

Article

Faith-Based Health Communication in Public Health Crises: A Scoping Review

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Abstract

Faith-based health communication has become an important component of public health responses, yet evidence remains fragmented across religious actors, message strategies, communication channels, and implementation contexts. This scoping review mapped the literature to identify recurring communication functions, evidence gaps, and implications for future public health crises. Scopus and Web of Science were searched for studies published between 2021 and 2026. Following screening and eligibility assessment, 40 studies were synthesized using the Population–Concept–Context framework. Although the evidence was drawn primarily from COVID-19 research, the pandemic was treated as an empirical case for understanding faith-based communication across public health crises. The review found that communication effectiveness depends on the interaction among legitimate authority, culturally meaningful translation of health messages, and the institutional capacity to support implementation, rather than on messenger credibility or communication channels alone. Building on these findings, the review advances an evidence-informed Authority–Translation–Capacity (ATC) analytical framework for interpreting faith-based health communication across diverse religious and institutional settings. The evidence base remains dominated by cross-sectional, qualitative, and descriptive studies, highlighting the need for comparative, longitudinal, and implementation-oriented research. The proposed framework offers a foundation for strengthening communication preparedness and engaging faith institutions as collaborative partners in future public health emergencies.

Keyword

Faith-Based Health Communication, Public Health Crises, Public Health Preparedness, Scoping Review



Abstrak

Komunikasi kesehatan berbasis agama telah menjadi komponen penting dalam respons kesehatan masyarakat, tetapi bukti yang tersedia masih terfragmentasi pada aktor keagamaan, strategi pesan, saluran komunikasi, dan konteks implementasi. Scoping review ini memetakan literatur untuk mengidentifikasi fungsi-fungsi komunikasi yang berulang, kesenjangan bukti, serta implikasinya bagi penanganan krisis kesehatan masyarakat di masa depan. Penelusuran literatur dilakukan pada basis data Scopus dan Web of Science terhadap publikasi tahun 2021–2026. Setelah proses penyaringan dan penilaian kelayakan, sebanyak 40 studi disintesis menggunakan kerangka Population–Concept–Context (PCC). Meskipun bukti yang dianalisis terutama berasal dari penelitian selama pandemi COVID-19, pandemi tersebut diperlakukan sebagai kasus empiris untuk memahami komunikasi kesehatan berbasis agama dalam berbagai krisis kesehatan masyarakat. Hasil kajian menunjukkan bahwa efektivitas komunikasi tidak hanya ditentukan oleh kredibilitas komunikator atau saluran komunikasi, tetapi oleh interaksi antara otoritas yang sah, penerjemahan pesan kesehatan yang bermakna secara budaya, dan kapasitas kelembagaan untuk mendukung implementasi. Berdasarkan sintesis tersebut, kajian ini mengembangkan kerangka analitis Authority–Translation–Capacity (ATC) sebagai pendekatan untuk memahami komunikasi kesehatan berbasis agama dalam berbagai konteks keagamaan dan kelembagaan. Basis bukti yang tersedia masih didominasi oleh penelitian potong lintang, kualitatif, dan deskriptif, sehingga diperlukan penelitian komparatif, longitudinal, dan berorientasi implementasi. Kerangka ATC yang diusulkan memberikan landasan konseptual untuk memperkuat kesiapsiagaan komunikasi serta mendorong keterlibatan lembaga keagamaan sebagai mitra dalam perancangan, pelaksanaan, dan evaluasi komunikasi kesehatan pada krisis kesehatan masyarakat di masa depan.

Kata Kunci

Komunikasi Kesehatan Berbasis Agama, Kesiapsiagaan Kesehatan Masyarakat, Krisis Kesehatan Masyarakat, Scoping Review

Introduction

Public health crises depend not only on the availability of scientific guidance but also on whether communities trust, understand, and are able to act on that guidance. These responses are shaped by institutional trust, cultural values, economic capacity, religious interpretation, and access to communication infrastructure. Evidence from infectious-disease emergencies shows that community engagement involving local leaders, faith-based organizations, community groups, and health committees strengthens trust building, risk communication, surveillance, and implementation of public health interventions (Gilmore et al., 2020).

Religious institutions are particularly influential where worship spaces, schools, hospitals, charitable organizations, and community networks constitute established social infrastructure. During public health emergencies, health guidance often intersects with religious beliefs and practices, raising questions about legitimate authority, collective responsibility, moral obligation, and the practical limits of compliance. The COVID-19 pandemic provides a well-documented empirical case for examining how faith-based health communication operates under conditions of uncertainty, institutional pressure, misinformation, and constrained access to health services. Although the findings are context dependent, they offer valuable insights for

strengthening communication preparedness in future infectious-disease outbreaks and other public health emergencies.

Evidence from diverse settings indicates that faith leaders and organizations perform roles extending well beyond the transmission of official health messages. African American pastors supported community engagement in health research and communication, faith leaders in the Democratic Republic of Congo called for greater involvement in message design, and Islamic organizations in the United States collaborated with Muslim clinicians to deliver culturally and linguistically tailored health information (Hayes et al., 2021; Baba et al., 2022; Yasmin et al., 2022). These findings suggest that faith-based communication is shaped not only by who delivers the message but also by how religious authority is integrated with institutional partnerships, cultural interpretation, and community engagement.

However, religious involvement does not necessarily guarantee message acceptance or behavioural change. Faith-related communication may strengthen protection, solidarity, and collective responsibility, yet it may also coexist with fatalistic interpretations, institutional distrust, misinformation, or competing sources of authority. The rapid expansion of digital communication further complicates this landscape by enabling sermons, institutional statements, personal testimonies, rumours, and corrective messages to circulate simultaneously within the same information environment (Jaravaza et al., 2024; Idler et al., 2022). Consequently, the presence of a trusted religious messenger alone cannot explain whether health guidance is understood, accepted, or translated into preventive behaviour.

Indonesia illustrates both the potential and the limitations of faith-based health communication within this broader international context. Among 1,097 Muhammadiyah members, 66.7% performed *tarawih* prayers and 67.4% observed Eid prayers at home during the pandemic, although some congregational settings lacked adequate preventive facilities and compliance with protective measures remained inconsistent. Likewise, a survey of 5,326 households in South Tangerang reported high levels of mask use (79%) and hand hygiene (74%), but lower adherence to physical distancing (59%) and routine disinfection (37%). Knowledge, positive attitudes, and proactive community leadership were associated with stronger preventive practices (Nurmansyah et al., 2022; Boerman & Nasir, 2024). These findings illustrate that religious guidance can facilitate behavioural adaptation, but its effectiveness ultimately depends on organizational coordination, local resources, and broader community conditions.

Despite the growing body of research on faith-based health communication during COVID-19, the evidence remains fragmented across disciplines, religious traditions, communication channels, and behavioural outcomes. Existing studies have examined religious leaders, source credibility, message framing, vaccine attitudes, communication platforms, and health behaviours, but these elements are often analysed in isolation. Consequently, less attention has been given to how three interrelated communication functions operate together: whether health guidance is regarded as legitimate, how biomedical information is translated into culturally and morally meaningful terms, and whether communities possess the material and institutional capacity to act on that guidance. Without distinguishing these functions, communication failure may be attributed too readily to religious belief or message content, when the underlying

constraints lie in institutional inconsistency, limited access to services, or inadequate implementation capacity.

