christian aid

UNDERSTANDING THE ROLE OF RELIGIOUS ACTORS

IN PUBLIC HEALTH CRISES IN NIGERIA.

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FOREWORD

The essential role of religious actors in international development cannot be overemphasised as noted by scholars, activists and development practitioners working and thinking at the very 'local' level of aid and development delivery. This owes to the fact that faith and religion remain key influencing factors in communities' response to both behavioural and structural change.

In Nigeria, religion is part of the fabric of daily life and arguably inseparable from the public sphere. Religious dynamics permeates the space of culture, society, and politics from national to grassroots levels. However, the importance of faith actors is more evident in times of public health crises as they have historically played vital supportive roles spiritually, politically, and materially for individuals and communities living in poverty.

This has earned them immense trust from their communities as they are viewed as reliable community leaders with crucial social access and 'spiritual capital.' The trust that local religious actors enjoy allows them to negotiate these intricacies with more ease than other actors. On the other hand, faith actors have also been involved in harmful practices in crises settings like public health emergencies, ranging from stigmatizing certain groups and ostracizing them from necessary relief mechanisms, to spreading misinformation regarding health issues.

This complex interrelationships of culture, tradition, stigma, and discrimination continue to shape the uptake of health services and how health systems interface with communities. It is to this end that this scoping research was conducted to examine the role that religious actors have played during public health crises in Nigeria. This is with a view to understanding the identities, dynamics and recognizing the multiplicity of religious actors in crises settings.

It is our hope that this study will increase understanding of the unique role of faith leaders in public health crises and expand knowledge on how to effectively maximise this potential towards gaining social approval in future public health crises interventions. If faith actors are considered the gateway to credible health information and services among community members, synergy building between public health authorities and religious leaders becomes imperative.

We therefore present this study as a contribution to the body of knowledge on effective public health interventions at the grassroots.

Temitope Fashola
Country Director
Christian Aid (UK) Nigeria, 2023

1.0 INTRODUCTION

1.0 INTRODUCTION

This project is designed to address a key gap in academic work, viz, the fact that whilst there is significant study of religious actors, there is little work that is designed or co-created by the religious communities themselves. This is a gap identified not only by Christian Aid researchers, but also by the Religion and Sustainable Communities Working Groups, and the Joint Learning Initiative on Faith-Led Communities.

Therefore, the study provided below is better understood as a scoping study that aimed, through autoethnographic accounts, workshops and focused conversations, to understand what the experiences and needs of affected religious communities were, especially in terms of what focus and design needs might be required for a larger scale project that would look at the interstice of religion, international development and public health.

As such, we provide report findings that highlight key learnings from the study,

as well as recommendations for the design and lines of learning for a more in-depth piece of work.

We do, however, acknowledge that, due to a variety of limitations, we were not able to carry out this project to the exacting nature of what we intended. The details on this are provided in the section on limitations.

SOME INTRODUCTORY NOTES ON THE BACKGROUND

Scholars, activists, and development practitioners working and thinking at the very 'local' level of aid delivery note the importance of the role of religious actors in international development. (Wilkinson, 2020; Tomalin, 2012). This is because faith and religion are key influencing factors in how communities relate to change, both behavioural and structural. In countries like Nigeria, where this research is focused, religious dynamics are an important cultural, social and political factor. Local faith actors often operate at national levels and link to grassroots, community initiatives. As Tomalin (2020) and others have argued, religious actors and religious traditions have historically played a major role in supporting - spiritually, politically, and materially - those who were experiencing poverty, both at the individual and the community level. Events such as natural disasters and public health crises further underline the importance of religious actors, especially at the local level.

Academic studies, as well as reports from development organizations during public health crises such as the Ebola epidemic, the ongoing AIDS crisis,

as well as the recent COVID-19 pandemic, have noted the importance of religious actors as trusted community leaders with vital social access and spiritual capital (ReliefWeb, 2021; Marshall, 2017).

This is due to the fact that there exist complex interrelationships of culture, tradition, stigma, and discrimination that affect uptake of health services and shape how health systems interface with communities (Achimescu & Sultanescu, 2021).

The trust that local religious actors enjoy allows them to negotiate these intricacies with more ease than other actors. During the Ebola and the COVID-19 crisis, Christian Aid learning reviews, for example, found that religious actors also played a key role in sharing accurate fact-based messages, combating myths, and offering vital support mechanisms (Newman & Ranawana, 2021). In the Ebola and AIDS crises, religious actors were also key to assisting in social justice roles such as advocacy for women who required access to healthcare (Epko, 2020). Conversely, religious actors have also been involved in harmful practices in these settings. This can range from stigmatizing certain groups and ostracizing them from necessary relief mechanisms, to spreading misinformation regarding health issues (Newman & Ranawana, 2021).

In international development, public health, as well as religious studies, there are numerous studies on the role of the religious actor as an agent responding to a significant crisis. However, certain gaps in the knowledge were still apparent. One of the key questions that we can see across all disciplines is on the identity and definition of the religious actor.

The term 'religious actor' can indicate a variety of individuals and communities. These may be centralized or decentralized, global or local, grassroots or national, operating formally or informally at different levels, and often across institutional and territorial boundaries in practical and/or theoretical domains. Religious actors need not belong to a 'mainstream' faith or religious denomination but can also be spiritual healers, medicine men or women, or other informal categories (Haynes, 2019). Hence there is difficulty in providing one finite definition. What is important, however, is that the local community recognizes the actor/s as a trusted leader (Marshall, 2017).

This is especially true in a country like Nigeria where the religious actor is more often also a community representative or mobiliser. Many studies do understand that there is great variety, formality and informality to religious actors. Yet, both academic research and development/humanitarian action do not always engage or include traditional healers or spiritualists or syncretic actors as religious actors. Diversifying our understandings of religious actors may then also provide key lessons for how practitioners deliver development aid, and how they can better include local knowledge into such delivery.

In the main, this corresponds first to existing critiques from critical voices in international development who have evidenced the 'design' problem in how aid is provided. Aid does not always work in the way it is intended, and quite often, it is because, at the design stage, it does not include the direct involvement of those most affected. As Flint and zu Natrup (2018) have argued, in their audit of development design programmes, even participatory and consultative exercises can end up being largely tick box efforts with 'little meaningful impact on how aid is delivered'.

Further to this, as Wilson (2017) highlights, limited engagement with only a certain set of actors risks silencing the complex engagements and knowledge that local communities will have with ideas of development. Dui-Rae and Rees (2010), in an in-depth audit of the aid delivery of international finance mechanisms also found that a lack of attention to religious diversity elides the fact that religious actors are deeply involved in both top-down development and in contesting development; thus, a singular form of agency cannot be generalised to all religious actors involved in development. Both studies directly correlate to the fact that, if development and humanitarian processes have a limited view of who is understood as a religious actor or leader, we can risk marginalising and silencing the diverse groups and complex entanglements of spiritual life lived every day.

Secondarily, as noted by Singh (2011) in an in-depth study on religious groups in India, Nigeria, Tanzania and Pakistan, where certain groups are already marginalised, engagement with only 'institutional' religious actors can risk double marginalisation, as well as concretize the power that a hegemonic religious group holds. In our study findings as well, respondents noted that there were also some instances highlighted where a religious leader may only be interested in their own religious group. This leads them to discriminate against other communities, or against traditional leaders. This is made more complex because of sectarian - ethnic conflict that is undermining the society.

This research project aimed to address these specific gaps using Nigeria as a case study. Nigeria is chosen as the study site as it is a country that has been impacted by the three public health crises mentioned, and also because of the powerful role that religious actors play in the country. For this study, an interdisciplinary team of international development practitioners, a public health expert and a religious studies expert were brought together to design and implement the research.

