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**Temasektion**

# The role of religion in health promotion

## How the Danish health authorities use arguments from Islam

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Public Health; Public Policy; Health Authorities; Religious Arguments; Religious Freedom; Religion & Health; Islam & Health

**Abstract:** The starting point of this article is a debate that took place in Denmark in 2021, when the Danish Health Authority together with Islamic organizations produced a pamphlet on Covid-19 vaccination which contained answers to religious questions Muslims might have about the vaccine. The pamphlet was broadly condemned by Danish politicians. This article shows that this was far from the first time that the Danish health authorities have used or referred to specific interpretations of Islam. In this article, we investigate both how the Danish health authorities have used or considered Islam and the questions this raises regarding how to consider religion in relation to health. The article highlights the many different ways that health authorities might interact with Islam, including partnerships with imams and Islamic organizations, referencing religious rulings in information material, providing advice to Muslims on how to handle religious practices such as Ramadan in a healthy way, and adjusting health regulations to allow Muslims to practice their religion. Based on these examples, the article presents insights regarding the dynamics of which health authorities have to be aware when attempting to interact with religion, and the key considerations to have in mind when religion and health interact in society.

As part of its efforts during the Covid-19 pandemic, the Danish Health Authority (Sundhedsstyrelsen, SST) decided to cooperate with seven Islamic organizations in creating a pamphlet titled "FAQs about Islam and vaccination against COVID-19", published on 5 May 2021 (Minhaj Ul-Quran International Denmark et al. 2021). Under the headline "Answers to questions about health", the first half of the pamphlet contained medical

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information, including information on whether the vaccines were safe, whether they affected fertility or DNA, and whether the vaccines contained fetal cells. The second half of the pamphlet had the title "Answers to religious questions", and contained information on whether the vaccines were halal, whether Muslims were religiously allowed to take a vaccination that could cause temporary illness, whether Muslims had a religious obligation to take the vaccine, and whether it was religiously allowed to take the vaccine during Ramadan. According to the pamphlet, the first half consisted of answers given by the SST, while the second half contained answers provided by the Islamic organizations but with the SST contributing professional knowledge to the answers.

The pamphlet was not well received in the Danish media and among Danish politicians. The vaccine pamphlet led to the parliament questioning the Minister of Health, who ultimately informed the SST that he considered the pamphlet to be a mistake. In answer to the parliament, the minister said that in his view the expertise of government agencies should not be entangled in religious arguments and that the pamphlet was in a grey area since it could be seen as mixing health professionalism with religion (Sundhedsudvalget 2021a). Despite this criticism, an employee of the SST stated in an interview that the SST would do the same again, and also for other religions, when a health problem had its roots in theology (Christoffersen 2021).

Internationally, numerous health campaigns have involved religious actors or religious arguments, and the public health literature extensively discusses how health campaigns can involve religion and whether a willingness to engage with religious arguments is a necessary element of health professionalism. As this article shows, there have also been several examples of the Danish health authorities, especially the SST, involving Islam and/or Islamic organizations in health campaigns.

Based on and inspired by this context, this article investigates how the Danish health authorities have used or considered Islam in their efforts and communication. First, we briefly touch upon public health theory and introduce some of the existing literature on the interplay between religion and health. Following this, we engage with this theory through examples of how the Danish health authorities have previously interacted with Islam. We use these examples and the theory to provide guidan-

ce on some important questions to consider before implementing health initiatives involving religion, and to discuss the extent to which religion can and should be considered in such interactions. It should be noted that we have not investigated which considerations the Danish health authorities have already had when planning these initiatives, so we fully recognize that they might already have considered some of these issues. However, the considerations we raise are meant as broad recommendations also to other health authorities, as well as for academic researchers.

We only investigate the already publicly available information on the Danish health authorities' use of Islam. Certainly, more knowledge could have been gathered through extensive requests for public access to internal documentation from authorities, but our aim was not to draw attention to any unknown initiatives, but, rather, to focus on the fact that the Danish Health Authorities have for many years openly been including Islam in their health initiatives. For the same reason, we have deliberately searched for examples of earlier initiatives in the database of the Danish Parliament to identify initiatives about which Danish politicians have been directly informed. We have also searched in professional journals, for example, those for nurses, and on websites of the Danish health authorities. In this article, we include all the examples of campaigns and initiatives where the Danish health authorities have involved Islam of which we have become aware.

After discussing the various types of initiatives the Danish health authorities have previously implemented and the considerations raised by these, we briefly look at other practical situations where health personnel might have to interact with religion, but here we have not included all possible examples of this. Finally, we return to the specific efforts made during the Covid-19 pandemic and present our conclusions.

## In light of public health theory

In 1988, Acheson defined public health as "the science and art of preventing disease, prolonging life and promoting health through the organized efforts of society" (Marks, Hunter, and Alderslade 2011). Public health practice is thus concerned with

assessing health problems, promoting policies to improve health and protect populations, and ensuring that there are resources to meet public health needs (Idler 2014). To fulfill such functions, public health practitioners and researchers continuously aim to understand what determines disease and the well-being of individuals and populations. Well-recognized determinants considered in research and practice include demographic characteristics, such as age and sex, and social determinants including living status and socio-economic status. For the role and function to be successful, it is crucial that all the determinants are understood, as well as the complex interaction between them.

