Whole-Person Health and the Five Pillars of Islam: A Critical Narrative Review and Health-System Framework for Nigeria

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Abstract

Background: The Five Pillars of Islam may influence health through meaning, daily routine, embodied movement, social redistribution, fasting practices and mass-gathering preparedness. However, faith-health literature often conflates devotional significance with clinical efficacy and gives insufficient attention to adverse effects, lawful exemptions, governance and pluralism.

Objective: To critically appraise published evidence relevant to the Five Pillars and whole-person health, and to develop an ethically bounded, Nigeria-relevant framework across primary, secondary, tertiary and quaternary prevention.

Methods: This critical narrative review was informed by the Scale for the Assessment of Narrative Review Articles. PubMed/MEDLINE and targeted bibliographic searches of journal platforms and official Nigerian sources were undertaken for literature available to July 2026. Peer-reviewed reviews, meta-analyses, clinical guidance, policy analyses and relevant primary studies were prioritised. Unpublished presentations, unverifiable citations, duplicated sources and articles used solely as formatting exemplars were excluded. Every retained reference was checked against a journal record, DOI, PubMed record or official publication catalogue.

Results: The evidence is uneven. For Shahadah, health inferences are indirect and arise mainly from broader research on meaning, religious coping and dignity. Salah may support structure, gentle movement and contemplative regulation, but the clinical evidence remains limited and heterogeneous. Quran recitation may reduce situational anxiety, although study quality and generalisability vary. Zakat has a plausible role in social protection and access to care, but direct evidence of health outcomes is sparse and implementation requires transparent pooling, eligibility, purchasing and audit. Ramadan fasting produces small and usually transient metabolic changes in healthy adults, while people with chronic illness require risk stratification and medication planning. Hajj has the strongest population-health evidence through mass-gathering medicine, vaccination, surveillance, heat protection and emergency preparedness. The review proposes the PILLARS-P4 framework, where P4 refers to the four levels of prevention.

Conclusion: The Five Pillars can provide culturally meaningful entry points for whole-person care without being medicalised. Responsible application requires evidence-based treatment, voluntary spiritual care, lawful exemptions, inclusive access, robust financial governance and safeguards against both under-treatment and overmedicalisation.

Keywords: Five Pillars of Islam, whole-person health, spiritual care, health promotion, Nigeria, quaternary prevention

Introduction

Whole-person healthcare recognises that illness is experienced through the body, emotions, relationships, values, identity and sources of meaning. Religion and spirituality can shape coping, behaviour, social support, treatment choices and the interpretation of suffering. They may also generate distress through guilt, stigma, fatalism, conflict or coercive advice. Clinical relevance therefore depends less on whether a patient is religious than on how beliefs and practices function in that person's life [3-5].

For Muslims, the Five Pillars—Shahadah, Salah, Zakat, Sawm and Hajj—provide a recurring structure for belief, worship, social responsibility, restraint and communal belonging. A published overview has linked the Pillars with spiritual and physical wellbeing [2]. That literature is valuable as a conceptual starting point, but it does not establish that each practice has a direct, uniform or clinically meaningful effect on health.

Overstatement creates two risks. The first is medicalisation of worship: devotional practices may be presented as treatments for disorders that require assessment, medication, psychotherapy, rehabilitation or surgery. The second is therapeutic neglect: clinicians or communities may encourage prayer or fasting while overlooking contraindications, religious exemptions, disability adaptation or the patient's right to decline spiritual interventions. A rigorous review must therefore distinguish theological meaning, plausible mechanism, empirical evidence and health-system application.

The Nigerian setting makes this distinction especially important. Nigeria is culturally, linguistically, socioeconomically and religiously heterogeneous [6]. Its health system combines federal and state institutions, public and private providers, faith-based services, community networks and a large informal economy. Financial barriers remain substantial, with persistent reliance on out-of-pocket payment and uneven insurance coverage [7,8]. The National Health Insurance Authority reforms and the Basic Health Care Provision Fund offer opportunities for broader coverage, yet implementation depends on enrolment, quality, accountability, subnational leadership and public trust [9-12].

This review addresses four questions: (1) what health-relevant mechanisms can reasonably be linked to each Pillar; (2) what is the quality and boundary of the available evidence; (3) how can these mechanisms be organised across primary, secondary, tertiary and quaternary prevention; and (4) what governance safeguards are required for implementation in Nigeria?

Methods

Review design and reporting standard

A critical narrative review was selected because the question spans spirituality, clinical care, Islamic bioethics, public health, health financing and implementation science. The review was informed by SANRA, which emphasises the importance and aims of the review, description of the literature search, appropriate referencing, presentation of evidence levels and clinically relevant outcomes [1]. This manuscript is not a systematic review, and no claim of exhaustive retrieval or pooled effect estimation is made.

