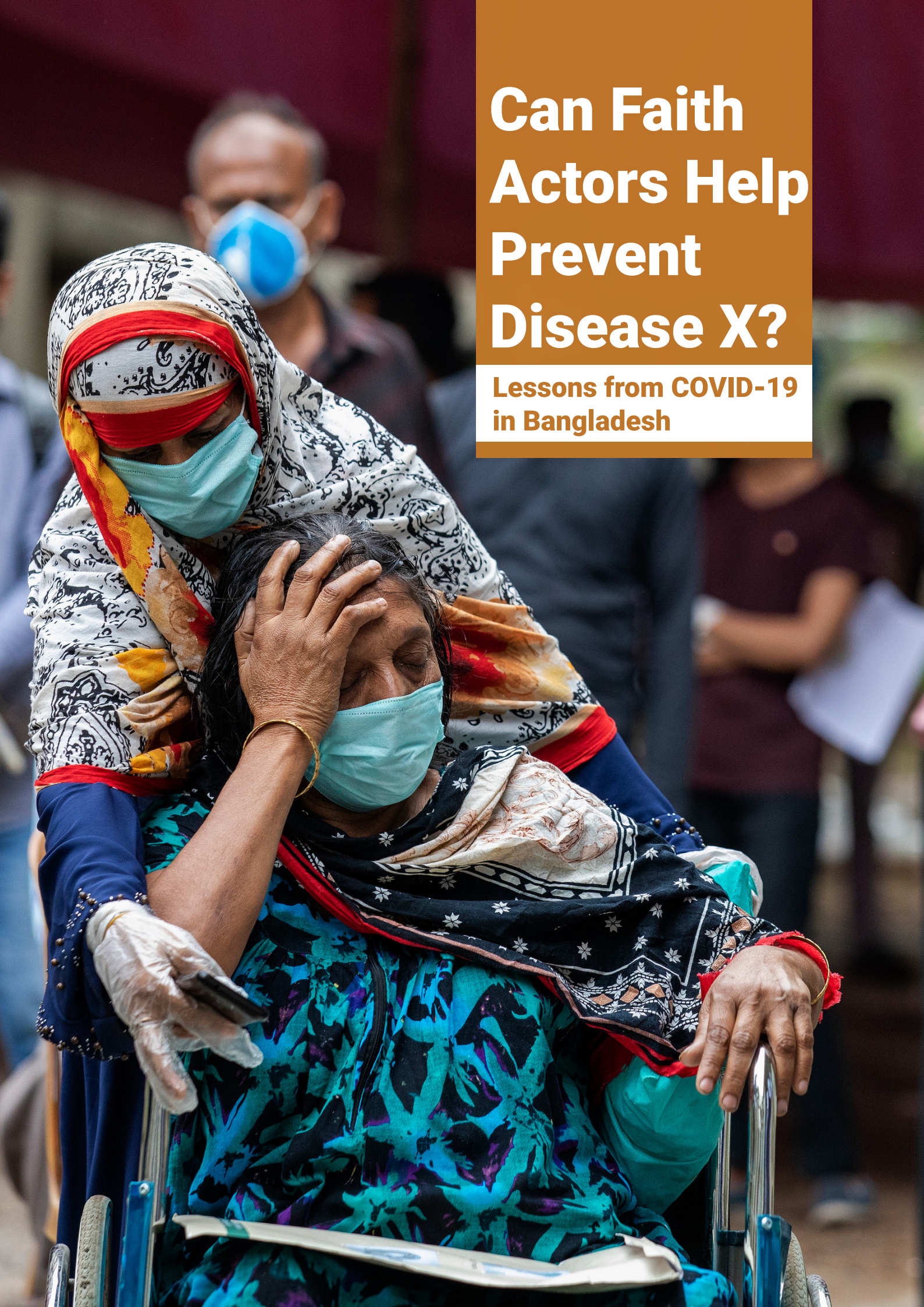
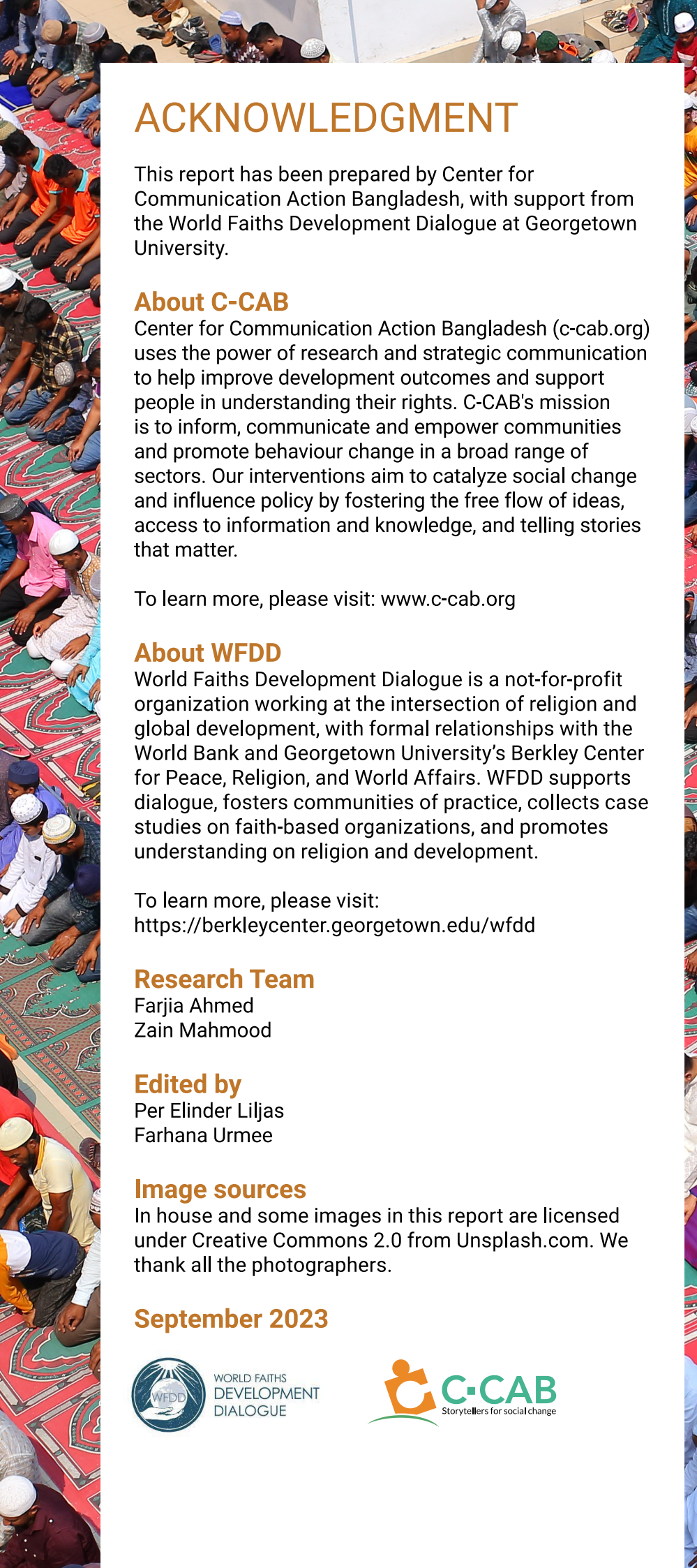


Can Faith Actors Help Prevent Disease X?

Lessons from COVID-19 in Bangladesh



ACKNOWLEDGMENT

This report has been prepared by Center for Communication Action Bangladesh, with support from the World Faiths Development Dialogue at Georgetown University.

About C-CAB

Center for Communication Action Bangladesh (c-cab.org) uses the power of research and strategic communication to help improve development outcomes and support people in understanding their rights. C-CAB's mission is to inform, communicate and empower communities and promote behaviour change in a broad range of sectors. Our interventions aim to catalyze social change and influence policy by fostering the free flow of ideas, access to information and knowledge, and telling stories that matter.

To learn more, please visit: www.c-cab.org

About WFDD

World Faiths Development Dialogue is a not-for-profit organization working at the intersection of religion and global development, with formal relationships with the World Bank and Georgetown University's Berkley Center for Peace, Religion, and World Affairs. WFDD supports dialogue, fosters communities of practice, collects case studies on faith-based organizations, and promotes understanding on religion and development.

To learn more, please visit:
https://berkleycenter.georgetown.edu/wfdd

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September 2023

WORLD FAITHS DEVELOPMENT DIALOGUE

C-CAB
Storytellers for social change

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EXECUTIVE SUMMARY

As the world confronts the effects of climate change, we are increasingly seeing the emergence of new diseases and the resurgence of old ones. According to some estimates, there is more than a one in four chance of another global pandemic in the next decade. The World Health Organization calls this unknown threat 'Disease X'.

One of the lessons of the COVID-19 pandemic is that policymakers or scientists alone cannot combat a worldwide public health emergency. Tackling pandemics requires a 'whole of society' approach.

