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Determinants of Health in Abrahamic Scriptures: A Comparative Thematic Analysis of the Quran, Bible, and Torah

Belay Sitotaw Goshu[1], Muhammad Ridwan[2]
[1]Department of Physics, Dire Dawa University, Dire Dawa, Ethiopia
[2]Universitas Islam Negeri Sumatera Utara, Indonesia
Email: belaysitotaw@gmail.com, bukharyahmedal@gmail.com

Abstract:

Mainstream models of health determinants, including the Dahlgren Whitehead rainbow model and WHO frameworks, overlook spiritual and religious factors despite growing evidence of their influence on health outcomes. Abrahamic scriptures the Quran, Bible, and Torah contain extensive guidance on health, yet no systematic comparative analysis has mapped their determinants. This study aimed to identify, categorise, and compare health determinants articulated in the Quran, Bible, and Torah, and to integrate findings into contemporary public health discourse. A comparative qualitative thematic analysis was conducted. Deductive codes were derived from existing determinant models; inductive codes emerged from scriptural analysis. Texts included the Quran (Arabic with Saheeh International translation), the Bible (NIV/NRSV), and the Torah (Jewish Publication Society translation). Rigour was ensured through audit trails, peer debriefing, and negative case analysis. Four determinant categories were identified: metaphysical (divine will, sin, spiritual forces, prayer), behavioural (diet, hygiene, rest, sexual ethics, intoxicants), social (charity, community responsibility, justice, governance), and psychological (faith, gratitude, repentance). All three scriptures affirm metaphysical determinants. Behavioural determinants are strongest in the Quran and Torah; social determinants are strongest in the Bible; psychological determinants are strong in the Quran and Bible, moderate in the Torah. Conclusion: Abrahamic scriptures present a holistic model in which the divine human relationship is the primary health determinant, extending beyond secular frameworks. Public health practice should integrate spiritual determinants through culturally competent promotion, faith based interventions, and clinical spiritual assessment. Future research should quantify scriptural determinants and extend analysis to other religious traditions.

Keywords:
Determinants of health; Abrahamic scriptures; Quran; Bible; Torah; spiritual health; comparative thematic analysis

I. Introduction

1.1 Introduction

The concept of health determinants has evolved significantly over the past three decades, moving beyond biomedical explanations toward a more comprehensive understanding of the multifactorial nature of health outcomes. Among the most influential frameworks is the Dahlgren and Whitehead (1991) "rainbow model," which conceptualises health determinants as layers of influence ranging from individual biological and behavioural factors to broader social, economic, and environmental conditions (Dahlgren & Whitehead, 1991). This socioecological model illustrates how health is shaped not merely by individual choices or genetic predispositions but by the complex interplay between personal characteristics, living and working conditions, community networks, and macro-level policies (Bonner, 2018). The model's enduring influence

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is evidenced by its continued application across public health research and policy, including recent adaptations to address digital determinants of health (Kickbusch et al., 2022).

The World Health Organization (WHO) has been instrumental in advancing the global discourse on health determinants. The landmark final report of the WHO Commission on Social Determinants of Health, Closing the Gap in a Generation (CSDH, 2008), provided compelling evidence that social inequalities rooted in differential access to power, resources, and opportunity are primary drivers of health inequities worldwide. The Commission identified structural determinants (governance, policy, cultural values) and intermediary determinants (material circumstances, psychosocial factors, biological and behavioural factors, and health systems) as key pathways through which social position influences health outcomes (CSDH, 2008). Contemporary systematic reviews continue to affirm the importance of these determinants, with recent studies examining, for example, the role of contextual nonmedical health factors in critical care outcomes (Khan et al., 2025) and the intersection of gender with social determinants in shaping health inequalities (Garcia et al., 2025). Taken together, the current evidence base robustly demonstrates that health is a function of multiple, interacting determinants that span individual, interpersonal, community, and policy levels.

1.2 The Neglect of Spiritual and Religious Determinants in Mainstream Models

Despite the growing sophistication of health determinant frameworks, a notable and persistent omission remains: the spiritual and religious dimensions of human life. Interestingly, although spirituality is consistently linked to health and well-being, it does not appear in key models of health determinants, such as the classic layer diagram of Dahlgren and Whitehead (1993), nor in many influential policy discourses (Scriven, 2010). This absence has been characterised as a significant omission in the discourse of health improvement (Scriven, 2010). Indeed, for many people, the WHO's definition of health even with its reference to physical, mental, and social well-being does not reflect their own understanding of health, precisely because it lacks aspects such as spiritual well-being (Trachsel, 2024). Responding to such concerns, the WHO called in 2023 for a vision of health that integrates physical, mental, psychological, emotional, spiritual, and social well-being (Trachsel, 2024).

Nonetheless, medical practitioners often remain reluctant to consider spiritual aspects, citing a perceived lack of statistical evidence or the difficulty of measuring spirituality (Trachsel, 2024). One main argument against the inclusion of religion and spirituality issues in health care is this perceived lack of possible metrics, even as research on the topic continues to emerge (Trachsel, 2024). A recent large-scale study among 42,843 children across eight countries examined whether healthy spirituality might act as an unrecognised intermediary determinant of health, contributing to health inequities (Michaelson et al., 2024). The findings revealed that spiritual health potentially mediates the relationship between socioeconomic position and mental health in some Western countries, suggesting that spiritual determinants are empirically measurable and clinically relevant (Michaelson et al., 2024). More broadly, systematic reviews have consistently linked religion and spirituality to better physical and mental health outcomes, including reduced mortality risk, improved quality of life, and enhanced coping mechanisms among patients with chronic illnesses (Koenig, 2024; Park et al., 2024). Despite this evidence, religious faith as a social determinant of health deserves greater recognition than it currently receives in standard models (Michaelson et al., 2024), and researchers and policymakers remain unlikely to harness the positive aspects of religious faith if its status as a key social determinant remains unacknowledged (Whitehead & Dahlgren, 2026).

1.3 Rationale for Studying Abrahamic Scriptures

The Abrahamic religions; Judaism, Christianity, and Islam are among the world's most influential moral and intellectual traditions, collectively claiming the adherence of over half of the global population. Each tradition possesses a foundational scripture the Torah, the Bible, and the Qur'an—that provides comprehensive guidance not only for worship and ethics but also for daily living, including matters pertaining to health, illness, and healing. Scholars have noted that the theology of health is a nascent field that emerged from Western academia only a few decades ago but has deep roots in celestial religions, with a historical review revealing a widespread belief across centuries in the strong connection between religion and human well-being (Aliakbari & Nazari, 2025). Indeed, religious guidance has been used for millennia to maintain and improve health, and healing was often considered one of the roles and duties of religious scholars, with recovery believed to depend on supernatural forces (Aliakbari & Nazari, 2025).

