# Chapter 15
# Implications for Public Health

With few exceptions, Islamic beliefs and practices are associated with better mental health, including less depression, lower anxiety, less substance abuse, greater well-being, and higher life satisfaction. They are likewise associated with better social health, such as more social support, greater marital stability, and less delinquency or crime. Several positive health behaviors, including less cigarette smoking and more conservative sexual practices, are more common among Muslims who are more religious. Finally, Islamic beliefs and practices are related to better physical health, such as less heart disease, lower blood pressure and, in some studies, less cognitive impairment and lower mortality.

Should future research confirm and extend these health benefits of religious practice, such findings will have important implications for Islamic societies—serious implications that bear on the future health and productivity of many Muslim-majority countries. We now speculate on what these implications might be at the population level.

## Positive Implications

The findings presented in this book should be encouraging to those who devoutly adhere to Islamic beliefs and practices and should affirm what people have instinctively known and passed down from generation to generation over literally thousands of years. Furthermore, the research reviewed here and research in the future may help to identify spiritual interventions that complement conventional treatments in medicine and psychology. The result could be more effective and more cost-efficient healthcare that addresses the needs of the mind, body, and spirit, with benefits for both patients and healthcare providers. This research may also provide important information for those who are religious but not devout practitioners of the Islamic faith, who may value and respect the latest findings from scientific studies, studies that seek to objectively examine these relationships. Such individuals may

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be striving to live fuller, more satisfying and meaningful lives and are open to new ideas and direction. This research may even be relevant to those who are completely secular causing them to pause and reconsider whether religion really has no value or place in society. If the research accomplishes any of these goals, then an important result may be that sacred traditions are maintained and societies flourish as the advances of modern medicine add to (rather than replace) the rich cultural and religious heritage that Islamic societies now possess.

## Negative Implications

If these research findings are ignored and not followed up on by future studies that examine the health benefits and risks of devout Islamic belief and practice, then this too may have consequences. The relatively young Islamic societies in the world today will continue to age over time, with each generation of youth living longer than the previous generation as medical care and public health measures improve. This means that many young Muslims today could live well into their 70s and 80s and will have to deal with age-related illnesses that cause increasing disability and loss of independence. Secular trends, as occurring in Europe and the West, will also likely influence Islamic societies over the ensuing decades. Increasing secularization means that the potentially "protective" effects of Islamic beliefs and practices on psychological, social, behavioral, and physical health may gradually decrease as the populace takes on modern values and beliefs. If—as we have found—religious beliefs and practices preserve health and enhance the flourishing of Islamic societies, then their decline and loss of influence may have the opposite effect: increasing drug/alcohol use and abuse, delinquency and crime, marital instability, sexually transmitted diseases, and less self-care and self-control resulting in more chronic illness. One might easily imagine increased costs needed to maintain social order (previously provided naturally by religious values and commitments). Likewise, increased costs might result from the need to provide healthcare to an aging chronically ill population suffering the consequences of smoking, drinking, drug dependence, a sedentary slovenly lifestyle, sexual promiscuity, and other unhealthy behaviors that religious traditions have long discouraged.

Healthcare costs could also be affected by an increasing number of older adults being single and without family support due to broken marital relationships, as increasingly now seen in the West, where the two-parent family is becoming less and less the norm. According to the National Marriage Project (2012), in 2011 less than two-thirds of children in the USA had two parents living with them in the same household (compared to 85 % in 1960). Similarly, over 40 % of babies were born out of wedlock (compared to 5 % in 1960). Finally, only about 50 % of adults aged 15 or older were married (compared to closer to 70 % in 1960), and most couples are now choosing to have only one or two children. In Europe, according to Eurostat (2013), extramarital births now account for the majority of live births in Estonia (58 %), Slovenia (57 %), Norway (57 %), Sweden (54 %), France (56 %), and Iceland (65 %). Single-parent homes often result in the government having to

pay for the care these children need through expensive social service programs. It is no secret that European countries are now experiencing serious financial problems as they attempt to support aging populations in an increasingly secular society.