Faith leaders can play an essential role in health emergencies as community influencers and 'information intermediaries'. Engaging these leaders is important as they can mobilize the community, build trust and combat misinformation and stigma. . The COVID-19 pandemic led to a renewed emphasis on the public's health and hygiene behavior. Faith communities were thrust into the spotlight as controversies erupted over 'super-spreader events' and 'vaccine hesitancy'.

For countries in the Global South, such as Bangladesh, limited healthcare resources and weak infrastructure meant a heavy reliance on changing individual and community behavior to prevent the spread of COVID-19. The United Nations has repeatedly urged governments to make Risk Communication and Community Engagement (RCCE) one of the key pillars of their public health response.

Shortly after the COVID-19 pandemic abated, Bangladesh was struck by deadly waves of dengue fever, which have killed more than 1,200 people so far. Once again, the influx of patients has strained the country's healthcare system and placed a renewed focus on the lessons learned from the COVID-19 response.

Center for Communication Action Bangladesh (C-CAB) carried out a knowledge, attitudes, and practices (KAP) study to better understand knowledge gaps, cultural beliefs, and behavioral patterns among faith leaders in five administrative divisions of Bangladesh – Dhaka, Chittagong, Khulna, Sylhet, and Rajshahi.

The study examined faith leaders' perceptions of infectious diseases like COVID-19 and sought to identify practices that might help or hinder efforts to contain an outbreak. It also looked into attitudes towards vaccines and public health restrictions such as limiting religious events. In addition, the research explored the respondents' own understanding of the role faith leaders can play in a public health response.

The results showed that overall, the majority of faith leaders were well-informed about the basics of the COVID-19 pandemic, in line with government advice and scientific consensus. However, the research also uncovered significant knowledge gaps and superstitious attitudes that could complicate a health response.

The majority (81%) of respondents say they believe in human-to-human transmission of Covid-19 while 96% indicate they recommend vaccination; 87% say they took the vaccine themselves. However, at the same time, 62% of faith leaders believe Covid-19 is 'God's punishment'. This could hark back to a belief held in the community that the disease commonly afflicts 'sinners'.

Most faith leaders (65%) believe there are alternative treatments for Covid-19, such as hot water (40%), antibiotics (22%) or traditional medicine (20%). Nearly a fifth (19%) of religious leaders say they do not believe in the concept of infectious disease altogether.

Approximately 40% of respondents said they would agree with a policy of closing places of worship to control infections. At the same time, 86% of religious leaders say they believe masks should be worn for religious ceremonies during an outbreak. However, only 26% said they wore masks regularly to avoid transmission.

Older religious leaders (70+) appeared to be less well-informed than younger ones. Older leaders were less likely to say they heard about the Omicron variant of the coronavirus. Older leaders also were significantly less likely to agree to the closure of places of worship to contain an outbreak.

Faith leaders appeared keen to be involved in community-based health activity, with 94% of respondents saying faith leaders have an important role to play in a public health response.

However, just 32% said they had been reached out to by a government agency to contribute meaningfully to the COVID-19 response, underscoring that there is a significant opportunity to engage faith leaders in future public health responses.

This KAP study among the faith leaders of Bangladesh provides important clues about the information ecosystem, which is key to the preparation and dissemination of prevention messages

The results provides important pointers for future interventions and opportunities to fill existing gaps in health management and collaboration between key players.

More robust social and behavior change interventions are needed if we want to be better prepared for future public health challenges.

87%
of faith leaders took the COVID-19 vaccine

62%
believe a pandemic is God's punishment

65%
believe there are alt treatments for COVID-19

19%
don't believe in the concept of infectious disease

40%
agree with closing places of worship to control infections

26%
wore masks regularly to avoid transmission

94%
said faith leaders can play a role in health responses

32%
said they had been approached to play a role

Possible recommendations to be considered for future public health responses are:

1. Engage, mobilize and train faith leaders as community influencers and conduits of information.

2. Religious leaders can support and coordinate awareness campaigns and mobilise communities for preventive behaviours and vaccination.

3. Empower faith leaders to maintain healthy and preventive behaviours in their places of worship.

4. Train faith leaders to combat stigma and counter misinformation.

5. Engage faith leaders as counsellors to provide psychosocial support.

6. Specific cultural or religious beliefs that are not aligned with health protocols need to be appropriately clarified. In this type of sensitive work, utilizing existing networks of faith-based organizations to engage faith leaders could help address the issue.

7. Faith leaders should be engaged as representatives in their community capable of sharing health information. This will allow health authorities to reach remote and marginalized areas.

8. Provide support for compliance with health protocols during religious ceremonies and/or at places of worship.

BACKGROUND

The COVID-19 pandemic will not be the last time a virus threatens our lives and livelihoods. While the pandemic has been devastating, it has also been a wake-up call to the world about the need for better preparedness and a more coherent response to future public health crises.

Most scientists agree that epidemics and pandemics will be more frequent in the future, driven by climate change, globalization, urbanization and human-animal contact (Haileamlak, 2022).

According to some estimates, there is more than a one in four chance in the next decade of another global pandemic. We don't yet know whether this will be a resurgent disease or an entirely new pathogen making the jump from animals to humans such as COVID, SARS, Ebola or HIV. The World Health Organisation refers to this unknown future threat as 'Disease X' (Ramgolam, 2023).

The COVID-19 pandemic showed how unprepared most countries are for unanticipated health risks. One of the biggest lessons from the pandemic is that a public health response is not just about science, or policy. It has profound social, economic, cultural and ethical consequences. To prepare for the next big public health crisis, experts are urging a 'whole of society' approach, where governments, scientists, policymakers, civil society and community influencers work together to combat the threat (Ortenzi et al., 2023).

For countries in the Global South, which have borne the brunt of pandemic devastation, the risk is acute. Countries like Bangladesh have inadequate medical resources and weak infrastructure, which are quickly put under strain by a disease outbreak (Levin et al., 2022)

Lacking social safety nets, developing countries such as Bangladesh cannot afford the strict lockdowns and health regulations richer countries can execute.

Developing countries must rely heavily on preventive positive behavior, both at individual and community level.

COVID-19 arrived in Bangladesh in March 2020. Following the detection of the first cases, the government of Bangladesh imposed a lockdown. Despite this, cases continued to rise in April, and government hospitals were quickly overwhelmed (Ahmed et al., 2023)

Bangladesh suffered through several waves of COVID-19 infections, which killed more than 29,000 people (WHO, 2023)

The South Asian country, which mounted a response characterized by close collaboration between the government and NGOs, may have coped with the pandemic slightly better than its neighbors such as India (Biswas, 2022)

However, the pandemic underscored the vulnerability of the Bangladesh health sector and the economy to such major shocks.

More recently, the most severe dengue outbreak in Bangladesh's history has claimed over 1,000 lives. This unprecedented outbreak has been exacerbated by rising temperatures linked to the climate crisis, causing the disease to spread beyond densely populated urban areas. Since January 2023, more than 1,000 people, including over 100 children, have succumbed to the mosquito-borne illness, with infections exceeding 208,000 cases (Regan, 2023).

The dengue outbreak has once again placed a strain on the healthcare system and put a fresh focus on the questions – what lessons has Bangladesh learned from the COVID-19 pandemic and whether the country is better equipped to handle disease outbreaks than it was a few years ago? How can we apply the 'whole of society' approach to better handle health crises such as the dengue outbreak?

Religion plays an important role in traditional Bangladeshi society and in the country's wider social dynamics; moreover, faith leaders are often opinion-makers who have a considerable impact on social attitudes and behaviors (Adams, 2015). During the COVID-19 pandemic, various approaches were implemented to support community behavior change, one of which was through faith networks. Faith-based organizations and religious actors have been on the frontline, mitigating the impacts of COVID-19 and providing communities with guidance and support.

Research from the NGO BRAC has shown that in areas where community groups became involved, the infection rate declined. Their involvement encouraged prevention practices, identification of cases and quarantining. It facilitated the provision of food and medicine (Chowdhury, 2021)

In this sense, faith leaders can play an important role in enhancing public awareness of disease protocols and disease prevention. However, many faith leaders have been prevented from playing this role during the pandemic due to superstition and archaic knowledge, attitudes, and practices. The official COVID-19 response has generally failed to engage these influential actors. Much more needs to be done to engage faith leaders as community influencers.

The role of faith groups in the COVID-19 response has not been without controversy in Bangladesh and wider South Asia. Religious groups have been accused of defying COVID-19 regulations by holding religious events like funerals (Mahmud, 2020)

To better understand the role of faith leaders during health crises, this research focused on the knowledge, attitudes, and practices of faith leaders in Bangladesh during the COVID-19 pandemic. The study covered current knowledge gaps, cultural beliefs, and behavioral patterns among faith leaders in five administrative districts of Bangladesh, to develop recommendations for future public health initiatives.