However, a less recognized – and debated – (social) determinant is religion. Research in the field connecting religion and health dates back to the 1950s, with increasing interest and available empirical literature since then (VanderWeele 2017). In numerous studies, religion, religious attitudes, attendance at religious services, and overall spirituality have been proposed as important determinants for several health outcomes. Perhaps the strongest evidence in the existing literature is that on service attendance (partially due to data on this measure being the most available), which has been linked to reduced all-cause mortality but also several other health outcomes (e.g., depression and suicide) (VanderWeele 2017). Service attendance and other measures of religion have also been linked to lower blood pressure, better cardiovascular health, better immune function, and overall favorable subjective well-being (reviewed and summarized in VanderWeele 2017; Idler 2014; H. G. Koenig, King, and Carson 2012). There are also several reports in the literature on the negative associations of religion with health. For example, spiritual struggles have been associated with worse health (VanderWeele 2017). Religious beliefs have also been linked to delays in seeking healthcare and replacement of modern medicine and treatment (Chatters 2000).

It is important to note that all such findings warrant careful consideration. For example, research on health outcomes for religious groups (e.g., those who attend services) may be subject to several methodological issues known in public health research. These include research on selected populations, reverse causation, and issues of variation and validity in the measurement of the construct of religion. Further, several conceptual

issues may lead to confounding the observed links with external factors that are interlinked and perhaps misattributed to religion. For example, it could be that people with a certain lifestyle or with certain personality traits are both more likely to be healthy (or unhealthy) and more likely to be religious, without religion being the reason for their healthy lifestyle. Another issue, of course, is how to define religion, and what the concept encompasses. Such issues and others are widely acknowledged in this field of research. Several developed conceptual models that link health and religion recognize the multidimensionality of both; that is, several mechanisms are possible in these links, making the links difficult to understand (Chatters 2000).

There are a number of reasons why health promotion programs may need to consider religion. Religion may influence health behavior, and understanding health behavior is a key component for successful health promotion. Indeed, the most prevalent healthcare models used in health promotion practice all focus on describing and targeting behavioral factors, including perceptions, beliefs, and attitudes, to ensure the acquisition and maintenance of the health promotion program (Galloway 2003). In the 1950s, the U.S Public Health service observed a lack of participation in several health screening and prevention programs (particularly immunization programs) (Rosenstock 1974; Galloway 2003). As a result, one of the most prevalent models used today, the Health Belief Model, was developed. The model suggests that whether people take health-related action depends on – amongst other factors – their perceptions of benefits and/or harms from that action. These perceptions are determined by several factors, including socio-demographic factors such as ethnicity and age. Religion, religious beliefs, and/or spirituality similarly influence health beliefs (Kirn 1991).

Moreover, religion may influence people's needs. Promotion programs, theories, and models in their diversity all include as either the core or one of the key components a needs-assessment step. The following of one's religion or spirituality is a need in itself and following guidance and rules in a religion further defines individuals' other needs. These can range from their need for physicians who understand their religious views and norms, to nutritious needs such as kosher meals in a hospital setting, swine-free vaccines, and so on. Indeed, physicians are often met with such needs and must navigate them to provide

and maintain patient-centered care (Isaac, Hay, and Lubetkin 2016).

Another role of religion in the healthcare context is the action it prompts in a healthcare provider. For example, numerous studies have pointed out that women who wear concealing clothing are more likely to be vitamin D deficient (Ojah and Welch 2012). Therefore, a physician may be more likely to order a vitamin D-level test for a woman wearing such clothing for religious reasons. In clinical practice, physicians must be informed by clinical guidelines on whether or not vitamin D tests, for example, should be made on the patient. These clinical guidelines are informed by clinicians, public health efforts, and the responsible health authorities. This shows that regardless of whether physicians actively consider religion in practice, the healthcare system will inevitably have to interact with religious beliefs, or the results of these beliefs, such as clothing.

Finally, regardless of the direction of the links between religion/spirituality and health (i.e., positive or negative health outcomes), it is clear that religion is an important determinant of health and is a public health interest (VanderWeele 2017).

So how should religion be taken into account in health promotion? Internationally, several hospitals and other medical institutions have incorporated religion and/or spirituality to complement their treatment approaches (Chatters 2000). Moreover, many health promotion interventions have been made that either incorporate religion as part of the intervention approach in some way or take place at a religious institution, often referred to as "faith-based" and "faith-placed", respectively. Examples include interventions for smoking cessation, weight loss, and nutrition (VanderWeele 2017; Chatters 2000).

There are also several examples of established partnerships between health and religious institutions that aim to promote health (VanderWeele 2017). This is not surprising since, in a lot of cases, religious institutions possess some form of authority, power, and legitimacy among their community members and can be fruitful facilitators for the development and implementation of health promotion programs (Chatters 2000). However, such partnerships are not without tensions (VanderWeele 2017). In the following, we use examples from the Danish setting to discuss considerations regarding the involvement of religion in public health efforts.

## Earlier examples of Islam being used by the Danish health authorities

The political debate concerning the pamphlet on Covid-19 vaccines could give the impression that this was the first time the Danish health authorities have involved religion and religious organizations in their health campaigns, or at least that it was the first time they publicly did so in relation to Islam. However, this is not the case.

We describe the initiatives taken by the Danish health authorities under various headlines/topics, based on how the health authorities interacted with Islam. After presenting the relevant examples, we, under each headline, reflect on them and discuss the perspectives raised by each case. For each topic, our focus is on highlighting the relevant considerations for the health authorities to bear in mind when choosing to implement such initiatives, as well as issues of general importance.

### Partnerships with imams: the case of female genital mutilation

In Danish, the official term for female genital mutilation (FGM) literally translates as "female circumcision", but in this article the Danish term will be translated as FGM, since that is the common term in English (United Nations Population Fund 2022).