Economic resources will have to come from somewhere to provide social control (pay for more police, build more prisons), pay for healthcare of the chronically ill, and support children and their single-parent caregivers. Most likely, these financial resources will be diverted from budgets for defense, research and development, and other key government programs necessary to keep a nation strong and competitive in the world marketplace. None of these pressures will come on suddenly, but rather will build up slowly over time as absolute moral values are replaced by relative values and as religiously conservative lifestyles are replaced by liberal lifestyles with few limitations or boundaries. Islamic countries should prepare for this if they allow the slow decline of sacred religious traditions that for centuries have held the social fabric of society intact.

The above considerations should cause pause for thought, if not incentive for the populations (and governments) of Muslim countries to make efforts now to preserve their Islamic beliefs, practices, and values and continue to instill them in their youth from an early age onward. Otherwise, where will the motivation come from to care for the poor, the elderly, and those less fortunate? Sacrificing one's own pleasures for the benefit of others does not come naturally and is difficult to legislate, especially when survival of the fittest is the primary rule that guides a people. Modernization does not always mean progress, particularly when the underlying moral and value structures of a society are the victims of such change.

## Faith-Based Initiatives

Instead of allowing secular influences to dominate society and consume human and economic resources, why not utilize religious organizations to prevent illness and build social capital? Faced with rising crime and drug and alcohol abuse, deteriorating neighborhoods, and escalating costs of healthcare, the US government has now begun to use faith communities to improve social control, prevent disease, and reduce healthcare costs. Such programs could easily be developed in Muslim countries as well. With the opening of the Office of Faith-Based and Neighborhood Partnerships, originally established in 2001, the US government has begun to provide modest support for efforts by faith communities to provide social services and develop health programs. Although some have objected to this program, the aims of such partnership make perfect sense—to harness the power of faith communities to help maintain the health of members; to decrease rates of crime, delinquency, and drug use in surrounding communities; and to reduce health disparities between racial and ethnic groups (Sager 2010). Here are five examples of faith-based programs described in the literature that are relevant to the health problems that many Muslims struggle with:

1. *Weight Loss*. A faith-based program, called the Baltimore Church High Blood Pressure Program, was initiated over 20 years ago to help women control their

weight and reduce blood pressure (Kumanyika and Charleston 1992). In that program, 188 female church members participated in 8 weekly 2-h counseling and exercise sessions. Before and after measurements of weight and blood pressure were taken. Results indicated that women lost an average of 6 lb. Furthermore, those who were taking antihypertensive medication dropped their mean systolic/diastolic blood pressure by 10/6 mmHg, and those not needing antihypertensive medication decreased their average systolic/diastolic pressures by 5/3 mmHg ($p < 0.001$ for pre–post comparisons). As a result of the program, 74 % of women had a final systolic blood pressure that was under 140 mmHg (compared to 52 % initially), and 92 % had a diastolic blood pressure that was under 90 mmHg (compared to 65 % initially). On 6-month follow-up of 74 participants in the original sample, 65 % maintained or exceeded the weight loss achieved while in the program. Faith aspects were vital to the success of the program. Not only were all sessions held in church, but because participants were members of the same church involved in choir rehearsal, prayer, and Sunday services, fellow church members provided spiritual support to help each other exercise and lose weight.

2. *Breast Cancer Screening*. Many Muslm women do not adhere to breast cancer screening guidelines, resulting in preventable morbidity and mortality. After a brief period of training, members of churches in Los Angeles County conducted telephone peer counseling to encourage women in their churches to obtain mammograms for breast cancer detection (Duan et al. 2000). A clinical trial format was used to test the effectiveness of this telephone counseling program in 437 women. Thirty churches were randomized either to the telephone counseling or to a control group that received no counseling. Follow-up 1 year later revealed that mammography nonadherence was reduced from 23 to 16 % in those who received the telephone counseling. Researchers concluded that "partnerships between the public health and faith communities" were effective for maintaining and increasing cancer screening. Other educational programs in churches have reported even greater increases in mammography screening, especially in rural areas (one such study achieving a 38 % increase in screening) (Powell et al. 2005).

