

# The Role of Faith-Based Organizations in the Ethical Aspects of Pandemic Flu Planning—Lessons Learned from the Toronto SARS Experience

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Are restrictive measures and duties to care ethically reasonable acceptable to faith-based organizations? This study describes the perceptions of individually interviewed spiritual leaders of the disease control measures used during the recent SARS outbreak in Toronto. Four central themes were identified: the relationship between religious obligation and civic responsibilities; the role of faith-based organizations in supporting public health restrictive measures; the reciprocal obligations of public health and religious communities during restrictions; and justifiable limits to duties to care. We conclude that, within certain constraints, spiritual leaders find restrictive measures ethically reasonable and that spiritual leaders can play an important role during pandemic and epidemic control planning. Public health officials should therefore include them in the early and ongoing deliberations of the criteria and logistics for implementation during public health emergencies.

*Computer models and analyses of past flu outbreaks indicate that there is a role for community-wide intervention—such as isolating infected people or voluntary quarantine—to control illnesses and deaths during the next pandemic flu, says a new report from the Institute of Medicine.*

*Institute of Medicine of the National Academies*

*If you love your neighbor, you will not want to encourage the spread of disease.*

*Catholic Priest in Toronto, 2005*

Current planning activities for control of a pandemic influenza consume substantial public health resources. The ability to identify and contain sick and exposed individuals within a proper ethical framework early is a key epidemic interventional strategy (Institute of Medicine of the National Academies). During an epidemic, restrictive measures are more effective if individuals are cooperative. Cooperation is more likely to occur with adequate social supports. In many communities, social supports

are provided through faith-based organizations, led by committed spiritual leaders (SLs). In our search of the pandemic control literature, there have been no studies of the role of faith-based organizations during a communicable disease outbreak. Only recently have public health authorities begun to recognize this potential source of assistance (Centers for Disease Control, Community Strategy), although there is nothing in the recent literature that evaluates the experiences of spiritual leaders from different faiths during communicable disease outbreaks.

Religious institutions have affected the public's health and policy decisions about public health for millennia. Quarantine is prescribed for certain types of uncleanliness in the Hebrew Bible (for example, the 7-day repetitive quarantine prescribed for leprosy (Leviticus, chap. 13). During the severe epidemic of the third century CE, 'Jews and Christians nursed the sick of their communities to a greater extent than did pagans' (Weaver *et al.*, 2006). The church unsuccessfully attempted to protect the Jews from persecution during the fourteenth

century plague (Kelly, 2005). Many spiritual leaders in the United States were influential in advancing the eugenics movement in the early twentieth century (Rosen, 2004).

Spiritual leaders can be powerful proponents of good public health hygiene measures; during the 2003 Toronto outbreak of severe acute respiratory syndrome (SARS), Catholic churches altered their practices by foregoing drinking from common communion cups, avoiding kissing crucifixes and bowing instead of shaking hands as gestures of peace during Easter mass. As well, the Jewish and Muslim communities significantly changed traditional practices of preparations of the body for burial to meet public health measures implemented in an effort to contain the spread of the disease. As Bishop John Boissonneau of the Toronto Archdiocese stated, 'Some people may feel a certain tension or stress between what they regard as their religious duty and their public health duty. They honour God by following directives for the health of the community' (CBC News).

But just as religious leaders can help in epidemic situations, they also can hurt. In 2003, the World Health Organization polio vaccine campaign in Nigeria was set back substantially because Islamic spiritual leaders opposed vaccination; they believed the vaccines were unsafe, contaminated and 'part of a U.S. plot to limit Nigeria's population by spreading AIDS and increasing infertility' (Chen, 2004).

Toronto was the major North American city afflicted by the SARS outbreak that spread to selected cities around the world in 2003. We wanted to understand better how spiritual leaders of established religions viewed the relationship between their religious communities with the public health efforts that occurred during SARS.

In this paper, we report the results of personal interviews with 14 spiritual leaders in Ontario, Canada following the SARS outbreak of 2003. Our objective was to identify their perceptions of the ethical issues around disease control measures used, as well as how they and their religions/religious institutions viewed (i) their roles in supporting restrictive measures during public health emergencies, and (ii) health care workers' (HCWs) and spiritual leaders' duties to provide care during outbreaks.

