

## CHAPTER 2

### LITERATURE REVIEW

This chapter discusses topics with regard to the present study which covers topics as follow:

1. Overview of Religiosity
2. Islamic Religiosity
3. Factors Influencing Religiosity
4. Religiosity Measurement
5. Health Status
6. Health from Islamic Perspective
7. Factors Influencing Health Status
8. Measurement of Health Status
9. The Relationship between Religiosity and Health Status

#### **1. Overview of Religiosity**

Religion is an organized system of beliefs, practices, rituals, and symbols designed to facilitate closeness to God (higher power or ultimate truth) and to foster understanding and harmony of a person's relationship and responsibility to oneself and to others (Thoresen, 1999). Furthermore, religion in general can be conceptualized as a multidimensional construct encompassing values and beliefs, personality, a search for meaning in life, self knowledge and the development of self control, and salubrious behaviors (Cacioppo & Brandon, 2002). Religiosity or religious involvement then refers

to the commitment of an individual to their religion, or in other words, it is the quality of being religious (Hixson, Gruchow, & Morgan, 1998).

Religiosity has been explored in numerous studies employing different terms or dimensions. The summary of studies regarding religiosity is presented in Table 1. After reviewing existing literatures, the researcher considers that the term and description of religious orientation by Allport and Ross (1967) is the most suitable model and concept applied to Islamic conceptualization. As already mentioned, religiosity or religious involvement is conceptualized as distinguish between behavioral and subjective dimensions (Chatters, 2000). The behavioral component pertains to activities or practices that reflect organizational or public religious expression (*e.g.* prayer attendance) and non-organizational practices such as private prayer, reading religious materials. In this study it referred to the practice of Islamic teachings in daily life of Muslims. While the subjective dimension is religious orientation that proposed by Allport and Ross (1967) of reverence to attitude dimension.

Religious orientation is employed to refer to the extent to which individual practices or lives out their religious beliefs and values which is divided into two motives: intrinsic and extrinsic (Dezutter *et al.*, 2006; Hixson, Gruchow, & Morgan, 1998; McCormick, Hoekman & Smith, 2000; Paek 2006). Intrinsic orientation (IR) is described as when individuals have wholly committed to their religious beliefs and the influence of religion is evident in every aspect of their life (Maltby & Day, 2002). In a short, a person with a strong internal religious orientation tends to seek to live their daily life according to their religion. Paek (2006) found that IR has been positively correlated with self-motivation and emotional sensitivity. Moreover, IR was also found to be positively correlated with meaning in life (Earnshaw, 2000), purpose in life, and

Table 1  
Summary of Dimensions or Terms used in Studies Regarding Religiosity

Authors and Year	Term or Dimension used
Allport, 1950; Allport & Ross, 1967; Ardel, 2006; Berndt, 1999; Cohen, Pierce Jr, Chambers, Meade, Gorvine, & Koenig, 2005; Dezutter <i>et al.</i> , 2006; Earnshaw, 2000; Hills, Francis, & Robbins, 2004; Hixson, Gruchow, & Morgan, 1998; Koenig, Kvale, & Ferrel, 1988; Khan & Watson, 2005; Maltby and Day, 2002; McCormick, Hoekman & Smith, 2000; Paek, 2006; Salsman & Carlson, 2005	Religious orientation  (some scholars used the term “religious attitude” to change religious orientation but still used the same framework as religious orientation)
Koenig, Kvale, & Ferrel, 1988; Koenig 1997; Hixson, Gruchow, & Morgan, 1998; Levin <i>et al.</i> , 1995; Franzini, Ribble, & Wingfield, 2005	Organizational religious and non-organizational
Koenig, George, & Siegler, 1988; Koenig, Cohen, Blazer, Pieper, Meador, 1992; Pargament, 1990; Koenig, Pargament, & Nielsen, 1998; Maltby and Day, 2002;	Religious coping
Francis <i>et al.</i> 2004; Dezutter <i>et al.</i> 2006	Religious attitude
Koenig, 1988; Glenn, n.d.; Holt, Haire-Joshu, Lukwago, Lewellyn, & Kreuter, 2005	Religious belief
Hixson, Gruchow, & Morgan, 1998	Religious knowledge, religious experience, religious well being
Dezutter <i>et al.</i> , 2006; Fetzer, 1999; Holt, Haire-Joshu, Lukwago, Lewellyn, & Kreuter, 2005; Koenig, 1988; Koenig, Cohen, Goerge, Hays, Larson, Blazer, 1997; Koenig, 1997; Maselko & Kubzansky, 2006; Paek, 2006; Yeager <i>et al.</i> , 2006.	Religious behavior, private religious activity, public religious activity, Prayer (church attendance), religious practice, religious involvement

satisfaction in life (Dezutter *et al.*, 2006). Meaning in life has been found to positively affect health (Earnshaw, 2000).

