Why religion and spirituality matter for public health — evidence, implications, and resources, ed. Doug Oman, Springer, 2018

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A little over a decade ago, I found myself sitting in a lecture hall as part of a course simply called AIDS: Public Health Implications. I had enrolled in it as a part of an interdisciplinary fellowship year during my doctoral studies in religion. For two semesters, I had the opportunity to sit in on the global health conversation as conducted within the professional education of future public health practitioners.

The course covered the virology, epidemiology, and history of the AIDS epidemic and was co-taught by one of the foremost medical researchers in the field and a respected social epidemiologist, both of whom had significant field experience in sub-Saharan Africa. This particular night, however, featured a guest speaker, an Atlanta community member who was HIV positive. He had contracted the virus as a young, gay man in rural Georgia. Raised in a devout Christian community, he experienced HIV as a punishment for his sins as a homosexual. Already marginalized by his identity as a gay man, his status as HIV positive made reconciliation with his faith community and his family impossible.

His story of alienation and pain has become for many in the public health community the conventional wisdom about the relationship between Christianity and AIDS in America. Christianity, according to this line of thinking, served as a cultural barrier to effective AIDS education, prevention, and treatment. No effort was made that night or any other night during the course to offer a counter-narrative about the involvement of Christian communities in AIDS hospice care or the efforts of global Christian communions to combat stigma and discrimination against persons living with HIV and AIDS. As he spoke to the lecture hall full of aspiring public health professionals, I was cognizant that this may be the most personal story they will hear about Christianity and AIDS — in effect, a testimonial.

A decade later, I can't help but wonder how that evening, that whole course, might have been different if Doug Oman's edited volume had been available. The volume is, arguably, the most comprehensive effort to date to provide public health students, faculty, and professionals with the empirical tools to understand religion and spirituality (R/S) as an underappreciated but essential dimension of not only individual health behavior and outcomes, but also population health dynamics. The volume reads, to borrow from the language of theology, as a kind of empirical apologetic. Part one covers exhaustively the evidence base for religion and spirituality as a causative and not merely correlative factor for many group-level phenomena affecting population health. Individually, many of the chapters in part one marshal evidence for established subfields within public health such as environmental health, infectious disease, and nutrition. Taken together with the broader state-of-the-field reviews that bookend part one, these chapters attempt both to firmly establish and to move beyond what is often

referred to as the "generic model" of causal effects of religion and spirituality on individual health.

The generic model conceptualizes religious beliefs, practices, etc. as primary inputs that are then mediated by the more conventional determinants of health including health behaviors, social connections, and mental health. For example, the generic model suggests that to understand (and ultimately work with) what determines the physical health of a Seventh Day Adventist who abstains from alcohol and meat consumption (health behaviors), one needs to acknowledge and account for the role of religious beliefs in shaping those particular health behaviors. To establish and expand the generic model, Oman relies on a remarkable range of empirical evidence, much of which has emerged in the past two decades.

Many of the chapters in part one are authored or co-authored by Oman, though the later parts of the book draw on a wider variety of voices. Part one is essentially a report out of the findings from two large Templeton funded research studies Oman directed as a faculty at the University of California-Berkeley. Oman is also upfront about his indebtedness to the seminal work done by Harold Koenig in the *Handbook of Religion and Health*[1] as a well as the complementarity of works such as Ellen Idler's recent edited volume, *Religion as a Social Determinant of Health*.[2] The latter is the culmination of much of the work profiled in the chapter on Emory University's religion and public health initiatives, many of which I had the privilege of participating while a graduate student.

This range and, importantly for Oman, the credibility of religion as a causal factor, are made possible by the growing number of meta-analysis and meta-synthesis articles that place the burden of proof on the skeptics. In the chapter, "Weighing the Evidence: What Is Revealed by 100+ Meta-Analyses and Systematic Reviews," a title indicative of both part one's primary methodology and, perhaps, suggestive of his empirical apologetic, Oman asks "Can anyone sincerely maintain that religion and spirituality are entirely non-causal epiphenomenal byproducts of other variables"? (p. 278)

The need for a volume like this arises precisely from the persistence of sincerely held doubts (or, at minimum, unexamined biases) among public health professionals and faculty about the relevance of religion and spirituality to their work. Whether we employ sweeping language like the (re)turn to religion or the more subdued frame of a heightened sensitivity to interdiscplinary academic discourse, professional practice, and participation in a democracy defined by pluralism requires in the early 21st century a basic level of religious literacy. Public health, according to Oman, has been late to the party, and this volume serves as a way to catch public health folks up. The logic reads something like this: (1) religion remains an important aspect of how individuals and groups make sense of the threats to and potential for human flourishing and (2) religious entities (e.g., churches) persist as potential and actualized assets in communities — especially vulnerable communities — that affect health behaviors, access to health resources, etc. of members and non-members (e.g., through health screenings hosted at a church). Therefore, public health professionals cannot ignore religion in their efforts to improve health at the population level.