On 30 April 2000, the SST held an informational meeting in a conference room in the Danish Parliament's building. It was held in cooperation with an Islamic organization (Det Islamiske Forbund i Danmark) and was titled "Islam's view on women's rights and on female genital mutilation". The SST had sent an invitation directly to the parliament's Committee on Legal Affairs, which is still available on the parliament's website (Retsudvalget 2000). In the invitation, the SST explained that since 1997 it had been conducting an information campaign about female genital mutilation. According to the SST, to promote this effort further, it was:

> [N]ecessary to involve the imams in Denmark. The imams enjoy a lot of respect, and the possibilities for changing opinions, especially among the Somalis in Denmark, depend to a large degree on whether the

> imams take an active part in this information effort or not, and, among other things, on whether they are willing to bring the topic up in mosques. (Our translation of Retsudvalget 2000, 4)

The invitation further explained that the SST had already held a meeting with five Danish imams in 1997. The conclusion on this meeting by the imams had been (according to the SST, but the quote seems to have been taken from somewhere else) that:

> [I]nfibulation has no role in Islam. But Sunna has; or it is a discussion point, and something that we need to clarify with our religious leaders. (Our translation of Retsudvalget 2000, 4)

Thus, according to the SST, the aim of the larger informational meeting in 2000 was to follow up on this previous meeting. The SST described in the invitation that there was a need to discuss and clarify a number of topics at the meeting, including:

> Firstly, the question of Sunna's place in Islam which, among other things, includes the question of how the Hadith collections should be interpreted in connection with female genital mutilation. Other than this, the meeting should serve to clarify that regardless of the view on Sunna the Imams might have, all forms of female genital mutilation are forbidden in Denmark. The Imams should therefore be helpful in spreading the fact that female genital mutilation in all forms is punishable, and that there are often very serious health risks and problems connected with female genital mutilation. (Our translation of Retsudvalget 2000, 4)

As can be seen, the SST was at this point deeply involved in understanding, debating, and influencing quite detailed elements of Islamic theology and jurisprudence. Despite the original meeting in 1997 not having led to a clear statement on female genital mutilation from the imams, the SST had still referred to religious views in their informational material between 1997-2000. In 1999, SST published a book meant as a tool for municipalities to disseminate knowledge about female genital mutilation to relevant employees (Sundhedsstyrelsen 1999). In this book, the SST wrote that it would be beneficial if those who would be giving Somalis information about FGM knew

that it was not an Islamic duty and that Islam increasingly rejects the tradition. The SST also stated that employees in the municipalities should be educated in the task of giving such information (Sundhedsstyrelsen 1999, 21). The SST further wrote that, according to Islamic scholars, FGM was not mentioned anywhere in the Quran, and that this fact had also been included in an informational video produced by the SST in 1998 (Sundhedsstyrelsen 1999, 37).

At the meeting in 2000, one of the speakers was Mohamed Fuad El-Barazi, imam and chair of the Islamic organization that was co-organizing the event. According to news reports from the time, he cited Quran verses to show that men and women are equal in Islam and that women are not to be oppressed (Ritzau 2000). Another speaker was the then Danish Minister of Health, Sonja Mikkelsen. In her speech, she stated:

> I appeal to you. You have the possibility to go out in the mosques and inform people about the risks and consequences that are connected with female genital mutilation. It is very important that you do so. (Our translation of Ritzau 2000)

In sum, as we can see, the SST had a cooperation with Danish imams that dated back to 1997: they used information about Islamic rules to spread their own health-related messages, the Danish Minister of Health was involved in encouraging cooperation between imams and the SST, and all of this took place in the building of the Danish Parliament, with the full knowledge of the relevant parliamentary committee and with media reports on the meeting.

In 2005, the SST's effort proved successful when six Danish imams issued a fatwa stating that FGM should be avoided by Muslims. One of these imams, described in the media as the most prominent of them, was al-Barazi, who had spoken at the conference in 2000 (Kjølbye 2007). Two others were the Danish convert Abdul Wahid Petersen and Fatih Alev, who are both born in Denmark and who at the time were active in creating a "Danish Islam", but did not have a permanent mosque. Their involvement in this specific fatwa has been described as an early sign of them having achieved a good position in the wider Muslim community (Petersen 2019).

Officially, we have not found evidence that the SST was

directly involved in the creation of this fatwa. However, the fatwa is very directly a consequence of the process the SST initiated. The fatwa was issued in connection with a Nordic conference on FGM, which once again took place in the parliament's building, and was arranged by an NGO dedicated to the fight against FGM ("FMP – Foreningen mod pigeomskæring") (Næser, Viholt, and Cetti 2013, 33). While this is a private organization, it is open about being a direct result of the SST's efforts, and at least two of the primary members of the organization were also involved in the SST's campaign. The first chair of the organization had a Somali background and had been a member of the working group that created the previously mentioned book by the SST in 1999 (Ritzau 2002), and had also been one of the two people leading the meeting in 2000 (Retsudvalget 2000, 3). She has spoken openly about how she herself changed her views on FGM after her aunt told her that it was not mentioned in the Quran (Jespersen 2002). Another founding member of the NGO had previously been an SST employee and head of the SST's campaign which ended in 2000 (Aagaard 2002). The NGO has explained in its own material that it originally continued the efforts initiated by the SST, including contact with the imams (Næser, Viholt, and Cetti 2013, 33). Thus, at the very least, the SST's campaign created contact between a network of people who ultimately continued the SST's original ambition, leading to the creation of the fatwa.

Several questions regarding partnerships between religious organizations and health authorities could be raised in relation to this example and that of the Covid-19 vaccination pamphlet, both of which included close cooperation between the SST and imams. First and foremost, this campaign was based on the argument, as stated in the first quote above, that imams in Denmark have strong influence over the community, and can therefore change the opinions of other Danish Muslims. This is debatable. The Danish Muslim community has no central authorities and encompasses very diverse practices. This is highlighted in relation to issues of divorce, where it has been argued that challenges mainly arise out of power relations in local communities (Liversage and Petersen 2020, 8). Further, even in local communities, Muslims might not primarily seek their opinions from local imams, but instead from other local actors (family members etc.) or from international actors, online resources,

and so on. This raises the question of whether a campaign like this works at all. To our knowledge, it has not been investigated whether the fatwa or the cooperation with imams influenced individual Muslims' views and behavior, and neither have their perceptions of this cooperation. There is a need for more information on the extent to which cooperation with imams can influence perceptions in the Muslim community.

