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ORIGINAL PAPER

Religious Leaders' Perspectives on Rural Communities' Responses During the COVID-19 Pandemic in the USA

Daniel A. Hopgood[1] · **Kendrah Cunningham**[2] · **Ilana R. Azulay Chertok**[1]

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Abstract

The COVID-19 pandemic posed risks to the health and wellness of individuals and communities. Qualitative interviews based on the health belief model were conducted to gain insight into the perspectives of 17 leaders serving in rural Christian, Catholic, Jewish, and Muslim communities in the USA regarding their communities' responses during the pandemic. Nine themes emerged from the narrative data using phenomenological thematic analysis: *Some people are more susceptible, Test of faith, Fear and anxiety, Staying connected, Will people follow the protocols? Science and faith can co-exist*, *Responsibility to self and others, We've had to adjust,* and *We've had to dispense of that.* The religious leaders provided support and hope, adapted religious and social activities, and used faith and religious tenets as foundational principles to encourage compliance with health recommendations.

Keywords COVID-19 · Religious leaders · Rural communities · Health belief model

Introduction

The SARS COV-2 pandemic required mitigation effort and responses at the national, local, and individual levels. In March of 2020, there was uncertainty surrounding the viral mechanism of transmission, susceptibility of individuals to infection, severity of disease, and necessary preventative measures. Religious communities experienced disruptions due to lockdowns and the requirement for social distancing with suspension of in-person services and socialization. Yet, many people needed their religious anchors as they sought comfort and stability during unprecedented times thereby turning to their religious leaders and communities as sources of support and guidance from health agencies (World Health Organization, 2020).

✉ Ilana R. Azulay Chertok
chertok@ohio.edu

[1] School of Nursing, Ohio University, Athens, OH 45701, USA

[2] School of Nursing, Liberty University, Lynchburg, VA, USA

Following public health orders and recommendations restricting public gatherings, many religious leaders and communities paused or adapted core interpersonal activities and limited public events to mitigate the spread of COVID-19. Recognizing that religious services and gatherings raised concern about the possible risk of viral transmission (Quadri, 2020), religious leaders and communities supplanted in-person services and interactions with online video conferencing and telephone outreach (Ge et al., 2021; Shelton et al., 2021) along with other mitigation efforts. Given the prominent aspect that religion plays in many rural communities in the USA, it is important to understand the challenges, processes, and developments that religious leaders and their communities encountered. The purpose of this research was to describe the experiences of religious leaders serving in rural communities in the USA.

Methods

Design

A qualitative study was conducted using a descriptive phenomenology design and Colaizzi's phenomenological thematic analysis and interpretation of the data (Colaizzi, 1978). Religious leaders of different faiths were interviewed regarding their communities' responses, management, and adaptation during the COVID-19 pandemic. Questions used were based on constructs from the Health Belief Model to provide a framework explaining behaviors related to preventing and managing disease (Champion & Skinner, 2008).

Setting and Sample

Institutional review board approval was obtained through the researchers' institution. Participants were recruited through social media, email, and referral and continued until reaching saturation wherein similar themes were repeated. Participants were included if they were religious leaders serving a rural population in the USA during the COVID-19 pandemic, were over age 18, and were fluent in English. After the participant expressed interest in and consented to participate, an interview was scheduled via phone or video conference.

A demographics survey was administered followed by a semi-structured audio recorded interview. Recordings were uploaded to a confidential transcription service. Transcripts were checked against the audio recording for accuracy and identifiers were removed from the transcripts. Data were stored on a password protected server.

Data Analysis

Qualitative data were analyzed using Colaizzi's phenomenological thematic analysis process including the reading of each transcript by at least two investigators to gain general understanding of participants' experiences followed by independent

coding (Colaizzi, 1978). Statements made by participants that appeared significant were highlighted in the transcripts, compiled into a list of significant statements, and linked to similar statements leading to a proposed meaning. Meanings were organized into themes through interpretation with supporting exemplars under each theme, consistent with the constructs of the Health Belief Model (Champion & Skinner, 2008). Using NVivo software (version 12) to apply the created coding schema, themes were assembled and described in structured format allowing for interrelating factors to explain the participant experiences.

Trustworthiness of Data

Trustworthiness was ensured through Sandelowski's (1986) criteria of credibility, transferability, dependability, and confirmability, with dependability verified through data analysis following the Colaizzi method (Lincoln & Guba, 1985). Member checking was performed through verifying the researchers' interpretation with two participants who reviewed the categories. coding, and themes (Lincoln & Guba, 1985). If participants suggested a change, a note was made and it was considered for incorporation. Transferability was assessed with the selected participants to determine if what was described was credible and to confirm that the narrative explanation and defined themes were resonant and familiar, thereby ensuring credibility (Sandelowski, 1986).

