

Global faith-based responses to COVID-19:

Local, national, and international faith-based organizations and health care providers on the frontline of COVID-19 response

Key findings

- Community-based education, prevention, and public health promotion are the foremost ways in which faith-based organizations are currently responding to the COVID-19 crisis.
- These organizations need increased access to personal protective equipment (PPE) but are also interested in more support around preparedness for outbreaks and surge capacity, as well as their ability to help counter stigma and discrimination.
- Funding is a clear challenge, both for routine programs and covering emergency COVID-19 response.
- Local religious leaders and faith communities remain highly involved in FBO programs, including spreading public health messages through radio, televised prayer, PA systems, phone calls, SMS, and WhatsApp.

Introduction

Christian Connections for International Health (CCIH) and the Joint Learning Initiative on Faith and Local Communities (JLI) wanted to learn how faith-based organizations and health care providers in international development have used their specific skill sets, partnerships, and assets to counter the spread of COVID-19. Previous research shows that these actors are highly influential and trusted in communities where faith is important and engagement with religious leaders and faith communities has been game-changing in previous epidemic responses, such as Ebola in West Africa in 2014-2015. Not only are faith-based health care providers responsible for a substantial percentage of all health care in many countries (depending on context) around the world, faith-based organizations at local, national, and international levels find ways to reach out to communities to help prevent the spread of the virus.

Purpose, method

CCIH and JLI circulated a survey through their networks to identify current activities and unmet needs for support among faith-based health providers and organizations during the coronavirus (COVID-19) outbreak.

Description of Respondents

- N=52, drawn from both CCIH and JLI networks.
- Survey conducted from April 8-22, 2020, online.
- Included direct care providers and associations; NGOs at community, national and global levels; and networks of religious leaders.
- Respondents represent local and national organizations (58%) and international organizations (42%).
- Global response to COVID - 90% work in Africa, 39% Asia, 31% Latin America/Carribbean, 21% Europe, 14% North America, 8% Australia.
- While 42% work in multiple regions, 50% work only in Africa. The others work only in either Asia or LAC.

Results

Most participants focus on community-based education, prevention, and promotion (85%) and over half are providing supplies (67%) and health worker training (63%). Of all types of activities, 96% are engaged in two or more, with 35% providing 6 or more types of services.

Participants rated their needs for information, supplies, and training. The top-rated needs, based on the proportion rating need high or very high, are:

1. Protective gear and training in its use (71%)
2. Preparedness for outbreaks, and surge demand (65%)
3. Preventing stigma and fear (62%)

Fortunately, most participants believe the guidelines they are receiving are relevant to the environment in which they work. This is particularly true for handwashing (75% rate relevance high or very high) and physical distancing (62%).

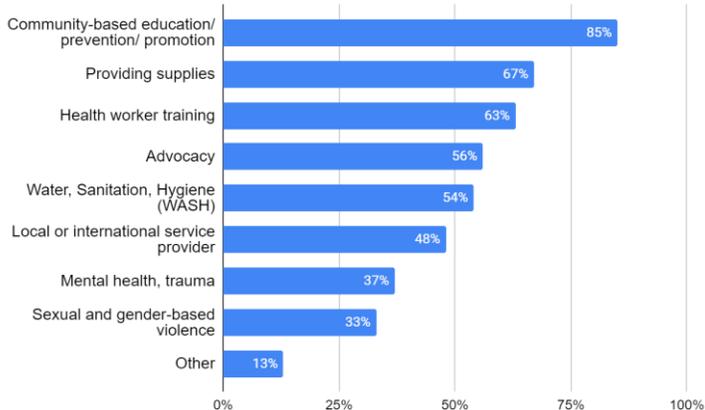
Obstacles and Challenges

Not surprisingly, 90% of participants reported funding as the top obstacle they encounter, followed by supplies/materials (including PPE, treatment, health, and sanitation supplies) at 73%.

