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ORIGINAL PAPER

"The First Person They Call is Their Pastor": The Role of New York City Faith Leaders in Supporting Their Congregation's Health and Well-Being During COVID-19

Rachel P. Sklar[1] · **Roberta E. Goldman**[2]

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Abstract
This article reports findings from a qualitative study of New York City faith leaders' efforts to mitigate the effects of the COVID-19 pandemic on their communities during the first two years of the pandemic. Faith leaders were recruited via reputational case sampling to participate in individual, key informant interviews. This study used a social-contextual approach to health promotion by exploring the influence of faith leaders and religious communities on health behaviors. Results suggest that engaged faith leaders worked individually and collaboratively to support the changing physical, emotional, and spiritual needs of their religious communities and those in the surrounding area. This study highlights the importance of faith leaders as supporters, communicators, and advocates, and provides directions for future research on the impact of faith leaders on individuals' experiences and health behaviors during a pandemic.

Keywords COVID-19 · Faith leader · Public health · New York City

Introduction

In times of health emergency, faith leaders have a unique ability to shape the experiences of their immediate communities and those in the surrounding area. Due to the large proportion of individuals involved with religious communities in the U.S., the potential for impact is great. In the New York City (NYC) metropolitan area, the proportion of adults identifying with a religious group is 76%, slightly lower than the country-wide proportion of 84.2% (Religion in America n.d., 2022).

✉ Rachel P. Sklar
rachel.p.sklar@gmail.com

[1] Division of Biology and Medicine, Brown University, Providence, RI, USA

[2] Warren Alpert Medical School, Brown University, Providence, RI, USA

Discussion of the impact of faith leaders and communities on health is prevalent in pre-pandemic and pandemic literature. Previous research has highlighted how faith leaders can encourage healthy behaviors in their communities (Anshel & Smith, 2014). Historically, faith-based public health interventions have been implemented for medical issues such as HIV, cancer screening, physical activity, and the H1N1 influenza virus, with many centered around Black and Latino churches (Allen et al., 2014; Brewer & Williams, 2019; Flórez et al., 2020; Hill & McNeely, 2013; Kiser & Lovelace, 2019; Young & Stewart, 2006). Many such interventions occur as partnerships between medical and public health establishments and faith-based communities, which can include community-based outreach, health policy advocacy by faith organizations, and federal partnerships (Barnes & Curtis, 2009; Levin, 2016). Beyond intentional health interventions, studies have shown that connections to religion, religious community, or spirituality can have health benefits such as a decrease in mortality, increase in positive mental health outcomes, and decrease in hopelessness, depression, and suicidal behaviors, though there is criticism of response bias in this field (de Oliveira Maraldi, 2020; Hovey et al., 2014; Koenig, 2015; Lucchetti et al., 2011)**.**

COVID-19 began to spread in NYC in February 2020 (Zimmer, 2020). Early on, little was known about the disease and hospitals were materially unprepared for the surge (Brenner, 2022; Hart, 2023). While the development of vaccines has somewhat eased public concern, the pandemic remains ongoing and new variants threaten additional waves of infection (Aleem et al., 2022; Parker-Pope & Sheikh, 2022; "Tracking the Return to Normal," n.d 2022). The unique circumstances and potential influence of faith organizations, leaders, and communities during the COVID-19 pandemic were acknowledged by the World Health Organization, which released guidance in April 2020 about how religious leaders and organizations can protect their communities by adopting safety practices, providing education, helping individuals remain connected, and supporting community members (World Health Organization, 2020).

Scholarship prior to the COVID-19 pandemic on public perception of social distancing measures during a pandemic addressed the competing concerns between public desire to keep faith centers open because of their role as sites of support, prayer, and information sharing while also acknowledging their potential role in disease spread. Previous research predicted opposition to a mandate closing faith centers during a pandemic (Baum et al., 2009), which proved correct during the early COVID-19 pandemic when restrictions on gathering in faith centers caused tensions between religious communities and the government, culminating in Supreme Court cases (Dias, 2020; Liptak, 2020; Stack, 2020a, c).