2.0 CONTEXT AND BACKGROUND

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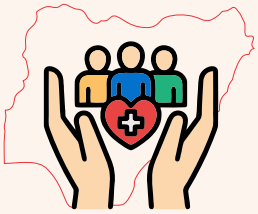
PUBLIC HEALTH CRISES IN NIGERIA AND MULTISECTORAL RESPONSES



In the past several decades, Nigeria has faced a number of public health related crises, particularly in terms of large-scale communicable diseases such as HIV/AIDs, Ebola and, in 2019, COVID-19. These diseases had different but serious impacts on society (Onyekuru et al., 2023). HIV/AIDS, for example, is a long-term challenge for Nigeria, affecting not only health infrastructure but also social and economic progress. Although academics agree that HIV prevalence amongst adults in Nigeria is low at 3.2%, it remains an ongoing and chronic problem (Awofala and Ogundele 2018). Public health academics also note that other than these diseases, other transmissible conditions such as hepatitis, measles, lower respiratory infections, diarrheal diseases, and tuberculosis were also amongst public health challenges (Sasidharan & Dhillon, 2020).

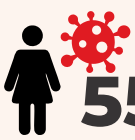
As such, attention has focused on large-scale effects such as Ebola and Covid-19, without recognizing that mundane and persistent conditions are also burdens for the day-to-day work of nurses, health care providers and public health facilities. Hence, more focus on the local and the community related efforts is required. In some states like Borno, health infrastructures function only very poorly (Aregbeshola, 2016). The WHO has noted that for countries like Nigeria, due to the intersections of socio-economic and political issues that limit, for example, access to healthcare, the constant need to fight multiple outbreaks poses a complex challenge.

However, we continue to be cognizant of the larger scale diseases at play in this context.

Nnanji et al. (2021) note that in West Africa, Covid-19, Lassa Fever and the Ebola Virus are now the most prevalent infectious diseases in the region.

Lassa Fever was first identified in Nigeria in 1969 and is an acute viral infection and viral haemorrhagic fever. The Ebola Virus was most concerning in West Africa in the years 2014, with a typical fatality rate of 50%. The Ebola Virus affected countries in Western Africa in both social and economic ways. It caused loss of income from economic activities because of worker illness as well as the restriction of movement.

The social impacts included a negative effect to community cohesion, closing of community centers, businesses and schools, food insecurity, as well as mental health issues connected to high morbidity and mortality (Onyekuru et al., 2023; Relief Web, 2021; Ameh et al., 2018; Kamurodeen et al., 2020).



Fawole et al. (2016), also highlight the significant impact to women who made up 55% of the Ebola cases in Nigeria.

Their particular exposure was caused due to being at the frontlines both occupationally and domestically in caregiving roles (ibid).

Academics and development practitioners note that Nigeria, in particular, being a populous country with a high number of daily wage earners was immediately affected by closure of businesses and movement restrictions (Bashiru et al., 2022). While the public health response in Nigeria was effective, using an incident management approach, and also being part of a global cooperation strategy (Ameh et al., 2018), it created significant impacts at the community level and also at the level of the public health infrastructure (Relief Web, 2021).

COVID-19 was first detected in February 2020 in Nigeria and carried with it much of the same socio-economic implications as the Ebola Virus. Amzat et al.

(**2020**) in their study of the medical response provided in the first **100** days noted that the incidences of COVID-19 grew steadily from the external case and individual cases to a community transmission.

When lockdown measures were relaxed, an upsurge of cases of

52% were recorded (ibid).

Obi-Ani et al. (2020), in their study of social media during the COVID-19 pandemic found that misinformation and public 'scares' contributed to communities being less trusting of public health measures. This, in turn, caused an upsurge in cases and a breakdown in public trust. What was found to be effective were multi sectoral responses that combined both social and medical efforts to contain contamination (Amzat et al., 2020; Abayomi et al., 2021; Etteh et al., 2020). The 2021 Christian Aid study found that the most effective mitigation in Nigeria occurred when government agencies, faith actors, youth groups, media, community groups and civil society organizations came together to build public trust and support public health measures. Abayomi et al. (2021) agreed, noting that effective response came from partnerships with both public and private entities, community engagement, as well as political commitment. Studies that have examined the HIV/AIDs and Ebola crisis too have also concluded the importance of multi-sectorial and community level engagement (Asekun-Olarinmoye et al., 2022). It is in terms of community engagement that the religious actor becomes important. In the sections that follow we discuss why this is important.

RELIGIOUS ACTORS IN NIGERIA

56%
CHRISTIANS

42%
MUSLIMS

Religion is central to the lives of most Nigerians, with most religious scholars agreeing that Christians and Muslims make up about half of the population each (Vaughan, 2016; Campbell, 2020; Adelakun, 2021). An Afrobarometer survey of 2017 found that 56% of the population identified as Christian with 42% identifying as Muslim (McKinnon, 2021).

Traditional religious practices and beliefs that existed before Islam and Christianity arrived in Nigeria are also still practiced, mostly in syncretic ways, as quoted beautifully in Fig 1. Religious beliefs, identities and practices are public social markers, that is, they are part of one's public identity. Whether it is a social event, a workplace meeting, or a dispute over land or water, religion plays a vital role. Religion is part of the fabric of daily life in Nigeria and is arguably inseparable from the public sphere. It is a fact of life (Vaughan, 2016), and a source of conflict, not only between what we may call 'institutional' actors like Christian and Muslim groups but also between institutional actors and traditional religionists.

The post-colonial and inter-ethnic politics are significantly complex and complicated and have been severally detailed in various studies and is too lengthy to unpack in this brief report, however we refer you to studies such as Falola's Violence in Nigeria: The Crisis of Religious Politics, Mustapha and Ehrhardt's Creed and Grievance: Muslim- Christian Relations and Conflict, and Vaughan's Religion and the Making of Nigeria. This is a non-exhaustive list. We can provide some brief notes.

In the late 1960s, for example, religion was one factor in the civil conflict that became the Biafra war, and since the mid-1980s, tensions between Muslims and Christians have been a constant in Nigerian politics (Afolabi, 2015).

Colonial policies towards Muslim and Christian communities institutionalized racial and religious differences —with far-reaching consequences before and after independence (Ojo & Lateju, 2010).

It is important to note that for traditional religionists, a source of conflict is also associated primarily with the displacement and violence associated to the European civilising mission (Adkagaba, 2022; Edward & Akipu, 2014).

Okeke et al. (2017), for example, in their investigation of the tensions between Christianity and African traditional region, found that there was occasional destruction of lives and people's artifacts and groves by Christians in Igbo towns[1].

"The people are at the moment; we can say that the people at the moment are syncretic. They are syncretic, when we say that people are syncretic means one leg in the custom and traditions and one leg in the church. So, you can see that they are at the moment, they are not consistent in the faith so to say. They so much believe in the traditions and customs of the land. So, Christianity or the faith is a kind of an appendage to them." – ***Autoethnographic account from Anglican Pastor in Anambra State***

Fig 1

Religious leaders and religious communities also often provide social services, social mobility and financial support. Christian Aid's own work in Nigeria has noted that many religious organisations often provide services that public institutions have not been able to meet.

[1] It should be noted that this study also found significant syncretism being practiced by Igbo people who were able to worship in both Christian and traditional fashions. These violences are not only limited to Igbo towns, but also to Yoruba and other ethnic groups.

Several studies (Alao, 2022; Ucheaga et al., 2010; Okafor et al., 2022, Nuhu et al., 2018) that looked at public health responses to HIV/AIDS as well as the Ebola Virus noted that during these times, religious leaders and faith-based organisations not only provided spiritual guidance, but also a variety of local health and social services. Jegede's (2009) study of the role traditional religion, for example, could play in HIV/AIDs in Nigeria, noted the importance of ritual as a healing technique, as well as the communal element to the treatment of diseases that could be further mobilised for effective mitigation. It should also be noted that sometimes, these can be 'club goods' (Chatham House, 2021), where service provision is provided as a reward for religious adherence.

As is the case with many contexts that are religiously diverse, religion too is practiced in nuanced and multiple ways. As aforementioned, one of the key points in our report findings are the tensions not only between Muslim and Christian leaders, but also the tensions between these 'institutional' leaders and traditional religious actors. Many religious leaders hold significant power and influence in the country and can be key actors influencing and even modifying behaviour.

As an example, Desmon (2018) and also Adedini (2018), in separate studies found that 65-70% of women who had listened to a sermon or a talk by a religious leader that was pro-contraception were more likely to use forms of modern contraception. Another example is a 2015 study by Onyima and Ojiama in Anambra State that found that young adults often rely on the financial advice of religious leaders, often allowing financial habits to be dictated by their local cleric. As discussed in the introductory sections, religious actors are amongst the most trusted and, are often more influential than government officials or secular community leaders.

