Religion, Culture, and Health Equity among Marginalized U.S. Populations: Pathways, Evidence, and Practice Implications

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DOI: https://doi.org/10.51244/IJRSI.2026.13010199

Received: 22 January 2026; Accepted: 28 January 2026; Published: 16 February 2026

ABSTRACT

Religion and culture are not peripheral influences on health in the United States; they shape beliefs about illness, experiences of discrimination, coping strategies, social support, care-seeking behaviors, and trust in institutions. For marginalized populations whose health is already constrained by structural racism, poverty, immigration stress, and unequal access to care religion and culture can function as both protective resources and sites of vulnerability. A growing body of peer-reviewed evidence shows that religious involvement and spirituality are associated with mental health resilience and health behaviors in Black and Latino communities across the life course, while culturally and religiously incongruent care can intensify mistrust, reduce engagement, and deepen inequities. Faith-based organizations (FBOs), including Black churches, have demonstrated capacity to deliver health promotion interventions at scale, and systematic reviews suggest such programs can improve behaviors and support equity-oriented prevention strategies. This piece argue that achieving health equity requires moving beyond generic “cultural competence” toward structural competence, humble partnership with communities, and measurable integration of spiritual and cultural needs into patient-centered care.

Keywords: Health equity; Religion; Spirituality; Cultural humility; Marginalized populations; Faith-based health promotion; Social determinants of health; Patient trust; Culturally responsive care

INTRODUCTION

Why religion and culture belong in U.S. health equity research

Health equity work in the United States has increasingly recognized that inequities are not simply the product of individual choices, but of structural and social conditions that shape exposure, opportunity, and power [1-3]. Within this landscape, religion and culture are often treated as “personal preferences” or “soft variables.” Yet for many communities especially those historically marginalized religious identity and cultural tradition function as organizing systems that shape how health is defined, how suffering is interpreted, how institutions are trusted or feared, and how care decisions are made [4, 5]. Religion can serve as a stabilizing force under adversity, offering meaning-making, social ties, moral frameworks, and practical support [6-8]. It can also become a channel through which stigma, exclusion, and discrimination are experienced.

A useful conceptual shift is to treat spirituality and religion as socially patterned determinants of health rather than optional add-ons. A 2024 *Health Affairs* essay argues for recognizing spirituality as a determinant of health linked to valued human goods and lived community practices, and it highlights implications for policy and health systems when spirituality is taken seriously rather than sidelined [9]. This framing matters for equity: marginalized groups often rely on spiritual communities for social protection and navigation of hostile environments, while simultaneously facing discrimination tied to religious identity [10, 11]. Religion and culture also shape the “fit” between patients and health systems. When clinical environments ignore or misunderstand religious practices (diet, modesty, prayer, end-of-life rituals, gender concordance), patients may disengage or experience care as disrespectful [12]. Clinical guidance sources emphasize that cultural and religious competence can improve communication and outcomes by meeting social and religious needs more effectively [13]. The equity implication is direct: the burden of miscommunication is not evenly distributed. It concentrates among those already vulnerable due to language barriers, poverty, minority stress, and historical medical mistrust.

METHODOLOGY/LITERATURE SEARCH

For this review, the literature search and methodology were planned to capture evidence across public health, medicine, medical anthropology, sociology of religion, psychology, and health policy because “religion,” “culture,” and “health equity” are not housed in one discipline. The review was therefore designed as an integrative, structured narrative synthesis with systematic elements, meaning it combined a transparent search strategy and screening steps with a deeper interpretive analysis of how religion and culture function as pathways that shape inequities for marginalized populations in the United States. The overarching goal was not only to summarize what has been published, but to organize the evidence into practical pathways and practice implications that clinicians, public health programs, and health systems can use.

