Religion as a social force in health: complexities and contradictions

Ellen Idler and colleagues argue that durable partnerships with religious bodies can contribute to better population health outcomes

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The relationship between religion and public health regularly makes headlines in the press, with both conflict and cooperation as themes. Recent examples include: "Battling covid when religion and 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 measures; in others, the opposite occurs.

Religion is a set of spiritual beliefs and practices that manifest not only at individual level but at institutional levels through congregations of organised religions and faith based, charitable organisations. At the individual level religion may manifest as public participation in worship services of a congregation, as private practices such as prayer or meditation, or as private beliefs in the tenets of a faith or identifying as a religious person. Alongside education, income, ethnicity, and gender, religion has a quantifiable, demonstrable effect on population health.[4] However, religion is different from other socioeconomic determinants of health; its unique complexities can produce both harmful and protective health effects. It therefore warrants a different conceptualisation as a social determinant of health, both to mitigate its harmful effects and to realise its protective and generative impact.

Not all tensions between public health and religious institutions are reconcilable, but engagement between public health actors and religious actors is essential because religion's health effects are real, contradictory, and complex. These effects are relevant not only at the level of personal religiousness and individual health outcomes but also at the institutional and national levels.

Religion has a largely protective effect for individuals

Globally, many people see their health through a religious or spiritual lens, even in countries where there is little public participation in religious services. Religion shapes people's "healthworlds"—their complex ways of understanding health or illness that extend beyond biomedical science and clinical procedures.[5]

Religious beliefs, practices, and affiliations can influence everyday health lifestyles and responses to health crisis and vulnerability, even for many ostensibly secular people. A 2022 systematic review of research on religion's effects on individual health considered studies of patients with serious illness and a wide range of population based health indicators.[6] In the meta-analysis, attendance at religious services (compared with never attending) had a dose-response protective effect for all-cause mortality (hazard ratio for frequent attendance 0.73, 95% confidence interval 0.63 to 0.84) and for depression (odds ratio 0.67, 95% CI 0.58 to 0.81). There was also strong evidence that 50-90% of seriously ill patients desired spiritual care alongside clinical care in inpatient settings, and that spirituality was associated with better quality of life. The evidence from this analysis 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.[6]

Benefits of engagement with religious and faith based organisations

Religion is more than a set of private practices and beliefs related to individual health outcomes. Scholarship on the public health effect of religious institutions has grown in the past decade,[7-9] influencing public health research, practice,[10] and policy.[11] There is no health matter—or country—for which partnerships with faith based organisations are irrelevant.

Faith based health facilities provide a substantial percentage of health services in many low and middle income countries, especially in sub-Saharan Africa. The African Religious Health Assets Programme,[12] a consortium of researchers and practitioners in public health and religious studies, identified the varied contributions of faith based organisations to the health worlds of local communities. Faith based health facilities have substantially contributed to clinical care for people with HIV and been an essential part of progress made to date. For example, the US President's Emergency Plan for AIDS Relief (PEPFAR)-UNAIDS Faith Initiative calculated that 21% of all HIV clinical care in Kenya was provided by faith based health facilities providing services such as antiretroviral therapy.[13] In Brazil, where some aspects of HIV care (such as use of condoms) violated religious beliefs, some faith based organisations focused instead on areas such as care of people who were dying or had drug addiction.[14]

Long running partnerships between religious organisations and public health agencies have been effective in promoting health. For example, US faith based organisations have collaborated with state and local public health bodies to run food programmes and vaccination drives. For example, the Faithful Families Thriving Communities programme began with 41 churches in 2008 partnering with the North Carolina Division of Public Health and North Carolina State University to improve the health of local people.[15] In the UK, faith groups supported the NHS

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during the covid pandemic, including by running faith based vaccine centres and supporting campaigns to tackle misinformation, and are moving into other types of social care partnerships.[16]

Although religious institutions can facilitate public health initiatives in many cases, achieving some population health outcomes may require negotiation and engagement between public health actors and religious institutions. Not engaging with religious institutions is also a form of intervention and can produce negative health effects or slow down progress in achieving desired health outcomes.

Dealing with tensions created by differing views

The 2014 Ebola epidemic in west Africa provides an example of an initial non-alignment of faith communities' practices with public health practices and the efforts that brought them together. Many community members refused to report household deaths during the early stages of the epidemic because health protection measures prevented traditional religious rituals to prepare the body for burial.[17] In response, leaders from Muslim, Christian, and indigenous spiritual traditions indicated that they were willing and able to reshape religious beliefs and rituals about burial to conform with protective public health practices. Working with interfaith organisations, the World Health Organization modified its "safe" burial guidance to become the "safe and dignified" protocol.[18] This evolving response to Ebola 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. Religious institutions thus can provide important checks on (unintended) negative consequences of public health measures that discount religious beliefs and practices and offer compromises that promote better health outcomes.

