Religion as a Social Force in Health: Complexities and Contradictions

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KEY MESSAGES

- Research shows that, at the individual level, religious participation is a protective social factor for multiple outcomes in health, including all-cause mortality
- Faith-based institutions often partner successfully with public health agencies to prevent disease and promote health

- Religious groups may also foster adverse public health outcomes by promoting stigma, asserting religious liberties of individuals over the collective, and influencing policies that are not shared in religiously diverse societies

Contributors and sources

The four authors have long commitments to research and practice in the intersection between religion and public health. Ellen Idler and John Blevins work at Emory University on the Religion and Public Health Collaborative and the Interfaith Health Program, which originated at The Carter Center. James Cochrane is a founder of the African Religious Health Assets Programme (ARHAP) and convenor of the Leading Causes of Life Initiative. John Blevins and James Cochrane were contributors to *Religion as a Social Determinant of Public Health* (Idler, Editor; Oxford; 2014), the product of a two-year, 25-person faculty seminar at Emory. Mohamed Jalloh is the CDC Country Director for Cameroon; with John Blevins and Ellen Idler he was a contributor to the March 2019 Special Section of the *American Journal of Public Health* on "Faith-Based Organizations and Public Health". Ellen Idler drafted an initial version of the paper but all authors contributed text and references to the document.

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We have no conflicts of interest to declare.

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Standfirst

Because religion's influence on public health can be both harmful and protective, it cannot be universally vilified, championed, or ignored. Rather, as Ellen Idler and colleagues argue, public health must critically assess religion's varied effects to establish more effective and durable partnerships with religious actors that can contribute to better population health outcomes.

Introduction

Headlines on religion and public health appear regularly in the press, with both conflict and cooperation as themes: "Battling COVID: When Religion, Public Health Collide",[1] "Churches and Mosques Educate on Ebola",[2] "Uganda: HIV Positive Teens Choose Religion over ARV."[3] In some cases, religious institutions protect and support public health; in others, the opposite occurs. In this paper we argue that engagement with religion is imperative for medicine and public health -- not to promote religion or to grant it special status, but because the health effects are real, contradictory, and complex.

In previous work, we have framed religion as a social determinant of health, arguing that – alongside education, income, race, and gender – it has a quantifiable, demonstrable impact on population health.[4] Although socioeconomic status determinants have more well-understood associations with health, religion is a different social force with unique complexities that can dually produce harmful and protective health effects. Unlike the interval, scaled measures of income and education where advantage clearly accrues to health, religion is multifaceted, exhibiting conflicting associations. Religion, a set of spiritual beliefs and practices manifested at both the individual and institutional level, warrants a different conceptualization as a social determinant, both to mitigate its harmful effects and to realize its protective and generative impact. Some tensions between public health and religion may be reconcilable, and some not, but the efficacy and durability of public health requires taking religious institutions seriously. While attempting engagement and partnership may not always be successful, without the attempt no lessons will be learned.

Five Lessons

The following observations have evolved from our collective decades working across social sciences, public health, religion, and theology, seeing firsthand that religions are frequently active in the public health space – for good or ill – and cannot be ignored.

First, people around the world regularly see their health through a religious or spiritual lens, even in supposedly 'secular' contexts. Health behaviors are thus informed by norms and values beyond those set by medical or clinical interventions. Public health practitioners often fail to perceive these complex influences, which remain powerful in many communities and should be taken into account.

Second, *public health institutions can successfully engage with religious actors to realize public health outcomes*. There is no health issue for which partnerships with faith-based organizations is irrelevant. Finding common ground for action for the public good may take vision and patience, but it can lead to mutually beneficial relationships and engender working partnerships, as trust is built iteratively over time. Public health actors must recognize that achieving certain population health outcomes may require negotiation and engagement with religious institutions in varying contexts. We further argue that non-engagement with religious institutions is a form of intervention that can produce negative health effects or slow down progress in achieving desired health outcomes.

Third, *at times religion may facilitate public health initiatives, and even serve as a check on their (unintended) negative consequences*. Religious leaders and communities have periodically critiqued public health recommendations that discount religious beliefs and practices, and offered compromises that promoted better health outcomes. At the same time, there are notable examples of the harms of religion on health, and some longstanding tensions between public health and religion may be irreconcilable.

