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Developing religiously-tailored health messages for behavioral change: Introducing the reframe, reprioritize, and reform ("3R") model

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ABSTRACT

Rationale: As community health interventions advance from being faith-*placed* to authentically faith-*based,* greater discussion is needed about the theory, practice, and ethics of delivering health messages embedded within a religious worldview. While there is much potential to leverage religion to promote health behaviors and improve health outcomes, there is also a risk of co-opting religious teachings for strictly biomedical ends.

Objective: To describe the development, implementation, and ethical dimensions of a conceptual model for religiously-tailoring health messages.

Method: We used data from 6 focus groups and 19 interviews with women aged 40 and older sampled from diverse Muslim community organizations to map out how religious beliefs and values impact mammography-related behavioral, normative and control beliefs. These beliefs were further grouped into those that enhance mammography intention (facilitators) and those that impede intention (barriers). In concert with a multi-disciplinary advisory board, and by drawing upon leading theories of health behavior change, we developed the "3R" model for crafting religiously-tailored health messages.

Results: The 3R model addresses barrier beliefs, which are beliefs that negatively impact adopting a health behavior, by (i) *reframing* the belief within a relevant religious worldview, (ii) *reprioritizing* the belief by introducing another religious belief that has greater resonance with participants, and (iii) *reforming* the belief by uncovering logical flaws and/or theological misinterpretations. These approaches were used to create messages for a peer-led, mosque-based, educational intervention designed to improve mammography intention among Muslim women.

Conclusions: There are benefits and potential ethical challenges to using religiously tailored messages to promote health behaviors. Our theoretically driven 3R model aids interventionists in crafting messages that address beliefs that hinder healthy behaviors. It is particularly useful in the context of faith-*based* interventions for it highlights the ethical choices that must be made when incorporating religious values and beliefs in tailored messages.

1. Introduction

Achieving health equity, eliminating healthcare disparities, and improving the health of all segments of the US population are the US Department of Health and Human Services Healthy People 2020 guideline's overarching goals (ODPHP). To achieve these objectives, targeted *and* tailored approaches to minority health interventions are essential. Targeted approaches select population subgroups based on intrinsic characteristics relevant to the intervention's health promotion goals (Pasick, 2001; Pasick, D'onofrio and Otero-Sabogal, 1996). For example, a researcher might recruit individuals with low levels of self-efficacy for empowerment training. Tailoring, on the other hand, refers to applying various methods to design interventions that conform to the specific values and norms of the individual or the group (e.g., cultural tailoring based on race/ethnicity), or to their behavioral characteristics (e.g., using techniques to move people along stages of change) (Shirazi et al., 2015; Kreuter et al., 2003; Pasick, 2001). Some scholars hold that tailoring must occur at the level of individual characteristics, while others state that adapting interventions based on group-level characteristics also represents a tailoring strategy (Pasick, 2001).

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Targeting and tailoring are both effective strategies that promote behavioral change by delivering health messages that are specific to an intended audience(Kreuter et al., 2003). Because these messages engage with the particular belief structures and worldviews of individuals and communities, they can be more persuasive than generic messages (Kreuter et al. 1999, 2003; Shirazi et al., 2015). Studies show that culturally-tailored interventions can be more effective in promoting health behavior change (e.g., reducing smoking, improving diet, increasing cancer screening) than non-tailored approaches (Kreuter et al., 2005; Wu et al., 2009; Shirazi et al., 2015; Champion et al., 2002). Culturally-tailored messages also appear to be better retained than non-specific health messages (Ramos et al., 2013). Finally, culturally-tailored health interventions can more effectively engage populations that have historically been hard to reach (e.g., racial/ethnic minorities), and promote value-concordant, health decision-making (Kreuter et al., 2005; Holt et al., 2003). Given the benefits of tailored approaches to health behavior change among specialized populations, these strategies are becoming increasingly important for achieving health equity.

1.1. Religiously-tailored health interventions

Religion provides a framework through which many individuals attach value and meaning to health and health behaviors. Consequently, religiously-tailored messages and interventions may be a particularly effective form of cultural-tailoring for some populations. Several studies show that individuals have greater trust in religiously-tailored health messages compared to general non-tailored ones (Kreuter et al. 2003, 2005; Holt et al., 2003), and that patients have more positive thoughts about cancer screening when exposed to spiritually-framed messages in comparison to non-spiritual messages (Best et al., 2016).