The scope and guiding framework were defined before the search began. Key concepts were operationalized to reduce ambiguity during screening. “Religion” was defined broadly to include institutional affiliation (e.g., churches, mosques, temples), religious beliefs and practices (prayer, fasting, ritual healing), spirituality (meaning-making, transcendence, moral frameworks), and faith-based community life (social networks, leadership influence, and congregational resources). “Culture” was defined as shared values, norms, language, identity, and lived practices that shape help-seeking behavior, communication with providers, and trust in institutions. “Health equity” was treated as differences in health outcomes and healthcare access that are systematic, avoidable, and unjust, with attention to structural drivers such as racism, discrimination, immigration policy, poverty, stigma, geography, and healthcare system bias. “Marginalized U.S. populations” were specified as groups experiencing historically entrenched or structurally produced disadvantage in health, including but not limited to racial/ethnic minorities, immigrants and refugees (including undocumented communities), linguistic minorities, people experiencing homelessness, people with disabilities, and individuals in carceral or re-entry settings.

A conceptual pathway model was used to structure the review from the start so the search would not become a loose collection of unrelated studies. The model anticipated that religion and culture can influence health equity through multiple routes: shaping explanatory models of illness and healing; influencing preventive behaviors and treatment adherence; affecting trust in healthcare institutions; producing either protective social support or harmful stigma; mediating exposure to discrimination; facilitating community-based service delivery through faith-based organizations; and interacting with structural barriers such as insurance access, immigration enforcement, and geographically uneven healthcare resources. This pathway framing informed the extraction template and the way findings were synthesized into evidence-to-practice implications.

The literature search was conducted across multidisciplinary databases chosen to balance biomedical coverage with social-science and humanities perspectives. Core health databases typically included PubMed/MEDLINE and CINAHL (for nursing and allied health perspectives), while broad indexing databases such as Scopus and Web of Science were used to capture cross-disciplinary studies and citation networks. PsycINFO was used to identify work on identity, stigma, coping, trauma, help-seeking, and religious/spiritual interventions. For policy and social determinants literature, databases such as SocINDEX and relevant public policy repositories were included when available, and Google Scholar was used as a supplementary source to identify influential articles, reports, and frequently cited frameworks that sometimes fall outside traditional indexing. The search also included forward and backward citation chasing, meaning that key “anchor” studies and conceptual papers were used to locate newer papers that cite them and older papers that they reference, which is especially important in topics where terminology differs by field.

Search terms were developed iteratively using a combination of controlled vocabulary (for example, MeSH terms in PubMed) and free-text keywords to capture the many ways authors describe religion, culture, and inequity. Keyword clusters were created for (1) religion/spirituality (religion, spirituality, faith, religiosity, prayer, church, mosque, clergy, chaplain, faith-based, congregational, pastoral care), (2) culture and identity (culture, cultural beliefs, cultural competence, cultural humility, acculturation, language, ethnicity, identity, norms), (3) equity and disparities (health equity, health disparities, inequity, social determinants, structural racism, discrimination, stigma, trust, access to care), (4) the U.S. setting (United States, U.S., American, specific states/cities when needed), and (5) marginalized populations (Black/African American, Hispanic/Latino, Indigenous/Native American, immigrant, refugee, undocumented, asylum, homelessness, incarceration, rural underserved, low-income). These clusters were combined with Boolean operators (AND/OR) and adapted per database so that studies could be retrieved even when authors used different labels, such as “spiritual care” instead of “religion,” or “minority stress” instead of “discrimination.”

To ensure relevance to contemporary healthcare practice and policy, inclusion and exclusion criteria were pre-specified. Studies were included if they were focused on the United States; explicitly addressed religion and/or spirituality and culture as determinants, contexts, or interventions related to health, healthcare access, patient experience, or outcomes; and involved marginalized populations or explicitly analyzed disparities. Both quantitative and qualitative studies were included because equity pathways often require qualitative evidence to explain mechanisms (trust, stigma, identity negotiation, provider-patient communication), while quantitative studies contribute strength by estimating associations and disparities across groups. Mixed-methods studies, implementation research, community-based participatory research, and evaluations of faith-based interventions were also eligible because they directly inform practice implications. Studies were excluded if they were not U.S.-based, did not connect religion/culture to health or healthcare, focused only on majority populations without equity relevance, or were opinion pieces without identifiable evidence or analytic grounding. Where theological discourse was present without health outcomes or healthcare implications, those works were treated as background context rather than evidence.