## Methods

### Participants and Setting

This qualitative study was undertaken in the Greater Toronto Area (GTA), a large, multi-cultural urban centre that was significantly impacted by the SARS outbreak. Following a compilation of all available spiritual organi-

zations in the GTA, purposive and snowball sampling of spiritual leaders representing main communities in the GTA were used to recruit participants by invitation letters to 20 spiritual leaders (Marshall, 1996; Devers and Frankel, 2000; Teddlie and Yu, 2007). Fourteen individuals replied, all of whom were able and willing to provide informed consent. All 14 spiritual leaders (SLs) were interviewed, consisting of eight Christian participants from five denominations (Baptist, Catholic, Lutheran, Protestant and United Church), two Jewish participants (Orthodox rabbis), two Buddhist participants (one Thai monk and one academic reverend), one Muslim participant and one Punjabi Sikh participant. Five of the participants worked in a SARS-designated hospital. Two participants were women. All participants provided informed consent (either in writing or verbally) in advance of their participation. The study received approval from the research ethics boards of the University of Toronto and The Hospital for Sick Children.

### Data Collection

Data were collected through in-depth, semistructured interviews using an interview guide that was first developed by identifying domains of inquiry from a literature review and from discussions among the research team. One of us (CMB) conducted all of the interviews, either in person or on the telephone. All interviews were audio-recorded and transcribed verbatim, following which CMB verified the accuracy of the transcription and clarified any inaudible passages. We continued interviews until saturation was reached.

### Data Analysis

Data analysis proceeded simultaneously with data collection (Denzin and Lincoln, 2005). Thus, data analysis began after the first interview, allowing us to identify emerging themes from the onset. Consistent with the constant comparative method, emerging themes from the early interviews were explored in subsequent interviews using a thematic analysis (Fereday and Muir-Cochrane, 2006). The systematic analysis was conducted first by identifying overarching themes or conceptual categories, which were then further developed by iteration in order to eliminate redundancy and ensure that categories were comprehensive and captured central themes of the study.

## Results

Participants' views were organized according to four central themes: the relationship between religious obligation

and civic responsibilities, the role of faith-based organizations in supporting public health restrictive measures, the reciprocal obligations of public health and religious communities during restrictions and the justifiable limits to duties to care.

### Relationship between Religious Obligation and Civic Responsibilities

All SLs expressed the view that individual rights must be balanced with rights of the society, that otherwise fully freedom-oriented individual rights need to be compromised during public health emergencies and that rights do not come unlinked from social obligations. As the Baptist minister stated, if individual and collective rights conflict, then with communicable diseases, ‘. . . it seems to me that the rights of the collective, or the society, supersede the rights of the individual to wander around spreading [disease].’ This was echoed by all of the spiritual leaders without exception. Often the origin of this attitude arose from the concept that, as stated by one Roman Catholic SL, ‘My faith requires me to care for my neighbor and to care for the world. [So I would want to cooperate with public health (PH)] to the fullest extent possible.’

One SL (Catholic) qualified his response. He proclaimed the need ‘to obey civil authorities. [But] if there is a clash between . . . the will of God and the will of the civil authority, then God must be obeyed and the civil authority disobeyed.’

One key comment from the Punjabi Sikh emphasized that though the civil authorities would be obeyed, those authorities have a special obligation to inquire from various communities what the effects might be religiously or culturally on any imposed civil requirements. For example, in the Punjabi culture the mother-son relationship is considered more sacred than the wife-husband relationship, so if there were visitation restrictions the authorities would need to permit the individuals to decide with whom visits may occur.

### The Role of Faith-Based Organizations in Supporting Public Health Restrictive Measures

None of the SLs objected to the use of restrictive measures such as quarantine, isolation and visitation restrictions during an epidemic.<sup>1</sup> They all stated they would defer to medical/PH personnel as to when and how restrictive measures should be imposed and which ones were appropriate. But several SLs provided a caveat—that restrictions should be imposed only for medical reasons, not for political ones; if there was the perception that

restrictions were being implemented unjustly, such as discriminating based on religious affiliation or ethnic background, they would be actively opposed.