Recent empirical scholarship has begun to examine health determinants explicitly from scriptural perspectives. A comprehensive study of the Qur'an identified 744 codes (health-influencing factors) across 420 verses, confirming factors aligned with contemporary health science, including age, sex, genetics, material circumstances, behavioural factors, psychosocial factors, and political and socioeconomic contexts—while also revealing theologically grounded determinants such as divine will, religious injunctions, and the influence of the unseen realm (Fakhri & Yoosefee, 2025). Similarly, comparative studies have examined patients' rights across holy books, demonstrating that the Torah warned government officials who failed to observe patients' rights, the Bible stressed the importance of treatment and care for the sick, and the Qur'an insisted on the exemption of patients from physical religious duties (Hatami et al., 2013). Further, the three Abrahamic faiths share a holistic view of human beings, affirming that wholeness, wellness, and health are gifts from the Creator God, and that the practice of health care is "prophetic" in character, concerned with complete healing and the restoration of wholeness (Stefanovic, 2025).

However, despite these individual and comparative studies, there remains a significant gap: no study to date has systematically compared the three Abrahamic scriptures side by side using a consistent analytical framework to identify, categorise, and contrast the full range of health determinants as articulated within each tradition. The present study addresses this gap by undertaking a comparative thematic analysis of the Qur'an, the Bible, and the Torah.

1.4 Research Question

This study is guided by the following research question: What are the health determinants articulated within the Qur'an, the Bible, and the Torah, and how do these determinants compare across the three Abrahamic scriptures?

1.5 Study Objectives

The principal objectives of this study are as follows:

a. To identify health determinants explicitly or implicitly referenced in the Qur'an, the Bible, and the Torah.
b. To categorise these determinants into thematic domains (e.g., metaphysical, behavioural, social, psychological).
c. To compare the identified determinants across the three scriptures, noting similarities, differences, and unique contributions.
d. To situate the findings within contemporary public health discourse on determinants of health.

e. To propose an integrated framework that incorporates spiritual and religious determinants derived from scripture into existing health determinant models.

The remainder of this paper is organised as follows. Section 2 presents a review of the relevant literature on religion, spirituality, and health, as well as existing comparative studies on Abrahamic traditions and health. Section 3 describes the methodological approach, including the comparative thematic analysis procedure, text selection criteria, and strategies for ensuring analytical rigour. Section 4 reports the findings, organised by thematic category and scripture. Section 5 discusses the implications of these findings for public health theory, policy, and practice, addresses study limitations, and offers directions for future research. Section 6 concludes the paper by summarising its contributions and offering final reflections on the integration of spiritual determinants into mainstream health frameworks.

II. Review of Literatures

2.1 WHO and Dahlgren-Whitehead Models of DOH

The modern conceptualisation of health determinants has been profoundly shaped by two interconnected frameworks: the Dahlgren and Whitehead "rainbow model" and the WHO Commission on Social Determinants of Health framework. Developed in 1991, the Dahlgren-Whitehead model maps the layered influences on health outcomes in a now-iconic diagram that places the individual at the centre, surrounded by successive layers of influence (Dahlgren & Whitehead, 1991). The innermost layer encompasses individual lifestyle factors; the next layer covers social and community networks; the third layer includes living and working conditions; and the outermost layer captures broader socioeconomic, cultural and environmental conditions (Dahlgren & Whitehead, 1991). As the WHO has recently observed, this rainbow model maps the interaction between individuals and lifestyle factors, community influences, living and working conditions, and the social conditions that surround them, all of which are themselves encapsulated within economic, political and commercial determinants (World Health Organization, 2025). The model's enduring influence is evidenced by its continued application across diverse public health research contexts, from suicide prevention among elderly populations (Silva et al., 2025) to the development of indicator-based frameworks for monitoring health inequalities (Tsampoukas et al., 2025), and from reframing long-term care policy (Hamblin, 2025) to understanding the social risk of informal caregiving (Zadro & Chapman, 2025).

The World Health Organization's Commission on Social Determinants of Health (CSDH), established in 2005, provided the most authoritative global statement on health determinants with its 2008 final report, Closing the Gap in a Generation (CSDH, 2008). The Commission articulated that social justice is fundamentally a matter of life and death, affecting the way people lives, their consequent chance of illness, and their risk of premature death (CSDH, 2008). The report distinguished between structural determinants—governance, policy, cultural values, and intermediary determinants that include material circumstances, psychosocial factors, biological and behavioural factors, and health systems (CSDH, 2008). The Commission called on governments and global organisations to lead action on social determinants with the aim of achieving health equity within a generation, asserting that such a goal is both achievable and imperative (CSDH, 2008). Collectively, these frameworks have established that health is determined not merely by individual choices or biological predispositions but by the complex, multi-layered interplay of personal, social, economic, and political forces (Bonner, 2018).

2.2 Religion and Health: Existing Evidence

The relationship between religion, spirituality (R/S) and health has received increasing attention in the academic literature (Koenig et al., 2024). Studies involving quantitative measurement of R/S and health have reported many positive associations between these constructs, with systematic reviews consistently linking religious involvement to better physical and mental health outcomes, including reduced mortality risk, improved quality of life, and enhanced coping mechanisms among patients with chronic illnesses (Koenig, 2024; Park et al., 2024). The Handbook of Religion and Health (Koenig et al., 2024) now in its third edition, provides a comprehensive review of the history, research, and discussions on religion and health, examining almost every aspect of health and reviewing past and more recent research on the relationship between religion and health outcomes (Koenig et al., 2024).

However, scholars have raised important methodological concerns. Koenig and colleagues (2024) have warned that some measures of R/S have been contaminated with indicators of mental health, such that when R/S is defined and measured a priori in overlapping terms with mental health, subsequent positive associations become tautological—correlating a construct with itself—thus producing associations that are uninterpretable and misleading (Koenig et al., 2024). This critique underscores the need for uncontaminated measures in future studies of R/S and health (Koenig et al., 2024). A recent narrative review by Fuller (2025) identifies and critically analyses three dominant approaches in public health scholarship: religion as a quantifiable variable; religious institutions as partners in health promotion; and religion as a social force shaping public health (Fuller, 2025). The review advocates for reciprocal engagement between public health and religious studies scholars to produce more nuanced, culturally responsive, and theoretically grounded research (Fuller, 2025).

Public health professionals regularly engage faith communities to improve public health. A systematic review by Gunderson and colleagues (2025), encompassing 121 articles reporting on 96 distinct projects, characterised approaches to engaging faith communities on vaccination, genetic and genomic healthcare, and colorectal cancer screening (Gunderson et al., 2025). Notably, the majority of projects (77.1%) reported primarily engaging faith communities for reasons unrelated to faith, suggesting missed opportunities to leverage religious values and beliefs that might inform attitudes toward health behaviours (Gunderson et al., 2025). In the specific context of Muslim minorities, a review by Selim and colleagues (2025) examined how Islamic principles were incorporated into health and wellbeing interventions, revealing profound integration of Islamic principles that amplified motivation, enhanced treatment engagement, improved health literacy, and supported wellbeing, with active community involvement critical to successful adaptation (Selim et al., 2025).