The screening process followed a staged approach to reduce bias. First, duplicates were removed and titles and abstracts were reviewed to exclude clearly irrelevant citations. Next, full-text screening was conducted for articles that appeared eligible or uncertain, applying the criteria consistently. When studies addressed religion or culture only tangentially, a relevance threshold was used: the study needed to provide data, analysis, or actionable insight into how religion/culture shaped a health equity dimension—access, quality, outcomes, or lived experience—rather than merely listing religion as a demographic variable. Any disagreements during screening were resolved by re-checking the criteria and focusing on whether the study contributed to the pathway model or the practice implications.

Data extraction was designed to support synthesis rather than just summarization. For each included study, key details were recorded: publication year; study design; setting (community, clinic, hospital, faith institution, detention center); population characteristics (race/ethnicity, immigration status, language, gender identity, socioeconomic context); health topic (maternal health, mental health, chronic disease, infectious disease, vaccination, end-of-life care, substance use, etc.); how religion/spirituality and culture were defined and measured; outcomes examined (utilization, adherence, trust, satisfaction, mortality, mental health indicators, screening uptake); and the main findings relevant to equity. Special attention was given to mechanisms how and why effects occurred such as whether clergy influence increased preventive service uptake, whether religious stigma reduced mental health help-seeking, or whether culturally and religiously tailored communication improved trust. Practice- and policy-relevant elements were extracted as well, such as implementation barriers, workforce training needs, community partnerships, and recommendations for culturally and spiritually responsive care.

Quality appraisal was incorporated in a pragmatic way suited to an integrative review. Because evidence in this area spans randomized trials, observational studies, qualitative interviews, ethnographies, and program evaluations, a single rigid tool can be inappropriate. Instead, methodological rigor was judged using design-appropriate criteria: for quantitative studies, emphasis was placed on sampling, measurement validity, confounding control, and clarity of analytic strategy; for qualitative studies, emphasis was placed on sampling strategy, transparency of coding/analysis, reflexivity, triangulation, and credibility of interpretations; and for intervention and implementation studies, emphasis was placed on fidelity, context description, feasibility, and outcome measurement. Rather than excluding all lower-quality studies, the review weighted conclusions toward stronger designs and treated weaker evidence as hypothesis-generating, clearly distinguishing between well-supported patterns and emerging signals.

The synthesis strategy used thematic and pathway-based integration. Findings were grouped into the main pathways (for example: trust and historical trauma; stigma and moral framing; social support and social capital; religious coping and resilience; health behaviors shaped by belief systems; navigation support from faith communities; culturally and spiritually tailored interventions; and structural constraints that modify all pathways). Within each pathway, the review compared evidence across populations and settings to identify where effects were consistent and where they diverged. For example, religion might function as a protective resource for coping in one context while acting as a barrier through stigma in another; the synthesis explicitly documented these tensions rather than forcing a single narrative. When quantitative results were available, the review summarized directions and magnitudes of associations in a cautious, non-meta-analytic way (unless the literature was sufficiently homogenous), while qualitative insights were used to explain the “why” behind patterns, such as how immigration fear interacts with faith community support to shape care-seeking.

To translate evidence into practice implications, the review applied an “evidence-to-action” lens at the end of each thematic pathway. This translation step focused on what clinicians, public health practitioners, and health systems can do differently: how to elicit patients’ religious and cultural needs without stereotyping; how to use culturally humble communication; how to collaborate ethically with faith-based organizations; how to design interventions that respect autonomy and diversity within religious groups; and how to anticipate equity risks such as exclusion of non-religious patients or reinforcement of stigma. Recommendations were tied back to the strongest evidence and were framed as implementation-oriented steps, such as training modules, screening questions for spiritual needs, referral pathways to chaplaincy or culturally relevant community supports, and strategies for engaging faith leaders in vaccination, mental health outreach, maternal health navigation, or chronic disease education.

