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The Role and Impact of Faith-Based Organisations in the Management of and Response to COVID-19 in Low-Resource Settings

Policy & Practice Note

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Abstract

The COVID-19 crisis is affecting millions of lives and has wreaked some of its greatest havoc and suffering among the vulnerable and marginalised populations of the world, many of whom belong to religious and faith-based communities. In times of crisis and difficulty, religion and faith are a source of hope and strength for many. In this paper, we underscore the critical role and impact that some faith-based organisations have had in the pandemic crisis response and management of three countries: Brazil,

Indonesia and Sri Lanka. In Brazil, Pastoral da Criança is leveraging their mobile phone application to fight mis-information about COVID-19. In Indonesia, Muhammadiyah launched a COVID-19 command centre to support treatment in hospitals, to disseminate guidelines for religious activities backed by science, and to provide water, sanitation and hygiene packages, food and financial support to the most vulnerable and neglected. In Sri Lanka, Sarvodaya is working closely with religious and community leaders on risk communication and community engagement messages and is also providing hygiene care and economic relief packages to the marginalised. We further discuss some of the challenges these organisations have faced and propose recommendations for greater engagement with this group of global public health actors to maximise their contributions and impact in the crisis management of and response to future infectious disease outbreaks, epidemics or pandemics in low-resource settings.

Keywords

faith-based organisations – COVID-19 – global health – sustainable development – low- and middle-income countries

1 Introduction

Karl Marx famously said that "religion is opium for the people" (Marx 1844). This statement has again been reified in the context of a global pandemic that is affecting millions of lives globally. The pandemic has wreaked some of its greatest havoc and suffering among the vulnerable and marginalised populations of the world, many of whom belong to religious and faith-based communities encumbered by extreme poverty and a lack of basic housing, clean water and sanitation. These basic living essentials are imperative to successfully practise some of the non-pharmaceutical interventions that are currently recommended by many public health authorities in poor and rich countries worldwide.

In times of crisis and difficulty – such as the times we currently live in – religion and faith are a source of hope and strength for many, a "spiritual" opium that numbs and relieves the pain and anguish, somewhat giving credence to Marx's aforementioned quote. One externality of this spiritual opium during the COVID-19 crisis is that some religious institutions were still holding large faith gatherings at the onset and peak of the pandemic in 2020, thereby spurring clusters of outbreaks in various countries globally because congregants were not physically distancing, wearing masks, or practising hand hygiene

measures (Wildman et al. 2020). In this sense, some religious institutions and leaders have directly or indirectly perpetuated the spread of the SARS-CoV-2 virus (the causative pathogen of COVID-19) and the subsequent morbidity and mortality that have ensued, especially in many impoverished communities in low- and middle-income countries (LMICS) (Jaja, Anyanwu and Jaja 2020). But perhaps more importantly and less emphasised is the fact that religious and faith-based organisations (FBOS) have also formed the bedrock of the pandemic crisis response to COVID-19 in many resource-constrained settings globally, promoting and safeguarding the mental, physical, psycho-social and spiritual well-being of millions of people around the world.

For the uninitiated, a faith-based organisation is an organisation (usually non-profit) that is inspired by religion or religious beliefs and values that drive its social mission and work in grassroots/local communities (Bielefeld and Cleveland 2013). FBOS have been providing succour and social protection to vulnerable and marginalised populations as far back as the Middle Ages, a time when the maxims of love and charity were commonplace and the tenets by which the greatest religions of that epoch have lived by, even up till this present day (Rys 2010).

Global health and international development organisations have over the last few decades begun to recognise and value the very important role that faith-based organisations play in eradicating poverty and poverty-related infectious diseases like HIV/AIDS, malaria and tuberculosis (Duff and Buckingham 2015). This is why the United Nations created an interagency task force on religion and development in 2010. However, it was not until the post-Millennium Development Goals era that it was evidently clear to global (health) governance actors and advocates that one of the most pragmatic ways to fast-track the achievement of the world's ambitious Sustainable Development Goals (SDGS) by 2030 was to actively engage these FBOS in the decision-making and planning processes of global health and development bodies. Specialised agencies of the United Nations like the World Health Organization (WHO) and the World Bank Group, and intergovernmental forums like the G20, are continuously advocating and spearheading these new inclusive governance approaches and mechanisms (Welsh 2020). For instance, the WHO's Framework of Engagement with Non-State Actors adopted in 2016 formally recognises faith-based organisations as non-state actors to engage with, and since 2015 the World Bank Group has intensified its collaboration with FBOS active in LMICS to accelerate the scale and impact of their activities in impoverished settings (The World Bank n.d.).