Literature on the role of faith and faith communities worldwide during the COVID-19 pandemic has emphasized that the actions of some faith communities encouraged viral spread and the actions of many others saved lives (Lee et al., 2022; Levin, 2020, 2022). One review of 58 articles about diverse religious communities across the world between February and July 2020 classified their contributions into "beneficial" and "detrimental," "mitigation & adaptation" and "transmission," respectively, finding that 71.9% of the articles focused on their beneficial roles. Examples cited included their beneficial roles in encouraging safe practices

like closing in-person facilities, collaborating with healthcare providers and governments, and their detrimental roles in spreading misinformation or inciting distrust for science and public health and causing COVID-19 outbreaks (Lee et al., 2022). Other research has focused on the roles of faith leaders and communities in places such as Michigan, Maryland, England, and the Philippines, and highlighted impactful interventions including a webinar to decrease vaccine hesitancy for Black Church congregations, medical-religious partnership community calls, and the role of churches in providing social services (del Castillo et al., 2020; Galiatsatos et al., 2020; Modell & Kardia, 2020; Peteet et al., 2022; Village & Francis, 2020). Much research has also focused on the connection between faith and coping and mental health during the pandemic (Pankowski & Wytrychiewicz-Pankowska, 2023; Schnabel & Schieman, 2022).

Media coverage in NYC highlighted the same dichotomy, highlighting stories of communities contributing to viral spread as well as contributing to public health efforts (Conger et al., 2020; Estrin, 2020; Hoffman, 2021; Stack, 2020b; c). This study had the goal of adding to the body of work on the positive impacts of faith leaders and faith communities on health during the pandemic in NYC. We explored the experiences and contributions of NYC faith leaders to promote the health and well-being of their religious communities and surrounding areas during the COVID-19 pandemic, including how they adapted programming and created new initiatives in response to the public health crisis. We aimed to identify the roles of faith leaders and religious communities in affecting health behaviors and coping during the COVID-19 pandemic in NYC.

Methods

Theoretical Framework

We used the Social Contextual Model as our theoretical framework for this study. This model outlines the influence of multiple phenomena on individuals' health behaviors and decision-making, where these factors are a reflection of the social and cultural contexts in which an individual lives (Nagler et al., 2013; Sorensen et al., 2003). For this study, faith leaders and religious communities constitute critical elements of the social context.

Ethics Oversight

The Institutional Review Board (IRB) at Brown University determined that participants in this study were acting as key informants per IRB guidelines. As such, this study did not meet the conditions for human subjects research and did not require IRB approval.

Nomenclature

Clergy and lay leaders, hereafter referred to as faith leaders, were interviewed. We describe the organizations in which they work as religious communities or congregations.

Sampling and Recruitment

Faith leaders in NYC were recruited to participate in individual, qualitative, key informant interviews for this study. As key informants, participants were asked to speak in a professional capacity and provide information about their religious community from their observations (Marshall, 1996). A purposive, criterion based, reputational case sample (Devers & Frankel, 2000) was obtained by soliciting recommendations from public health and/or religiously-connected professionals for individuals who fit the following inclusion criteria: 1) has a formal or informal leadership role in a religious community that is located in one of the five boroughs of NYC, contains a significant proportion of NYC residents as congregants, or has influence in a NYC religious community; and (2) engaged in health-focused work within their role during the pandemic. Potential participants were provided basic information about the study via email and/or phone to assess their interest in participating in an interview regarding their work during the pandemic. We ceased recruitment/data collection when we reached data saturation such that several religious groups were included among interviewees and no new themes or content were arising from interviews.

Data Collection

Interviews were conducted in a semi-structured manner (Bernard, 2000) based on an interview guide created specifically for this study. The interview guide was informed by a literature review, one author's work experience at the NYC Department of Health and Mental Hygiene (NYC DOHMH), and discussions with NYC DOHMH employees, faith leaders, and experts on faith-based public health work. These discussions provided insight on the experiences of faith leaders during the pandemic and topics of public health interest. The interview guide was informed by these discussions and designed to elicit data in response to the overall study aim. Core questions were supplemented by spontaneous probes and follow-up questions. Interviews were conducted in English by one researcher between October 2021 and August 2022.

Interviews were conducted via Zoom or phone call, with the exception of one interview via email communication, and took between 45 and 120 min. Interviews were video and/or audio recorded with the permission of the participant after verbal consent was obtained. Audio recordings were transcribed using Otter.ai transcription software. The transcripts were reviewed by one researcher for accuracy.

