Religion as a Social Force in Health: Complexities and Contradictions

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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 organizations 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. 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 CDC Country Director for Cameroon; with John Blevins 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.

Conflicts of Interest

We have no conflicts of interest to declare.

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Standfirst

Religion's role in public health can be both harmful and protective, but should not be ignored, as Ellen Idler and colleagues argue

Introduction

Headlines on religion and public health have appeared frequently since 2020: "Battling COVID: When Religion, Public Health Collide",[1] "Theocratic influence in state policy has been to detriment of people's well-being",[2] "Launch of Global Multi-Religious Faith-in-Action COVID-19 Initiative."[3] In some cases, religious institutions protect and support public health; in other cases, the opposite occurs. How can we address these contradictions?

In previous work, we have framed religion as a social determinant of health, arguing that it should be considered – alongside education, income, race, and gender – as having a quantifiable, demonstrable impact on population health.[4] Although socioeconomic status determinants tend to have more well-understood associations with health, religion has unique complexities, with both harmful and protective demonstrated health impacts. Unlike the interval, scaled measures of income and education, religion is multifaceted, exhibiting variable associations with health. Religion is a social determinant of health, but because of its multi-layered manifestations and dependence on social context, it warrants a different conceptualization, both to prevent its harmful effects and to realize its protective and generative impact.

COVID-19 (and other) vaccine hesitancies among religious groups in the U.S. and around the world are well-known examples of the public health harm caused by religious influence. However, a more comprehensive view was taken by a major systematic review and meta-analysis of religion's effects on health that was published in July 2022.[5] In the review, one Delphi panel considered prior studies of patients with serious illness; a second assessed research on a wide range of population-based health indicators including mortality. The first panel identified strong evidence for including spiritual care alongside clinical care for seriously ill patients. The second concluded that there was strong evidence that attendance at religious services had a dose-response protective effect for all-cause mortality. On balance, the review

showed that evidence from studies at the individual level falls strongly on the protective side, including for patients with all types of serious illness, and for all causes of mortality.

To reconcile this contradiction of help and harm, the relationship of religion to public health should be conceptualized not only at the level of individual religiousness and health outcomes, but also at the level of organizations – faith-based and secular – and of states and nations. This is of particular importance for women, who are more religiously observant than men, and more subjected to religious regulation of their rights and bodily autonomy.

Not just individuals, but organizations

There is substantial published research on the impacts of religion on individuals, patients, and populations. Scholarship on the public health impact of religion has grown in recent years[6-8], influencing public health research and practice[9], and public health 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, and have been a primary impetus for recent public health and faith partnerships. The groundbreaking African Religious Health Assets Programme,[11] a consortium of researchers and practitioners in public health and religious studies, furthered this work by demonstrating the varied contributions of faith communities and faith-based organizations (FBOs) to the health of local communities in both tangible and intangible ways.

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 COVID-19 pandemic invigorated many such “trusted messenger” partnerships, particularly interfaith partnerships that mobilized to promote vaccines, once available. A computational text analysis of COVID-19 statements on 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.[12]

Certainly, religious institutions and groups that promote vaccine refusal, or stigmatize and discriminate against others based on gender, 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 that has been spread through various channels, including religious ones.[13] Another example is the 2003-2004 boycott and suspension of oral

polio vaccine (OPV) in five states in northern Nigeria because it was believed to cause sterility in Muslim girls.[14] 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. This demonstrates how the power of religious institutions can produce negative health effects that linger for years. Beyond documented threats to immunization, religious institutions have also created discriminatory environments that contribute to adverse mental health outcomes among sub-populations in society, including among young people who identify as lesbian, gay, bisexual, transgender, and queer (LGBTQ). Despite religiosity being associated with positive mental health outcomes among young people in general,[15] those who identify as LGBTQ have experienced religious discrimination with associated negative mental health outcomes.[16]

Religious beliefs can also affect individual level uptake barriers in myriad health areas, including mortality surveillance efforts. For example, after the 2014-2015 Ebola epidemic, the Government of Sierra Leone aimed to maintain reporting of all deaths through a central toll-free number (the 1-1-7 line). Although death reporting to this line increased exponentially during the epidemic,[17] it quickly plummeted after the epidemic ended. A study investigating reasons for not reporting deaths found that it was partly linked to people's religious belief that "death is God's will." Many people viewed prompt religious burial as a higher priority than death reporting, which could cause burial delays.[18] Similar religious concerns led to under-reporting of deaths during the early stages of the Ebola epidemic, which contributed to the community spread of Ebola. At the same time, religious leaders demonstrated during the epidemic that they were willing and able to reshape religious beliefs about burial rites to conform with protective public health practices. The extrinsic engagement of religious institutions was a central pillar of the public health response mounted to curb the Ebola epidemic.[19] Religious institutions also have a prominent role in supporting public health responses to health emergencies, including the COVID-19 pandemic.[20] 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 religious institutions.[21]

