Article

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The Influence of Religious Leaders and Faith-Based Organizations on Health Observance, Behaviors and Public Health Policies

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ABSTRACT

International, national, and local religious leaders and organizations' contributions to promote public health are increasingly being explored and explicated. Religious leaders and faith-based organizations can potentially play strong roles in influencing health behaviours, and compelling obedience to health policies, and health intervention measures. Importantly, they can help frame approaches that will ensure the successful implementation of health policies and measures. The central aim of this qualitative study is to explore and examine the role of religious bodies, as community gatekeepers and trusted authorities, in supporting health interventions and promoting their compliance. This study particularly focuses on the extent of their influence and the nature of the support they offer. The population for this study comprises 15 Christian and Muslim religious leaders in Yola North and South Local Government Area of Adamawa state in Nigeria who represented the views of their organizations. The questions centred on the spiritual, psychosocial, and humanitarian role they played during the peak outbreak of the COVID-19 Pandemic, the dialogues and partnerships they had with the government and health authorities, and the extent of their contribution to supporting health policies. The study finds that religious leaders can positively lend their reputation, offer guidance, and galvanize community effort to support behavioural changes, drive healthcare and ensure compliance with health measures.

Keyword: Public Health Policies; Health Interventions; Religious/Spiritual Leaders; Faith-Based Organizations; Pandemic

1. Introduction

The advent of the 2019 novel coronavirus (COVID-19) further heightened the need for comprehensive health policies that will control and mitigate the spread of contagious diseases. Measures to mitigate the impact of pandemics and epidemics include positive protective behaviors, movement restrictions, vaccinations, and health consciousness (Ayouni, i., et al, 2021; Wijesinghe, et al., 2021). However, complying with precautionary approaches for disease prevention and control largely depends on the motivation, education, and actions of individuals and the community (Ayouni, et al, 2021; Wijesinghe, et al, 2021). There is no denying that religious leaders and faith-based organizations can significantly contribute to ensuring compliance with health measures (Essa-Hadad, et al, 2022), yet, their specific roles in this regard have not been exploited fully. According to a Pew Research Center's comprehensive demographic study of more than 230 countries, an estimated 84% of the world population is religiously affiliated (Pew Research Center a). As of 2010, more than six-in-ten

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people are Christians (63%) and more than three-in-ten are Muslims (30%) in Sub-Saharan Africa. Furthermore, 3% do not identify as religious and a smaller percentage of less than 1% are followers of folk or traditional religion in the region (Pew Research Center b). In Nigeria, a significant proportion of the population identifies with a religious belief and practices their religion (Pew Research Center c). Many religious followers rely on the teachings, rituals, ethics, and examples set by their leaders. A high degree of faith practice and adherence rest on leadership direction, thus, faith-based leaders are able to command a high degree of voluntary commitment and compliance to instructions. In light of their influence, it is important to analyze how effective they are in controlling health policies and directing health behaviors.

Literature has shown how religious leaders can positively lend their reputation, offer guidance, and galvanize community efforts to support behavioral changes and compliance with health measures (Melillo, Strachan, O'Brien, Wonodi, Bormet M, & Fountain, 2022). Take the case of COVID-19, for example, faith organizations could be helpful in controlling the pandemic by encouraging testing and vaccination, complying with lockdown and social distancing directives, and destigmatization of the disease which could prevent people from seeking help (Essa-Hadad, et al, 2022; Rachmawatia, 2022). On the other hand, religious leaders could jeopardize health measures through conspiracy theories and misinformation (Vitriol & Marsh 2021; Wonodi, et al. 2022 Dwoskin, 2021), thus, there is a need to take into account their voices and underscore their importance in health-related interventions.

While several studies reveal that religious clergies have played essential roles in bridging communities and policy by promoting trust in state-mandated public-health measures around the world (Essa-Hadad, et al, 2022; Wijesinghe et al, 2022) research in Nigeria has seldom addressed how differences within faith traditions, denominations, clergy hierarchies, and scriptural interpretations shape effectiveness in health policy support. This qualitative study examines the role of religious organizations and faith-based leaders with a particular focus on the extent of their influence and support for health policies, treatments, and health-related preventive and mitigating measures within Nigeria. It offers a unique insight into the relationship that religious organizations have with society besides spiritual nourishment. Beyond their direct influence on their believers, this study also examines the ways in which religious leaders can contribute to framing approaches that will ensure the successful implementation of health policies and measures. The study concludes that the role of religious bodies, as community gatekeepers and trusted authorities in supporting health interventions and promoting their compliance, should be taken into account. In the case of COVID-19, for example, dialogue with religious leaders, by the government, can help control the pandemic through vaccination, social distancing and control, transmission and mitigation health measures, and the destigmatization of the disease which could prevent people from seeking help. On the other hand, religious leaders could undermine health measures through conspiracy theories and misinformation, thus, there is a need to take into account their voices and underscore their importance in health-related interventions.

2. Faith-Based Organization and Religious Leaders

Faith-based organization is a religious structure, body of communicants, or organization that exists for purposes of advancing religious objectives, 'mutual support and edification in piety, worship, and religious observance' (The Law Insider Dictionary). Religious institutions and faith communities constitute_one of the most organized civil institutions in the world (The Health Communication Capacity Collaborative). Many religious organizations involve communities of believers whose identity and missions are shaped by a religious or spiritual relationship with a supernatural being. Religious/faith-based organizations have been recognized for their potential capacity to provide health services and interventions to communities (The Health Communication Capacity Collaborative; Schoenberg, 2017; Lipsky, 2011).

Religious or spiritual leader (a cleric or clergyman) is an authoritative figure who typically teaches, preaches, conducts worship, leads meditation and prayers, performs pastoral functions, or is recognized as having authority within a religious group (Homolka & Schöttler 2013). Characteristically, a religious leader stands as an intermediary between a supreme deity and the followers, communicating God's divine will and fulfilling spiritual needs (The Health Communication Capacity Collaborative).

In the heat of the COVID-19 pandemic, religious leaders and religious organizations featured prominently through their sermons, actions, approaches, and responses to the

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government's control procedures and policies (Wijesinghe, et al., 2021). Before considering their response, however, it is pertinent to provide a brief background of the pandemic and health mitigation measures in this regard.

3. COVID-19 Control Measures and Religious Organization's Response

In late 2019, the world woke up to the news of a highly contagious virus slowly ravaging parts of China (Keni, 2020) and soon spread to other parts of the world (Shang, 2021). In early 2020, it was announced by the government that Nigeria had inevitably recorded its first infection (Okeke 2020). Subsequently, the Nigerian government, at the federal and state levels, and the relevant authority the National Center for Disease Control (NCDC), adopted certain policy and legal measures and undertook regulatory precautionary steps to control and manage the devastating effect of the virus (Rauf, 2020; Shodunke, 2022). These regulations include curfews, restriction of movements and stay-at-home orders (lockdown) (Rauf, 2020; Shodunke, 2022). Others sought to compel the isolation, quarantine, care, and treatment of victims of an infectious disease (Rauf, 2020; Shodunke, 2022). Many state laws and regulations also empowered the appropriate agencies to arrest and punished defaulters and monitor compliance with health directives like compulsory mask-wearing, and detention of suspect or confirmed cases (Rauf, 2020; Shodunke, 2022). The government also promoted personal hygiene such as regular handwashing with soap and water and the use of alcohol-based hand sanitizer (Certain businesses were exempted from the lockdown restrictions particularly those providing health-related and essential services, including hospitals and related medical establishments, organizations in healthcare-related manufacturing and distribution, as well as commercial establishments involved in food processing, distribution, and retail companies, petroleum distribution and retail entities, power generation, transmission and distribution companies and private security companies). The lockdown measures were imperative, even in the face of their implication on macroeconomics, social and religious liberties, and other freedoms.