Search approach and eligibility

PubMed/MEDLINE was searched, supplemented by targeted searches of journal platforms, DOI records and official Nigerian publication catalogues. Searches covered literature available to July 2026. Core concepts included: "Five Pillars of Islam" and health; religion, spirituality and clinical care; Salah or Islamic prayer and health; Quran recitation and anxiety; Zakat, welfare and health financing; Ramadan fasting and clinical risk; Hajj and mass-gathering medicine; Islamic bioethics; quaternary prevention; Nigeria health financing; health insurance; and the Basic Health Care Provision Fund. Eligible sources were peer-reviewed systematic reviews, meta-analyses, narrative reviews, clinical guidance, policy analyses, implementation studies and selected primary studies directly relevant to the review questions. Official Nigerian reports were eligible when needed for national context. Sources

were excluded when they were unpublished, unverifiable, duplicated, used only as writing or formatting exemplars, or unable to support the claim for which they had been cited. Every retained reference was checked against a stable journal, DOI, PubMed or official catalogue record.

Synthesis and evidentiary interpretation

Evidence was synthesised by Pillar and then mapped to four levels of prevention. Primary prevention refers to health promotion and risk reduction before disease develops. Secondary prevention refers to early detection and timely intervention. Tertiary prevention aims to reduce disability and support rehabilitation after disease is established. Quaternary prevention protects people from unnecessary, disproportionate or harmful medical intervention [24]. The analysis also considered autonomy, non-discrimination, avoidance of harm and plural accountability in Muslim biomedical ethics [25].

Results

Evidentiary boundaries

The reviewed literature supports a cautious, mechanism-based interpretation. The evidence does not justify ranking the Pillars by medical benefit or treating worship as a standardised health intervention. Rather, the Pillars can provide culturally meaningful settings in which established health actions—education, screening, adherence support, financial protection, rehabilitation, vaccination and risk communication—may become more acceptable or accessible. The strength of evidence differs substantially across the five domains.

Shahadah: meaning, personhood and religious coping

Shahadah expresses monotheistic faith and commitment. Its possible health relevance is indirect. Broader literature on religion and spirituality associates positive religious coping, meaning, hope and supportive communities with better psychological adjustment in many, but not all, settings [3,4]. Serious illness often raises questions of identity, guilt, hope, mortality and dignity, and clinicians may appropriately explore these concerns when the patient welcomes such discussion [5].

The main clinical application is therefore person-centred spiritual assessment rather than a claim that declaration of faith treats disease. A clinician may ask what gives the patient strength, whether illness has affected religious practice, and whether support from an imam or trusted family member would help. The same assessment must identify religious struggle, fear of divine punishment, stigma or fatalistic interpretations that could worsen distress or delay care. Spiritual discussion should remain voluntary and should never be used to judge adherence, explain illness as moral failure or deny evidence-based treatment.

Salah: routine, embodied worship and contemplative regulation

Salah combines regular timing, recitation, attention, postural transitions and, for many worshippers, congregational connection. A published review describes possible musculoskeletal, cardiovascular, neurological and psychological effects, but the underlying studies are heterogeneous and do not support strong therapeutic conclusions [15]. The

movements are generally low intensity and may contribute to mobility or daily structure, yet they are not substitutes for prescribed physical activity, physiotherapy or rehabilitation.

Systematic and scoping reviews suggest that listening to Quran recitation may reduce anxiety, stress or depressive symptoms in some contexts [16,17]. However, many studies are small, geographically concentrated, difficult to blind and vulnerable to expectancy effects. The most defensible clinical position is to offer Quran recitation or prayer-compatible relaxation as an optional adjunct for patients who value it, while preserving standard assessment and treatment. Adapted prayer postures, seating, tayammum and other accommodations should be discussed with appropriate religious and clinical guidance when pain, disability or infection-control requirements limit usual practice.

Zakat: social protection, access and governance

Zakat has the clearest potential to influence social determinants of health because it redistributes resources towards eligible recipients. It may support transport, nutrition, medicines, diagnostics, assistive devices, insurance contributions, rehabilitation or emergency care. Research on Zakat distribution confirms that governance, targeting, institutional capacity and scalability are central concerns [18]. A Sudanese analysis also illustrates the potential, and the limitations, of linking Zakat resources to social health insurance [19].