Finally, the methodology explicitly documented limitations and safeguards. Publication bias was anticipated because successful community programs are more likely to be published, while unsuccessful partnerships may remain undocumented. Terminology bias was also addressed, recognizing that some communities avoid “religion” language and use “spirituality” or “values,” and that studies may under-measure culture by reducing it to race/ethnicity alone. The review acknowledged heterogeneity across religions, denominations, immigrant generations, and regional contexts, and therefore avoided treating any religious or cultural group as monolithic. Ethical considerations were also embedded in the approach, particularly the importance of respecting patient autonomy, preventing coercive faith-based care practices, and ensuring that culturally or religiously tailored interventions remain inclusive and equity-enhancing rather than exclusionary.

Conceptual foundations: How religion and culture shape health equity pathways

Religion and culture as protective social resources

Across many marginalized groups, religious institutions function as durable community infrastructures [14, 15]. They provide social networks, mutual aid, guidance during illness, caregiving support, and structured opportunities for health promotion. In the U.S., the Black church has historically served as a key institution for civic engagement, social cohesion, and collective coping under racism, and it remains a major site for health programming [16-19]. Studies of African American churches document the prevalence of health promotion activities and examine organizational capacities that shape whether and how churches deliver health programs [20-23]. These findings support a public health logic, where formal systems are distrusted or inaccessible, trusted faith institutions can provide culturally legitimate pathways to prevention, screening, and behavior change [24, 25]. Religion also supports mental health resilience through mechanisms such as meaning-making, spiritual coping, and identity affirmation [26, 27]. A large review focusing on Black and Latino Americans emphasizes that religion can be a source of resilience and is associated with mental health and well-being outcomes across the life course, especially in contexts of social adversity [28-30]. The protective dimension is not only psychological; it can influence health behaviors, reduce social isolation, and buffer stress, all of which matter for chronic disease trajectories.

Religion and culture as sites of vulnerability: discrimination, minority stress, and mistrust

Religious identity can become a vector for discrimination, which is itself a health risk factor through chronic stress pathways and through reduced access to care [31, 32]. Research documenting perceived anti-Muslim discrimination in U.S. healthcare settings describes discriminatory behaviors and the extent to which Muslims report such experiences in clinical environments [33-35]. These experiences can translate into delayed care-seeking, avoidance of preventive services, and worsening of chronic conditions especially when discrimination intersects with racialization, immigration status, and language barriers. Studies on Muslim patient needs emphasizes that perceived discrimination and transgenerational trauma can shape clinical encounters and that proactive accommodations and informed care can mitigate harm [35, 36]. The equity lens here is critical: discrimination is not merely interpersonal discomfort. It is a mechanism that redistributes risk by shaping who receives respectful, timely, and appropriate care. Cultural mismatch also generates vulnerability [37]. When healthcare delivery is culturally incongruent communication styles, explanatory models of illness, or family decision-making norms patients may be labeled “noncompliant” when the real issue is misalignment between system design and lived realities [38]. Cultural and religious competence guidance explicitly links culturally competent care to improved outcomes, suggesting that the absence of such competence can drive inequities.

Religion, culture, and structural determinants: moving from “competence” to equity

A central equity insight is that religion and culture do not operate in a vacuum [39]. They are entangled with housing segregation, food access, environmental exposures, labor conditions, policing, immigration enforcement, and insurance design. When public health treats religion and culture purely as patient preferences, it risks missing how these domains are shaped by and respond to structural inequality [40]. This is why many scholars argue for expanding from cultural competence (individual provider skills) to structural competence (recognizing institutional and policy drivers of inequity) [41, 42]. In practice, this means designing care environments and public health interventions that do not demand assimilation into the dominant culture as the price of health access. It also means treating religious discrimination as a civil rights and patient safety issue, not simply “sensitivity training.”