The federal and state governments also restricted public and social/religious gatherings and shut down schools, vocational institutions, and airports to flatten the spread of COVID-19 (Mike & Godfree 2021; Campbell 2020). In Kaduna and Adamawa states, for example, religious congregational worship was completely suspended (Agency Report 2021; Nwaka 2020). Thus, many religious organizations had to alter their long-standing religious practices and traditions to comply with these measures and avoid the spread of the virus. The policy measures were greeted with mixed reactions. While some organizations complied with the policy directives and measures, others vehemently opposed the measures, with some religious leaders boldly denouncing the control effort of the state (Agency Report 2021; Nwaka 2020; Okoye & Obulor 2021).

A few Pentecostal preachers and radical Islamic clerics, and their followers denounced the government's restrictive measures on grounds of religious freedom, political propaganda, and an attack on their religious beliefs and the faith community (Okoye & Obulor 2021). The freedom of thought, conscience, and religion is provided in Section 38 of the 1999 Constitution of the Federal Republic of Nigeria (CFRN). Section 38(1) states that everyone is entitled to the freedom of thought and religion, the freedom to change his or her religion, and the freedom to manifest and propagate his belief in worship, teaching, or practice, whether privately or publicly. This right is complimented by Section 39 of the constitution on the freedom of expression, Section 35 on the right to personal liberty, and Section 40 on the right to assemble and associate. Many religious adherents typically manifest and propagate their belief in a gathering. Consequently, the restrictive orders were seen to violate fundamental human rights as people could not propagate and practice their belief in congregational worship, prayers, teaching, or in a manner they deem fit. This human rights objection is, however, countered by the fact that the constitution in Section 45 allows the government to limit human rights in the interest of public health, safety, and interest. Accordingly, the pandemic posed public health and safety challenges that warranted the approach adopted by the state.

The lockdown and stay-at-home orders, especially, were perceived as a satanic and evil move to prevent worshipers from practicing their faith and honoring their God in an assembly (Okoye & Obulor 2021). Consequently, many religious ministers and worshippers flouted the lockdown measures with reckless abandon (Okoye & Obulor 2021). There are reports of pastors flagrantly contravening the lockdown directives and leading congregational service or prayer sessions in spite of the official regulation (Nwaka 2020; Okoye & Obulor 2021). This

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violation prompted the harassment and arrest of religious ministers and their worshippers who defied the government's restrictions by security agents during worship services (Nwaka 2020). An example is the arrest of the presiding pastor of Jesus Reigns Family Church in Abuja on March 29 during church service (The Punch, 2020). Several imams were sanctioned and suspended for violating the state-imposed containment measures (Olukoya & Mohammed). The invasion of worship centers and the arrest of religious leaders fueled the speculation that the restriction was a disguised attack on the church and repression of religious belief. A prominent religious leader was quoted to have said

The church is God's banquet hall where we are fed with spiritual food to keep us alive and strong. So whatever stops the church from fellowshipping [sic] is out to destroy what God is building. There must be a devil behind it. It is not virus, it is demon (sic), there is a demon at work behind the scene, I told you in the morning I can smell a rat (Olukoya S, & Mohammed).

Buttressing the perspective of the critics, Abati writes that:

> *"There are also some religious leaders going about telling the people that Corona Virus cannot touch Christians or Muslims. One popular Pastor even preached on Sunday that whoever goes for testing is likely to be infected and so, no Christian should go for testing because Corona Virus is a manifestation of the anti-Christ (Abati 2020)".*

Some clerics were vocal in rejecting and criticizing the government containment approach. For instance, an Anglican Bishop of Amichi, condemned the government and his fellow religious ministers for closing their worship centers, while also making the point that the people require the centers for spiritual nourishment to wade through the pandemic (Nwaka 2020). According to Obi-Ani, Anikwenze and Isiani, social media were proactively utilized as platforms to religious-related spread information about the virus (Obi-Ani, Anikwenze & Isiani 2020).

To further undermine the severity of the pandemic, it was widely alleged to be a common cold or malaria that does not require the closure of churches to contain (Ibrahim, 2020). Some religious leaders out rightly debunked the existence of the virus while others publicly announced that the virus cannot harm faithful Christians and Muslims (Abati 2020). Accordingly, 'they are carrying corrosive anointing in addition to being covered by the special blood of Jesus'(Okoye & Obulor 2021) and so faithful followers are immune to infections. Pastor Oyakhilome in his televised program repeatedly asserted that the virus is a conspiracy by the world government to establish 'a new world order' through the instrumentality of the 5G networks (Adelakun, 2020). For this conspiracy theory, he was fined by the Office of Communication (OFCOM), the British broadcast regulator, and prevented from airing in the British air space in May 2020 for an 'inaccurate and potentially harmful' coronavirus claim (The Cable). In lending their voices to the issue, a popular and well-respected Muslim cleric, Sani Yahaya asserted in his sermons that the COVID-19 virus is a mere ruse by the West to impede the efforts of the Muslim faithful in their religious obligations (The Cable). A few other religious leaders resorted to the claim that they had quick healing solutions to the pandemic (Obi-Ani, Anikwenze & Isiani 2020). T. B. Joshua, for example, claimed that COVID-19 would disappear after heavy rainfall on March 27 (Nwaka 2020). Another popular preacher asked the government to gather all those who had tested positive for COVID-19 for healing and deliverance (Nwaka 2020).

Government efforts were weakened by the defiance of the people as fueled by the support of their religious leaders. In Katsina State, ardent followers resorted to violence when the State Task Force dispersed a crowd that gathered to pray after a Muslim cleric insisted on holding Friday prayers in defiance of government directives (Abati 2020). Aggravated by the disruption and perceived harassment, some of the members of the group stormed a police station and burnt down the vehicles in the compound (Abati 2020). Criticism and public outcry led the government to relax its enforcement approach against religious organizations and some of the religious restrictions, especially during the festive period, even in the face of a high transmission rate (Olajumoke, Okafor & Oyedele 2021).

Conversely, many faith organizations and spiritual leaders facilitated compliance with the government's preventive and control measures. According to Okoye and Obulor, mainstream Muslim authorities such as the Nigerian Supreme Council of Islamic Affairs (NSCIA), Christian churches such as the Catholic, Presbyterian, Anglican, Methodist, and some Pentecostal churches complied with the restrictions and even provided other forms of welfare support to ameliorate the economic effect of the restrictions (Okoye & Obulor 2021). Some religious ministers and religious organizations went as far as opening their facilities for COVID-19 containment measures including quarantine and isolation (Nwaka 2020). Many of these

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organizations instructed their members to abide by the public health authorities' directives, observe healthy behaviors and adopt precautionary practices (Campbell, 2020).