Qualitative Data Analysis

Data were analyzed simultaneously from interview recordings and transcripts using the immersion/crystallization method (Borkan, 1999). Each transcript was read in its entirety to keep all the data within the context of the interview. Data were then sorted into main topics addressed (Table 1). Sorted data were then analyzed to identify themes, patterns, and differences that arose across interviews.

Results

Sixteen interviews were conducted with faith leaders representing fifteen religious communities (Table 2). The sample consisted mainly of congregational faith leaders, complemented by a few faith leaders in other roles to provide a broader sense of the work of faith leaders in this time.

Additional Roles and Health-Focused Involvement Prior to the Pandemic

Participants described a variety of health-focused involvements prior to the pandemic. As one rabbi described: "We've tried to make the synagogue be a space where we can talk about issues that aren't only directly related to religious life, but also connected to the whole person" (Faith Leader 6). Participants worked on projects about issues including HIV/AIDS, mental health, food and housing insecurity, cancer, diabetes, health insurance promotion, and racial equity. This work took forms including resource fairs and speakers. Some participants organized these events on their own for their individual communities, while others did so in collaboration with governmental, religious, and/or medical organizations for broader audiences. Many relied on the expertise of member volunteers. A few said physical

Table 1 14 Main topics

1	Organizations they were involved with in a professional capacity
2	Faith community demographic information
3	Health-focused work prior to pandemic
4	Sources of information regarding COVID-19
5	Communication methods regarding COVID-19
6	Main ways that the COVID-19 pandemic affected their religious community
7	Health-related initiatives during the pandemic
8	Communal feedback
9	Involvement with organized programs for faith leaders
10	Strengths of their group in responding to the pandemic
11	Weaknesses of their group in responding to pandemic and barriers faced
12	Changes or new initiatives introduced during the pandemic that they want to continue
13	Advice for others looking to get involved
14	Additional stories

Table 2 Participant demographic characteristics

Number	Faith	Borough	Role	Institution and/or community as described by the participant
1	Methodist	Manhattan	Lay leader	Community, educational facility, and political platform serving all people and a wide age range, located in a multicultural area. Many congregants are on public assistance
2	Baptist	Manhattan	Pastor	A majority elderly African American community, mostly low-income or on retirement fixed-income. Congregants are mainly high school graduates working in a variety of fields. Most rent their homes
3	Protestant	Queens	Pastor	The church serves a very diverse community of attendees, as well as those in the surrounding area
4	Presbyterian	Bronx	Pastor	Congregants are largely African American and Latino. Church is located in the poorest congressional district in the state and has initiatives that serve its congregants and the broader community
5	Episcopal	Queens	Lay leader	District in which the church is located has 17% living below the Federal Poverty Level. There is 15% unemployment. Racially, it is 66% Black
6	Conservative Jewish	Manhattan	Rabbi	Largely highly educated, financially comfortable community, ranging from families with young children to older adults
7	Conservative Jewish	Manhattan	Rabbi	Community trends high income and highly educated. The community is predominantly white
8	Orthodox Jewish	Bronx	Rabbi	Mainly middle class congregation, with some struggling financially. Age ranging from young families to older adults
9	Muslim	Mainly Bronx, some initiatives outside	Chaplain	Initiatives aimed at engaging Muslims, interfaith leaders, and others. Outreach efforts served a majority Hispanic and African American population
10	Ultra-Orthodox Jewish	NJ with influence in Brooklyn (interconnected Ultra-Orthodox Community)	Rabbi	The audience of their writing and social media communications includes Ultra-Orthodox Jews from across New York and New Jersey
11	Baptist	Manhattan	Deacon	Socioeconomically diverse African American community that is majority female, trending middle age and retired
12	Baptist	Manhattan	Deacon	Same community as above
13	Baptist	Manhattan	Pastor	Predominantly African Americans working in a wide range of professions

Table 2 (continued)

Number	Faith	Borough	Role	Institution and/or community as described by the participant
14	Muslim	Queens	Trustee	Mainly professionals from India, Pakistan, Bangladesh, and Guyana. Majority of the community is 30–50 years old, with young families and older adults in addition
15	Catholic	Manhattan	Chaplain	Serves a nursing home and hospice with short and long-term residents ranging in age, but mainly 70 + and majority female. Occupants are from a wide variety of socioeconomic backgrounds
16	Catholic	Multi-Borough	Chaplain & VP	Organization cares for thousands a day, ranging in background, socioeconomic status, and age

exams and screenings performed at their health fairs were the only medical care some congregants received in a year. Most participants also volunteered in organizations outside their religious communities.