65-70%

In Nigeria, religious institutions are also well dispersed throughout the country and therefore have capacity to wield large scale influence (Oluduro, 2010). Academics and activists working in international development also lobby for religious leaders to be champions of initiatives such as the Sustainable Development Goals in order to ensure more 'buy in' from a wider range of Nigerian communities (Akinloye, 2018). Proponents of environmental justice also focus on how the understood rationales of African Traditional Religious Values can be leveraged to teach Climate Change mitigation strategies using a combination of the influence of the religious leader and the values already inherent in their practice (Onah et al., 2016).

This short brief highlights the pluriversality of the religious context in Nigeria, and how deeply imbricated religiosity is in large scale events such as public health crises and security issues. Certainly, this brief is not an exhaustive one, but only indicative of the complex and multiple nature of the context in which this study was carried out. In trying to answer one of the key questions of this project - how can we define a religious leader - it was clear from the literature review that such a definition would not be a clear one. Nigeria has multiple kinds of religious leaders, and religious practice is, even when in tension, often syncretic.

3.0

OBJECTIVES AND METHODOLOGY FOR THE STUDY

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THIS STUDY HAD THREE KEY OBJECTIVES:

Objective 1: To understand if the gaps identified within academia and the development landscape in relation to who is a religious actor and their role in public health crises has relevance for religious communities based in Nigeria, and for how we approach our development practice.

Objective 2: To test a methodological approach which aims to decolonise knowledge and shift power in research, centring community knowledge within public health crises and academic discourse.

Objective 3: To use the findings from this research to co-design a bigger, multi-context piece of research with academic partners based in the global south to deepen our understanding of, and development practice on the intersection between faith, development and public health.

THE FOLLOWING ARE THE MAIN RESEARCH QUESTIONS THAT WERE USED FOR THE DESIGN OF THE PROJECT:

RQ1: Who are the religious actors and what are their roles in health emergencies in Nigeria and what does this mean for development delivery?

RQ2: What knowledge exist in the affected communities/religious communities regarding the role that religious actors play in public health crises? Do this knowledge challenge development assumptions?

METHODOLOGICAL APPROACH

The methodological approach for this study also aimed to address the fact that whilst there is significant study of religious actors, there is little work that is designed or co-created by the religious communities themselves. This, as aforementioned, was a gap identified not only by Christian Aid researchers, but also by the Religion and Sustainable Communities Working Groups, and the Joint Learning Initiative on Faith-Led Communities.

The research intended to consider how the religious community has collected and held knowledge and ask if the gaps identified are relevant and necessary to these religious communities. In centering community knowledge, the research aimed to take on a decolonial praxis to its methodology. The research intended to ascertain what questions were missing in the research design from the point of view of community knowledge and whether this suggests an interruption of the research question as posed. Through this process, it was hoped that a new or different set of research and learning questions may be identified for a further phase of research. In doing so, the research intended to engage identified religious communities in conversations on knowledge systems and how these systems may restrain communal forms of knowledge; a focus that was very key to the validation workshops that were held after the first round of fieldwork.

Ethics was central to our research process, ensuring that space was created to understand what this means and requires from the community perspective, and ensuring that we responded to and met their ethical standards, as well as abide by social research ethics (Please see Appendix II for the Ethics instruments).

The methodological approach was also iterative, narrative, and dialogic with a significant participatory and ethnographic focus. While there is no known prescribed toolkit for a 'decolonised' methodology, the importance here is placed on the ethical and reflexive ways of engaging a community in a conversation on a knowledge gap. This is a process that occurred at levels of the research so that national and global researchers could also commit to reflexive practice in the way in which they engage the community-based researchers.

The approach to collecting the required information was two-fold. First was a series of consultative and participatory key informant interviews and focus groups. Community researchers worked with partner communities, as well as CA programme staff in Nigeria to structure and put together these processes. All field researchers were also asked to do a 'debrief' session to critically reflect on the learning. Prior to beginning research, all enumerators and research coordinators attended training sessions with the PIs where we discussed the different methodological approaches and discussed the importance of reflexivity in undertaking this research.

The research also used a process of autoethnography where we asked selected religious leaders (four in each state) to provide an oral or written description of their experience navigating public health crises in their context. This process allowed for the respondents to provide an account of their experience using only their expressions, unmediated by the enumerator.

SELECTED SAMPLE

The research was carried out in Northern Nigeria (Kaduna State) and Southern Nigeria (Anambra State) where Christian Aid has extensive programmatic experience and relationships with religious leaders. This allowed the researchers to already have an established trust relationship and, therefore, could engage directly with the religious leaders who we have already identified. It also allowed the research explore grassroots community groups. We also spoke to communities who had previously been part of Christian Aid's programmatic approaches regarding their own identification and engagement with a wider spectrum of people who they class as religious leaders. The local articulation of who is seen as a religious leader was supplemented with religious leader typographies identified through the focus group discussion and literature review.

The field survey was conducted with members of the selected communities in Makarfi and Kaduna North Local Government Areas (LGAs) in Kaduna State, Ogbaru and Ayamelum LGAs in Anambra State. The report draws on the participants' responses from community leaders/traditional rulers, faith actors, youth, and women. In the research design, our definition of faith actor or religious actor included both institutional and traditional actors. We were also curious to find out how the local community defined such an actor.

Below, we provide a brief description of the two states in which we conducted fieldwork:

ANAMBRA STATE

Anambra State is one of the five states that make up the South-East geopolitical zone of Nigeria. It has interstate boundaries with Delta State to the West, Imo and Rivers States to the South, Enugu State to the East, and Kogi State to the North. It derives its name from the Anambra River, a tributary of the River Niger. The state capital is Awka. Christianity is the dominant religion in Anambra State, although a number of its inhabitants practise traditional religion. Anambra state has two large commercial cities which are Onitsha (being the biggest city) and Nnewi (the second largest city).

KADUNA STATE

Kaduna State is the third most populous state in Nigeria. Kaduna has distinct differences in religion, ethnicity, traditions, and social norms between the predominantly Hausa/Moslem population in the northern part of the state and Christians of a variety of ethnic groups in the southern part. Kaduna town, the state capital, was the administrative and military capital of the defunct Northern Region and remains the unofficial political capital of northern Nigeria.

DATA COLLECTION

Rq1 was answered using Focus Group Discussions (FGDs) with members of the community. Inclusion criteria was limited to community leaders and those living in poverty who are above 18 years of age and who lived through the AIDS pandemic and the Ebola and Covid-19 health crises. We aimed to have as equal representation as possible along gender lines, although this was not always possible due to conflict and cultural dynamics in each area. Data was collected in the four local government areas identified in the research.

Rq2 was answered using Key Informant Interviews (KIIs) with Christian, Muslim and other faith or spiritual leaders identified through the literature review and through the research findings. Due to many religious leaders' being male, it is likely this sample will be skewed towards male voices.

Where possible, women leaders within faith organisations were also included. The primary inclusion criteria were those who experienced both the Ebola and Covid-19 health crises.

To respond to the needs of Objective 2, autoethnographies were also carried out amongst selected religious leaders.

The following table provides details of the Data Collection. It should be noted that during the data collection period, research coordinators did their best to adhere by any stipulations for security, COVID-19 and trust raised by the local community leaders, and therefore collected only as much data as was ethically possible. In one case, in Kaduna state, we had to postpone data collection due to a new ruling that dissuaded groups from gathering in certain spaces such as churches and school rooms. As such, the final FGDs were conducted in the office space of a local leader. Additionally, the validation workshops that were conducted after the fieldwork and initial analysis were complete were also delayed due to security concerns and only completed in October 2023.

STATE	FGDs	KIIS	AUTOETHNOGRAPHICS
Anambra State	Eight	Six	Five
Kaduna State	Eight	Six	Four

Following the collection of data, a first phase of analysis was done by the research team.

A second phase of analysis then took place wherein the findings were presented to key community members and stakeholders in each state in October 2023.