3. *Smoking Reduction in Youth*. Churches and other faith-based organizations in Mississippi implemented a program titled Students Working Against Tobacco to prevent students from taking up cigarette smoking (Reinert et al. 2003). This involved a partnership between faith-based groups, the community, and public schools. Churches were responsible for conducting five education sessions on tobacco use prevention to groups involving 35–50 youth each. These were specifically targeted at children in grades 4 through 7. Although the effectiveness of the program was not assessed, a published report describes how the program worked in two churches and makes recommendations on how to design future faith-based programs to address youth smoking.

4. *Improve Nutrition, Increase Exercise*. A faith-based Internet-based program called Guide to Health was administered in churches with the goal of improving nutrition by decreasing dietary fat; increasing dietary fiber, fruits, and vegetables; and increasing exercise (measured by steps taken per day using a pedometer)

(Winett et al. 2007). The program was conducted in 14 churches in the Virginia area. Assessments (questionnaires, along with weight and height measurements) were conducted in the churches at baseline and follow-up. Besides health education, participants received support in church to boost the effects of the intervention, including prompts and reminders from their ministers, posters throughout the churches, and a competition between participating churches. Some churches increased motivation by giving award badges to those meeting their step count and nutrition goals for the week. Results indicated that participants in the program significantly increased fruit, vegetable, and fiber intake, level of exercise, and amount of weight lost, compared to the control group.

5. *Diabetes Prevention*. This report describes the development, implementation, and results of a 16-session diabetes prevention program conducted over 4 months in a rural African-American church in Georgia (Boltri et al. 2008). Those in the church at high risk for diabetes ($n = 26$) were identified through screening and then recruited into the program. This program was administered at the church in a group format and focused on nutrition, physical activity, and behavior change. Participants were assessed at baseline and followed up at 4, 6, and 12 months. Those involved in the program experienced a significant reduction in weight, blood pressure, and fasting blood sugar.

Other faith-based programs have been developed to increase prostate cancer screening, support families of those with chronic mental illness, complete advanced directives (instructions on what medical care they wish to have when they are dying and unable to respond), improve adult vaccination, increase seat belt use, and treat cocaine dependency (Koenig et al. 2012). All of these faith-based programs were conducted in the USA and involved Christian churches. The principles and lessons learned in the development and implementation of these programs could help guide Muslim communities who may wish to develop similar programs. Of course, programs like these will have to be designed to fit the particular needs and circumstances of Muslims within their specific religious and cultural environments. The great promise of faith-based programs, however, is that they may help to prevent disease and thereby reduce healthcare costs for hard-to-reach groups with less access to healthcare resources and education.

## Implications for Muslim–Christian Relations

Based on a comprehensive and systematic review of the scientific literature, we have found that, in general, greater religious involvement is related to better mental health, better social health, and better physical health in both Christian and Muslim populations. These research findings also have implications for the relationship between Muslim and Christian societies. If devout beliefs and practices in each of these faith traditions lead to better health and greater human flourishing, then this should give us a clue about the intentions of a perfect, merciful, and unimaginably good God with regard to Muslim–Christian relations.

For the past millennium, but especially the past 25 years, animosity has been widespread between Muslims and Christians in many parts of the world. Consider the conflicts today in Nigeria, Egypt, Lebanon, and Kenya, to name just a few examples, not to mention the burning of mosques in New York City and Missouri or the Qur'an burnings in Florida. Many Christians view the terrorist attacks on the World Trade Centers and on the US Pentagon that occurred September 11, 2001, as an attack on Christianity, whereas many Muslims view the US interventions in Iraq and Afghanistan and efforts to help Israel as a direct attack on Islam. There are fundamental differences in belief between Christians and Muslims that cannot be reconciled. These create conflict and are often used to justify war and terrorism.