This message is reinforced at the end of each chapter in the "Ideas for Application to Public Health Practice." Most of the ideas are introduced by the general exhortation "be aware." "Be aware and acknowledge that religious communities are often among the most important respondents to disasters." Or, "Be aware that religious communities are perhaps the largest source of 'social capital' in the US." The body of the chapters serves, then, as the reference point one can reach for to confirm that, "yes, in fact, I am now aware," and as the starting point for helping others (read: public health students) become aware. I must admit these exhortations fell flat in most cases, adding little value to the chapters and, ironically, reinforcing an overly simplistic, yet

persistent trope in public health campaigns: knowledge equals behavior change.

The second half of the book (parts two, three, and four) show what this awareness can lead to in terms of both professional practice (part two) and academic public health education (part three). The examples from part three are drawn from curricular and co-curricular initiatives at highly respected universities. They read largely as report outs, documenting the uniqueness of their respective programming. As such, they are likely to prove most useful for universities looking for, on the one hand, ideas of how to begin integrating religion and spirituality into their curriculum, and, on the other hand, a barometer to gauge the degree to which this integration makes sense in their particular context. The take away from these seems to be that more could be done to integrate R/S more thoroughly, even in settings where, historically, institutional support for religion and public health dialogue is strong.

Part four includes two brief chapters, the first of which may be of particular interest here given its global perspective. Co-authored by Liz Grant and Oman, it is the only chapter to set the religion and health conversation explicitly within this wider frame, a limitation Oman identifies upfront in the introduction. This limitation is articulated as largely the result of insufficient empirical data on religion and health outside the U.S. The evidence in this chapter is offered as snapshots of religion and public health in low income settings, with sub-Saharan Africa as the primary point of reference. The chapter's concluding remark is a fitting reminder of the volume's primary aim, even as it gave me pause to consider what gets lost when working so hard to translate R/S value into particular type evidence recognized by contemporary public health: "The shared trajectory of religion and public health is as old as their co-presence on the planet, although this collaborative trajectory is increasingly available in new modern forms, and is increasingly informed by empirical evidence." (p. 460)

The global chapter and two chapters in part two offer a more compelling answer to the question in the book's title: Why religion and spirituality matter for public health. As someone whose introduction to global health came through primary training in Christian ethics and the work of a global religion and public health collaborative that included Grant and the co-authors of a chapter in part two, I am not the audience for part one; I am already convinced that R/S matters for public health (as I suspect are many readers of this journal). But the reason I am convinced is due only in part to empirical evidence generated by the various methodological tools favored increasingly in the social sciences. In part two, we see more clearly that the real value of R/S to public health emerges in transdisciplinary spaces made possible when the phenomenon of human being and flourishing are conceptualized in holistic terms like healthworlds rather than as the aggregation of relationships between independent and dependent variables.

For example, Nancy Epstein's chapter in part two takes as its orienting frame socio-ecology, emphasizing the "dynamic interrelations of individual, social, and environmental factors." Epstein makes clear that "public health and religious communities share a number of important prevailing values and commitments, particularly with regard to promoting peace, health, and well-being, social justice, and addressing social determinants of health." (p. 308) This claim is rooted in the practical wisdom she has gained from years as a rabbi and community health worker, labels that one suspects are not so neatly delineated in her sense of self and vocation. And this last point is what likely accounts for my concerns about the evidence base privileged in part one.

To be sure, the emphasis on empirical evidence in charting pathways for both perceiving and partnering with the health assets of R/S entities remains critical, a point underscored in the chapter by Teresa Cutts and Gary Gunderson, "Implications for Public Health Systems and Clinical Practitioners:

Strengths of Congregations, Religious Health Assets, and Leading Causes of Life." The three frameworks signaled in the chapter subtitle reflect Gunderson's primary areas of research (and practice) over the past several decades. But as with Epstein, the case studies Gunderson and Cutts highlight suggest that practical, salutogenic efforts to respond to the complex, dynamic relationships between public health and R/S often emerge in places where empirical evidence, practical wisdom, and the religious imagination are all valued as informing, and even transforming, one another. One suspects, if the part two chapters are representative, that these are all places where the insights are made possible by the relationships not only among these three ways of knowing, but more importantly the relationships cultivated among the knowers, that is, the people working together to address community health.