Regardless of whether such cooperation works or not, another important question to raise is whether acknowledging specific imams as partners gives them more authority and/or legitimacy in the eyes of the Muslim community. If that is the case, then that leads to several possible consequences. Although we do not know the likelihood of these consequences taking Ωplace, they are important to contemplate. The questions we raise should not be seen as a criticism of partnerships between health authorities and religious organizations but are instead meant to highlight the considerations that might be relevant to take into account in order to reach the full potential of such partnerships, the best positive outcomes, and sustainability in the long term.

**A)** Such cooperation, especially if done continuously, could permanently create new dynamics and structures in the Muslim community, whereby the imams participating in these partnerships would ultimately achieve a stronger position because they are seen as having the legitimacy of the Danish state. This could result in their gaining more attention from Muslims in regard to other issues as well. This could lead both to the Muslim community preferring these imams to those without such partnerships, and also to Muslims approaching them in connection with issues in which they would previously not have involved imams at all. For the Danish authorities, such changes in power dynamics should not necessarily be seen as a negative consequence, as it could also be a way to strengthen positive voices in the Muslim community. It is, however, important for the health authorities to keep in mind that the partnership might influence dynamics outside of the concrete issue with which the partnership deals.

**B)** Another important consequence to keep in mind is

whether parts of the Muslim community might feel excluded by the authorities' choices regarding whom to involve in the campaign. If the authorities continuously only involve imams from the Sunni Muslim community, for example, it might lead to the Shia Muslim community feeling excluded and ultimately reacting negatively to such partnerships. The same can be the case for different movements within the Sunni Muslim community. Further, Muslims that are not at all actively connected to mosques and imams might react negatively to the fact that the health authorities choose to approach Muslims specifically through imams. Thus, it is important always to consider carefully when planning such partnerships to be sure they involve all of the most relevant actors, while avoiding feelings of exclusion among other groups.

**C)** Further, because of the legitimacy that such partnerships might bestow on certain imams, it is also important for the health authorities to consider beforehand how they will react if the imams involved in such a partnership make statements that run counter to other aims the Danish authorities are trying to achieve. Is it necessary to create guidelines for which behavior and views are acceptable for imams entering into such a partnership? Should the Danish health authorities publicly react if an imam involved in a partnership makes statements about other issues, perhaps to make it clear that these other views are not legitimized by the authorities? This probably depends on the exact situation, but it is important for health authorities that choose to engage with religious views through partnerships to consider beforehand how to avoid being seen as legitimizing other religious views that their partners might be disseminating.

However, regardless of these concerns, this specific partnership also highlights an example of a topic where it is obvious why the health authorities would wish to involve imams. FGM can have dire consequences for the individuals involved. If religious views play a role in the prevalence of this practice, and if some individuals in society are actively spreading such views, then it

can be necessary for the health authorities to address such views and to provide an avenue for opposing religious understandings. If individuals feel a need for their actions to be in accordance with their religion, then the health authorities cannot just ignore this if they are trying to change such views.

## Finding out what Islam says: the case of health workers' clothing

Another interesting example of the need for the Danish health authorities to familiarize themselves with Islamic arguments on a topic relates to the clothes worn by health personnel in Denmark. In 2011, the SST produced a guide on what personnel in the health and nursing sector were allowed to wear (Sundhedsstyrelsen 2011). In the introduction, three general requirements were highlighted, one of which was that employees in contact with patients/citizens had to have short sleeves for hygiene reasons.

In 2014, this led to a major debate in the media and within the health sector when two Muslim employees were fired from Hvidovre Hospital after insisting on wearing clothes with long sleeves. One of these explained that she had contacted several imams to find out if she was allowed to wear short sleeves at work, but they had all informed her that she had to cover her arms to the wrist according to Islam (Okkels 2014).

In a reply to a question by a member of parliament, the SST stated that before producing their guide, they had been in contact with Mangfoldighedsnetværket ("The Plurality Network"), which the SST described as an organization consisting of health personnel with another ethnic background than Danish. According to the SST, this organization had informed them that wearing short sleeves was not prohibited according to Islam, which the SST had taken into account when producing the guide (Sundheds- og Forebyggelsesudvalget 2014). The SST revealed their correspondence with Mangfoldighedsnetværket, which showed that it was Özlem Cekic, a member of parliament but also the chair of Mangfoldighedsnetværket, who had given the SST this information on the rules in Islam. The SST had specifically asked whether Muslims would find it "far more acceptable" to have sleeves 5 cm below the elbow, as opposed to sleeves immediately above the elbow, since the SST would then consider making an exception for Muslims. However, the ques-

tion also revealed that if it was seen as unacceptable for Muslims not to cover the entire arm, then no exceptions would be made. Cekic had replied to this request as follows:

> Even in religions, including Islam, you are as a health worker exempted from many rules. Because of that, you can wear short sleeves if the profession requires it. I have asked around concerning how short the sleeves can be. The majority of Muslims I have asked say that sleeves immediately below the elbow will be a consideration that will make them very happy. Therefore my proposal is, if there is not a big difference in hygiene, that many prefer sleeves immediately below the elbow. It is an awesome signal to send to current, but also future practicing Muslim colleagues, that the health profession is diverse. (Our translation of Sundheds- og Forebyggelsesudvalget 2014)

In the media, Cekic's response to the Muslim employee at Hvidovre Hospital who had asked several imams about the Islamic view on sleeves, was: "She should probably talk to some other imams." (Our translation of Okkels 2014)

As the media story showed, this was not a topic on which there was agreement among Muslims. Both women had asked around their part of the Muslim community, and they had received completely different answers. Thus, if the SST had originally asked someone else, it would also have received a different answer, although it does not seem that its guidance would have been different in that case. In fact, despite Cekic's endorsement of an exception for Muslim women allowing them to wear sleeves covering the elbow, the guide that the SST ultimately published contained no such exemption.

