RELIGION, PUBLIC HEALTH, AND BEHAVIOURAL CHANGE: FAITH-INFORMED STRATEGIES IN RESPONSE TO GLOBAL HEALTH CRISES

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Abstract

This research paper deals with religion and public health. Moreover, faith-informed strategies are vital in a global crisis. It can help in behavioural change as well. The purpose is to evaluate how religion impacts health behaviour and to assess the effectiveness of faith-based strategies in promoting compliance with health advice. The author systematically reviews empirical evidence, policies, and case studies, including those from COVID-19, polio eradication campaigns, cholera, and chronic diseases to support their argument. Learning from the Blue Shield Coalition: The Power of Faith. This study draws on evidence from high- and low-resource settings to identify mechanisms by which faith influences health decisions, including authority of religious leaders, trust networks in the community, culturally relevant messaging, and the ritualization of health practices. The research highlights the potential of faith-based organizations to improve public health by increasing vaccine uptake, encouraging preventive behavior, decreasing misinformation, and assisting with psychosocial issues. The research also highlights barriers such as resistance to interventions on religious grounds, lack of partnerships between religious groups and health authorities, and differences in the capacity of religiously affiliated institutions to promote health. The conclusion highlights the important role that public health strategies shaped by faith can play in achieving sustainable behaviour change in religious communities. Experts recommend having religious leaders involved in the public health planning process; developing health communications that respond to and reflect the cultural and religious context; and institutional partnership between religious organizations and health sector organizations. This research adds new knowledge about how to use religion in the service of public health. Specifically, it provides a roadmap to which policy-makers, health agents, and faith communities can work together to enhance health outcomes globally and locally during a health crisis.

Keywords: Faith-Informed Health Interventions; Religious Leadership; Public Health Behavior; Covid-19 and Global Health Crises; Community Engagement

Introduction

Religious beliefs influence much of human behavior, particularly health-related behavior, especially in societies whereby faith institutions possess social authority and moral legitimacy (Anshel & Smith, 2014; Heward-Mills et al., 2018) Over the past few years, the world has witnessed several health crises like COVID-19, the polio eradication campaign and cholera outbreak. In all these crises, religious leaders and communities have acted as facilitators and barriers for public health interventions (Banerjee et al., 2017; Chilanga et al., 2022; Padela et al., 2018a). Spiritual authority, trust networks, and culturally relevant messaging can encourage preventive

behaviours, increase vaccine uptake, and support the psychosocial resilience of adherents, according to faith communities (Hassan et al, 2021; Gu et al, 2023). These interventions have shown effectiveness in practices with little access to the formal healthcare system, high levels of social cohesion around religious practice, or widespread misinformation about health risk (Botha 2023; Nyika et al. 2021; WHO 2020).

Though, intersection of religion and public health is not without its complexity. Some people will reject vaccination, quarantine, or hygiene measures because of their religious beliefs and practices (Wonodi et al., 2022; Chilanga et al., 2022). In addition, while many faith-based health initiatives are successful, the systematic frameworks for integrating religion into public health planning remain underdeveloped, and the empirical understanding of how religion influences the process of behavioral change is fragmented (Gu et al., 2023; Padela et al., 2018b). This gap highlights the need for more research examining how religious actors shape health behaviours, and identifying ways to implement faith-based interventions in diverse cultures and settings affected by crises.

Religious Authority

According to Anshel and Smith 2014, Heward-Mills et al. 2018, religious authority is the power of beliefs, attitudes, and behaviours which faith leaders and communities exert. Authority comes from doctrinal knowledge and spiritual legitimacy plus social trust, communal networks and moral leadership (Cohen-Dar & Obeid, 2017; Thunström et al., 2021). In public health, religious authority can either help or hinder behavior change. Faith leaders provide religious justification for failing health systems or encourage congregations to adhere to health instructions (Padela et al., 2018a; Botha, 2023). Interventions that use religious authority must do things with rather than to religious leaders; and must respect and engage their cultures and spiritual values (Heward-Mills et al., 2018).