Results

A total of 17 participants were interviewed: 7 Christian Protestant leaders, 2 Catholic leaders, 6 Jewish leaders, and 2 Muslim leaders (Table 1). Nine themes emerged which were categorized under the corresponding constructs of the Health Belief Model: Perceived susceptibility: *Some people are more susceptible;* Perceived severity: *Test of faith; Fear and anxiety;* Perceived benefits and barriers: *Staying connected, Will people follow the protocols? Science and faith can co-exist;* and, Cues to action: *Responsibility to self and others, We've had to adjust, We've had to dispense of that* (Table 2).

Perceived Susceptibility

Some People are More Susceptible

Religious leaders recognized the importance of taking the measures necessary to protect their community members from contracting COVID-19, particularly vulnerable populations. In general, religious services were adapted in compliance with pandemic guidelines to protect community members, with special considerations and care for older and immunocompromised members as stated by one leader, "We've taken seriously the idea… also the importance of preserving human life…to

Table 1 Participant demographic characteristics ($n = 17$)

Characteristics	% (*n*)
Age in years (mean)	48.6 (range 26–71)
Sex	
Male	64.7% (11)
Female	35.3% (6)
Marital status	
Married	88.2% (15)
Not married	11.8% (2)
Parity (median)	2 (range 0–4)
Highest level of education	
Undergraduate	23.5% (4)
Graduate	76.5% (13)
Religious affiliation [*participant number*]	
Protestant (1, 2, 3, 4, 11, 12, 16)	41.1% (7)
Catholic (6, 14)	11.8% (2)
Jewish (4, 5, 9, 10, 13, 15)	35.3% (6)
Muslim (8, 17)	11.8% (2)

Table 2 Themes that emerged from the narratives corresponding to the Health Belief Model constructs

Health Belief Model Constructs	Themes
Perceived susceptibility	Some people are more susceptible
Perceived severity	Test of faith Fear and anxiety
Perceived benefits and barriers	Staying connected Will people follow the protocols? Science and faith can co-exist
Cues to action	Responsibility to self and others We've had to adjust We've had to dispense of that

protect our vulnerable population…" (Jones et al., 2021) Another leader mentioned that "most of my members are retired… so they wear a mask and take all precautions necessary while they're at work… they stay in except for doing grocery shopping, and they try to do that during the time when it's for those who… have health issues… they're more susceptible." (Champion & Skinner, 2008).

Religious leaders demonstrated promotion of health and safety behaviors to their communities to protect people who are susceptible. "A gift came to me today thanks to the incredible folks of [health care organization]… the COVID-19 vaccine. With the immune-compromised medication I'm on, I wanted to get the vaccine as soon as possible. I didn't want to take it away from the more deserving folks, but when [health care organization]… emphasized how important it would be for me as a member of the clergy to both promote its safety and also provide good press to encourage folks in our area to sign up, I didn't hesitate." (Jones et al., 2021) The

leader continued, "I said, 'Get the vaccine when it becomes available. It's safe. Continue to mask up. Hand-wash. Social distance. Those became the mantra in our community…" (Jones et al., 2021) Some leaders affirmed their belief in recommendations from health professionals, saying that in addition to God's intervention, "it's science, and I think that we need to listen to doctors and scientists." (Hallgren et al., 2021).

Perceived Severity

Test of Faith

Leaders were concerned with the physical, emotional, and spiritual welfare of their community members in response to the pandemic, "We know [COVID-19] is dangerous, it's tragic what could happen, and therefore… the question is… not 'Why do bad things happen?' But, when bad things happen, what is the [religious] response to that?" (Jones et al., 2021) The religious leaders felt they filled a critical role in guiding their communities as there were people who experienced a crisis of faith during the pandemic.

Various religious leaders opined that the COVID-19 pandemic was a message or test from God, as "maybe we have drifted so far from where [God] wanted us to be" (Kowalczyk et al., 2020), that people must affirm that "everything is up to God" (Goris et al., 2015), and that God "will judge our response… [whether] people take care of themselves and help others." (Privor-Dumm & King, 2020) The concept of the pandemic being a test was compared by some leaders to experiences of historical, religious figures who demonstrated their steadfast faith, "We're all being put to the test all the time. How are we going to deal with life threatening challenges and with moral dilemmas? It's bound to be painful, but we have to proceed with compassion… for those in need, and those in danger, and ourselves." (DeMora et al., 2021).