OBJECTIVES

This study evaluated the knowledge, attitudes, and practices of Bangladeshi faith leaders at the time of the COVID-19 pandemic to identify related sociodemographic variables, awareness of pandemic symptoms, perceived risks, misconceptions, fears, and awareness of and ability to carry out preventive behaviors.

Some of the principal areas of inquiry of the study were:

- Common beliefs among faith leaders about COVID-19 and infectious diseases
- Individual, group (social), and structural (system) barriers to preventive behavior
- Issues around the stigma associated with COVID-19
- Cultural and faith issues associated with hygiene behavior
- Perceptions of the role of faith leaders in a public health response

This report aims to highlight the knowledge, attitudes, and practices of faith leaders in the five largest districts of Bangladesh about COVID-19 in particular and infectious diseases in general. Understanding faith leaders' knowledge and knowledge gaps would assist policymakers in improving the engagement of faith leaders as community influencers during a pandemic.

In addition, this report aims to provide recommendations for effective community engagement and draw wider lessons for future public health emergencies.

DEFINITION OF FAITH LEADERS, THEIR ACTIVITIES AND RELATIONSHIPS

A faith leader is someone who is affiliated with a religion or spiritual path that is recognized by the community and empowered to provide religious guidance and spiritual advice.

Faith leaders are considered to have influence in their communities and among the broader civil society. These leaders are authorized representatives of religious institutions or are leaders as a result of the consensus of the faith community. Religious leaders include clerics, imams, lamas, monks, nuns, rabbis, ministers, priests, and traditional indigenous spiritual advisers, such as shamans, sages, swamis, and sukias (United Nations Development Programme, 2014).

Faith leaders are often the most respected figures in their communities, and they play a powerful role in shaping attitudes, opinions, and behaviors due to the trust that is placed in them by their faith communities. Faith leaders are integrated into their communities through service and compassionate networks and can therefore reach the most vulnerable and identify those most in need (WHO, 2019).

Faith leaders are usually anchored to particular buildings or social centers, where they conduct teaching, preaching, meditation, worship, or prayer. Activities include having spiritual oversight of institutions such as schools, faith-based gatherings, youth organizations, seminaries, orphanages, hospitals, refuges, pilgrimage sites, prisons, and military establishments (Wright, 2015). Faith leaders and faith communities are among the largest and best-organized civil institutions in the world, claiming the allegiance of billions of believers and bridging the divides of race, class, and nationality.

Perhaps more than any other civil society representatives, faith leaders have the experience of establishing and working with international partnerships (Health Communication Capacity Collaborative, 2020).

Faith communities are diverse in their definition; however, it is possible to distinguish these communities based on the way that they operate, at three main levels:

1. Informal social groups or local faith communities, such as local women's groups or youth groups.

2. Formal worshipping communities with an organized hierarchy and leadership, such as major religious faith groupings (for example, Islam, Hinduism, Buddhism, and Christianity) and sub-divisions of organized religion (for example, Sunni Islam, Theravada Buddhism, and Catholic Christianity).

3. Independent faith-based non-governmental organizations (NGOs), such as Islamic Relief and Tearfund. These also include faith-linked networks, such as the Ecumenical Advocacy Alliance, Caritas Internationalis, and the World Conference of Religions for Peace (WHO, 2019).

Through the influence of faith leaders, it is possible to foster dialogue to raise awareness and motivate changes in attitudes, behaviors, and practices, while also ensuring increasing knowledge within their faith community to meet wider community needs.

METHODOLOGY

Center for Communication Action Bangladesh conducted a mixed-method study to better understand knowledge gaps, attitudes and practices among faith leaders regarding COVID-19 in particular and infectious diseases in general. Primary data was triangulated using both quantitative and qualitative methods. Secondary data was derived from a systematic literature review.

The research team conducted phone-based surveys, using a structured questionnaire, to collect data from a total of 383 respondents across Chittagong, Dhaka, Khulna, Rajshahi, and Sylhet Districts between July and October 2022. Proportionate stratification was carried out based on lists of Muslim, Hindu, Buddhist, and Christian priests obtained from the Ministry of Religious Affairs and other official sources To better understand, validate and contextualize the findings, eight In-depth interviews were conducted between February and April 2023.

In addition to the primary data, literature reviews were conducted to gain an understanding of the existing research into faith actors' relationships, institutions, and initiatives that were relevant to faith leaders' roles during the COVID-19 pandemic.

1. Data Collection

The survey covered general information about the faith leaders; basic knowledge about COVID-19 and infectious diseases, including causes and treatment; their responses to social and mobility restrictions; cultural practices and beliefs; information consumption patterns and their perception of faith leaders' role in public health responses.

Illustrative survey questions:

General Information	Age, religion, gender, location
Basic Covid-19 Knowledge	• Have you heard about covid-19? • Have you heard about Omicron? • What causes Covid-19? • Have you taken the Covid vaccine? • Do you think the vaccine is helpful in preventing Covid?
Social and Mobility	• Do you know the meaning of social distancing? • Do you know the meaning of quarantine? • Do you think that COVID-19 can spread from person to person? • Have you participated in any community activity in response to Covid? • In order to prevent contracting and spreading COVID-19, do you avoid going to crowded places? • In order to prevent contracting and spreading COVID-19, do you avoid handshaking, hugging? • In order to prevent contracting and spreading COVID-19, do you use facial masks?

Cultural and religious Beliefs

- Do you believe in the concept of infectious disease?
- Do you believe traditional healers (kabiraj, herbal practitioner) can cure or treat you for corona virus?
- Do you believe corona virus only disease only takes sinners?
- Do you believe that spiritual healers can cure or treat you for corona virus?
- Do you believe that Covid-19 is God's punishment?
- In order to prevent contracting Covid-19, do you use herbal products and traditional medicine?
- Would you allow a person who died from coronavirus to be buried in your local graveyard?
- Does scripture say anything about helping the sick?
- Do you think people should wear masks during prayer in a place of worship?
- Do you think people should gather for funeral prayer even if there may be risk of Covid-19 spreading?
- If the pandemic surges, would you agree with a decision to temporarily close a place of worship?
- Did you face any difficulty with religious practice during Covid-19?
- Do worshipers wear masks in your mosque/temple/church?

Information and Communication

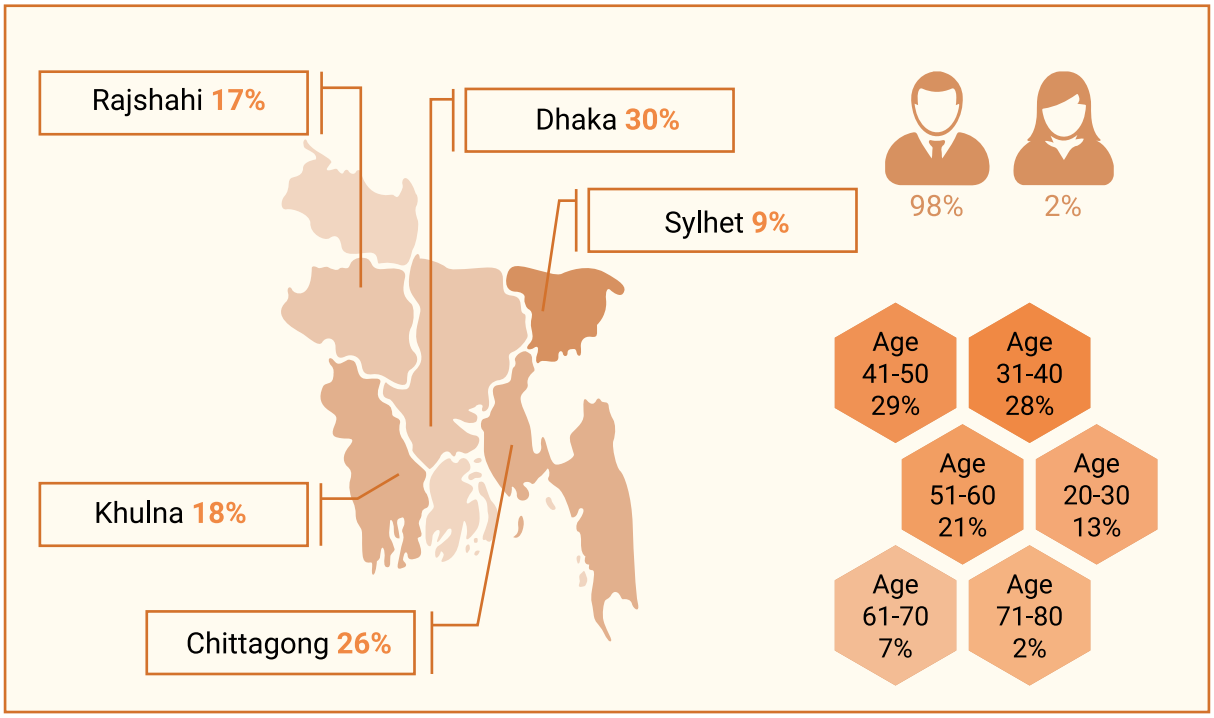
- What are your main sources of information for coronavirus?
- What are the best communication methods to reach religious leaders with public health information?
- Do you advise people to take the vaccine during your sermons?
- Do you advise people to take preventive steps to stop Covid?
- What role do religious leaders have in a public health emergency?
- Have you participated in any community activity in response to Covid?
- Has any government agency reached out to you to help in the Covid response?
- In your opinion, are religious leaders (Imams, priests, pastors) playing an important role in the response to Covid-19?