Evidence base: what the literature shows and what it struggles to capture

Measurement challenges: religiosity, spirituality, and cultural identity

A persistent challenge in the evidence base is measurement. Studies vary widely in how they define and measure religion and spirituality (service attendance, private prayer, spiritual coping, denominational affiliation, perceived closeness to God, or spiritual well-being) [43, 44]. Different measures capture different mechanisms. Attendance may reflect social integration; private spirituality may reflect coping; doctrinal beliefs may shape health decisions [45]. When studies treat religion as a single variable, they often obscure these distinctions. Another difficulty is that religion and culture are heterogeneous within marginalized categories. “Latino” encompasses diverse national origins, immigration histories, and religious traditions. “Muslim” includes multiple ethnicities, languages, sects, and cultural practices. This heterogeneity matters for intervention design and for interpreting associations. Despite these challenges, population-focused work provides useful insight. For example, research on a U.S. South Asian population notes that relatively little work exists on religion/spirituality and health in that group, highlighting the broader gap: many minority religious communities remain underrepresented in health equity research despite clear relevance [46-48].

Strength of evidence: mental health resilience and community interventions

The evidence linking religion/spirituality to mental health resilience in Black and Latino communities is among the most developed areas [49, 50]. The review by Nguyen synthesizes literature showing that religion is salient in these communities and is associated with mental health and well-being outcomes across adulthood and later life [51]. While not every finding is positive or causal, the literature consistently points to religious engagement as a meaningful social determinant of coping and support. Faith-based health promotion also has a substantial evidence base. A review of church-based health promotion interventions describes how churches can influence health behaviors at multiple levels, and it emphasizes lessons learned for designing effective programs [52].

More recently, a 2023 systematic review and meta-analysis of church-based interventions reports that many interventions target physical activity and diet and indicates the breadth of faith-based programming evaluated in the literature [53]. Together, these sources support a pragmatic conclusion: faith-based platforms can deliver prevention programming with equity potential, especially when programs are community-designed and culturally resonant.

Gaps and biases: causality, generalizability, and underrepresented groups

Many studies are observational and cannot cleanly separate causality from selection effects (healthier individuals may be more likely to participate in religious communities). There is also a tendency to focus on Christian contexts, particularly Black churches, which are critically important but not the full landscape of religious diversity among marginalized groups [54, 55]. Muslim, Sikh, Hindu, Buddhist, Jewish, and Indigenous spiritual contexts are less represented in the health equity literature relative to their population relevance and the discrimination burdens they may face [56-59]. A further bias is that intervention studies often prioritize behavioral outcomes (diet, physical activity) while under-investigating structural outcomes (insurance navigation, language access, discrimination reduction, and policy advocacy), therefore equity requires both.

Religion, culture, and health equity among Black/African American communities

Historical context: faith institutions as health infrastructures under racism

The Black church has long functioned as more than a religious space; it has been a civic institution built under conditions where mainstream systems were exclusionary or harmful [60, 61]. This history matters for health equity because it helps explain why faith spaces can be trusted venues for health engagement and why messaging delivered through them may carry legitimacy that health systems struggle to achieve. Faith-based organizations have increasingly offered health fairs, screenings, chronic disease education, and mental health support programs [62-64]. A study examining African American faith-based organizations highlights the role churches can play in addressing health disparities and notes the increasing presence of health-related activities [65]. Organizational capacity leadership support, health ministry structure, partnerships predicts the scope and sustainability of these efforts, which becomes important for designing scalable interventions rather than one-off events.

Mental health resilience, coping, and the complexity of “religion as protective”

The mental health literature explain religion as a resource for coping with chronic stress and discrimination [66]. Review studies emphasizes the salience of religion for Black Americans across adulthood and later life and discusses associations with mental health and well-being [67-69]. In equity terms, this is significant because chronic stress is a central pathway through which racism and disadvantage become embodied. Religion can provide meaning, supportive relationships, and identity affirmation that help buffer stress. At the same time, protective effects depend on context. Certain religious norms may contribute to stigma around mental health care or discourage disclosure. Some faith communities may frame depression or anxiety primarily as spiritual weakness rather than health conditions. Public health programs that partner with faith institutions need to navigate these dynamics carefully, supporting spiritual strengths while promoting evidence-based mental health pathways. A particularly important development has been culturally responsive spiritual communication in clinical contexts. Research examining religious and spiritual health care communication among African Americans and clinicians highlights how addressing spiritual needs can foster trust and improve perceived care quality in serious illness contexts [70-72]. For health equity, this suggests that spiritual responsiveness is not only a community intervention strategy but also a clinical trust strategy.