Accordingly, this review adopts an international perspective while treating Muslim communities and Indonesia as analytically important subcontexts. Rather than assuming that evidence from Christian, Jewish, Muslim, and multi-faith settings is directly comparable, the review identifies recurring communication functions across diverse religious and institutional contexts while recognising their contextual differences. To guide this synthesis, the review develops an evidence-informed analytical framework comprising three interrelated dimensions: authority, translation, and capacity. Authority refers to the recognized legitimacy of religious or institutional actors to communicate, interpret, endorse, and implement health guidance. Translation refers to the process through which biomedical information is rendered understandable, culturally meaningful, morally acceptable, and locally actionable. Capacity refers to the material, organizational, social, and institutional conditions that enable accepted guidance to be translated into practice. Although analytically distinct, these dimensions are mutually reinforcing: authority without translation may produce trusted but poorly understood guidance, translation without authority may produce culturally relevant messages that lack legitimacy, and authority and translation without capacity may generate acceptance without sustained action.

Guided by this framework, the review addresses the following question: How have faith-based actors, message strategies, communication channels, and implementation conditions been studied in relation to preventive behaviour during public health crises, and what conceptual, contextual, and methodological gaps remain? The review maps messenger roles, forms of authority, message strategies, communication channels, behavioural and intermediate outcomes, implementation conditions, and evidence gaps. Although the evidence synthesized derives primarily from studies conducted during the COVID-19 pandemic, the review treats COVID-19 as an empirical case for generating evidence-informed insights applicable to future public health crises. Rather than estimating pooled effects or ranking the effectiveness of religious interventions, the review seeks to provide an integrated understanding of how authority, translation, and capacity interact in faith-based health communication.

Methods

Review Design and Protocol Logic

A scoping-review design was selected because the literature spans communication studies, public health, behavioural science, religion and health, vaccination research, and digital media. The purpose was to map concepts, study characteristics, and gaps rather than to estimate a pooled intervention effect. The review was structured according to the Arksey–O'Malley framework, subsequent methodological refinements, JBI guidance, and PRISMA-ScR reporting principles. (Arksey & O'Malley, 2005; Levac et al., 2010; Munn et al., 2018; Peters et al., 2024; Tricco et al., 2018).

The Population Concept Context framework defined the review boundaries. Population encompassed community members, religious leaders, faith organizations, health professionals, and public-health stakeholders. The concept was faith-based health communication related to COVID-19 prevention, including messengers, message

strategies, communication channels, trust, misinformation, and behavioural responses. The context was unrestricted geographically. Muslim communities and Indonesian studies were identified during data charting as analytically important subcontexts rather than as formal eligibility restrictions.

Information Sources and Search Strategy

Scopus and Web of Science were searched using terms related to health communication, reScopus and Web of Science were searched using a predefined search strategy developed for this review. Because the review examined faith-based health communication through the empirical case of the COVID-19 pandemic to generate insights relevant to future public health crises, the search strategy intentionally focused on terms related to health communication, religion or faith-based actors, and COVID-19. Searches were limited to publications published between 2021 and 2026. Reference lists of eligible reviews and included studies were screened to ensure bibliographic completeness; however, supporting methodological and theoretical publications identified through this process were not treated as review evidence.

The following search string was applied: (“health communication” OR “public health communication” OR “risk communication” OR “health information” OR “health promotion”) AND (Islam* OR Muslim* OR religi* OR faith-based OR “religious communication”) AND (COVID-19 OR coronavirus OR SARS-CoV-2).

The searches retrieved 526 records (336 from Scopus and 190 from Web of Science). After applying the publication-year restriction and removing one retracted record, 492 records remained (309 from Scopus and 183 from Web of Science). Records were then deduplicated using DOI and standardized title matching, yielding 337 unique records for screening.

Eligibility Criteria

Eligible sources were peer-reviewed empirical articles or reviews published from 2021 through 2026. A source had to examine at least one explicit faith-based communication element—such as a religious messenger, faith institution, religious or moral frame, faith-linked channel, or religion-specific information environment—and connect that element to COVID-19 prevention, vaccination, testing, protective practice, or a proximal communication outcome such as trust, comprehension, risk perception, or intention. Programme evaluations and rigorously described implementation studies were eligible.

Sources were excluded when religion appeared only as a demographic covariate; when communication processes, sources, frames, or channels were not examined; when the outcome concerned spiritual coping or mental health without a preventive-communication dimension; when the publication was a protocol, commentary, meeting abstract, book chapter, letter, or retracted article; or when bibliographic or methodological information was insufficient. Foundational theory and methods references were used to interpret the evidence but were not counted among included sources.

Screening and Selection

Title and abstract screening was followed by full-text eligibility assessment. Screening decisions were reconciled against the operational criteria above, and full-text exclusions were documented with reasons. Of 337 unique records, 289 were excluded

during title and abstract screening. Forty-eight reports were assessed at full text; eight were excluded and 40 sources were included. The selection process is summarized in Figure 1. (Pollock et al., 2021).

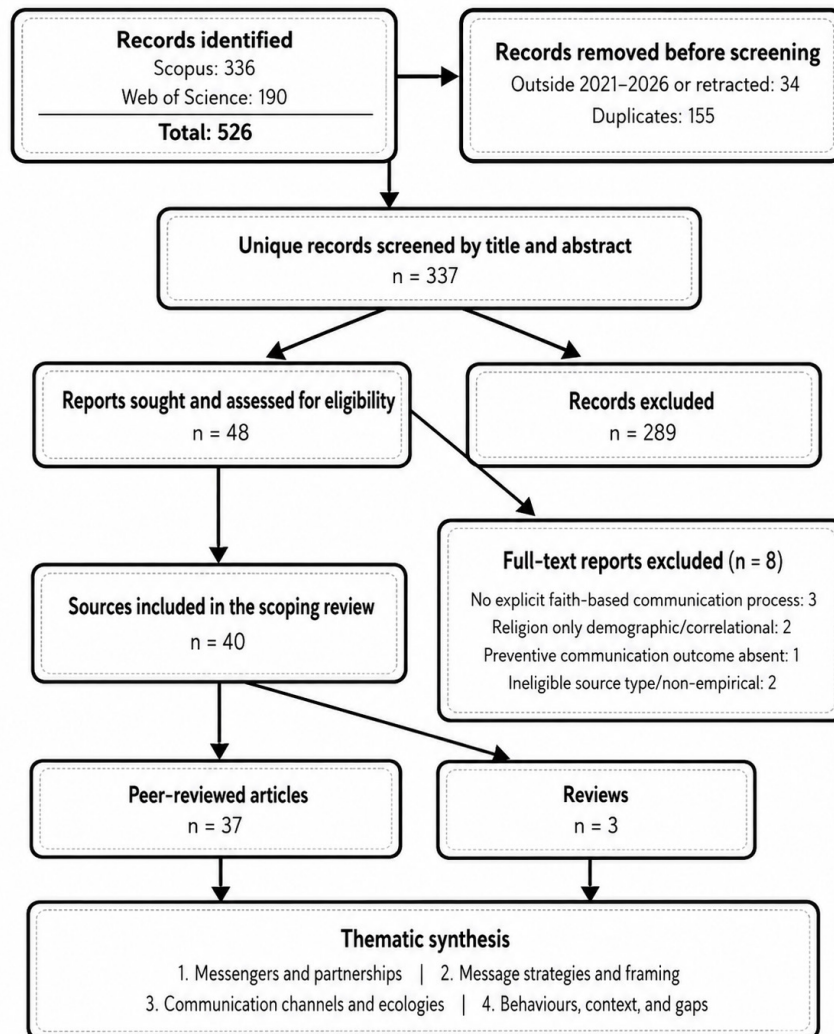


Figure 1. PRISMA-ScR flow diagram for database identification, screening, eligibility assessment, and inclusion.