2.3 Health Concepts in Islamic Tradition

In Islamic tradition, health is understood as a precious gift and blessing from Allah that should be protected and enhanced, for without good health Muslims cannot fulfil their role as vicegerents (Khalifah) on earth to enjoin good and forbid evil (Chaudhury, 2019). The Quran, while primarily a book of guidance, nonetheless makes explicit reference to health and healing, with six verses described as verses of shifaa' (healing) (Chaudhury, 2019). Key verses include Surah As-Shu'ara 26:80, in which Prophet Ibrahim recognises God as the ultimate healer ("And when I fall sick, He heals me"), and Surah Al-Imran 3:49, in which Prophet Isa is described as curing the blind and leprous by God's permission (Chaudhury, 2019). The Quran utilises three distinct approaches to achieve its healing and health-promoting effect: the legal approach, the guiding approach, and the direct healing approach (Abdul-Rahman, 2020).

Health in Islam is situated within the Maqasid Shari'ah the higher objectives of Islamic jurisprudence, which define the preservation of five essentials in human life: faith and morality, life, intellect, progeny, and wealth (Chaudhury, 2019). The Quranic verse "And if anyone saved one life, it would be as if he had saved mankind entirely" (Surah Al-Maidah, 5:32) underscores the profound value placed on health preservation (Chaudhury, 2019). A pervasive emphasis on preventative health strategies permeates the Islamic paradigm, reflected in foundational injunctions such as the hadith "Cleanliness is half of faith" and Quranic directives to eat only lawful and good food and to avoid intoxicants (Chaudhury, 2019). A comprehensive study of the Quran identified 744 codes (health-influencing factors) across 420 verses, confirming factors aligned with contemporary health science, including age, sex, genetics, material circumstances, behavioural factors, psychosocial factors, and political and socioeconomic contexts, while also revealing theologically grounded determinants such as divine will, religious injunctions, and the influence of the unseen realm (Fakhri & Yoosefee, 2025).

2.4 Health Concepts in Christian Tradition

Christian theology approaches health through the lens of shalom, a Hebraic concept denoting completeness, welfare, and peace that extends far beyond the mere absence of disease. Within this framework, the primary determinant of health is the individual's proper relationship with God, and scriptural commands are understood not as arbitrary impositions but as divinely ordained guidance for human flourishing. Recent scholarship by VanderWeele (2025), recipient of the 2025 Dallas Willard Book Award for A Theology of Health: Wholeness and Human Flourishing, provides a systematic exposition of Christian theology's relevance for understanding the concept of health and promoting wholeness (VanderWeele, 2025). This theological perspective positions the practice of healthcare as prophetic in character, concerned with complete healing and restoration to wholeness (Stefanovic, 2025).

The Bible addresses the philosophy of disease, exploring the concept of illness, its terminology, causes, types, and theological objectives, as well as investigating healing methods mentioned in the biblical text (Al-Rawi, 2025). A recent comparative study examining the theology of disease in the Bible finds that while some similarities exist regarding the types, causes, purposes, and treatments of illness across religious traditions, fundamental differences arise from distinct theological frameworks (Al-Rawi, 2025). Contemporary approaches to healing that focus on the concept of "the body as healer" have been evaluated through a biblical-theological lens, exploring its relevance for spiritual formation (Porter, 2025). Additionally, exegetical analyses of healing narratives, such as the healing of the woman with a twelve-year hemorrhage in Luke 8:43–48 explore the integration of divine healing within contemporary medical practice, synthesising theological perspectives on divine healing with medical research on faith-based interventions (Sekanabo, 2025). The Christian tradition thus presents a vision of health that integrates the spiritual, physical, social and communal dimensions of human existence.

2.5 Health Concepts in Jewish Tradition

Jewish tradition approaches health from a foundation of divine commandment and moral responsibility. The Torah acknowledges God as the ultimate healer: "I am the Lord who heals you" (Exodus 15:26) (Karaite Jewish Congregation, 2025). However, far from precluding human medical intervention, Judaism explicitly recognises and mandates the practice of medicine. The Torah verse in Exodus 21:19, which addresses liability for injury and states "He shall surely cause him to be healed," is interpreted by the rabbis as providing not merely permission but a positive commandment, a mitzvah for physicians to heal (Karaite Jewish Congregation, 2025; Aish, 2025). The medieval philosopher and physician Maimonides taught that healing the sick is one of

the highest forms of service to God, writing that "The physician has permission to heal, and it is a commandment, a religious duty, for him to do so" (Aish, 2025; Karaite Jewish Congregation, 2025). The Code of Jewish Law thus appropriately states: "The Torah gives permission to the physician to heal; moreover, this is a mitzvah" (Aish, 2025).

Central to Jewish health ethics is the principle of pikuach nefesh the obligation to save and preserve life, which overrides almost all other religious commandments, including Sabbath observance (Karaite Jewish Congregation, 2025). This understanding places healing not merely as an act of kindness but as a divine commandment, with the Talmud teaching that "he who saves a single life, it is as though he has saved an entire world" (Mishnah Sanhedrin 4:5) (Karaite Jewish Congregation, 2025). Just as physicians have a duty to heal, Judaism places responsibility on patients to seek healing, derived from Deuteronomy 4:15 which command: "Take utmost care and guard your soul diligently" (Karaite Jewish Congregation, 2025). To reject medical treatment out of misplaced faith or fatalism is viewed as undermining the very partnership God established between divine providence and human effort (Karaite Jewish Congregation, 2025). The Torah addresses ailments as having both material and spiritual causes (mi-tzad ha-homer and mi-tzad ha-nefesh), reflecting an ancient understanding of the interconnectedness of physical and spiritual health (Cooper, 2025). The Jewish tradition of healing thus unites medicine, faith, and moral responsibility into a single act of holiness (Karaite Jewish Congregation, 2025).

2.6 Gap in Comparative Scripture-Based DOH Research

Despite substantial scholarship on religion and health, and despite the emergence of the theology of health as a distinct field of inquiry (Aliakbari & Nazari, 2025), a significant gap persists in the literature: no systematic comparative study has comprehensively analysed the full range of health determinants as articulated across the foundational scriptures of all three Abrahamic traditions using a consistent analytical framework. Existing comparative studies have focused on specific issues, such as patients' rights across holy books (Hatami et al., 2013) or have examined theological frameworks without systematically mapping determinants onto contemporary public health models (Stefanovic, 2025). While the theology of health in the Abrahamic religions shares a relatively common historical background, with religious guidance used for millennia to maintain and improve health (Aliakbari & Nazari, 2025), the determinants of health have yet to be comparatively mapped across the Quran, Bible, and Torah in a way that facilitates integration with established social determinants of health frameworks.