Thus, what the case primarily shows is that the Danish health authorities have to be careful with how they obtain information about Islamic rules. Cekic did not speak for all Muslims and her reply did not cover all the opinions within Islam, which also shows that the SST can be (and maybe has been) strategic in who they ask for guidance. In the FGM campaign, the SST seemingly found it very important to talk directly with leading Danish imams, claiming that this was because the relevant Muslim community respected the imams and would listen to their guidance. With regard to the clothing of health employees, the

SST instead opted to ask an organization consisting of the actual health employees who would be affected by the rules and who might also better understand the practical need for shorter sleeves in their profession.

Thus, following on from the points raised in the previous section, which highlighted that different groups in the Muslim community might feel included or excluded by collaborations with specific imams, this new case further underscores that many voices exist in the Muslim community. Muslims have different opinions about what Islam says in regard to specific topics, and they use different sources to find answers, which complicates the task for health authorities who are attempting to find out what Islam says when planning a health initiative. Under such circumstances, therefore, we suggest that health authorities consider how to handle the fact that many different views exist in the Muslim community. This includes addressing how best to discover the views that exist within the relevant target group, and determining whether it is enough to know the most predominant views, or whether the concrete health initiative requires deeper knowledge of the multitude of existing views. It would also be relevant for the health authorities to consider whether they can avoid (and whether they want to avoid) giving legitimacy to one specific view if that is the view on which they build the health campaign.

## Referencing religious rulings: the case of gelatin in medicine

As mentioned in the introduction, this article was inspired by the criticism the SST received for producing a pamphlet containing religious rulings regarding the Covid-19 vaccination. We present here a case in which the Danish health authorities have done the same for another vaccine.

Statens Serum Institut, which is under the auspices of the Danish Ministry of Health and tasked, among other things, with preparing Denmark for infectious diseases and biological threats (Statens Serum Institut 2018), has information about the influenza vaccination on their website (Statens Serum Institut 2021), which mentions that the primary vaccine used for children in Denmark (a nasal spray) contains gelatin from pigs. The website further mentions that this can be a problem for the very

small group of people who are allergic to this gelatin, but then continues to say:

> Other than this, there are religious groups, e.g. Jews, Muslims, and Seventh-Day Adventists, who follow dietary rules that forbid pork products. However, leaders from international religious groups have approved the use of vaccines containing gelatin, among other reasons because the gelatin found in the vaccine is so highly purified and hydrolyzed (broken down by water) that there are no pork products in the final vaccine. Leaders of religious groups are at the same time of the opinion that the benefits of receiving vaccines outweigh adherence to religious dietary laws. (Our translation of Statens Serum Institut 2021)

Following this information, the website says that "based on this, parents should be able to agree to vaccinate their children" with the specific vaccine, but if they still refuse, physicians can instead offer an alternative (inactivated) vaccine.

Thus, in connection with this vaccine, the Danish health authorities also refer to the opinions of religious leaders, thereby disseminating certain religious views and giving them legitimacy. The context also suggests that the Statens Serum Institut intends Danish physicians to use the information on the website to inform parents of these religious rulings, thereby convincing them to let their children get vaccinated.

It is unclear how long the Danish health authorities have referred to religious rulings regarding influenza vaccination. The information only seems to have been placed on the specific website in October 2021, when Denmark decided to offer an influenza vaccination to children (Web Archive 2021). This was after the SST had already been publicly criticized for their vaccination pamphlet on Covid-19 vaccines.

As early as 2005, the Danish Parliament was informed about and discussed similar issues with medicine containing gelatin. Based on a media story, some political parties suggested that Danish physicians should inform Muslim patients about whether a medicine contained gelatin from pigs. This led to the Minister of Health giving a long written reply to the Health Committee in the parliament, informing them of what other European countries, as well as Muslim-majority countries, were

doing in relation to Muslims' views on gelatin in medicine. The reply mentions that the Danish health authorities had from the English health authorities received a copy of a letter from the World Health Organization (WHO) addressed to physicians. In the letter, physicians were informed about a seminar in 1995 involving 112 Islamic scholars, which had concluded that Muslims were allowed to consume gelatin, even though it originated in impure animals. In the letter, the WHO recommended that physicians inform Muslims about this religious ruling and that Muslims were also informed about this through the media "to free them of the worries regarding consuming medicine containing gelatin" (our translation of Sundhedsudvalget 2005). The Danish Minister concluded that he did not see a need for physicians to inform Muslims about whether medicine contained gelatin from pigs. He did not comment on whether the Danish health authorities were going to follow the WHO's advice on informing Muslims that religious scholars had allowed the consumption of gelatin, but the document reveals that the Danish health authorities, the minister, and members of parliament had been informed that the WHO recommended such efforts.

Thus, this case is about the health care system referring to religious rulings, which raises several questions for the health authorities, the first being about the positive and negative consequences of this. As the letter from the WHO stated, referring to such rulings can help free Muslims of their worries regarding issues where they are in doubt about what their religion allows. Referring to such rulings can also improve public health, by increasing vaccination rates, for example.