Data Charting and Synthesis

The charting form captured author and year, country, source type, design, population, faith context, messenger, authority type, message strategy, communication channel, preventive or proximal outcome, facilitators, barriers, principal findings, and limitations. The categories of messenger, frame, channel, mediator, behaviour, and contextual moderator were specified deductively from communication and behavioural theory and refined inductively during charting.

Descriptive mapping summarized publication year, source type, geographic distribution, and evidence design. Thematic synthesis then organized the evidence into four domains: messengers and institutional partnerships; message strategies and religious framing; communication channels and information ecologies; and preventive behaviours, contextual conditions, and evidence gaps. No formal risk-of-bias score was used because the aim was evidence mapping rather than effect estimation. Instead,

study design, measurement limitations, and evidence maturity were charted and used to qualify interpretation.

Theoretical Background

Faith-Based Health Communication as a Trust-Based System

Faith-based health communication is a relational process connecting religious authority, public-health expertise, community identity, and behavioural guidance. Credibility depends on expertise, trustworthiness, religious legitimacy, moral integrity, cultural proximity, and institutional consistency. (Hovland & Weiss, 1951; Pornpitakpan, 2004).

Authority within faith-based communication is therefore heterogeneous and distributed. Religious scholars may hold theological authority, faith organizations institutional legitimacy, clinicians medical expertise, local committees operational authority, peers experiential credibility, and digital preachers networked visibility. These forms may reinforce one another or compete.

Trust is shaped by prior relationships, transparency, competence, fairness, and responsiveness. Religious actors should therefore participate in framing, translation, delivery, feedback, and evaluation rather than being used instrumentally as late-stage distribution channels. (Vaughan & Tinker, 2009). This broader role supports the authority component of the review's framework by recognizing that legitimacy is produced through relationships and institutional practice rather than communicator status alone.

Religious Framing, Risk Perception, and Behaviour

Behavioural theories help explain how audiences interpret and respond to faith-based health messages. The Health Belief Model explains preventive action through perceived susceptibility, severity, benefits, barriers, cues to action, and self-efficacy. Faith-based communication may shape these constructs by framing vulnerability, protection of life, avoidance of harm, and collective responsibility. (Rosenstock et al., 1988).

The Theory of Planned Behavior adds attitudes, subjective norms, and perceived control. Congregational norms and family expectations may shape intentions, while employment, facilities, and access determine whether intentions can be enacted. (Ajzen, 1991). Social cognitive theory emphasizes reciprocal interaction among beliefs, observed behaviour, and social environments. Religious leaders can model preventive conduct and reinforce norms, while community networks influence self-efficacy. (Bandura, 2001).

Risk-information processing and fear-appeal models further explain why exposure does not guarantee action. Threat messages are most likely to support danger control when audiences consider recommended actions effective and feasible; when efficacy is low, fear may produce denial, defensiveness, or fatalistic reassurance. (Griffin et al., 1999; Witte, 1992; Rimal & Real, 2003). Vaccine hesitancy is context-specific and shaped by confidence, complacency, convenience, risk calculation, collective responsibility, and trust. Religion is therefore neither a fixed protective factor nor a universal barrier. (MacDonald, 2015; Larson et al., 2014).

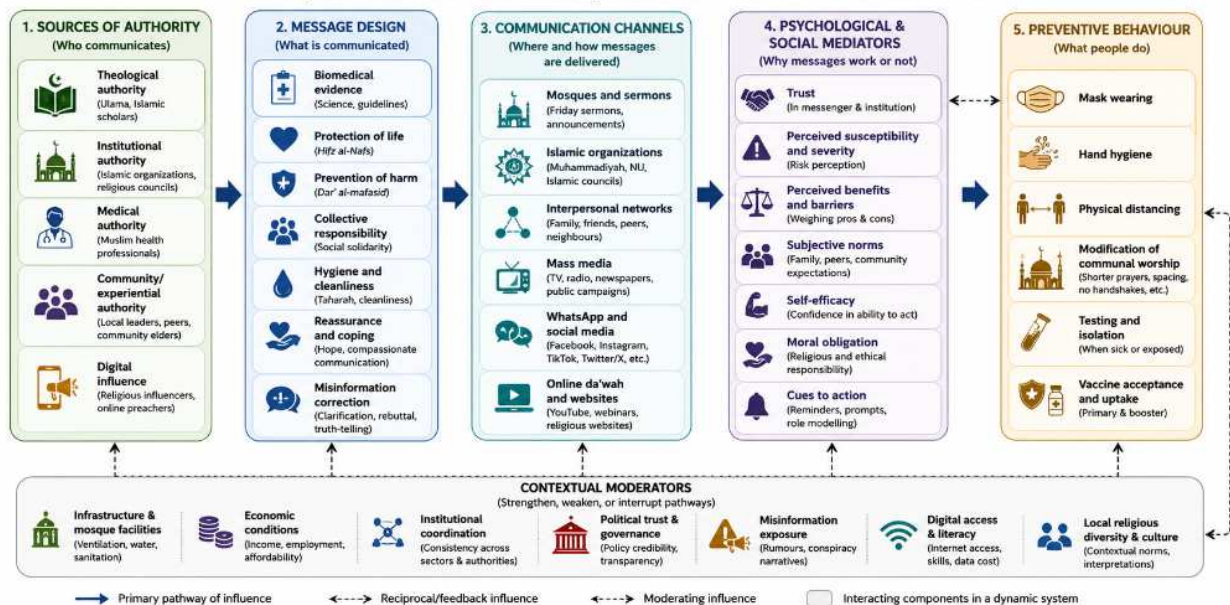


Figure 2. Integrative framework linking religious authority, health communication, behavioural mediators, and preventive behaviour.

Figure 2 presents authority, message design, communication channels, interpretation, behavioural mediators, capacity, and preventive behaviour as reciprocal rather than strictly linear components. The framework is applied most explicitly to Muslim-majority and Indonesian settings where religious interpretation, organizational authority, communal worship, and public health implementation intersect visibly. The broader review examines whether comparable communication functions also appear across Christian, Jewish, multi-faith, and other religious settings without assuming that these traditions are doctrinally or institutionally interchangeable. Contextual conditions, including facilities, economic resources, political trust, digital access, service availability, and religious diversity, may strengthen, weaken, or interrupt the pathway from communication to action.

Communication Ecology and Controversies

Faith-based health communication operates within a communication ecology that includes worship settings, religious organizations, families, health services, television, radio, WhatsApp, YouTube, websites, and social media. As messages move across these environments, they may be amplified, simplified, reframed, contested, politicized, or distorted (Kasperson et al., 1988; Chaffee & Metzger, 2001). The meaning of a message therefore depends not only on its original content but also on the actors, platforms, and social relationships through which it circulates.

