patients, families, and communities can place their confidence in primary care providers, social workers, nurses and nurse practitioners, psychiatrists, and clinical and school psychologists to have the skills needed to screen, assess, and initially help suicidal patients. Although it is time to move beyond the veneer of training that is expected for working professionals in those states that have mandates, we are uncertain whether there yet is sufficient outrage to demand such changes. However such changes come about, we recall the response to the question, "How do you get to Carnegie Hall?" *Practice, practice, practice*. We await the time when this admonition is commonly accepted as a key element for preventing death from suicide and other adverse self-injury outcomes that share common risks. AJPH

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Islamophobia and the Public Health Implications of Religious Hatred

See also Samari et al., p. 829; e1.

This month's issue of *AJPH* contains the results of a systematic review by Samari et al. (p. 829; e1) documenting the effects of Islamophobia from a sample of 53 English-language studies of Muslims conducted in North America, Europe, Australia, and New Zealand. The findings implicate religious discrimination, racism, and hatred directed toward Muslims as significant determinants or correlates of a host of negative outcomes.

This review is groundbreaking for reasons other than its affirmation of the deleterious health impact of Islamophobia. For one, little in the way of health-related outcome data has appeared up to now on determinants of physical health or psychological distress among Muslims.[1] Relative to other faith traditions, we know much less about how the experience of being a Muslim and of practicing Islam serves as a risk or protective factor against subsequent morbidity, mortality, or disability, whether physical or psychological.

Although the reviewed studies surveyed respondents from different countries and different Muslim ethnic populations and involved different outcome measures, basic trends across the studies are apparent. Religious discrimination targeting Muslims is significantly associated with poor physical and mental health outcomes, including greater psychological distress; more depressive symptoms; higher levels of fear, anxiety, and posttraumatic stress disorder; more self-harm; lower self-esteem; poorer self-rated health; less physical activity and more activity limitation days; unhealthier diet; higher body mass index; worse blood pressure and cholesterol readings; less access to health care services (e.g., maternity care); and less health care–seeking behavior, including screening tests.

Islamophobia in the global West is a source of hardship and distress experienced by millions of innocent human beings. Its persistence calls our attention to enduring attitudes and behaviors toward Muslims that are a cause of much suffering. It is just as worthy of our condemnation as other notable group hatreds responsible for persecution of religious minorities, such as toward Christians in Syria and Sudan, Sufis in Iran, Jews in Scandinavia, Sikhs in India, and Buddhists in China.

POPULATION HEALTH CONSEQUENCES

Islamophobia, as documented in the Samari et al. study, is a double tragedy in the context of public health. First, it is a violation of the human rights of a significant minority population in US society and is a source of dissension and even violence, as with any collective hatred toward a marginalized "other." Second, as the study shows, there are measurably harmful consequences for the well-being of Muslims, physical as well as psychological.

Although not a focus of the study, there is another potentially detrimental health-related consequence of Islamophobia. For decades, religious institutions and individuals across the religious spectrum have been significant resources for public health agencies. Partnerships between the faith-based and public health sectors exist globally and at the local, state, and federal levels of government. Many of the values and

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ethical teachings espoused by the major faith traditions reinforce the mission of those of us working to prevent morbidity and mortality and promote population health. Religion, broadly, serves as a radix of supportive resources, social control–regulating health behaviors, social capital, and myriad psychosocial and sociopolitical influences on health status.[2]

Concomitantly, efforts to suppress the free exercise of religion and to project baseless hatred onto groups of people on account of their religious identity deny valuable personal and institutional resources that might otherwise be brought to bear to advance public health objectives. Islamophobia thus may serve to inhibit the full participation of Muslim organizations and people striving to fulfill their covenant with Allāh in laboring for justice and compassion toward others. This includes ministering to the medically underserved, responding to environmental degradation, and participating in interfaith alliances to advance the cause of social well-being.[3]

The consonance of the core moral teachings and ethical pillars of Islam with the core principles of public health underscores the damage that marginalizing our Muslim brothers and sisters wreaks on the well-being of our communities, our nation, and our world. Our field is famously defined, in part, by a characteristic set of professional values, including a focus on primary prevention (forestalling problems that, if neglected, could cause harm), a commitment to communitarianism and social justice (working together collectively to serve the greater good and reduce the inequalities that underlie population health disparities), and a global perspective (honoring the intrinsic human rights of all people, particularly those with the fewest resources and the most disadvantages).[4] These values would be familiar to any observant Muslim.[5]

Celebrated Muslim philosopher and Iranian expatriate Seyyed Hossein Nasr explained that "above all, Muslims must always seek to judge justly. . . . Fighting injustice, oppression, and evildoing is itself just and the means of establishing justice. . . . [This] ideal is very central to the Islamic concept of justice and a just society."[6(p253–255)] These concepts of righteousness originate in the Qur'ān and in Ḥadīths attributed to the Prophet, such as "O people! Worship Allah, the Beneficent, feed His bondsmen, and spread Salaam [peace] much, and you will reach Heaven in safety."[7(p437)] Normative Muslim teachings require actions to prevent evil from befalling others and to promote the public good, including the well-being of those of other faiths. The fate of one's soul indeed depends upon whether one has earnestly labored in the cause of attending to the needs of the less fortunate and in making peace.

WHY THIS MATTERS

The downstream effects of Islamophobia for public health are harmful and avoidable. Hatred and exclusion directed toward any group of people, of course, is cause for concern. All of us lose out when any of us are discriminated against, persecuted, or oppressed for freely exercising our faith, something guaranteed by the US Constitution and laws. To borrow a current phrase, Islamophobia creates very bad optics for our nation and does not bode well for the future of a society becoming rapidly more diverse culturally, linguistically, and religiously.

But the persistence of Islamophobia should be of special concern to those of us in public health because a flourishing Muslim-American community is a valuable source of wholesome other-regarding values that, as noted, also define the mission of the public health sector. These Islamic values are strongly parallel to the best that other major faith traditions offer, as in the preferential option for the poor and vulnerable found in Catholic social teaching, the concept of *tikkun olam* (repairing and healing the world) taught in rabbinic Judaism, the *ahiṃsā* (compassion and nonviolence) of Hinduism, and the *bodhicitta* (awakened mind) of Buddhism that seeks compassion for all sentient beings. These values also correspond to those that underlie our work as public health scientists and professionals.

We hope that the important study by Samari et al. will contribute to a more focused discussion of the potential damage that the enduring embarrassment of Islamophobia in the United States threatens to inflict upon the health of the population and upon the practice of public health. We also hope that it encourages a larger discussion of the harm done by religious hatred, in general, to both personal flourishing and communal relations among all Americans. Finally, we pray that this editorial, written collaboratively by a Jewish epidemiologist and a Protestant sociologist, can exemplify the potential of interfaith partnerships for speaking out against injustices directed toward religious minorities. AJPH

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