Public Health, Religion, and Spirituality Bulletin
Fall 2020, Issue 3, pp. 10–17
[Online 7 Nov. 2020, Article A015 • ISSN 2689-7024]
https://publichealthrs.org/a015/

Covid-19 and Religion/Spirituality: A Global Review from a Public Health Perspective

Doug Oman[1]

The SARS-CoV-2 coronavirus has upended daily life worldwide, infecting tens of millions of people, causing more than a million deaths to date due to Covid-19 disease, and inflicting a massive but largely unmapped burden of long-term disability and lowered quality of life among survivors. Religion and spirituality are among the strongest motivators of human action. Can the field of public health, religion and spirituality shed any light on how we can best respond to the pandemic? This article offers a selective review.

By Fall 2020 as this article was finalized, many dozens of professional journal articles from more than 30 countries, primarily peer-reviewed, had already been published about religion, spirituality, and the pandemic. Of these, a dozen-plus *empirical* studies have examined religion/spirituality (R/S) in relation to the pandemic. Available publications have reported a wide range of views, events, and findings. The aim of this brief article is to give the reader an introductory feeling for this literature by highlighting responses to three overarching questions that emerge repeatedly in this literature: 1) Does religion reduce or exacerbate risk of contracting COVID-19 disease? 2) How are religious communities responding? 3) What's needed from health professionals in relation to religion/spirituality and COVID-19? The article concludes by inviting readers' thoughts on best next steps.

Q1: Does Religion Reduce or Exacerbate Risk of Contracting COVID-19?

At least three US-based empirical studies have investigated and reached divergent conclusions about whether R/S engagement reduces or exacerbates risk behaviors for infection with SARS-CoV-2 and contracting Covid-19 disease (DeFranza et al., Lindow, 2020; Hill et al., 2020; Perry et al., 2020). These three studies employed widely varying research designs. Two were conducted at a collective ("ecological") level. They investigated whether US states and metropolitan areas that are more religious had engaged, early in the pandemic, in stronger protective behaviors. More specifically, did they engage in stronger social distancing behaviors? As a proxy for collective engagement in social distancing behaviors, both of these studies analyzed total aggregate *physical* mobility, measured via indicators of movement by automobiles or mobile phones. One study by DeFranza and colleagues (2020) appeared in *American Psychologist* and analyzed daily time series from the 53 largest US metropolitan areas, finding that areas with larger numbers of religious congregations were *less* adherent to shelter-in-place directives, after controlling for (aggregate level) education, unemployment, and poverty (data from March, 2020). Similarly, Hill and colleagues (2020) in *Journal of Religion and Health*, reported that US states with greater state-level religiosity measured by a six-item index exhibited *weaker* responses to stay-at-home orders, after adjusting for aggregate-level age, race, unemployment, and governor's political party (from February 24 to April 13). Such findings suggest that religious involvement may *exacerbate* risk of contracting Covid-19, at least in the United States.

In contrast, Perry and colleagues (2020) in *Journal for the Scientific Study of Religion* reported that a 3-item scale of religious commitment, comprised

of items for prayer frequency, religious importance, and service attendance, "was the leading predictor that Americans engaged in *more frequent* precautionary behaviors" (p. 405, emphasis added). These investigators used longitudinal panel data from a nationally representative sample of US adults (n=1255) from August 2019 to May 2020. However, in contrast to the protectiveness of religious commitment, Perry and colleagues (2020) found that COVID-19 risk behavior was *exacerbated* among respondents who reported higher levels of *Christian nationalism*, conceptualized as "an ideology that idealizes and advocates a fusion of American civic life with a particular type of Christian identity and culture" (p. 406). Furthermore, their 6-item measure of Christian nationalism "was the leading predictor that Americans engaged in incautious behavior like eating in restaurants, visiting family/friends, or gathering with 10+ persons (though not attending church), and was the second strongest predictor among Americans who took fewer precautions like wearing a mask or sanitizing/washing one's hands" (p. 405).