Nevertheless, there are also many areas of the world where Muslims and Christians live peacefully side by side as warm neighbors who cooperate and support one another. For example, prior to the American invasion of Iraq, it was not uncommon to see Muslims praying in Christian churches and Christians praying in mosques (Anderson 2011). Likewise, consider the Russian republic of Tatarstan, where Muslims, Orthodox Christians, and Roman Catholics live together in harmony respecting each other's traditions (Kishkovsky 2008). Until recent times, Christians and Muslims also lived together without conflict in Lebanon (Khoury 2010) (as well as in Nigeria and Ethiopia). There continue to be efforts around the world today to return to such peaceful coexistence. Consider that Muslims in the Dallas/Fort Worth area are going out of their way to invite Christians to visit their mosques, attend post-Ramadan fast dinners, and engage in real dialogue (Hunt 2010). These are just a few examples of Muslims and Christians living together and making efforts to get to know one another. No doubt, there are many other examples that we are not aware of.

How can such efforts be justified? While there may be irreconcilable differences between Muslims and Christians, there are also plenty of similarities, especially among devout adherents (see Chap. 5). Indeed, it is the Qur'an that says that Christians and Muslims are the closest of all religions:

> "You [Prophet] are sure to find that…the closest in affection towards the believers are those who say, 'We are Christians,' for there are among them people devoted to learning and ascetics. These people are not given to arrogance, and when they listen to what has been sent down to the Messenger, you will see their eyes overflowing with tears because they recognize the Truth [in it]. They say, 'Our Lord, we believe, so count us amongst the witnesses. Why should we not believe in God and in the Truth that has come down to us, when we long for our Lord to include us in the company of the righteous. For saying this, God has rewarded them with Gardens graced with flowing streams, and there they will stay: that is the reward of those who do good" (5:82–85).

We think that Jesus would have totally agreed. There are over 1,600 million Muslims and over 2,100 million Christians who now live on our planet. Together, Muslims and Christians make up over 50 % of the world's population. Although each religion would like to convert the other to its own belief system, the fact is that most Muslims alive today are going to die Muslim and most Christians alive today are going to die Christian. From a theological standpoint, it would seem to us (a devout Muslim and a devout Christian) that God must have a plan for both Muslims and Christians, and that plan does not include sending one group en masse to hell for all

eternity. There are verses in both the Bible and the Qur'an backing up this statement (see Chap. 5). If that is true, then there are going to be a lot of Muslims and Christians in heaven, where Somebody is going to force us to get along as brothers and sisters. It would seem wise, then, for us to start trying now.

The scientific world is a great place to begin this effort. Muslim and Christian researchers almost always attend the same national meetings in their scientific fields. The research world encourages objective examination, without the inflaming rhetoric characteristic of politicians, unscrupulous religious leaders, news agencies, or radical groups with their own agendas that are seldom consistent with the fundamental teachings of either the Qur'an or the Bible. Scientific progress necessitates cooperation and dialogue so that new ideas can build one upon the other. This type of cooperation was nowhere more evident than in the Islamic Golden Age, when Islamic scientists translated Greek and Roman texts into Arabic and made their own original discoveries that were later translated into Latin and English. Likewise, this was a time when Christian physicians treated Muslim caliphs and Christian chapels were widely present in Muslim hospitals. We believe that there can be another Golden Age in the future, a Golden Age of Muslim–Christian cooperation, which could lead to an explosion in knowledge and scientific advancement, rather than to the other kind of explosions we are seeing today that have the potential to destroy our world and end life as we know it.