The 2014/2015 and more recent 2018/2020 Ebola epidemics in West Africa and the Democratic Republic of Congo, respectively, are vivid reminders that FBOS are also important stakeholders in the global health security agenda

to keep us all safe from the threats of emerging and re-emerging infectious diseases (Marshall, Wilkinson and Robinson 2020). The lack of engagement by global, national and local public health authorities with West African religious and faith-based leaders and organisations at the onset of the 2014/2015 Ebola epidemic crisis management led to widespread community outbreaks often from religious burial ceremonies and other gatherings or activities where infection prevention and control measures were not adequately implemented or followed (Marshall and Smith 2015; Marshall 2020). Unfortunately, the lessons learnt from the West African experience were not quickly applied in the context of the Democratic Republic of Congo's epidemic, further complicating the response in a milieu of violent conflict between the government and rebellious armed groups that entrenched societal distrust and misinformation (ReliefWeb 2019; Balibuno, Badjonga and Mollet 2020). Since the beginning of the COVID-19 pandemic, UNICEF (in collaboration with Religions for Peace and the Joint Learning Institute on Faith and Local Communities) and the WHO have published guidance and recommendations for religious leaders and faith-based communities that were co-developed with this specific group of actors, thus reaffirming the crucial role they play in the crisis management of the pandemic (World Health Organization 2020; UNICEF 2020).

Our organisation, the Ahimsa Fund and Partners, is part of a growing network of global health stakeholders that is actively marshalling and empowering FBOs in their social mission to deliver preventive and curative public healthcare services in various communities in LMICs, and we are also advocating for and fostering collaborations and partnerships among these FBOs to bolster the impact of their work globally. As close observers and collaborators, we want to highlight in this paper the critical role and impact that some of these organisations have had in the COVID-19 pandemic response and management of three countries: Brazil, Indonesia and Sri Lanka. These FBOs were chosen because they represent three different faith communities within Ahimsa's network. The insights were gathered (using unstructured interviews and focus group discussions) from our monthly virtual check-in meetings with representatives of these organisations who are leading their COVID-19 work. We proceed further to discuss some of the challenges these organisations have faced and propose recommendations for greater engagement with this group of global public health actors to maximise their contributions and impact in the (crisis) management of and response to future infectious disease outbreaks, epidemics or pandemics in low-resource settings.

1.1 *Pastoral da Criança* (*Brazil*)

Pastoral da Criança is a Catholic faith-based organisation that was founded in 1983 to provide health and nutrition services to all children and women in

Brazil regardless of their religious affiliations. It has since extended its reach to twelve other Latin American, African and Asian countries, namely Argentina, Bolivia, Colombia, Dominican Republic, Guatemala, Haiti, Peru, Venezuela, Benin, Guinea Bissau, Mozambique and the Philippines. Pastoral da Criança's social mission is to prevent the deaths of mothers and infants by providing follow-up home visits to educate pregnant women and households with children under the age of six on nutritional and health needs. Their impact has been massive, to date serving over 700,000 children and 41,000 pregnant women using their growing network of 72,000 volunteers in Brazil alone, just before the pandemic hit. As a social mission of the Brazilian Catholic Church, Pastoral da Criança has built a lot of credibility and trust since its founding, contributing enormously to the reduction of infant and maternal mortality in many regions and municipalities (SciELO 2003). Brazil has more Roman Catholics than any other country in the world, estimated at 123 million people or 65% of the entire population in 2010, while more recently 58% of Brazilians identified as Catholics in a survey conducted in 2018 (Pew Research Center 2013; Statista 2018).