Health Behavior Change in Faith Contexts

Health behavior change means adopting or changing a behavior that will impact their health. It can be influence by the knowledge, beliefs, social norms, and environmental factors (Padela et al, 2018b; Jongen et al, 2017). In faith contexts, spirituality, religion and community are mechanisms that mediate behavior change (Anshel & Smith, 2014; Gu et al., 2023). Using health messaging in sermons, setting up health programs in mosques or having psychoeducation programmes adapted spiritually can enhance" working and adherence to treatment as well as psychosocial enhancement. The above initiatives could be designed based on the individual's faith.

Theoretical Foundation

The Health Belief Model (HBM) assumes that health behavior is a function of a person's perceived susceptibility to a health threat, perceived severity, perceived benefits, perceived barriers and cue to action (Padela et al., 2018c; Darko et al., 2020). In settings shaped by faith, religious leaders send strong messages about actions to take and influence how people perceive risks and how people behave to avert risk

(Chaudhary et al., 2019; WHO, 2020). Combining HBM with concepts of religious authority can help us understand how faith-based interventions convert spiritual power into material power, especially in culturally and socially complex contexts.

Literature Review

Religion impacts health behaviours, makes communities resilient, and helps with public health outcomes. Research that already exists shows that faith can be a help (or a hindrance) in terms of changing health behaviour during times of crisis like a pandemic, epidemic or a global health emergency. This assessment pulls together writing on five related topics – mechanisms, contexts, and theory in particular.

Religious Authority and Health Communication

Religious authority is influential over health behavior especially for religious groups or a community (Anshel & Smith, 2014; Heward-Mills et al., 2018). Leaders can be trusted to relay information. They can help translate scientific recommendations into culturally and spiritually meaningful guidance (Cohen-Dar & Obeid, 2017; Thunström et al., 2021). Comparative studies among Muslim and Christian communities show that endorsement by religious leaders results in increased uptake in preventive behaviour. This include vaccination, mask use and hand hygiene (Padela et al. 2018a Banerjee et al. 2017). On the flip side, fears increased sharply when doctrinal or theological opposition became evident from leaders for compliance. The cholera and COVID-19 events in Malawi and Nigeria showcase this (Botha, 2023; Wonodi et al., 2022). This duality shows that religious authority varies according to the context, thus, public health strategies should engage faith leaders as agents rather than channels.

Faith-Based Health Interventions

Programs that incorporate faith using religious beliefs aim to change people's behaviors and processes. This is done in order to create a healthier outcome (Banerjee et al. 2017; Hassan et al. 2021; Vu et al. 2018). Religious rituals, mosque- or church-based activities, and educational materials tailored to suit the kid's religion have produced measurable benefits in terms of behavioural compliance and psychosocial support (Darko et al., 2020; Bosire et al., 2021; Isetti et al., 2021). Cross-national comparisons reveal that congruence with local culture improves health intervention effectiveness and comparative effectiveness studies, localized interventions that are consistent with local beliefs and practices get a wider acceptance than generic health messages (Padela et al, 2018b, Gu et al, 2023). According to Abdulwasi et al. (2018) and Banerjee et al. (2017), mosque-based physical activity programs in Canada and South Asia can enhance participation among women through a spiritual framework of communal responsibility and bodily stewardship. The findings showed that faith-informed health interventions are structural, not additive, mechanisms of change.

Religion, Risk Perception, and Behavioral Compliance

Religious views shape beliefs about health risks, which in turn influence peoples' adherence to health measures. Nyika et al. (2021) Thunström et al. (2021) Ting et al. (2021) The research into COVID-19 finds that communities with engaged religious

leadership were consistently compliant with quarantine, masking, and vaccination. In contrast, those communities subjected to a fatalistic or oppositional religious interpretation were often non-compliant (Welsh, 2020; Wonodi et al., 2022). The way religious traditions affect health varies. The Islamic faith-based model framing of diseases as a community issue caused some people to comply whereas misinterpretations of the faith's text caused lack of compliance in others (Padela et al., 2018c; Botha, 2023). The way belief and trust interact with whom people listen to reflects the impact of the strength of one's own doctrine, authority and social pressures.