Specifically related to restrictive measures (quarantine, isolation and other precautionary protections), nearly all SLs claimed that if restrictions were justified on medical/public health grounds, then there were no circumstances under which they as spiritual leaders, or their religions or religious theologies, could imagine purposefully breaking them. The two major concerns were (i) how to provide pastoral or other services to restricted individuals (discussed later) so that the individual or family restricted does not feel abandoned by the community, and (ii) how to assure that people are being provided care with respect so that they do not feel as if they are pariahs, stigmatised, denigrated or being ostracised. One Catholic spiritual leader stated that he would consider breaking restrictive measures in dire circumstances, such as a child in isolation who didn’t have anyone to comfort her, but he would take all appropriate precautions (mask, gloves, etc.) and recognize that this might require that he then be restricted as well.

Further, even in providing pastoral care, the SLs agreed that the use of modern technology can substitute for in-person delivery of care. The use of the telephone, webcams or taped messages/prayers is acceptable in restriction-required emergencies. As one SL stated, ‘. . . spiritual care does not necessarily require personal presence.’ None of the SLs stated an absolute need in potentially dangerous circumstances to be in the physical presence of the patient to manage the spiritual necessities of their religion, with one notable exception: conducting last rites or prayers for a dying person. That said, participants who felt this way, agreed that in the event they did break restrictions, they would agree to observe restrictions themselves.

When asked what evidence would be appropriate for the justification of the implementation of restrictive measures during a public health emergency, most agreed that they would trust in the medical authorities. Specifically, SLs thought that PH restrictive measures should be carefully crafted by legislators and/or PH officials so that they properly balance individual and societal rights. Their trust in the decision-making process would be enhanced through good communication during the process, including transparency of decision-making through consultation with community groups, evidence of effectiveness of the restrictions and a sense that the response to the threat is proportional to the effects of the measures. As one SL stated, the evidence needs to be transparent, based on shared values, science and fair and non-discriminatory application.

Many participants conveyed their implicit trust of PH authorities. A Catholic priest said: ‘I’ve never, anywhere in my life, in four or five different countries met doctors, nurses, who’ve been hostile to or uncooperative with representatives of the churches.’ The Buddhist monk echoed this sentiment: ‘I expect professionals to be honest and have integrity.’ But it was also clear that some ethnic minority communities had a history of suspicion towards authorities because of past discriminatory practices. One SL stated, ‘. . . if I thought that policies were being applied in an unfair discriminatory manner, then I would agitate for fair policies.’ Another SL, emphasizing the need for shared understanding, said ‘. . . concern for the safety of my community is a religious duty and it’s also a civic duty. Those duties might come into conflict if I thought that the civic leaders were in any way untrustworthy.’

In particular, the Baptist minister felt that there had been discrimination against the Chinese community during SARS. This was due to the fact that SARS was originally imported from China and the index case was Chinese. Chinese communities in the GTA expressed concerns about the disproportionate impact of SARS on their communities and businesses, so much so that the prime minister of Canada visited Chinatown to demonstrate solidarity with the Chinese community. His church preaches to watch out for discrimination of other groups: ‘In the context of public health . . . if [a restrictive measure] wasn’t blatantly unjust discrimination against a particular group . . . then I don’t think that there would be any faith ground on which [we] would oppose [restrictive] measures.’ His faith community held meetings at Chinese churches ‘to symbolize our opposition to the injustice of that [discrimination].’

In short, the SLs agreed that a fair, just, non-discriminatory, justified set of restrictive measures would have their active support; they would preach that their communities have an obligation to comply—that it is an obligation within the theological morality of their faiths.