The interpretable yet divergent findings from these three studies underscore the importance of remembering that religion and spirituality are each multidimensional, and that whereas some dimensions may show salutary effects, others may show detrimental effects in specific contexts (e.g., Miller & Thoresen, 2003; Oman, 2018; see also Vermeer & Kregting, 2020 for a collective-level study in the Netherlands). In public health, where partnerships with faith-based organizations are often of great practical importance, such multivalent potentials of religion must be recognize and properly navigated: How can public health workers productively ally themselves with the salutary tendencies in religious communities and individuals, while mitigating or at least not exacerbating tendencies that are less healthy?

Q2: How are Religious Communities Worldwide Responding?

Jenny Trinitapoli and Alexander Weinreb's (2012) well-researched and thought-provoking book, *Religion and AIDS in Africa*, is to date perhaps the most in-depth study and consideration of religion in relation to a modern pandemic. Citing Horden (1999), Trinitapoli and Weinreb note that

> Historical accounts of the role of religion in times of plague, from the Roman era through the early modern period… all highlight the relevance of religion to… two types of 'management' epidemics demand:… to be understood, or managed conceptually; and… to be managed practically (p. 203).

In today's coronavirus pandemic, this dual conceptual/practical relevance of religion is illustrated by the wide range of topics addressed by recent journal articles on R/S and the pandemic. For example, several articles, some primarily conceptual, have addressed the possibilities and pitfalls of responding to the pandemic through so-called "virtual religion" (Parish, 2020, p. 6). One article by Jun (2020, p. 1) sought to address "controversial theological issues and reflect on them from an ecclesiological perspective [in relation to] ministries in virtual reality." Similarly, Parish (2020, p. 1) analyzed "different understandings of religion, church, and community in the period of a pandemic… [situating] the debates… in the context of historical precedent, personal experience, and theoretical approaches" (see also Pityana, 2020; VanderWeele & Long, 2020). Other published articles have profiled efforts to practice more socially distanced forms of religion by Parsis (Zoroastrians) in Pakistan (Engineer, 2020), Christians in the UK (Bryson et al., 2020), Christians in Italy (Madera, 2020), Christians elsewhere in Europe (Parish, 2020), and adherents to Afro-Brazilian religions in Brazil (Capponi et al., 2020).

A somewhat different emphasis on religion's practical roles in responding to the pandemic is evident in multiple articles reporting on cancellation of pilgrimages in Saudi Arabia (Ebrahim & Memish, 2020; Memish et al., 2020; Yezli & Khan, 2020). Furthermore, adherence to additional safety-promoting proclamations by Muslim leaders has been examined by an empirical study in Indonesia (Hanafi et al., 2020, about responses to a fatwa, n=1139). Some of these protective measures have been effective, but in other cases, populations have shown persistence in religious observance despite attempts by religious leaders to mandate reduced social contacts (e.g., Pabbajah et al., 2020, Indonesian Muslims). Some articles have discussed or documented the dangers of allowing large religious gatherings to proceed as usual, sometimes arguing that "Religious, social, and political leaders have to exhibit sagacity and adopt a pragmatic approach" (Quadri, 2020, p. 220; see also Badshah & Ullah, 2020).

Religious coping is the focus of several articles that have probed the intertwined conceptual and practical responses of religious individuals as they employ religious methods of coping in response to pandemic stresses. Empirical studies are available of pandemic religious coping by Jews in the USA (Pirutinsky et al., 2020, n=419), by Christians and Muslims in the United Arab Emirates (Thomas & Barbato, 2020, n=611), by African American Christians in the USA (Adams & Tyson, 2020, art-based inquiry with n=2), by Roman Catholic Christians in Poland (Kowalczyk et al., 2020, n=324), and by medical patients in India (Mishra et al., 2020, n=30). One study in Indonesia even investigated the role of Muslim religiosity in the survival of small businesses during the pandemic (Utomo, 2020, n=120).

Religious leaders are often under great stress, which is exacerbated by pandemics. Thus, Greene and colleagues (2020) made several recommendations for attending to the health of religious leaders, who may sometimes experience moral dilemmas in choosing between prescribed safety and traditional practice – among their recommendations were "Setting aside time to focus on spirituality" and that "It is important to acknowledge the moral conflicts that will likely emerge [from dilemmas in dealing with COVID-19]. Discussing them with colleagues and being prepared for some of the possible responses may facilitate coping and acceptance of distress" (p. S144).