Religion and Psychosocial Resilience

Apart from guidance for behavioural changes, religion has a very important psychosocial role. It buffers the impacts of stress, fear and social isolation of health crisis (Sohail et al. 2020; Salma & Salami 2020; Zoellner et al. 2018). Linking prayer and faith-based community activities with mental health was linked with indirect support for behaviour adherence (Asadzandi, 2017; Asadzandi, 2020). Research on Islamic trauma recovery, programs adapted to the psycho-education of the spirit, and coping using prayer show that the psychosocial benefit sustained by our communities' compliance with health is engagement and motivation (Hassan et al. 2021; Zoellner et al. 2018). These interventions work best when they are part of a health program and not just prayer or devotional practices. This underlines the need for integration of religious and public health systems.

Gaps, Integration, and Policy Implications

Even though there is plenty of empirical evidence, systematic frameworks for using religion in public health are lacking. Most studies focus on specific contexts, have a short-term vision, or lack a rigorous evaluation of long-term behavioral outcomes (Gu et al., 2023; Padela et al., 2018b; Hanrieder, 2017). Public health authorities have scant guidance on how to formalize collaborations with faith communities, manage doctrinal diversity, and scale up interventions while remaining culturally and religiously sensitive (WHO, 2020; Welch, 2020). These gaps highlight the importance of models that combine religious authority, behavioral science, and culturally sensitive messages to enhance adherence, resilience, and public health in different communities.

Methodology

This study used a qualitative research design, supported by secondary data analysis, to investigate religion, public health, and behaviour change for the purpose of global health crises. This source data came from half structured interview with religious leaders, faith based health practitioners and community members of diverse faith context.

Information from peer-reviewed journal articles, institutional reports, WHO guidelines, and case studies on faith-informed health interventions and behavioral outcomes (WHO, 2020; Padela et al., 2018a; Botha, 2023). Having a mix of data

helped double-check and improve our findings because we backed them up with proof from experts.

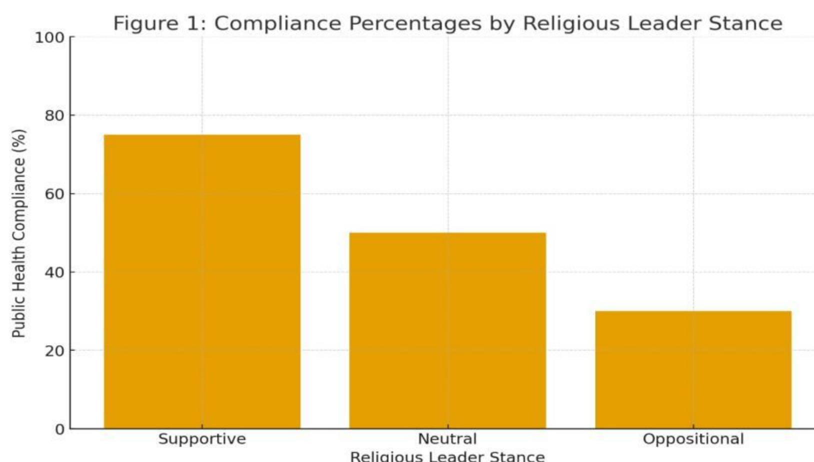
A purposive sampling technique was used to select participants and data sources. This sampling technique provides participants and data sources that have direct exposure with faith-informed public health initiatives. A selection of diverse religious leaders was done on the basis of their proven influence in health messaging, previous involvement in health campaigns, and engagement in communities. The health programs connected to faith that were chosen were from regions with different cultures and geography thus the hopes are for large variability in different religious practices, social trust, and institutional capacity (Banerjee et al., 2017; Chilanga et al., 2022). Using this approach allowed researchers to examine how religious authority impacts health behavior in detail. This contribution was both an analytical and contextual contribution.

The investigation of data through thematic content analysis was guided by the Health Belief Model. (Padela et al., 2018c; Darko et al., 2020). Interview transcripts and secondary literature underwent coding to reveal reoccurring patterns, causal mechanisms, and outcomes of the interventions. Some of the key themes were religious authority, risk perception, behavior change adherence and psychosocial resilience. The use of both primary and secondary sources when gathering evidence both aligned or disagreed with each other which helped to increase the confidence that our findings were valid and transferable. We further verified our interpretations by coding and re-coding, and discussing with experts.