Finally, when asked whether more intrusive measures, such as monitoring devices to assure compliance with restrictive measures, would be acceptable to their religious communities, the SLs were cautious in accepting their use, but did not rule them out. For the most part, they had faith in the goodwill of the populace to adhere to restriction requirements, but also recognized that during SARS many people did not adhere out of lack of understanding. As the United Church of Canada minister stated, ‘everybody feels they are the exception—out of ignorance [not malevolence].’ Those with the most direct SARS experience wanted to trust individuals to comply, but also recognized the limitations to this. One Catholic priest stated, ‘If a patient is being naughty, then

such things [greater surveillance methods] are right and proper. . .’

## Reciprocal Obligations of Public Health and Religious Communities during Restrictions

Many SLs indicated that restrictive measures entailed great stress and wondered: How will they get food? Maintain their shelters? Get baby formula, diapers or other critical supplies? Support themselves financially so they can pay the bills? Avoid losing their jobs? Get medicines and health care? Whose responsibility is it to provide for these items? Nearly all agreed that if PH authorities required restriction of movement of individuals, then they needed to assure the provision of health care and medications. However, beyond that narrow range of care there was a diversity of views by SLs on how these other items should be provided.

While all the faith communities felt they had a mission to provide care to those in need, some participants (Lutheran, Catholic, Baptist) were more likely to suggest that the PH authorities (government) were responsible for supplying material goods—food and other supplies and supports such as education. At the same time, these communities would actively attend to the quarantined individuals’ spiritual needs, and perhaps a helping financial hand.

Some religious communities, as expressed by the Sikh, Islamic and Jewish SLs, took personally and seriously the responsibility of their religious communities to provide for most of the material items as well as tend to the spiritual needs of their respective communities. As a rabbi expressed, ‘In the Orthodox community, patients are taken care of—without fanfare. There are groups of people, such as the *Bikur Holim* Society for the sick, which help, provide care, meals, anything a sick person needs, all for free. Giving, helping, caring is integral in the community—it is the norm—and I’m sure in many other communities as well.’

The academic Catholic priest identified an area of great need for quarantined individuals: giving people a sense of the bigger picture spiritually, ‘that they’re not in it alone, that their fears are shared, that their suffering is shared by their faith community but also by God. . .’ The Lutheran minister said he would ‘preach a message which frees people from fear through the good news of the Gospel of Christ.’

## Justifiable Limits to Duties to Care

When asked how they view the duty to care during public health emergencies, SLs generally came to the same

position during the interview process: they would start with the *prima facie* statement that health and pastoral care workers take on a certain obligation to put themselves at risk during infectious disease outbreaks. Or, as one SL stated, he prefers not to think of them as ‘*duties*, but *responsibilities*.’ When questioned further about the limits to those risks, they would mitigate their responses to accept reasonable limitations—the duty or responsibility is not as absolute as they might have first declared. For example, the Baptist SL said ‘Once you step into the kitchen, you’re obligated to work within that framework [of risk]. . . .’ A Catholic priest said that health care is like the priesthood, ‘a calling from God.’ They then agreed that risk should only be taken on with all possible safeguards—with SARS that included masks, gowns, gloves, etc. Upon further reflection, allowances might be made for single parents who have to care for children, pregnant women or those taking care of elderly parents. Additionally, the conscience and values of the person have to be respected—they might choose to let their families take precedence over their jobs.

In other words, with three exceptions (Jewish, Buddhist and Sikh) the SLs started with an absolute position and then slowly worked their way towards a more nuanced one. The absolute position was related to personal sacrifice, even possibly death, such as the position taken by the Islamic SL and other Christian SLs, who said it might be accepted and necessary for a health care worker to die in the line of duty. But ultimately the SLs realized that taking on a profession does not irreversibly create an obligation to take on mortal risk. This reflected the original position of the two rabbis, for example, who stated that HCWs (and by extension, pastoral care workers) do not have to provide care if ‘it’s going to kill [them]’ or ‘it’s going to spread more disease.’ Putting yourself at risk may be ‘a great *mitzvah*. . . but it’s not an obligation.’ The Talmud says that one need not give care ‘at the cost of your own life.’ HCWs should be able to refuse to provide care during an infectious disease outbreak if it is medically probable that they would be infected and endangered, because one life is not more important than another. The Sikh SL echoed this point, claiming that ‘Purely from a Sikh religious point of view, life is sacred and must be preserved. Period.’