Q3: What's Needed from Clinical and Public Health Professionals?

Last but not least, many articles have addressed how health professionals should understand or interact with religion in view of the pandemic. Many immediate practical responses have been advocated. For example, Koenig (2020, p. 776) described "seven simple ways that geriatric psychiatrists can help religious elders make use of their faith to relieve anxiety and help protect themselves and others during this COVID-19 pandemic." In the journal *Mindfulness*, Oman and colleagues (2020) reviewed randomized trial evidence on frequent repetition of a holy name or a mantram, a cross-culturally widespread spiritual practice extensively studied in the US Veterans Healthcare System, as holding "promise to benefit all major groups affected by the pandemic" including healthcare workers working with COVID-19 patients, patients and their families, and the general public. They suggested that such holy name/mantram repetition may be especially beneficial for COVID-19 patients experiencing respiratory distress, for whom conventional mindfulness approaches to stress management and resilience-building "may be ineffective or even contra-indicated" (p. 6).

On a more collective level, with an eye on population health, physicians at the Mayo Clinic systematically tabulated recommendations for how physicians could helpfully advise religious communities on responding to COVID-19 for Jews, Christians, and Muslims (Merry et al., 2020, p. 2 in pdf; each tradition was represented in the team of authors). Similarly, Bruce (2020, p. 425) argued for the importance of "African American churches, mosques, and temples as essential for an

immediate, comprehensive, and sustained response to the elevated risk for and spread of COVID-19 among African Americans."

More broadly, commentaries from countries as diverse as the US, Pakistan, and Somaliland have advocated for the value of partnerships between health professionals and community religious leaders, or have reported instructive experiences (Bentley et al., 2020; Galiatsatos et al., 2020; Hashmi et al., 2020; Hong & Handal, 2020; Thompkins et al., 2020). In Brazil, Kevern and colleagues (2020) reported on the history and pandemic response of a network of approximately 2500 volunteers, coordinated by the Catholic Church, that was for many years a recipient of much governmental support. Survey findings indicated that the model "may be exportable to other middle-income countries," with the network's "speedy and flexible response… to the coronavirus pandemic suggest[ing] that this type of NGO will have a role in response to future national crises" (p. 1).

On the other hand, also in Brazil, an entirely different and possibly complementary approach was described by Ribeiro and colleagues (2020, p. 1 in pdf), who recounted the well-received launch of a "Spiritual Care Hotline Project" in which trained psychiatrists and psychologists field requests for spiritually welcoming mental healthcare. These providers engage in structured interactions that encompass "(i) presentation, (ii) the main reason for calling, (iii) compassionate and affective listening, (iv) reading a short text with reflective content, and (v) prayer if the attendee feels comfortable," followed when appropriate by referrals.

Some commentators have warned that frontline health professionals may find themselves in excruciating dilemmas in conducting patient care, perhaps especially if healthcare systems are overwhelmed, putting them – like the religious leaders mentioned earlier – at risk for moral injury, understandable as "the lasting emotional, psychological, social, behavioral, and spiritual impact of actions that violate [one's] core moral values and behavioral expectations of self or others" (Shortland et al., 2020, p. S128; see also Borges et al., 2020). For spiritual support of healthcare professionals, Amiel and Ulitzur (2020, p. 840) described a program of three weekly sessions designed to understand stress and its sources and "adopt resilience strategies based on spiritual care tools" that included "deep listening", "connecting to personal resilience resources," and other methods.

New research is of course needed. Thus, writing in *Mental Health Religion & Culture*, Dein, Loewenthal, Lewis, and Pargament (2020) identified an agenda of seven issues that require future research, including studies of the comparative impact on mental health of virtual versus face-to-face religious activities; whether prejudice can be reduced in the context of the pandemic; and strategies for enhancing preventative behavior related to COVID-19 in religious groups. Various other agendas and suggestions for future research have also been offered – for example, based on a survey of 27 chaplaincy teams in the UK, Harrison and Scarle (2020) identified several pandemic-related chaplaincy issues requiring further inquiry, such as clarifying best practices regarding staff support.

Now What?