Digital users often rely on authority cues, institutional logos, follower counts, peer sharing, and interactivity. Misinformation correction must therefore address why a claim is trusted and provide a coherent alternative through credible community and health messengers. (Metzger et al., 2003; Lewandowsky et al., 2012).

Central controversies include restrictions on worship, variation within and between religious traditions, vaccine safety and halal concerns, politicization, and the difference between unwillingness and inability to comply. Economic pressure,

occupational exposure, digital inequality, and inadequate sanitation can prevent adherence even when messages are accepted.

Results and Discussion

Forty sources published between 2021 and 2026 were included: five from 2021, ten from 2022, seven from 2023, ten from 2024, five from 2025, and three from 2026. Thirty-seven were peer-reviewed articles and three were reviews. Evidence came from Asia, Africa, Europe, North America, and Australia; six sources contained Indonesian data or an explicit Indonesian comparison. Most studies used cross-sectional, qualitative, content-analytic, or programme-description designs. Experimental comparisons, longitudinal follow-up, and direct observation of congregational behaviour were uncommon. The evidence covered Asia, Africa, Europe, North America, and Australia, while six sources contained Indonesian data or an explicit comparison involving Indonesia.

Messengers, Religious Authority, and Institutional Partnerships

Table 1 shows that faith actors functioned as interpreters, advocates, organizers, trusted messengers, and co-designers. Indonesian evidence positioned mosques and religious leaders within broader community systems rather than as isolated causes of behaviour. (Nurmansyah et al., 2022; Boerman & Nasir, 2024).

Relational trust and institutional partnership were recurring mechanisms. Pastors supported research engagement; faith leaders requested co-production of messages; Islamic organizations partnered with Muslim clinicians; and religious leaders worked with health workers to address vaccine concerns. (Hayes et al., 2021; Baba et al., 2022; Yasmin et al., 2022; Fesshaye et al., 2023).

Messenger credibility was multidimensional. Clinical expertise, local familiarity, pastoral support, organizational capacity, and implementation authority were distributed across different actors, making coordinated partnerships more plausible than a single “best messenger” model. (McDermid et al., 2024; Sklar & Goldman, 2023; Banerjee et al., 2022; Allen et al., 2025).

In Muslim settings, credibility frequently depended on the alignment of religious interpretation, medical expertise, and organizational trust. Indonesian and other Muslim-community studies showed that religious authority could legitimize behavioural adaptation, but such legitimacy remained dependent on institutional coordination, locally relevant explanation, and the availability of practical support.

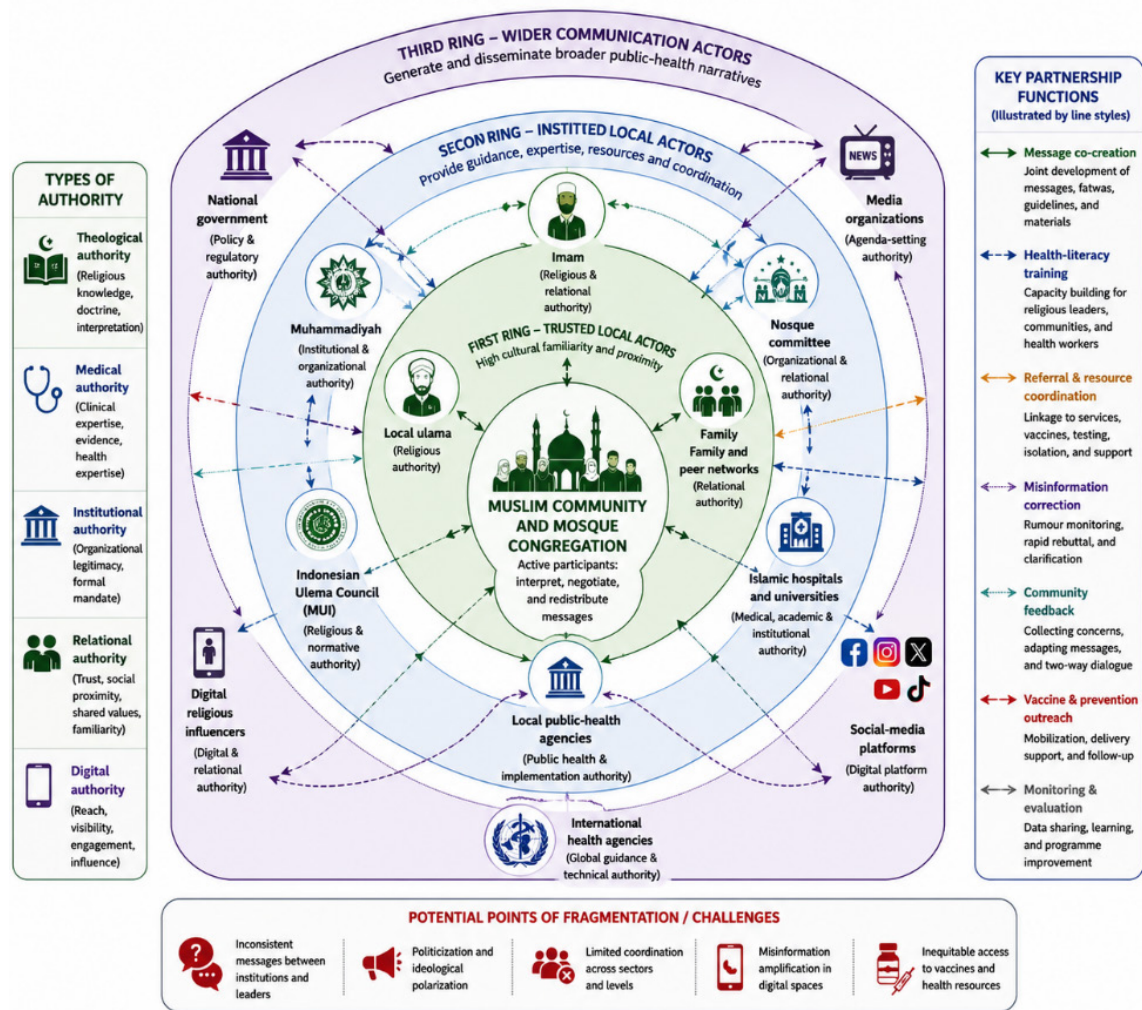


Figure 3. Spectrum of messengers and institutional partnerships in faith-based COVID-19 health communication.

Figure 3 emphasizes that congregations are active participants who interpret and redistribute messages. Stronger partnerships combine message co-creation, health-literacy training, resource referral, community feedback, and misinformation correction; fragmentation occurs when governmental, religious, clinical, and digital actors provide inconsistent guidance.

Table 1. Messengers, authority, partnerships, and principal findings.

References	Setting/design	Messenger or institution	Authority	Communication role	Principal finding
Nurmansyah et al. (2022)	Indonesia; survey, n=1,097	Mosques, religious leaders, Muhammadiyah	Religious and organizational	Worship modification and mosque prevention	Home worship was common, but facilities and adherence were uneven.
Boerman and Nasir (2024)	Indonesia; household survey, n=5,326	Community and religious leaders within a multisector coalition	Community and institutional	Community mobilization	Leadership, knowledge, and attitudes were associated with stronger adherence.
Hayes et al. (2021)	United States; implementation lessons	African American pastors	Relational and religious	Research engagement and health communication	Pastors were trusted partners whose roles extended beyond message delivery.