Faith-based interventions: evidence, lessons, and equity implementation

Faith-based health promotion interventions have a long track record as illustrated in Table 1 below. The comprehensive review by Campbell and colleagues argues that church-based health promotion can reach broad populations and has potential to reduce disparities, emphasizing socioecological influence and the importance of formative research and partnerships [73]. This is a key equity lesson: effective programs are not simply “delivered” to churches; they are co-developed with them, tailored to denominations and community priorities, and aligned with spiritual language without replacing science. Church-based interventions indicates that the most common programs target physical activity and diet, with others focusing on stress management and medication adherence [74, 75]. These intervention domains matter because cardiometabolic disease is a major driver of inequities. However, the next frontier is integrating structural navigation insurance literacy, hypertension medication access, safe spaces for exercise, food security supports into faith-based programming so that interventions do not implicitly blame individuals for constraints created by inequitable environments.

Table 1: Pathways linking religion and culture to health equity among marginalized populations

Pathway	**How it operates**	**Equity relevance**	**Example indicators**
Social support & cohesion	Congregational networks, mutual aid, caregiving	Buffers stress, improves adherence, reduces isolation	Support availability, loneliness, caregiving resources
Meaning-making & coping	Spiritual coping, hope, identity affirmation	Reduces stress-related harm, improves resilience	Coping scales, depressive symptoms, perceived purpose
Health behaviors	Norms around diet, substance use, physical activity	Can reduce or increase risk depending on context	Diet/PA metrics, smoking/alcohol patterns
Access & navigation	Trusted intermediaries, health ministries, outreach	Reaches underserved, improves screening and linkage	Screening rates, insurance enrollment, referrals
Discrimination & minority stress	Bias in healthcare, microaggressions, exclusion	Increases avoidance, delays care, worsens outcomes	Reported discrimination, mistrust, delayed care
Clinical concordance	Respect for rituals, modesty, prayer, family decision-making	Improves trust and engagement	Patient experience measures, shared decision-making

Religion, culture, and health equity among Latino/Hispanic communities

Religious involvement, familismo, and social support as health pathways

Latino communities in the U.S. encompass diverse cultural and religious contexts, including Catholic, evangelical, Pentecostal, and increasingly non-Christian traditions [76, 77]. Across many Latino communities, familismo (strong family orientation) and collectivist norms shape caregiving, decision-making, and support [78, 79]. Religious communities often reinforce these networks by providing social belonging, childcare support, and mutual aid functions that matter for health access and adherence. The literature reviewed includes Latino Americans and highlights how religion can be linked to mental health and well-being across adulthood, reflecting resilience roles in communities facing immigration stress and discrimination [80-82]. In practice, this suggests interventions that integrate family and faith contexts may be more effective and culturally consonant than individual-only approaches. Yet, as with all groups, religion can cut both ways. For some individuals, religious stigma can intensify stress (for example, around sexuality, domestic violence disclosure, or reproductive health). Equity-oriented programs should aim to expand supportive functions of faith communities while reducing harm through trauma-informed, stigma-aware partnerships.

Immigration, language, and cultural mismatch in healthcare

Cultural mismatch becomes especially consequential when combined with language barriers and immigration enforcement fear [83]. Patients may delay care due to fear of systems, especially if past experiences in home countries involved corruption or abuse. Religious and community organizations often serve as trusted intermediaries in this environment, offering navigation support and credible information that can counter misinformation and fear [84, 85]. From a health system standpoint, culturally and religiously competent care requires not only interpreter services but also respect for family decision-making practices and culturally grounded explanatory models of illness. Clinical guidance on cultural and religious competence explains how meeting social and religious needs can improve outcomes. For Latino communities, this often means respecting family roles, spiritual coping practices, and culturally specific health beliefs while ensuring that evidence-based care remains accessible and understandable [86, 87].