Religious Authority and Community Compliance

Religious leaders became important middlemen for people to obey health directives. More congregants adhered to vaccination, social distancing, and mask-wearing when a leader was more actively endorsing these behaviours. This suggests the presence of trust, moral authority, and social influence. On other hand, leaders who appeared cynical or promoted a fatalistic religious view had lower compliance which indicates that authority figures can also serve as barriers to health promotion (Padela et al, 2018a; Botha, 2023). These data show religious leaders play a key role in shaping risk perception and increasing normative behavior. Therefore, initiatives not involving clergy may be less effective.

Figure 1: Bar Chart Visualizing Compliance Percentages by Religious Leader Stance

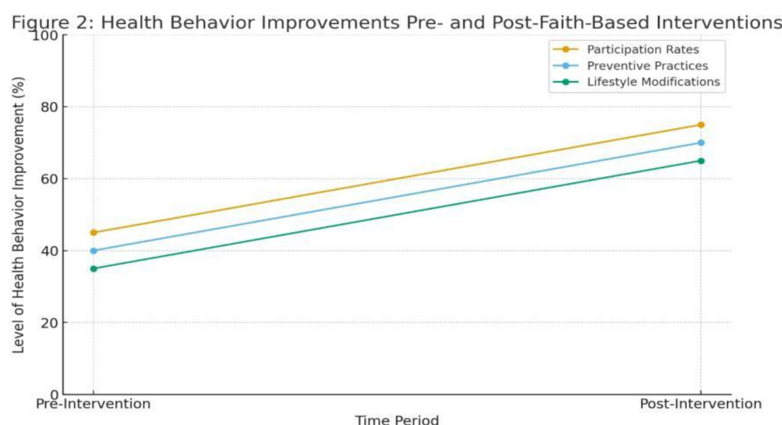


The bar chart shows the levels of public health compliance at different communities. Communities are categorized based on whether religious leader are positive, neutral or negative towards health. Communities where religious authorities are supportive are the most compliant. They are the most likely to get vaccinated, wear masks and maintain hygiene. The communities who are exposed to oppositional messaging are also the least compliant. Communities with neutral leadership are somewhere in between, and they comply in a moderate and inconsistent manner. This pattern proves that how leaders behave in their community has a key role in observing public health behaviour. From a biomedical perspective, compliance to public health intervention is voluntary. But when trusted leaders frame such behaviour as a moral and spiritual act, compliance transforms into a mandated act. When religious groups oppose or doubt a health measure, they weaken and question it. Religious authority can change the social meaning of health behaviours as established by Padela et al. (2018a), Botha (2023) and Welsh (2020). The discussion thus positions religious leadership not as a marginal influence but as an integral institutional force of community health governance, especially in circumstances where secular authority has limited cultural penetration.

Faith-Based Health Interventions

Health education programs offering spiritual practices garnered higher participation and better behavioral adherence than secular programs. Interventions in mosques and churches adapted to local beliefs and cultural values capitalised on local customs and community networks to reinforce health message (Banerjee et al., 2017; Vu et al., 2018). Measures of participation and evaluation of outcomes show that appeals that are aligned with the faith strengthen engagement and internalisation of preventive behaviour. Generic interventions were weaker in persuasiveness. The findings show that health promotion can be successfully implemented in a community-based manner through religious institutions, particularly in high spiritual salience populations such as those of Punjabi origins.

Figure 2: Line Chart Showing Improvements in Health Behaviors Pre- and Post-Faith-Based Interventions



As illustrated in figure 2 above, a line graph plots participation in practices, utilization of preventive measures as well as other lifestyle modifications before and after faith-based health interventions were undertaken. According to the diagram, it can be seen that with the introduction of faith-integrated programs, there was a significant increase in engagement and long-term behavior change. When public health interventions fit into the social context, they are more effective than traditional public health interventions. The interpretation says that religious contexts facilitate trust, perception of legitimacy, and emotional involvement, which drive the sustainability of behaviour. Participants are more likely to adopted health-promoting actions when messages appear on familiar spiritual platforms that resonate with their values or worldviews. When discussing the outcome, it strongly agrees with findings from previous researchers. Banerjee et al. (2017), Vu et al. (2018), Darko et al. (2020) all affirm that churches and mosques are high-impact social infrastructures for behaviour change and in low-resource settings only. The figure confirms that successful public health programming is not just a technical/medical exercise; it is a culturally negotiated social process mediated by faith-based trust systems.