Baba et al. (2022)	Democratic Republic of Congo; participatory qualitative study	Faith leaders and health authorities	Religious and institutional	Message interpretation and co-production	Predetermined messages limited understanding; leaders requested co-created communication.
Yasmin et al. (2022)	United States; community partnership report	Islamic organizations and Muslim clinicians	Religious, medical, and cultural	Tailored education and question-and-answer sessions	Arabic interpretation and Muslim clinicians improved cultural accessibility.
Fesshayee et al. (2023)	Bangladesh; 40 interviews	Religious leaders and health workers	Religious and medical	Vaccine promotion and reassurance	Trust supported promotion; rumours and changing rules generated uncertainty.
McDermid et al. (2024)	Australia; national survey, n=1,227	Clinicians, community leaders, and religious leaders	Medical, community, and religious	Vaccine information and recommendation	Preferred information sources differed by language background.
Sklar and Goldman (2023)	United States; qualitative interviews	Faith leaders	Pastoral and advocacy	Communication, support, and resource coordination	Leaders responded to physical, emotional, and spiritual needs.
Banerjee et al. (2022)	Rural India; co-designed initiative	Faith leaders and community health workers	Religious and implementation	Vaccine ambassadorship and co-design	Context-sensitive co-design was preferred to externally imposed messaging.
Allen et al. (2025)	Rural Alabama; qualitative study	Church leaders	Relational and organizational	Prevention, vaccination support, and problem solving	Leaders combined health information with social and technological support.

Message Strategies, Religious Framing, and Persuasive Content

Table 2 maps a continuum from biomedical explanation to moral framing, normative guidance, dialogue, narrative, and misinformation response. Multi-faith and religious-authority studies showed that prevention could be legitimized through responsibility and social protection, but audience reception depended on consistency and local interpretation. (Tan et al., 2022; Mbivnjo et al., 2021; Kostruba, 2021).

Religious framing was conditional rather than uniformly beneficial. Biomedical, cultural, and spiritual explanations often coexisted, while misinformation and faith-healing claims could weaken vaccine confidence. Scientific explanation was most useful when it addressed uncertainty without dismissing local belief. (Jaravaza et al., 2024; Mchome et al., 2021; Kamalrathne et al., 2024).

Narratives and moral language increased relevance by connecting technical guidance to lived experience, protection of life, prevention of harm, and collective responsibility. Yet long-term behavioural evidence remained limited, and religious discourse also contained counter-narratives that resisted official guidance. (Ballout et al., 2026; Idler et al., 2022; Irfan et al., 2025; Magrath & Nichter, 2023).



Figure 4. Religious and persuasive message strategies used in COVID-19 prevention communication.

Figure 4 contrasts a constructive pathway (credibility, comprehension, trust, efficacy, and preventive action) with a counterproductive pathway (inconsistency, confusion, fatalism, distrust, and hesitancy). The model clarifies that religious framing is beneficial only when it is accurate, coherent, and compatible with audience experience.

Table 2. Message strategies, religious framing, and reported communication outcomes.

References	Setting	Preventive topic	Message strategy	Religious/cultural frame	Reported outcome
Tan et al. (2022)	Malaysia	Distancing and gatherings	Faith–evidence reconciliation	Communal obligation, protection, and scientific guidance	Religious organizations could support evidence-informed decisions.
Mbivnjo et al. (2021)	Uganda	Distancing and misinformation	Formal online religious guidance	Responsibility, justice, and social protection	Religious statements incorporated public-health guidance.
Kostruba (2021)	Online religious discourse	Distancing and spiritual coping	Simple informational and emotional messaging	Prayer, humility, and collective vulnerability	Religious discourse broadly reinforced health guidance.
Jaravaza et al. (2024)	Rural Zimbabwe	Vaccination	WhatsApp promotion versus faith-healing narratives	Known senders, sacred practices, and local belief	Religious misinformation weakened confidence in some settings.
Mchome et al. (2021)	Tanzania	Masking, distancing, and hygiene	Biomedical, cultural, and religious frames	Spiritual practices alongside preventive guidance	Multiple explanatory frames coexisted in everyday practice.
Kamalrathne et al. (2024)	Sri Lanka	Vaccination	Scientific explanation and misinformation correction	Religion among multiple hesitancy determinants	Poor understanding and misinformation contributed to delayed or rejected vaccination.
Ballout et al. (2026)	International scoping review	Vaccination	Storytelling and culturally tailored narratives	Identification, emotion, and trusted messengers	Narratives increased engagement, but long-term behavioural evidence was limited.

Idler et al. (2022)	International digital religious texts	Pandemic response	Narratives and counter-narratives	Religious meaning, authority, and competing interpretations	Religious discourse included both public-health support and resistance.
Irfan et al. (2025)	Islamic ethical review	Infectious-disease prevention	Islamic jurisprudential and ethical framing	Protection of life and prevention of harm	Islamic frameworks can legitimate prevention when accurately interpreted.
Magrath and Nichter (2023)	Indonesia; case study	Health-promotion messaging	Moral framing	Responsibility, solidarity, and socially resonant values	Moral frames can translate technical guidance into locally meaningful action.

In Muslim and Indonesian contexts, translation often involved more than linguistic adaptation. It included jurisprudential interpretation, moral framing, discussion of collective responsibility, and adjustment of guidance to congregational worship and locally recognized values.

Communication Channels and Information Ecologies

Table 3 demonstrates a hybrid ecology in which virtual workshops, text messages, multilingual campaigns, and social media extended communication beyond worship spaces. Existing faith-health partnerships supported rapid adaptation, while digital channels improved continuity but did not guarantee behavioural effects. (Marin et al., 2025; Whitley et al., 2024; Ioannides et al., 2023; Uzuegbunam, 2024).

Community-specific channels included street posters, bilingual outreach, trusted non-governmental spokespersons, vaccine detailing, and church-based testing. These studies show that reach and credibility are produced by combinations of channel, messenger, language, and institutional setting. (Zalcborg-Block, 2025; Arief & Budiman, 2026; Cross et al., 2025; Diallo et al., 2023; Berkley-Patton et al., 2022).

The Haredi case further illustrated how religious authority and healthcare institutions structure access to information. Communication ecologies therefore involve reciprocal adaptation and feedback, not merely dissemination from a central source. (Zalcborg et al., 2026).