Moreover, despite calls to recognise religious faith as a social determinant of health (Whitehead & Dahlgren, 2026), mainstream models continue to omit spiritual dimensions (Michaelson et al., 2024; Trachsel, 2024). A recent large-scale study has begun to address this gap by demonstrating that spiritual health potentially mediates the relationship between socioeconomic position and mental health in some Western countries (Michaelson et al., 2024), yet the specific content of spiritual determinants, as articulated within religious scriptures remains largely unexamined. Although a comprehensive study of the Quran has identified health determinants from the Islamic perspective (Fakhri & Yoosefee, 2025), no equivalent systematic analysis exists for the Bible and Torah using comparable methodology. The present study therefore addresses an urgent and timely gap by undertaking a comparative thematic analysis of health determinants across the three Abrahamic scriptures, with the aim of contributing to the integration of spiritual and religious determinants into mainstream public health discourse.

III. Research Methods

3.1 Research Design: Comparative Qualitative Thematic Analysis

This study employed a **comparative qualitative thematic analysis** design. Thematic analysis is a method for systematically identifying, organising, and interpreting patterns of meaning across qualitative data (Braun & Clarke, 2006, 2021). It is widely used in health and religious studies for its flexibility and theoretical freedom, making it particularly suitable for the textual analysis of scriptures (Fereday & Muir-Cochrane, 2006). Following the reflexive thematic approach outlined by Braun and Clarke (2019), this study acknowledged that theme generation involves the active, interpretive engagement of researchers with the data, rather than passive extraction.

The comparative element followed established guidelines for comparative religious research (Patton, 2015; Smith, 2000), providing a systematic contrast of themes across three distinct but related textual traditions. This design allowed for the identification of unique determinants, shared elements, and an integrated cross-faith framework capable of dialogue with contemporary public health models (Creswell & Poth, 2018).

3.2 Text Selection Criteria

Text selection followed purposive sampling principles (Palinkas et al., 2015). Given that the complete scriptural canons of the Quran, Bible, and Torah are too extensive for exhaustive line-by-line analysis in a single study, a focused approach was adopted based on established inclusion and exclusion criteria (Levitt, 2021).

a. Inclusion criteria**:** Verses or passages explicitly mentioning health, illness, healing, medicine, hygiene, cleanliness, diet, bodily functions, medical ethics, or divine healing. Passages discussing suffering, sin, repentance, or death clearly linked to physical or mental well-being were also included. All verses had to originate from the recognised canonical texts.
b. Exclusion criteria**:** Purely eschatological passages with no health application, purely legal or ritual passages unrelated to health, and contested or apocryphal texts were excluded.

3.3 Data Extraction Strategy

Data extraction employed a systematic approach informed by scriptural review methodologies (Holden et al., 2021; Tong et al., 2012). The process consisted of five sequential stages:

a. Literature and scope definition**:** The research problem was defined, and the search parameters within each scripture were established.
b. Systematic scriptural search**:** Each text was systematically examined using keyword searches. For the Quran, this involved a targeted search for specific verses combined with a broader reading of adjacent verses to maintain context (Fakhri & Yoosefee, 2025). For the Bible and Torah, digital concordances and search tools (e.g., Blue Letter Bible, BibleHub) were used to locate relevant passages (Patton, 2015).
c. Primary verse extraction**:** All identified candidate verses were extracted and recorded in a master database. For each verse, the citation, the full English text, the original language citation (for the Quran), and the immediate context were documented (Saldaña, 2021).

d. Definition and categorisation**:** Extracted verses were examined to define the health determinant being discussed and to assign it to a preliminary category based on the emerging coding framework.
e. Contextual cross-validation**:** Each verse was re-evaluated against its broader *surah*, chapter, or pericope to ensure that the health determinant was not taken out of its narrative or legal context. Where passages were ambiguous, standard scholarly commentaries were consulted (e.g., *Tafsir ibn Kathir* for the Quran (Ismāʿīl ibn ʿUmar ibn Kathīr, 2000); *The Jewish Study Bible* for the Torah (Berlin & Brettler, 2014)).

3.4 Thematic Coding Framework

The coding framework employed a hybrid approach, integrating deductive codes derived from existing models of health determinants with inductive codes that emerged directly from the scriptural texts (Fereday & Muir-Cochrane, 2006).

3.5 Rigour and Trustworthiness (Credibility, Dependability, Confirmability)

To ensure the quality of this qualitative research, the criteria of trustworthiness as established by Lincoln and Guba (1985) were systematically applied. These criteria parallel the quantitative concepts of internal validity, reliability, objectivity, and external validity, respectively (Korstjens & Moser, 2018).

Table 2: Trustworthiness Criteria and Application Strategies

Criterion	Definition	Application Strategy
Credibility	Confidence in the truth of the findings (parallels internal validity)	Prolonged engagement with texts (Nowell et al., 2017); peer debriefing sessions among research team members; member checking through consultation with religious scholars for interpretation of ambiguous passages; triangulation across multiple English translations and original language sources (Patton, 2015).
Dependability	Consistency and replicability of findings (parallels reliability)	Maintenance of a detailed audit trail documenting all analytical decisions from raw data to final themes (Lincoln & Guba, 1985); reflexive journaling recording the researcher's evolving interpretations and assumptions (Braun & Clarke, 2021).

Confirmability	The degree to which findings are shaped by the data, not researcher bias (parallels objectivity)	Explicit linkage of every formulated theme to specific, cited textual evidence; rigorous negative case analysis (seeking and reporting instances that contradict emerging themes) (Miles et al., 2020); disclosure of the research team's theological and academic positionality (Levitt, 2021).
Transferability	The applicability of findings to other contexts (parallels external validity)	Provision of thick, detailed descriptions of the three scriptural corpora and the analytical context, enabling readers to assess the applicability of findings to other religious, cultural, or public health settings (Korstjens & Moser, 2018).

3.6 Ethical Considerations

This qualitative study posed no risk to human subjects**,** as it analysed established, publicly available religious scriptures rather than human participants or their data (Resnik, 2020). Nevertheless, several key ethical imperatives were observed:

a. Respect for texts**:** The scriptures were treated with academic integrity, interpreted within their original historical, literary, and theological contexts (Smith, 2000). Deliberate de-contextualisation or misrepresentation was actively avoided. All translation comparisons were performed transparently (Patton, 2015).
b. Commitment to objectivity**:** All findings were derived from and directly anchored to the primary source texts. Interpretive claims were supported by explicit textual citations to avoid eisegesis the imposition of the researcher's meaning onto the text (Levitt, 2021).
c. Neutrality in comparative judgment**:** The study approached each tradition with methodological neutrality, refraining from favouring one scripture over another or imposing external hierarchies of value. Divergences were reported descriptively and non-judgmentally (Patton, 2015).
d. Acknowledgement of limitations**:** The inherent limitations of the methodology including the challenge of interpretation in translation, the vastness of the scriptural canons, and the absence of a single, universally recognised hermeneutic for any of the three texts—were openly acknowledged and addressed in the limitations section of the final publication (Creswell & Poth, 2018).
e. Institutional review**:** The study was conducted under the policies and ethical guidelines of the authors' host institutions regarding scholarly research on cultural and religious texts.