From the foregoing, religion in the pandemic's present context, is arguably, a social influence and determinant of health with corresponding beneficial or harmful effects. It is, therefore, safe to say that religion and faith-based organizations can potentially promote or undermine the government's effort to implement a public health policy and program.

4. How Religious Institutions Contribute to the Implementation of Health Policies, Interventions, and Measures

Many religious texts and doctrines enjoin their believers to help improve the conditions of the sick or offer some form of assistance (Pennisi, 2011; Wijesinghe, et al., 2021). Scholars have pointed to the roles that religious actors and organizations play in shaping ideologies, precipitating development, and enhancing social welfare (Rakodi, 2014; Cheng & Brown, 2015; Idler, 2014; Wineburg & Poole 2019). Practitioners, organizations, and governments have also recommended and sought religious leaders and bodies for their norm-shaping ability and socialization influence, and the shaping of government policies (Family Planning 2020 (FP20) 2019). Other scholars have reiterated the need for science, religions, and governments to work in a concerted manner for the common good and well-being of all (Wijesinghe, et al, 2021). In this respect, this qualitative study examined the ways religious organizations can influence, impact, promote and enhance healthcare and heath-driven policies, particularly in times of health crises such as the COVID-19 pandemic

5. Method

5.1. Research Design

For the purpose of this study, a qualitative approach was adopted. This study employed the survey method with the use of questionnaires to elicit responses that will examine, investigate, and reveal the answers to the research questions in the study. The research work also followed up with semi-structured interviews of the Muslim and Christian religious leaders in Yola North and South Communities of Adamawa State. The questions centred on the spiritual, psychosocial, and humanitarian role they played during the peak outbreak of the COVID-19 Pandemic, the dialogues and partnerships they had with the government and health authorities, and the extent of their contribution to supporting health policies. The questionnaire was important in drawing meaningful research conclusions and gathering information from the respondents. Afterward, the questionnaires were analyzed, summarized, presented, and interpreted to draw valid conclusions and make recommendations. Thematic content analysis was employed to analyse the data

The study also relied on secondary data; textbooks, journal articles, conference papers, reports, internet sources etc, to allow the researcher to gather preliminary information and summarize the current situation and other relevant phenomena.

Table 1. General Characteristics of Research Participants/Respondents

Participants/Respondents	Religion/Affiliation	Location
Religious Leader 1	Christian (Catholic)	Yola North
Religious Leader 2	Christian (Catholic)	Yola South
Religious Leader 3	Muslim	Yola North
Religious Leader 4	Muslim	Yola North
Religious Leader 5	Christian (Catholic)	Yola South
Religious Leader 6	Muslim	Yola South
Religious Leader 7	Muslim	Yola South
Religious Leader 8	Muslim	Yola North
Religious Leader 9	Christian (Pentecostal)	Yola North
Religious Leader 10	Christian (Anglican)	Yola North
Religious Leader 11	Christian (Catholic)	Yola South
Religious Leader 12	Christian (Pentecostal)	Yola North
Religious Leader 13	Christian (Pentecostal)	Yola North
Religious Leader 14	Muslim	Yola South
Religious Leader 15	Christian (Pentecostal)	Yola North

The population for this study comprises 15 Christian and Muslim religious leaders in Yola North and South Local Government Area who represented the views of their organizations. The 15 religious leaders comprise Catholic Priests (4), Pentecostal Pastors (4), Anglican Priest (1) and Muslim Clerics (6) who were selected from the general population. The various

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religious sects were chosen in order to include a diverse and representative sample of the community. The empirical research work is carried out in the Yola North and South Local Government area of Adamawa State. Adamawa is a deeply religious state in the Northeastern part of Nigeria, with its capital at Yola North. The state is one of the largest states in Nigeria, with an area of about 36, 917 square kilometres.

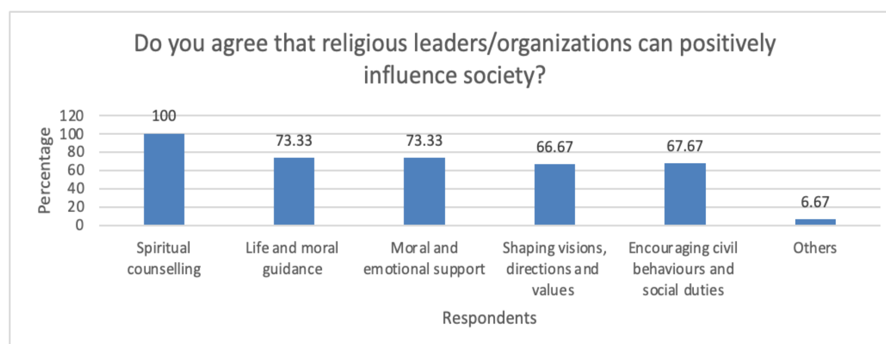
5.2. Sample and Sampling Technique

Intensive purposeful sampling was used to locate and recruit 15 religious leaders/participants. These religious leaders also represented the views of their organizations. This sampling technique was adopted to provide in-depth specific knowledge about the subject and to reveal insightful knowledge about the role they played during the outbreak of the COVID-19 Pandemic. The choice of this sampling technique is to collect information from which the study can learn a great deal about issues of central importance to the aim of the inquiry. The inclusion criteria include religious leaders from the Christian and Muslim faith in Yola south and North, Adamawa state.

6. Result And Data Analysis

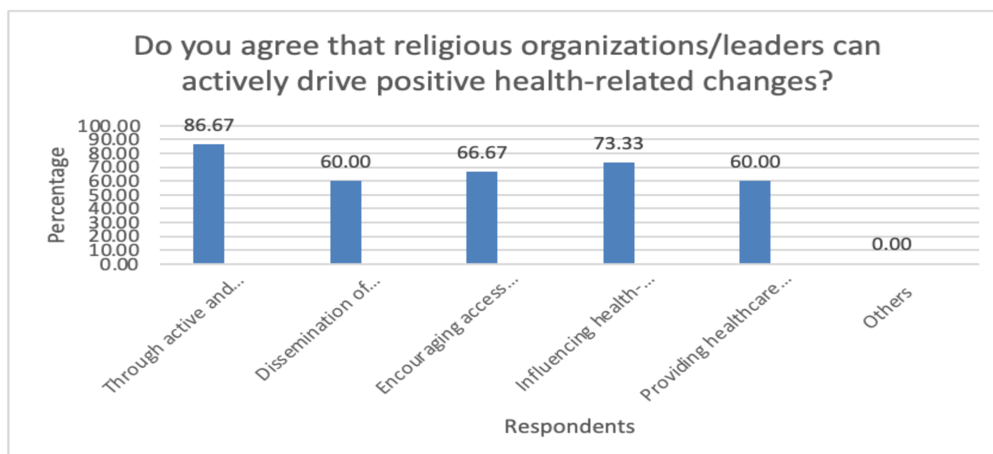
All respondents agreed that religious leaders/organizations can positively influence society. 73.33% of the respondents specifically indicated that religious leaders can positively influence through spiritual counselling, 73% indicated through life and moral guidance and 66.67% indicated that they can influence by shaping visions, directions and values. Furthermore, 67.67% revealed that they positively impact by encouraging civil behaviours and social duties.