The pandemic has negatively impacted their work, by preventing some of their volunteers from engaging in home visits due to shelter-in-place and (semi-)lockdown restrictions in different Brazilian regions, but it has also enabled them to leverage their innovative Home Visit Android mobile health (mHealth) application, which has been supporting the work they did prior to the pandemic. The mobile application can work offline when there is minimal or no internet connectivity and can sync data to and from cloud storage after connectivity is restored. There are several features on the application: (i) volunteers can share guidelines on health and nutrition with families via email, Bluetooth and WhatsApp, (ii) it has a chat function for two-way communication between users and app coordinators, and (iii) has e-trainings on health, nutrition, hygiene, child development and citizenship. Since the pandemic, they have included new e-trainings on toys and plays to enable households to keep their children entertained at home, on food and home vegetable gardens to teach families about healthy foods and vegetable home garden planting, and on fighting against coronavirus misinformation and disinformation using reliable and trustworthy sources like the WHO and other national and regional health agencies. Over 13,000 people in Brazil have participated in the 'fight against coronavirus' e-training since the start of the pandemic. The mHealth application is available in Portuguese, Spanish, English, French and Haitian Creole languages and is also currently downloadable in Guinea Bissau, Mozambique and Peru, with the content adapted to local realities in the different countries.

1.2 *Muhammadiyah* (*Indonesia*)

Established in 1912, Muhammadiyah is arguably one of the largest and most influential Islamic faith-based organisations in Indonesia and the world, with well over 29 million members in 2008. It currently has more than 130 universities, over 10,000 elementary and kindergarten schools and over 107 hospitals and 250 clinics, through which it provides educational and healthcare services to millions of people in Indonesia. Since the onset of the pandemic, Muhammadiyah has been supporting the federal government's response with its COVID-19 command centre, which is overseeing the organisation's pandemic healthcare response by responding to mild, moderate and severe cases of the disease in various parts of the country. They have supplied more than 500,000 items of personal protective equipment, including surgical-grade masks, hazmat suits, face shields, goggles, shoe covers and other equipment like ventilators and oxygen concentrators to their network of hospitals providing COVID-19 medical care, with support from international development agencies like the WHO and United States Agency for International Development. They are also supporting the prevention and control of the pandemic by working with other private companies like Unilever to train students and teachers about personal hygiene, provide hygiene kits (with hand sanitisers and reusable cloth masks), and build water and sanitation facilities in various communities that lack access to these amenities.

Indonesia has the world's largest Muslim population, estimated at 205 million in 2010, so Muhammadiyah as an Islamic FBO has played a pivotal role in shaping the public's perception of the pandemic, especially regarding contentious issues like vaccinations and funeral rites, by disseminating guidelines or fatwas regarding vaccination for COVID-19 prevention, religious worship in COVID-19 emergency conditions, Eid al-Fitr prayers, Arafah fasting, Eid al-Adha, etc. that are aligned with international and national public health measures/protocols on infection prevention and control (Pew Research Center 2010). Additionally, they are also addressing the adverse socioeconomic impact of COVID-19 by providing foodstuffs and cash assistance such as business capital stimulus packages to families and small businesses in various districts and provinces of Indonesia.

1.3 *Sarvodaya Shramadana Movement* (*Sri Lanka*)

The Sarvodaya Shramadana Movement was founded in 1958 on Buddhist and Gandhian principles. Sarvodaya is an indigenous FBO that is addressing development challenges in Sri Lanka. They engage in a broad range of activities including educational training, disaster response and humanitarian relief, and conflict resolution and peacebuilding, and they have been instrumental to

the progress made on various health, educational, sociocultural and economic development outcomes in Sri Lanka. Right from the onset of the COVID-19 pandemic, Sarvodaya – with 34 district centres and a presence in over 3,000 villages – offered all its residential and training centres to the Sri Lankan government to be used as quarantine facilities. They have also been actively working in close liaison with all relevant local, national and international stakeholders to plan, support and strengthen a "whole of society" response to the pandemic. For instance, thanks to this approach, the leadership and meaningful participation of women and girls in all decision-making has been critical to the success of the response.

In Sri Lanka, at least 70% of the population believe that religion plays an important role in their lives and society, hence religious and faith-based leaders are considered respected and trust-worthy sources of public health information (Poushter and Fetterolf 2019). Sarvodaya has leveraged this by working closely with global health authorities like the WHO, the Sri Lankan government and religious leaders in various communities across Sri Lanka to develop and disseminate risk communication and community engagement (RCCE) guidelines, especially for religious worship and other religious activities, to avoid or ameliorate further community spread and outbreaks of COVID-19. With these partners, they have also created and disseminated accurate and culturally appropriate general public information about COVID-19 prevention, control and treatment via television and radio broadcast media channels, print media and digital/social media platforms in the local languages of Sinhala, Tamil and English. This has been crucial to curtail the impact of (stigmatisation and discrimination from) misinformation and disinformation infodemics that are hampering the global and national response.