On the other hand, extrinsic motive (ER) is described to be when people use religion as a mean for self-serving purposes such as social status, group affiliation (Paek, 2006; Shannon, 2004). Furthermore, Hills *et al.* (2004) proposed that extrinsic orientation is always instrumental and utilitarian. ER may provide protection, consolation, social status, and as an ego defense (Maltby & Day, 2002). It has a core idea in the cultivation of social relationships (Cohen, Pierce, Chambers, Meade, Gorvine, & Koenig, 2005). Social relationship is a source of meaning in life (Earnshaw, 2000) and could be a source of emotional support. McCormick *et al.* (2000) suggested that people with this orientation may find religion useful to provide security and solace; sociability and distraction; and status and self-justification. An individual with extrinsic orientation tends to participate in religious activities to meet personal needs or for personal advantages, and may be more influenced by other social forces. Paek suggests that the proposed theory of religious orientation posits that intrinsic and extrinsic motives differ in nature and are associated with dissimilar psycho-social outcomes.

Religious orientation represents a deep core of religiosity which is more strongly related to a person's underlying personality features rather than superficial aspect of religious practices or behavior (Dezutter *et al.*, 2006). Religious orientation, particularly for intrinsic motives, manifests as playing a significant role in shaping the religious attitude of an individual which will reflect in religious practices that represent a deep engagement to religion. It is expected that those who have deeper intrinsic religious orientation are those who are more involved in religious practice (Dezutter *et al.*, 2006). Maselko and Kubzansky (2006) note that in most studies church attendances, religious

service attendance, prayer either private or public, and reading religious texts have been viewed as representing religious engagement. One study found that there is a moderately strong correlation between an intrinsic religious motive and church attendance (Ardelt, 2006). In extrinsic individuals, religious practices may be performed rather to meet personal needs and to gain social affiliation than as a representation of a religious attitude. Measuring religiosity accurately, therefore, requires considering both religious attitude or orientation and religious behavior.

## **2. Islamic Religiosity**

Concept of religious orientation is congruent with the core aspect of Islamic religiosity. From an Islamic perspective, intrinsic religious orientation can be seen as the soul of being a Muslim. Islam means complete and peaceful submission to the will of Allah (God) and obedience to His law (Gulam, 2003; Hooker, 1996; Maulana, 2002). It means that Muslims are those who demonstrate total acceptance and sincere intention with total compliance toward Allah. Therefore, once a person accepts Islam as his religion, it is not merely a matter regarding the intention and confession of being a Muslim, but practicing Islamic principles and teachings represents truly engagement to Islam. It is known as *taqwa*.

*Taqwa* (piety) is Arabic meaning self-defense and avoidance (Fatwa Bank, 2002), denoting a believer's strict observance of the commandments of the *shari`ah* (Islamic laws) and the Divine laws of nature and life (Fatwa Bank). The word *taqwa* is mentioned 151 times in the Holy *Qur`an*, indicating the importance of the involvement of Islam in the life of Muslims (Karolia, 2003). *Taqwa* will have a reflection in an individual's character and behaviour. Karolia (2003) states that *taqwa* is established as a result of the moral development and correct behaviour of a good Muslim.

Islam is held upon the five pillars of the Islamic faith, which are obligatory duties toward Muslims. This is the foundation of Muslim life. The five pillars include testimony of faith (*shahadah*), prayer (*salaah*), charity (*zakah*), fasting (*sawm*), and pilgrimage (*hajj*). The performance of these duties, inculcating complete surrender to God, forming a powerful spiritual mechanism for building morally of individuals and a community, and establishing a socio-economic order based on purity, justice, equality and brotherhood (Zarabozo, 2003). Therefore, the five obligatory duties are not mere rituals but it is a gift from God which forms the pillars for the development of a Muslim's personality for collective life (Zarabozo).

The first pillar, testimony of faith, is witness of an individual's belief (*iman*) by which one becomes a Muslim. It is the fundamental expression of Islamic faith and the core of all Islamic law (Hooker, 1996). The significance of this declaration is the belief that the only purpose of life is to serve and obey God, and this is achieved through the teachings and practices of the Prophet, Muhammad (Zahid, n.d.)

The second pillar of Islam is the performance of prayer. Prayer is the first act of worshiping Allah that has been made obligatory for all believers and serves as the foundation of Islam together with bearing witness (Mababaya, 2006). Prayer constitutes the physical, mental, and spiritual submission to Allah (Mababaya). In prayer, the believer symbolizes his submission to God by both kneeling and prostrating himself as part of the ritual (Hooker, 1996). Regarding the essential of prayer, the *Holy Qur'an* states that nothing brings a human being closer to God than prostration in prayer and that the adherence of Muslim to prayers is the first thing God values and praises, as it indicates a good relationship of a Muslim to Allah.

