these churches provide a well-needed service for the poor, and healing services that give meaning to the lives of those involved. It became apparent that Zionism provides a solution to today's problems facing the poor. The healing services are offered free of charge. Two principles guide the activities of these churches, namely self-help and mutual aid. Furthermore they have a strict moral code of conduct that prohibits polygamy, sex-before marriage and violence. This moral code contributes to the well-being of the members of these churches (Kiernan 1994:51-53). In this study involving the Africa Gospel Church it was assumed that religious involvement would have the same positive influence on members of the Africa Gospel Church. The researcher specifically focused on the religious beliefs of the Africa Gospel Church to determine how those beliefs would shape the health seeking behaviour of its members.

The health seeking behaviour of a mother with regard to illness prevention and treatment determines a child's health and survival (Howlader & Bhuiyan 1999:55-59). The researchers analysed the maternity history data for 1996/1997 obtained from the Bangladesh Demographic and Health Survey (BDHS), to investigate the health seeking behaviours of mothers, to identify factors that may have influenced their health-seeking

behaviours and to assess how these behaviours affect infant and child mortality. The results suggested that mortality risk declined with an increased birth interval and that infant and child mortality decreased with an increase in the mother's educational level. The researchers detected that a mother with a higher level of education is more likely to utilise health care services than mothers with a lower level of education. The utilisation of antenatal care during pregnancy and postnatal care after delivery were associated with a lowering of infant and child mortality rates (Howlader & Bhuiyan 1999:59-75). These research results suggest that under-utilisation of antenatal and postnatal services by members of the Africa Gospel Church could contribute towards high infant and child mortality rates. Use of contraceptives would also reduce the birth interval and ultimately reduce infant and child mortality.

A debate on the merits and demerits of immunisation adds an interesting dimension to the commonly held belief that immunisation of children is good and keeps them healthy. Allen (1999:340-346), contends that childhood illnesses like mumps, measles, whooping cough have declined due to the success of the immunisation campaign in the United States of America. On the other hand Moskowitz (1999:345-353) argues that vaccination lowers immunity. According to him many children aged five to sixteen contract measles in spite of having been vaccinated at a younger age. He argues that people become immuno-compromised as a result of vaccinations, which leave them more susceptible to infection.

The above issues highlight the complexity of the issue of health seeking behaviour in a religious context. While the merits of immunisation can be debated from opposing scientific points of view, a religious dimension can also come into play especially when dealing with the health seeking behaviours of religious groupings. It is also important to consider the types of health practitioners when studying the health seeking behaviours of

members of a specific church. Furthermore a researcher must acknowledge the contributions of churches with regard to health care delivery.

2.9 SUMMARY

Leininger's (1991:49) culture care theory was introduced as the conceptual framework of this study. The sunrise model of the theory was used to guide data collection by enabling the researcher to focus on the religious dimension and its influence on people's perceptions on health, illness and care, and their health seeking behaviour. The issues of culture, religion and health were examined. It was proposed that religion and culture are interrelated, and that both influence health, illness and health seeking practices. Previous research has indicated that religion has a positive influence on health, but that some harmful implications are also possible. It was also found that religious affiliation influences utilisation of health services.