Figure 1. Positive role of religious leaders in society



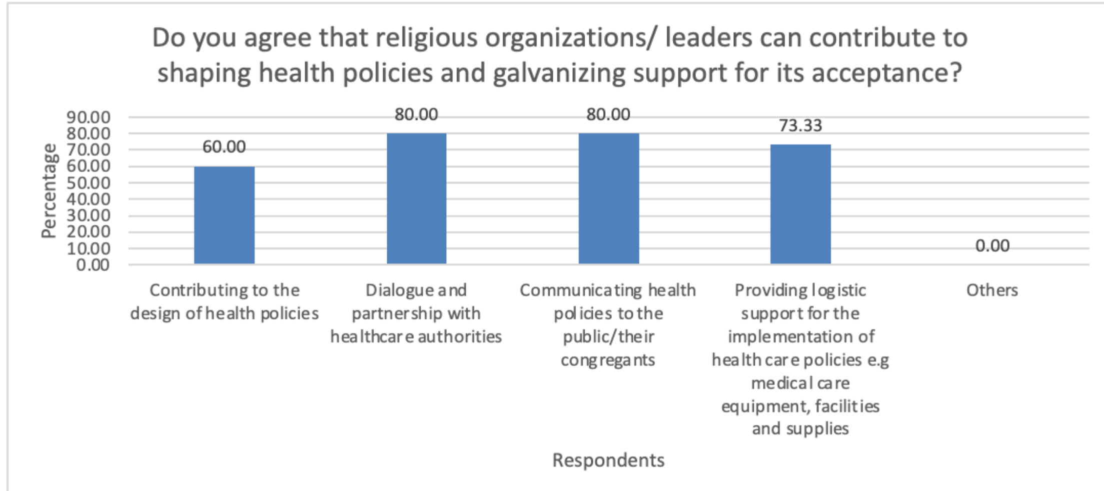
All the respondents agreed that religious organizations/leaders can actively drive positive health-related changes (100%). Furthermore, 86.67% agreed that religious organizations and their leaders can do this through active and direct campaigns on safety health measures and practices, 60.00% indicated the dissemination of verifiable health information/ public announcements, and 66.67% stated that they can contribute by encouraging access to healthcare treatments. 73.33% also indicated that they can do this by influencing health-seeking behaviours/ maintaining healthy lifestyles and 60.00% elected the option of providing healthcare facilities, services, medical equipment and other infrastructure support.

Figure 2. Role of religious leaders in driving positive health changes



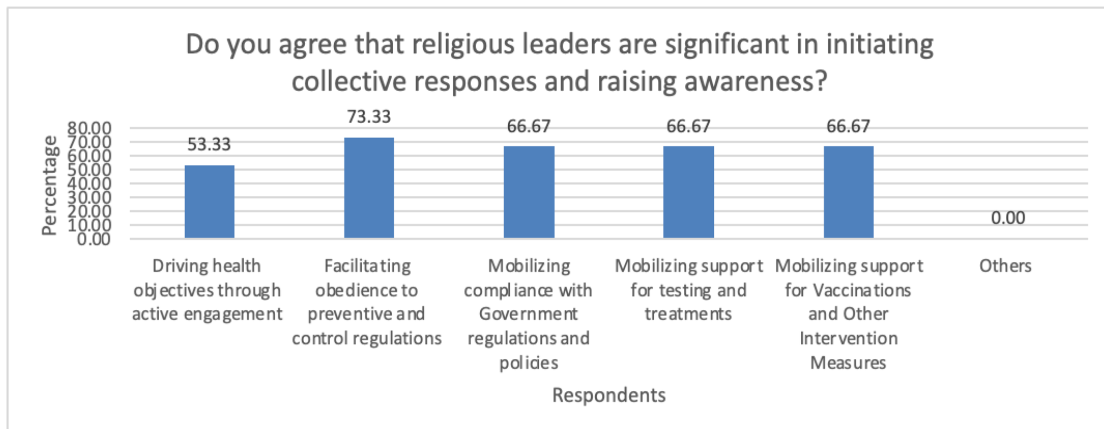
All respondents agreed that religious organizations/ leaders can contribute to shaping health policies and galvanizing support for their acceptance (100%). Specifically, 60.00% of respondents further noted that religious leaders and organizations can do this by contributing to the design of health policies and 80.00% indicated this contribution through dialogue and partnership with healthcare authorities. 80.00% also indicated that they can shape health policies by communicating health policies to the public/their congregants and 73.33% indicated that this can be done by providing logistic support for the implementation of health care policies e.g medical care equipment, facilities, and supplies.

Figure 3. Role of religious leaders in shaping health policies



On whether or not religious leaders are significant in initiating collective responses and raising awareness, all participants agreed in the affirmative (100%). On this note, 53.33% further revealed that religious leaders can drive health objectives through active engagement. 73.33% also agreed religious leaders can facilitate obedience to preventive and control regulations and 66.67% indicated that they can mobilize compliance with government regulations and policies. Furthermore, 66.67% indicated that they can mobilize support for testing and treatments and 66.67% agreed that faith-based leaders can mobilize the necessary support for vaccinations and other intervention measures.

Figure 4. Role of religious leaders in initiating a collective response and raising awareness



The respondents were divided on whether religious organizations can take the lead by encouraging treatments and dispelling myths associated with testing, vaccinations/immunization, treatments and other health interventions. While 93.33% of participants affirmed that religious organizations can take the lead in this respect, 6.67% disagreed. Those who agreed indicated that religious leaders can dispel myths, rumours and misinformation information, encourage recourse to verifiable scientific information, encourage access to health information by public authorities, e.g NCDC and discourage stigmatization. The stated reasons for disagreement range from questionable information to lack of adequate information.

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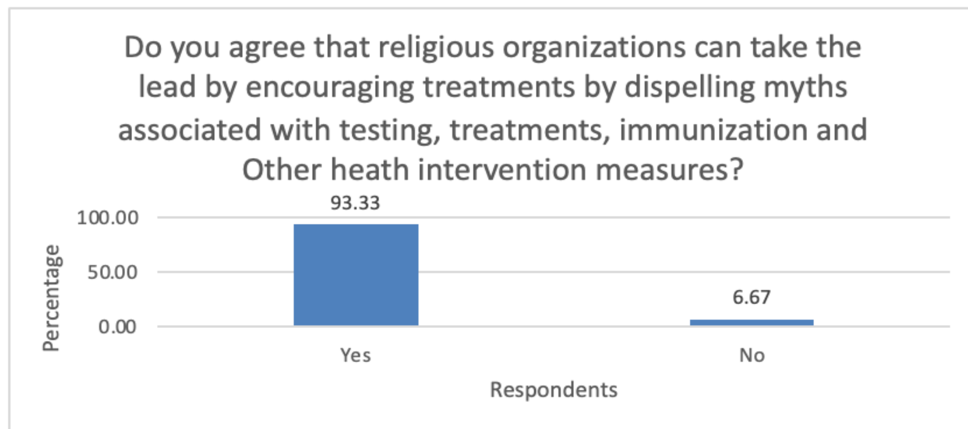
Figure 5. Role of religious organizations in encouraging treatments and dispelling myths



