05-May-2023
Religion as a Social Force in Health: Complexities and Contradictions
BMJ-2022-074052

Dear Dr. Idler,

Thank you for sending us this paper and giving us the chance to consider your work. We sent it out for external peer review and it was also reviewed and discussed by Analysis manuscript committee members (Juan Franco, Huseyin Naci, Jennifer Rasanathan and myself).

We enjoyed reading this paper. The topic is important, and we think it will be of much interest to our readers. We would like to offer you a Major Revision on this paper. We ask you to please revise your text in response to comments from the editors and reviewers and resubmit your manuscript within 4-6 weeks.

The editors' and reviewers' comments are at the end of this letter, and the editors' comments are below:

Along with the revised text, please provide a track change version as well as a point by point response to our comments and those of the reviewers. We also ask that you keep the revised manuscript within the word count of 1800-2000 words.

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We hope you will find the comments useful. Please don't hesitate to contact me if anything is unclear or if you have any questions.

Best wishes and we look forward to your revised paper,
Rachael

Rachael Hinton, PhD
Associate Editor, The BMJ

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Editors' comments
The editorial committee was very supportive of the topic and appreciates the efforts gone into submitting the paper to us. The committee thought the paper makes a good start, however we felt it in its current form the paper reads as quite descriptive and could go further to build a case around an argument. We provide more details below: The essential task of an Analysis article is to put forward a persuasive, nuanced stance on an issue about which there is some debate. In order to be persuasive, authors use evidence to build towards a central argument while also addressing opposing views. The important thing is we're encouraging authors to move away from a completely neutral voice even if we still expect them to be even handed with interpretation of the evidence. The major issue for the committee was that it found it difficult to see where the debate was or what the paper was trying to argue for. We appreciate this is a tricky topic to write about, but what we really hope you can do is narrow in on an area where there is debate that you can demonstrate and put forward a view beyond describing and summarizing cases. We really encourage you to be explicit about what you are arguing for, as well as the action/solution/way forward being proposed (also noted by reviewers related to the "reflections" section). For example, based on the editorial and reviewer comments, we felt one debate which could used to re-centre the paper around could be: "We know the science", taken narrowly, sets up a hierarchical power relationship with respect to knowledge. However, (given the relationship between religion and health in the form of social determinants), there is no health issue for which partnerships with faith-based organizations/actors is irrelevant. It takes vision and patience, sometimes, to find common ground for action for the public good." This would require examples to be identified where people have - to their detriment - tried to ignore religion as well as examples (e.g. on sexual and reproductive health) where people have been able to find productive/meaningful common ground across the different levels (and manage the contradictory role that religion can play in public health). We wondered if this suggestion might be interesting to you? The conclusions also start to point nicely to this argument: "Public health interventions working alongside religious institutions can engage religion's effects to support positive health outcomes within and across social contexts." We also appreciate you may also have other ideas for bringing out the debate more strongly. Related to the above, the committee felt the opening statement of the problem could be more than headlines, where the paper starts to set out the debate with concrete examples.
The committee felt the section giving examples of how religion has interacted with health was helpful; however, we felt the examples/discussion on nation-states could be sufficiently strengthened. The literature on the role of religion as a social determinant of health at the individual level is well-established. However, the issue becomes more complex when religion permeates (or dominates) decision-making at the nation-state level. This could be strengthened by bringing in the argument for example, that women are "more subjected to religious regulation of their rights and bodily autonomy." The reviewers suggest introducing Roe v Wade here, but including more international examples from countries like Iran, Turkey, and other parts of the world may also be helpful.
The committee agreed with the reviewers' suggestions to strengthen the "reflections" section of the paper. Currently, it feels disjointed from the rest of the paper, and it's not clear how these points follow from the literature covered earlier. More examples of initially acrimonious or contentious partnerships that ultimately proved fruitful would be worthwhile to