This year's professional literature on COVID-19 and religion/spirituality is by no means exhausted by the foregoing whirlwind tour of selected writings on these three overarching questions. Many other recent professional articles have addressed these questions, as well as other topics ranging from advocacy of inter-religious collaboration on COVID-19 to psychometrically analyzing religious items on COVID-19 anxiety screening tools (e.g., Corpuz, 2020; Lee, 2020). Our own PHRS Network is likewise compiling a set of COVID-related resources and links that build on the evidence cited above (see http://www.publichealthrs.org/resources/).

As the pandemic lingers and R/S-COVID-19 questions persist and multiply, much useful

background may be found in the pre-existing public health and religion/spirituality literature, which has carefully attended to numerous issues concerning religion/spirituality and infectious diseases (Oman & Riley, 2018), and has also wrestled with the "paradox" that religion generally correlates favorably with individual health measures, but that some dimensions may correlate with unhealthy collective norms or behaviors – as we noted has been occurring in the USA with COVID-19 (Oman & Nuru-Jeter, 2018, p. 115).

On a practical level, public health has given a great deal of attention to salutary partnerships between health professionals and religious communities (Epstein, 2018; Grant & Oman, 2018; Idler et al., 2019). The art of such partnering is profoundly local, yet successful partnerships can inspire efforts both near and far. The present literature search identified published articles on religion and COVID-19 from Australia, Bosnia, Brazil, China, Colombia, Ethiopia, India, Indonesia, Iran, Ireland, Israel, Italy, Japan, Kenya, Korea, Malaysia, Mexico, the Netherlands, Nigeria, Pakistan, Philippines, Poland, Portugal, Saudi Arabia, Somaliland, South Africa, Spain, Turkey, Uganda, Ukraine, the United Arab Emirates, the United Kingdom, the United States, and Vietnam. Translating such widespread interest into improved collaboration between religion and public health – one goal of the religion/spirituality and public health field, and of the *Public Health, Religion and Spirituality Bulletin* and Network – will boost global pandemic control efforts, benefiting everyone. We invite the *Bulletin*'s readers to share with us their ideas about how to foster such advances – send your thoughts to the editorial team c/o PHRScovid@publichealthrs.org, and/or take our Fall 2020 reader's survey (https://publichealthrs.org/s001/).

References

Adams, R. D., & Tyson, C. A. (2020). "There is a balm in Gilead": Black social workers' spiritual counterstory on the COVID-19 crisis. *Social Work in Public Health, 35*, 523-532. https://doi.org/10.1080/19371918.2020.1806169

Amiel, G. E., & Ulitzur, N. (2020). Caring for the caregivers: Mental and spiritual support for healthcare teams during the COVID-19 pandemic and beyond. *Journal of Cancer Education, 35*, 839-840. https://doi.org/10.1007/s13187-020-01859-2

Badshah, S., & Ullah, A. (2020). Spread of coronavirus disease-19 among devotees during religious congregations. *Annals of Thoracic Medicine, 15*, 105-106. https://doi.org/10.4103/atm.ATM_162_20

Bentley, J. A., Mohamed, F., Feeny, N., Ahmed, L. B., Musa, K., Tubeec, A. M., . . . Zoellner, L. (2020). Local to global: Somali perspectives on faith, community, and resilience in response to COVID-19. *Psychological Trauma: Theory, Research, Practice, and Policy, 12*, S261-S263. https://doi.org/10.1037/tra0000854

Borges, L. M., Barnes, S. M., Farnsworth, J. K., Bahraini, N. H., & Brenner, L. A. (2020). A commentary on moral injury among health care providers during the COVID-19 pandemic. *Psychological Trauma: Theory, Research, Practice, and Policy, 12*, S138-S140. https://doi.org/10.1037/tra0000698

Bruce, M. A. (2020). COVID-19 and African American religious institutions. *Ethnicity & disease, 30*, 425-428. https://doi.org/10.18865/ed.30.3.425

Bryson, J. R., Andres, L., & Davies, A. (2020). COVID-19, virtual church services and a new temporary geography of home. *Tijdschrift voor economische en sociale geografie, 111*, 360-372. https://doi.org/10.1111/tesg.12436