Charity (*zakah*) is the third pillar. The meaning of the word *zakah* is purification and growth. This means the *zakat* purifies the believer by encouraging a charitable disposition and a lack of attachment to worldly belongings (Hooker, 1996). Islam manifestly understands the material world as created for the enjoyment of humanity (Hooker). However, individual's duties to God involve distributing one's wealth to the less fortunate. Each year Muslims who have assets over their outstanding debts must voluntarily pay two and half percent of their assets. Maulana (2002) suggests that *zakah* represents the unbreakable bond between members of the community as it makes a fair contribution to social stability and stops up the channels leading to class hatred and makes it possible for the springs of brotherhood and solidarity to gush forth.

Fasting is the fourth pillar of Islam. It is prescribed as a way of training the mind and body in self-restraints (the Holy Qur'an 2:183). The main function of fasting is to purify a Muslims' spirit (Athar, 1998). Fasting involves abstinence from eating, drinking, smoking and marital intercourse and should be observed throughout the daylight hours in obedience to God's command. This teaches the believer self-control and patience, as well as reminding them of their responsibility for other human beings in the world who lack provisions (Zahoor, 1998). It also draws the attention to Muslims of the importance of avoiding excessive eating. The third and fourth pillars clearly represent that Islam emphasizes the importance of the development of good community and social life (*ummah*). Muslims are encouraged to become individuals whose target is to serve other people, not merely their own problems.

The element of *imaan* (faith) is another basic concept that has a significant role in building Muslims' personality (Maulana, 2002). Faith is a combination of belief, statement, and deed (Islamonline, 2004). Maulana states that whereas the concept of the

five pillars is the foundation from which the Islamic lifestyle is founded on, the elements of *imaan* is its building blocks. There is expectation then that the actions of Muslims will follow this belief so that the outward behavior will be in harmony with the inner belief. The element of faith encompasses six articles. First is faith in the unity of God, second is faith in Allah's Angels, the third is faith in Allah's Prophets, and fourth is faith in Allah's Revealed Books. Furthermore, the fifth article of faith is belief in life after death and the last is belief in divine decree, in Arabic is *al-qadr*. Muslims believe that Allah has full power and knowledge of all things, and that nothing happens except by His will and with His full knowledge.

The intention to worship Allah is a fundament underpinning Muslims' actions. Allah states in the Holy Qur'an that to Him the values of worship and the rewards gained by an individual rely on the action after having the intention, which is the best intention is to worship Allah or Allah centered. From this conceptualization it is clear that Muslims are supposed to have a more intrinsic motive rather than an extrinsic motive and realize it into their daily life. In this situation religion elicits high involvement, in which all aspects in the individual's life attached to and reflect religious values. However, Allah makes clear in the Holy Qur'an that the majority of people are "wrongdoers" and "ungrateful" to their Creator for they refuse absolute submission to Allah. Religion may be used only for social status and gained personal benefits. So that, it is a fact that Muslims may have difference levels of *taqwa* or adherence to Islam.

### **3. Factors Influencing Religiosity**

Existing studies found that different levels of religiosity were influenced by several variables such as age, gender, educational background, and socioeconomic status (Holland, 2002; Taylor & Lockery, 1995; Glenn, n.d.; Koenig, Kvale, & Ferrel,



1988; Maselko & Kubzansky, 2006) and interpersonal tension (Cacioppo & Brandon, 2002).

Age is shown as influencing religiosity. Holland (2002) found, regarding religious beliefs that older subjects scored higher than did the younger. Another study that had used data from the National Survey of Black Americans found that adults and older Black adults are frequent church attenders, have high rates of church membership, have a high likelihood of characterizing themselves as religious, and are extensively involved in private religious activities (Taylor & Lockery, 1995). However, Glenn (n.d.) found that age was not significantly related to religiosity, although there was a trend in this direction.

Gender also demonstrates an influence on the level of religiosity. Koenig *et al.* (1988) study about religion and well being among older adults found that the effects of religion on well being were greatest in women. Furthermore, Maselko and Kubzansky (2006) note that one survey reports that women in the US were more likely to indicate the importance of religion than men, and reported that more women (42%) attended religious service than did men (37%). Similarly, a study in religious coping by Koenig, Goerge, and Siegler (1988) also revealed that women mentioned religious coping behavior more frequently than did men (58% vs. 32%). Whereas, Francis *et al.* (2004) and Glenn (n.d.) found there were no significant differences in results between men and women.

Educational background in several studies demonstrates influencing the level of religiosity among people. Data from the internet encyclopedia, Wikipedia (2006), presents a positive correlation between educational level and religiosity. It found 41% of subjects with only elementary school education attend church regularly, 76% of

college graduates attend church regularly, and 78% of subjects who have a graduate degree attend church regularly. However, the encyclopedia also indicates that study from the US in 2000 as finding a negative correlation between educational level and religiosity, and further supported by another survey made as recently as 2006 that reports a definite belief in God declines with educational level. Holland (2002) also reports that people with a lower education score higher for religious beliefs than do people with a higher education. Whereas, Glenn (n.d.) found the education factor was not significantly related to religiosity.