Sarvodaya has also been instrumental in distributing hygiene and economic relief packages to daily-wage workers and vulnerable and poverty-stricken communities with assistance from philanthropic donors.

2 Challenges and Opportunities

The challenges and opportunities highlighted below are a mix of anecdotal and global reflections to highlight the role and impact that FBOs could have if they are actively engaged in the response and management of the pandemic.

2.1 *Funding and Partnerships*

The resource mobilisation needed to address the health and socioeconomic impact of a pandemic is just as unprecedented as the pandemic itself, but

regrettably, as of mid-June 2020, only 0.07% of funds channelled through the United Nations had reached local non-governmental organisations (including FBOs) responding to COVID-19 (Konyndyk, Saez and Warden 2020). FBOs like Sarvodaya, Muhammadiyah and Pastoral da Criança rely on the philanthropic benevolence of (charitably inclined and religious/faith-based) donors, volunteers and state partners to deliver the outputs and outcomes highlighted above, but huge funding gaps continue to hamper the execution of their programme goals and objectives. The pandemic offers an opportunity for private-sector entities in particular to plug resource gaps by increasing funding and partnerships with FBOs, and vice versa (Cheney 2021). For example, Unilever partnered with Muhammadiyah early on during the COVID-19 pandemic to upgrade water, sanitation and hygiene facilities in Indonesian boarding schools and to provide other hygiene kits necessary to maintain optimal hand and personal hygiene practices in various communities and districts.

FBOs are important gatekeepers that have built trust and reliable networks from decades of consistent engagements with local communities. Private organisations and national and international development agencies can leverage this instead of starting from scratch or reinventing the wheel when attempting to establish cordial working relationships in these communities. We hope to see more formal engagements between private funders, development agencies and FBOs during and after the pandemic (Lieberman 2020).

On the other hand, FBOs are mostly working in silos in the absence of partnerships with other local, national and international partners as they respond to the pandemic in various settings. There is likewise a general need for better accountability, transparency and coherence between FBOs operating in low-resource countries and regions and the specific need for a coordinated and systematic approach to resource mobilisation and collaboration for the epidemic/pandemic response between FBOs with a focus on strengthening community resilience, thereby avoiding competitive "me first" approaches. The Sarvodaya Shramadana Movement is a leading voice and proponent of these kinds of collaborative "whole of society" approaches that bring all relevant stakeholders together, working hand in glove for the betterment of the most vulnerable in Sri Lanka.

2.2 *Risk Communication and Community Engagement*

RCCE has not been optimal at global, regional and national levels for several (sometimes interconnected) reasons. One of them, as alluded to earlier, is a lack of early and/or consistent active consultations with faith-based actors by international and national public health agencies, especially in the absence of an emergency. There is also a general tendency for stakeholder engagement

fatigue with faith-based actors to quickly set in after the imminent risks in a crisis are surmounted and countries are out of the woods. A recent report by the World Bank, assessing country readiness for COVID-19 vaccines in LMICs, revealed that only 27% of countries (as of mid-February 2021) had developed social mobilisation and public engagement strategies to encourage people to get vaccinated. Advocacy, community engagement, and risk and safety communication strategies are key in epidemic and pandemic crisis management to proactively combat misinformation and disinformation about health products like vaccines and to improve the confidence in, acceptance of and demand for these products (The World Bank 2021; Wouters et al. 2021). It is paramount that FBOs are intimately embedded in RCCE working groups/advisory committees within national public health ministries and international development or global health organisations from the early onset of infectious disease (crisis) management and response. There is also a need to optimise risk communication channels to ensure a trilateral two-way communication between religious/faith-based local communities, faith-based organisations and national health authorities (see Figure 1 below). This will help to quickly identify communication gaps and to rapidly counter or suppress misinformation and disinformation.