Charity is not equivalent to health financing. Sustainable financial protection requires predictable revenue, risk pooling, explicit benefit design, strategic purchasing, provider payment, quality assurance, fraud control and grievance mechanisms. Nigeria's experience with out-of-pocket expenditure, community-based insurance, the NHIA and the BHCPF shows that coverage alone is insufficient when enrolment, service quality and accountability remain weak [7-14]. Zakat should therefore function as a complementary subsidy or social-protection layer within regulated systems, not as a parallel pathway that fragments care or exposes poor households to discretionary decisions.

Eligibility rules require particular care. Classical Zakat categories must be interpreted by competent religious authorities, while public services remain governed by law, clinical need and non-discrimination. When Zakat funds support a public facility or pooled insurance mechanism, agreements should specify who benefits, what services are covered, how providers are paid, how conflicts of interest are managed and how non-Muslim residents access publicly funded services.

Sawm: modest metabolic effects, clinical planning and lawful exemption

Ramadan fasting differs from many popular intermittent-fasting regimens because it involves dawn-to-sunset abstinence from food and fluid, altered sleep and meal timing, and variable post-sunset dietary patterns. In healthy adults, meta-analyses show small average reductions in body weight and modest changes in some cardiometabolic or glucometabolic markers; effects vary by setting and are often transient [20-22]. These findings do not justify presenting Ramadan fasting as a universal

treatment for obesity, diabetes or cardiovascular disease.

The clinically important issue is risk stratification. People with diabetes, pregnancy complications, renal disease, frailty, epilepsy, severe mental illness, recurrent hypoglycaemia, dehydration risk or safety-critical occupations may require medication adjustment, monitoring or advice not to fast. The IDF-DAR guidance emphasises pre-Ramadan assessment, education, individualised treatment and shared decision-making [23]. Such services can be incorporated into primary care, diabetes clinics, antenatal care, mental health services, pharmacies and mosque-linked outreach.

Quaternary prevention is essential. Clinicians should not pressure patients to fast, and families or religious leaders should not override clear medical risk. Conversely, clinicians should not dismiss fasting without understanding the patient's values or available adaptations. Respectful discussion of lawful exemption can reduce shame, concealment and unsafe self-management.

Hajj: mass-gathering medicine and public-health readiness

Hajj has the strongest population-level evidence among the Pillars because it is a major international mass gathering. Research describes risks from communicable disease, heat, crowd density, cardiovascular events, trauma, medication disruption and chronic illness [26-29]. The literature has also helped establish mass-gathering medicine as a distinct field concerned with surveillance, vaccination, preparedness, emergency response and international coordination [26,27].

For Nigerian pilgrims, the practical implications include pre-travel assessment, vaccination, medication reconciliation, heat-risk education, physical preparation, identification of frailty, women's health support, mental health planning, travel insurance and post-travel surveillance. Heat risk deserves increasing attention, particularly for older adults and people with chronic disease [29]. Fitness-to-travel decisions should be clinically reasoned, clearly documented and communicated with religious sensitivity. Deferral when travel is unsafe is an expression of preserving life rather than a denial of faith.

The PILLARS-P4 health architecture

The PILLARS-P4 health architecture is an original conceptual framework developed from this synthesis. It is intended to guide programme design and research; it has not yet been validated as a clinical or policy instrument. "PILLARS" identifies seven implementation domains, while "P4" refers to four levels of prevention.

PILLARS implementation domains:

• Purpose and personhood: recognise meaning, dignity, identity and patient-defined spiritual resources.

• Integrated worship-care routines: accommodate worship while preserving clinical standards and infection control.

• Livelihood and social protection: connect charitable resources with transparent financing and social support.

• Lifestyle discipline and risk modification: use culturally salient periods and settings for evidence-based health promotion.

• Assembly and public-health readiness: apply surveillance, vaccination, travel medicine and emergency planning to large gatherings.

• Rights and plural accountability: protect autonomy, confidentiality, inclusion and lawful access for Muslims and non-Muslims.

• Safeguards against harm: prevent delayed care, coercion, unsafe fasting, unnecessary testing, fraud and overmedicalisation.