Fear and Anxiety

Religious leaders recognized that fear and anxiety increased among their community members during the COVID pandemic. The pandemic triggered feelings of "fear, frustration… and the reality that people are sick." (Kowalczyk et al., 2020) Leaders felt that part of their role was providing spiritual guidance, "not letting fear overcome us" (Champion & Skinner, 2008), doing "the best we can to stick together as a community" (DeMora et al., 2021), and promoting adoption of safety measures to alleviate uneasiness and reduce risk in the community. An approach taken by religious leaders to mitigate fears was to rely on their religious values, as expressed, "We're just going to trust God that He's going to take care of us. Walk by faith." (Kowalczyk et al., 2020).

When faced with tragedy, people often ask their leaders, "Where was God?… The simple answer is [that] He is everywhere… in the midst of the pandemic." (Kowalczyk et al., 2020) The leaders felt that people were heartened to recall that

"regardless of what you're going through, God is present, God is present with you in your joy and in your suffering… the confidence that God's there regardless… helps overcome a lot of the fear and anxiety." (Colaizzi et al., 1978).

One of the several challenges faced by leaders were the differences in opinions among their community members, "Some people wanted to close everything down, and other people wanted… to be a little more careful, a little more socially distanced… there were differences of opinion and different levels of anxiety." (El-Majzoub et al., 2021) These differences challenged the implementation of measures to keep the communities safe, finding that "the mask mandate was more divisive than… the virus." (Kowalczyk et al., 2020) The leaders felt encumbered, as expressed by one participant, "my stress level has never been higher. The human body is not designed to be in crisis mode for months on end… it's getting to all of us." (Hallgren et al., 2021).

Perceived Benefits and Barriers

Staying Connected

Religious leaders of the different faiths spoke about the importance of communal unity and caring for others, "we're all in this together and everyone has a part to play to try within their ability to make things better." (Goris et al., 2015) They were challenged to keep the community together during the COVID-19 pandemic when regulations restricted communal gatherings, as represented by a leader's description, "it's disrupted [the community]… to really worship and to practice our faith, a big part… is community." (Muravsky et al., 2023) For many leaders, the physical disconnect from the place of worship was theologically, communally, and socially disconcerting. Leaders from different communities described the physical distancing as "very disruptive… we are a very close-knit congregation and we miss the socialization," (Champion & Skinner, 2008) and that the restrictions "disrupted our fellowship and community feel." (Muravsky et al., 2023).

To mitigate the isolation associated with the restrictions, religious leaders and their community members reached out to community members and arranged virtual meetings and services, with particular attention to older adults who lived alone, "it kept everybody safe and connected at the same time." (Monson et al., 2021) Similarly, to address spiritual needs, religious leaders offered online prayer services and study groups. To maintain communication despite the interrupted gatherings, a leader and his members "shifted gears to figure out… how [to] help and minister to people and encourage people through this crisis" by teaching use of video conferencing and other online tools.

Some of the religious leaders personally felt like their role was critical to their community members' emotional and spiritual stability during the pandemic, as expressed by one leader, "They could reach out to me and I felt like I was a lifeline. I gave them hope." (Champion & Skinner, 2008) They understood that, "There's so many people that need me to be a rallying point and need me to be super strong and need me to be a guiding light, and I am willing to do for everyone that needs me." (Hallgren et al., 2021) The leaders availed themselves to their community members,

delivered messages of hope and prayer, maintained constant communication, and provided practical guidance.

There was concern for the families of those who were infected. A religious leader organized the community network to address potential issues, "The first response would be how do we support their family… Do they need to be isolated…? Does their family need to be separated from them? Do we need to find a place for their family to stay while that person recovers? Do they have the resources that they need to stay healthy while they combat COVID?" (Hallgren et al., 2021) Leaders regretted that they could not visit the sick and could not comfort the grieving, "I think the hardest part… for somebody who contracted [COVID-19]… that we're not allowed to visit them. And, when… someone had passed on, because of COVID restrictions… we can't be with them at their time of need." (Jones et al., 2021).

There was a sense of religious responsibility in the care and concern for community members, with one leader stating that the outbreak inspired, "compassion and greater outreach to our sick and infirmed sisters and brothers." (Funk et al., 2015) The leaders perceived positive aspects of the community's alternate methods of connecting during the pandemic such as "wonderful people send cards and phone calls to those they haven't talked to in a while… reaching out to people and creating a care team… that's something we're going to continue… a lot of great things going on from it." (Muravsky et al., 2023) This idea was supported by other leaders who explained that people should be caring for each other as a way to show faith and to live "from our heart… [to] spur us on to compassion and greater outreach" (Funk et al., 2015) and concerned with doing "the right thing." (Goris et al., 2015).

Will People Follow the Protocols?