IV. Results and Discussion

4.1 Metaphysical Determinants

The comparative analysis revealed that all three Abrahamic scriptures recognise a foundational layer of health determinants operating beyond the physical realm. These metaphysical determinants consistently shape health outcomes through divine agency, moral causality, spiritual beings, and devotional practices.

4.2 Behavioral and Lifestyle Determinants

The behavioral and lifestyle determinants form the most visibly codified layer across the Abrahamic scriptures, providing direct, practical guidance for adherents. These laws are presented not merely as spiritual obligations but as divine prescriptions for physical and communal well-being.

4.3 Social and Communal Determinants

Beyond individual behaviour, each scripture positions the social fabric and governance structures as codified health determinants operating through charity, collective responsibility, distributive justice, and religious law.

4.4 Psychological and Spiritual States

All three scriptures identify internal psychological conditions; faith, fear, gratitude, and repentance not merely as emotional states but as active health determinants. These states directly influence physical health outcomes and mediate the relationship between individuals and the divine.

4.5 Comparative Summary of Findings

The comparative thematic analysis revealed both convergence and divergence across the three Abrahamic scriptures regarding determinants of health. Table 1 summarises the relative emphasis placed on each determinant category.

Table 3: Comparative Emphasis of Health Determinants across Scriptures

Determinant Category	Quran	Bible	Torah
Metaphysical	Present	Present	Present
Behavioral	Strong	Moderate	Strong
Social	Moderate	Strong	Moderate
Psychological	Strong	Strong	Moderate

All three scriptures unanimously acknowledge metaphysical determinants—divine will, sin, spiritual beings, and prayer—as foundational to health. No tradition reduces health to purely material causation.

Behavioral determinants (diet, hygiene, rest, sexual ethics, intoxicants) receive strongest emphasis in the Quran and Torah, both of which codify extensive legal prescriptions. The Bible exhibits moderate emphasis, with the New Testament relaxing dietary and purity laws while retaining moral prohibitions.

Social and communal determinants (charity, collective responsibility for the sick, justice, and governance) are most prominently developed in the Bible, particularly in the prophetic call for justice and the early church's communal care practices. The Quran and Torah present moderate but still substantial social frameworks.

Psychological and spiritual states (faith, fear, gratitude, repentance) are strongly emphasised in both the Quran and Bible, where internal dispositions are explicitly linked to mental and physical outcomes. The Torah contains these themes but with comparatively less systematic development.

These findings indicate that while all three scriptures integrate spiritual, behavioural, social and psychological determinants, their relative weighting differs, reflecting distinct theological and legal traditions.

4.6 Discussion

a. Integration of Findings with Existing DOH Models

The present findings extend established social determinants of health (SDOH) frameworks by demonstrating that metaphysical, behavioural, social, and psychological determinants as articulated in Abrahamic scriptures map meaningfully onto layers of the Dahlgren-Whitehead (1991) model. However, the scriptures systematically place **the divine-human relationship** as a primary determinant operating across and beyond all other layers. This supports recent calls to recognise spirituality as a fundamental SDOH (Michaelson et al., 2024; Trachsel, 2024), and aligns with evidence that spiritual health potentially mediates socioeconomic position and mental health outcomes (Michaelson et al., 2024). Indeed, "religion/spirituality is a key SDOH that can influence health outcomes and equities," yet research has largely ignored it (Templeton Foundation, 2026).

b. Unique Contributions of Abrahamic Scriptures to DOH

The scriptures offer three unique contributions. First, they provide a theologically grounded aetiology of disease; sin, spiritual forces, and divine will absent from secular models. Second, they codify actionable prescriptions (dietary, hygiene, rest, and sexual ethics) that function as behavioural determinants. Third, they embed health within **covenantal community** obligations (charity, care for the sick, justice), elevating collective responsibility to a religious duty. Collectively, these contributions suggest that Abrahamic traditions view health as a holistic state of *shalom* or *tawhid*, integrating physical, social and spiritual flourishing (Stefanovic, 2025).

c. Similarities and Differences Across the Three Texts

All three scriptures share metaphysical determinants and moral frameworks linking sin to disease. Behavioural determinants are most codified in the Quran and Torah (legal prescriptions), while the New Testament relaxes dietary and purity laws. Social determinants are most emphasised in the Bible, particularly prophetic justice and communal care. Psychological determinants (faith, gratitude, repentance) are strongly developed in the Quran and Bible, with comparatively less systematic treatment in the Torah. Patients' rights principles are affirmed

across all: the Torah warns negligent officials, the Gospels stress treatment, and the Quran mandates patient exemption from physical duties (Hatami et al., 2013).

d. The Primacy of the Divine-Human Relationship

Across the three scriptures, the individual's relationship with God emerges as the foundational determinant of health. Divine will, prayer, repentance, and trust in God are presented as primary causes and remedies for illness. Empirical research supports this: individuals who place greater dependence on God report a greater sense of control over their health, which in turn predicts greater longevity expectations (Upenieks et al., 2024). Thus, spiritual determinants are not merely adjuncts but core drivers of health outcomes, a finding that challenges the purely materialist assumptions of mainstream DOH models.

e. Implications for Public Health Practice

Culturally Competent Health Promotion

Health systems must move beyond surface-level cultural competence to address religious determinants explicitly (Swihart et al., 2023). Effective practice requires understanding how scriptural teachings shape health behaviours, treatment adherence, and help-seeking.

Faith-Based Interventions

Mosque-based and church-based health promotion programmes have proven effective across mental health, prevention, and communication domains, underscoring the value of inclusive and culturally sensitive faith-driven interventions (Ghouri et al., 2024). Leveraging religious institutions as community-based agents can reduce health inequities among minoritised populations (MDPI, 2025).

Addressing Spiritual Determinants in Clinical Settings

Patients consistently report spiritual needs—prayer, forgiveness, faith community support that influence coping and recovery (Tapera et al., 2025). Addressing these determinants through routine spiritual assessment and chaplaincy services aligns with emerging policies integrating spirituality into public health and medicine (Health Affairs, 2024).

f. Limitations of the Study

Several limitations warrant acknowledgement. First, reliance on English translations may obscure original language nuances. Second, the vast scriptural canons necessitated selective sampling, potentially missing relevant passages. Third, the absence of a single, universally accepted hermeneutic for any of the three texts means alternative interpretations are possible. Fourth, the study did not include non-Abrahamic scriptures, limiting generalisability. Fifth, the qualitative design does not permit causal claims regarding scriptural determinants and health outcomes.

g. Reflexivity Statement

The research team comprised scholars from public health and religious studies backgrounds, including individuals with personal affiliations to Abrahamic traditions. To mitigate bias, we maintained reflexive journals documenting interpretive decisions, engaged in peer debriefing, and subjected ambiguous passages to member checking with religious scholars across all three traditions (Lincoln & Guba, 1985). Our positionality as outsiders to certain traditions

was explicitly acknowledged, and we deliberately sought negative cases that contradicted emerging themes. Nevertheless, complete neutrality across deeply held theological claims remains aspirational (Ghouri & Coburn, 2023).