When the Nigerian government issued a lockdown directive during the peak period of the COVID-19 pandemic, 93.33% of religious leaders indicated that they partially or fully altered their religious practices and traditions including group worship to comply with the government's control measures, and to avoid the spread of the virus. However, 6.67% of respondents did not alter, limit, or modify their religious practices

Figure 6. Role of religious organizations in complying with health control measures

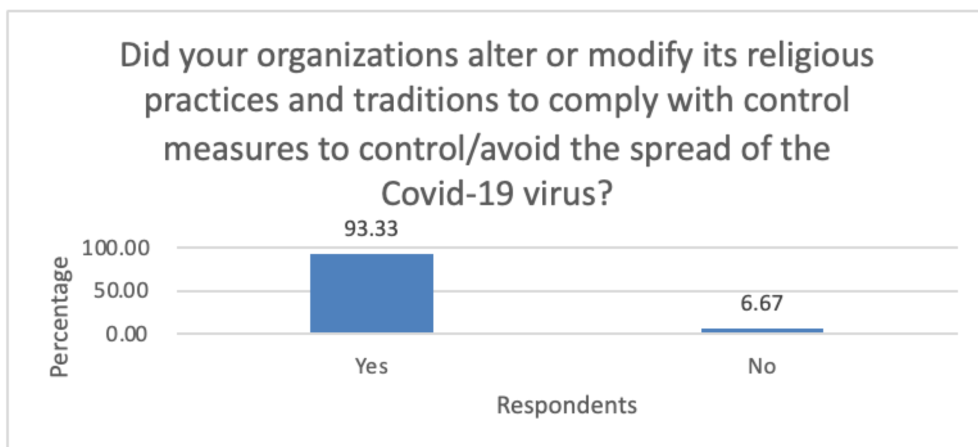
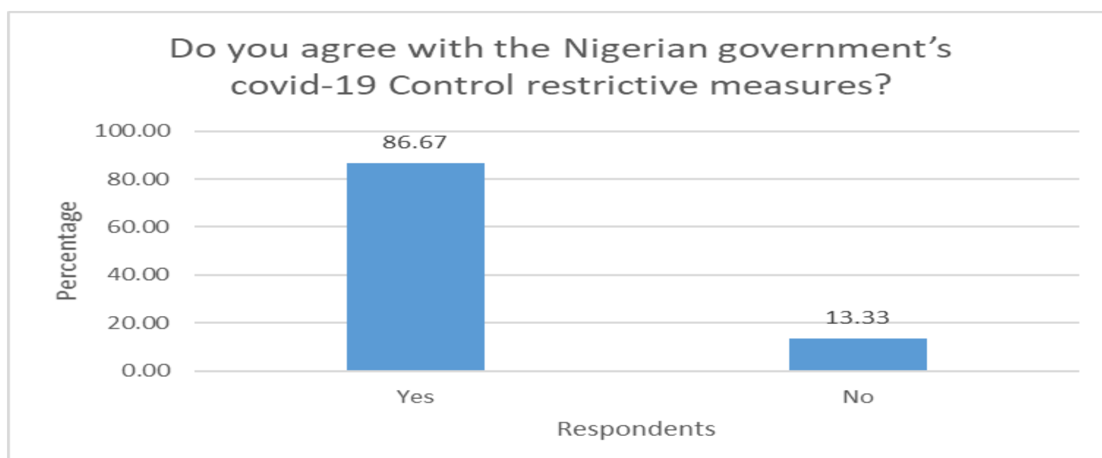


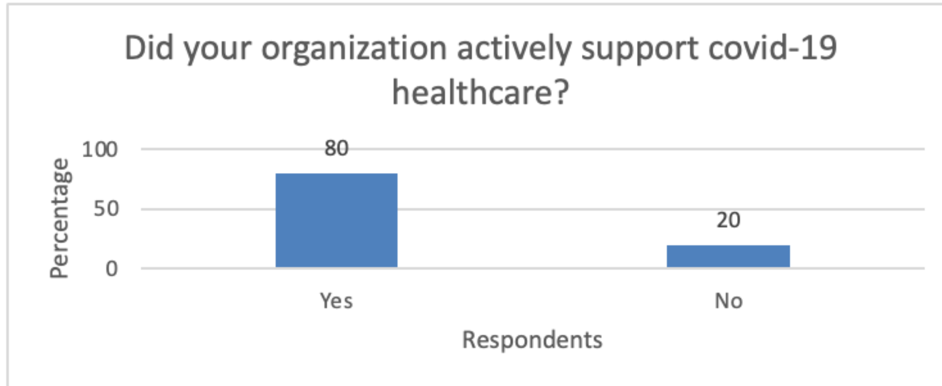
Figure 7 indicates that 86.67% of respondents supported the imposition of the restrictive measures while 13.33% disagreed with the control measures. Those who disagreed indicated that it was not necessary, mere political propaganda, too restrictive and excessive. Some revealed that they did not believe in the pandemic and it was an undue encroachment of the state into religious affairs.

Figure 7. Response to government's control measures



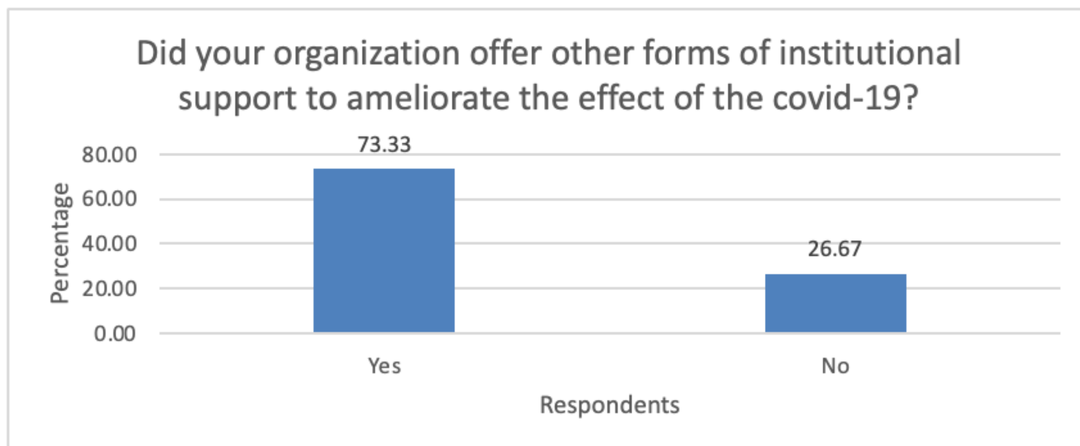
80% of all respondents indicated that their religious organization actively supported Covid-19 healthcare. Specifically, such support ranged from encouraging testing, conventional (orthodox) treatments/unconventional (traditional/herbal) treatments, vaccinations and raising public awareness on health matters and precautionary measures. 20% indicated that they did not actively offer healthcare support.