Sources of Information Regarding COVID-19

Interview participants used many sources of information about COVID-19 including numerous city, state, and federal information sources, as well as medical and public health workers in their communities. Medically-trained congregants served as assets by advising clergy on decisions, either informally or formally as part of committees focused on COVID-19.

Communication Methods Regarding COVID-19

Participants communicated about COVID-19 to their communities via virtual and in-person methods. Many incorporated messages about COVID-19 in sermons, including words of encouragement and education. One participant expressed what he saw as the power of this communication strategy:

> Faith-based institutions, as you know, speak to more people on their Sabbath day than any other institution in America combined. So in essence, we have the platform to really engage our congregation and to promote many of the public health initiatives that the city and the state and the nation was having difficulty in addressing. And certainly in communities of color. (Faith Leader 4)

One participant created a segment of weekly sermons where he talked about myths regarding COVID-19, and another discussed a virtual weekly program that was started during the pandemic where their pastor would speak about religious topics and informally talk about the pandemic and promote adherence to the CDC guidelines. Many also hosted events where medical experts from inside and outside their communities shared information.

Primary Ways the COVID-19 Pandemic Affected Their Religious Communities

Participants discussed stories of the sickness and death brought about by the pandemic, as well as the associated trauma for those surviving. Some cited great loss in their community, with one recounting losing 10% of his congregation during the pandemic. One participant spoke about a family who put their father in quarantine in the basement while he was infected with COVID-19 and found him dead a few days later after he was not answering their phone calls. Another cited how he reassured a woman who "thought she had heard 30 bodies removed the day before on her floor. But she'd been worrying that every pair of wheels on a cart was a gurney with a dead person, which wasn't true at all" (Faith Leader 16).

Some participants discussed the need to provide increased support for congregants in satisfying basic needs during the pandemic. Many of their congregants

lost jobs during the pandemic, resulting in an increase in food and housing insecurity. Others expressed surprise that more of their congregants did not, at least openly, ask for support in satisfying basic necessities.

The mental health implications came up as a main effect of the pandemic in almost every interview. Participants cited observing sadness, fear, stress, anxiety, hopelessness, and depression in their congregants. Most participants spoke of the pervasiveness of loneliness, particularly for older and single populations, and how congregants struggled specifically with their inability to gather with their religious community in-person. In contrast, one participant perceived older adults as particularly resilient in this time due to experience with prior crises.

Many participants also discussed the pressure on clergy members, specifically, during the pandemic, as they were tasked with supporting their communities amidst their own personal and familial struggles during the pandemic. Clergy members shared stories of their own losses and stress coping with the pandemic and the ways in which these changed their lives, personally and professionally. One participant described the stress the clergy faced, saying "sometimes you become emotionless, you just… you go through the motions" (Faith Leader 13). Some spoke specifically about how personally and spiritually difficult it was for them to close their houses of worship. Many also mentioned the challenges associated with the inability to connect in-person. A specific example of this frustration was cited by one participant who discussed the particular challenge of being unable to welcome new community members in-person, saying: "We've really had to kind of come up with new ways of doing outreach, just because the tried and true ones we've been doing for 1000s of years were not available to us" (Faith Leader 7). In light of this stress, faith leaders mentioned the importance of volunteers in their work, with one saying "Number one, you have to have a team" (Faith Leader 1).

Health-Related Initiatives During the Pandemic

These data were sorted into subtopics for analysis based on the main ideas discussed: distribution of supplies; information-sharing; serving other health needs; NYC Test & Trace Corps involvement; vaccines; community check-ins; community events; advocacy; mental health support.

A common theme was the responsibility of faith organizations to satisfy needs. As one rabbi said:

> For a lot of people the synagogue is their primary point of connection outside their home. So they would turn to us for any need that they had, so sometimes it was 'can you help me understand whether I need to wash my hands in hot water or cold water. (Faith Leader 8)

A similar sentiment was stated by another participant: "I always tell everybody, whether you are practicing or not, stay connected with your center, because that's how people know your situation, or at least if you're in need, you could talk to them" (Faith Leader 14). Another participant described how they received direct calls from congregants facing issues like food insecurity, the inability to contact relatives at

the hospital, or essential workers worried about bringing COVID-19 home to their families. The participant said, in the face of these issues, "The first person they call is their pastor" (Faith Leader 3).