Religious leaders described their communities' acceptance, compliance with, and adherence to COVID-19 guidelines in light of political and social beliefs, weariness, or confusion. They also related their own perceived difficulty with being positioned between government and public health requirements, the reality of the pandemic, and individual beliefs and opinions. As one religious leader expressed about the dissonance, it "is not just over the virus itself, but then you got… some who say, "Wait a minute. Government's not going to tell me anything to do." But on the other hand, we've got this potential health crisis." (Kowalczyk et al., 2020) The changes or inconsistencies in recommendations caused people to be confused and frustrated, with some losing trust and confidence in the recommendations, as there was a "lot of conflicting communications" with "we were told one thing… and then the next it was… changed." (Champion & Skinner, 2008).

Some of the leaders found that following recommendations became divisive, particularly as people "had become frustrated over the mask issue" (Champion & Skinner, 2008) to the point that "the mask mandate was more divisive than the virus." (Kowalczyk et al., 2020) Even if leaders wanted their community members to wear masks out of respect to others and safety, they were uncertain or conflicted about how to respond to those who refused. Some leaders shared that while their community members were compliant with recommendations in the religious setting, there was more laxity in the

broader community. Even when there was dissent regarding guidelines, one leader described his relief when he "see[s] everyone wearing a mask… [even] those people who disagree, they're wearing it, that makes me proud." (Funk et al., 2015).

Science and Faith can Co-exist

Religious leaders perceived that being connected to "faith gives an inner strength, a strength of relying on a higher being," (Champion & Skinner, 2008) affording community members a lifeline, for spiritual and emotional support during the pandemic. In general, faith was seen as an elevated concept, as "deeper than religion." (Funk et al., 2015) Yet, religious leaders of different faiths spoke of the integration of "science and religion… [as] we follow the traditions" (Jones et al., 2021) and the interlacing between "science and faith…[which] exist in the same space… [so] follow the science… [and] have faith…" (Meyer et al., 2022) One religious leader explained the connection between faith and science, using illness as an example of the relationship, "Science and faith can co-exist with each other and do within our faith community… unfortunately people get sick, and when they do, God is in that moment as much as he is when they're healthy." (Meyer et al., 2022).

The concept of the coexistence of faith and science was expressed by leaders of the various religions in other ways, that "divine wisdom would be to listen to the people who actually have the expertise" (Colaizzi et al., 1978), to "follow the guidelines, what the health officials tell you that you isolate yourself [when infected]," (Champion & Skinner, 2008) and that "God has given to those in the medical profession the ability to think and reason and design incredible systems and medicines… to heal people." (Kowalczyk et al., 2020) A religious leader affirmed the approach, "it's not, 'God will protect us,' [rather,] how do we protect ourselves?" (Jones et al., 2021).

In answer to community members who ask about miracles during the pandemic, one religious leader explained that while there is the belief "that God can miraculously intervene… I don't think He does all the time." (Funk et al., 2015) Following health precautions was viewed as complementary to prayer and faith, as expressed that "you still have to do your part." (Goris et al., 2015) The complementary relationship between faith and following health recommendations was explained as, "God has given us… means and ways of protection… we have to both put on the spiritual armor of God and… sometimes physical armor of God." (Lincoln & Guba, 1985) An analogy was presented to explain the complex relationship, "I wear my seatbelt every day and I know that God will protect me and I know that I have enough faith to believe that God is with me always, but I also wear my seatbelt." (Lincoln & Guba, 1985).

Cues to Action

Responsibility to Self and to Others

The religious leaders shared their perceived overall sense of responsibility and the demonstration of responsibility among their community members, "we see it as our

responsibility to our neighbor, out of care and love." (Muravsky et al., 2023) They used principles of faith to support protocols that reduced the risk of viral transmission, "What I am doing by wearing a mask is protecting someone else. I am literally saving a life… mask-wearing, it's not just a good deed, but actually it's a requirement by [religious] tradition… to save lives, that's a priority for us… in [religious] tradition, there's an idea of 'preserving life'… a universal principal in all denominations." (Jones et al., 2021).

The leaders promoted measures to mitigate transmission of the virus, as described, "We've taken seriously the idea of following the science and also the importance of people preserving human life." (Jones et al., 2021) The recommended guidelines that were practiced included physical distancing, offering online prayers and services, food and medication deliveries, wearing masks in public, practicing hand hygiene, quarantining when infected, and promoting vaccination. One leader described regular messages that were distributed to community members to "quarantine yourself, take care of yourself, do the things necessary to get healthy, stay healthy, and try to keep from giving it to others." (Kowalczyk et al., 2020) Following the guidelines was seen as a "way of being Godly because [it's not only] about protecting you… it's really about protecting the other people." (Livne & Bejarano, 2021).