Economic status is other factor that affects the level of religiosity. Glenn (n.d.) noted that annual income has a positive correlation with religiosity (religiosity increases with income), even though the relationship was low. Taylor and Lockery (1995) found those of a higher socioeconomic status display a greater degree of religious involvement than their counterparts. Whilst, Gaede (1977) states that the relationship between socioeconomic status and religious participation may be due to educational rather than economic factors. Furthermore, data from Wikipedia (2006) presents that a surveyed opinion by nations comparing religiosity between developed and developing countries found inconsistent results. Americans and Canadians who are wealthy nations had different level of religiosity in term of considering the importance of religion. Americans are much more religious (59%) compared to 30% Canadians. Whereas, people in developing countries displayed the same view as Americans who expressed that religion is very important, that interpreted as having a higher religiosity.

Interpersonal tension may be a factor that can explain the phenomenon of a difference in level of religiosity (Cacioppo & Brandon, 2002). Cacioppo and Brandon suggest that the interpersonal tensions that may influence religious involvement can

result from unshared beliefs and convictions, anger, disappointment, and mistrust toward God. Intellectual or emotional strains and confusion may rise when individuals try to adopt a given religious belief system. Moreover, problems emerge from the unrealistic pursuit of virtue and perfection is another reason for the different levels of adherence among people to religion (Cacioppo & Brandon). That happens particularly among those individuals who do not rely on religious affiliation only based on faith, but are seeking answers in their mind to life and living. They analyze and criticize concepts, doctrines or practices of religion and their questions may not get clear answers from religion or else religion cannot satisfy their needs. Changes or differences in life orientation among people also provide explanation why people demonstrate different engagement toward religion. In today's rush world, people tend to underestimate religious values and rely more on material values which are often more contrary to each other.

In Islamic perspective, *taqwa* (religiosity) can be perfectly obtained if an individual has faith (*imaan*) and consciousness of Allah. To achieve this ideal state, knowledge of Allah, the Holy Qur'an, and Islamic principles are significant sources. In turn, faith and knowledge will lead to actions into daily life as manifestation of *taqwa*. Under this basic concept, therefore any imbalance in faith and knowledge will have an affect on actions, which further determines the level of *taqwa*. This principle can be easily understood in the explanation of factors influencing religiosity proposed by contemporary scholars presented above.

#### **4. Religiosity Measurement**

The examination and determination of the level of religiosity in previous studies were mostly not in a specific categorization. It was based on mean or median score, and

it was used to classify whether someone was in a higher or lower level from another individual. In early studies the examination of religiosity often relied on a single religious measurement such as frequency of church attendance or prayer but it has been argued that they do not reflect the complexity of religiosity (Kendler, *et al.*, 2003). Currently, researchers agree that conceptual models of religious involvement now view various dimensions of religiosity encompassing cognitive, emotional, behavioral and motivational aspects (Dezutter *et al.*, 2006).

Various instruments had been used in previous studies regarding religiosity. Simple instrument with a single item (How often do you go to church? or How often do you attend religious services?) was employed to measure religious practice (Koenig, 1997; Dezutter *et al.*, 2006). Another simple question “How important is religion for you?” was used in measuring belief salience (Dezutter *et al.*, 2006). Pargament (1990) used the Religious Coping (R-COPE) Scale to measure the use of religious beliefs to cope with illness and trauma. It consists of a 14 indicator model of positive and negative religious coping (Maltby & Day, 2002). Whereas, Koenig (1992) used the Religious Coping Index that consists of three items of open-ended question to measure the same dimension of religiosity.

Several studies used terms of religious attitude and employed an instrument with a title of religious attitude such as the Francis Scale of Attitudes toward Christianity and Religious Attitudes and Practices Inventory. However, other researchers measured religious attitude with reference to religious orientation and used the Religious Orientation Scale. A study found that the Francis religious attitude has a positive correlation with the Religious Orientation Scale (Francis *et al.*, 2004). The Francis Scale of Attitudes toward religion was used and tested within different faith contexts,

including a Muslim population (Francis *et al.*). This instrument concerns the affective responses to God, Holy books, Church or Mosque, and prayer. The full format consists of 24 items with a short scale covering only seven items. Whereas, the Islamic version is the Sahin-Francis Scale of Attitude toward Islam, is a 23-item Likert-type instrument. A study assessed the psychometric properties of the instrument and found that its reliability and validity supported further use (Sahin & Francis, 2002). Moreover, the Santa Clara Strength of Religious Faith Questionnaire (the SCORF) by Plante and Boccaccini (1997), a tool consisting of 10 items, rated a four point likert scale (Keller, 2005).