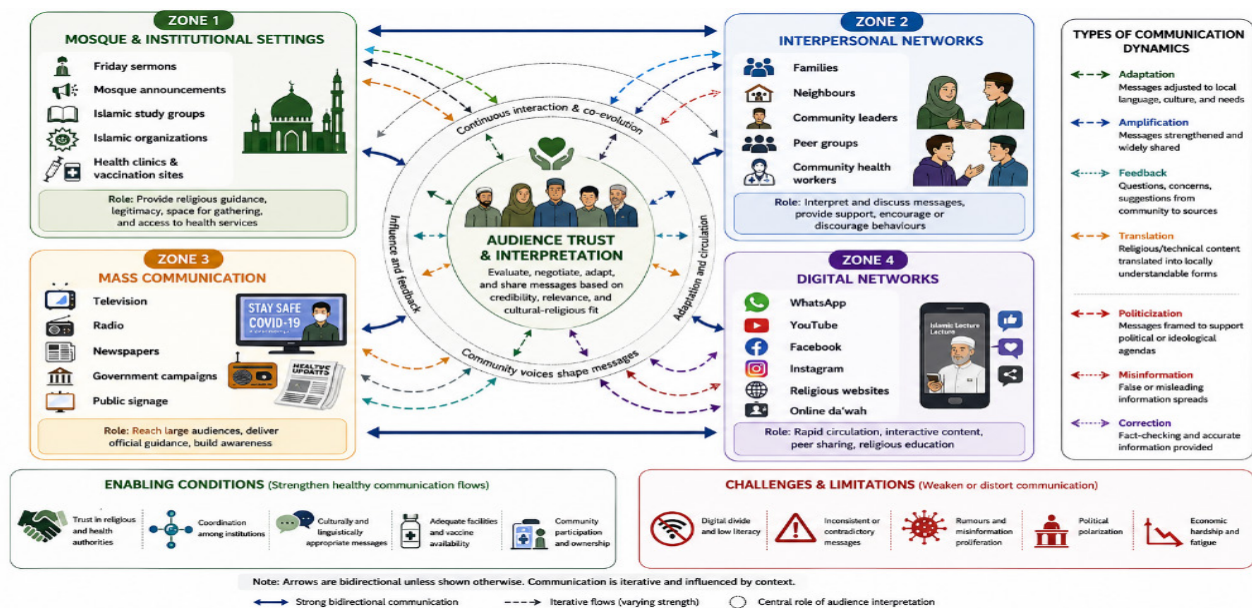


Figure 5. Hybrid communication ecology connecting worship settings, interpersonal networks, mass media, and digital platforms.

Figure 5 shows that messages are translated, amplified, contested, corrected, and redistributed as they move between institutional, interpersonal, mass-media, and digital zones. Hybrid strategies can combine reach and local credibility, but they must address digital exclusion, contradictory guidance, and misinformation.

Table 3. Communication channels, sources, and implementation findings.

References	Setting	Channel	Source or partner	Implementation finding
Marin et al. (2025)	New York City	Virtual workshops	Community Health Advisors in 13 faith organizations	Existing partnerships enabled 47 workshops reaching more than 800 participants.
Whitley et al. (2024)	Los Angeles	Text messaging	Faith-based intervention team	Direct mobile delivery was feasible; behavioural effects were not isolated.
Ioannides et al. (2023)	Australia	Multilingual local campaign	Health agencies, cultural workers, and religious leaders	Interagency outreach was associated with an 87% increase in testing.
Uzuegbunam (2024)	Nigeria	Social media and support networks	Authorities, peers, and religious actors	Digital engagement shaped risk perceptions but exposed users to an infodemic.
Zalcborg-Block (2025)	Israel	Street posters	Ultra-Orthodox community institutions	Local visual channels translated official guidance into community-specific messages.
Arief and Budiman (2026)	Indonesia and Australia	Governmental and non-governmental spokespersons	Public institutions and trusted non-state actors	Trust and credibility varied by spokesperson type and national context.
Cross et al. (2025)	Michigan, United States	Bilingual and multi-channel outreach	Religious, community, and public-health leaders	Participants valued trusted messengers but criticized inconsistent English-only communication.
Diallo et al. (2023)	Northeast Bronx, United States	Vaccine detailing and community outreach	Businesses and faith-based organizations	Most eligible partners agreed to act as health champions.
Berkley-Patton et al. (2022)	United States	Church-based testing	Faith-health-academic partnership	Church infrastructure supported testing access and trusted community engagement.
Zalcborg et al. (2026)	Israel	Community-specific healthcare communication	Religious authorities and healthcare institutions	Authority and trust structured access to health information in a religious minority.

The Indonesian comparative evidence similarly showed that credibility varied by spokesperson type and national context. This finding supports the interpretation that channels cannot be evaluated independently from the authority attached to the source and the institutional environment in which the message is received.

Preventive Behaviours, Contextual Conditions, and Evidence Gaps

Table 4 shows that preventive outcomes were shaped by information sources, religious authority, organizational context, and access conditions. Associations between religious or community sources and vaccination attitudes were not uniform and could reflect prior source selection as well as message effects. (Ber et al., 2024; Asiamah et al., 2024).

Indonesian studies demonstrated that vaccine hesitancy was embedded in social-ecological and trust-related conditions rather than reducible to religiosity. Community-level prevention models in Sri Lanka and comparative work with Muslim and Christian leaders similarly indicated that institutional partnerships and local interpretation mattered. (Chait et al., 2024; Sujarwoto et al., 2023; Wijesinghe et al., 2022; Essa-Hadad et al., 2022).

Localized vaccination services, regional reviews, and studies of religious diversity showed that access, subgroup variation, and homogeneous public portrayals can affect compliance. Evidence gaps concern comparative messenger effects, direct observation, longitudinal outcomes, digital religious influence, and co-created intervention evaluation. (Kasstan et al., 2022; Memon et al., 2024; Barmania & Reiss, 2021; Taragin-Zeller et al., 2023).

Table 4. Preventive outcomes, contextual determinants, limitations, and research priorities.

References	Setting/population	Outcome	Communication or contextual determinant	Main finding	Priority/limitation
Ber et al. (2024)	Ultra-Orthodox Israel	Fourth-dose intention	Religious authority and community-specific channels	Tailored channels were associated with vaccination intention.	Small sample and intention outcome.
Asiamah et al. (2024)	United States; n=10,221	Vaccination and anti-vaccination sentiment	Experts, social media, and community/religious leaders	Associations varied by information source.	Cross-sectional; source selection may precede hesitancy.
Chait et al. (2024)	Indonesia	Vaccine hesitancy and refusal	Social-ecological determinants in a highly religious setting	Individual, social, and institutional factors interacted.	Causal pathways were not established.
Sujarwoto et al. (2023)	Malang, Indonesia	Vaccine hesitancy	Trust, information, and sociodemographic determinants	Hesitancy reflected multiple interacting influences.	Cross-sectional and district-specific.
Wijesinghe et al. (2022)	Sri Lanka	Community prevention	Religious-leader engagement model	Religious leaders supported community-level prevention.	Transferability depends on institutional context.
Essa-Hadad et al. (2022)	Israel	Community adherence and vaccination	Muslim and Christian religious leaders	Leaders adapted health guidance for their communities.	Comparative observational evidence.
Kasstan et al. (2022)	United Kingdom	Vaccine access	Minority-group collaboration and localized services	Co-delivery addressed trust and access barriers.	Qualitative and context-specific.
Memon et al. (2024)	South Asia; systematic review	Preventive behaviour and coping	Risk perception and cultural-religious beliefs	Tailored, culturally sensitive communication was recommended.	Heterogeneous countries and measures.
Barmania and Reiss (2021)	International perspective	Health promotion	Religion as a public-health partner and social determinant	Religion should be incorporated into health-promotion planning.	Conceptual rather than intervention evidence.
Taragin-Zeller et al. (2023)	Israel; representative survey, n=800	Compliance with health guidance	Religious diversity, knowledge, and public concern	Subgroups differed in compliance; homogeneous portrayals were misleading.	Single religious population and self-report.