The volume trades, for the most part, on the assumption that religion and spirituality are best understood as one among many factors that contribute to population health in ways we can isolate and measure to determine the strength of correlation and the direction, if any, of causation. But is R/S just another type of information that can be shoehorned into an existing framework for understanding health? Or can religion and conceptual frameworks within religion help public health understand (and act in) the world in which it finds its meaning, purpose, and authority? Perhaps, it is unfair to expect these questions to be addressed in a volume so explicitly focused on marshalling an empirical evidence base from within the epistemological and discursive structures of public health. A strategy of immanent critique, or critique from within, that I am sympathetic to and which, in the end, may prove to be more effective in convincing skeptics of why R/S should be included in public health curricula. But I am left to wonder whether the value of R/S, that is, why it matters, can really be assessed confidently if public health encounters R/S as an object of study rather than as a co-participant in conceptualizing and actualizing the conditions necessary for human flourishing?

There are moments throughout the volume in which this conspicuous absence makes itself known, though often more by implication. In part three, for example, the report out from Harvard on their "Initiative on Health, Religion, and Spirituality," includes a recognition that "[w]hile the Initiative has brought many faculty together from Harvard's school of Public Health, Medical School, and affiliated hospitals, further work is needed to integrate with ongoing research and teaching carried out by faculty at the Divinity School, the School of Arts and Sciences, and elsewhere at Harvard." (pp. 380-81) How would this work look different if faculty with deep knowledge of and experience in the formative education of religious leaders (i.e., the Divinity School faculty) were more fully integrated into the conversation about why R/S matters?

A decade after sitting in that lecture hall listening to the testimonial about how religious communities can amplify the devastating effects of HIV/AIDS — no less a part of the story of why religion matters to public health than its salutogenic effects — I am left to wonder how the follow-up classes might have looked had perspectives from religious practitioners and the faculty of theology been included. The absence of any follow-up conversations, let alone the voices of those whose commitments to public health stem from their religious commitments, left the hundred or so aspiring public health professionals in that lecture hall with few, if any, resources for developing a nuanced understanding of R/S and public health. (As the chapter "Religion and Public Health at Emory" points out, there did exist and continues to exist a course on Faith and Health at that time, though enrollment for this course has historically been driven by theology students. Since that time, a course on HIV/AIDS and religion has been developed as well a dual degree MPH/MDiv program.) But, it did imply the type of causal relationship Oman's volume is intent on

demonstrating through empirical research, and therein lies the danger.

It may very well be that MPH faculty cognizant of a more sophisticated model of R/S as a causal factor in public health would have been in a better position to offer their students additional context for understanding this one man's testimonial. It is important to note that these students' own religious beliefs are not simply checked at the door to the lecture hall. And Oman's surveys of MPH deans and students suggest a willingness, albeit variable, to consider options for integrating R/S more intentionally in their curricula. There is no question that the empirical evidence for the impact of R/S has expanded, even as Oman dutifully shows it to be mixed and not always grounded appropriately in the methodological standards demanded in the empirical sciences. As such, the volume serves notice to public health faculty and professionals that R/S can no longer be dismissed as beyond the scope of practice or as insubstantial as a body of research relevant to professional formation in public health or as too fraught to engage or . . . the list of potential reasons for excluding is likely long.

The publication of this volume refutes the de facto exclusion of R/S among many of those responsible for creating the policies and implementing the practices for protecting the health of the public. I just hope that in the quest for demonstrating theoretical cogency and empirical causality, we do not lose sight of the myriad ways in which the complexity of the religious mind and the capacity of the religious imagination persistently call into question existing paradigms and the dominant epistemologies that sustain them.[3]

References

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Submitted 1 June 2020, accepted 11 June 2020, published 29 June 2020

Competing Interests: None declared.

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Cite this article as: Bersagel Braley MT. Why religion and spirituality matter for public health — evidence, implications, and resources, ed. Doug Oman, Springer, 2018. Christ J for Global Health. June 2020; 7(2):159-163. https://doi.org/10.15566/cjgh.v7i2.399