2. Data Analysis

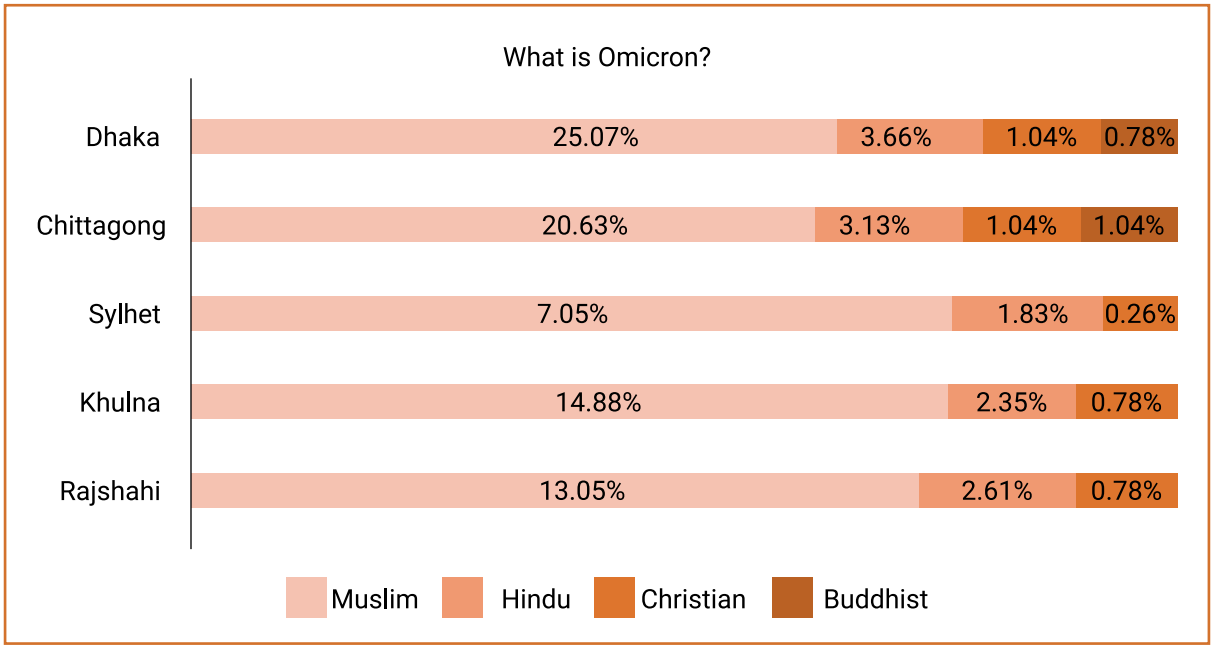
The survey data was analyzed using the STATA statistical software. The results have been interpreted in this report in the form of descriptive narratives, tables, charts, and graphs.

RESPONDENTS' PROFILES

Proportional numbers of faith leaders from the five largest districts in Bangladesh were interviewed, with more than 50% of respondents being from Dhaka and Chittagong, as the first- and second-largest districts in Bangladesh. The age range varied from 21 to 80 years old, with 78% proportionally divided between 31-60 years old.



The majority of faith leaders were male, and 81% were Muslim, followed by 10% Hindu, while Christian and Buddhist religious leaders comprised 9% of the sample. The breakdown of faith leaders' religions by district is shown below.



This sampling of respondents represents the knowledge, attitudes, and practices of faith leaders from the five largest districts in Bangladesh.

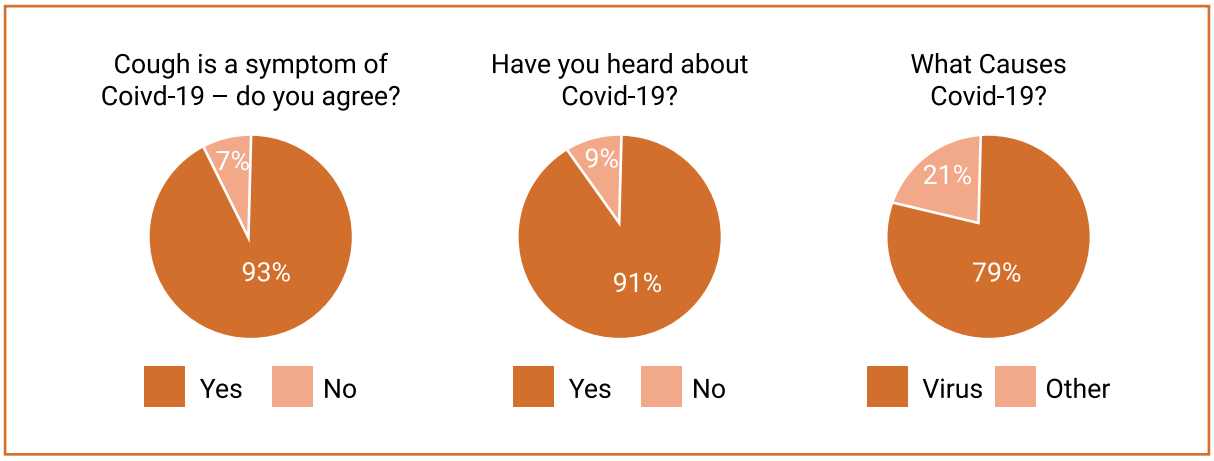
ETHICAL CONSIDERATIONS

Before, during and after data collection, the following ethical norms were followed:

- Participation was completely voluntary and informed consent was obtained from the participants
- The 'Do no harm' principle was followed
- The survey was anonymous and personal information from survey participants were kept at a minimum following an anonymization approach
- The interviews were conducted at a time of their choosing
- People under 18 years old were not included in the survey

COVID-19 KNOWLEDGE

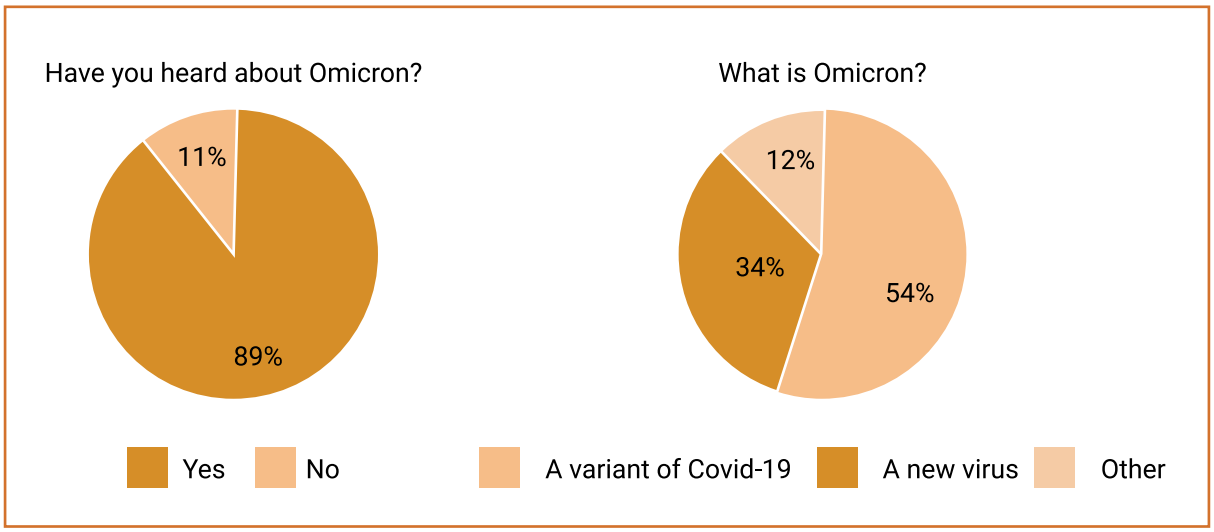
In total, 90% of faith leaders across the five districts in Bangladesh had heard about COVID-19, but only 79% of them knew what caused it. The remaining 21% thought that COVID-19 was caused by bacteria, bad water, or some other cause. While there was a lack of knowledge about its cause, 93% of faith leaders knew that coughing is one of the symptoms of COVID-19.