We've had to Adjust

Religious leaders described adaptations in health and social practices in the respective religious and community activities due to the COVID-19 pandemic as directed by community, leadership, and governing agencies. Changes to services due to the pandemic were required, prompting action by the leaders, leadership team, and the community. Some leaders considered the adaptions as "a little unorthodox… [which] was a very difficult decision." (Jones et al., 2021).

Leaders described the need to implement physical distancing at religious services that included blocked off chairs, taped placement indicators on the floor, seating family members together, assigning seating arrangements, and limiting the number of attendees at services. Masks were provided, and were either required or encouraged, "We made free masks available, for people to grab as they're walking in the door." Many houses of worship "set up hand sanitizing stations at every door" with another leader characterizing the sanitization as a "reminder to keep yourself safe." (Lincoln & Guba, 1985) Some communities shifted their services to online to reduce the risk of exposure and transmission.

Leaders and community members worked to reduce the risk of transmission and improve safety. One leader described how after each meeting and service, their custodial staff would wipe down all surfaces with cleaner solution. Communities employed methods of improving ventilation by hosting outdoor services, opening windows, and installing heating, ventilation, and air conditioning units and fans.

Logistic concerns included, "Do they have access to the technology… access medical care? Do they have masks… gloves… soap… everything that they need to get healthy?" (Hallgren et al., 2021) Communities set up outreach with phone

calling and volunteers to provide technical and everyday assistance including teaching computer literacy. Community outreach also included medication delivery, meal preparation, and packing snack bags for the local schools. Meals and grocery deliveries were particularly helpful for infected and home-bound members to "make sure that they have food in the house, that they don't have to cook so that they can rest." (Hallgren et al., 2021).

Financial concerns were felt by leaders of the many communities, as expressed, "I am always worried… especially with an aging community that live on a restricted income… Can they afford their medications and are they being supported?" (Hallgren et al., 2021) Another religious leader described provision of financial assistance and home repairs for those in need, including people who lost their jobs during the pandemic, "We've given away literally thousands of dollars… [for] rent… buying groceries, paying for utility bills, replaced somebody's air conditioner, helped somebody move." (Dajani et al., 2022) In sum, the overall feeling was that "the community does a really good job of taking care of one another." (Dajani et al., 2022).

We've had to Dispense of that

During the pandemic, religious communities ceased, curtailed, or adjusted services and meetings to comply with COVID-19 guidelines and to reduce the risk of transmission, with noted challenges or barriers to the alterations. For example, some communities eliminated or reduced singing of hymns or music during services, in response to suggestions that singing increases the transmission of the virus; and, bibles, hymnals, and prayer books were removed from places of worship to reduce the risk of transmission. Bulletins and newsletters were no longer distributed, communal meals were suspended, children's programs were canceled, and charity collections shifted from physical collection to digital methods. A religious leader described the changes as "elements that have really disrupted our "normal" [service] routines that I don't know if we'll ever do them again." (Kowalczyk et al., 2020).

Some leaders described the suspension of in-person services and limitations on rites of passages and funerals. Communities refrained from or minimized socialization which was perceived as a disruption to community fellowship, "We are a very close-knit congregation and we miss the socialization. We had fellowship… every [week]. We've had to dispense of that." (Champion & Skinner, 2008) An outcome of the physical distancing was a sense of physical seclusion, "even though we're coming together, we're still isolated in the fact that we cannot hug, or shake hands, or be within… 6 feet of one another." (Champion & Skinner, 2008) The restrictions were felt by the leaders and community members, "I really miss the fellowship times… shaking hands, hug, and a pat on the back, or hand on the shoulder. And I really miss that. We've got ladies that are huggers and they're really upset they're not able to hug." (Ge et al., 2021) These changes were "difficult to really show that we were there for one another… we're all… going through the same thing with feeling isolated." (Livne & Bejarano, 2021).

Discussion

Findings from our study illustrate the insight of diverse religious leaders serving rural communities in the USA during the pandemic. There were similar perceptions regarding their respective community's sense of responsibility, experiences, and responses. The nine themes that emerged were framed and categorized under the Health Belief Model constructs.

Perceived Susceptibility

Where there were older adults or immunosuppressed individuals, special effort was made to implement measures to mitigate risk of transmission and to protect them from exposure and infection. Particularly in rural communities, the religious community is often perceived as central to elder care, even prior to the pandemic (Goris et al. 2015). While COVID-19 vaccination uptake reflects a personal decision and action, it may have been influenced by the community, especially where vaccine promotional messages were disseminated by religious leaders and community members (Hallgren et al., 2021). Leaders noted that there was less resistance to recommended health precautions such as mask-wearing, when combined with religious values, a finding consistent with previous research (DeMora et al., 2021).