These workshops included individuals who had been part of the empirical research, as well as development practitioners, religious leaders, and local level officials. These workshops were used to verify and validate the findings and analysis as well as to tease out the design for the multi-country research project that forms Objective three.

4.0 FINDINGS OF THE DATA COLLECTION

4.0 FINDINGS OF THE DATA COLLECTION

In this section, we provide some of the key findings from the field data collection. Based on the findings of the study, it is clear that the community members have a clear understanding of the role of the religious leaders, and who they identify as religious leaders among them, their functions and the roles they play during health emergencies. From what can be understood from the findings, we can say that Religious Leaders (RLs) or Faith Leaders (FLs) are community influencers who hold leadership roles with any religious organization, mainly as formal and informal groups as far as such persons are recognized in their community. The RLs organize, lead, coordinate and administer religious groups or faith communities (Ummah [in Islamic tradition]) inspired by similar faith and sacred doctrines and principles as a guide into spirituality and divination. The findings revealed that the RLs are critical stakeholders within the community because of their social status. The RLs unite the community and constitute the theological and communal moral compass. The table below provides an overall overview of some of the findings regarding the key roles that religious actors play.

KEY ROLES	BRIEF DESCRIPTIONS
Divine intervention	Prayers and invocation of God to avert emergencies and disasters. The foundation of this is that "With God all things are possible"
Health enlightenment/ education	The RIs preach and discuss current issues and crises. The sermon dwells on health themes and religious, traditional and modern ways of averting such health emergencies.
Myths confirmers/ disapprovers	A major priority in health emergencies is how to control misinformation and disinformation. The RIs provide a forum to debunk or affirm myths and legends concerning any outbreak.
Teaching faith and resilience	In health emergencies, RIs serve to mobilize community members for mobilization for community resilience, anility to use available means and resources to reach a definite goal, in this case prevention and treatment.
Influencers (health and illness behaviour)	In most cases, faith community members listen to RIs, hence they influence how they respond in terms of the use of preventive and treatment measures.
Magnifiers of community voices/needs	They also help to raise the voice of the community members in term of healthcare needs and aspirations during agencies.
Welfare provision and support system	Many RIs and faith communities provide support system or social capital for the vulnerable in the communities. Sometimes they provide succor in terms of cash and in-kind support

4.1 THE RELIGIOUS LEADER IS A FIGURE OF TRUST AND AUTHORITY

"Government gave us drugs during these outbreaks for treatment and our traditionalists too always do their own medicines." ***(Female FGD Umumbo, Anambra state)***

"Seriously people don't joke with the messages of the religious teachers because most of them are elderly and experienced and also when they give verses to read and pray, it always works because we have tried that and seen results." ***(Male FGD Makarfi, Kaduna State).***

One of the key findings was that the data collection affirmed much of what was noted in initial consultations and literature reviews, that the faith leader or religious leader is consistently seen as a figure of trust and authority. Many respondents constantly affirmed their significant levels of trust in their religious leader. For some, this was connected to their view of the religious leader as a kind of parent. Others affirmed that they believed that the faith actor has the power to intervene spiritually and provide protection against infection and therefore change a crisis situation. In a male FGD in Kaduna state, for example, respondents noted that religious actors play a fatherly role in the community and therefore, there is so much trust and a strong bond between them.

In an FGD conducted in Makarfi, in Kaduna, respondents affirmed that there is an existing, strong mutual trust and relationship between the community members and faith actors. This makes whatever information they present to their followers accepted without questioning. Similarly, in two of the female FGDs conducted in Anambra state, the respondents described how there was a lot of different information that had spread during the COVID-19 and Ebola pandemics. However, they waited to hear from the church leaders as to the best way forward before following hygiene measures. This was related to the significant trust they had in that religious leader.

Most participants across board noted that they would do as a religious actor directed without questioning. When it came to issues like a public health crisis, from experience, they knew that the religious leaders would receive information and pass it on to them. They professed a level of trust for their local religious actor that was higher than that for public health officials or other external parties. Faith actors were also noted in Anambra state as the person or persons to go to when seeking assistance on behalf of an ill person during a health emergency. An enumerator's notes describe this as the participant seeing the religious leader or faith actor as a kind of public advocate for the community during health crises.

"The church assisted the masses with the little we could. We told people to always wear their face masks, though it wasn't that easy, because telling elderly people in the villages to [do so] some of them were complaining that they were nearly choked, wearing he facemasks all the time. But we still encouraged them. Earlier this year there was an outbreak of measles and many children died. So we encouraged parents to take them to the health centers ...let them do their best and committed the rest to the hands of God. So later on, prayers we are made to avert the situation and the children, we didn't go ahead losing too many after that" ***- Autoenthography Female leader in Ayamelum.***

In the validation workshops, for example, in Makarfi LGA, a Ward Head noted that during the Covid-19 pandemic, they only felt able to acknowledge the existence of the virus when it was confirmed by the religious leaders. A group of women respondents at the workshops also noted that the polio vaccine was never accepted in their community until the religious leaders advised community members to accept immunization for their children. These women also noted that one of the reasons that they turn to the traditional leader for assistance is due to the lack of skilled medical personnel in their community

Another instance that increases the bond of trust between the religious actor and their community is the fact that the religious leader is not only approached as a source of knowledge and information. The religious leader also provides 'complementary care' as detailed in the table above. As the religious leader provides prayers and seeks divine intervention, or as in the case of those adhering to traditionalist religion, provide holistic cures, they are a point of healing also. In the validation workshops, respondents also noted that either through doubts in modern healthcare, or the lack of skilled medical professionals in an area, many will turn to the traditional healers and traditional leaders for medical assistance as well. This further increases the bond between the religious leader and the community.

It should be understood here also that this trust has other layers of complexity. As we discuss at various points below, there are also tensions between religious groups, and an awareness that some leaders may favour their own community over another, whether it is regarding information provision or the distribution of aid items. In Ossamala Ogbaru LGA, some respondents noted that the traditional leaders received more trust due to exclusivity of burial practices. That is, in this case, Christian actors would only provide burial rites for their own 'active' members, and therefore, if a non- active Church member or a non-Christian person dies, one would require a lay member or, if possible, a traditional elder to perform the burial. An instance was also given during the communal crisis in Ossamala; it was the traditional religious leaders that brought a solution to it using their method of worship.

In addition, during the validation workshops, it was clear that some of the authority that the religious leaders hold is due to their existence as a non-government entity. For example, some respondents noted that they had faced having to pay a government official for access to services that should be free. In many of the workshops, respondents also noted the importance of, for example, 'vigilante' groups who keep the peace. This word should not be understood in the direct English translation but is better understood as community groups who take on a kind of community policing because there is very little trust in formal police institutions to respond efficiently and quickly to any issue.

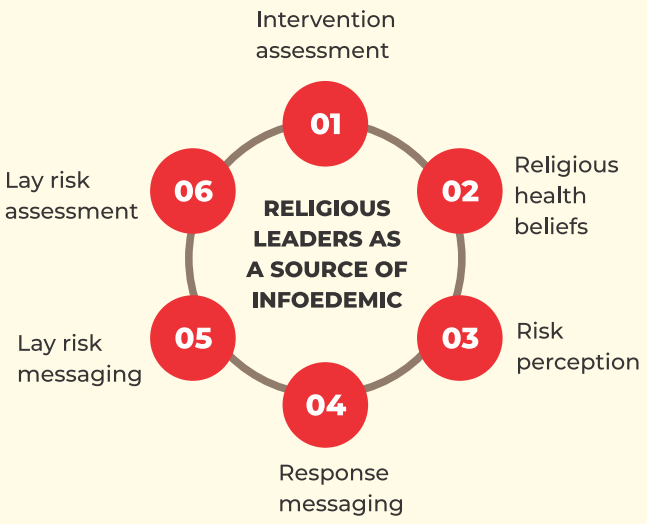
In Kaduna North LGA, for example, participants stressed the need for the inclusion of community organizations as stakeholders in the research because of their influence in the community. They also highlighted the vital role of women in health care related issues, noting that women also serve a vital role in public health crisis as they are the primary caregivers in their families. They also recommended the inclusion of local vigilantes like the Joint Task Force (JTF), association of persons living with disabilities and market associations in disseminating health related information.