However, expecting physicians to refer to such rulings in their interactions with patients can also place them in very sensitive situations, as previously discussed in Sloan et. al (2000). We would therefore suggest that the health authorities consider the following questions regarding how physicians should handle this problem before implementing a health initiative that expects this of them. First and foremost, it would be fruitful to have considered whether the role of the physician – and the health care system more generally – is only one of providing access to information about these religious rulings, or whether they should also more actively try to convince patients to follow these religious rulings as opposed to others (which might see medicine with gelatin, for example, as not

being religiously allowed). It is also important to consider when physicians should tell patients about such information: that is, whether physicians should only mention it if the patient asks them for religious advice; whether physicians should use the information to object if their Muslim patient claims the vaccine is not allowed in Islam (thus trying to convince the patient otherwise); or whether physicians should actively seek out Muslim patients and spread this information to them, even if not asked.

This raises a number of ethical questions. One of them concerns the patients' autonomy in questions of religion and whether it is problematic to invalidate their personal religious views by referring them to the possibly opposing views of religious scholars. Another is whether it is ethically correct for non-Muslim physicians to give advice on what the religion says and how it should be practiced when they do not believe in it themselves, and when their aims are ultimately different from the religious aims. A third ethical question relates to religious questions being very personal. There are many other personal questions on which physicians generally do not give advice. Marital status is associated with health, but does that mean that physicians should advise patients on whether to stay in a marriage? Child-bearing is associated with lower cancer risks, but would a physician therefore advise a patient to have children? From an ethical point of view, it should be considered whether decisions on religion are similarly personal and sensitive topics about which physicians should be careful to push opinions.

Further, as already mentioned, the multitude of religious views among Muslims complicates this matter. It is therefore also relevant to consider how physicians should handle the spectrum of opinion when referring Muslims to religious rulings and how physicians should gain information about which religious rulings are considered valid by Muslims and the religious context for each ruling.

Lastly, it would be relevant for health authorities to consider before implementing such initiatives whether physicians should, therefore, be trained in how to handle such religious conversations and whether guidelines should be provided for when and how to reference religious rulings, or whether it should instead be left to the individual physician to decide on these matters in concrete situations.

While many of these questions highlight the challenges that can arise out of physicians engaging with religion, it should also be pointed out here that challenges can similarly arise if religion is ignored in the patient-physician relationship. General practitioners, in particular, ideally develop a personal relationship with their patients, which means their patients confide in them and discuss their concerns with them. Physicians also need to consider how to make their patients feel encouraged to raise any health-related issue, even one that involves religion. It is also not necessarily up to the physicians to decide whether religion becomes a part of their conversations with patients, as it might be the patients initiating the contact to the physicians with questions related to religion. The following section highlights an example of this.

## Advice on healthy religious practice: the case of diabetes in Ramadan

In March 2022, around two weeks before the start of Ramadan, the Municipality of Copenhagen made a Facebook post wishing people a happy Ramadan and encouraging anyone with type-2 diabetes who was planning to fast to contact the physician treating them for diabetes before Ramadan (Københavns Kommune 2022). The post contained a link to the website of the municipality's Center for Diabetes, which contained advice on how to handle Ramadan when dealing with diabetes. This also included the advice to speak with a physician or with the center before Ramadan about when during the day to take medication, and on how often to measure blood sugar (Center for Diabetes - Kbh 2022). The website contained a video interview with a physician from the Steno Diabetes Center Copenhagen, who gave further concrete advice, such as measuring blood sugar regularly and stopping the fast if the levels reached below four or above sixteen. The Steno Diabetes Center Copenhagen also produced a pamphlet on diabetes and Ramadan in 2020 in several languages, which contains further advice (Steno Diabetes Center Copenhagen 2020), as does the website of their knowledge center (Videnscenter for Diabetes 2021). The private Danish organization Diabetesforeningen has even more concrete advice on their website, including the recommendation to bring water and dextrose to the special Tarawih prayers carried out at night in Ramadan (Diabetesforeningen 2022). This web-

site links to a video made in 2013 by Region Hovedstaden, the entity responsible for hospitals in Copenhagen. The Danish College of General Practitioners even recommends in their guidelines that physicians take the initiative to have conversations about fasting with diabetes with Muslim patients during their yearly check up (Dansk Selskab for Almen Medicin 2019).

As can be seen in this specific case, Danish health institutions are reaching out to Muslims on the subject of a religious practice that these institutions know can potentially cause health problems if carried out without the necessary health information. It shows an example of how being aware of religious practices and disseminating advice in connection with them can potentially improve public health. Given that the general advice in these sources is for Muslims to contact their physicians to discuss the matter, the case also highlights that physicians cannot avoid dealing with religion. If a Muslim patient wants to have a conversation about how to fast safely in Ramadan, the physician will have to find a way to handle such questions and patients need to have trust in their physician to be able to have such conversations. Importantly, there needs to be trust that the physician will seriously consider solutions for how the patient can best fast without harming their health. If the response is merely that they should not fast, patients might not follow the recommendation or be willing to have such necessary conversations.

The case also highlights how difficult it can be for physicians and health authorities to avoid referring to religious rulings. Several of the mentioned sources directly state that it is religiously allowed for Muslims to measure their blood sugar during Ramadan, presumably something about which patients have been in doubt.

Diabetes appears to be the area targeted by the most information on health and Ramadan so far, but similar discussions could arise concerning other diseases, involving people taking thyroid medication, for example.

## Adjusting health regulations to religion: circumcision and burials

The circumcision of male children is legal in Denmark, although it was heavily debated in 2020 whether it should be restricted.