The vast majority of participants had initiatives where their organization or committee gave necessities and/or monetary support to members of their religious community and/or the surrounding area as part of their work during the pandemic. Many worked with associated food banks or conducted food drives to support their communities and their respective areas. One participant described how at the beginning of the pandemic, she would "personally cook 700 plates of food… and would drive all day long" to deliver food to seniors (Faith Leader 9). Initiatives to distribute personal protective equipment (PPE), which they sourced from member donations and government programs, were also common. Initiatives to provide monetary assistance from congregational funds or donations to congregants and organizations in their borough were organized by two faith communities. Another faith organization had a table outside their building where they gave away clothes, food, PPE, and health-related information to anyone who walked by. A few participants also had initiatives to deliver groceries to ensure that those uncomfortable leaving their homes received proper nutrition.

Almost every participant described how providing mental health support and connectedness were priorities. Approximately a third of participants described programs where staff and/or volunteers conducted check-in calls on a one-time or repeated basis. They described relay or phone tree systems where member lists were divided among those making the calls, where the overall goal, as one put it, was to "make sure that every member of the synagogue basically got a phone call saying, 'Hey, how are you? What can we do?'" (Faith Leader 7). Some of these initiatives were more socially-oriented, aimed at checking-in on congregants, while others were designed by community social workers and structured with questions to identify and solve particular issues. Participants also provided individualized support in a variety of other ways, including hosting group catch-up sessions weekly on Zoom, providing virtual support groups, and offering one-on-one prayer via telephone. Some also hosted events with experts to discuss mental health, stress, and anxiety.

Most increased programming offerings in general to help their religious community feel connected virtually despite physical separation. They increased weekly prayer services and educational events, with some hosting virtual programming every day. Many expressed the programming goals and impact within a religious lens, explaining the impact of religious activities like Bible study:

> Applying the Word to our daily lives…, give[s] us the strength and help[s] us to understand that we are in fact overcomers, so if we just keep our hearts and minds focused on what the Word of God says, we will come through strengthened, stronger, because we are not in this alone. (Faith Leader 13)

Some organized programming targeted for the unique needs of demographic groups—children, parents, older adults, or essential workers. One participant created a learning series for healthcare workers based on religious texts to help them think about the spiritual issues at play in their role in the pandemic. The faith leader who ran this program reported: "The doctors appreciated having a place where they

could be participants and not leaders" (Faith Leader 6). Participants also hosted online educational programs about the pandemic.

Many participants discussed struggling to find new ways to support congregants during life cycle events, particularly when congregants had relatives in the hospital or were mourning loved ones. As one faith leader said, "Family is a very important part of who we are as a people. And they started to take away those rights to be there for our loved ones who were being affected by the pandemic" (Faith Leader 4). When faced with deaths in the community, they typically limited funeral sizes, consistent with state and city guidelines, and had virtual bereavement support.

Almost all participants engaged in vaccine promotion initiatives. The sentiment, "We have advocated it at every turn," expressed by one participant, was common (Faith Leader 2). Some congregations served as vaccine sites, and most had volunteers who supported individuals in getting vaccine appointments. Many provided education and countered misinformation. A common goal was providing information regarding vaccination so that individuals would be able to make informed decisions for themselves. As one participant put it, they provided their congregants with:

> the information that they need to make an educated decision. There used to be a commercial from a clothing company that used to say the educated consumer is our best customer. So I went along with that, and educate[d] people about what they needed to do, and they made the choices. (Faith Leader 4)

Another expressed a similar perspective: "Moving from a no to a maybe is a big step, and eventually maybe they will go on and have the comfort in order to get the vaccine" (Faith Leader 1). About a third of participants reported collaboration with NYC Test & Trace Corps programs, either serving as a testing site or hosting mobile testing vans outside their buildings. One participant described how their food bank hosted Test & Trace vans and vaccine opportunities to make testing and vaccines more convenient and accessible.

A few participants were engaged in advocacy projects regarding health needs with the state and local governments. One participant lobbied for mobile testing to increase accessibility of tests, which came to fruition months later. Another promoted vaccine equity by "literally wr[iting] to every single elected official in the Bronx" to increase vaccination opportunities and allocate vaccines for local populations (Faith Leader 4). This work resulted in the opening of additional vaccination sites, including sites at a stadium and at an apartment complex targeted for older adults unable to travel to vaccination sites elsewhere.