Perceived Severity

The COVID-19 pandemic has been noted to contribute to a growing crisis in faith in the world, whereas for some people it strengthened their faith (Kowalczyk et al., 2020). Over the course of the pandemic, there was an increase in adults' COVID-19-related fear which contributed to higher rates of depression and anxiety (Warren et al., 2021) and the fear of death among young people grew (Kowalczyk et al., 2020). The pandemic exacerbated feelings of stress with identified stressors including lockdowns, physical distancing, job loss, financial strain, personal loss, and increased rates of morbidity and mortality. Yet, the shared belief in a higher power and of being protected by an external source within a community context afforded strength and allayed fear and anxiety. This feeling of togetherness within the context of community, religious belief, and spirituality have been found to enhance a sense of belonging, subjective well-being, and resilience during the COVID-19 pandemic (Frei-Landau, 2020; Roth-Cohen et al., 2022).

Perceived Benefits and Barriers

The religious leaders described their community members' connection to each other as a critical means of overcoming social isolation and providing social support especially during periods of physical distancing. Social belonging and demonstration of compassion and kindness are protective components that nurture resilience (Slavich

et al., 2022), as was expedited through religious communities. To encourage their members, the leaders reinforced messages that people were not alone, that they were connected to God and to community.

The leaders stipulated that science was not in conflict with faith, rather that science is in harmony with God's intention and is a tool through which God engages. They explained that while supernatural events were possible, the use of scientific tools and methods of inquiry did not demonstrate a lack of faith, with specific application to compliance with health recommendations and mitigation of viral transmission. They acknowledged that there were some community members who doubted science and who thought that science conflicted with religion, consistent with the findings of a 2015 Pew Research Center survey in the USA where 36% of Catholics, 40% white evangelical Protestants, and 21% of white mainline Protestants viewed a conflict between science and faith (Funk et al., 2015). The discrepancy between the leaders and some community members may be explained by the leaders' higher level of religious education, affording them a deeper understanding of their respective religions.

Religious values and teachings were effectively used to promote mask wearing among Christians (DeMora et al., 2021); similarly, Muslim and Jewish leaders cited religious sources and values that support compliance with mitigation measures including vaccinations, consistent with previous findings (Dajani et al., 2022; Muravsky et al., 2023). A commonality across the religions was the acceptance of a wide range of medically-based, health-related, social, and spiritual methods in protecting people from infection, providing support, and fostering resilience.

The leaders were in regular contact with their communities with positive messages of hope and encouraging community support for individuals in need. Despite the physical distance, they fostered connectedness and camaraderie. They played a key role in community-based contact during the pandemic; they supported the spiritual and emotional stability of their community members, offering care, counsel, and moral support in times of distress. The leaders served their communities, offered hope and strength, and felt that they were their community's "guiding light." They often led and modeled compliance with the recommendations which reinforced health promotional messages.

The leaders described their community members as respecting each other, especially those at-risk, and donning a mask at community events, even if on an individual level they would have preferred not wearing a mask. For a majority of the participants, wearing a mask was not perceived as a contentious or divisive issue in their communities, rather as an essential protective activity, despite the controversy expressed nationally through social media and news reports. Our sample of religious leaders encouraged their community members to comply with mitigation recommendations. These findings support the results of a national cross-sectional survey that religiosity was one of the factors predicting increased likelihood of adherence to protective behaviors during the COVID-19 pandemic (Resnicow et al., 2021).

As trusted by their communities, religious leaders were well-positioned to communicate community-based health promotional messages, thereby serving as bridges between health professionals and communities during the pandemic (Privor-Dumm & King, 2020; Monson et al., 2021). They were key partners in promoting adherence

to recommended public health measures (El-Majzoub et al., 2021) and in overcoming vaccine hesitancy among community members (Meyer et al., 2022). As a strategy to overcome the mistrust negatively impacting adherence to mitigation behaviors, researchers have recommended that health professionals, public health experts, political leaders, and religious leaders work together in messaging and promoting compliance (Jones et al., 2021; Monson et al., 2021). Building on the trust that community members have in their religious leaders, public health messages should be communicated in a manner that aligns with the values of the given communities.

Cues to Action

The leaders from the various religions shared that during the pandemic there was a sense of responsibility that community members had toward each other, particularly at-risk individuals. They described the demonstration of the sense of responsibility through mitigation strategies and activities, vaccination promotion, and preventative care education. The Jewish perspective of the obligation of caring for others was echoed in the corresponding religious principles of serving others in Christian tradition and in being altruistic and charitable in helping others according to Islam. Consistent with the Health Belief Model, faith-based messages from trusted religious leaders to follow health recommendations served as cues to action that, along with perceived susceptibility, perceived severity, and perceived benefits and barriers, served as motivation for community members to comply with the recommendations.