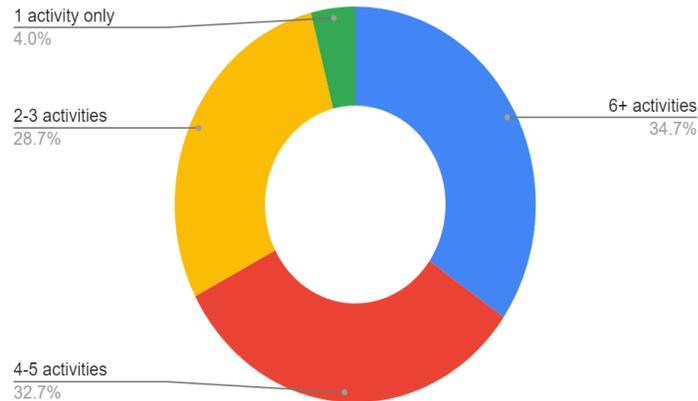
Many respondents noted the need for advocacy and prevention materials, not just technical information. Just over half (56%) of the participants feel they have information or training they could share with others. Some responses noted that some of the greatest obstacles were still unknown, for example, the best ways to access communities and share information without potentially spreading the virus.

A number of respondents were concerned about continuing to serve vulnerable communities while COVID-19 restrictions were in place. For example, how to reach “some elderly people, who are the most vulnerable” and find it “difficult to use mobile app[s] and computer[s].” Some participants also noted that partnerships and collaborations (for example, with other FBOs and Ministries of Health) are a crucial part of the response, but it can also be challenging to establish these partnerships.

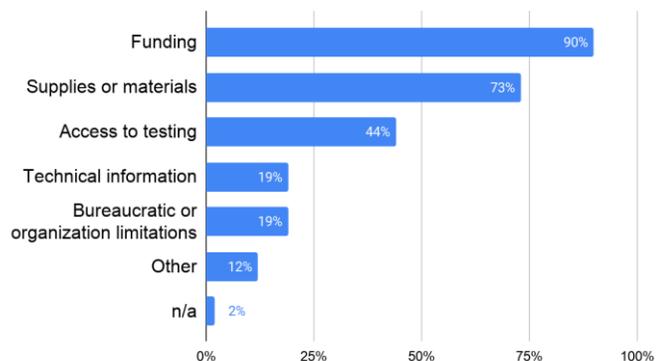
What type of activities are you doing?



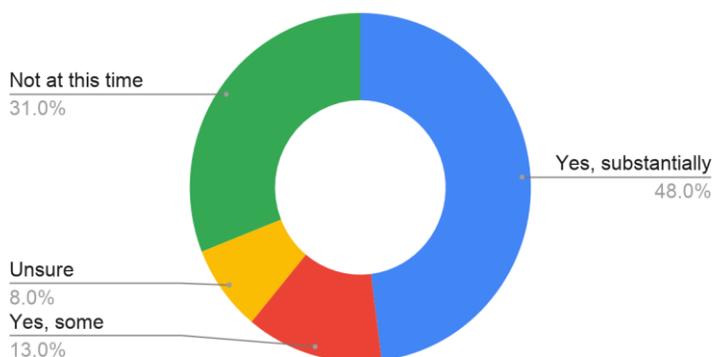
How many activities are you doing now?



What obstacles are you encountering?



Experiencing financial cost from COVID-19 that are not yet met by grants or other support



Overall, 79% of participants are facing increased financial costs from COVID-19 that are not yet met by grants or other support. As a result, 88% report strain on their organization's ability to address other (routine) programs.

Networking and Integration with Religious Leaders

Participants regularly work with religious leaders and faith communities to implement projects. This has not changed with COVID-19, even while efforts have shifted to particularly COVID-19 oriented work. The main way that people work with religious leaders is through education and awareness raising. This includes providing public health messages for religious leaders, translating these messages into local languages, and working with religious leaders to cascade these messages throughout faith communities. In some cases, the provision of public health information is integrated with religious teachings so that the messages are responding to both the medical and spiritual aspects of the crisis.

Methods for spreading public health messages with religious leaders and faith communities include radio, televised prayer, information to small prayer groups, PA systems, phone calls, SMS, and WhatsApp (particularly for connecting with younger people). Topics covered include physical distancing, hygiene, confinement rules, and coping with stigma.

Participants also explained that partnerships and networks between FBOs is important for shared efforts and that linking to relevant health authorities, such as Ministries of Health, is also key. Other, but less frequently mentioned, efforts with religious leaders and faith communities included training for pastoral care for those in and out of hospitals, training for trauma healing and coping with the crisis, and training faith-based health care workers.

Conclusions

The majority of participants are responding, coordinating, and modifying programs to respond to the COVID-19 pandemic. This is not without challenges and those vary depending on program focus and context. Faith-based organizations have critical links to religious leaders and faith communities who can play a central role in helping spread public health messages. They are also starting to help people cope with the crisis through trauma healing and spiritual support.

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