Many participants also continued to address non-COVID health issues. A few prioritized HIV education and prevention, which they saw as important "Because people feel that COVID is the only disease that's out here. And they fail to realize that we still have the HIV, which is so prevalent" (Faith Leader 1). Other examples of non-COVID-related health programming included supporting government initiatives to provide air conditioning to older adults who were unable to get to cooling centers, as well as hosting awareness panels focused on issues like prostate and colon cancer.

When talking about their advice for faith leaders looking to get involved in health-focused work, a few mentioned prayer, with one saying, "You start with prayer, you

start with common sense," but then added "You start with listening to the experts in those fields" (Faith Leader 2). Another acknowledged that faith leaders tend to be very busy, but expressed the importance of taking on health-related work in addition to their spiritual responsibilities: "Our clergy need to know that there are times that they have to step up to the plate for issues that are largely affecting our congregations in our community… It's like in the military, you focus your battle where the war is at its greatest" (Faith Leader 4).

Collaboration

Most participants cited collaboration, or at least communication, with other faith-based and/or government organizations. Involvement ranged from the NYC DOHMH and City Hall to community partnerships of one or many faiths, largely organized by geographic region. For some, this involvement was particularly important for information and resources at the beginning of the pandemic, while others spoke of their continued role as the pandemic progressed. Some also spoke about how the pandemic motivated them to continue and/or grow partnerships with other organizations for health-focused work and education.

Communal Feedback

While most participants expressed that their congregants were sad to be unable to gather in person, most cited little or no resistance to the decisions made by their leadership. Some said that people sought out alternative communities when their religious community was not meeting their religious needs or their preferences regarding COVID-19 precautions. A few participants did face resistance to their mask and vaccine distribution efforts from congregants. A powerful discussion occurred with one participant, who spoke of pushback after a speaking engagement where he was called to speak about the pandemic as a "trusted voice in the community," and someone told him: "we used to trust you, but if you're promoting this, we might have to reevaluate" (Faith Leader 2).

Jewish participants spoke about adaptations made regarding use of technology on the Jewish sabbath, and in the context of the reception of these policies. Some communities choose to not add technology in accordance with their normal practices and interpretations of Jewish law, while others chose to integrate more technology into their worship than prior to the pandemic.

Strengths, Weaknesses, and Barriers

When discussing what they saw as the strengths of their group in responding to the pandemic, participants had a variety of responses. One participant described her committee's dedication, saying:

> Oh, we were out front 100% responding to the pandemic… As a matter of fact, we really did not have any fear of our own lives. That was the strange

part, but we weren't thinking about we were not thinking about ourselves, we were thinking about others." (Faith Leader 1)

Some discussed gaining the trust of their communities and innovating in the face of challenges. Others discussed their utilization of technology. A also powerfully described how they "stay[ed] true to [their] values" and "The values and the mission never changes. Even in the midst of a pandemic" (Faith Leader 16).

When asked about weaknesses of their response and barriers to health-focused work, participants cited issues specific to their congregations, as well as difficulties faced city-wide. One participant cited that their faith organization could have had a better system to support those infected with COVID-19. A few participants also emphasized the lack of access and inequitable distribution of resources like vaccines and testing vans in the city. They described how it was difficult to encourage vaccinations and testing when these resources were inaccessible to their congregants due to difficulties with appointment availability and transportation. A few also spoke about their difficulty understanding and working with the changing guidelines, though one noted that when their organization communicated with the city, they were helpful.

Limitations

This study was a small, exploratory study, which aimed to identify themes and key topics relevant to the work of faith leaders in NYC on health-related issues during the COVID-19 pandemic. Limitations of this study include its sample size and scope. Recruitment for this study took place over a busy time for faith leaders, particularly those who prioritized the pandemic response, causing difficulties with recruitment. Purposive, reputational case recruitment ensured that those recruited for interviews were engaged in COVID-related work with their communities, however we were unable to include leaders of all boroughs and faiths in NYC, nor was our sample size large enough to compare responses by faith type.