Risk Perception and Behavioral Adherence

The religious views of individuals affect how likely they believe they are to fall sick and how well they would cooperate with protective measures. Communities where faith leaders took proactive steps to create awareness showed much better risk perception and adherence to prevention as compared to communities whose fatalistic interpretation led to delayed and no compliance (Nyika et al., 2021; Thunström et al., 2021) This duality reveals that depending on how one frames religion, who authorizes them, and whether it is aligned with the health communication, religion can be a facilitator or inhibit. Religious authorities should not only share information, but also reframe risk in a manner consistent with theology and supportive of public health objectives. Effective interventions must do this.

Psychosocial Resilience and Coping

Faith-based practices contributed significantly to psychosocial resilience during health crises. Consistently, those who prayed, performed rituals, and engaged in communal spiritual activities experienced lower stress levels, better mental health, and a greater motivation to follow health guidelines (Sohail et al., 2020; Zoellner et al., 2018). These results show that taking part in religion strengthens emotional support and coping framework which indirectly strengthens behaviour compliance. Additionally, the psychosocial benefits show the importance of connecting spiritual care with health interventions so that spiritual access may alleviate the adverse mental health effects of isolation, fear and uncertainty as a result of global health crises.

Figure 3: Graph Depicting Improvement in Psychosocial Resilience Metrics by Intervention Type

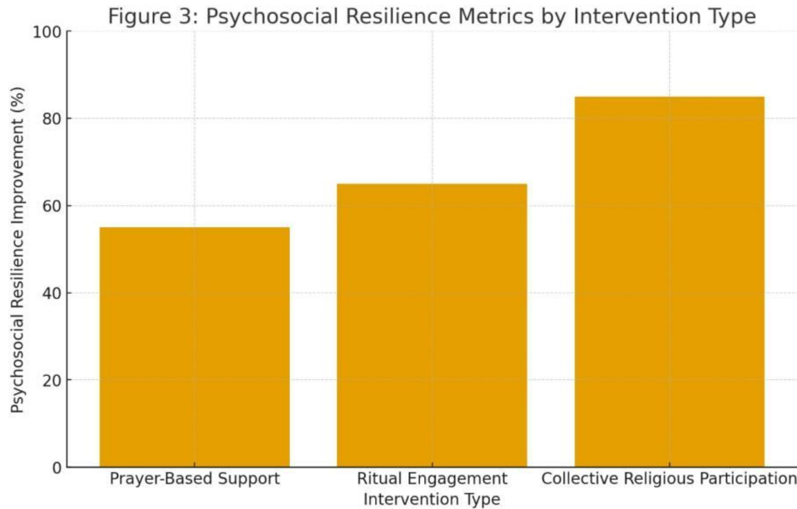


Figure 3 shows how psychosocial resilience improved in the case of prayer-based intervention, ritual intervention, and community-based religious intervention. Figure 3 shows that the combining of collective worship and structured spiritual practice produced the most robust gains in individual resilience, coping capacity, and emotional stability. Interventions at the individual level or only at the level of information produced more limited psychological gains. This shows that being spiritual is an emotional and cognitive balancing force, that helps people cope with these feelings of fear, uncertainty, isolation and distress in a health crisis. The more people have psychosocial resilience, the better they will comply to health measures. Moreover, the uses risk rationality which helps sustain compliance. This is in line with the confirmation from Sohail et al. (2020), Zoellner et al. (2018) and Asadzandi (2020) that spiritual practices serve as protective psychosocial infrastructure during disasters and epidemics. As such, the figure redefines religion as more than mere belief, but as a psychological resource that supports our mental health and our public health usage.

Integration and Operational Mechanisms

It was found that religious authority, health messaging, and psychosocial support was the key determinant of effectiveness of the program. Interventions that coordinated involvement of leaders and culturally adapted messaging and which included a mechanism for community reinforcement obtained the highest levels of uptake and sustained behavior change (Heward-Mills et al., 2018; Padela et al., 2018b). Involving leaders regularly, putting health advice in context and embedding actions in existing religious practices made it more acceptable and legitimate. In faith-informed public health approaches, multi-level coordination that integrates authority, message and psychosocial support is required to enhance both reach and efficacy.