1.2 THE RELIGIOUS LEADER AS A KEY FOCAL POINT FOR INFORMATION AND COMBATTING DISINFORMATION.

This high level of trust in the religious leader leads directly to the fact that the role that religious leaders play as key focal points for information and combatting disinformation cannot be set aside. However, this also means that the religious leader can also be a source of disinformation, and that they could easily abuse the power and trust that they enjoy. Throughout the discussions that we had with community members and drawing from the autoethnographies by the religious leaders themselves, we had long accounts of how religious leaders helped to increase congregational awareness of preventative measures. Religious leaders used gathering points like Friday worship or Sunday mass to spread sensitization messages, promote hand-washing, and social distancing. Religious gatherings like weekly worship or traditional ceremonies were key sites where these regulations could be discussed, as well as where community members could exchange knowledge regarding a health emergency.

In autoethnographies, religious leaders noted that they would frequently receive information from health authorities, and they were then required to disseminate this widely. Religious leaders were also privy to information regarding community transmission rates, or the occurrence of a health emergency in an area. They, in turn, inform the public health authorities of this issue. In Kaduna state, it was noted that such information is often disseminated in a hierarchical way in the community.

It should be noted that the religious actor is not the only source of information on these matters but is a vital nodal point. Community members also receive information from public health centres, as well as social and mass media. In both states, older participants noted that they will still validate this information with the religious leader. It was interesting to note the rising role of youth in this scenario, using social media to verify information. During our validation workshops, respondents asked for the creation of a social media platform for the sole purpose of disseminating health related information during a public health crisis. They also requested that market associations be included in the system for distributing health information.



In some FGDs, we noted some participants highlighting that they do not always fully accept the information from the religious actors. Some participants said that they do not always accept what the religious actors preach, and as such, they may act in ways that are contrary to the instructions of the faith actors. The members of the congregation or followers further serve as sources of health-related information to the religious actors. In Kaduna state, some participants said that they get information that goes around from house to house and then verify it with the religious leaders. Religious leaders we spoke to said that they always verify such information from lay sources before passing it on. (We map some of this in the diagram above).

"For the information which we got, we got most of those information from government, they send information across when we do pastors conference; they teach about health issues and hazards; we get information from there as well even if you are in a small station and you don't go, the other pastors that are in the big parishes they will go, when they come back they pass information down to small stations for the protection of members."- ***KII with Christian Pastor in Anambra State***

Fig 4

That there is this nuance to information reception and transmission is important as there have been cases where religious actors have abused the trust and power that they have in the community. We did not encounter any specific cases of this reported to us in the initial fieldwork, but other studies done by Christian Aid, as well as other research organizations have flagged this. During the validation workshops, we were informed by respondents that there are times that misinformation can occur when a religious leader is seeking to favour their own community.

For example, in Ossamala Ogbaru LGA, majority of the workshop participants noted that Church leaders are more likely to favour the members of their church, hence, there was more trust in traditional leaders who were more liberal in their sectarianism. However, they did note that despite such favouritism, they were more inclined to believe a church leader over a government official. This is due to significantly low levels of trust and confidence in government officials as detailed in the previous section.

In the initial fieldwork, what we most frequently discussed or saw flagged was instances where religious actors have spread misinformation or caused further harm through stigmatization of a person suffering from an illness.

Most of the religious actors we spoke to noted that they encourage their communities to appeal both to medicine as well as traditional healing and /or prayers, this is not always the case[2]. Traditional medicine here refers to health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies applied singularly or in combination to treat, diagnose and prevent illnesses or maintain well-being. However, one or two religious leaders we spoke to noted that they have less faith in modern medicinal methods. One participant in Kaduna state noted that religious leaders working nowadays are more amenable to modern medicine methods than in the past. As such, this suspicious attitude to modern medicine is now only limited to a few. We can also triangulate this against the discussions held during the validation workshops of the lack of skilled medical professionals available in some areas, as well as some community members not trusting modern healthcare methods.

This could create difficulty during a health emergency. It should be noted that this is not limited to any specific religious group. For example, two Christian leaders can have differing views.

What we can see from the different discussions, as well as triangulation with the literature review and consulting with internal and external discussants, is that there is a complex mix of accurate information and misinformation. This can have the double function of encouraging as well as hindering health emergency efforts. In religious communities, it is easily possible for there to be a belief that a virus such as COVID-19 or a prolonged outbreak of a disease (cholera) is related to a judgement from God or a fulfilment of Scripture. Persons who adhere to a religion or a faith are more susceptible to believing in apocalyptic statements. The religious actor's powerful connection as a messenger of or from the Divine makes them at once an important nodal point for being a source of public health information, but also a source that is high risk.

*"The district head and the community leader give order for an announcement to be made in every corner of the community that there is a disease outbreak, and such measures should be taken to overcome it, and if such outbreak is found, should be reported to the community leader. In order to avoid such pandemic [sic] our clerics in their sermons talk about measures to be taken. Clerics, during the sermons, will inform their followers of a new outbreak and the people will unite with the Government to overcome such event to the extent the community leader announces that a sanitation is going to take place"- **KII with Muslim community leader, Kaduna State***
Fig 5

It is therefore a complex difficulty that faith actors will be listened to, for the most part, without question. This raises a query for public health authorities for how to and who to work with as a key community partner. It is also important to understand that in the Nigerian context, the community extends beyond simply the place of worship or who you worship with, it is, as we noted in the introduction, part of the fabric of everyday life. What are the ways in which to build and maintain a critical relationship? Mitigating this risk and developing strategies for how to work with religious actors is a key discussion to be taken forward for academics and practitioners.

[2] traditional healing in this context is, traditional/unorthodox medicine. It is not tied to any specific religion, but rather culture and tradition

4.3 RELIGIOUS ACTORS ARE KEY COLLABORATORS FOR PUBLIC OFFICIALS.

Primary healthcare centers serve as the first point of reference in health emergencies among all communities. Faith actors and other stakeholders advocate for reporting all strange diseases in the communities to the primary healthcare centers. The study further understands that most community members understand whenever a particular disease has become an outbreak. They gathered this knowledge through house-to-house information, which is appropriately reported to the concerned authorities.

"If you come to this community, majority attend church. If there is any disease that is in town, they announce it in church and they inform people who came to church to disseminate the information. Then for those who don't go to church, there is a health centre around and they post banners and posters in the hospital to illustrate diseases and their causes. Sometimes, the health Centre ask the town crier to make announcement of diseases. Now we get information easily than before because churches are available and hospitals too."
– FGD in Umunankwo, Anambra State
Fig 6

Community members generally prefer primary healthcare centers to tertiary hospitals because of the unnecessary delay involved in the latter.

Religious actors remain important stakeholders in supplementing and complementing public officials' efforts in addressing epidemics. It was clear, from the autoethnographies, as well as the testimonies from the focus group discussions that the religious actors played a critical role in the coordinated response to pandemics, particularly in terms of social referrals, and social approval of interventions to ensure acceptance and saturation including compliance with broadcast messages.

There is good collaboration and synergy between public health authorities and community leaders. Religious actors that we spoke to noted that they are well briefed by public health authorities. Building this relationship further, as well as maintaining the links between multiple stakeholders (health authorities, CSOs, traditional leaders, religious actors, government agencies) is important. While this finding could be generalised across board, in Anambra state, there was some discussion that highlighted that there was little synergy in terms of information as well as material provision between traditionalist and Christian religious actors. This is due to tensions between them concerning questions of whether or not a religious actor has legitimacy, as well as congregational size. Some of this has been teased in the preceding sections, but we must also add here a very key point from Ossamala Ogbaru LGA, where African Traditional Leaders noted that organisations like Christian Aid are more comfortable working with Christian or Islamic leaders, and therefore the traditional leaders are not always included in briefings, development activities, or as key nodal points to distribute or carry out development interventions.