Not just organizations, but nation states

The global HIV response has taken place at all levels. Nation states, including the United States through the President's Emergency Plan for AIDS Relief (PEPFAR), have played a critical role in global HIV response. Working with religious institutions has been a key component in global

efforts to end the AIDS epidemic. For example, the contributions of faith-based health facilities in providing HIV clinical care are substantial and the capacities these facilities provide has 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. [22]

However, religion presents complex inter-related influences in the global HIV response. Advocacy from Evangelical Protestant leaders (ordained and lay) was influential in building political support for the passage of PEPFAR but 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.[23] Funding for abstinence-only approaches had an unintended consequence of providing financial support to faith-based organizations in various 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.[24] In short, disentangling the varied influences of religion in relation to HIV– both positive and negative–across the social field is challenging but worth the effort.

Reflections on lessons learned

Five key lessons summarize our experiences and observations from our collective several decades working across social sciences, public health, religion, and theology.

First, people around the world often see their health through a religious or spiritual lens, even in 'secular' contexts. They adapt their behavior informed by norms and values beyond those set by medical or clinical interventions even as those norms impact such interventions. Public health practitioners often fail to perceive these complex behaviors, which remain present and powerful in many communities.

Second, public health institutions can engage with religious actors. There is no health issue for which partnerships with faith-based organizations is irrelevant. It takes vision and patience, sometimes, to find common ground for action for the public good. But doing so can lead to mutually beneficial relationships and provoke more working partnerships, as trust is built.

Third, simultaneously, religion can be conceptualized as both benefit and corrective – as both facilitator of public health initiatives, and as a check on them. Religious leaders and

communities have sometimes critiqued public health recommendations that discount religious beliefs and practices, and offered compromises.

Fourth, public health workers can enhance the humility and respect they feel for local communities, including faith communities. "We know the science", taken narrowly, sets up a hierarchical power relationship with respect to knowledge. The growth of the *social* sciences in public health helps understand what it takes to work with communities to implement public health practices. Respect means recognizing more than human and religious rights – it includes respect of each party for the other.

Finally, religion or spirituality is a place where many -- even ostensibly secular people -- turn in crisis. The respect of public health practitioners for community beliefs and practices is crucially important in times of crisis and vulnerability.

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, including the better-known social determinants. Whether religion is a positive or negative contributor to health depends upon its expressions. Initiatives such as PEPFAR and The Global Fund, or the *Thriving Together* response to COVID-19 now adopted by several US federal agencies, have recognized that religious actors or faith communities everywhere embark on activities that contribute to the health of individuals and populations, and fill many gaps in health systems, from provision, delivery, prevention, and support to medical or clinical intervention.

If the formal role and influence of religious communities is stronger in some societies than in others, in much of the world religion in some form remains important in daily public and private life, shaping people's "healthworlds"[25]—their complex ways of understanding and responding to health or illness that incorporate but also extend beyond biomedical science and clinical procedures. "Healthworlds" are constructed by individuals and populations from positive subjective norms and values, and not simply from an "ignorance of science."

Public health interventions working alongside religious institutions can engage religion's effects to support positive health outcomes within and across social contexts. While the multivalent effects of religion on health can be harmful or protective, it will thus 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 outcomes is essential for global public health.

References

1. Global Press Journal. Battling the virus when religion and public health collide, 2022. Available from: https://globalpressjournal.com/africa/zimbabwe/religion-public-health-collide/ [accessed December 22 2022].

2. Khan A. Theocratic influence in state policy has been to detriment of people's well-being, 2022. Available from: https://globalpressjournal.com/africa/zimbabwe/religion-public-health-collide/ [accessed December 20 2022].

3. UNICEF. Launch of Global Multi-Religious Faith-in-Action Covid-19 Initiative, 2020. Available from: https://www.unicef.org/press-releases/launch-global-multi-religious-faith-action-covid-19-initiative [accessed December 20 2022].

4. Idler E., Editor. *Religion as a social determinant of public health*. New York: Oxford University Press; 2014.

5. Balboni TA, VanderWeele TJ, Doane-Soares SD, et al. Spirituality in serious illness and health. *JAMA* 2022;328(2):184-97. doi: 10.1001/jama.2022.11086

6. Gunderson GR, Cochrane JR. *Religion and the health of the public: shifting the paradigm*. New York: Palgrave MacMillan; 2012.