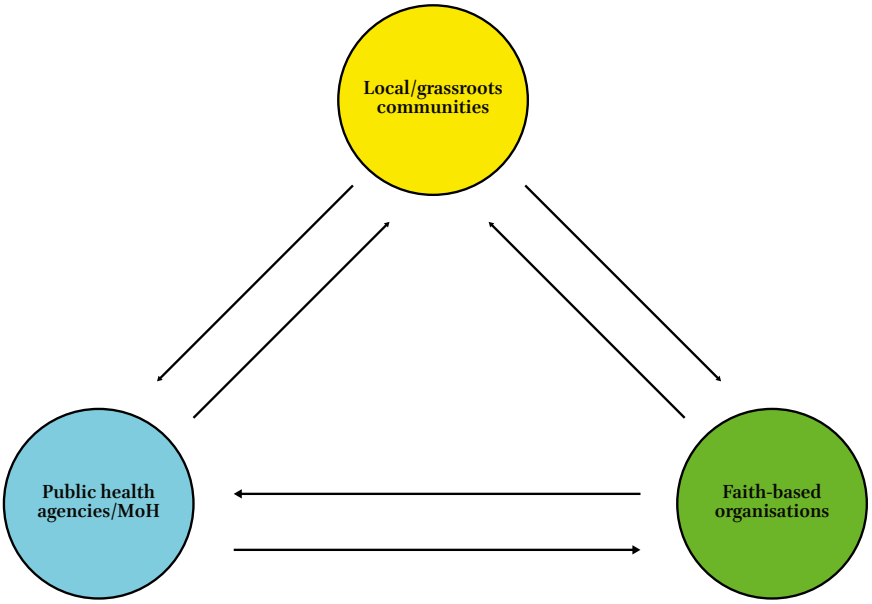

FIGURE 1 Trilateral two-way communication between local/grassroots communities, faith-based organisations and public health agencies/Ministry of Health (MoH)

2.3 *Vaccine Access Inequity*

COVID-19 has laid bare the colossal disparities between the haves and have-nots of the world. While many high-income countries were close to vaccinating half of their vaccine-eligible adult populations by the middle of 2021, most economically disadvantaged countries had not vaccinated even 20% of their populations within that same timeline. WHO's Director General, Dr Tedros Adhanom Ghebreyesus, has called this vaccine inequity "a catastrophic moral failure" and has said that the gap in vaccine access and distribution between the rich and poor is "becoming more grotesque every day". The COVAX facility, a WHO-led joint global sharing initiative with Gavi, the Vaccine Alliance and the Coalition for Epidemic Preparedness Initiative, aims to provide 2 billion doses of vaccine to the most vulnerable in LMICs by the end of 2021. As at the time of writing, COVAX had only delivered 29 million doses of vaccines to 46 countries in Africa, Asia and Latin America (Human Vaccines Project n.d.).

The sheer scale and speed of vaccinations required to achieve herd immunity in low-resource settings means that these countries cannot rely only on existing (or sometimes even non-existent) national or international development infrastructure and mechanisms. There is an urgent need and opportunity to leverage the integrated network of volunteers, health personnel and infrastructural assets of FBOs across LMICs to expedite vaccine access and delivery in hard-to-reach areas and underserved communities in developing countries (Wilkinson and Marshall 2021).

3 Recommendations and Conclusion

To conclude, we would like to propose some recommendations for actionable changes:

- Multilateral and intergovernmental global (health) governance fora/organisations like the United Nations, G20, World Bank and Global Fund must allocate more funding to FBOs working in LMICs to accelerate the impact of their pandemic interventions in low-resource settings.
- Private-sector funders and partners must explore more funding and partnership opportunities with mission-driven FBOs that align with their values and/or corporate social responsibilities, barring any conflict(s) of interest that may arise after proper due diligence and risk–benefit assessments of such engagements.
- FBOs must institute and strengthen accountable and transparent mechanisms that will enable them to generate and disseminate evidence-based

faith-centred data to support the impact of their engagements in vulnerable communities. The Joint Learning Initiative on Faith and Local Communities has a monitoring, evaluation, accountability and learning hub that is supporting FBOs with best practices to achieve this.
– FBOs must foster and advocate for more local, national and global interfaith and intra-faith collaborations and partnerships that strengthen coherent COVID-19 responses across all development actors.

Global public health authorities and international development actors around the world have had many opportunities in the last few decades to significantly elevate and prioritise the inevitable role that FBOs play in the timely and successful management of and response to infectious disease outbreaks or epidemics, and more broadly their role and impact in achieving the SDGs. The COVID-19 pandemic is another time of reckoning to go beyond rhetoric and implement long-lasting reforms and actions that would keep the world healthier and safer for all, especially for religious and faith-based communities in low-resource settings.

Disclaimer

The views expressed in this policy and practice paper are primarily those of the authors and do not necessarily represent the policy or views of their affiliated institutions.

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