Capponi, G., & Carneiro Araújo, P. (2020). Occupying new spaces: The "digital turn" of Afro-Brazilian religions during the Covid-19 outbreak. *International Journal of Latin American Religions*. https://doi.org/10.1007/s41603-020-00121-3

Corpuz, J. C. G. (2020). Religions in action: The role of interreligious dialogue in the COVID-19

pandemic. *Journal of Public Health*, fdaa149. https://doi.org/10.1093/pubmed/fdaa149

DeFranza, D., Lindow, M., Harrison, K., Mishra, A., & Mishra, H. (2020). Religion and reactance to COVID-19 mitigation guidelines. *American Psychologist*. https://doi.org/10.1037/amp0000717

Dein, S., Loewenthal, K., Lewis, C. A., & Pargament, K. I. (2020). COVID-19, mental health and religion: An agenda for future research. *Mental Health, Religion & Culture, 23*, 1-9. https://doi.org/10.1080/13674676.2020.1768725

Ebrahim, S. H., & Memish, Z. A. (2020). Saudi Arabia's drastic measures to curb the COVID-19 outbreak: Temporary suspension of the Umrah pilgrimage. *Journal of Travel Medicine, 27*, taaa029. https://doi.org/10.1093/jtm/taaa029

Engineer, A. (2020). Of religion and technology: Karachi's Parsis take a unique approach to COVID-19 limitations. *EnviroLab Asia, 4*, 1. https://doi.org/10.5642/envirolabasia.20200401.01

Epstein, N. E. (2018). Implications for community health practitioners: Framing religion and spirituality within a social ecological framework. In D. Oman (Ed.), *Why religion and spirituality matter for public health: Evidence, implications, and resources* (pp. 305-322). Cham, Switzerland: Springer International. https://doi.org/10.1007/978-3-319-73966-3_17

Galiatsatos, P., Monson, K., Oluyinka, M., Negro, D., Hughes, N., Maydan, D., . . . Hale, W. D. (2020). Community calls: Lessons and insights gained from a medical–religious community engagement during the COVID-19 pandemic. *Journal of Religion and Health, 59*, 2256-2262. https://doi.org/10.1007/s10943-020-01057-w

Grant, L., & Oman, D. (2018). International and global perspectives on spirituality, religion, and public health. In D. Oman (Ed.), *Why religion and spirituality matter for public health: Evidence, implications, and resources* (pp. 447-462). Cham, Switzerland: Springer International. https://doi.org/10.1007/978-3-319-73966-3_27

Greene, T., Bloomfield, M. A. P., & Billings, J. (2020). Psychological trauma and moral injury in religious leaders during COVID-19. *Psychological Trauma: Theory, Research, Practice, and Policy, 12*, S143-S145. https://doi.org/10.1037/tra0000641

Hanafi, Y., Taufiq, A., Saefi, M., Ikhsan, M. A., Diyana, T. N., Hadiyanto, A., . . . Mawardi, A. I. (2020). Indonesian ulema council fatwa on religious practices during Covid-19 pandemic: An investigation of Muslim compliance. https://doi.org/10.21203/rs.3.rs-33784/v1

Harrison, S., & Scarle, J. (2020). How are chaplaincy departments responding amidst the COVID-19 pandemic? A snapshot of UK responses to a questionnaire. *Health and Social Care Chaplaincy, 8*, 143–153. https://doi.org/10.1558/hscc.41624

Hashmi, F. K., Iqbal, Q., Haque, N., & Saleem, F. (2020). Religious cliché and stigma: A brief response to overlooked barriers in COVID-19 management. *Journal of Religion and Health*. https://doi.org/10.1007/s10943-020-01063-y

Hill, T. D., Gonzalez, K., & Burdette, A. M. (2020). The blood of Christ compels them: State religiosity and state population mobility during the coronavirus (COVID-19) pandemic. *Journal of Religion and Health, 59*, 2229-2242. https://doi.org/10.1007/s10943-020-01058-9

Hong, B. A., & Handal, P. J. (2020). Science, religion, government, and SARS-CoV-2: A time for synergy. *Journal of Religion and Health, 59*, 2263-2268. https://doi.org/10.1007/s10943-020-01047-y