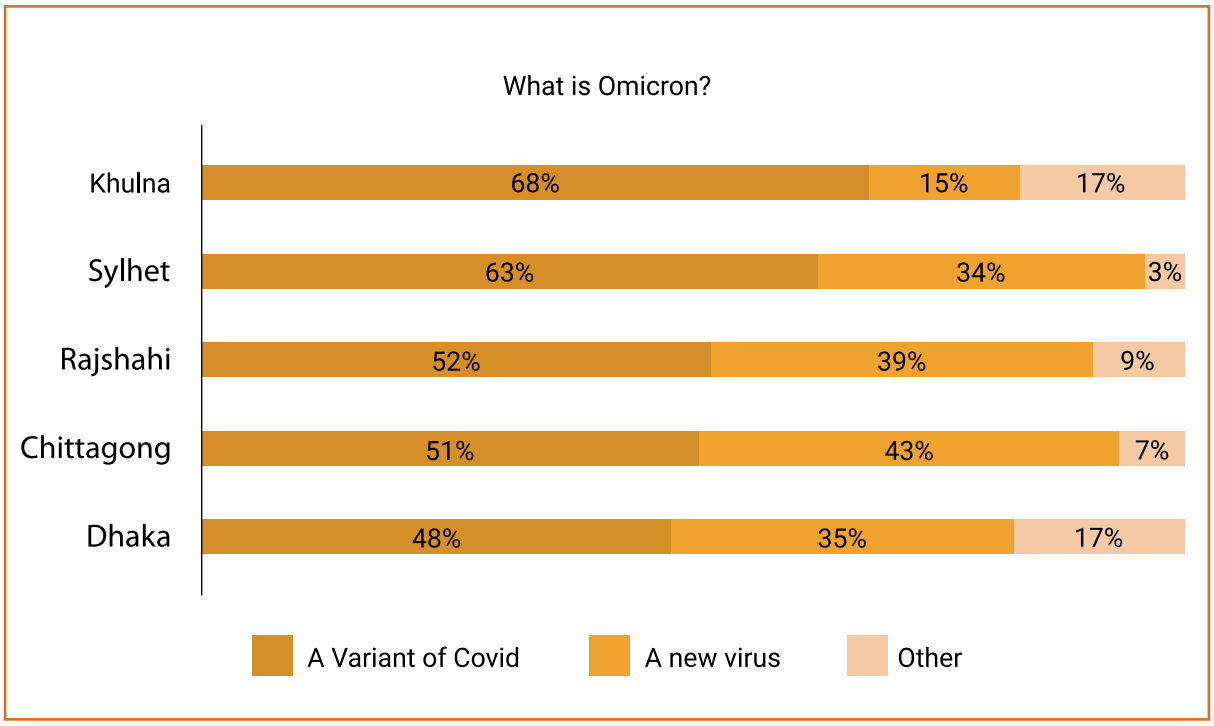
These findings show that even after 2 years of the outbreak of COVID-19 in Bangladesh, between 9% and 29% of faith leaders had limited or erroneous information about the virus and the disease.

> *"It is recorded in Bukhari that the Prophet (PBUH) said, 'Visit the sick, feed the hungry and free the one who is imprisoned (unjustly)"*
> -Imam, 51, IDI

The variant of SARS-CoV-2 (the virus that causes COVID-19) known as Omicron was first reported to WHO on November 24, 2021, and was subsequently designated a variant of concern. After more than a year since the first Omicron case, only 89% of faith leaders had heard about it, with 54% of them knowing that Omicron is a variant of COVID-19.



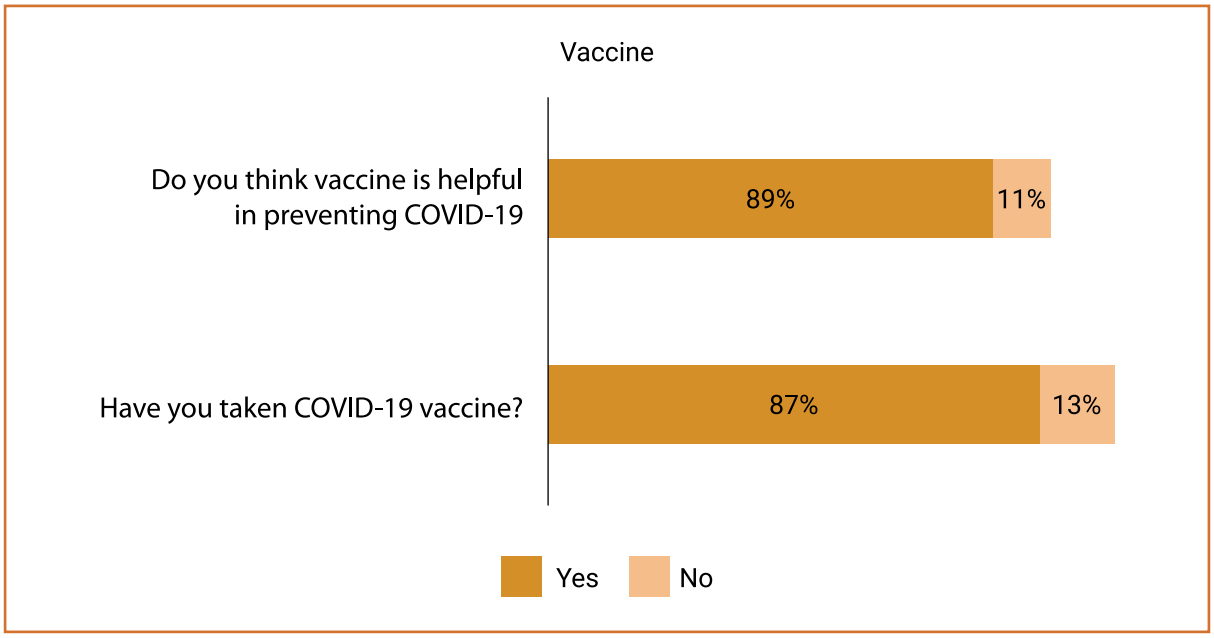
Between 32% and 52% of faith leaders from the five districts in Bangladesh did not know that Omicron is a variant of COVID-19.



These findings indicate that faith leaders received limited information about the virus and the disease it causes.

Getting vaccinated against COVID-19 can lower your risk of contracting and spreading the virus that causes COVID-19 and significantly lower the risk of serious illness and death.

As shown in the graph below, the majority of the faith leaders had been vaccinated and thought that vaccination helped prevent the disease.



It can be concluded that more than 80% of faith leaders have an accurate understanding of the benefits of the COVID-19 vaccine; however, on average 17% of respondents had limited COVID-19 knowledge and 42% had limited knowledge about Omicron. This data suggests there is room for improvement in providing more detailed health information at community level, especially to faith leaders, who can act as important 'information intermediaries'.

SOCIAL AND MOBILITY ISSUES

Social Distancing and Quarantine

Social distancing means limiting close contact among people, both indoors and outdoors. The aim is to prevent the spread of COVID-19, even among those who are already vaccinated. Social distancing is recommended during the widespread outbreak of a respiratory infectious disease.

Quarantine is used for people who do not have symptoms of COVID-19 but who might have been exposed to someone with the infection. The purpose is to prevent the unintentional infection of others, should the contact in fact be infected. Anyone who has been in close contact with a person who has COVID-19 should self-quarantine.

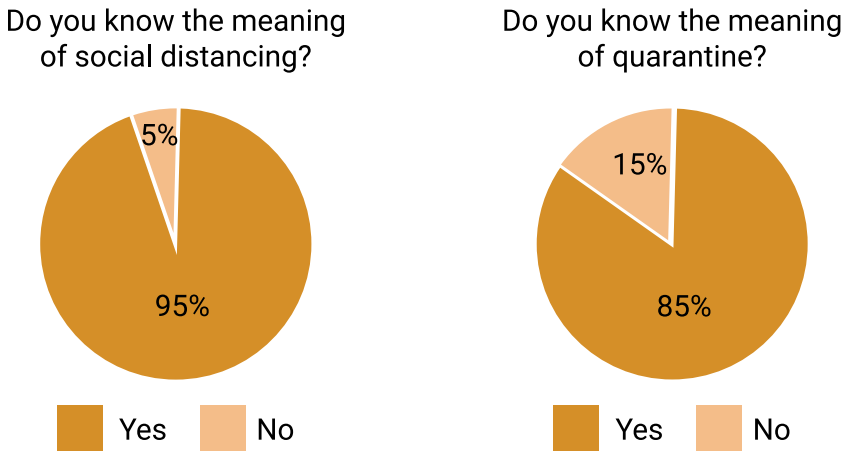
The survey found that the vast majority of faith leaders understood the meaning of social distancing while fewer understood quarantine.

COVID-19 Transmission

COVID-19 is transmitted when an infected person breathes out droplets containing the virus. These particles can be breathed in by other people or land in their eyes, nose, or mouth. In some circumstances, these droplets may contaminate surfaces they touch. People who are closer than about 2 meters (6 feet) to an infected person are most likely to become infected themselves.