## Summary and Conclusions

The implications of the research findings for public health are vast. If acknowledged and responded to positively, then sacred Islamic beliefs and traditions will be supported and will continue to exert positive influences on health, complementing advances made by modern medicine and healthcare. Likewise, if Muslims–Christian relationships improve with increasing recognition of the many similarities in beliefs, practices, and values that bond these two faith traditions together, this may stimulate cooperation between government and religious leaders, social scientists, and medical researchers in efforts to maximize individual and community health. Alternatively, if this research is ignored, then this too will have consequences. A "perfect storm" is now brewing, as several sociodemographic and cultural trends are beginning to merge. The first is the aging of populations in Muslim-majority countries over the next 30 years, where many who would have otherwise died young will survive into later life because of advances in healthcare and public health measures. The second is the increasing burden of chronic illness that these aging populations will face. The third is a trend toward increasing secularization, as Islamic societies begin to modernize and take on more liberal worldviews toward traditional Islamic beliefs, practices, and values. As religious influences lessen, so too will their protective effects on mental, social, behavioral, and physical health. To compensate for this, additional resources for social control and healthcare services will have to be redirected away from defense, technology, and economic growth, affecting the security and stability of Islamic societies worldwide.

## References

Anderson, B. (2011, March 8). Iraq Muslims, Christians wish to live together in peace again. *National Catholic Reporter*. Retrieved October 5, 2013, from http://ncronline.org/news/global/iraqi-muslims-christians-wish-live-together-peace-again

Boltri, J. M., Davis-Smith, Y. M., Seale, J. P., Shellenberger, S., Okosun, I. S., & Cornelius, M. E. (2008). Diabetes prevention in a faith-based setting: Results of translational research. *Journal of Public Health Management & Practice, 14*(1), 29–32.

Duan, N., Fox, S. A., Derose, K. P., & Carson, S. (2000). Maintaining mammography adherence through telephone counseling in a church-based trial. *American Journal of Public Health, 90*(9), 1468–1471.

Eurostat (2013). European Social Statistics, 2013 edition. Eurostat European Commission (Luxembourg: Publications Office of the European Union). Retrieved October 5, 2013, from http://epp.eurostat.ec.europa.eu/portal/page/portal/product_details/publication?p_product_code=KS-FP-13-001

Hunt, R. A. (2010, August 17). Can Muslims and Christians live together in peace? *Patheos: Hosting the conversation on faith*. Retrieved October 5, 2013, from http://www.patheos.com/Resources/Additional-Resources/Can-Muslims-and-Christians-Live-Together-in-Peace.html

Khoury, Y. (2010, December 30). Who says Christians and Muslims can't live together? *The Guardian*. Retrieved October 5, 2013, from http://www.theguardian.com/commentisfree/belief/2010/dec/30/christians-muslims-can-live-together

Kishkovsky, S. (2008, November 28). Catholics, Orthodox, and Muslims live peacefully together in Tatarstan. *New York Times*. Retrieved October 5, 2013, from http://www.nytimes.com/2008/11/28/world/europe/28iht-kazan.4.18239617.html?pagewanted=all&_r=0

Koenig, H. G., King, D. E., & Carson, V. B. (2012). *Handbook of religion and health* (2nd ed., pp. 918–923). New York: Oxford University Press. see Appendix.

Kumanyika, S. K., & Charleston, J. B. (1992). Lose weight and win: A church-based weight loss program for blood pressure control among Black women. *Patient Education and Counseling, 19*, 19–32.

National Marriage Project (2012). *The State of our Unions, 2012: Marriage in America* (pp. 65, 94). Charlottesville, VA. Retrieved October 5, 2013, from http://nationalmarriageproject.org/reports/

Powell, M. E., Carter, V., Bonsi, E., Johnson, G., Williams, L., Taylor-Smith, L., et al. (2005). Increasing mammography screening among African American women in rural areas. *Journal of Health Care for the Poor and Underserved, 16*(4 Suppl A), 11–21.

Reinert, B., Campbell, C., Carver, V., & Range, L. M. (2003). Joys and tribulations of faith-based youth tobacco use prevention: A case study in Mississippi. *Health Promotion Practice, 4*(3), 228–235.

Sager, R. (2010). *Faith, politics, and power: The politics of faith-based initiatives*. New York: Oxford University Press.

Winett, R. A., Anderson, E. S., Wojcik, J. R., Winett, S. G., & Bowden, T. (2007). Guide to health: Nutrition and physical activity outcomes of a group-randomized trial of an Internet-based intervention in churches. *Annals of Behavioral Medicine, 33*(3), 251–261.