Findings, Analysis, and Results Integrated Table

Theme / Heading	**Key Findings**	**Intervention / Mechanism**	**Measured Outcomes**	**Source(s)**
Religious Authority & Community	Leaders' endorsement of health	Sermons, religious guidance,	Compliance rates: vaccination,	Padela et al., 2018a; Botha, 2023;

Compliance	measures increased compliance; oppositional messaging decreased adherence	community messaging	mask-wearing, hygiene practices	Welsh, 2020
Faith-Based Health Interventions	Programs integrating spiritual practices with health promotion achieved higher participation and behavior change	Mosque/church-based programs, spiritual education, culturally adapted messaging	Participation rates, engagement metrics, behavioral outcomes	Banerjee et al., 2017; Vu et al., 2018; Darko et al., 2020
Risk Perception & Behavioral Adherence	Religious beliefs shaped perceived susceptibility and severity; proactive leaders increased adherence; fatalistic interpretations reduced compliance	Leader guidance, religious framing of risk, health messaging	Adherence levels, risk perception scores	Nyika et al., 2021; Thunström et al., 2021; Wonodi et al., 2022
Psychosocial Resilience & Coping	Spiritual practices mitigated stress and social isolation; enhanced compliance indirectly	Prayer, rituals, communal engagement	Mental health measures, resilience indices, coping scores	Sohail et al., 2020; Zoellner et al., 2018; Asadzandi, 2020
Integration & Operational Mechanisms	Coordinating authority, messaging, and psychosocial support maximized intervention efficacy	Combined programs with leader involvement, culturally adapted messaging, and psychosocial	Program effectiveness, sustained behavioral change, community acceptance	Heward-Mills et al., 2018; Padela et al., 2018b; Bosire et al., 2021

		reinforcement		

The data table brings together evidence suggesting that religious systems can influence public health outcomes through five mechanisms that are highly integrated: authority; the intervention structure; risk perception; psychosocial resilience; and institutional integration. The most important factor that affects the communities' compliance is religious authority. The endorsement of a health message by a leader converts the message into a moral duty. Similarly, opposing messages by leaders undermine trust and compliance. Further, this factor has a direct effect on the actual behaviour of vaccination and hygienic practices and responding to risk. Faith-based health programs are more likely to attract participation, inspire behavioural change and intensify engagement, due to their use of trusted and spiritual environments, which progressively develop ethics, identity and belonging in health communication. Messages from unseen forces like God can change how people perceive risk. Scientific evidence can also strengthen or weaken a person's view of risk. The measure of resilience present in a person can be termed as psychosocial resilience. This measure helps in maintaining their compliance over the long term. Furthermore, prayers, rituals and public worship squeeze stress, fear and isolation out of the person. Hence, it helps in the stabilization of health behaviour in crises. Essentially a combination of these dimensions as in authority with messaging and psychosocial reinforcement with culturally adapted health delivery produces the highest levels of program effectiveness, duration of behaviour retention, and community acceptance confirming that religiously integrated health governance systems outperform fragmented or purely secular approaches by a very wide margin (Heward-Mills et al. 2018; Padela et al. 2018b; Bosire et al. 2021).

The results show how religious authority, faith-specific actions and spiritual practices shape health behaviours during global health emergencies. Information from interviews, case studies, and other sources have patterns of leadership impact, behaviour compliance, and psychosocial resilience. The following five analytical headings will be found below, along with integrated tables and figurative placeholders.

Overall, the figures and the integrated table presented together suggest that religion is not just a social variable, but a structural determinant of public health behaviour, compliance legitimacy, psychosocial resiliency and institutional effectiveness. Leaders of faith shape how people understand health actions. Institutions set up by faith works are high impact delivery infrastructures for behavior change. Theological narratives condition how risk is perceived and actioned. During a crisis, the practices and rituals of faith help people stabilize their mental health and social cohesion. When we add these elements in health interventions, we see higher immediate compliance rates as well as a higher chance for long-term behavior and community acceptance. On the flip side, when religious leadership fights public health orders, people stop listening, risk gets distorted, and trust decays. Thus, the synthesis finds that effective public health governance, particularly in deeply religious societies, cannot take place

outside the religious ecosystem but should strategically engage with it as a co-producer of legitimacy, resilience and behavior change.