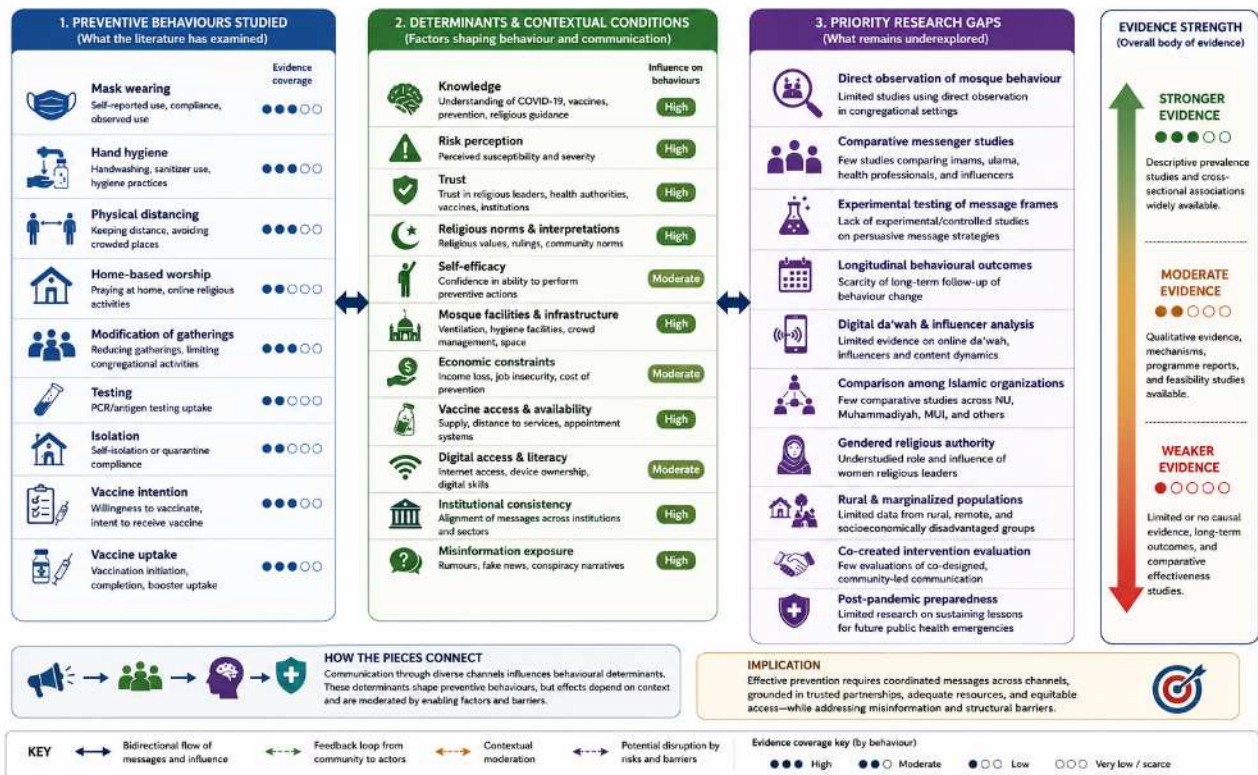


Figure 6. Evidence map of preventive behaviours, contextual determinants, and priority research gaps.

Figure 6 distinguishes relatively stronger descriptive and cross-sectional evidence from moderate qualitative and feasibility evidence and weak causal or comparative evidence. The map indicates that the field is ready for more focused intervention and mechanism studies, but not for definitive rankings of messenger, frame, or channel effectiveness.

Across the four result domains, three recurring functions were identified. First, authority concerned whose guidance was recognized as legitimate. The evidence showed that authority was distributed across religious leaders, clinicians, faith organizations, public institutions, local committees, peers, and digital actors. Religious legitimacy alone was insufficient when technical accuracy, institutional consistency, or service coordination was weak. Conversely, medical expertise did not always generate trust when communicators lacked cultural proximity or community recognition.

Second, translation concerned how guidance was made understandable, culturally meaningful, morally legitimate, and locally actionable. This function included linguistic adaptation, religious interpretation, moral framing, narrative, dialogue, co-design, and misinformation correction. Translation was most credible when it preserved biomedical accuracy while addressing community values, uncertainty, and practical concerns.

Third, capacity concerned whether accepted guidance could be enacted. Capacity included access to vaccination and testing, sanitation facilities, safe-worship arrangements, digital access, financial resources, organizational coordination, and consistent institutional guidance. Several studies showed that acceptance and intention could coexist with limited action when these conditions were absent.

These three functions were interdependent. Authority without translation could produce trusted but poorly understood guidance. Translation without authority

could produce relevant messages that lacked legitimacy. Authority and translation without capacity could generate acceptance without behavioural enactment. The mapped evidence therefore supports evaluating faith-based health communication as a coordinated system rather than as a discrete message, messenger, or channel intervention.

Interpreting Faith-Based Health Communication in Public Health Crises

This review indicates that faith-based health communication is a system rather than a discrete intervention. Religious and public-health authorities shape message design; messages circulate through institutional, interpersonal, mass-media, and digital channels; and audiences interpret them through trust, perceived risk, norms, efficacy, prior belief, and practical capacity. Preventive behaviour is consequently moderated by coordination, resources, social context, and misinformation exposure.

The evidence does not support a simple claim that religious authority either promotes or obstructs prevention. Indonesian Muslims modified worship while some congregational facilities and practices remained inadequate; community leadership was associated with adherence but operated within a multisectoral environment. Similarly, religious subgroups differed internally, and homogeneous portrayals obscured variation in practice and trust. (Nurmansyah et al., 2022; Boerman & Nasir, 2024; Taragin-Zeller et al., 2023).

Co-creation emerged as a more defensible practice principle than one-way transmission. Faith leaders possess knowledge of congregational concerns, ritual practice, local language, and practical barriers, while clinicians and public-health agencies provide technical expertise and service access. Partnership is therefore not merely a strategy for borrowing religious trust; it is a means of combining distinct forms of authority and implementation capacity.

Conflicting associations between religious information sources and vaccine hesitancy require careful interpretation. Cross-sectional studies cannot determine whether a source created hesitancy or whether hesitant individuals preferentially selected that source. Message content, prior trust, institutional alignment, and social identity must be measured before causal claims are made.

Message framing was equally conditional. Protection of life, prevention of harm, and collective responsibility can make biomedical guidance morally resonant, while fear without efficacy or fatalistic reassurance can reduce action. Narrative and emotional strategies may increase identification, but sustained behavioural effects remain insufficiently evaluated.

Digital channels expanded reach and continuity but lowered barriers to misinformation. Authority cues, institutional symbols, peer forwarding, and platform visibility may substitute for evaluation of evidence. Preparedness should therefore include coordinated monitoring and rapid correction involving religious authorities, health professionals, communication specialists, and community administrators.

The knowledge-behaviour gap reinforces the importance of implementation capacity. Communication should be linked to vaccination access, sanitation, safe-worship procedures, testing, economic support, and transparent institutional processes. Nonadherence should not be attributed to belief when structural conditions prevent action.

An Authority–Translation–Capacity (ATC) Framework for Faith-Based Health Communication

The authority–translation–capacity framework emerged from recurring functions identified across the four result domains. Studies of messengers and institutional partnerships highlighted the importance of authority: whose guidance was considered legitimate and credible. Studies of message strategies, religious framing, multilingual communication, and co-design demonstrated the role of translation: how biomedical guidance was rendered understandable, culturally meaningful, morally acceptable, and locally relevant. Studies of service access, organizational coordination, facilities, and material barriers established the importance of capacity: whether accepted guidance could be enacted.