Another instrument is the Fetzer Multidimensional Measurement of Religiousness/Spirituality and Religious Attitudes and Practices Inventory (Kendler *et al.*, 2003). The scale encompasses domains of Religious Preference, Religious/Spiritual History, Organizational Religiousness, Private Religious Practices, Religious Support, Religious and Spiritual Coping, Values/Beliefs, Commitment, Forgiveness, Daily Spiritual Experiences, and Overall Self-Ranking (Kendler *et al.*).

The Religious Orientation Scale by Allport and Ross (1967) is the most widely known in measuring religiosity (Ardelt, 2006; Berndt, 1999; Dezuter *et al.*, 2005; Cohen *et al.*, 2005; Maltby, 1999; & Paek, 2006). It has many variants as a result of its development but all are highly intercorrelated (Donahue, 2004). The original Religious Orientation Scale consists of 20 items that are divided into two subscales: intrinsic (11 items) and extrinsic (9 items) orientation (Maltby, 1999). Maltby noted three studies employing the Religious Orientation Scale (Kirkpatrick, 1989; McPherson, 1989; and Leong & Zachar, 1990) and suggested that three factors emerged from the scale: intrinsic, extrinsic personal (religion as a source of comfort), and extrinsic social

(religion as a social gain). It has a measured, and demonstrated reliability and validity as a psychometric scale with Cronbach's alphas for the instruments of intrinsic scale = 0.83; extrinsic-personal scale = 0.72; and extrinsic-social = 0.68 (Salsman & Carlson, 2005).

There are several derived Religious Orientations Scales. Hoge (1972) modified Intrinsic Religious Scale, which consists of 10 statements (National Institutes of Health, n.d.). The Religious Life Inventory (RLI) by Batson & Schoenrade (1991) with 32 items that was designed to assess the extrinsic, intrinsic and quest orientations of religiosity. Hills, Francis, and Robbins (2004) then revised the RLI, which include 24 of the original 32 items. Furthermore, the Age-Universal I-E Scale is another derived and revised measure of the Religious Orientation Scale (Dezutter *et al.*, 2006; Maltby, 1999).

To sum up, different instruments have been employed in measuring religiosity as its variation in the terms used and dimensions measured. However, the majority of researchers agree that religious orientation is a fundamental concept of religiosity. It is reflected in the development of the instrument in which many researchers are interested in and is involved in the development process to improve its validity and reliability.

## **5. Health Status**

Health status is self-assessed refers to the perception of a person of his or her health or condition compared to other persons in his or her age group (Statistics Canada, 2006). Quan (2006) proposed that health status is the current state of individual's health, including the status of wellness, fitness, and any underlying diseases or injuries. While American Thoracic Society (2007) suggests that health status is an individual's relative

level of wellness and illness, taking into account the presence of biological or physiological dysfunction, symptoms, and functional impairment.

The concept of health itself can be approached from different perspectives. It may be viewed as actualization, a model of health with the phrase “high-level wellness” to signify the ideal state of health in every dimension that maximize individual potential (DeWit, 2005; Hickman, 2006). Health is also seen in term of functioning. American Thoracic Society (2007) proposed that functional status is “an individual's ability to perform normal daily activities required to meet basic needs, fulfill usual roles, and maintain health and well-being”. Functional status covers functional capacity and functional performance. Functional capacity represents an individual's maximum capacity to perform daily activities in the physical, psychological, social, and spiritual domains of life. Meanwhile, functional performance refers to the activities people actually do during the course of their daily lives. American Thoracic Society further suggests that functional status can be influenced by biological or physiological impairment, symptoms, mood, and other factors. It is also likely to be influenced by health perceptions which are subjective ratings by the affected individual of his or her health status. Some people perceive themselves as healthy despite suffering from one or more chronic diseases, while others perceive themselves as ill when no objective evidence of disease can be found (American Thoracic Society).

## **6. Health from Islamic Perspective**

Health, the Prophet Muhammad mentioned as a blessing that Allah has bestowed on humans (Maulana, 2002). Humans must appreciate and thank Allah's grace through truly worshipping Him by following His commands and demonstrate in real actions during the whole of life. Furthermore, it is emphasized that being healthy is

vital for Muslims in that it enables Muslims to undergo daily life with ease and also to carry out the Muslims' responsibility as *khalifah* (representatives) of Allah in this world to nurturing life. Therefore, maintaining health is part of worship and subservience to Allah since a weak individual may not perform his duties towards Allah, his family and community as a strong healthy person can do. Religious commitment by Muslims to the five pillars of Islam is a major concept linking to health, it is a foundation of a Muslims' personality, behavior and lifestyle is founded (Maulana, 2002).