COVID-19 is spread in three main ways:

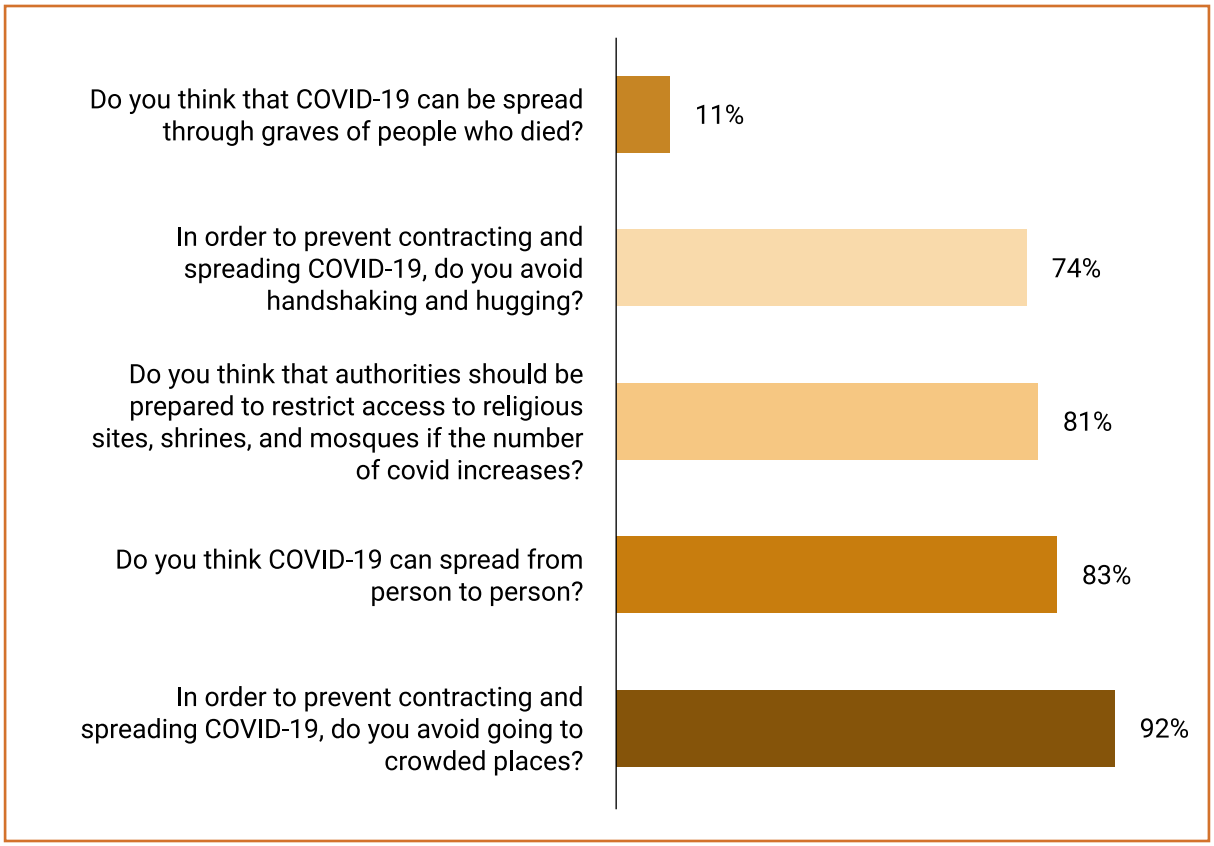
- Breathing in the air when close to an infected person who is exhaling small droplets and particles that contain the virus.
- Having small droplets and particles that contain the virus land in the eyes, nose, or mouth, especially through sprays, such as a cough or sneeze.
- Touching the eyes, nose, or mouth with hands that have the virus on them.



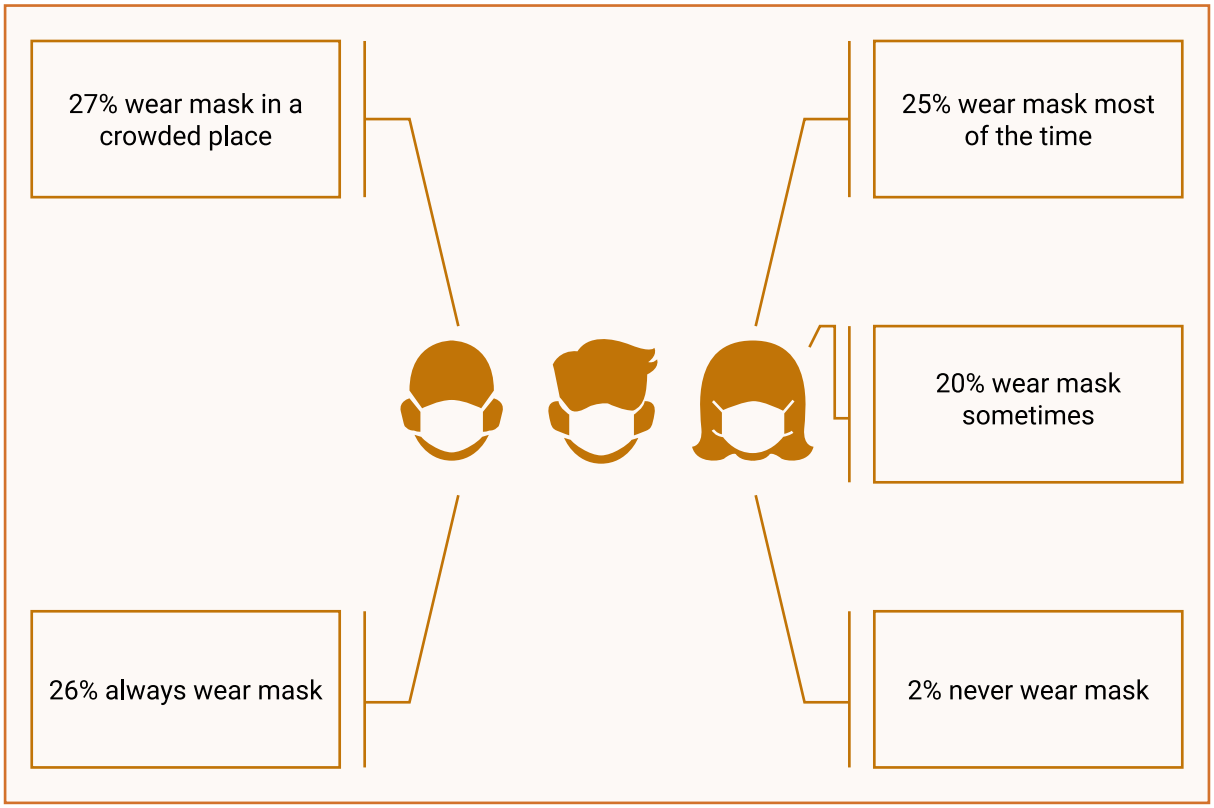
"Jesus said, 'Heal the sick, cleanse the lepers'. It is our duty to assist people in sickness."

-Priest, 46, IDI

Most faith leaders understood that COVID-19 can spread from person to person, and they engaged in preventive action to avoid spreading and contracting COVID-19. The graph below shows the percentage of 'yes' responses to the following questions:



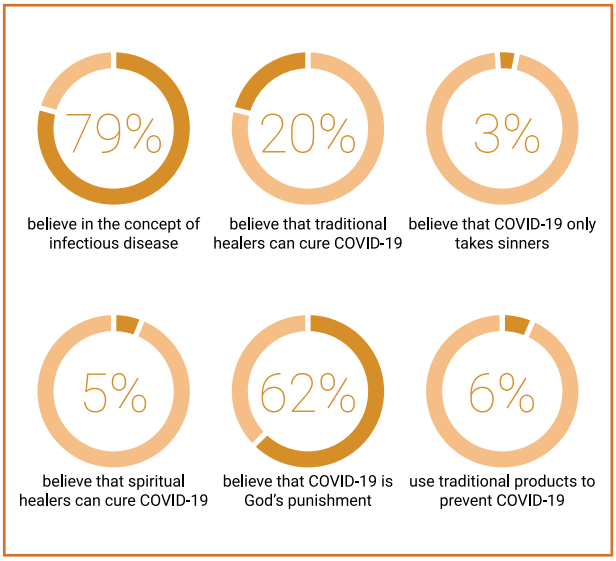
Faith leaders' mask usage appeared to be quite low, with just 26% of faith leaders saying they always wore masks to prevent the transmission of COVID-19



CULTURAL AND RELIGIOUS BELIEFS

Human behavior is driven by norms and cultural values that have been followed from generation to generation during the height of theCOVID-19 pandemic, social restrictions were implemented that sometimes did not align with common practices and cultural beliefs in the community. Awareness, education, and adjustments are therefore needed to comply with health protocols to make infectious diseases manageable.