Future research would benefit from a larger sample of engaged faith leaders from a greater diversity of religious communities to get a broader understanding of the work done in NYC and elsewhere, and to enable comparison among groups. Further discussion with faith leaders from different faiths would highlight the best ways to engage leaders of each faith identity and highlight factors that influenced differential responses. Studies of the role of faith leadership in each of the five boroughs of NYC may also provide insights to tailor mobilization in different boroughs. Additionally, future research should include faith leaders who were unable or chose not to implement safety precautions among their congregations during the pandemic. Learning about their reasoning and motivations can inform initiatives to reduce barriers and better engage faith leaders in public health work. Future narrative work on the impact of the COVID-19 pandemic should also center the stories of and held by faith leaders.

Discussion

This study highlighted the many ways that faith leaders served their communities during the COVID-19 pandemic in NYC. Overall, it is clear that our participants prioritized serving the changing needs of their communities, including providing access to necessities, supporting mental, spiritual, and physical health, and providing accurate information about the pandemic. High degrees of communication between congregants and faith leaders, initiated by both parties, enabled participants to assess needs and provide services and programming targeted specifically to their communities. This bi-directional leader-congregant engagement, ability to procure resources, and connections with outside individuals and organizations uniquely positioned these faith leaders to play important roles in their communities during the pandemic. Religious communities used technology to keep their communities connected, although many noted that portions of their communities were unable to use or afford the technology, which some addressed by providing assistance.

Consistent with past efforts to establish food banks at faith sites (Riediger et al., 2022), many faith leaders prioritized distributing basic necessities to members of their organization and people in the surrounding area. Faith leaders working in lower income communities had to pay more attention to fulfilling their congregants' needs in the face of unemployment, rising prices, and shortages. Their institutions were ideal distribution sites due to their space and connection to community networks.

The interviews in this study also addressed topics of vaccines and testing, two key elements of the public health response to the pandemic. Faith leaders took a variety of approaches to vaccine encouragement, in line with other initiatives which occurred across the country (Faith, 2021; Peteet et al., 2022). Research into the comparative effectiveness of vaccine promotion and education programs in faith organizations would provide evidence for best practices. While involvement with vaccination efforts was discussed by almost all our study participants, fewer were involved with initiatives to encourage testing. Future research is warranted about whether this difference is due to comparative perception of importance, differential opportunities for engagement, governmental staffing and support, accessibility of services, or other factors. This information would assist in the development of strategies for faith-based engagement around health promotion in the future.

Participants also spoke extensively about their role as supporters, confidants and important connections for people outside of their families, as was also evident in a study out of England about the work of clergy and lay leaders in rural and non-rural settings during the pandemic (Village & Francis, 2020). In our study, some congregants reached out to faith leaders on their own, and others were contacted by outreach through programs like phone trees, which highlight the role of faith leaders and communities in connecting with people who may be otherwise isolated. These initiatives show ways in which religious community involvement supported mental health during the pandemic, consistent with

other studies that connected religious service attendance and religious belief with lower levels of mental and psychological distress in the general population and caregivers specifically during the COVID-19 pandemic (Schnabel & Schieman, 2022; Sen et al., 2022). The emotional stories shared by participants about their congregants' struggles during the pandemic suggests their importance as confidants. This showcases the importance of speaking with faith leaders to record the effects of the pandemic and learn lessons for future health crisis situations. Additionally, participants' use of their platforms to advocate for their community's needs, resulting in programs that increased accessibility of city services, shows the potential power of faith leader voices.

Faith leaders prioritizing educating their communities about COVID-19 was a theme in this study, and its importance is substantiated by survey results (Nortey & Lipka, 2021). While in the overall population, clergy are not a main source of COVID-19 health information (Ali et al., 2020), of those who attend religious services regularly, one report found that 61% would trust their clergy to provide information about the COVID-19 vaccine—higher than the percentage of those individuals who reported trust in public health officials, state and local elected officials, and the news media (Nortey & Lipka, 2021). This statistic highlights the importance of clergy in health communication to their community members, which many faith leaders discussed. Further studies on the trust that varying demographics place in faith leaders for health-related information may be useful for prioritizing where to focus these initiatives. Also, as health-related communication is delivered by lay leaders in some communities and clergy in other communities, it would be useful to separately assess their trustworthiness.