Ultimately, the Danish Prime Minister settled the discussion by refusing to ban the tradition, referring to the need to protect the Jewish minority. While the Danish health authorities in no way promote the circumcision of male children and are also not trying to use religious argumentation to reduce the tradition (as they did with FGM), the tradition is a good example of how the Danish health authorities and politicians take religion into account when formulating health regulations. Health ministers have been open about the fact that the tradition is regulated in dialogue with religious groups, including representatives from both the Jewish and the Muslim communities (Nørby 2018). Given that the Jewish community generally follows more strict religious rules regarding this procedure than Muslims, it is primarily Jewish religious rules that have had to be taken into account when legislating on the limits of what is allowed.

A specific example of Islam being taken into account is seen in relation to regulation on amputated body parts. On the website of one of the five Danish regions (the administrative entities in Denmark responsible for the hospitals) the following sentence can be found:

> [The SST] and the Ministry of Ecclesiastical Affairs have announced that according to the Muslim faith it is important that amputated body parts are not burned, but instead buried so that the person can eventually be buried in the same spot and thereby be reunited with the amputated body parts. Therefore, a description has been made concerning how we should handle this. (Our translation of Region Nordjylland 2019)

The website continues to explain the procedures health personnel should carry out if a Muslim patient requests such a burial of body parts. Notice that this announcement describes "the" Muslim faith; in other words, the description assumes that there is only one understanding within Islam of this question.

Such examples highlight that the health authorities might have to consider religion when producing general guidelines and regulations. Ultimately, not doing so could be a breach of international human rights standards, since Denmark would need to have legitimate reasons for restricting religious practices and have considered the proportionality of doing so. To be able to carry out such an assessment, the authorities must be infor-

med about religious practices and the extent to which legitimate aims could be reached without restricting these practices.

## Other practical situations between patients and health care personnel

There is a difference between the larger informational campaigns carried out by the Danish health authorities and the practical difficulties that health personnel may face when interacting with Muslim patients in daily life, but it is also relevant to mention what we know about the latter here.

The Danish accreditation standards for Danish hospitals include the requirement that a hospital "respects and supports the patient's and the relatives' cultural and religious needs and wishes about existential and spiritual support" (IKAS 2012, sec. 2.1.4). For example, Danish hospitals provide food that conforms with Muslims' religious dietary rules. This is one example of situations where the health sector needs to know what Islam says about a specific topic so that they can adjust their care and offers to these rules.

An earlier interview study conducted by one of the authors of this paper revealed that some physicians have requested information from imams about what Islam says about the brain death criteria because they wanted to be informed about the religious rules before engaging in conversations with Muslim family members about turning off a respirator. Further, an Islamic authority has produced a pamphlet about special issues to be aware of regarding Muslim patients, several thousand copies of which have been distributed in the health care system (Schultz-Knudsen 2021, 328). The Danish Center for Organdonation has also made a video with a Danish imam where he argues for the permissibility in Islam of organ donation (Dansk Center for Organdonation 2022).

An Islamic authority in the mentioned interview study described knowing of physicians who encourage Muslims to take care of their bodies and exercise by referring to how Islam also encourages this. Earlier literature has similarly provided examples of how Danish prison guards and case workers in municipalities have used arguments from Islam to convince Muslims of, for example, the importance of getting a job (Petersen and Vinding 2020, 220). In Copenhagen, one imam has

been employed at a hospital (Christensen, Kühle, and Vinding 2020) and has handled many conversations with Muslim patients and their next of kin about their situations, offering them spiritual advice (Ahrens 2018).

Over the years the Danish Nurses' Organization member magazine has published a number of articles focusing on how to provide good care for Muslim patients. Some of these articles also recommend that health care personnel inform patients about religious rules, letting Muslim patients know, for example, that Islam allows them to not fast in Ramadan if they are sick (Hagerup 2016). The articles also offer many other examples of situations where the authors argue that nurses should be informed of Islamic rules in order to provide the best possible care: some Muslim patients, for example, might not want to be alone with the opposite gender, might see their family as having an important role in their hospital stay, might want to be able to pray, might not want a non-Muslim to touch their Quran, or might have special religious practices during childbirth or death (Pedersen 2003). There are likely many more situations where Danish health care personnel in their daily meetings with Muslims must either take their patients' religion into account or directly choose to employ religious arguments in an attempt to achieve the aims of the health care system.

## Efforts during the Covid-19 pandemic

As mentioned in the introduction, during the pandemic the SST produced a pamphlet about Covid-19 vaccinations in cooperation with Islamic organizations, which led to severe criticism from large parts of the Danish Parliament. The SST has explained to the parliament that they held two virtual meetings with one imam and had further phone and email contact with the same imam, who then coordinated all contact with the other Islamic organizations. The SST also highlighted that the Islamic organizations had not had any influence on the health-related content of the pamphlet (Sundhedsudvalget 2021b).

However, the vaccine pamphlet was far from the only effort Danish health authorities made in regard to Muslims during Covid-19. The Danish Institute for Human Rights produced a report showing that Covid-19 was disproportionately affecting ethnic minorities. There were several reasons for this, including

them generally living closer together, having jobs with more exposure to people, more often already having worse health, and having poor access to information. However, drawing on quotes from interviews, the report also notes the role of religion, specifically Islam. Some interviewees mentioned that a very small group of Muslims considered that it was Allah's will whether they were sick or not, while others had been in doubt about whether it was allowed in Islam to use alcohol to sterilize hands. Yet it was also mentioned that some imams had been out spreading awareness about Covid-19 (Vikkelsø Slot, Søndergaard, and Zaken 2020, 30–31).