Fourth, *public health workers ought to enhance the humility and respect they feel for local communities, including faith communities*. "We know the science", taken narrowly, creates a hierarchical power relationship with respect to knowledge. The growth of social science methods in public health builds understanding of how to respect communities' knowledge and priorities. This goes beyond human and religious rights – it includes respect of each party for the other, their different forms of power, and their own relevant insights about health.

Fifth and finally, *religion or spirituality is a resource during times of crisis and vulnerability, even for many ostensibly secular people*. Respect of public health practitioners for communities' religious beliefs and practices is particularly crucial in acute emergencies and crises.

To illustrate these lessons, we share examples that are organized in a social-ecological frame, with evidence at the individual, organizational, and nation-state level.

Religion and health at the individual level

A recent major systematic review of research on religion's effects on individual health considered prior studies of patients with serious illness and a wide range of population-based health indicators.[5] It concluded there was strong evidence for including spiritual care alongside clinical care for seriously ill patients, and that attendance at religious services had a dose-response protective effect for all-cause mortality. The evidence of this summary of hundreds of well-conducted studies falls strongly on the protective side, including for patients with all types of serious illness, and for all causes of mortality. [5] This body of work provides many examples of Lessons 1 and 5, uncovering hidden influences of religion in daily health lifestyles and in crises of serious illness.

Yet, there undoubtedly also exist many instances of harms to health, as we detail below. To reconcile this contradiction of help and harm we need a wider, social-ecological view that conceptualizes not only the level of individual religiousness and health outcomes, but also the levels of organizations (faith-based and secular), and of nation-states.

Not just individuals, but organizations

Religion is more than a set of private practices and beliefs related to individual health outcomes such as those studied in the systematic review noted above. Lessons 2, 3, and 4 are well-represented in scholarship on the public health impact of religious institutions, which has grown in recent years[6-8], influencing public health research, practice[9], and policy.[10] Faith-based health facilities provide a substantial percentage of the health services in many low- and middle-income countries, especially in sub-Saharan Africa. The African Religious Health Assets Programme,[11] a consortium of researchers and practitioners in public health and religious studies, demonstrated the varied contributions of faith-based organizations (FBOs) to the "healthworlds"[12] of local communities in both tangible and intangible ways. Similarly, efforts to

improve child mortality surveillance in low- and middle-income countries have benefited from the early and sustained engagement of religious leaders and institutions.[13]

Organizational partnerships in religion and public health were the subject of a special section of the *American Journal of Public Health* in March 2019; the papers provide examples of U.S. faith-based organizations' food programs and vaccination drives. The COVID-19 pandemic invigorated many such "trusted messenger" partnerships around the world, particularly interfaith partnerships that mobilized to promote vaccines. Despite the media narratives of religious obstruction to public health guidance, a computational text analysis of COVID-19 statements on global religious groups' own web sites showed messages that tracked closely with guidance for faith communities from the World Health Organization and the U.S. Centers for Disease Control and Prevention.[14]

Certainly, religious institutions and groups that promote vaccine refusal, or stigmatize and discriminate against others based on gender, gender identity, sexuality, religion, race, or other group characteristics, are also present. Tetanus vaccine refusal has been linked to infertility fears in segments of the population, a message spread through various channels, including religious ones.[15] Similarly, the 2003-2004 boycott and suspension of oral polio vaccine (OPV) in five states in northern Nigeria occurred because it was believed to cause sterility in Muslim girls.[16] Complex institutional struggles between the federal government and the Supreme Council for Sharia in Nigeria coupled with historical sociocultural dynamics precipitated the OPV boycott, leaving many children at greater risk of polio, showing that religious institutions can engender negative health effects that linger for years.

Beyond resistance to immunization, religious institutions have also created discriminatory environments that contribute to adverse mental health outcomes among sub-populations in society, including among people who identify as lesbian, gay, bisexual, transgender, and queer (LGBTQ). Despite religiosity generally being associated with numerous positive mental health outcomes,[5] those who identify as LGBTQ have experienced religious discrimination with associated negative mental health outcomes.[17]

The Ebola epidemic provides an example of an initial non-alignment of faith communities' practices with public health practices, and efforts that brought them successfully together. Many community members refused to report household deaths during the early stages of the epidemic

because such reporting led to a prohibition of traditional religious rituals to prepare the body for burial.[18] In response, leaders from Muslim, Christian, and indigenous spiritual traditions demonstrated that they were willing and able to reshape religious beliefs and rituals about burial to conform with protective public health practices; working with faith-based organizations, the World Health Organization modified its "safe" burial guidance to become the "safe and dignified" protocol.[19] The religious response to Ebola, which featured prominently in the CDC Museum's exhibit on the epidemic,[20] was successful in large part because the faith leaders had pre-existing networks of trust and communication with each other and with public health officials. It exemplifies every single one of the five lessons: a faith-based and public health relationship that began with conflict and harm transformed to cooperation and protection, with both sides shifting from their original positions to find common ground.