7. Blevins, J. *Christianity's role in United States global health and development policy: To transfer the empire of the world*. New York: Routledge; 2019.

8. Winiger F, Peng-Keller S. Religion and the World Health Organization: an evolving relationship. *BMJ Glob Health* 2021;6(4) doi: 10.1136/bmjgh-2020-004073

9. Olivier, J, Tsimpo C, Gemignani R, Shojo M, Coulombe H, Dimmock F, Cong Nguyen M, et al. 2015. Understanding the roles of faith-based health-care providers in Africa: Review of the Evidence with a focus on magnitude, reach, cost, and satisfaction." *The Lancet* 2015; 386: 1765–1775. doi: 10.1016/S0140-6736(15)60251-3

10. For example, see The Faith-Based Coalition for The Global Fund To Fight AIDS, Malaria, and TB. https://www.2030collaborative.com/faith-based-coalition-for-the-global-fund

11. World Health Organization. African Religious Health Assets Programme. Appreciating assets: The contribution of religion to universal access in Africa. Cape Town: World Health Organization; 2006.

12. Idler E, Bernau JA, Zaras D. Narratives and counter-narratives in religious responses to COVID-19: A computational text analysis. *PLoS One* 2022;17(2):e0262905. doi: 10.1371/journal.pone.0262905

13. Kiyuka PK, Moindi RO, Murunga N, et al. Assessing risk perceptions that contribute to tetanus toxoid maternal vaccine hesitancy in Kilifi County, Kenya. *medRxiv* 2021:2021.04.11.21255279. doi: 10.1101/2021.04.11.21255279

14. Ghinai I, Willott C, Dadari I, et al. Listening to the rumours: What the northern Nigeria polio vaccine boycott can tell us ten years on. *Global public health* 2013;8(10):1138-50. doi: 10.1080/17441692.2013.859720

15. Wong YJ, Rew L, Slaikeu KD. A systematic review of recent research on adolescent religiosity/spirituality and mental health. *Issues Ment Health Nurs* 2006;27(2):161-83. doi: 10.1080/01612840500436941

16. Gibbs JJ, Goldbach J. Religious conflict, sexual identity, and suicidal behaviors among LGBT young adults. *Arch Suicide Res* 2015;19(4):472-88. doi: 10.1080/13811118.2015.1004476

17. Alpren C, Jalloh MF, Kaiser R, et al. The 117 call alert system in Sierra Leone: from rapid Ebola notification to routine death reporting. *BMJ Glob Health* 2017;2(3):e000392. doi: 10.1136/bmjgh-2017-000392

18. Jalloh MF, Kinsman J, Conteh J, et al. Barriers and facilitators to reporting deaths following Ebola surveillance in Sierra Leone: implications for sustainable mortality surveillance based on an exploratory qualitative assessment. *BMJ Open* 2021;11(5):e042976. doi: 10.1136/bmjopen-2020-042976

19. Blevins JB, Jalloh MF, Robinson DA. Faith and global health practice in Ebola and HIV emergencies. *Am J Public Health* 2019;109(3):379-84. doi: 10.2105/AJPH.2018.304870 [published Online First: 2019/01/25]

20. World Health Organization. Collaboration in health emergencies: WHO strategy for engaging faith partners & Kenya case study. YouTube: World Health Organization; 2021.

21. Degefa K, Tadesse A, Ackley C, et al. Using traditional healers to treat child malnutrition: a qualitative study of health-seeking behaviour in eastern Ethiopia. *BMC Public Health* 2022;22(1):873. doi: 10.1186/s12889-022-13323-5

22. UNAIDS. *A Common Vision: Faith-Based Partnerships to Sustain Progress Against HIV.* Geneva: UNAIDS, 2019. Available from https://ihpemory.org/wp-content/uploads/2019/09/A-Common-Vision-Report_FINAL_2019.pdf [Accessed 31 March 2023].

23. Epstein H. The invisible cure: Why we are losing the fight against AIDS in Africa: Macmillan Publishers; 2007.

24. Evertz, S. 2010. How ideology trumped science: Why PEPFAR failed to meet its potential. Washington, DC: The Center for American Progress and the Council for Global Equality. Available from https://www.americanprogress.org/article/how-ideology-trumped-science/ [Accessed 6 February 2023].

25. Germond P, Cochrane JR. Healthworlds: Conceptualizing landscapes of health and healing. *Sociology* 2010;44(2):307-24. doi: 10.1177/0038038509357202