Link towards the health continuum is shown in prayer as the second pillar. The benefits of the performance of regular prayers on health as proposed by Mababaya (2006) are as follows: prayers, as showed in its movements/positions serve as a natural source of physical exercises. Prayer also cultivates the ability to relax because one of the important requirements that should be observed while praying is attaining calmness in the performance of each act (*tum'aneenah*). In addition, when prayer is performed in congregation, it promotes a bond of brotherhood, unity and equality among Muslim worshippers. Performing prayers can also develop an optimistic outlook in life as praying done to the God who is most forgiving and whose guidance Muslims seek help. This can be a source of emotional and mental health.

A more direct link towards health is demonstrated in the habitual steps of washing (*wudhu*) that a Muslim must do prior to the prayers (Maulana, 2002). *Wudhu* is primarily for physical cleansing but it is also considered a symbol of spiritual cleansing. It involves the washing of the face, hands to the elbows, rubbing the head with water and washing the feet up to the ankles respectively. It is a duty-bound to clean which is done at least five times a day and is clearly a sign of the importance of hygiene within Islam. Ablution is not only cleansing vital parts of the body from dust and dirt but also



refreshes them. The Prophet also encouraged doing ablution before going to bed. Interestingly, this same ritual is also encouraged by yoga experts who say that washing important motor and sensory organs such as the hands, arms, eyes, legs, mouth and genitals before sleep using cool water relaxes the body preparing it for a deep sleep (Tawfik, 2003).

In placing the third pillar, *zakah*, on the continuum of health, Maulana (2002) argues that when looked at from the point of the giver of alms the impact of *zakah* is rather at the community level. Its link lies in the provision of enabling factors through the setting up of an obligatory mechanism for all Muslims to share in their wealth. This sharing mechanism obviously provides an environment, which encourages wealth redistribution and so fosters the reduction of inequities to a certain extent in a community. However, the impact on the individual Muslim can also be felt. The feelings of happiness from doing good things to contribute to help others emerges as hope of achieving Allah's approval and rewards and gives meaning in life. It is also another source of spiritual and mental health.

The fourth pillar is fasting. Benefits of fasting for health including it offers a compulsory rest to the overworked human machine (body), thus it helps to get rid of most of the toxins in the body (Athar, 1998). By adhering to this duty, Muslims are also called upon to be disciplined and be able to breakout from harmful habits such as eating too much and smoking (Maulana, 2002). Furthermore, Kazim (2002) proposes that fasting has benefits in improving both the quality and intensity of the depth of sleep, it significantly increases deep sleep and also accelerates synthesis of memory molecules, which is important in the regulation of the body cell' functions. Therefore, fasting not only gives rest to the body but also stabilizes the secretion of hormones, which may

have role in controlling behavior (Tawfik, 2003). The last pillar is the hajj which is visiting Mecca in Saudi Arabia. The rituals of Hajj start with the intention in making the trip by which a Muslim makes a commitment into a spiritual journey. This spiritual journey encourages Muslims to share experiences and knowledge amongst each other through organized sermons, and a source in building social relationships among Muslims from all over the world.

The concept of *imaan*/faith is another concept that supports the concept and practice of health in Islamic perspective. Maulana (2002) proposes that *imaan* can be described as a basic concept that shapes the attitudes and subjective norms of Muslims towards behavioral intention, and behavior in adherence to the Islamic principles and teachings. Its link with health in two ways, firstly by reinforcing religious worship and prayers which lead to benefits on health as presented in previous parts, and secondly it highlights the importance of religious involvement and fellowship with other people to create an enabling environment for social support by encouraging social organization (Maulana).

The Prophet Muhammad throughout his life practiced healthy living, maintaining healthy eating and a balanced diet has been stressed as importance from the start. Allah says in the Holy Qur'an (2:172) "*O' Believers! Eat of the good and pure (lawful) that We have provided you with and be grateful to Allah, if you truly worship Him.*" Muslims are encouraged to ensure that the physical body is kept healthy, as well as the soul and spirit. Thus, in turn it will aid Muslims in the service of both his spiritual and material attainment. For this reason, certain foods have been prohibited due to their bad/harmful effects, and permitted all other pure, good and clean food products. Furthermore, the Holy Qur'an goes to the extent of giving useful tips regarding a

balanced diet (Arafa, n.d.). Moderation in eating and drinking has also been stressed in Islam. Direct reference has been made in the Holy Qur'an (7:31) "*And eat and drink, but waste not in extravagance, certainly He (Allah) likes not those who waste in extravagance.*" Furthermore, personal hygiene and cleanliness are also concerned of the Prophet such as cleansing dress and dwelling place from the impurity of filth, bathing, brushing teeth (*siwak*), cleaning nostrils, trimming nails, and removing of armpit and pubic hair. In addition, the Prophet recommended and advised Muslims to teach their children about swimming, archery, and horse riding which are sources of exercise and pleasure activities (Athar, n.d.).