These functions were analytically distinct but empirically interdependent. Authority without effective translation could produce guidance that was trusted but poorly understood. Translation without recognized authority could produce culturally relevant messages that lacked legitimacy. Authority and translation without capacity could produce acceptance or intention without behavioural implementation. Conversely, services and resources could remain underused when communicators lacked trust or legitimacy.

The framework therefore does not propose a simple linear pathway from messenger to behaviour. It describes a reciprocal system in which legitimacy, meaning-making, and implementation conditions interact. Institutional inconsistency may weaken authority; inadequate translation may reduce comprehension and trust; and limited capacity may undermine the perceived credibility of guidance when recommended action is not practically feasible.

1. Relationship to Existing Communication and Behavioural Models

The framework complements rather than replaces existing communication and behavioural theories. Source-credibility theory explains how expertise and trustworthiness affect message acceptance, but the authority component extends credibility to theological, relational, institutional, community, and operational legitimacy. The Health Belief Model explains perceived susceptibility, severity, benefits, barriers, cues to action, and self-efficacy, while the Theory of Planned Behavior emphasizes attitudes, subjective norms, and perceived behavioural control. These models help explain individual interpretation and intention but provide less direct attention to who is authorized to interpret biomedical guidance within a religious community.

Social cognitive theory contributes an understanding of modelling, reinforcement, and reciprocal interaction between individuals and their social environments. Fear-appeal and risk-processing models explain why threat messages require credible and feasible responses. Communication-ecology approaches explain how messages circulate, change, and compete across multiple channels. The authority–translation–capacity framework integrates these insights at the system level by distinguishing source legitimacy, cultural and moral meaning-making, and the material and institutional conditions required for action.

Its theoretical contribution therefore lies not in replacing established models but in bringing together functions that are often studied separately. This distinction is particularly useful in faith-based communication because religious legitimacy,

biomedical accuracy, cultural interpretation, and service delivery are frequently distributed across different actors and institutions.

2. Muslim and Indonesian Interpretation

The international evidence identified recurring communication functions across Christian, Jewish, Muslim, and multi-faith settings, but these findings should not be treated as doctrinally interchangeable. In Muslim settings, translation may involve Islamic ethical principles, jurisprudential interpretation, halal concerns, and adaptation of congregational worship. In Indonesia, large religious organizations, mosque networks, community leadership structures, and multisectoral partnerships provide distinctive forms of organizational and social infrastructure.

The Indonesian evidence supports the broader framework while also showing its contextual limits. Religious legitimacy could facilitate changes in worship and preventive practice, but implementation depended on facilities, institutional coordination, public trust, and local leadership. The relevance of the framework therefore lies in identifying comparable communication functions across settings while preserving differences in theology, organizational structure, and political context.

3. Implications for Future Public Health Crises

COVID-19 provides a valuable case for preparedness because it exposed how rapidly scientific uncertainty, religious interpretation, political contestation, and implementation constraints can interact. The findings suggest several principles for future public health crises.

Religious institutions should be engaged before emergencies occur rather than recruited only after messages have been finalized. Preparedness planning should identify the different forms of authority operating within communities, establish mechanisms for co-design and rapid translation, and connect communication with service delivery. Faith leaders and organizations may also contribute to community feedback, misinformation monitoring, resource referral, and evaluation.

Evaluation should extend beyond message reach or reported trust. Studies should assess whether messages are accurately understood, considered legitimate, connected to feasible action, and supported by adequate services and resources. The framework may therefore help planners diagnose whether communication failure reflects weak authority, inadequate translation, limited capacity, or misalignment among all three.

4. Limitations and Research Priorities

The evidence base remains methodologically limited. Most included studies used cross-sectional, qualitative, content-analytic, or programme-description designs. Direct observation, experimental comparison, longitudinal follow-up, validated exposure measures, and organizational comparison were uncommon. Women religious leaders, young people, rural populations, and marginalized communities were also underrepresented.

The review itself has several limitations. Searches were restricted to Scopus and Web of Science and to publications from 2021 through 2026, which may have excluded regional literature, grey literature, and relevant evidence from early 2020. The inclusion of multiple religious traditions strengthened comparative mapping but limited direct

transfer to any single faith or national context. In addition, the authority–translation–capacity framework was developed through interpretive synthesis rather than formal theory testing.

Future research should compare single-messenger and integrated religious–medical teams, test alternative religious, moral, and biomedical frames, and examine whether access and organizational capacity moderate communication effects. Longitudinal studies, field experiments, direct observation, and digital-network analysis are needed to assess mechanisms and behavioural outcomes. The framework should also be tested prospectively across different diseases, public health emergencies, faith traditions, and institutional settings.

Conclusion

This scoping review synthesized evidence from 40 studies on faith-based health communication, drawing primarily on research conducted during the COVID-19 pandemic to generate insights relevant to future public health crises. Across diverse religious and institutional contexts, faith leaders, faith-based organizations, health professionals, community actors, and public health institutions contributed not only as messengers but also as interpreters, advocates, implementation partners, resource coordinators, and co-designers of health communication. The review further demonstrates that communication outcomes are shaped not by any single component in isolation, but by the interaction among messenger legitimacy, message interpretation, communication channels, and the institutional conditions that enable communities to translate guidance into preventive action. Beyond mapping the existing literature, this review contributes an evidence-informed analytical framework comprising three interrelated dimensions: authority, translation, and capacity. Authority explains why particular actors or institutions are regarded as legitimate sources of health guidance. Translation explains how biomedical information is interpreted in culturally meaningful, morally acceptable, and locally actionable ways. Capacity explains whether communities possess the organizational, material, and institutional resources necessary to implement accepted guidance. Considered together, these dimensions provide a more comprehensive explanation of faith-based health communication than approaches focusing exclusively on messenger credibility, message content, or communication channels. The framework therefore offers an analytical perspective for understanding why communication may succeed in some settings yet produce limited behavioural change in others despite similar messages or trusted religious leadership. The evidence base remains limited by the predominance of cross-sectional, qualitative, and descriptive studies, and by this review's restriction to publications indexed in Scopus and Web of Science between 2021 and 2026. Accordingly, the proposed Authority–Translation–Capacity (ATC) framework should be regarded as an evidence-informed analytical heuristic rather than a validated causal model. Future research should evaluate the ATC framework across diverse religious traditions, institutional settings, and public health emergencies using comparative, longitudinal, and implementation-oriented designs. Religious institutions should also be examined as collaborative partners in communication design, implementation, and evaluation, rather than merely as channels for disseminating health information. Ultimately, faith-based health communication should be assessed by how effectively legitimate authority, meaningful translation, and practical capacity work together to

support equitable, evidence-informed action in future public health crises.

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Data availability:

The database exports, screening log, eligibility decisions, and charting framework used for this review are documented in Supplementary File 1 and are available from the corresponding author upon reasonable request.

Declaration of generative AI and AI-assisted technologies:

During preparation, the authors used ChatGPT to support language editing, document organization, and figure development. The authors reviewed and revised all content, verified the evidence and references, and take full responsibility for the manuscript.

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