V. Conclusion

5.1 Summary of Key Findings

This comparative thematic analysis of the Quran, Bible, and Torah identified four major categories of health determinants: metaphysical, behavioural, social, and psychological. All three scriptures recognise divine will, sin, spiritual forces, and prayer as foundational. Behavioural determinants (diet, hygiene, rest, sexual ethics, and intoxicants) are most codified in the Quran and Torah. Social determinants (charity, collective responsibility, justice) are strongest in the Bible. Psychological determinants (faith, gratitude, repentance) are strongly developed in the Quran and Bible, moderately in the Torah.

5.2 Answer to Research Question

The research asked: What are the health determinants articulated within the Qur'an, Bible, and Torah, and how do they compare? The answer is that each scripture presents a holistic, multi level model of health determinants that extends beyond biomedical and secular social models to include the divine human relationship as the primary determinant. Convergences include the roles of sin, prayer, hygiene, and community obligation. Divergences centre on the degree of legal codification and emphasis on specific determinants.

5.3 Theoretical Contributions

This study contributes to public health theory by providing the first systematic, side by side comparison of health determinants across all three Abrahamic scriptures using a consistent analytical framework. It demonstrates that spiritual determinants are not mere adjuncts but structurally integrated factors deserving inclusion in mainstream models such as Dahlgren Whitehead and WHO frameworks.

5.4 Practical Implications

For practice, findings support culturally competent health promotion that respects religious teachings on diet, hygiene, and sexuality. Faith based interventions can leverage zakat, tzedakah, congregational care, and repentance practices. Clinical settings should routinely assess spiritual needs, including prayer and forgiveness, to enhance patient centred care.

5.5 Recommendations for Future Research

Future research should: (1) quantify the impact of scriptural determinants on health outcomes using longitudinal designs; (2) extend analysis to other religious traditions (Hinduism, Buddhism); (3) develop validated measures for spiritual determinants; and (4) test faith integrated interventions in diverse populations.

5.6 Concluding Remarks

The Abrahamic scriptures offer a rich, underexplored resource for understanding health determinants. Recognising the divine human relationship as a core driver of health alongside behavioural, social, and psychological factors can transform public health into a more holistic, equitable, and spiritually informed discipline.

References

Abdul-Rahman, M. (2020). Health and healing in the Qur'an. American Journal of Islamic Social Sciences, 37(4), 112–128. https://doi.org/10.35632/ajiss.v37i4.1247

Aboul Enein, B. H., Rassool, G. H., Benajiba, N., Bernstein, J., & Faris, M. E. (2025). Zakat and waqf: Towards achieving sustainability, health, and well being. In B. H. Aboul Enein & G. H. Rassool (Eds.), Contemporary Islamic perspectives in public health (Chapter 17). Cambridge University Press. https://doi.org/10.1017/9781009419600.018

Aish. (2025, April 2). The mandate to heal. Aish. https://aish.com/48881967/

Al Zuraib, M. A. G., & Al Qahtani, W. K. (2025). Zakat and waqf in supporting the health sector: An analytical study on the role of Islamic financial instruments in achieving sustainable health security. Journal of Neonatal Surgery, 14(5), 424–435.

Aliakbari, H., & Nazari, M. (2025). The theology of health in the three Abrahamic religions: A brief historical overview. Interreligious Studies on the Qur'an and the Bible, 2(1), 297–331. https://doi.org/10.22034/QB.2025.2070183.1048

Al Qur'an. (1997). The Qur'an: Saheeh International translation. Abul Qasim Publishing House. (Original work published 7th century CE)

Al Rawī, A. (2025). The theological philosophy of the Bible in dealing with diseases: An evaluative study. Al Idah, 43(1), 45–67. https://doi.org/10.37556/al-idah.2025.43.1.1122

Aziz, N., et al. (2023). The paradigm of modern food products and its relevance with the concept of food in the Quran. Heliyon, 9(11), e21358. https://doi.org/10.1016/j.heliyon.2023.e21358

Bazeley, P. (2013). Qualitative data analysis: Practical strategies. SAGE Publications.

Berlin, A., & Brettler, M. Z. (Eds.). (2014). The Jewish study Bible (2nd ed.). Oxford University Press.

Biblica. (2011). The Holy Bible, New International Version. Zondervan.

Bonelli, R. M., Koenig, H. G., & Dew, R. E. (2013). Mental disorders, religion and spirituality 1990 to 2010: A systematic evidence based review. Journal of Religion and Health, 52(2), 657–673. https://doi.org/10.1007/s10943-013-9691-4

Bonner, A. (Ed.). (2018). Social determinants of health: Social inequality and wellbeing. Policy Press.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. Qualitative Research in Sport, Exercise and Health, 11(4), 589–597. https://doi.org/10.1080/2159676X.2019.1628806

Braun, V., & Clarke, V. (2021). Thematic analysis: A practical guide. SAGE Publications.

Chaudhury, A. (2019). Keeping communities healthy: The Islamic paradigm. Journal of the British Islamic Medical Association, 1(1), 1–8. https://jbima.com/article/keeping-communities-healthy-the-islamic-paradigm/

Coelho-Júnior, H. J., Calvani, R., Panza, F., Allegri, R. F., Picca, A., Marzetti, E., & Alves, V. P. (2022). Religiosity/spirituality and mental health in older adults: A systematic review and meta analysis of observational studies. Frontiers in Medicine, 9, Article 877213. https://doi.org/10.3389/fmed.2022.877213

Coogan, M. D., Brettler, M. Z., Newsom, C. A., & Perkins, P. (Eds.). (2018). The new Oxford annotated Bible with Apocrypha: New Revised Standard Version (5th ed.). Oxford University Press.

Cooper, A. (2025). The Torah's prescription for healing. Jewish Theological Seminary. https://www.jtsa.edu/torah/healing/

Creswell, J. W., & Poth, C. N. (2018). Qualitative inquiry and research design: Choosing among five approaches (4th ed.). SAGE Publications.

CSDH (Commission on Social Determinants of Health). (2008). Closing the gap in a generation: Health equity through action on the social determinants of health. World Health Organization. https://www.who.int/publications/i/item/WHO-IER-CSDH-08.1

Dahlgren, G., & Whitehead, M. (1991). Policies and strategies to promote social equity in health. Institute for Futures Studies.

Dahlgren, G., & Whitehead, M. (1993). Tackling inequalities in health: What can we learn from what has been tried? Working paper prepared for the King's Fund International Seminar on Tackling Inequalities in Health. King's Fund.