One of the issues that is clear here is that there is good coordination between different actors when it comes to mobilising a public health response. For institutional religious leaders, there remains a tension when it comes to the syncretic practice that their adherents often adopt. For some, like the Anglican Pastor in Anambra state, this is something to be tolerated as it is part of a long-term practice, but for others, like a religious female leader also in Anambra state, this is something to be changed. For some of these institutional actors, their own historical survival and methods of conversion are also tied to their willingness to undergo a process of inculturation, that is adapt, their religion to Nigerian traditional religion as well. This explains why one or two of the autoethnographies acknowledged that they encourage their flock to seek help from the medical officials, from God, and also through traditional healing methods. This further underscores the need to have a very diverse approach to how we understand religious actors. For example, one of the discussions that we had as a research team already helps to think about the nuances of definition. Our discussion focused on the fact that within the community, traditional healers in most instances are not always considered to be religious actors. This is because they possess little or no adequate religious knowledge that qualifies them to be referred as a religious actor. They are only knowledgeable in traditional medicine and other traditional means of healing, which the society qualifies them to be expert in that field. Yet, the medicinal aid they provide has a spiritual component to it due to the nature of traditional healing.

Within this, we also acknowledge that a religious actor, on the other hand, need not to have any knowledge of traditional means of healing before the society qualifies him to be a religious actor.

4.4 COMMUNITY CARE

One of the overriding discussions in both states was the discussions of long-term health issues. This was not limited to Ebola or Covid-19, but also to conditions such as Lassa Fever, cholera, as well as an unnamed fever condition that community members noted were plaguing their families. At the time of conducting this study, some communities were experiencing a health emergency or a strange disease.

"Teachers of faith do pray and share prayer books during which [sic] pandemic and they told people say the prayer with lemon i.e., praying and taking the lemon after each prayer. I did that and it was a success. Everybody prays and our hope is for our prayers to be answered and even the Christians are observant. We belong [sic] to some meeting with them and prayers with some both izala and derika mosques are said. They are really trying and is only God that will bless them both Islam and Christian teachers of faith." – ***FGD with older female respondents in Kaduna State.***
Fig 8

"For instance, consistent challenge of typhoid, malaria. And let me say that all these other major issues of course, from time to time, you can see cases of tuberculosis, yes, but all these later conventional disease challenges, are not all that visible at the moment but the ones that the natives usually suffer from, has to do with typhoid, malaria, then tuberculosis and several of them are coming in as a result of poor access to potable water and then the environment because several of them go into the bush to defecate and as a result, is a serious environmental hazard and some of us who are part of the community we inhale those things and keep on sensitizing them that it is not proper." – ***Autoethnographic account by Pastor in Anambra state***

The public health crisis that occurred in our presence and has been prolonged is cholera. It lasted long more than any other health crisis that happened here. We have seen it several times, several deaths have been recorded, and sometimes some houses had to be closed. Sometimes when someone dies from cholera, community members run away and refuse to participate in the final rites of congregational prayers simply because of the fear of being affected- ***Kaduna North Autoethnography***
Fig 7

The immediate health emergency in Kaduna state is cholera, which has been recurring in most communities. The cause of the outbreak is linked to poor sanitation and improper refuse management in the affected communities. Some faith actors maintained that their religion has an already established protocol to be deployed in cases of health emergencies. They believe that if strictly adhered to, will help contain and protect other community members yet to be affected.

In Anambra state, faith leaders noted transmissible diseases like tuberculosis, typhoid, cholera were significant issues, and noted their efforts towards working with public officials to build better sanitation and improve access to water so that such diseases could be contained. This remains a significant problem for the community. There is a lot of fear of contamination, as well as social isolation connected to this issue, and continued efforts by different actors like public officials and religious leaders to address this in both structural and cultural ways.

The long-term nature of contagious diseases means that within the communities we spoke to, there is a high level of understanding of measures that are required to contain contagion. This explains in many ways why community participants often told us that when they are told to 'eat a lemon, wash hands, not shake hands, wear a mask', they do so. This also explains the smooth functioning of a line of information between public health officials and community leaders. As depicted in the quote from the textbox above, we can also see interfaith cooperation between Muslim and Christian communities who share meetings and therefore also information. In some interviews, participants noted (both states) that they feel able to directly consult health care personnel in case of a health issue or health emergency. In some interviews, it was also noted that community members relied on modern medicine, spiritual healing, as well as home-brewed medications and herbs when confronted with a health issue. This underscores some of the discussion above that community members use multiple approaches when dealing with health issues, especially long-term issues.

In Anambra state, it was noted that traditional leaders also often provide treatment for community ailments. Here, we must once again remind the reader of the various complex levels of who provides what care, where community care is clearly delivered through multiple stakeholders, such as vigilante forces, market associations, primary caregivers, as well as institutional and traditional faith actors. In recognizing this, it becomes important that any future research or development work should include community organizations, informal faith organizations, market associations and local vigilante groups as actors for both design and delivery.

5.0 DISCUSSION OF FINDINGS

5.0 DISCUSSION OF FINDINGS

The discussion portion of this report attempts to respond to the two research questions. As a reminder, they are:

RQ1: Who are the religious actors and what are their roles in health emergencies in Nigeria and what does this mean for development delivery?

RQ2: What knowledges exist in the affected communities/religious communities regarding the role that religious actors play in public health crises? Do these knowledges challenge development assumptions?

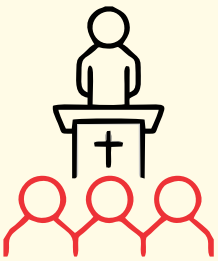
5.1 THE MULTIDIMENSIONALITY OF THE RELIGIOUS LEADER.

Let us begin by looking at the first portion of the first question. Who are the religious actors in this scenario? It is clear that religious actors in this context are diverse, coming from what we might call institutional spaces like Islam and Christianity, but also from traditional spaces. This was already evident from the literature review we conducted, as well as from the held knowledge regarding this context. In the interviews that were conducted, participants noted the religious leader with whom they held affiliation, but also mentioned they would also turn to traditional leaders or traditional healers as well.

As such, if we want to answer the question of who a religious actor is, and who decides, which frames and titles this study, we can answer readily that there is no direct definition of who a religious actor is. For the communities that we spoke with, we could argue that it is not precisely about the particularity of the religious actor, but rather the focus on the person who provides a service of healing, care and trust in the community. It is about the role that they serve. More often than not, this is the religious leader because they have long held that position in this society, though we acknowledge that among young people the authority they have is shifting.

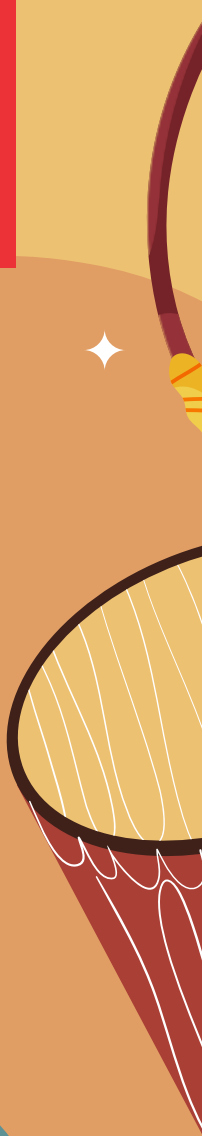
It is also important here to note how often the interviews mentioned the communal aspect of the response. That is, that they received information at worship meetings, and when gathering for prayer and reading.

The religious leaders are important because communal gathering occurs in the space that the religious leader convenes. Individuals do seek out religious leaders for blessings, divine interventions and assistance during a health emergency, and the collective nature of what occurs in these communities is also important. It is because of the religious leader's ability to convene that they also become an important nodal point for public health officials. As such, we can see that the religious leader can be defined in holistic and spiritual terms, but also in terms of the very practical role that they play. These roles are permanently intertwined. They are the practical 'go to' because of the spiritual role that they play, and the practical role that they play concretises their focal point as spiritual leader.



The syncretic nature of these communities also becomes very important here. Practice is multiple and syncretic, with quite a few respondents- though of course not all- comfortable with seeking assistance from different spaces. One could argue that quite a few of the respondents had a 'double allegiance'. This description of double allegiance was also underscored in some of the autoethnographic accounts which note equal levels of belief in ritualistic charms, as well as Divine blessings.