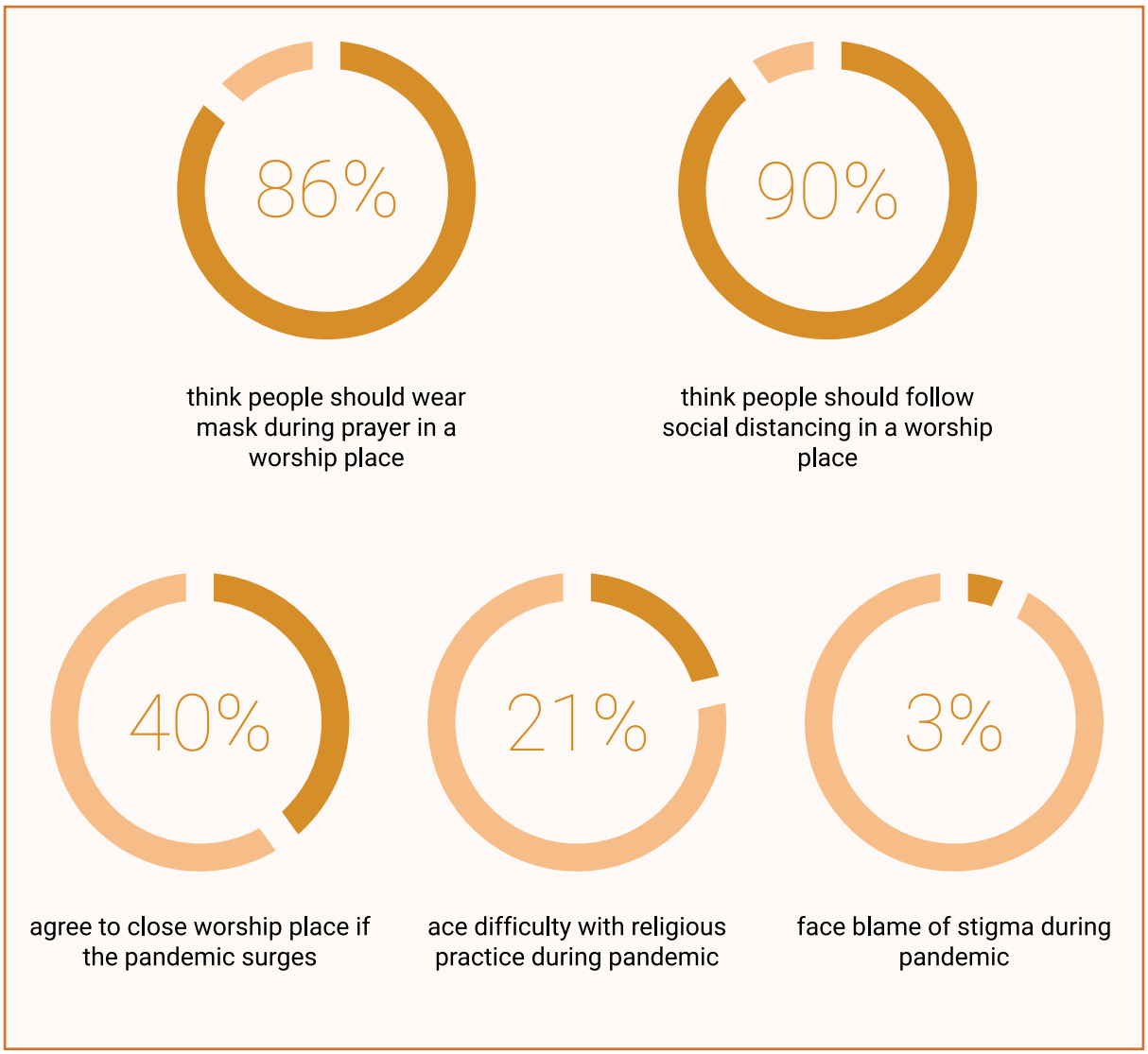
The following data illustrates faith leaders' beliefs about infectious diseases in general and COVID-19 in particular.



> *"According to scripture, serving creation means serving the creator."*
>
> -Priest, 33, IDI

Religious practice in a place of worship becomes a cultural practice in the community; it is how the community expresses its faith and beliefs. Specific practices have always been performed during prayer in a place of worship, and it is challenging to change that habit regardless of whether there is a pandemic or not. However, during a pandemic, health protocols must be followed everywhere, including in places of worship.

The following data illustrates faith leaders' thoughts about health protocol activities in a place of worship.



The majority of faith leaders thought it important that health protocols are followed in a place of worship, with most of them agreeing that people should wear masks and that social distancing should be implemented in a place of worship. However, almost half opposed temporarily closing a place of worship if health requirements demanded so and some complained of difficulties engaging in religious practices or of experiencing stigma as faith leaders.

It can be concluded that, from the faith leaders' perspective, it is more important to be able to go to a place of worship and pray for salvation than to ensure people can comply with health protocols during a pandemic.

A place of worship is one of the places where individuals in the community interact with one another, so some protocols, such as wearing a mask, are important to follow to help prevent the spread of the disease.

The following data illustrate how primary protocols in a place of worship were implemented in five districts across Bangladesh:

Very few worshippers consistently wore a mask in their place of worship. This fact suggests that places of worship can represent a potential hotspot for the spread of airborne and droplet-based disease.

A more detailed look at the findings from each district is shown in the table below:

DHAKA	CHITTAGONG	RAJSHAHI	KHULNA	SYLHET
• **9% always** wear mask • **28%** wear mask **most of the time** • **22% rarely** wear mask • **41%** wear mask **sometimes**	• **21% always** wear mask • **18%** wear mask **most of the time** • **23% rarely** wear mask • **38%** wear mask **sometimes**	• **3% always** wear mask • **21%** wear mask **most of the time** • **27% rarely** wear mask • **49%** wear mask **sometimes**	• **12% always** wear mask • **2%** think **it's not possible** to wear mask • **27%** wear mask **most of the time** • **26% rarely** wear mask • **33%** wear mask **sometimes**	• **20% always** wear mask • **25%** wear mask **most of the time** • **30% rarely** wear mask • **25%** wear mask **sometimes**

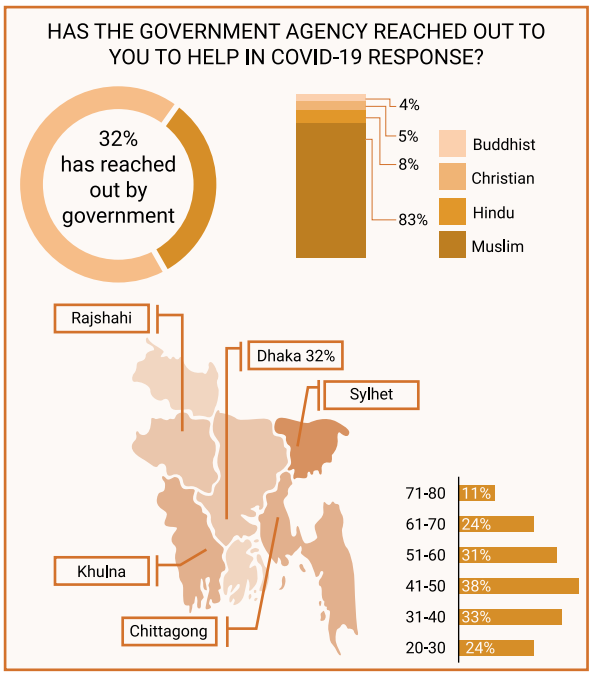
INFORMATION CONSUMPTION

More than half of the respondents said they usually got information from newspapers and TV. Approximately 26% said they got their news from Facebook, while friends and family networks was close behind. More than 60% said announcements in mosques, temples and churches were the best way to reach worshippers. Loudspeaker announcements in the locality was preferred by 35% of faith leaders.

ROLE OF FAITH LEADERS IN A HEALTH RESPONSE

The vast majority of respondents (94%) said faith leaders can play a major role in a public health response.

Information and communication are key approaches to preventing and controlling an epidemic. Updated and reliable information is needed to deliver and communicate public health messages to the community, to ensure everyone has the same understanding about how to manage any surges in the disease..



Among 381 faith leaders, just 32% said they had been reached by a government agency to contribute to the COVID-19 response; most of these (83%) were Muslim faith leaders, followed by Hindu, Christian, and Buddhist leaders. More than half were faith leaders in Sylhet, and the age range was proportionally distributed between those aged 20-70 years old. The majority of faith leaders said there was no meaningful outreach from official agencies to get them to play a role in the response to COVID-19.

CASE STUDY – Engaging Faith Leaders

UNICEF, Rohingya camps

Exploratory consultations with imams in Rohingya camps and with officials from the Islamic Foundation Bangladesh (IFB) in Cox's Bazar have reinforced the keen interest of religious leaders in supporting community engagement and social mobilization interventions in both host and refugee communities. To facilitate this process, UNICEF and IFB expanded their collaboration with imams and religious leaders across Rohingya and host communities. The aim was to reach 150,000 people in the Rohingya camps and 50,000 people from host communities, including in the Sadar, Ramu, Ukhiya, and Teknaf Upazilas sub-districts of Cox's Bazar.