Figure 8. Role of religious organization in supporting covid-19 healthcare measures



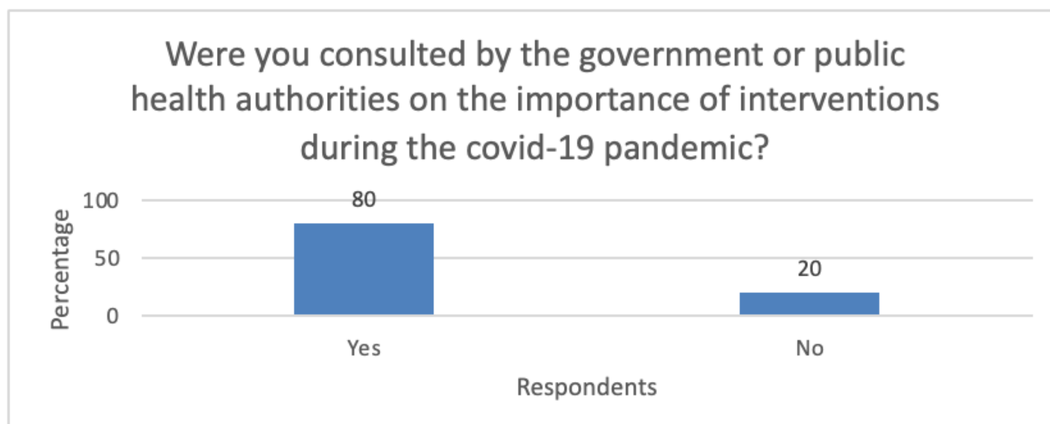
73.33% of respondents indicated that their organization offered other forms of institutional support to ameliorate the effect of the covid-19 such as quarantine, isolation and medical facilities. Others offered or donated healthcare equipment such as PPE and gloves. 26.67% of respondents did not offer institutional support.

Figure 9. Role of religious organizations in offering institutional support



80% of participants revealed that they were directly consulted by the government or public health authorities on the importance of interventions during the covid-19 pandemic while 20% indicated that they were not consulted.

Figure 10. The participation of religious organizations in control policy measures



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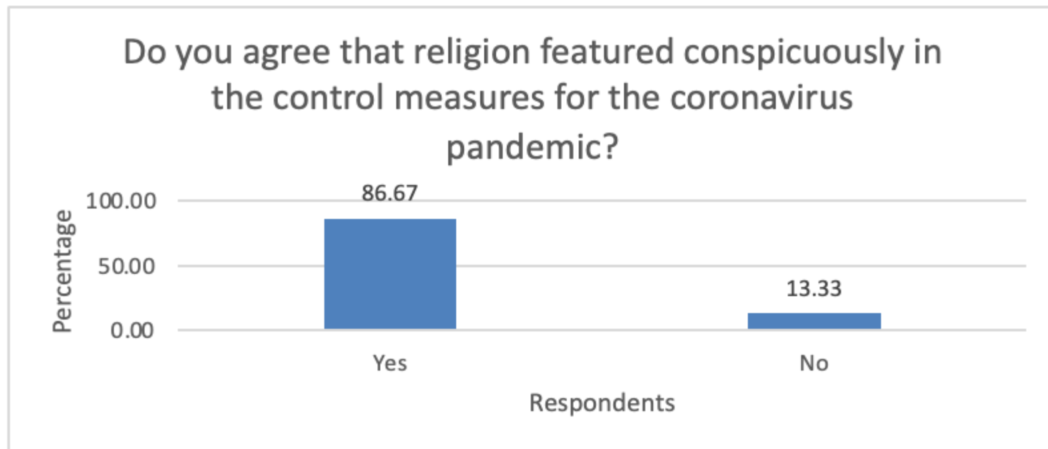
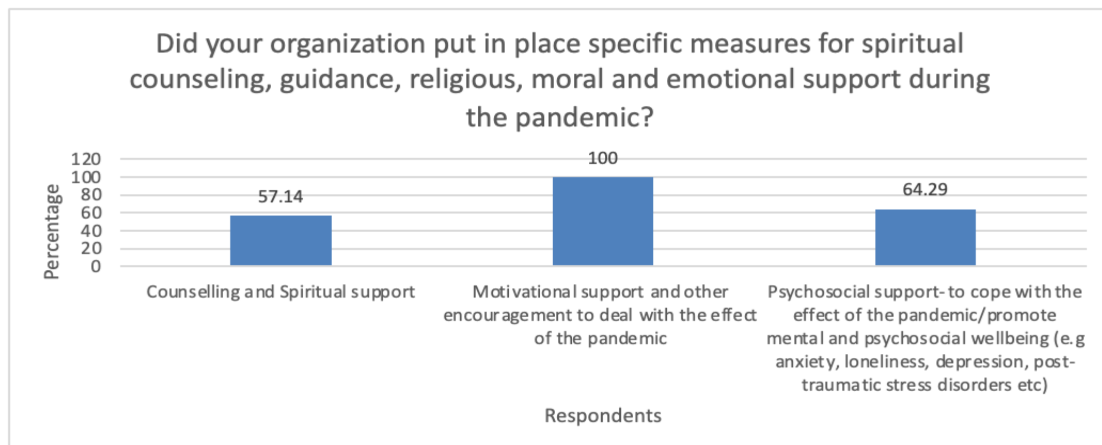
In Figure 11, 88.67% of respondents concluded and agreed that religion featured conspicuously in the control measures for the coronavirus pandemic while 13.33% indicated that religion did not play a major role in the control of the covid-19 Pandemic.

Figure 11. Religious support during the pandemic



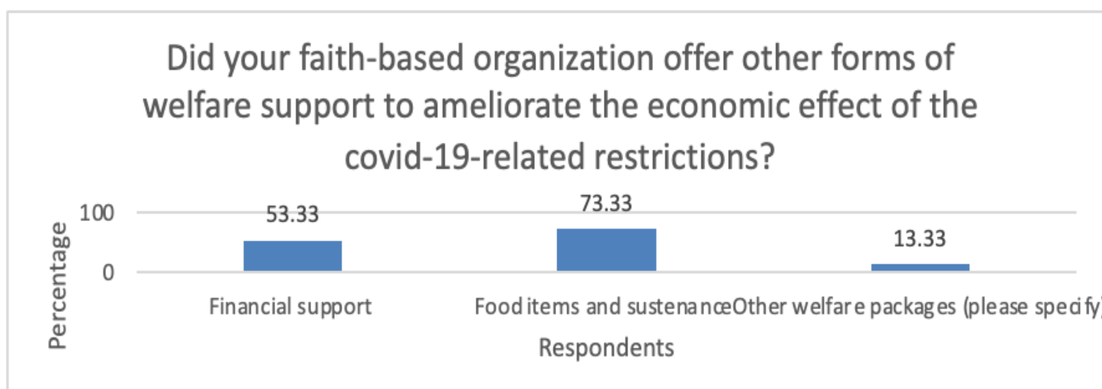
57.14% of the respondents affirmed that they offered counselling and spiritual support during the pandemic. 100% indicated that they offered motivational support and other encouragement to deal with the effect of the pandemic and 64.29% indicated that they specifically offered psychosocial support to cope with the effect of the pandemic/promote mental and psychosocial wellbeing (e.g anxiety, loneliness, depression, post-traumatic stress disorders etc).

Figure 12. Moral, regious and emotional support offered by religious organizations



During the Covid-Pandemic, 53.33% revealed that they offered financial support, 73.33% revealed that they donated food items and sustenance, and 13.33% offered other welfare packages.