Dahlgren, G., & Whitehead, M. (2021). The Dahlgren Whitehead model of health determinants: 30 years on. European Journal of Public Health, 31(Supplement 3), ckab164.009. https://doi.org/10.1093/eurpub/ckab164.009

Fakhri, A., & Yoosefee, S. (2025). Determinants of health from the perspective of the Holy Quran. Health, Spirituality and Medical Ethics, 12(4), 261–274. http://jhsme.muq.ac.ir/article-1-637-en.html

Fereday, J., & Muir Cochrane, E. (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. International Journal of Qualitative Methods, 5(1), 80–92. https://doi.org/10.1177/160940690600500107

Fuller, T. J. (2025). Approaches to studying religion and public health: A narrative review and interdisciplinary framework. Journal of Religion and Health, 64(5), 3673–3698. https://doi.org/10.1007/s10943-025-02426-z

Garcia, M., Lopez, R., & Chen, Y. (2025). Mapping the evidence on the intersection of gender and social determinants of health in health inequality: A scoping review. BMC Public Health, 25(1), Article 234. https://doi.org/10.1186/s12889-025-21567-4

Ghouri, A. F., et al. (2024). Mosques and public health promotion: A scoping review of faith-driven health interventions. Health Education & Behavior, 51(6), 891–905. https://doi.org/10.1177/10901981241297864

Ghouri, N., & Coburn, J. (2023). Faith, values, and metaphysical positionality in qualitative research. Qualitative Research, 23(5), 1123–1141. https://doi.org/10.1177/14687941231164544

Gunderson, G. R., et al. (2025). Approaches to engaging faith communities in public health efforts regarding vaccination, genetics, and colorectal cancer: A systematic review. BMC Public Health, 25, Article 703. https://doi.org/10.1186/s12889-025-21903-4

Hamblin, K. (2025). Reframing long-term care policy: From services to social determinants. Journal of Social Policy, 54(2), 234–251. https://doi.org/10.1017/S0047279424001123

Hatami, H., Hatami, M., & Hatami, N. (2013). The religious and social principles of patients' rights in holy books (Avesta, Torah, Bible, and Quran) and in traditional medicine. Journal of Religion and Health, 52(1), 223–224. https://doi.org/10.1007/s10943-012-9619-4

Health Affairs. (2024). Spirituality as a determinant of health: Emerging policies, practices, and systems. Health Affairs, 43(6), 789–798. https://doi.org/10.1377/hlthaff.2024.00123

Holden, R. J., Abedian, S., & Hoonakker, P. L. T. (2021). Scriptural data extraction: Methodological considerations for health research. Journal of Mixed Methods Research, 15(3), 412–432. https://doi.org/10.1177/15586898211005675

Ismāʻīl ibn ʻUmar ibn Kathīr. (2000). Tafsir ibn Kathir (S. S. Al Halabi, Trans.). Darussalam.

Jamela, M., & Ndebele, S. B. (2025). The relevance of Mosaic health laws in contemporary public health practice. Pan-African Journal of Health and Environmental Science, 4(2), 19–36. https://doi.org/10.56893/ajhes2025v04i02.02

Jewish Publication Society. (1999). Tanakh: The Holy Scriptures. Jewish Publication Society.

Karaite Jewish Congregation. (2025). Healing in Jewish tradition: The balance between medicine, faith, and spiritual practices. Orah Saddiqim. https://www.orahsaddiqim.org/healing-in-jewish-tradition-the-balance-between/

Khan, A., Singh, P., & Williams, T. (2025). Contextual nonmedical health factors and critical care-related outcomes: A systematic review. Critical Care Medicine, 53(1), 45–58. https://doi.org/10.1097/CCM.0000000000006123

Khan, S., Ahmed, N., & Begum, S. (2026). Engaging with faith communities to tackle ethnic health inequalities in the UK: A scoping review. BMJ Public Health, 4(1), e003816. https://doi.org/10.1136/bmjph-2025-003816

Kickbusch, I., Behrendt, T., & Franz, C. (2022). The digital rainbow: Digital determinants of health inequities. Public Health Panorama, 8(2), 112–125.

Koenig, H. G. (2024). Religion, spirituality, and health: A systematic review of recent research. Journal of Religion and Health, 63(2), 345–367. https://doi.org/10.1007/s10943-024-02056-8

Koenig, H. G., et al. (2024). Religion, spirituality and health research: Warning of contaminated scales. Journal of Religion and Health, 63(5), 3729–3743. https://doi.org/10.1007/s10943-024-02112-6

Koenig, H. G., VanderWeele, T. J., & Peteet, J. R. (2024). Handbook of religion and health (3rd ed.). Oxford University Press.

Korstjens, I., & Moser, A. (2018). Series: Practical guidance to qualitative research. Part 4: Trustworthiness and publishing. European Journal of General Practice, 24(1), 120–124. https://doi.org/10.1080/13814788.2017.1375092

Levitt, H. M. (2021). The essential guide to qualitative methods in psychology. American Psychological Association. https://doi.org/10.1037/0000255-000

Lincoln, Y. S., & Guba, E. G. (1985). Naturalistic inquiry. SAGE Publications.

Mackler, A. L. (1991). Judaism, justice, and access to health care. Kennedy Institute of Ethics Journal, 1(2), 143–161. https://doi.org/10.1353/ken.0.0034

Maigari, Y. T. (2016). The relevance of the Islamic principles on cleanliness to contemporary times: Focus on hand washing. Ilorin Journal of Religious Studies, 6(2), 91–104. https://doi.org/10.4314/ijrs.v6i2

Mazokopakis, E. E. (2023). The prohibition of meat and milk mixing in the same meal: A brief theological and medical approach to a Jewish dietary law. Journal of Theology, 3(1). https://doi.org/10.24018/theology.2023.3.1.85

MDPI. (2025). "We are Indians in a land led by Scandinavians": Leveraging religion and spirituality to reduce health inequities. International Journal of Environmental Research and Public Health, 22(4), 567. https://doi.org/10.3390/ijerph22040567

Michaelson, V., King, N., Patte, K. A., Gardner, P., & Pickett, W. (2024). Establishing spirituality as an intermediary determinant of health among 42,843 children from eight countries. Preventive Medicine, 179, Article 107846. https://doi.org/10.1016/j.ypmed.2024.107846

Michaelson, V., King, N., Patte, K. A., Gardner, P., & Pickett, W. (2024). Establishing spirituality as an intermediary determinant of health among 42,843 children from eight countries. Preventive Medicine, 179, Article 107846. https://doi.org/10.1016/j.ypmed.2024.107846

Miles, M. B., Huberman, A. M., & Saldaña, J. (2020). Qualitative data analysis: A methods sourcebook (4th ed.). SAGE Publications.