Not just organizations, but nation states

The biggest threat to public health from religious institutions comes not at the individual or the organizational level, but at the level of the nation-state, when policies advocated by a single religious community are enacted and enforced for an entire population. This is particularly important for women, who are more religiously observant than men, and more subjected to religious regulation of their rights and bodily autonomy. The recent conservative shift in the U.S. Supreme Court, motivated by the "religious right", has resulted in the abolition of women's rights to control their bodies in an increasing number of states, perhaps nationally if the ban on medication abortion is upheld. This restriction of the rights of all women is especially problematic in an increasingly secular U.S. society where banning abortions is a view held by a small minority of the population, even among the religiously observant.[21]

Lesson 4, about policies at nation-state level, is also reflected in the HIV pandemic response. Nation-states -- including the United States through the President's Emergency Plan for AIDS Relief (PEPFAR) -- working with religious institutions have been key to global efforts to end the AIDS epidemic.[22] The capacities of faith-based health facilities in providing HIV clinical care are substantial and have been an essential part of progress made to date. For example, the PEPFAR-UNAIDS Faith Initiative conducted a secondary data analysis of HIV treatment visits in Kenya, calculating that 21% of all HIV clinical care was provided by faith-based health facilities.[23] In another example from Brazil, FBOs singled out aspects of the HIV epidemic to which they could contribute without violating their religious beliefs, as in the use of condoms.[24]

At the same time, religion generates complex inter-related influences in the global HIV response. If advocacy from Evangelical Protestant leaders was influential in building political support for the passage of PEPFAR, their support was secured in part by championing HIV prevention programs that prioritized abstinence-only messages over comprehensive HIV prevention grounded in evidence-based practice.[26] Funding for abstinence-only approaches had the unintended consequence of providing financial support to some faith-based organizations in countries such as Uganda, Tanzania, and Nigeria whose leaders later worked to pass strict legal prohibitions on homosexuality that contributed to violence against LGBTQ communities.[26] In short, disentangling the varied influences of religion in relation to HIV– both positive and negative–is challenging but necessary.

Conclusions

Does religion have a positive or a detrimental effect on population health? In any society, religion is embedded in the context of the full range of factors that impact health at individual, organizational, and nation-state levels. Whether religion is a positive or negative contributor to health depends upon its expressions. Initiatives such as PEPFAR and The Global Fund[10], or the *Thriving Together* response to COVID-19 now adopted by several US federal agencies[27], have recognized that religious actors or faith communities embark on activities that contribute to the health of individuals and populations, often filling gaps in health systems, from delivery, prevention, and support to medical or clinical intervention.

The formal role and influence of religious communities may be stronger in some societies than others, but in much of the world religion in some form nonetheless remains important in daily public and private life. It shapes people's "healthworlds"[12]—their complex ways of understanding health or illness that incorporate but also extend beyond biomedical science and clinical procedures. "Healthworlds" are constructed by individuals and populations from positive norms and values, and not simply from an "ignorance of science."

Public health interventions can work alongside religious institutions to support positive health outcomes within and across social contexts, we argue, despite our first-hand knowledge that the conflicts between religion and public health can seem – or even be – intractable. Notwithstanding high-stakes tensions as in vaccine resistance or religious minorities enforcing their beliefs through the power of the state, partnership and engagement are critical to reducing tension and to forging win-win scenarios where possible. The public health research community

can also help religious communities address the negative manifestations of stigma and abuse and support efforts in promoting positive well-being. The multivalent effects of religion on health can be harmful or protective, but religion will likely remain an enduring, if complex and contradictory, social determinant of health for most people around the world. A nuanced approach to understanding, shaping, and responding to its effects on health and wellbeing, especially in supporting its positive effects, is essential for global public health.

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