## **7. Factors Influencing Health Status**

Health is affected by many factors that may be internal or external to the individual and may or may not be consciously under the person's control (Taylor, Lillis, & LeMone, 2001). In detail the factors influencing health encompass:

### **Individual Characteristics**

The ability of a person to manage their health status may be significantly affected by age and development level (Craven & Hirnle, 2000). Young children, school age children, adolescents, and adults may have different abilities with health management depending on their knowledge, experience, and intellectual capacity. An older adult has an increased risk for one or more chronic illness (Taylor *et al.*, 2001). Moreover, genetics, gender, and race all strongly influence both an individual's health status and health practices (Taylor *et al.*). Genetic inheritance interacts with diet and the environment to promote or protect against a variety of diseases (Lindeman & McAthie, 1999:81). Findings have highlighted the importance of heredity in the incidence of certain type of cancers (Lindeman & McAthie). While race refers to a genetic or

biological similarity among people that used to mark or separate people from one another (Craven & Hirnle). An example, a middle-aged African American man is more prone to develop high blood pressure (Taylor *et al.*). Immunological status is another factor that influences susceptibility to disease. An immune system deficiency can be created by genetic abnormalities, disease, or poor nutritional status.

### **Cognition and Perception**

Cognitive and perceptual factors cover the area of meaning of health to a person, how it is important, and how an individual perceives control over their health, self-efficacy, health status, benefits, and barriers (Craven & Hirnle, 2000). The more an individual values health, the more likely they are to be involved in maintaining and promoting health. People may believe that primarily health control is under their intention (internal) or else factors are beyond their control are responsible for it (external) (Craven & Hirnle). Those who have an internal perception are more likely to engage in health seeking behaviors on their own compared to people from the external counterpart. The personal definition of health also influences how a person perceives health and the mechanics of maintaining health. Different people with the same health status may have different perceptions of that health status.

Previous experiences are a significant factor that may affect health. An individual who has negative past experiences with a health agency or health programme may not be interested in or may even refuse to participate in a programme to maintain or promote health. When particular health practice works well and its benefits can be realized a person is likely to participate again or continue keeping that practice. Relative's or friend's experiences regarding maintaining and promoting health can also affect an individual (Craven & Hirnle, 2000). In addition, Taylor *et al.* (2001) have

proposed educational background plays a major role in health behavior. An individual with a higher educational level will have more knowledge and may value health more. The more individuals value health, the more likely they are to practice health maintaining and health promoting behavior (Craven & Hirnle, 2003).

### **Behavior**

Human behavior is a major factor determining health (Lindeman & McAthie, 1999). People with an unhealthy lifestyle and habits such as poor diet, lack of exercise, use of tobacco and/or alcohol, lack of sleep, and poor dental hygiene are considered to have poorer health status and health maintenance (Craven & Hirnle, 2000). Most people who have some unhealthy habits may argue that they are not suffering from health problems, however unhealthy habits do carry some increased risk for future illness (Craven & Hirnle). Cigarette smoking contributes to diseases like lung cancer, heart disease, and chronic obstructive pulmonary disease (Lindeman & McAthie).

### **Environment**

The environmental dimension has a significant role in affecting a human's health. It encompasses elements of housing, sanitation, climate, and pollution of air, food, and water (Taylor *et al.*, 2001). Pollution, inadequate housing, unsanitary conditions, nearby highway, and the lack of safe play areas lead to poor health maintenance and health status (Craven & Hirnle). The work environment also needs to be considered as a source of health problems including long working hours, repetitious tasks, poor ventilation, poor lighting, loud noises, and lack of nutritious food (Craven & Hirnle). For example, one discovery in 1976 found that small bacterium that thrived in air conditioning cooling towers and in warm water system caused a fatal pneumonia among a number of people (Lindeman & McAthie).

### **Economic**

Economy has a significant role in health maintenance and also access to health care (Craven & Hirnle). Poverty may influence health as the access to nutritious food and adequate housing which cannot be afforded as well as medical screening and medical care (Craven & Hirnle, 2000). People in poverty have higher morbidity rates and are more likely to die from preventable diseases (Craven & Hirnle). Economic levels also influence the health practices and beliefs of individuals (Taylor *et al.*, 2001). Whereas those who have high incomes are more prone to stress-related habits and illness, while low income groups are less likely to seek medical care to prevent illness (Taylor *et al.*).

### **Culture, Values, and Beliefs**

Culture is a learned set of shared perceptions about beliefs, values, and norms that affect the behaviors of a relatively large group of people (Lindeman & McAthie, 1999: 83). The culture to which a person belongs influences their patterns of living and values concerning health and illness (Taylor *et al.*). Spiritual beliefs and values are other significant elements of an individual's health behaviors (Taylor *et al.*). Some people may achieve spiritual health through placing great value on physical health (Craven & Hirnle).