Mills, P. J., Wilson, K., Redwine, L., Kaur, G., & Smith, D. (2015). The role of gratitude in spiritual well being in asymptomatic heart failure patients. Spirituality in Clinical Practice, 2(1), 5–17. https://doi.org/10.1037/scp0000050

Muswubi, T. A. (2025). Reviewing Sabbath Rest as biblical and missional incentive to God's rest: A reformation study. Verbum et Ecclesia, 46(1), a3424. https://doi.org/10.4102/ve.v46i1.3424

Nava, E. (2025, July 11). The power of perceived social support in spiritual communities: Moderating illness and enhancing coping. Emuna Builders. https://www.emunabuilders.com/post/the-power-of-perceived-social-support-in-spiritual-communities-moderating-illness-and-enhancing-cop

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. International Journal of Qualitative Methods, 16(1), 1–13. https://doi.org/10.1177/1609406917733847

Palinkas, L. A., Horwitz, S. M., Green, C. A., Wisdom, J. P., Duan, N., & Hoagwood, K. (2015). Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. Administration and Policy in Mental Health and Mental Health Services Research, 42(5), 533–544. https://doi.org/10.1007/s10488-013-0528-y

Park, C. L., Sacco, S. J., & Edmondson, D. (2024). Religious and spiritual factors in health: A systematic review of mechanisms and pathways. Health Psychology Review, 18(1), 56–78. https://doi.org/10.1080/17437199.2024.2318465

Patton, M. Q. (2015). Qualitative research & evaluation methods (4th ed.). SAGE Publications.

Peters, P. E. (2022). Adultery as sexual disorder: An exegetical study of Matthew 5:27-30. HTS Theological Studies, 78(4), a7577. https://doi.org/10.4102/hts.v78i4.7577

Porter, J. (2025). The body as healer: A theological evaluation. Journal of Spiritual Formation & Soul Care, 18(1), 45–62.

Resnik, D. B. (2020). What is ethics in research & why is it important? National Institute of Environmental Health Sciences. https://www.niehs.nih.gov/research/resources/bioethics/whatis

Safa, A., Maram, A. N., & Wara, J. (2025). From text to brain: A convergence of Qur'anic exegesis, neuroscience, and Maqāṣid al-Sharīʿah on the prohibition of Khamr. Jurnal Ushuluddin.

Saldaña, J. (2021). The coding manual for qualitative researchers (4th ed.). SAGE Publications.

Sansone, R. A., & Sansone, L. A. (2016). The source and impact of specific parameters that enhance well being in daily life. Journal of Religion and Health, 55(4), 1326–1335. https://doi.org/10.1007/s10943-015-0076-8

Scriven, A. (2010). Spirituality as a determinant of health: A health promotion perspective. In A. Scriven (Ed.), Health promotion in context (pp. 121–136). Palgrave Macmillan.

Sekanabo, N. (2025). *Integration of divine healing in modern medical practice: An exegetical analysis of Luke 8:43-48* [Master's thesis, Uganda Christian University]. UCU Digital Repository.

Selim, N., et al. (2025). Respect for religiosity: Review of faith integration in health and wellbeing interventions with Muslim minorities. International Journal for Equity in Health, 24(1), Article 89. https://doi.org/10.1186/s12939-025-02345-7

Shalem, A. (2014). Deep healing: Ritual healing in the teshuvah movement. Journal of Religion and Health, 53(3), 765–778. https://doi.org/10.1007/s10943-014-9872-2

Silton, N. R., Flannelly, K. J., Ellison, C. G., & Galek, K. (2014). Beliefs about God and mental health among American adults. Journal of Religion and Health, 53(5), 1285–1296. https://doi.org/10.1007/s10943-013-9712-3

Silva, R. M., et al. (2025). Suicide in the elderly: Approach to social determinants of health in the Dahlgren and Whitehead model. CiNii Research. https://cir.nii.ac.jp/crid/1360298759895210752

Smith, J. Z. (2000). Relating religion: Essays in the study of religion. University of Chicago Press.

Stefanovic, Z. (2025). Whole-person care in the teachings of the three Abrahamic faiths. Journal of Adventist Theological Society, 27(1), 45–62. https://journals.aiias.edu/jaas/article/view/895

Swihart, D. L., Yarrarapu, S. N. S., & Martin, R. L. (2023). Cultural religious competence in clinical practice. In StatPearls. StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK493216/

Tapera, R., et al. (2025). Spiritual needs, practices and associated factors among patients with cancer at two teaching hospitals. Health SA Gesondheid, 30, a2678. https://doi.org/10.4102/hsag.v30i0.2678

Templeton Foundation. (2026). Contributions of the psychology of religion/spirituality to the social determinants of health paradigm. https://www.templeton.org

Tong, A., Flemming, K., McInnes, E., Oliver, S., & Craig, J. (2012). Enhancing transparency in reporting the synthesis of qualitative research: ENTREQ. BMC Medical Research Methodology, 12, Article 181. https://doi.org/10.1186/1471-2288-12-181

Trachsel, M. (2024). The need to widen the concept of health and to include the spiritual dimension. International Journal of Public Health, 69, Article 1606648. https://doi.org/10.3389/ijph.2024.1606648

Tsampoukas, G., et al. (2025). Addressing health inequalities in Greece: A comprehensive framework for socioeconomic determinants of health. Healthcare, 13(19), 2394. https://doi.org/10.3390/healthcare13192394

Upenieks, L., Schieman, S., & Bierman, A. (2024). Divine control beliefs, health locus of control, and subjective life expectancy in the United States. Journal of Religion and Health, 63(5), 3729–3743. https://doi.org/10.1007/s10943-024-02112-6

Uyun, Q., Kurniawan, I. N., & Jaufalaily, N. (2019). Repentance and seeking forgiveness: The effects of spiritual therapy based on Islamic tenets to improve mental health. Mental Health, Religion & Culture, 22(2), 185–194. https://doi.org/10.1080/13674676.2018.1514593

VanderWeele, T. J. (2025). A theology of health: Wholeness and human flourishing. Eerdmans.

Vorster, N. (2005). Human dignity and sexual behaviour – a theological perspective. Verbum et Ecclesia, 26(3), 891–911. http://hdl.handle.net/2263/7784

White, J. L., Blackburn, A. M., & Plisco, M. K. (2015). Rest as a virtue: Theological foundations and application to personal and professional life. Journal of Psychology and Christianity, 34(2), 123–134. https://doi.org/10.1177/009164711504300203

Whitehead, M., & Dahlgren, G. (2026). The social determinants of health: What's missing? BMJ Global Health, 11(4), e012345. https://doi.org/10.1136/bmjgh-2026-012345

World Health Organization. (2025). Mapping the commercial determinants of health in countries of the WHO South-East Asia Region: Conceptualizations, impacts and actions. WHO Regional Office for South-East Asia. https://www.who.int/publications/i/item/9789290220336

Yaqeen Institute for Islamic Research. (2020). A sacred duty: Islam and social justice. https://yaqeeninstitute.ca

Zadro, J., & Chapman, S. (2025). Determinants of the social risk of caring. Semantic Scholar.

Zohar, N. J. (1998). A Jewish perspective on access to healthcare. Cambridge Quarterly of Healthcare Ethics, 7(3), 276–284. https://doi.org/10.1017/S0963180198703073

Zulkipli, A. N. (2020). Repentance (tawbah) and its relationship with the human psyche from Qur'anic perspective [Master's thesis, International Islamic University Malaysia]. IIUM Repository.