Horden, P. (1999). Disease, dragons and saints: The management of epidemics in the dark ages. In T. Ranger & P. Slack (Eds.), *Epidemics and ideas: Essays on the historical perception of pestilence* (2nd ed., pp. 45-76). Cambridge, UK: Cambridge University Press. https://doi.org/10.1017/CBO9780511563645.004

Idler, E., Levin, J., VanderWeele, T. J., & Khan, A. (2019). Partnerships between public health

agencies and faith communities. *American Journal of Public Health, 109*, 346-347. https://doi.org/10.2105/ajph.2018.304941

Jun, G. (2020). Virtual reality church as a new mission frontier in the metaverse: Exploring theological controversies and missional potential of virtual reality church. *Transformation: An International Journal of Holistic Mission Studies*. https://doi.org/10.1177/0265378820963155

Kevern, P., Lopes, R. G. d. C., Barroso, Á. E., Côrte, B., & Lucena, C. (2020). The contribution of church-based networks to social care in the coronavirus pandemic and beyond: The case of Pastoral da Pessoa Idosa in Brazil *Religions, 11*, 486. https://doi.org/10.3390/rel11100486

Koenig, H. G. (2020). Ways of protecting religious older adults from the consequences of COVID-19. *The American Journal of Geriatric Psychiatry, 28*, 776-779. https://doi.org/10.1016/j.jagp.2020.04.004

Kowalczyk, O., Roszkowski, K., Montane, X., Pawliszak, W., Tylkowski, B., & Bajek, A. (2020). Religion and faith perception in a pandemic of COVID-19. *Journal of Religion and Health*. https://doi.org/10.1007/s10943-020-01088-3

Lee, S. A. (2020). Coronavirus anxiety scale: A brief mental health screener for COVID-19 related anxiety. *Death Studies, 44*, 393-401. https://doi.org/10.1080/07481187.2020.1748481

Madera, A. (2020). Some preliminary remarks on the impact of COVID-19 on the exercise of religious freedom in the United States and Italy. *Stato, Chiese e pluralismo confessionale*. https://doi.org/10.13130/1971-8543/14274

Memish, Z. A., Ahmed, Y., Alqahtani, S. A., & Ebrahim, S. H. (2020). Pausing superspreader events for COVID-19 mitigation: International Hajj pilgrimage cancellation. *Travel Medicine and Infectious Disease, 36*, 101817. https://doi.org/10.1016/j.tmaid.2020.101817

Merry, S. P., Havyer, R. D., McCoy, R. G., Elrashidi, M. Y., & Fischer, P. R. (2020). How can physicians advise faith communities during the COVID-19 pandemic? *Travel Medicine and Infectious Disease*, 101762. https://doi.org/10.1016/j.tmaid.2020.101762

Miller, W. R., & Thoresen, C. E. (2003). Spirituality, religion, and health: An emerging research field. *American Psychologist, 58*, 24-35. https://doi.org/10.1037/0003-066X.58.1.24

Mishra, S., Gupta, R., Bharati, S. J., & Biswas, S. (2020). Transmutation of spiritual credence during COVID-19 era in cancer patients: A case series. *Asian Pacific Journal of Cancer Care, 5*, 129-132. https://doi.org/10.31557/APJCC.2020.5.S1.129-132

Oman, D. (Ed.). (2018). *Why religion and spirituality matter for public health: Evidence, implications, and resources*. Cham, Switzerland: Springer International. https://doi.org/10.1007/978-3-319-73966-3

Oman, D., Bormann, J. E., & Kane, J. J. (2020). Mantram repetition as a portable mindfulness practice: Applications during the COVID-19 pandemic. *Mindfulness.* Online before print 16 Nov. 2020 (open access). https://doi.org/10.1007/s12671-020-01545-w

Oman, D., & Nuru-Jeter, A. M. (2018). Social identity and discrimination in religious/spiritual influences on health. In D. Oman (Ed.), *Why religion and spirituality matter for public health: Evidence, implications, and resources* (pp. 111-137). Cham, Switzerland: Springer International. https://doi.org/10.1007/978-3-319-73966-3_6

Oman, D., & Riley, L. W. (2018). Infectious diseases, religion, and spirituality. In D. Oman (Ed.), *Why religion and spirituality matter for public health: Evidence, implications, and resources* (pp. 153-163). Cham, Switzerland: Springer International. https://doi.org/10.1007/978-3-319-73966-3_8