include here. The effect of religion at the nation-state level is also an important area to explore further. The committee felt a clearer distinction could also be made between religion as a personal belief and institutions in the conclusions.
The committee also appreciates the complexity of different contexts in writing on this topic. However, the committee felt more consideration could be given to issues of intersectionality i.e. socioeconomic determinants of health. Depending on how it is defined, the "prevalence" of religiosity is predominately higher in low and middle-income countries, and high-income countries tend to have the higher levels of atheism. The committee wondered how this might play into health outcomes? (cause? consequence?). The paper starts to touch on this in the conclusions: "If the formal role and influence of religious communities is stronger in some societies than in others,..." Additional comments:
Please revise some of the more subjective language "substantial", "groundbreaking" and a committee member also suggested caution in the use and interpretation of Ref 5 in that it was a systematic review of observational studies that adapted "Cochrane criteria" to rate as low risk of bias large cross-sectional studies or with large effect size, and which was validated by a Delphi panel.
Some of the committee members also had some concerns with how the HIV situation is described. The negative effects of abstinence-only messages are not fully elaborated, which they were, as far as we know, very serious, especially in Uganda. While acknowledging the impact on LGBTQ communities, the committee also wondered if abstinence-only messages applied mostly to heterosexual partners. Moreover, in Uganda, the Bishop campaigned against the use of condoms even in serodiscordant couples (if our memory serves right).
Reviewers' comments

Reviewer: 1

Comments:
This article will make an excellent contribution to the field of religion and health. The authors draw on their decades of expertise in this arena to argue for a nuanced understanding of religion that goes beyond individual factors and takes into account the broader systemic and structural realities that shape life and health.
My suggestions for the piece are related to structure and order of ideas, not content. I really appreciated the layered and ecological approach (it seemed to me a very ecological approach, so could be worth noting that), but I wanted to hear a bit more varied examples in the section on nation-states. The previous section provides examples related to vaccine adoption and Ebola; for example, this seems an apt place to talk about religion and health in the US from an institutional level with the reversal of Roe v Wade and the active role religious institutions have played and continue to play in fighting against reproductive justice efforts.
I also wanted a bit more context or depth in the reflections section. The recommendations need some more context to help those outside the field understand what you mean by phrases like "we know the science," or to provide some examples for some of the recommendations given (even just citations to further reading would be helpful here). Additionally I think this section could use some transitions to help the reader connect these reflections to the individual to nation state themes noted above. I wonder if putting this section at the outset (after the introduction) to frame the work that you have done and what you have learned which sets the stage for how you are arguing that religion and health should be conceptualized? That might not be the right tactic to take, but I think there needs to be a smoother transition between the sections on how this is an ecological issue to the reflections. Maybe the examples in the reflections section could nod back to some of the examples that you cited earlier?
You have a definition of healthworlds at the conclusion - but I think explaining that earlier, and giving that context within the individual to nation-state structure that you are using would be helpful, instead of introducing that to readers at the end.
Finally, you all point out that women should have particular attention given discrimination by religious bodies, but throughout the piece are examples of this type of discrimination against LGBTQ+ people, and also it would be good to note the legacies of systemic racism that steep many religious traditions and shape their interactions with broader health communities.
These are just some suggestions for what is a wonderful and well-needed piece. I enjoyed reading it, and agree with the conclusions. I particularly like the framing of individual to nation-state, and think that is important to highlight in this work. Thank you!

Additional Questions:

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Reviewer: 2

Comments:
The article is well written with a balanced view on the impact of religion on public health at multiple levels. The conclusion is well supported by empirical evidence to date suggesting that religion has a powerful role to play, both harmful and protective, in shaping global public health and should not be ignored. I have the following suggestions for further strengthening the article.

The authors did a good job summarizing evidence on the protective effects that individual religious participation and faith-based organizations have on preventing diseases and reducing mortality at the population level. The authors may consider adding that religious communities also play a vital role in supporting vulnerable populations such as new immigrants and the unsheltered. For instance, in the United States, large proportions of supportive services such as food banks, shelter beds, and addiction recovery programs come from faith-based organizations. These services are essential for upholding dignity and meeting fundamental health needs for many marginalized populations. In many cases, religious communities and the public health sector have shared goals in protecting vulnerable populations and reducing disparities. Therefore, it may be worth briefly mentioning this as an example of how religion has helped fill the gaps in health systems.

Strengthening collaborations between the two sectors could also help religious communities better work towards the common good. With the support from other sectors, the religious communities can be better equipped to address internal issues such as corruption, stigmatization, and abuse scandals, etc. Scientific communities can also help provide evidence-based approaches to assess and bolster faith-based organizations' existing work on e.g., promoting prosocial behaviors, peacemaking, and fostering a sense of meaning in life, which are areas not directly covered in the health systems but are essential for promoting population health and wellbeing.

