

# Faith-Based Diabetes Prevention: Lessons for the 57 OIC Member States

Bishwajit Bhowmik, Tasnima Siddiquee, Abdul Basit<sup>1</sup>, Mesbah S. Kamel<sup>2</sup>, Adel A. El Sayed<sup>3</sup>, Mohamed Ali Eltom<sup>4</sup>, Nadima Shegem<sup>5</sup>, Abdulla Al-Hamaq<sup>6</sup>, Mohamed Hassanein<sup>7</sup>, Asher Fawwad<sup>1</sup>, Ashraf P. Valappil<sup>8</sup>, Rachid Malek<sup>9</sup>, Peter E. H. Schwarz<sup>9</sup>, Amit Gupta<sup>9</sup>, Banshi Saboo<sup>10</sup>, Shashank R. Joshi<sup>11</sup>, Vishwanathan Mohan<sup>12</sup>, Mads H. Jensen<sup>13</sup>, Anil Kapur<sup>13</sup>, Satoshi Kaneko<sup>14</sup>, Syed Z. Hossain<sup>15</sup>, Mohamed R. Amin<sup>15</sup>, A. K. Khan Azad

Centre for Global Health Research, Diabetic Association of Bangladesh, Dhaka, Bangladesh, <sup>1</sup>Indus Diabetes and Endocrinology Centre (IDEC), Indus Hospital and Health Network, Karachi, Pakistan, <sup>2</sup>Internal Medicine and Diabetes, Minia University, Minya, <sup>3</sup>Sohag Faculty of Medicine - Sohag University, Sohag, Egypt, <sup>4</sup>Endocrinology and Diabetes Clinic, Dubai, UAE, <sup>5</sup>Jordanian Society for the Care of Diabetes, Amman, Jordan, <sup>6</sup>Qatar Diabetes Association, Doha, Qatar, <sup>7</sup>Dubai Hospital, Dubai Health Authority, Dubai, UAE, <sup>8</sup>Department of Internal Medicine, Setif Hospital University, Setif, Algeria, <sup>9</sup>International Diabetes Federation, Brussels, Belgium, <sup>10</sup>Dia Care - Diabetes and Hormone Clinic, Ahmedabad, Gujarat, <sup>11</sup>Lilavati Hospital, Mumbai, Maharashtra, <sup>12</sup>Madras Diabetes Research Foundation (ICMR – Collaborating Centre of Excellence), Chennai, Tamil Nadu, India, <sup>13</sup>World Diabetes Foundation, Copenhagen, Denmark, <sup>14</sup>Institute of Topical Medicine, Nagasaki University, Nagasaki, Japan, <sup>15</sup>Directorate General of Health Services (DGHS), Dhaka, Bangladesh

The global burden of type 2 diabetes mellitus (T2DM) continues to rise at an alarming pace, disproportionately affecting low- and middle-income countries (LMICs).<sup>[1]</sup> Nearly three-quarters of people living with diabetes now reside in these settings, where health systems face constraints in financing, workforce, and access to long-term preventive care. In many Muslim-majority countries, diabetes prevalence is increasing alongside rapid urbanisation, dietary transitions, physical inactivity, and population ageing. Although clinic-based lifestyle interventions have demonstrated efficacy in controlled settings, their equitable and sustainable implementation at scale remains challenging. Against this backdrop, culturally grounded, community-embedded approaches are urgently needed.

Faith institutions remain among the most trusted, accessible, and influential social structures in many societies. Religious leaders often shape norms, behaviours, and collective priorities, particularly in matters linked to daily life and moral responsibility. This insight has prompted growing interest in faith-based health promotion models, where prevention messages are embedded within religious teachings and delivered through existing congregational networks. Evidence from diverse contexts suggests that such approaches can enhance reach, acceptability, and adherence—critical ingredients for diabetes prevention.

## EVIDENCE FROM FAITH-BASED INTERVENTIONS

One of the earliest and most cited examples is the Body and Soul programme conducted through African American churches in the United States.<sup>[2]</sup> This dietary intervention demonstrated that faith-anchored messaging, pastoral leadership, and peer support could significantly improve fruit and vegetable intake and related health behaviours at the community level, illustrating how churches can function as effective platforms for chronic disease prevention.<sup>[2]</sup> Although implemented in a high-income setting, the programme underscored a transferable principle: trusted faith leaders can translate health advice into culturally resonant action.