One Buddhist SL allowed the widest berth: people have different levels of tolerance for risk. They accept stress variously. Some people are afraid or selfish. Buddhism doesn’t permit a judgment of these differences; it is for each person to ‘find stillness in their own heart’ as to their comfort zone of risk. At the same time, both the Sikh and Buddhist SLs were clear, that if precautions can

be taken to minimize or eliminate risk, then there is no justification not to attend to others.

However, all of the SLs felt that there was a higher risk level that health care workers take on than the risk that might be required of the general population. Analogies were made with fire-fighters and police officers—they just can’t walk away from fires or crime situations when some risk occurs. Society counts on them to be there in times of emergency. But even fire-fighters make decisions not to enter burning buildings if they believe it will put them in mortal danger.

Do spiritual leaders also have a duty to provide care if by doing so their own health is at risk? The response to this question tended to be more absolute, and along the lines of the general initial responses of the SLs’ claims to HCWs’ duties. The Christian response tended towards self-sacrifice. As the Lutheran minister stated, ‘. . . in the best of all possible worlds every pastor would be willing to put their own well-being on the line for the sake of their people, to lay down their lives for their friends, in the model of Christ.’ He called this ‘the virtue of complete self-sacrifice’ and recognized that all pastors might not have developed this trait.

At the same time, the two United Church of Christ ministers claimed that the only reason not to deliver pastoral care to those in need is ‘exhaustion.’ It would be important to deal with questions that their flock might have, such as, ‘Why is God doing this to us? Is God punishing us?’ Consistent with expectations they have of health care providers, they did agree that those in pastoral care with compromised health, such as pregnancy, or cancer on chemotherapy, could opt out if they so wished.

## Discussion

In structured open-ended interviews with 14 Ontario spiritual leaders across various Western and Eastern traditions, we found a remarkable commonality in SL views about how individuals and organized religions ethically can cooperate and interact with North American public health authorities and requirements during public health emergencies. SLs justified civic duties to minimize harm to others through accepting various public health emergency, required restrictive measures through their religious dogma and a generally accepted morality of having care and compassion for others, not solely for oneself. Without prompting, they accept the same types of criteria for evidence for the imposition of restrictive measures as cohere with others’ elaborations of the principles of PH ethics—transparent, proportional, non-discriminatory, shared-values-based, effective, fair and burden-sharing (Kass, 2001; Callahan and Jennings,

2002; Childress *et al.*, 2002; Roberts and Reich, 2002; Upshur, 2002). These criteria encourage trust between faith-based communities and public health infrastructures.

SLs are also willing to advocate on behalf of PH restrictive measures during public health emergencies. Given that up to 40 per cent of the U.S. and Canadian populations attend weekly religious services, this is a very important outlet for PH communication during emergencies (Ontario Consultants on Religious Tolerance, The Barna Group). SLs are willing and able to bring strong educational messages to their congregations, encouraging them to comply with hygienic and public health emergency restrictive measures and providing them with comfort and courage to face the existing epidemic knowing they are not alone and that their communities, religion and God are supportive. SLs can reach a large segment of the population with a message of cooperation and compliance that can be very useful to PH officials during times of acute outbreaks of disease.

Trust in public institutions can be influenced by the preaching of spiritual leaders. As noted earlier with the WHO polio eradication program in Nigeria, where clergy are wary of public health motives or distrustful of public health workers, advances can be stymied. Similarly, having the cooperation and outspoken advocacy of spiritual leaders may be helpful for the ongoing cooperation and trust of the members of those organizations and the success of public health measures. With this trust shown in the cooperation and advocacy of SLs, public health messages can reach large audiences, bringing legitimacy to PH efforts and allowing PH planners to achieve disease control objectives.