Figure 13. Forms of support offered during the pandemic



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7. Discussions of Findings

While a plethora of literature has indicated the positive impact of religious leaders in leading healthcare and supporting health policies, there is little empirical research in this respect, especially in Nigeria. This study examined the role those religious leaders played during the Covid-19 pandemic, particularly in Adamawa state. This study provides deep insight into the various ways that faith-based organizations and clerics can promote positive healthcare behaviours and health policies. The results of the study conclude that there are valuable lessons that can be gleaned from the reaction of religious leaders and their approach to the pandemic.

7.1. The Impact of Faith-Based Institutions and their Leaders on Health Care

The first objective of this study was to investigate the influential role of faith-based leaders and organizations in driving healthcare. The findings revealed that they offered psychosocial, spiritual, and institutional support when necessary (Figures 1 and 2). During the Covid-19 pandemic, many indicated that they put in place specific measures for spiritual counseling, guidance, religious, moral and emotional support (Figure 12). Religious institutions also played a direct role as providers of healthcare facilities, services, and treatments (Figures 8 and 9). Many researchers have pointed to the positive role of faith-based groups in healthcare provision, particularly in weakened public health systems (Wijesinghe, et al., 2021; Olivier, et al, 2015; Spillman, 2016). In sub-Saharan Africa, for example, several faith-based healthcare facilities are estimated to be responsible for 20%-50% of healthcare services (Bormet, et al, 2021). For the poor, vulnerable and marginalized, especially in rural or remote locations, such health facilities and services constitute the sole or a significant source of healthcare (Bormet, et al, 2021). Although access to religious-based health facilities may be tied to a religious belief and spiritual wellbeing, it is often opened to the public in a manner that serves the general community. A study of 95 faith-based institutions by the Faith to Action Network Steering Council revealed that they provide a holistic approach to health in highlighting both physical and spiritual wellbeing (Faith to Action Network, 2014). More specifically, they provide health interventions, as well as advocacy and policy direction (Faith to Action Network, 2014). Significantly, the study also showed that faith organizations help in 'nurturing positive attitudes and values towards one's own sexual and reproductive health and rights' (Faith to Action Network, 2014). At a time when many countries are staggering under the weight of the COVID-19 Pandemic on their healthcare systems, faith-based healthcare is potentially crucial in supporting the state's interventions. They contributed directly by providing facility capacity for isolation and quarantine, and provided the medical treatments and medical personnel to treat COVID-19 complications (Figures 7 and 8). Another study showed that religious leaders influenced people's positive attitudes toward voluntary family planning through targeted spiritual messages and referrals to health facilities for family planning (Ruark, Kishoyian, Bormet, and Huber, 2019). It concluded that faith leaders are important providers of healthcare, especially in implementing community health projects (Ruark, Kishoyian, Bormet, and Huber, 2019).

7.2. The Role of Religious Leaders and Faith-Based Organizations in Positively Influencing Society

This study also found that leaders/organizations positively influenced society to a great extent (Figures 1-9). In many religious sects, the authority of spiritual leaders is seen to emanate from God and they act or influence under this delegated authority (Piper, 1995). They typically command the utmost respect, reverence, and devotion of their followers and the community as they are envisioned to have strong values, godly dignity, and high integrity (Uyovwieyovwe, 2019). Moreover, many religious texts demand total obedience and submission; thus, religious leaders benefit from the grace accorded to a supreme God.

Spiritual leaders perform a broad range of functions. As a part of their duties, they offer spiritual counseling, guidance, religious, moral, and emotional support to their adherents, as well as helping them to order their life affairs (Gerald; Wango; Faith to Action Network). They help in shaping the vision, direction, and values of their followers. They are expected to lead by example through selfless service to their congregation and their communities by ministering at hospitals, and correctional facilities, guiding youth groups, assisting the aged, orphans, widows, refugees etc., raising funds to support social and economic outreaches, and generally supporting community initiatives (Figure 1, 2 and 9) (United Nations Children's Fund, Regional Office for South Asia, 2020). They try to maintain a harmonious society

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through guidance, public awareness, and the promotion of peaceful existence (Figures 2 and 3) (Osajie, 2021). They also serve as development agents in promoting social justice, and democracy and enhancing the people's welfare (Figure 13). Other studies have indicated that religious leaders can also play vital roles in the community and national development by facilitating the construction of schools, hospitals, and care facilities (Osajie, 2021; The Urban Institute & Vidal, 2001).

Moreover, the involvement of faith leaders can influence the advocacy, support, implementation, and outcomes for health policies and programs, and the health behaviour of congregants and community members due to the immense authority they command in communities (Gross et al, 2018; Schoenberg, 2017). Their sphere of influence on health behaviour extends beyond the individual level and impacts the socio-cultural and policy levels (Figures 3 and 4) (Gross et al, 2018; Schoenberg, 2017). They can exert an overwhelming influence through scriptural influence, social and community influence and by serving as role models (Gross et al, 2018; Schoenberg, 2017).

7.3. Initiating Collective Response and Raising Awareness

This research found that religious leaders and faith-based institutions influence health objectives and mobilise compliance to preventive and control regulations (Figures 8 and 9). The participation of religious organizations and their leadership is, therefore, vital for initiating a collective response to public health challenges such as compliance with lockdown and stay-at-home measures, healthy and hygienic practices, destigmatization of patients, and inoculation against the disease. Faith leadership can work in conjunction with health authorities to coordinate awareness campaigns and mobilize community support for preventive, control, and curative health measures (Wijesinghe, et al., 2021). It is therefore safe to conclude that as a community resource, faith leaders are in a good position to organize and foster community participation in health programs.

7.4. Driving Social Change and Advocacy

Religious institutions can also play a key role in advocacy by driving social change through direct campaigns on safety and health measures and practices (Figures 2, 3, 4, 8 and 9). Religious leaders could act as gatekeepers in the dissemination of health information, especially in rural communities that have little or no access to verifiable information about a disease. Since faith significantly inspire healthcare beliefs and conducts, religious entities are more likely to influence health-seeking behaviors. Indeed, the ability of clerics to ground health or social change messages in religious doctrines accentuates their influence, especially in evoking people's moral and social duty (Lipsky, 2011).

7.5. Enhancing Public Engagement and Compliance with Government's Health Directives

Engagement with religious authorities is also important in determining how people get infected or transmit infections in the course of religious activities. By the second wave of the COVID-19 pandemic, many governments, including Adamawa state, had to issue a ban on all social and religious gatherings to curb the virus (Agency Report). This study finds that 93.33% of the religious leaders partially or fully altered their religious practices and traditions, including group worship, in compliance with government directives to control and avoid the spread of the virus (Figure 6). The actions taken by the religious organizations may have contributed to limiting the exposure to, and the spread of the disease (Abogonye, Aramide, & Musa, 2020; Adebowale). In this manner, proactive dialogue with religious leaders from the onset could help in the campaign against health epidemics and control the transmission rate. The study also notes that many religious leaders (86.67%) were in support of the government's restrictive measures for health reasons, although 13.33% disagreed with the control measures for reasons ranging from disbelief, necessity, restrictive control and excessiveness of the measures. (Figure 7).