Similarly, a mosque-based physical activity intervention among South Asian Muslim women in Ontario, Canada showed improvements in participation and acceptability when exercise promotion was delivered in a familiar religious and social environment.<sup>[3]</sup> These findings highlighted the role of mosques not only as places of worship but also as safe community spaces—particularly for women—where lifestyle interventions can be contextualised and normalised.

**Address for correspondence:** Prof./ Dr. Bishwajit Bhowmik, Centre for Global Health Research, Diabetic Association of Bangladesh, Dhaka, Bangladesh.  
E-mail: doctorbiplob@gmail.com

Received: 25-Jan-2026, Revised: 15-Mar-2026, Accepted: 16-Mar-2026,  
Published: 05-Jun-2026

### Access this article online

#### Quick Response Code:



Website:  
<https://journals.lww.com/JODB>

DOI:  
10.4103/jod.jod\_15\_26

This is an open access article distributed under the terms of the Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 License (CC BY-NC-ND), where it is permissible to download and share the work provided it is properly cited. The work cannot be changed in any way or used commercially without permission from the journal.

**For reprints contact:** WKHLRPMedknow\_reprints@wolterskluwer.com

**How to cite this article:** Bhowmik B, Siddiquee T, Basit A, Kamel MS, El Sayed AA, Eltom MA, *et al.* Faith-based diabetes prevention: Lessons for the 57 OIC member states. J Diabetol 0;0:0.

## THE BANGLADESH EXPERIENCE: DIABETES PREVENTION THROUGH RELIGIOUS LEADERS

Building on these global experiences, the Diabetic Association of Bangladesh (BADAS), in partnership with key government stakeholders—including the Islamic Foundation under the Ministry of Religious Affairs and the Non-Communicable Disease Control (NCDC) Program of the Ministry of Health and Family Welfare—as well as the World Diabetes Foundation (WDF), designed and implemented the Diabetes Prevention through Religious Leaders (DPRL) program.<sup>[4]</sup> This initiative trained imams and female religious assistants to integrate key lifestyle messages—healthy diet, regular physical activity, avoidance of tobacco, and early screening—into Friday sermons (khutbahs), counselling sessions, and mosque-based “diabetes corners.” These corners provided basic screening, referral, and health education, supported by digital data capture and linkage with the national diabetes registry.

The effectiveness of this approach was demonstrated in a rigorous cluster-randomized clinical trial conducted in rural Bangladesh. Over a 12-month period, a culturally adapted, mosque-based lifestyle intervention led by trained religious leaders resulted in a 42.5% relative risk reduction (absolute risk reduction 7.3 percentage points;  $P = .002$ ; hazard ratio 0.75, 95% CI 0.60–0.95;  $P = .02$ ) in incident T2DM among adults with prediabetes, alongside significant improvements in weight, glycaemic indices, blood pressure, lipid profile, physical activity, diabetes knowledge, and quality of life.<sup>[5]</sup> Notably, these benefits were achieved within existing community structures, without reliance on intensive clinical resources.

Although mosque-based clustering may raise concerns regarding potential selection bias—given that individuals attending religious institutions may differ in health behaviours—participant recruitment was conducted through community-wide screening using validated diabetes risk scores and oral glucose tolerance testing, independent of regular mosque attendance. Baseline characteristics were comparable between intervention and control clusters, and district-stratified randomization minimized systematic bias.

Beyond measurable clinical effects, the program achieved strong community engagement and high retention rates. The initiative has since been recognized by the World Health Organization under the Global Diabetes Compact and highlighted by the WHO South-East Asia Region’s SEAHEARTS platform as a best-practice example of faith-based engagement in non-communicable disease prevention.<sup>[6]</sup>

## A CASE FOR SCALING ACROSS OIC MEMBER STATES

The Organisation of Islamic Cooperation (OIC) comprises 57 Member States spanning South-East Asia, South Asia,

the Middle East, Africa, and parts of Europe—regions that collectively bear a substantial and growing share of the global diabetes burden. Despite diversity in language, culture, and health-system capacity, these countries share common religious institutions, values, and congregational practices. Mosques, madrasas, and affiliated community networks reach millions of people weekly, often extending into rural and underserved areas where formal health services are limited.