This becomes more established in places where there have been long term illnesses and chronic conditions. The focus group interviews made it very clear that what was most important was being in 'right relationships' and having the proper relevance for each other and for the religious actor, the divine and the community leader. This appears as paramount. One thing that was not very clear was the detail of what right relationships should look like. As such, it may be important for the in-depth research to consider a further conversation on what right relationships look like and why this might be important for development interventions.



We return then to the important role that religious actors/leaders play in the communities, particularly in terms of providing information, training, as well as spiritual succour. The chronic nature of different illnesses that are found in the community has concretised this role. In the interviews, the respondents often detailed these issues to use, particularly of the ongoing fever epidemic and requested our support for helping with addressing the disease as well. It is very clear that multiple sources of support are very welcome. As such, the religious actor provides the role of welfare support, spiritual succour, information point, convenor, advocate, as well as intercessor with both the divine and the public officials.

Due to the community engagement level of the interviews that we conducted; we can see the interventions that occur at the micro-level. Religious leaders- both institutional and traditional- assist individuals and families to help with the crisis, the insecurity and the stress, by providing contingency support, prayer, spiritual protection and counselling. They are also important in terms of promoting the willingness amongst community members to help each other, as well as increasing the ability to comply with public health regulations

"To date, some people do not trust and believe in vaccination simply because of the problem of the past; if such persists, there will be a problem, but when government sits with them and sensitize the faith actors and ensure they have 100% acceptance, they will ensure they convince their followers" - ***Makarfi Male FGD Participant.***
Fig 9

At what Hillebrand (2022) might call the 'meso' level, we see religious leaders being active in measures to promote medical education and mitigation, particularly in terms of educating on virus spread, proper hygiene and countering misinformation and rumour. It was often remarked to us how important it was to have the religious leader providing charitable assistance, whether through cash donation or basic food supplies. It was also interesting to note instances of multi-religious or twinned responses to the health crises.

In both this study, as well as secondary data we used as triangulation, it was clear that multi-stakeholder and interfaith responses were extremely effective in terms of mitigating the worst effects of the different pandemics. This suggests a key recommendation that the design of research or development programming, as well as its delivery and deployment requires not just the engagement but the intentional inclusion of multiple actors.

Perhaps we can then argue that the answer of 'who' is itself irrelevant because the religious leader or actor is so multidimensional and therefore a definition is unnecessary. Religiosity is deeply embedded into the very fabric of these communities, it is part of their everyday life, and so such definitions are meaningless. The religious actor is a fact of life, and constant, and the sense of the divine, or the many divines also very significant. This, we can say, testifies to the 'held' knowledge of the community. Here, most religious actors take on multidimensional roles. Some of this is due to the syncretic nature of practice, but it is also due to the practical realities of the communities where one individual may have to take on multiple roles.

We can also see that there is a dependency on institutional religious actors to be key nodal points for delivery of aid, as well as spiritual succour, both from the community, as well as from the local officials or development organisations who seem to work primarily with such actors. This is an important direct learning for development practitioners to ensure that, on the one hand, actors are not overburdened, but also that too much power and authority is not invested in a singular type of actor.

It also challenges development research and learning reviews by INGOs to always ensure that when attempting to understand the role that a particular actor or type of actors has played, that a full scoping of the context is first conducted. This should include a power analysis. Spirituality and its importance, that is, the role of the actor beyond just an information point or as a transactional character, is also often not included in development research and practice. The overwhelming picture of the religious actor or leader in this and in other studies is that their spiritual role is not subtractable or separate from their role as information-giver, welfare officer and educator. Spirituality should occupy a relatively prominent role in development research and practice, but it remains conspicuously under-researched in policy and programming of development organisations. Development theory and practice is then challenged to think of religious leaders as beyond functionality.

5.2 THE RELIGIOUS LEADER AND MISINFORMATION

Such positive roles are not always the case. As we noted in the findings regarding disinformation, religious leaders can also be found to be at fault for spreading rumours or siding with narratives that a particular disease is a curse sent from the Divine. We saw this especially discussed in the empirical findings from Kaduna state. This is a complex issue. The religious leader's assumed proximity to the Divine means that their attitude in terms of messaging and information is crucial and can have major impacts on the community. This issue is more prevalent amongst religious leaders who are not fully in agreement with modern medical methods. This makes community members susceptible to the disease and to conspiracy theories, as well as to the abuse of such things as prosperity teaching. In this study, including a previous Christian Aid study in a different context, there were religious leaders who interpreted these chronic diseases as God's curse or God's punishment. At a micro-level, this mostly serves to increase negative emotions such as fear, helplessness, and loneliness. In a context such as Nigeria which is 'incurably religious,' such interpretations are very dangerous, because of the deep rootedness of belief in the divine, or in spirits that may bring ill-will. Such interpretations are a permanent risk factor in deeply religious communities. A discussion with a Christian Aid staff also noted that this issue becomes more heightened when political actors agree with these incorrect interpretations and join with a religious leader to resist modern medical methods.

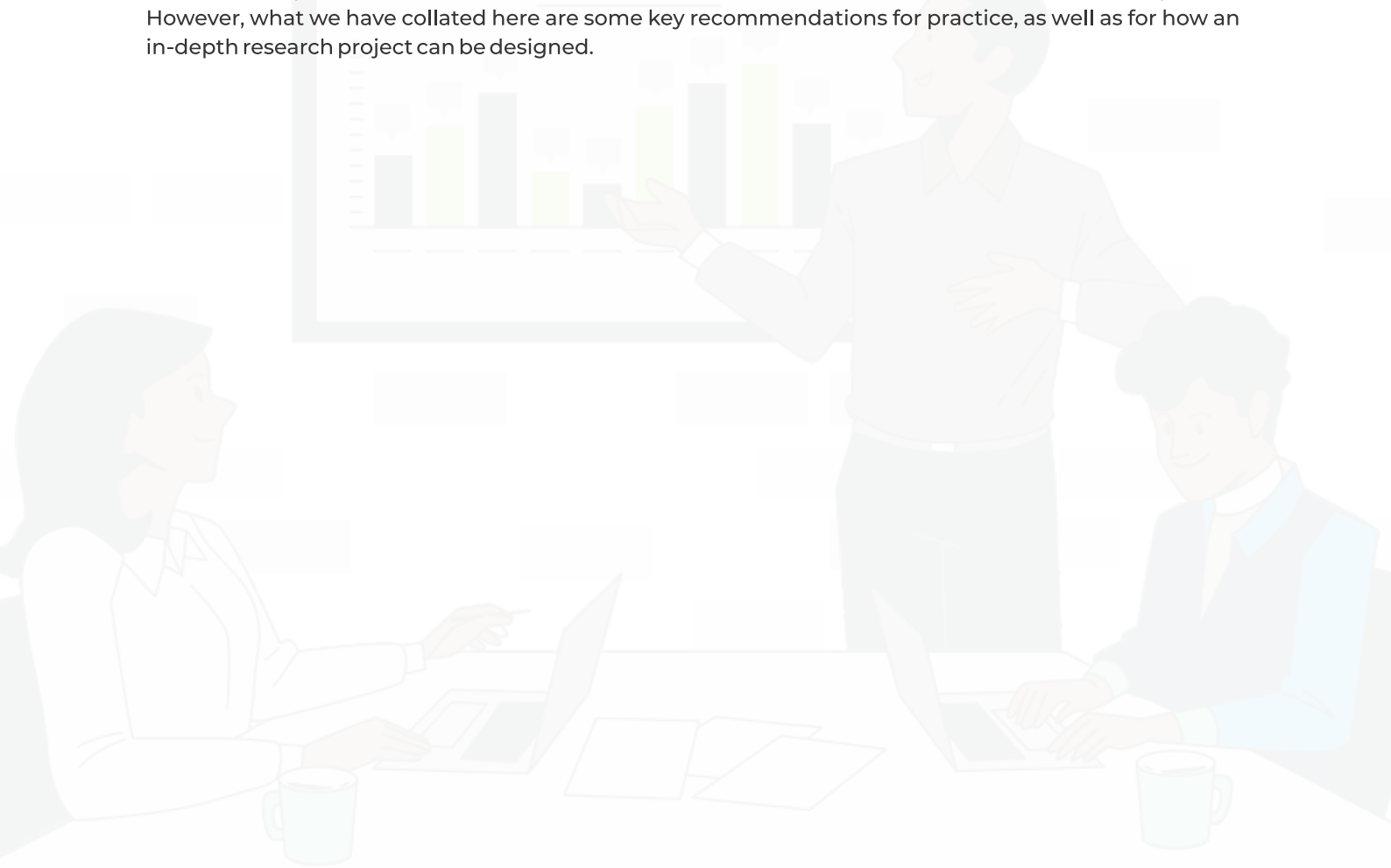
Some religious leaders, particularly in the autoethnographic accounts also noted that they sometimes felt overwhelmed, therefore, some individuals or families were neglected and they [the leader] felt unable to act in a visionary manner. In particular, for leaders who had dealt with multiple and long-term crises, there was a feeling that a strong moral vision and ethical drive was necessary. There also seemed some fatigue in the role of constantly informing, educating and responding which can lead to the leader having a sense of impatience or anger with the community. In the participant responses, there were also some instances highlighted, particularly in the Anambra case study and in Ossamala Ogbaru LGA, where a religious leader may only be interested in their own religious group. This is made more complex because of sectarian - ethnic conflict that is undermining the society, and as observed during the validation workshops, the exclusion of African Traditional Leaders, who are also very influential in their various communities in the design and delivery of. This leads them to discriminate against other communities, or against traditional leaders. Some of this kind of action is related to scarcity of resources. The risk factor here is that such inclusivity may lead adherents to violate public health regulations and, of course, reduces their willingness to extend solidarity beyond their own religious 'in' group. This is a particular hindrance when we see how important the multi-stakeholder response has been in alleviating the suffering caused by the health crises, as well as reducing risks. The experience in Ogbaru particularly highlights the need for thorough stakeholder mapping and power analysis to ensure inclusivity while engaging religious leaders.