Similarly, effective collaboration and partnership between the government and religious organizations are important in enhancing public engagement. The involvement of religious leaders can help in the ways people receive, connect with, or comply with the government's health directives. This study revealed that 80% of the respondents specifically supported COVID-19 healthcare by encouraging testing, conventional (orthodox) treatments/unconventional (traditional/herbal) treatments, vaccinations, and raising public awareness on health matters and precautionary measures. (Figure 8). 80% of participants

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also revealed that they were directly consulted by the government or public health authorities on the importance of interventions during the COVID-19 pandemic.

7.6. Shaping Health Policy and Galvanizing Support for Its Acceptance

The findings also indicate that faith-based organizations and their leaders contributed to shaping health policies (Figure 3). In particular, faith-based organizations brought to bear their expertise, views, ideas, and diverse perspectives, especially from a smaller section of society. As one author puts it, 'working with religious leaders plays a crucial role in engaging communities from designing and planning interventions to trust-building, social and behavior change communication, risk communication, surveillance tracing, logistic provision, and administration' (Wijesinghe, et al., 2021). Policies that enjoy the support of faith organizations could therefore be perceived as credible by followers and indeed, the larger community where they exert their influence.

7.7. Supporting Testing, Treatments, Vaccinations and Other Intervention Measures

Testing plays a role in identifying infected persons and preventing the further spread of a disease/virus. Distrust of testing facilities, scientific information, post-test treatments, fear of stigmatization, misinformation, and self-denial can, however, prevent people from getting tested (Vitriol and Marsh). Faith leaders took take the lead by encouraging testing and dispelling myths associated with testing and treatments (Figure 5). They can thus serve as channels for distributing correct and reliable information about testing procedures, activities, and treatments. The same is true for vaccine hesitancy and inoculation campaigns (Viskupič, & Wiltse 2022). They can build the interest of people to voluntarily get vaccinated as a proactive measure to prevent the spread of a virus and save lives by reducing fatality from complications (Viskupič, & Wiltse 2022). They can model appropriate and supportive responses because their members and the community trust them.

7.8. Offering Psychological, Social and Spiritual Support to Individuals

The results of this study provide some preliminary evidence that the faith community can also offer psychosocial, spiritual, and motivational support, and encouragement to deal with the effects of a pandemic, cope with health effects, and handle intervention measures (Figure 12) (Wijesinghe, et al., 2021). Religious leaders are highly regarded hence, they play a powerful role in shaping attitudes, morale, and opinions in line with faith-based teaching. Sedentary behavior, reports of death, and low levels of activity can lead to negative impacts on the emotional and mental wellbeing of individuals (Park, 2020). There are reports that the COVID-19 Pandemic had a significant effect on the psychological health and social wellbeing of many people (Fadipe, et al, 2021; Shahbaz et al, 2021; Caqueo-Urízar, et., 2021). The pandemic led to several mental problems including acute stress, post-traumatic stress, anxiety, depression, etc (Fadipe, et al, 2021; Shahbaz et al, 2021; Caqueo-Urízar, et al., 2021). While public health authorities offered health treatments for the physical effect of the COVID-19 virus, there is little evidence that they catered for the psychosocial impact of the disease itself and the measures undertaken to control the spread. Self-quarantine, confinement, social isolation, prolonged distancing economic pressures, and disenchantment can also cause additional stress and challenge the mental health of the citizens, especially children, the aged, singles, and other vulnerable groups (Merrill, 2021 J; Fadipe et al). Religious organizations and their leaders are in a good position to offer hope and solace in times of despair and financial and emotional struggles (Mróz & Roszak, 2022; Hong & Handal Mróz,). Indeed, the World Health Organization (WHO) has recognized the importance of praying, reading, sacred texts, spiritual rituals, corporate worship, and interventions by clerics as appropriate coping mechanisms (Carey & Cohen 2015).

8. Looking Forward: What Can Faith-Based Groups and Leaders Do for Health Policies, Programs, and Interventions?

The issuing of mitigation directives and simply compelling persons to inoculate against the virus to control public health emergencies and pandemics is not sufficient. A multifaceted, broader, and holistic approach that focuses on health behaviors and takes into account social, cultural, and religious factors can significantly produce positive results. The need for a socio-religious and cultural approach to combat a public health challenge, particularly, to increase the willingness to engage in disease mitigation, treatment, and control has been acknowledged by health organizations, medical experts, governments, and scientists around

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the world (Vitriol and Marsh; Götz, virtz, Galinsky, & Jachimowicz 2020; World Health Organization 2020). The general consensus is that a sustainable and coordinated social action led by community and religious leaders, policymakers, and key stakeholders to influence the social behaviour of the general public is significant in decreasing transmission rates and encouraging treatments Götz, virtz, Galinsky, & Jachimowicz 2020; World Health Organization 2020; Baicker et al, 2020).

For effective collaboration between religious organizations and government, a sustainable trusting relationship, deliberate consultation, and open communication must be fostered. Such a partnership should also take into account the divergent interests and perspectives of all parties. Furthermore, the government should help to build the capacity of religious entities to support health policies, programs, and interventions. Most importantly, the deliberate effort to train faith-based leaders on the importance of government interventions (such as education on the available vaccinations, their safety, and efficacy in addressing diseases) is central to engaging them in health intervention treatment programs. Religious leaders should also be trained on how to address, dispel and counter misinformation and disinformation which can put communities at risk (Wijesinghe, et al., 2021).

To overcome resistance and obstacles to the implementation of health measures, the government can liaise with trusted religious organizations, given the central place of religious institutions and faith leaders in shaping the behaviour and conduct of individuals. As one of the most respected figures in society, they play significant roles in building and strengthening values such as respect, authority, the sanctity of life, loyalty, and regard for hierarchy, which are essential to implementing government policies and complying with health interventions (Covrig, Ledesma, & Gifford 2013).

9. Conclusion

Religious leaders and organizations command the respect, support, and allegiance of billions yet, their contribution to precipitating health behaviour has largely been ignored by policymakers (Heward-Mills et al, 2018). Without a doubt, religious leaders play a pivotal role in driving healthcare, influencing health-related behaviours, and supporting health policies. The influence that the faith leaders wield over their congregants and communities can be exploited to create a more supportive environment for health measures, thus, health authorities should consider collaborating with them to enhance public health. It is also essential that they are proactively engaged in the fight against any pandemic or similar health crises. Faith communities are highly influential and have the potential to increase the reach of health information in communities. Spiritual leaders and institutions can play a significant role in saving lives, reducing illnesses and transmission of epidemics and pandemics, and cushioning the impact on the psychological, social, and emotional lives of individuals. Especially at the family and community levels, faith communities' religious leaders have the power to raise awareness, and influence attitudes behavior, and practices. They can shape policy and galvanize support for its acceptance and increase its uptake. As a community resource, they can also lead the drive for change through direct campaigns on diseases, prevention, and available treatments, hence, faith leaders should be better positioned to organize and foster community participation in health matters. The COVID-19 pandemic serves as a reminder to include the views, opinions, support, and effort of faith-based organizations and their leadership in government measures, policies, and interventions for the common good and welfare of all. In certain cases, particularly in restrictive locations, faith-based organizations can provide relief much more quickly than the state in a situation of a health emergency. Their outreach is significantly wide enough. Likewise, the people are more likely to trust health policies due to the seeming lack of political interests and on the basis of their religious inclinations.

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