Table 1. Evidence-informed mapping of the Five Pillars to whole-person health and prevention

Pillar	Plausible health mechanism and evidence boundary	Applications across prevention	Quaternary and ethical safeguards
Shahadah	Meaning, identity, hope, accountability and positive religious coping. Evidence is indirect and derived mainly from broader spirituality-health research.	Primary: dignity-based health literacy and stigma reduction. Secondary: voluntary spiritual history and identification of religious struggle. Tertiary: coping support in chronic illness, addiction, palliative care and rehabilitation.	Do not attribute illness to weak faith, impose theology or substitute "faith-only" advice for clinical care.
Salah	Routine, attention, recitation, gentle postural movement and social connection. Clinical evidence is limited and heterogeneous.	Primary: hygiene, daily structure, stress-management and mobility messages. Secondary: mosque-linked screening with formal referral. Tertiary: prayer adaptations within rehabilitation and disability care.	Do not present prayer as physiotherapy, psychotherapy or medication. Accommodate disability and infection-control needs.
Zakat	Redistribution and social protection; potential support for transport, nutrition, medicines, diagnostics and insurance subsidy. Direct health-outcome evidence is sparse.	Primary: premium subsidy and prevention outreach. Secondary: targeted screening and diagnostics. Tertiary: treatment, rehabilitation and palliative support.	Use explicit eligibility, pooled financing, provider contracts, audit, anti-fraud controls and grievance systems. Avoid sectarian access barriers.
Sawm	Self-regulation and altered meal timing. Small, variable and often transient metabolic changes in healthy adults.	Primary: nutrition, smoking cessation and pre-Ramadan education. Secondary: risk stratification and monitoring. Tertiary: medication adjustment and post-Ramadan follow-up.	Do not promote fasting as universal therapy. Protect people with high clinical or occupational risk and discuss lawful exemption.
Hajj	Mass-gathering preparedness, vaccination, surveillance, heat protection, physical preparation and emergency response. Strongest public-health evidence.	Primary: travel health education, vaccination and heat prevention. Secondary: fitness and chronic-disease assessment. Tertiary: emergency care coordination and post-travel surveillance.	Discourage unsafe travel, fraudulent certification and unnecessary testing. Protect privacy and communicate deferral respectfully.

Note: Applications are proposed pathways for implementation. They do not establish that devotional practice is a medical treatment.

Table 2. Priority implementation actions for Nigeria

Implementation domain	Recommended action	Core evaluation measures	Equity and safety requirement
Faith-sensitive primary care	Train staff in brief spiritual history-taking, prayer accommodation, referral boundaries and non-discrimination.	Proportion of facilities with written spiritual-care and referral protocols.	Participation must be voluntary; provide equivalent respectful care to all patients.
Pre-Ramadan clinical programme	Offer annual risk assessment for diabetes, pregnancy, renal disease, epilepsy, frailty, severe mental illness and high-risk work.	Attendance, medication plans, adverse events, emergency visits and patient-reported decision quality.	Explicitly document exemption counselling; avoid public labelling of patients who do not fast.
Zakat-supported financial protection	Pilot premium, transport or medicine subsidies through state insurance and accredited providers.	Coverage continuity, claim denial, catastrophic spending, service quality, fraud findings and equity.	Publish eligibility and appeal rules; separate religious fund governance from clinical decision-making.
Mosque-market screening and referral	Use trusted community sites for blood pressure, diabetes, maternal health, mental health and substance-use screening.	Referral completion, treatment initiation, false-positive burden and follow-up retention.	Screen only with consent; protect confidentiality and avoid unqualified diagnosis in public settings.
Hajj health platform	Standardise vaccination, fitness assessment, medication review, heat planning, emergency contacts and post-travel surveillance.	Vaccination completion, heat illness, admissions, medication interruptions and preventable evacuation.	Use consistent clinical criteria; prohibit exploitative certificates and unnecessary investigations.
Education and research	Integrate spiritual care, Islamic bioethics, pluralism, health economics and quaternary prevention into training.	Competence assessment, implementation outcomes, cost-effectiveness and equity audit.	Include women, disabled persons, minority faiths, patients and frontline providers in co-design.

P4 provides the operational sequence: primary prevention promotes health and reduces risk; secondary prevention detects problems early; tertiary prevention limits disability and supports recovery; and quaternary prevention limits avoidable harm from clinical, religious or administrative intervention. The framework is deliberately bidirectional: Islamic practices may offer trusted entry points for health action, while clinical ethics and prevention science set boundaries on what may responsibly be claimed or done.

Nigeria-specific implementation pathways

Implementation should vary by setting while maintaining common standards. Muslim-majority areas may use mosque networks, emirate structures, Islamiyyah schools, women's groups and Zakat institutions. Mixed settings require visibly inclusive governance and interfaith partnership. Urban areas need links with workplaces, pharmacies, health maintenance organisations, digital platforms and private providers. Conflict-affected settings require

humanitarian neutrality, confidentiality and protection from spiritualisation of trauma or poverty.