Due to the disproportionate effects on ethnic minorities, the SST and other agencies had a mapping made indicating which information channels ethnic minorities in Denmark were using to find information about Covid-19, to be better equipped to reach this group. Some of the recommendations in the report focused on spreading communication through trusted relations with people or institutions in the local environment. The report specifically mentioned churches and mosques:

> Many interviewees also mention that churches and mosques can be seen as gathering places and can be used as partners in getting information out since many meet here, and that both imams and others appear as authorities and role models that people listen to. Some say that some imams have already taken upon themselves a responsibility for communicating knowledge and advice on Covid-19 and that they are important for creating trust in the guidance on behavior, restrictions, and regulations. Other interviewees explain that they themselves have a role in the mosque and give lectures. (Our translation of Realize ApS and DRC Dansk Flygtningehjælp 2020)

The Danish health authorities used very similar methods. For instance, one municipality made an agreement with the chair of the local mosque, asking him to spread knowledge about a test center through WhatsApp (Wettergreen-Paltorp 2021). In another municipality, a mobile test center was placed at two different mosques, with testing taking place inside the mosques (Nilsson and Munch 2020; Ishøj Kommune 2020). A third municipality kept a test center open until 1 AM during Ramadan, knowing that some Muslims would not come during the

day. This was despite the local imam disagreeing and stating that Muslims could get tested during the day (Grønvald 2021). In some mosques, it was also possible to receive vaccinations, and in one case the head of the SST visited two mosques, gave a speech following the Friday sermon, and vaccinated people in connection with the arrangement (Frederiksen and Engelbrecht 2021). The SST also made a poster saying "Happy Ramadan" with some good advice on how to follow Covid-19 guidance during Ramadan, and listing a webpage with further information (Sundhedsstyrelsen 2021). On the webpage, it is mentioned that the advice had been sent to two consulting representatives from religious organizations as well as to a number of NGOs focused on ethnic minorities before it was made public. The website also linked to a video from the SST that directly mentioned Muslims' Tarawih prayer and Itikaf using the Islamic terms, and encouraged Muslims to carry out these actions at home and only with the people with whom they lived (Sundhedsstyrelsen 2020).

It was not only the Danish agencies that had a focus on religion during the health efforts aimed at Covid-19. Danish politicians decided to close down mosques and churches for a while during the pandemic, and the Danish restrictions in 2020 have been described as some of the most intense restrictions on religious activity in Europe (Kühle 2021; Ferrière 2020). Danish politicians were also aware, however, of the need to consider the population's religious feelings, which was made most clear in debates leading up to the Christian holidays, particularly Christmas and Easter, where it was discussed whether restrictions on churches should be eased (Riexinger et al. 2021). Danish politicians also acknowledged Islam and essentially contributed to a negotiation concerning how to practice Islam in the context of Covid-19. The Minister of Integration, Mattias Tesfaye, shared the advice from the authorities about how to celebrate Ramadan, and specifically encouraged Muslims to only break their fast with people with whom they lived, to pay charity digitally instead of in cash, and to celebrate Eid with a maximum of ten people (Westersø 2020). The Minister's communication was generally received negatively by Muslims on social media, who considered it scapegoating, while the SST's advice (mentioned above) was generally well received (Kühle 2021, 22, 30). Importantly, both communications can be seen as the Danish authorities entering into negotiations with Danish

Muslims, recognizing (and disseminating) certain ideas about what Muslims normally do during Ramadan. Instead of asking Muslims not to carry out their rituals, the authorities suggested alternative means, such as socializing and paying charity digitally, and praying, breaking the fast, and carrying out Itikaf at home. By doing this, the Danish authorities considered the Islamic rules, attempting to find acceptable solutions within the Islamic framework. Thus, they were part of a negotiation about how the Islamic rules could be interpreted in the context of a pandemic.

## Conclusion

In this article, we aimed to investigate how the Danish health authorities have used or considered Islam in their efforts and communication.

While the SST's interactions with Islam during the Covid-19 pandemic led to significant public debate, we have demonstrated that the Danish health authorities, as well as other institutions, have been interacting with Islam for many years and in many situations. Through the gathering of these examples, we have highlighted the many different ways that health authorities might interact with Islam. These include partnerships with imams and Islamic organizations, referencing religious rulings in information material, providing advice to Muslims on how to handle religious practices such as Ramadan in a healthy way, and adjusting health regulations to allow Muslims to practice their religion. Further, we have pointed out a number of practical situations in which physicians and other health personnel will have to deal with religion in daily life.

Throughout the article, we have used these examples to discuss and present insights regarding the dynamics that the health authorities have to be aware of when attempting to interact with religion, and the key considerations to have in mind when religion and health interact in society. We have also raised a number of relevant questions for further consideration. It could be relevant to look more deeply into the considerations which the health authorities have already had in connection with these initiatives, by applying to the health authorities for access to their internal information, for example. This could further inform which considerations to keep in mind for future initiatives.

Given that our questions highlight a number of difficulties that can arise out of such efforts, some readers might have considered whether it would not simply be better for the health authorities not to get involved with religion. As we have also tried to highlight, such a stance is also not possible. Religion is a core part of many people's lives and is an important health determinant. For this reason, when dealing both with individual patients and with societal health campaigns, religion will continue to show up as a relevant factor to consider and to include in initiatives. This article has shown that there have already been numerous efforts like that in Denmark, and with the many identified both during the pandemic and following the pandemic, it seems natural to assume that we will only see more examples of Islam being included in health efforts in the future. Muslims have become an integral part of society, and it is necessary to consider their perceptions and practices when planning health campaigns. For this reason, the questions we have raised are not meant to suggest that such initiatives should always be dropped, but instead to help inform such initiatives with important considerations in an attempt to ensure that, ultimately, they are fruitfully contributing to sustainable interactions between health authorities and religion for all involved parties.

The article also shows the need for more research into these interactions to reach this aim. We particularly need more empirical data on people's perceptions of such efforts and of their interactions in that regard with physicians and health authorities.

Finally, we would like to acknowledge that discussing the interaction between health and religion naturally oversimplifies both. However, since the questions surrounding this interaction are both controversial and prevalent, we must continue to address this topic.

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