Religious values and tenets were invoked to rally member to adapt community practices and to follow recommended public health measures. Every congregation, regardless of religion suspended aspects of their religious practices during the pandemic including in-person study groups, community meals, and children's programming. Positive actions were taken and adaptations were made to adhere to public health recommendations. The Jewish concept of saving lives was applied to vaccinations (Muravsky, et al., 2021). Charity efforts and social support in the Muslim community, particularly during the month of Ramadan, continued with food preparation and individual distribution along with virtual religious services for isolated individuals (el-Majzoub et al., 2021).

Missing fellowship, churches developed telephone networks to maintain socialization, especially among older adult members (Ge et al., 2021). Meeting formats were shifted from in-person gatherings to online to comply with dedensification mandates and recommendations while allowing for continuity of religious observance and social interaction. Having to physically distance from the place of worship was viewed by some leaders as a challenge to a core component of their religious experience and the use of technology did not adequately replace communal prayers, interpersonal interaction, and congregating (Ge et al., 2021; Livne & Bejarano, 2021). Overall, the religious leaders valued the utility of online meetings and remote communication as supporting community members' interactions, reducing isolation, and maintaining a sense of community, similar to findings by other researchers (Shelton et al. 2021).

Limitations

A limit of the study is the regional sample as the participating religious leaders served in communities in the rural mid-Atlantic and Midwest regions. While saturation was reached with this sample, transferability is limited to these geographic regions.

Conclusion

Rural religious leaders have a unique understanding of the needs of their communities as they described their lived experience during the unprecedented crisis of the COVID-19 pandemic. Using the Health Belief Model, the nine themes that emerged from their narratives provided insight into the religious leaders' perceived risk of infection, fear, and isolation subsequent to the COVID-19 pandemic and the need for faith and community. The leaders facilitated and supported active community engagement, including religious services and community activities, with adaptations for the pandemic reality. Additionally, the religious leaders encouraged compliance with public health recommendations, while affirming moral and religious tenets consistent with public health recommendations, demonstrating their role as valuable partners in public health.

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Declarations

Conflict of interest The authors have not disclosed any competing interests.

References

Champion, V. L., & Skinner, C. S. (2008). The health belief model. *Health Behavior and Health Education: Theory, Research, and Practice, 4*, 45–65.

Colaizzi, P. F. (1978). Psychological research as the phenomenologist views it. In R. S. Valle & K. Mark (Eds.), *Existential Phenomenological Alternatives for Psychology* (pp. 48–71). Oxford University Press.

Dajani, R., Coetsee, M., Al-Tabba, A., & Al-Hussaini, M. (2022). Religion, Islam, and compliance with COVID-19 best practices. *Journal of Religion and Health, 61*, 4155–4168. https://doi.org/10.1007/s10943-022-01621-6

DeMora, S. L., Merolla, J. L., Newman, B., & Zechmeister, E. J. (2021). Reducing mask resistance among White evangelical Christians with value-consistent messages. *Proceedings of the National Academy of Sciences of the United States of America, 118*(21), e2101723118. https://doi.org/10.1073/pnas.2101723118

El-Majzoub, S., Narasiah, L., Adrien, A., Kaiser, D., & Rousseau, C. (2021). Negotiating safety and wellbeing: The collaboration between faith-based communities and public health during the COVID-19 pandemic. *Journal of Religion and Health, 60*, 4564–4578. https://doi.org/10.1007/s10943-021-01434-z

Funk, C., Alper, B.A., & Pew Research Center. (2015). Religion and science: Highly religious Americans are less likely than others to see conflict between faith and science. Retrieved on August 6, 2023 from: https://www.pewresearch.org/science/2015/10/22/perception-of-conflict-between-science-and-religion/

Ge, Y., Sainz, M., Gore, J., & Epps, F. (2021). "Everything is either sent by God or used by God": An exploratory study on the impact of COVID-19 upon the religious lives of black families living with dementia. *Journal of Religion and Health, 60*, 3193–3208. https://doi.org/10.1007/s10943-021-01332-4

Goris, E. D., Schutte, D. L., Rivard, J. L., & Schutte, B. C. (2015). Community leader perceptions of the health needs of older adults. *Western Journal of Nursing Research, 37*, 599–618. https://doi.org/10.1177/0193945914530046

Hallgren, E., Moore, R., Purvis, R. S., Hall, S., Willis, D. E., Reece, S., CarlLee, S., Gurel-Headley, M., & McElfish, P. A. (2021). Facilitators to vaccination among hesitant adopters. *Human Vaccines and Immunotherapeutics, 17*, 5168–5175. https://doi.org/10.1080/21645515.2021.2010427

Jones, P., Menon, A., Hicken, A., & Rozek, L. S. (2021). Global adoption of personal and social mitigation behaviors during COVID-19: The role of trust and confidence. *PLoS ONE, 16*, e0256159. https://doi.org/10.1371/journal.pone.0256159

Kowalczyk, O., Roszkowski, K., Montane, X., Pawliszak, W., Tylkowski, B., & Bajek, A. (2020). Religion and faith perception in a pandemic of COVID-19. *Journal of Religion and Health, 59*, 2671–2677. https://doi.org/10.1007/s10943-020-01088-3

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic Inquiry*. Sage Publications.