### **Roles and Relationships**

Individuals who are in both comfortable roles and relationships often form strong support systems and gain benefits from available resources to promote health, while difficulty with roles and relationships can act as stressors for them (Craven & Hirnle). Taylor *et al.* suggest that the concept of self is an important factor in the way that a person relates to and with others. It incorporates how an individual feels about

self; the way she or he perceives their physical self; and also perceptions of own strengths and weaknesses; as results from a variety of past experiences, interpersonal interactions, physical and cultural influences, and education.

### **Emotional Factors and Coping**

This dimension shows the affects of the mind on body function and response to body conditions that in turn also affect health. Conditions such as stress, anxiety, calm, and relaxation can actually change the body's responses to health-illness status (Taylor *et al.*, 2001). Stress reducing techniques such as prayer, meditation, and relaxation breathing can promote emotional and physical health but some coping mechanisms such as denial and use of alcohol may emerge as generating health problems (Craven & Hirnle, 2000).

From the Islamic perspective, as already mentioned, health is regarded as a blessing given by Allah. Changes in an individuals' health status may be because the person behaves incorrectly or does not follow Allah's guidance. In this respect, the concept of factors influencing health proposed by contemporary scholars is congruent with Islamic teachings.

### **8. Measurement of Health Status**

Pender *et al.* (2002) have stated that the number of components to take into consideration in assessing health should be increased following the current definition of health that reflects concern for the individual as a total person, places health in the context of the social environment, and equate health with productive and creative living.

Regarding health when it is viewed beyond simply the absence of disease, then self-rated health is a way of assessing health (Maselko & Kubzansky, 2006). Subjective health is considered as a legitimate indicator of overall health status, providing a valid,

reliable and cost-effective means of health assessment (Kaplan & Baron-Epel, 2002). Goldman, Gleib, & Chang (2003) cited that most studies found that self-rated health status is a better predictor of subsequent mortality. Goldman *et al.* state that clinical measures are less powerful predictors than self-reports about well-being.

Previous studies employed various self-rated health instruments to measure health status. Self-assessed health status based on a simple question: “Regarding your current state of health, do you feel it is excellent, good, average, not so good, or poor?” has shown to be a strong predictor of future mortality in many studies (Yeager *et al.*, 2006). The Duke Health Profile (DUKE) has also been used. This is a 17-item generic self-report instrument containing six health measures (physical, mental, social, general, perceived health, and self-esteem) and four dysfunction measures (anxiety, depression, pain, and disability). DUKE is demonstrated as a brief measurement of health as an outcome of medical intervention and health promotion (Parkerson, Broadhead, & Tse, 1990). Another instrument is The General Health Questionnaire by Goldberg and Williams (1998). It is a thirty-item instrument concerned with the self-evaluation of general health and is assessed on a four-point scale ranging from “better than usual” to “much less than usual” (Francis *et al.*, 2004).

The most commonly used measure that has gained widespread acceptance as the standard health outcome measure is the SF-36 Health Survey (Bullinger, 1995, Ware *et al.*, 2000). It was constructed in 1986 as a 20-item short form that attempted to construct a comprehensive short-form health survey (Ware *et al.*). The questionnaire items derived from the definition of health by the WHO represented multiple operational indicators of health, including: behavioral function, well-being, objective reports and subjective ratings, and both favorable and unfavorable self-evaluations of general health



status (Ware *et al.*). The SF-36 Health Survey has been proven useful in surveys of general and specific populations, comparing the relative burden of diseases, and in differentiating the health benefits produced by a wide range of different treatments (Ware *et al.*). Psychometric evaluation of this instrument found that Cronbach's  $\alpha$  reliabilities ranged from 0.65 to 0.94 (Bullinger; Heyland, Hopman, Coe, Tranmer, & McColl, 2000) and correlated substantially ( $r = 0.40$  or greater) with most of the general health concepts (Heyland *et al.*; Ware *et al.*).

In holistic health frameworks, self-assessment has become more common in use in many studies to examine the health status of the subjects (Dossey *et al.*, 2005). It comprises six aspects that are measured including physical status, mental status, emotions, relationships, choices, and spirit (Dossey *et al.*). The reliability and validity of self-assessments have been proven in subjects with cancer or are acutely ill and hospitalized adult patients. Additionally, it can be used as an instrument to measure the self care components of the abilities assessment instrument for elderly women (Dossey *et al.*). Furthermore, Dossey *et al.* state that self-assessment appeared accurately to reflect the individuals' general condition.

## **9. The Relationship between Religiosity and Health Status**

Religiosity has been found to have a positive affect on the health of individuals. Biological outcomes have been found related to religiosity. A study of 112 female adults found that religiosity predicted systolic and diastolic blood pressure even after controlling for the body mass index and health behaviors (Hixson, Gruchow, & Morgan, 1998). Similarly, Masters, Hill, Kircher, Benson, and Fallon (2004) conduct a quasi-experimental study to examine the relationship between religious orientation and cardiovascular reactivity among older and younger people. It has been proposed that