The SLs we interviewed were satisfied with the measures and actions taken by the Ontario PH authorities during the SARS outbreak, partly because they viewed the actions taken as measured and reasonable and partly because they may have developed a level of trust in the past by working with Ontario PH authorities on trying to reduce what are sometimes couched in emergency terms: obesity, hypertension or other PH 'epidemics.' When pressed on how religious and PH communities might improve their work together, the SLs emphasized:

1. Communicate openly, directly and frequently.
2. Solicit SL input *in advance* of final policy-setting so that any unique community concerns can be addressed early.
3. Assure fair and non-discriminatory decision-making.
4. Use SLs to communicate with their faith-based communities—they can be supportive and persuasive.

It cannot be assumed that SLs will always agree with the advice of public health authorities. In fact, there have been many areas of disagreement between SLs and public health regarding population control and various health promotion campaigns. The comment by the Catholic spiritual leader that when there is a clash between civilian dictates and religious dictates, the religious ones will prevail is a reminder of this possibility. It is important to know this in advance and for public health authorities to be able to communicate rapidly with such communities in advance of a crisis to know where these differences may arise. If a large number of adherents may possibly be non-adherent to public health interventions, effective communication strategies and outreach may need to be in place. Whether a public health intervention will necessarily trump religious practice will likely be something that is discovered on a case-by-case basis. If public health authorities have an ongoing relationship with such communities, there will be a pre-existing relationship within which to create a space to discuss interventions and their implications for adherents. However, any practice that possibly would harm other non-adherent communities would likely be able to be mitigated under existing public health laws that specify health protection responsibilities of public health. How this impacts future relationships with public health is a matter of speculation and beyond the scope of this paper.

Our focus in this study was not on the overall relationship between public health and faith-based organizations. We think there is great utility in engaging faith-based communities. On pragmatic grounds, it increases the probability of achieving important public health goals. On more principled grounds, it demonstrates respect for and tolerance of, different communities, which is important in diverse cultures such as Toronto.

It is important, however, that such community resources not be ignored in emergency planning as they bring leadership skills and social capital to aid in crisis. Public health agencies are often underfunded and understaffed, and any ancillary support that can mitigate the effects and impact of isolative measures should be looked upon favourably by public health.

SLs take a nuanced view of an HCW's duty to provide care—an obligation for health care workers that should absorb a higher risk to their health, while at the same time limiting the risk through proper precautions that must be supplied by employers and the public health infrastructure; some HCWs may abandon their posts because of personal fear/stress, family obligations or compromised personal health. They may not totally abandon their patients or their posts; however, HCWs and the PH infrastructure as broadly defined

need to be sure there is adequately available and accessible care for those afflicted by the infectious disease outbreak. Similarly, with the exception of the idealism that is embedded in the Christian notion of the virtue of self-sacrifice for clergy, SLs also must attend to their flocks, but not to the complete jeopardy of their own health.

We recognize that there are limitations to this qualitative study. The most obvious is that these 14 SLs, while representing a diverse group of religions and denominations, do not represent all the denominations, factions and sects that exist and are found in cities like Toronto. Further, interpretations of theological belief and law can vary from SL to SL within the same religion and denomination. Religious tolerance and theology is influenced by the culture in which it is practiced: Canada's culture is heavily influenced by the principles under which it was organized by the Constitution Act of 1867: 'peace, order and good government'. Compare this symbolic phrase with that of the United States' 'life, liberty and the pursuit of happiness' and France's basis of 'liberté, égalité, fraternité'; whether our findings would hold in other nations awaits further study.

## Conclusion

We recommend that during pandemic flu planning, and epidemic control planning in general, PH officials include spiritual leaders in the early and ongoing deliberations of the criteria and logistics for implementation during public health emergencies. Educating SLs in the science, ethics and terminology of epidemics and disease control activities would help SLs explain to their congregants such activities during times of emergency, would develop and maintain the trust crucial to the enlistment of cooperation during restrictive measures imposed in public health emergencies for SLs and their communities, would add to the moral argument for advocacy by SLs, and would strengthen the overall conviction that each religious community is a member of the broader community at large.

## Notes

1. By 'quarantine' we mean the compulsory physical separation of exposed but not diseased individuals or groups. 'Isolation' is used to mean separation and confinement of individuals for whom there is evidence of infection. During the interviews it was common for SLs to use these terms interchangeably related to concerns of access or liberty restrictions.

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