Scaling a faith-based diabetes prevention model through OIC platforms offers several strategic advantages. First, it enables dissemination of prevention messages aligned with Islamic principles of moderation and stewardship of health. Second, it leverages existing human resources—religious leaders—who require modest training. Third, it facilitates structured South–South knowledge exchange, whereby OIC Member States can share standardized curricula for religious leaders, sermon guides integrating health and faith principles, digital monitoring systems, and implementation toolkits. Such collaboration allows contextual adaptation while maintaining fidelity to core evidence-based components.

The Bangladesh experience demonstrates that such programmes can move beyond awareness-raising to measurable clinical impact. Importantly, such models are not intended to replace health-system-led prevention strategies, but rather to complement them by strengthening community engagement, improving early detection and referral, and supporting sustained lifestyle change.

## POLICY AND RESEARCH IMPLICATIONS

For OIC Member States, adopting a coordinated faith-based diabetes prevention strategy could accelerate progress towards national NCD targets and the Sustainable Development Goals (SDGs), particularly SDG 3.4 on reducing premature mortality from NCDs.

Ministries of health, religious affairs, and education can jointly endorse standardised training curricula, sermon guides, and monitoring frameworks. Digital tools—already piloted in Bangladesh—can support data collection, quality assurance, and linkage with national registries, enabling evaluation at scale.

A formal cost-effectiveness analysis was not conducted within the trial; however, the intervention leveraged existing mosque infrastructure and volunteer networks, resulting in minimal incremental costs compared with clinic-based programmes. Future multi-country economic evaluations are warranted to quantify cost per case of diabetes prevented and long-term return on investment.

Adaptation to urban settings may require hybrid delivery models involving workplace mosques, Islamic community centres, women’s groups, and digital dissemination of sermons. Integration with primary healthcare systems

and national NCD registries will be essential to ensure continuity of screening, referral, and long-term follow-up.

## CONCLUSION

The convergence of rising diabetes prevalence, constrained health systems, and deeply rooted faith institutions presents a unique opportunity. Evidence from churches, mosques, and, most recently, a large-scale randomised trial in Bangladesh shows that religious leaders can be powerful allies in diabetes prevention. By mobilising this approach across 57 OIC Member States, the global community can harness faith as a force for health—transforming sermons into sustained lifestyle change and moving prevention from clinics into the heart of communities.

## Authors' contribution

BB conceived the manuscript and drafted the initial text. All authors contributed to critical revision for intellectual content and approved the final version.

## Financial support and sponsorship

Nil.

## Conflicts of interest

There are no conflicts of interest.

## REFERENCES

1. International Diabetes Federation. IDF Diabetes Atlas. 11th ed. Brussels: IDF; 2024.
2. Resnicow K, Campbell M, Carr C, McCarty F, Wang T, Periasamy S, *et al.* Body and soul: A dietary intervention conducted through African-American churches. *Am J Prev Med* 2004;27:97-105.
3. Banerjee AT, Landry M, Zawi M, Childerhose D, Stephens N, Shafique A, *et al.* A pilot examination of a mosque-based physical activity intervention for South Asian Muslim women in Ontario, Canada. *J Immigr Minor Health* 2017;19:349-57.
4. Bhowmik B, Siddiquee T, Hussain A, Khan AA. Diabetes prevention through religious leaders. *J Diabetol* 2022; 13:187.
5. Bhowmik B, Siddiquee T, Munir SB, Nasrin H, Islam T, Afroz T, *et al.* Faith-based lifestyle intervention for diabetes prevention among adults in Bangladesh: A cluster randomised clinical trial. *JAMA Network Open* 2025;8:e2538101.
6. World Health Organization. Prevention and Management of Diabetes and Related Cardiometabolic Parameters through Faith-Based Interventions in Bangladesh. WHO Global Diabetes Compact Newsletter; 2025. Available from: <https://apps.searo.who.int/seahearts/good-practices/prevention-diabetes-and-related-cardiometabolic-parameters-through-faith-based>.