Faith-based programming in Latino communities: opportunities and design principles

Faith-based interventions have been widely used in Latino communities, including diabetes prevention, screening programs, and vaccination outreach [88, 89]. The broader church-based intervention literature provides transferable design principles: community-based participatory methods, alignment with spiritual messaging, and integration with local health systems [90]. The equity opportunity is strong because faith institutions can reach individuals who are not routinely engaged with primary care, particularly in underinsured communities [91]. However, program sustainability often hinges on resource support. Faith institutions may be expected to serve as unpaid extensions of the health system. Equity-based partnership requires bidirectional benefit: resources, training, data feedback, and respect for church leadership structures rather than extractive engagement.

Religion, culture, and health equity among Muslim, Arab, and South Asian communities

Religious discrimination in healthcare and its health consequences

Among Muslim communities in the U.S., discrimination operates as a significant barrier to equitable care [92]. Research documenting perceived discrimination of Muslims in U.S. healthcare settings describes both the extent of discrimination and the types of behaviors reported, explaining that healthcare is not immune from broader social prejudice [93]. Such experiences can directly reduce healthcare utilization and trust, worsening chronic disease management and preventive care uptake. Discrimination also affects healthcare workers. Research on Muslim physicians describes experiences with discrimination and accommodation in the workforce, indicating that religious marginalization operates within healthcare institutions themselves [94, 95]. Workforce discrimination matters for patient equity because it shapes retention, representation, and the cultural climate of institutions.

Institutional accountability: civil rights, discrimination monitoring, and equitable access

Religious discrimination in healthcare should be addressed through civil rights frameworks and quality improvement. Documented experiences of discrimination among Muslims in healthcare settings point to the need for institutional accountability and systemic protections. Policies should ensure accessible complaint mechanisms, transparent investigations, and prevention strategies that include leadership commitment and measurable outcomes. Equitable access also includes coverage for culturally appropriate services interpreters, community health worker programs, and mental health services that are culturally responsive. Underinvestment in these supports often shifts burden onto communities and worsens inequities.

Training reform: from “competence checklists” to structural and relational competence

Training programs often rely on superficial cultural checklists. Equity-oriented practice requires deeper relational competence: listening skills, humility, awareness of power dynamics, and comfort discussing spiritual and cultural needs without stereotyping. Clinical education resources emphasize cultural and religious competence as a route to better care outcomes. Yet the next step is to integrate structural competence helping clinicians understand how racism, poverty, immigration policy, and discrimination shape patient behavior and health outcomes.

Research priorities: disaggregation, intersectionality, and implementation science

Research should prioritize disaggregated data and intersectional approaches. “Religious minority” is not a single experience; it intersects with race, ethnicity, gender, socioeconomic status, disability, and geography. Underrepresentation of certain groups in religion-health research such as South Asian populations indicates the need for targeted studies that reflect America’s religious diversity. Implementation science is also essential. We already know many strategies that can improve cultural responsiveness; the question is how to implement them at scale in fragmented U.S. health systems. Evaluations should measure not only patient satisfaction but equity outcomes: appointment adherence, preventive screening uptake, chronic disease control, and reduced disparities.

CONCLUSION

Religion and culture shape health equity among marginalized U.S. populations through mechanisms that are simultaneously social, psychological, institutional, and structural. The evidence base shows that religious involvement can support resilience and mental health, particularly among Black and Latino communities, and that faith-based interventions especially those embedded in trusted institutions can advance prevention and health promotion with real equity potential. At the same time, religious discrimination particularly documented among Muslim communities in healthcare settings functions as a mechanism of inequity that undermines trust, discourages care, and harms health. A health equity agenda that treats religion and culture as legitimate domains of care not as optional “cultural extras” can improve patient engagement, reduce mistrust, and strengthen community-centered prevention. The most equity-relevant path forward is not superficial cultural competence, but structurally informed, humble partnership: health systems that implement anti-discrimination accountability, clinically integrate spiritual needs with professionalism, and collaborate with faith and cultural institutions as co-equal public health partners. When these conditions are met, religion and culture can become powerful assets for equity rather than overlooked determinants of disparity.

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