Religiously-tailored health messages are examples of faith-*based* interventions (corresponding to Level 4 interventions in Lasater et al.'s schema), where intervention content is grounded in religious worldviews and scripture(Lasater et al., 1997). In comparison, faith-*placed* interventions have secular content and the intervention is merely housed within a religious setting (e.g., mosque, church) for participant convenience and familiarity, (corresponding to interventions between Levels 1–3 in Lasater et al.'s schema) (Holt et al., 2009; Winett et al., 1999; Lasater et al., 1997). Accordingly, while there is a substantial body of literature on health interventions set within religious communities, the ways in which religion is involved in these studies varies widely (DeHaven et al., 2004; Chatters et al., 1998; McNabb et al., 1993; McNabb et al., 1997). Moreover, few studies give focused attention to the merits and pitfalls of designing religiously tailored messages.

1.1.1. Effectiveness considerations of religiously-tailored health messages

All culturally-tailored interventions must consider effectiveness considerations, because the interventionist must select ideas and values that resonate deeply enough with individuals to motivate behavior change. Religious tailoring presents additional challenges because identifying which religious beliefs and values are more important than others, to both individuals and communities, is not easy or, at times, even possible. There is often substantial diversity of ideas among individuals and communities within a religion, and religious doctrines often embrace multiple interpretations of religious scripture. While working with religious authorities and community members can help identify which beliefs and values to leverage in behavior change messages, it is nonetheless an inexact process, and the effectiveness of particular messages requires scientific study.

1.1.2. Ethical considerations of religiously tailored health messages

Religiously-tailored health messages also present potential ethical considerations for health behavior interventionists because some religious practices might negatively impact health, religious orthodoxy (correct belief) and/or orthopraxy (correct conduct) can evolve or be contested, and there can be discordance between religious beliefs and health promotion behaviors. Indeed some religious beliefs and values are health promoting (e.g., the body is a temple), while others might lead to negative health behaviors (e.g., diseases are preordained by God), and some religious practices can pose health risks (e.g., fasting). Moreover, when legitimate religious beliefs and values are discordant with health promoting behaviors, or pose actual health risks, does the interventionist bear an ethical responsibility to disrupt religious doctrines and practices? Or are there reasons that justify *not* confronting certain religious beliefs, values or interpretations? In other words, when is the primacy of religious values and interpretations to be honored and when are religious ideas to be challenged?

Interventionists might have to decide whether to promote what is in the *bodily health interest* of the patient (e.g., support screening mammograms among age-appropriate women), or to support patients' religious beliefs and practices (e.g., views that God alone is in control of cancer onset and cure), or to find another ethically-acceptable solution. One might opt to ignore religious values and beliefs that challenge the target health behavior, but if these constructs are significant enough as barriers, behavior change might not occur. On the other hand, if the choice is made to use tailored messages to discredit religious beliefs, values or practices that hinder health, concerns may arise that health scientists are overstepping their roles and training. Consequently, a cautious, deliberate, collaborative approach is necessary when identifying which religious values and beliefs to emphasize, and which to confront or marginalize, when crafting tailored messages.

1.1.3. Case study: Muslim Americans and mammography

Before describing our religious tailoring model and its development, it is important to describe the health challenge we sought to address and our implementation context. Although some Muslim women seem to present with breast cancer at a younger age, with more advanced disease, and with worse morphological features than other groups (Rastogi et al., 2008; Moran et al., 2011; Kakarala et al., 2010; Alford et al., 2009; Nasseri and Moulton, 2011), mammography rates among American Muslims remain lower than the 75% national average and the Healthy People 2020 goal of 81% (2012) (Hasnain et al., 2012; Padela et al., 2015). Like most research conducted at the intersection of Islam and Muslim health (Laird et al., 2007), religious beliefs and values appear to influence screening practices both positively and negatively. For example, studies note that religion-related modesty concerns can prevent women from getting screened, while Islamic responsibilities to care of one's body may promote screening (Rajaram and Rashidi, 1999). Our formative research among an ethnically and racially diverse group of Muslim women in Chicago revealed similar influences. We found that views about being entrusted by God to care for the body tend to enhance women's intention for mammograms, and that fatalistic ideas and a preference for gender-concordant care can negatively impact screening decisions(Padela et al., 2016). Consequently, breast cancer screening disparities among American Muslims provide an opportunity to advance health equity through *targeted* interventions, and the strong relationships between religion and health behaviors among Muslims (Yong et al., 2009; Padela and Curlin, 2013) provide the basis for using religiously-*tailored* messages for behavior change.

To our knowledge, there is no consensus-based approach to the crafting of religion-laden messages, nor are there established guidelines for dealing with the ethical conundrums involved. Accordingly, this article describes a model for developing religiously-tailored messages, discusses it ethical dimensions, and illustrates its implementation within an intervention aimed at enhancing American Muslim women's intention for mammography. While strategies used in one intervention may not necessarily be work in another because of sociocultural, organizational and geopolitical contextual differences between religious communities, describing methods and ethical considerations of religiously-tailored message design can help to advance faith-based