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Please enter your name: Ying Chen

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Reviewer: 3

Comments:
This is an excellent, well-referenced article, based on a very sound understanding of the complex and often contradictory ground realities concerning the impact of the practice of religion in society on public health.
The authors have made a compelling case illustrating that religions may have detrimental or helpful influences on religion by exhibiting multifaceted and variable associations with health. The study also reminds us that disentangling the varied influences of religion both positive and negative–across the social field is critical.
Either way, not considering their effect on public health is not an option.

Addressing the nuanced relationship, the authors point to going beyond the level of individual religiousness and health outcomes; to the level of organisations, pointing to the evidence of impacts and contributions of faith communities and faith-based organisations on the health of communities in both tangible and intangible ways. The paper also gives convincing examples and relevant references to illustrate the thinking clearly.
The impressive body of knowledge has been effectively summarised into the concluding five take-home messages. This paper is a critical contribution to public health, altering policymakers and public health authorities to consider religion as a 'Social Force' in health.

Corrections/ improvements
Page 7 Lines 197, 198- to correct/ improve the sentence- 'Finally, religion or spirituality is a place where many -- even ostensibly secular people -- turn in crisis'.

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Please enter your name: Manoj Kurian

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Institution: World Council of Churches

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Reviewer: 4

Comments:
This article addresses an important and often underexplored area of focus - the complex and often contradictory relationships between religion and public health in the form of social determinants. This, especially in the light of COVID-19 and other religiously infused vaccine hesitancies, as well as a tendency by a number of secular actors, to ignore or merely demonise the varied roles of religion in public health, is an important contribution and to recognise it in the BMJ with its specific readership is recommended. The diagnosis of the contradictory roles of religion and some concrete examples of these are well done but I would have personally liked to see some examples within the gender space of public health also being used. I also appreciated the suggestion to look multi level (something along the lines of the socio-ecological model is of great value here). Researchers in the field such as myself have used a multi level model to explore violence and faith actors whose role often cuts across these levels.

I would however have liked to see a bit more nuance in laying out the particular drivers that typically in many contexts affect how religion(s) may respond on certain hot topic issues e.g. gender and sexuality - and the risks of engaging religion in these spaces as well as some examples of how organisations are working in practice to transform some of this harmful religious engagement on health related issues such as FGM/C, abortion, child marriage - especially in the global south. there was a sense that there is a need to 'reconcile' the harm and help contradiction - and I do not totally feel this is the right language.

As an expert on religion and public health related forms of violence I however found the five 'lessons' to be of rather limited value in terms of making an original contribution to managing or resolving the tensions of religions 'mixed blessing' role especially in the light of recent research studies and papers on this exact topic (e.g. Eyber and Palm 2019, A mixed blessing) . It is also unclear why these are termed as 'lessons' as they do not relate to a particular study - but appear to be more generalised shared insights from the combined life experience of the different authors (so I suggest a slight reframing here) I feel that the five lessons are the weakest part of the article - they read more as basic statements rather than arguments - ie that many people are spiritual, that there are partnerships in practice between FBOs and PHPs. They also tend at times towards addressing public health practitioners only (maybe due to the journal readership. However in my view suggestions that religion can be a corrective to public health, that its beliefs always need to be respected, that a hierarchy of knowledge that ignores religion is inadvisible can, whilst important, run the risk of being one way recommendations that fall into a religion and development faith advocacy paradigm (Oliver 2016). It is surely equally important that religions are also expected to respect the knowledge, insights and value of public health and the realities and wishes of secular people and that spiritual care is provided in a way that is shaped by the needs of the patient - and not the beliefs of the organisation. I would suggest that these lessons learned could benefit from more strongly highlighting this two way engagement between the two interrelated aspects to avoid a sense that religion as a whole has to be accepted, In the light of the contradictory roles that they note it plays in public health, I feel the lessons learned would benefit from reflecting more clearly how public health professionals can manage the reality of these contradictions (that were laid out so clearly in the first part of the article I also suggest that a definition of religion as used by the authors in this article is also added to give context. However I feel as a reasonably short article it offers an introduction to the need to engage with religion as a social determinant of health and could set the scene well for a series going into this issue in more depth that draw on specific pieces of research in more detail (which I feel is still needed). I suggest that these recommendations are passed back to the authors and they are invited to consider slightly revising the five lessons etc or better highlighting the 'diagnostic' feel of this piece rather than a 'treatment' feel. but that the article is approved in principle to be published in the BMJ as it is a topic which I feel the BMJ readership can benefit from engaging with.

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Please enter your name: Dr Selina Palm

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