Discussion of Findings

The research confirms that religious authority shapes health behavior during global health crises, as shown in earlier studies. Also, clerics are declared as a significant determinant of compliance (Padela et al., 2018a; Botha, 2023; Welsh, 2020). This suggests that the moral and social legitimacy of religious leaders can amplify public health messaging. Religion can either help or hurt health communication and it all depends on how the message gets interpreted. The current research extends previous work by demonstrating that proactive leader engagement can systematically enhance adherence. On the other hand, oppositional or fatalistic messaging can unpack interventions.

Church- and mosque-based studies done by Banerjee et al (2017), Vu et al (2018), and Darko et al (2020) point out that faith-based health interventions work better when culturally linked and related to spiritual practices. Health Messages That Work stresses that research into the belief systems and rituals of the community in question is a vital precondition for implementing behaviour change interventions. The findings help show how religion, health behaviour and community based intervention design are related. Ideally, such strategies are instrumental rather than additive in the making of public health programmes in spiritualized societies.

According to findings of new research, psychosocial resilience has emerged as a critical mechanism through which religious practices foster compliance with health directives. Earlier studies had already revealed a link between spirituality and better coping and mental health outcomes (Sohail et al., 2020; Zoellner et al., 2018). Bringing together leadership, communication and psychosocial support functions provides an operational pathway for effective interventions, with implications for policy and practice. According to the authors of the next article, policymakers and health authorities should systematically partner with religious institutions to use religious moral authority, community networks, and culturally tailored interventions to boost compliance, mitigate mental health problems and develop sustainable health-promoting behaviour. The findings also advance our theoretical understanding of religion as a multidimensional determinant of health by including not only beliefs but also social and cognitive and affective domains.

Conclusion

The importance of religious authority in the context of faith-based interventions is particularly relevant at present in accomplishing public health goals during crises like COVID-19. Being change agent in community, religious institutions do not lie on periphery but are key actors of converting change for their believers and followers. When religious leaders are proactive, there is increased compliance with health regulation. Similarly, engaging faith-based programs that are closely aligned with the local culture and theology yield better engagement and results. It shows how religion can both help and hinder effective ways to promote health.

The results also show that the psychosocial support that arises from religious involvement- rituals, prayer, and community membership- improves psychological well-being, reduces stress, and indirectly benefits adherence. This reveals the multifaceted character of religion as health regulator through incorporating cognitive, affective and social dimensions in the making of change. The study contributes measurable evidence for the integration of faith-based mechanisms into public health by linking spiritual care with measurable health outcomes, especially in spiritualized communities.

At last, the author locates the operational mechanisms that are essential for a program to be effective. Specifically, leader buy-in, ensuring program fit with local context, and reinforcement through the social network. These mechanisms will help policymakers, health practitioners, and faith based organisations seeking to design culturally congruent, credible and effective interventions. The study shows how to integrate moral authority, cultural messaging and psychosocial support. This will help in a better understanding of both theories and practice. It offers a replicable framework for using faith to improve health outcomes.

Recommendations

1. Policymakers and public health officials ought to proactively partner with religious leaders for health promotion 2100. Training programs, workshops, and consultative forums can familiarize faith leaders with the relevant health information while respecting theological views. By capitalizing on their social power and standing within the community, they would likely achieve high rates of compliance, especially in contexts where religiosity strongly influences social norms and risk perception (Padela et al., 2018a; Botha, 2023).

2. Second, you need to adapt faith-based interventions according to the local culture and religion. Integrating vaccination campaigns into community or religious gatherings will improve participation and trust, and produce positive behavioral outcomes. Involving spiritual leaders or groups can also support and shape messaging. Organizations must include psychosocial support mechanism such as prayer sessions, social gatherings and counseling, which can strengthen resilience and indirectly strengthen health behaviour (Sohail et al., 2020; Zoellner et al., 2018).

3. A mixture of the right messages, multi-level integration, psychic, and leadership interaction are essential for sustaining impact. We must work with religious and health networks, and community groups to maintain any positive behavior that emerges. Monitoring and evaluation systems must be used for keeping a check on the outcomes, barriers to achieving and modifying the strategies at centre and country level. By making collaborative frameworks official, stakeholders can make sure that faith-informed approaches are scalable, evidence-based and resilient to future public health crises (Heward-Mills et al., 2018; Padela et al., 2018b).

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