Pabbajah, M., Said, N. M., Faisal, M., Pabbajah, T. H., Jubba, H., & Juhansar. (2020). Deauthorization of the religious leader role in countering Covid-19: Perceptions and responses of Muslim societies on the ulama's policies in Indonesia. *International Journal of Criminology*

and Sociology, 9, 262-273. https://doi.org/10.6000/1929-4409.2020.09.25

Parish, H. (2020). The absence of presence and the presence of absence: Social distancing, sacraments, and the virtual religious community during the COVID-19 pandemic. *Religions, 11*, 276. https://doi.org/10.3390/rel11060276

Perry, S. L., Whitehead, A. L., & Grubbs, J. B. (2020). Culture wars and COVID-19 conduct: Christian nationalism, religiosity, and Americans' behavior during the coronavirus pandemic. *Journal for the Scientific Study of Religion, 59*, 405-416. https://doi.org/10.1111/jssr.12677

Pirutinsky, S., Cherniak, A. D., & Rosmarin, D. H. (2020). COVID-19, mental health, and religious coping among American orthodox Jews. *Journal of Religion and Health, 59*, 2288-2301. https://doi.org/10.1007/s10943-020-01070-z

Pityana, B. (2020). More eyes on COVID-19: Perspectives from religion studies – how Christian theology helps us make sense of the pandemic. *South African Journal of Science, 116*, 1-1. https://doi.org/10.17159/sajs.2020/8498

Quadri, S. A. (2020). COVID-19 and religious congregations: Implications for spread of novel pathogens. *International Journal of Infectious Diseases, 96*, 219-221. https://doi.org/10.1016/j.ijid.2020.05.007

Ribeiro, M. R. C., Damiano, R. F., Marujo, R., Nasri, F., & Lucchetti, G. (2020). The role of spirituality in the COVID-19 pandemic: A spiritual hotline project. *Journal of Public Health*. https://doi.org/10.1093/pubmed/fdaa120

Shortland, N., McGarry, P., & Merizalde, J. (2020). Moral medical decision-making: Colliding sacred values in response to COVID-19 pandemic. *Psychological Trauma: Theory, Research, Practice, and Policy, 12*, S128. https://doi.org/10.1037/tra0000612

Thomas, J., & Barbato, M. (2020). Positive religious coping and mental health among Christians and Muslims in response to the COVID-19 pandemic. *Religions, 11*, 498. https://doi.org/10.3390/rel11100498

Thompkins, F., Jr., Goldblum, P., Lai, T., Hansell, T., Barclay, A., & Brown, L. M. (2020). A culturally specific mental health and spirituality approach for African Americans facing the COVID-19 pandemic. *Psychological Trauma: Theory, Research, Practice, and Policy, 12*, 455-456. https://doi.org/10.1037/tra0000841

Trinitapoli, J. A., & Weinreb, A. (2012). *Religion and AIDS in Africa*. Oxford; New York: Oxford University Press. https://doi.org/10.1093/acprof:oso/9780195335941.001.0001

Utomo, H. S. (2020). The effect of Muslim religiosity and innovation capability on firm survival: A study on small enterprises during the Covid-19 pandemic. *IQTISHADIA, 13*, 179-193. https://doi.org/10.21043/iqtishadia.v13i2.7626

VanderWeele, T., & Long, K. (2020). Religious communities and love of neighbor in times of crisis. *Public Health, Religion and Spirituality Bulletin, Issue 2*, 10-12. https://www.publichealthrs.org/a012/

Vermeer, P., & Kregting, J. (2020). Religion and the transmission of COVID-19 in the Netherlands. *Religions, 11*, 393. https://doi.org/10.3390/rel11080393

Yezli, S., & Khan, A. (2020). COVID-19 social distancing in the kingdom of Saudi Arabia: Bold measures in the face of political, economic, social and religious challenges. *Travel Medicine and Infectious Disease, 37*, 101692. https://doi.org/10.1016/j.tmaid.2020.101692

---

[1]^ Doug Oman, School of Public Health, University of California, Berkeley (DougOman@Berkeley.edu).