The covid-19 pandemic also invigorated many trusted messenger partnerships around the world, particularly interfaith partnerships that mobilised to promote vaccines. Although media narratives often suggested religious obstruction to public health guidance during the covid-19 pandemic, a computational text analysis of covid-19 statements on the websites of global religious groups showed messages that tracked closely with guidance for faith communities from WHO and the US Centers for Disease Control and Prevention.[19]

Nevertheless, there are notable examples of the harms of religion on health, and some longstanding tensions between public health and religious institutions may be irreconcilable. For example, some religious institutions and groups promote vaccine refusal or stigmatise and discriminate against others based on gender, gender identity, sexuality, religion, race, or other group characteristics. Refusal of the tetanus vaccine among segments of the Kenyan population has been linked to infertility fears, a message spread through various channels, including religious ones.[20] Similarly, religious leaders drove the 2003-04 boycott and suspension of oral polio vaccine in five states in northern Nigeria because it was said to cause sterility in Muslim girls.[21] Complex institutional struggles between the federal government and the Supreme Council for Sharia in Nigeria coupled with historical sociocultural dynamics precipitated the vaccine boycott, leaving many children at greater risk of polio.[21] Religious institutions have also created discriminatory environments that contribute to adverse mental health outcomes among subpopulations in society, including among people who identify as lesbian, gay, bisexual, transgender, or queer (LGBTQ).[22]

Dangers of nations codifying religious beliefs

The biggest threat to public health from religious institutions comes when policies advocated by a single religious community are enacted and enforced for an entire population. The rise of Hindu nationalism in India and targeting of Muslim minorities, particularly during the covid pandemic is a notable example.[23] The codifying of religious beliefs particularly affects women, who are more likely than men to identify with a religion and practise it, and more subjected to religious regulation of their rights and bodily autonomy.[24] The recent conservative shift in the US Supreme Court, motivated by the "religious right," has resulted in the abolition, in many states, of women's rights to control their bodies through abortion. This restriction of the rights of all women is especially problematic in an increasingly secular US society where only a minority of the population supports banning abortions, even among the religiously observant.[25]

Although working with religious institutions at national level has been key to global efforts to end the AIDS epidemic,[26] some faith communities generated complex inter-related influences in the global HIV response. Advocacy from evangelical protestant leaders in the US was influential in building political support for the passage of PEPFAR, but their support was secured partly by championing HIV prevention programmes that prioritised abstinence-only messages over wider, evidence based preventive measures.[27] Funding for abstinence-only approaches had the unintended consequence of providing financial support to some faith based organisations in countries such as Uganda, Tanzania, and Nigeria where leaders later worked to pass strict legal prohibitions on homosexuality that contributed to violence against LGBTQ communities.[27] In short, disentangling the varied influences of religion in relation to HIV—both positive and negative—is challenging but necessary. In HIV and other public health challenges, much public health "good" may come with complications and even harm; these effects cannot be promoted or prevented without engagement.

Relationships based on respect

In any society, religion is embedded in all factors that affect health at individual, organisational, and national levels. Whether religion is a positive or negative contributor to health depends on its expressions. Initiatives such as PEPFAR, the Global Fund,[11] and the Thriving Together response to covid-19 now adopted by several US federal agencies[28] have recognised that religious actors and faith communities often fill 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 remains important in daily public and private life. Health beliefs are constructed by individuals and populations from positive norms and values, and not simply from an ignorance of science.[5] Public health practitioners' respect for communities' religious beliefs and practices is particularly crucial in acute emergencies and crises.

Public health workers need to have humility and respect for the views of local communities, including faith communities. The conviction that "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 for each party, their different forms of power, and their relevant insights about health.[17] Although the conflicts between religious and public health actors can seem —or even be—intractable, public health practitioners can work alongside religious institutions to support positive health outcomes within and across social contexts. Finding common ground for action for

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the public good may take vision and patience, and engagement and partnership between health and religious institutions may not always be successful. However, when trust is built iteratively over time, it can lead to mutually beneficial relationships and engender working partnerships.[15]

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 mutually beneficial solutions. The multivalent effects of religion on health can be harmful or protective, but religion is likely to 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. The aims of public health institutions and religious institutions are alike in that they strive to improve the quality of life for their members. They are mission driven. Their specific missions may diverge but they can also converge, and will do so if the two sincerely engage with each other.

Key messages

- Research shows that, at the individual level, religious participation is a protective social factor for multiple health outcomes, including all-cause mortality
- Faith based institutions often partner successfully with public health agencies to prevent disease and promote health
- Religious groups can also foster adverse public health outcomes by promoting stigma and influencing policies that are not shared in religiously diverse societies
- Partnerships between faith based and public health actors are critical to reducing tension and creating mutually beneficial approaches

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