Our study also highlights collaboration within and among faith organizations, as well as with non-faith groups. Participants described working with new and established partnerships with nearby faith leaders, which provided infrastructure for continued and timely collaboration around health issues and other initiatives. Participants also spoke highly of their work with governmental and hospital initiatives, which provided information, resources, and venues for collaboration. Other evidence of such partnerships comes out of a medical-religious partnership in Maryland, which implemented community calls and encouraged faith leaders to use their positions to share information about the pandemic (Galiatsatos et al., 2020). These programs are similar to those that occurred during other health emergencies and non-pandemic times (Barnes & Curtis, 2009; Kiser & Lovelace, 2019). The continuation of such collaborations are evidence of positive relationships between faith leaders and officials during the pandemic, despite conflict over gathering restrictions.

Another common theme was engagement in health-focused work prior to the pandemic. This likely enabled the faith leaders to respond more quickly and effectively to the pandemic by pivoting existing committees and partnerships for health-related engagement into pandemic projects. This suggests the continued importance of these committees and initiatives to ensure readiness for health emergencies. The development of and support for these programs will provide infrastructure to address health issues in non-pandemic times and respond to future emergencies. Faith leaders' involvement with other community organizations also likely made it easier to

mobilize groups of people. Faith leaders in NYC looking to get involved in health-related work should leverage existing groups for support and inspiration.

While the extreme toll the pandemic has taken on healthcare workers is commonly reported (Holmes et al., 2021; Salari et al., 2020), the unique stressors on faith leaders are often ignored. This study provided first-hand accounts of the work of highly-aware and engaged faith leaders to meet the challenges imposed on their communities by the pandemic, often adding new projects alongside their normal ones. In the face of this higher workload, a common theme of high-level stress among faith leaders arose in this study. These results highlight the importance of infrastructure and people to support faith leaders in times of pandemic crisis, as has been touched on in the literature (Greene et al., 2020; Village & Francis, 2020). In the face of this stress, the emphasis on the importance of teams and volunteers in these interviews shows how they helped alleviate some of the burden.

Other studies have highlighted similar aspects of the role of faith leaders and faith services during the COVID-19 pandemic. The results of our study are corroborated by work in Maryland, England, and the Philippines, which described the roles of clergy in rural and non-rural settings to provide education, spiritual support, and tangible pandemic assistance on their own and as part of a medical-religious partnership (del Castillo et al., 2020; Galiatsatos et al., 2020; Village & Francis, 2020). These common themes indicate the important and similar roles faith leaders and faith communities played in the COVID-19 pandemic.

Conclusions/Recommendations

Our study highlighted the many ways that faith leaders in NYC supported their community's health and well-being during the COVID-19 pandemic. We examined NYC as a case study, focusing on the experiences of faith leaders, and highlighting their roles in key initiatives throughout the pandemic. In a time of great change and need, faith leaders provided spiritual, material, monetary, and social support, and served as important educators, confidants, and advocates for their communities.

This study provides lessons learned that may benefit faith leaders and outside collaborators in preparing for health-focused work in future pandemics and non-pandemic times. Faith leaders should invest in organized groups of other faith leaders for support, resource-sharing, and collaboration on health-focused events and initiatives to share the oversight burden and expand their impact. Faith leaders should also establish and support health-focused committees within their organizations. These committees will be able to address public health issues that emerge and prepare for mobilization during pandemics and other health emergencies. This practice was shown to decrease the workload for faith leaders and enabled more effective responses. Public health officials, community leaders, and local governments should create and strengthen initiatives to educate faith leaders to serve as advocates for health promotion, solicit and value feedback from faith leaders about community needs, and provide support for faith leaders in coping with the stress of health emergencies. The development and support for these collaborations during non-pandemic times is important to ensure adequate preparation for future emergencies, such that

organizations have the infrastructure in place to respond quickly, effectively, and comprehensively to the needs of their communities during health crises.

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Declarations

Conflict of interest Rachel P. Sklar interned at the New York City Department of Health and Mental Hygiene from June to August 2020 as part of the Collegiate Leadership Internship Program at the NYU Bronfman Center. Roberta E. Goldman has no competing financial or non-financial interests to disclose.

Ethics Approval The Institutional Review Board (IRB) at Brown University determined that participants in this study were acting as key informants per IRB guidelines. As such, this study did not meet the conditions for human subjects research and did not require IRB approval.

Consent to Participate Consent to participate and be recorded was obtained from participants.

Consent to Publish Participants provided consent for their comments to be shared anonymously in a publication, and for their borough and religious faith to be shared.

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