Discussion

From devotional significance to proportionate health claims

The central finding is not that all Pillars improve all dimensions of health. It is that each Pillar creates a distinctive set of meanings, routines, social relations or public-health circumstances that may be used responsibly to support established health actions. This distinction protects both scientific integrity and religious integrity. Scientific integrity requires claims to match the strength and applicability of evidence. Religious integrity requires worship not to be reduced to a biomedical technique.

The evidence hierarchy is uneven. Studies of religion and spirituality provide broad associative support for meaning and coping, but do not isolate Shahadah as an intervention. The Salah literature is largely descriptive or based on small studies. Quran recitation reviews report favourable outcomes but identify methodological limitations. Zakat literature focuses more on distribution and welfare than clinical outcomes. Ramadan has a substantial meta-analytic literature, although effects among healthy participants cannot be generalised to people with chronic illness. Hajj is supported by an established mass-gathering health literature with clear operational endpoints.

Zakat should complement, not replace, universal health coverage

The policy attraction of Zakat is understandable in a setting where many households delay care or face financial hardship. Yet fragmented charitable payment can reproduce the weaknesses it seeks to solve: unpredictable revenue, narrow eligibility, delayed authorisation, supplier-induced demand and inequitable access. A stronger model links Zakat-supported subsidies to accredited providers, defined benefits, routine claims review and state social health insurance. This arrangement preserves the moral purpose of redistribution while using established mechanisms for pooling, purchasing and quality assurance.

Pilot programmes should begin with a limited, high-value package and pre-specified evaluation. Examples include insurance premiums for eligible informal-sector households, transport for obstetric emergencies, essential medicines for hypertension and diabetes, or rehabilitation support after disabling illness. Evaluation should measure not only numbers assisted but continuity of coverage, service quality, catastrophic expenditure, unmet need, adverse selection, administrative cost and distribution by sex, disability, residence and faith.

Pluralism, autonomy and professional boundaries

Faith-sensitive care is not the same as faith-directed care. It begins with the patient's preferences. Some Muslims will want explicit spiritual discussion; others will prefer ordinary clinical language or may practise differently. Non-Muslim patients in Muslim-led services must not experience proselytisation, inferior access or assumptions about their beliefs. Staff need clear boundaries: clinicians may assess spiritual needs and facilitate support, but should avoid acting beyond competence or using

professional authority to settle contested theological questions.

These boundaries are compatible with Muslim biomedical ethics, which includes diverse textual, contextual and methodological approaches rather than a single automatic answer to every clinical question [25]. Shared decision-making should therefore bring together clinical evidence, the patient's values, appropriate religious expertise and relevant law, especially when fasting, end-of-life care, disability or travel risk is contested.

Research agenda

- Develop and validate a culturally sensitive measure of faith-health acceptability and spiritual-care preference for Nigerian clinical settings.
- Evaluate mosque- and community-linked screening using pragmatic designs that measure referral completion, clinical outcomes, false-positive burden and cost.
- Test Zakat-supported insurance or transport subsidies with transparent eligibility, comparative cost-effectiveness and equity analysis.
- Establish prospective Nigerian Ramadan registries for high-risk chronic disease, medication adjustment and adverse events.
- Link Hajj medical records with pre-travel risk assessment and post-travel surveillance while protecting confidentiality.
- Study unintended consequences, including stigma, coercion, delayed treatment, overtesting, exclusion and diversion of funds from high-value care.

Strengths and limitations

This review improves reference integrity by excluding unpublished and unverifiable items, checking retained citations against stable bibliographic records and separating evidence from conceptual inference. It also corrects the conceptual distinction between levels of healthcare and levels of prevention and makes quaternary safeguards explicit. The main limitation is the narrative design. Search retrieval was structured but not exhaustive, study-level risk of bias was not independently duplicated and no meta-analysis was undertaken. Much of the evidence is indirect, geographically concentrated or heterogeneous. The PILLARS-P4 framework therefore requires prospective validation before it is used to judge services or allocate resources.

Conclusion

The Five Pillars can enrich whole-person healthcare when their role is described with scientific restraint. Shahadah may inform meaning and personhood; Salah may support routine, embodied worship and voluntary contemplative coping; Zakat may strengthen social protection; Sawm can create an annual window for risk assessment and health education; and Hajj provides a mature model for mass-gathering preparedness. None of these functions justifies replacing clinical assessment or established treatment.

For Nigeria, the most credible path is neither a parallel religious health system nor a secular system that ignores religious life. It is a plural, evidence-informed system that works with trusted faith networks while protecting autonomy, professional

standards, equitable access and public accountability. The PILLARS-P4 architecture offers a testable framework for that work, but its value will depend on implementation outcomes rather than conceptual appeal.

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