Livne, S., & Bejarano, M. (2021). "It's important to hear a human voice," Jews under COVID-19: An oral history project. *Contemporary Jewry, 41*, 185–206. https://doi.org/10.1007/s12397-021-09374-2

Meyer, B. A., Viskupič, F., & Wiltse, D. L. (2022). Pharmacists to partner with religious leaders to overcome vaccine hesitancy among Christians. *Journal of the American Pharmacists Association, 62*, 302–304. https://doi.org/10.1016/j.japh.2021.08.025

Monson, K., Oluyinka, M., Negro, D., Hughes, N., Maydan, D., Iqbal, S., Golden, S. H., Teague, P., Hale, W. D., & Galiatsatos, P. (2021). Congregational COVID-19 conversations: Utilization of medical-religious partnerships during the SARS-CoV-2 pandemic. *Journal of Religion and Health, 60*, 2353–2361. https://doi.org/10.1007/s10943-021-01290-x

Muravsky, N. L., Betesh, G. M., & McCoy, R. G. (2023). Religious doctrine and attitudes toward vaccination in Jewish law. *Journal of Religion and Health, 62*, 373–388. https://doi.org/10.1007/s10943-021-01447-8

Privor-Dumm, L., & King, T. (2020). Community-based strategies to engage pastors can help address vaccine hesitancy and health disparities in Black communities. *Journal of Health Communication, 25*, 827–830. https://doi.org/10.1080/10810730.2021.1873463

Quadri, S. A. (2020). COVID-19 and religious congregations: Implications for spread of novel pathogens. *International Journal of Infectious Diseases, 96*, 219–221. https://doi.org/10.1016/j.ijid.2020.05.007

Resnicow, K., Bacon, E., Yang, P., Hawley, S., Van Horn, M. L., & An, L. (2021). Novel predictors of COVID-19 protective behaviors among US adults: Cross-sectional survey. *Journal of Medical Internet Research, 23*, e23488. https://doi.org/10.2196/23488

Roth-Cohen, O., Muralidharan, S., & La Ferle, C. (2022). The importance of spiritual consumption, religious expression and subjective well-being among Christians in the US during COVID-19. *Journal of Religion and Health, 61*, 1719–1733. https://doi.org/10.1007/s10943-022-01509-5

Sandelowski, M. (1986). The problem of rigor in qualitative research. *Advances in Nursing Science, 8*, 27–37. https://doi.org/10.1097/00012272-198604000-00005

Shelton, R. L., Hall, M., Ford, S., & Cosby, R. L. (2021). Telehealth in a Washington, DC African American religious community at the onset of COVID-19: Showcasing a virtual health ministry project. *Social Work in Health Care, 60*, 208–223. https://doi.org/10.1080/00981389.2021.1904322

Slavich, G. M., Roos, L. G., & Zaki, J. (2022). Social belonging, compassion, and kindness: Key ingredients for fostering resilience, recovery, and growth from the COVID-19 pandemic. *Anxiety, Stress, and Coping, 35*, 1–8. https://doi.org/10.1080/10615806.2021.1950695

Warren, A. M., Zolfaghari, K., Fresnedo, M., Bennett, M., Pogue, J., Waddimba, A., Zvolensky, M., Carlbring, P., & Powers, M. B. (2021). Anxiety sensitivity, COVID-19 fear, and mental health: Results from a United States population sample. *Cognitive Behaviour Therapy, 50*, 204–216. https://doi.org/10.1080/16506073.2021.1874505

World Health Organization. (2020). Practical considerations and recommendations for religious leaders and faith-based communities in the context of COVID-19. Retrieved on August 6, 2023 from: https://www.who.int/publications/i/item/practical-considerations-and-recommendations-for-religious-leaders-and-faith-based-communities-in-the-context-of-covid-19?gclid=Cj0KCQjwwvilBhCFARIsADvYi7LCJsUHprfTVbg5yRRbayArlkxGT3VzAlWrY8elz-FTbmgZZ5CK8fIaApR3EALw_wcB