In Osoamala community, Ogbaru LGA, we saw how African Traditional Religious leaders - often referred to as The Chief Priest- were instrumental in helping the community keep hope and faith during moments of crisis like the COVID 19 pandemic amongst others. The story was told of how other religious leaders, who are usually posted from outside the community to serve in religious centers, had to return to their original homes as part of safety measures during the pandemic, leaving behind the chief priests who are usually indigenes of the community as the only major source of spiritual guidance and counsel in those difficult moments. While this emphasises the relevance of all stakeholders, it also underlines the challenge for development research and practice in terms of the need for continuous power analyses of the contexts in which work is conducted, and in discerning which actors one may work with. This also poses a challenge to localisation efforts, as it can be argued that not all local actors will engage with their communities in ways that are positive. As an example, in localisation efforts to 'shift power,' does power remain in the hands of those who are already powerful and who may continue to marginalise a community that is not part of their own 'in-group?' Institutional religious leaders who belong to, for example, Christian and Muslim affiliations, can be very powerful and this can be a detriment to those hailing from, for example, African religious traditions. Development research and practice is challenged to find ways to centre less institutional actors, or, to arrive at a definition of local actors that is reflective of the pluriverse of the context in which one is working.

5.3 LIMITATIONS OF DISCUSSION

It should be noted that this discussion does not include a fuller response to the research questions that have been posed. Whilst some of this will be filled in in later stages of the study once the final workshops have been completed, it is also true that the methodology did not yield in-depth empirical findings regarding the 'held' knowledge of the community that we were seeking. In part, this is due to the fact that in-depth interviews, focus groups and autoethnographies conducted in spaces where there has been chronic health issues and multiple problems, can act as a kind of 'confessional' where participants are simply speaking of their experience in a way such as to exorcise what they are going through. This is underscored by the fact that in most of the focus group discussions, there was a foregrounding of the health conditions that were present in the community and the 'ask' for assistance, or the complaint that these stories had been told multiple times and no assistance had been forthcoming.

It also indicates a fault in the methodology. In order to ascertain the kinds of 'knowledges' that we were seeking, it would have been more apt to approach the methodology in a more phenomenological manner, seeking to draw out and observe life worlds and interactions. It would have been more apt to also focus on the autoethnographies as more reflective pieces so that we could have drawn out the ways in which religious leaders understood their space and place in the community, not simply reflecting on the health crises. We must also acknowledge that the autoethnographies and KPIs collected were mostly from institutional religious leaders, so the data becomes limited. In part, a phenomenological approach would not have been possible due to the ongoing pandemic and the security situation. This was also not possible due to the funding limitations. This underscores the need for a longer-term study that is able to engage on the phenomenological level. To a great extent, the validation workshops allowed us to plug some of these methodological gaps, but this certainly underscored the fact that to have a robustly decolonized praxis, the research required to be longer term, and more phenomenologically attuned. It will also be important to understand how identities are understood and their connection to the spiritual. However, what we have collated here are some key recommendations for practice, as well as for how an in-depth research project can be designed.



6.0 CONCLUSION AND RECOMMENDATIONS

6.0 CONCLUSION AND RECOMMENDATIONS

From the data that we have gathered, and the discussion points raised, we can provide some conclusions and recommendations. They are as follows:

01 It is important that development research and practice foregrounds spirituality as a point of analysis in programme and practice, particularly in contexts that are deeply religious.

02 There is need for a power analysis in development research and practice that ensures a multiple or pluralistic approach to understanding local actors. Particularly, this should consider the inclusion of 'traditional' actors, and community actors alongside institutional actors.

03 There is need for a longer-term study that engages religious actors and lived experiences of the communities at a phenomenological level. This would also require extending the research area to other states and communities.

04 There should be a mapping exercise, done by public health officials working against multiple pandemics, that understand the effects that occur at micro and meso levels, especially in terms of information dissemination.

05 Skilled medical personnel should be deployed to rural communities to help build trust in the health system.

06 There should be a continuation of multi-stakeholders' responses, and the continued engagement with religious actors and leaders in this response and recognising that this extends beyond institutional actors like Christian or Muslim leaders. Religious leaders are an important liaison with the stakeholders in the health communities. Religious leaders should be involved in all engagements - trainings, seminars - from onset to enable them understand project objectives towards maximizing their participation. Reaching the community through the religious actor is always a considerable community engagement measure. Working to educate religious actors and leaders on modern medical methods may also help to dispel any difficulties some may have with scientific methods.

07 Development practice needs to consider the importance of a syncretic and multiple response to a health crisis for communities. Service delivery must not only focus on singular efforts like the delivery of hygiene packs, but also ways to support religious actors who may be providing welfare and services on multiple fronts. It is important to understand the dynamics of engaging different types of religious leaders available in the community during stakeholder engagement processes for different interventions.

08 There is need for public officials, researchers, and development practitioners to consider religious actors as significant stakeholders in managing health emergencies by implementing measures and initiatives that would equip them with the desired knowledge and synergy between them and other stakeholders. This is a key point forward to center spirituality for the next in-depth research piece.

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09 The specific areas of collaboration identified include appropriate social referrals, ethical practices, and social approval. In cases of health emergencies, the flow of help-seeking sometimes starts with the religious leader, who constitute an essential link in the lay referral network. Help-seeking in an emergency often starts with prayers from the religious leader, who should understand their health intervention limits and make appropriate referrals to the health center.

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10 Religious leaders could provide appropriate information about what is ethical and derived from religious principles on managing emergency care in terms of respect for persons. For instance, Covid-19 involves the management of the bodies of the victims. Burial rites are a significant component of religion and religious leaders should be involved in burial arrangements, symbolic practices and ritualized community behaviour. This further underscores the necessity for spirituality as a point of analysis and design.

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11 The data shows that spreading credible information to the community could be more accessible through the religious leaders. Passing information through the religious leaders, particularly those who are friendly to scientific methods, is a way of fighting conspiracy theories and myths concerning any outbreak. Most community members trust information from the religious leader; hence social approval might easily be attained. Social approval is a way of gaining community members' confidence in the disseminated information and could also facilitate compliance with disease control measures. This is why the synergy between the government (public health) authorities, and the religious leaders should be imperative. Development practitioners must help to create spaces where such synergies can be nurtured. However, there must be a power analysis done before such information systems are set up and development practitioners and public officials must work to ensure that actors such as African Traditional Leaders are included when defining religious leaders.

APPENDIXES

IN SECONDARY DOCUMENT.

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