A large proportion of development and humanitarian assistance is operational in countries and regions where faith and belief play a large part in shaping customs, practices, and frameworks of well-being. Understanding the religious dynamics in these contexts is essential for identifying drivers of social cohesion or, conversely, of inequalities and divisions. These dynamics shape the appropriate intervention and support. In times of emergency, faith-based actors can make an indispensable contribution, because, in the contexts of faith communities, they are the first responders on-site before, during, and after the time of an emergency.

Imams can be powerful catalysts for change in crisis situations, but their effectiveness depends on support and information access. However, religious leaders are a diverse group, and some may resist secular organizations' efforts, fearing it challenges their authority. Fundamentalist groups may uphold norms that challenge health interventions. Therefore, it's crucial to assess religious partners' commitment to shared humanitarian values. Religious teachings and resources offer a chance for sustainable change, given their significance in community identity. However interpretation varies among faiths, so it's vital to monitor how these resources are used to convey sensitive messages during religious practices and sermons.

Faith leaders play a meaningful role in building resilience and sharing effective communication, providing psychosocial and spiritual support, promoting inclusion, and countering stigma; they also enable the adaptation of traditional practices in cases where this is needed to avert risks.

> *"The community looks to us for spiritual guidance in times of peril. We have to answer the call."*
> -Bhikkhu, 57, IDI

RECOMMENDATIONS

This research highlighted that although faith leaders are well-placed to fulfil a crucial role in the community response to disease outbreaks, knowledge gaps, superstitious attitudes and a lack of mobilization hinder them from fulfilling this role.

Recommendations that can be considered for future public health emergencies:

1. Engage, mobilize and train faith leaders as community influencers and conduits of information.

2. Religious leaders can support and coordinate awareness campaigns and mobilise communities for preventive behaviours and vaccination.

3. Empower faith leaders to maintain healthy and preventive behaviours in their places of worship.

4. Train faith leaders to combat stigma and counter misinformation.

5. Engage faith leaders as counsellors to provide psychosocial support.

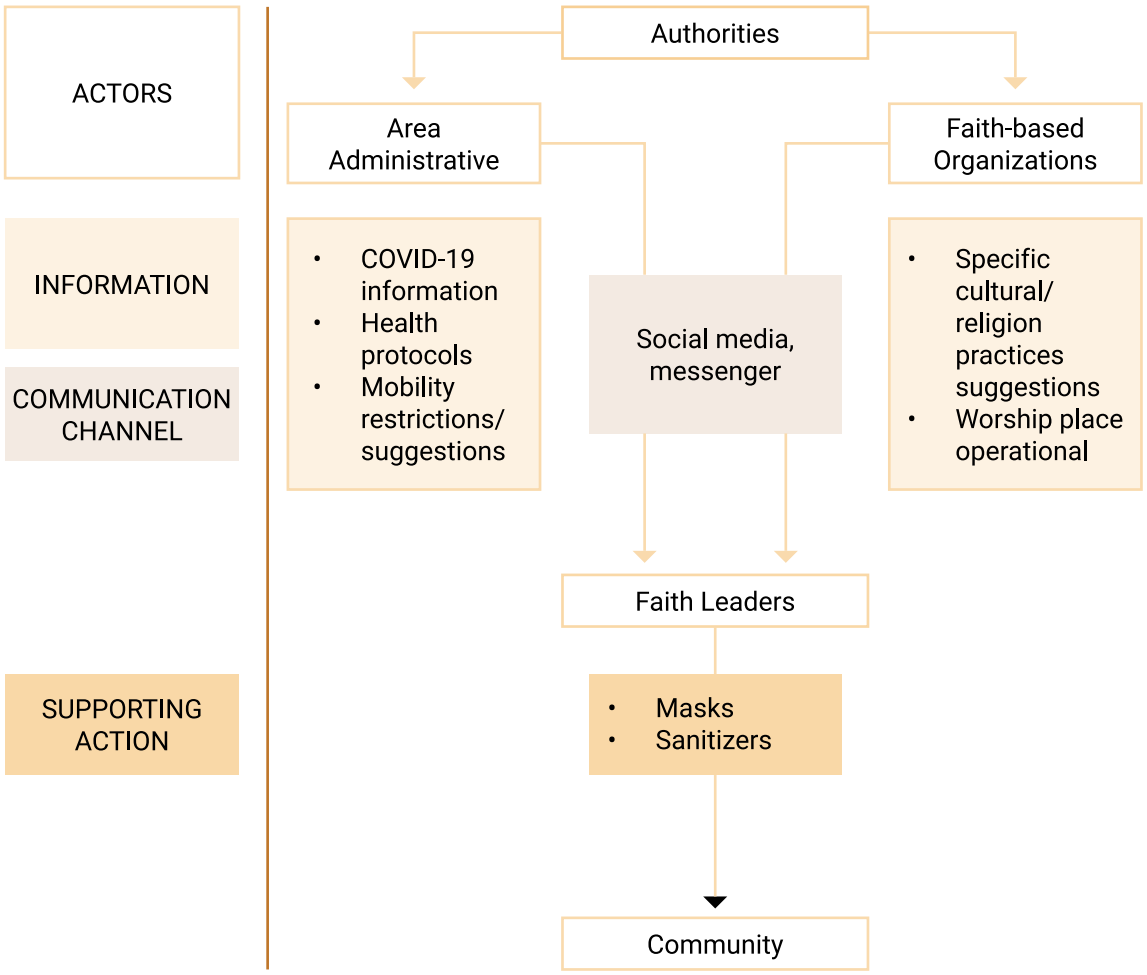
6. Specific cultural or religious beliefs that are not aligned with health protocols need to be appropriately clarified. In this type of sensitive work, utilizing existing networks of faith-based organizations to engage faith leaders could help address the issue.

7. Faith leaders should be engaged as representatives in their community capable of sharing health information. This will allow health authorities to reach remote and marginalized areas.

8. Provide support for compliance with health protocols during religious ceremonies and/or at places of worship.

This report is an invitation for collaboration and intervention to stakeholders from government agencies, faith-based organizations, and the profit and non-profit sectors. Such collaboration can help to improve public health by supporting community behavior change during health emergencies.

The possible flow for engagement and related activities could be as follows:



CONCLUSION

COVID-19's global presence and social transmission pathways require social and community responses.

Community behavior becomes the key to prevention and control; thus, it is crucial to engage communities and support the dissemination of accurate information. Looking at previous pandemic situations, it has been shown that communities have crucial roles to play in prevention and control. Countries worldwide are encouraged to reach out to their communities to support appropriate prevention and control in situations such as the COVID-19 pandemic (Gilmore et al., 2020).

Communities tend to rely on their religion during difficult times and religious leaders are among the people that they listen to. This social interaction can be utilized by engaging faith leaders to assist authorities in providing appropriate health advice and guidance to their community. Faith leaders and faith-based organizations have natural authority and extensive outreach within their communities, they are trusted by their community and are figures that the community looks up to.

While the role and influence of faith leaders in the community during COVID-19 have proven to be important, particularly in enhancing public awareness of COVID-19 protocols and disease prevention, the knowledge, attitudes, and practices of Bangladeshi faith leaders about COVID-19 are not considered to be fully aligned with global health protocols. The gaps have prevented them from playing that role effectively during the pandemic; thus, more efforts to engage faith leaders must be made in the future to address this gap.

Our findings indicate that limited COVID-19 information was received by between 9% and 29% of faith leaders for the past 2 years, since the start of the COVID-19 pandemic, although on average more than 50% of faith leaders knew about the Omicron variant. It should be highlighted therefore that detailed information about COVID-19 that faith leaders received was insufficient, in turn leading to insufficient information being received by communities.

Older religious leaders appeared to have less accurate knowledge in what concerns the latest developments surrounding COVID-19 and held different opinions and carried out different practices compared with younger leaders.

The findings make clear that much more can be done in educating and mobilizing faith leaders in public health responses.

Faith leaders aged **50 years old and above** are significantly less likely to **hear of Omicron**.

Faith leaders aged **40 years old and above** are significantly more likely **taken vaccine**. Interestingly, faith leaders of any age are not significantly more likely to believe that vaccines help or to advise vaccination during their sermons.

Pandemics force us to confront profound ethical questions about the value of human life, and about balancing health against personal and religious freedom. COVID-19 showed how unprepared we are for unanticipated health risks. We learned that a public health response is not just about science or policy. It has deep social, economic, cultural and ethical implications.

Just as faith communities play an important role in the quest to achieve Sustainable Development Goals by contributing to education, poverty alleviation, and social cohesion, they can be powerful stakeholders in the fight against a future pandemic by disseminating health information, providing assistance to those in need, and volunteering their time and energy in their communities' public health efforts. Controversial figures may easily capture the media spotlight, but faith communities, if properly mobilized, can use their 'spiritual capital' for the greater good.

Engaging faith leaders and faith communities effectively will increase our preparedness to control, manage and stop the next global pandemic.

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