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(148) AFRICAN CHRISTIANITY, PUBLIC HEALTH AND EPIDEMICS

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'I have come that they might have life, and have it abundantly' (John 10:10).

'For I was hungry and you gave me food, I was thirsty and you gave me something to drink, I was a stranger and you welcomed me, I was naked and you gave me clothing, I was sick and you took care of me, I was in prison and you visited me… just as you did it to one of the least of these who are members of my family, you did it to me' (Matt. 25:35, 36, 40).

The threefold mission of Jesus as recorded in Matthew 4:23-25 was 'to preach, to teach and to heal.' This has been at the forefront of the Christian expansion in Africa and elsewhere. Health services followed on or accompanied the establishment of churches and missions in the early days, from humble beginnings to the development of full-scale hospitals, health training institutions and multiple outreach services, predominantly for the poor and most marginalised in inaccessible areas.

Currently, faith-based organisations (FBOs) are among the major health providers in developing countries, and acknowledged to be providing 30-70% of health services in sub-Saharan Africa.[1] Whilst government health services are principally found in urban areas and along major transport routes, FBO health care facilities are most often located in the under-served areas, providing compassionate care to the marginalised, the poor and the vulnerable. Their services are not in competition with government services but are complementary and non-partisan. Whilst they are commonly recognised as providing the backbone of the rural health care provision, these same health care facilities are frequently not included in national statistics nor are their health providers included in policy and strategic decisions.

The Christian Health Associations

Over time, in many countries across Africa, the various Christian health service providers, principally Catholic and Protestant, chose to collaborate by forming national umbrella organisations that would coordinate the activities of the various Christian health institutions and health programmes, form joint procurement of drugs to reduce costs, and would liaise with their governments advocating for an enabling environment and for direct support (financial and personnel). In addition, these ecumenical organizations would provide administrative and technical support to all member units, especially those in inaccessible areas to provide holistic, quality, affordable and accessible health services with a preferential treatment option for the poor. Thus, proper collaboration was ensured in providing health needs that complemented government national efforts, as well as availing mechanisms for sharing and scaling up innovations. An example is the Christian Health Association of Malawi (CHAM) which currently operates 180 health facilities and twelve training colleges located throughout the country, providing 37% of health care and training up to 80% of the national health workers.[2]

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[1] Olivier J, Tsimpo C, Gemignani R, et al. Understanding the roles of faith-based health care providers in Africa: review of the evidence with a focus on magnitude, reach, cost, and satisfaction. *Lancet 2015; published on-line July 7. http:// dx.doi.org/10.1016/S0140-6736(15)60251-3.* Bandy, G, Crouch, A, Haenni, C et al. Building from common foundations: the World Health Organization and faith-based organizations in primary health care. World Health Organization, Geneva; 2008.

[2] Christian Health Association of Malawi. Web site: www.cham.org.

In 2007, the Africa Christian Health Associations' Platform (ACHAP) was formed to act as a continent-wide umbrella organisation for the many Christian health associations.

Primary Health Care

In 1968, the World Council of Churches identified, following several studies, that church health facilities were focused primarily on curative and palliative medical care, a top-down approach, which made little sustainable improvement in the overall health of the populations being served. They concluded that there was a need to focus more on prevention, with community engagement to help communities be more responsible for their own health, coupled with a renewed focus on addressing the social determinants of health, development and empowerment, a bottom-up approach. Working examples were identified and shared and thus the WCC Christian Medical Commission was one of the prime movers towards what is now universally known as 'community-based primary health care'. This led to a unique collaboration between WCC and WHO, and a non-state relationship which has persisted to this day. The contribution of the churches in the evolution in thinking and practice of primary health care is a lasting contribution to public health.[3]

Public Health

Public health refers to all organized measures to *prevent* disease, *promote* health, and *prolong life* among the population as a whole. The focus is on entire populations, not on individual patients or diseases.[4]

The philosophy of primary health care stressed an integrated approach to preventative, curative and promotion of health services both for the community and for the individual.

In the 1970s, Christian communities began to train village health workers to educate communities on basic health, hygiene and sanitation. They were also trained to recognise common conditions and treat with basic medical supplies or refer where necessary. Small health centres were established to provide low cost patient care, as well as provide facilities for routine antenatal services and early childhood health services. In these new decentralised health care systems, many mission hospitals began to play an essential role by acting as intermediaries between local village health services and the centralised state supported hospitals.[5]

The emergence of epidemics is where the Christian community and Christian health services have been most challenged and have effectively risen to the challenge. The following represent the best-known epidemics affecting Africa in the recent past.

Cholera

Cholera is an acute, diarrheal illness caused by infection of the intestine with the bacterium *Vibrio cholerae*. It tends to be found and spread in places with inadequate water treatment, poor sanitation, and inadequate hygiene. In 2008-2009, the deterioration of sanitary and water supplies around the cities, and a declining the health infrastructure in Zimbabwe led to an outbreak of cholera of epidemic proportions, affecting 52 out of 62 districts in all ten provinces resulting in 98,424 cases and 4,276 deaths.[6] It was

[3] Litsios. S, 'The Christian Medical Commission and Development of WHO's Primary Health Care Approach,' American Journal of Public Health. November 2004, 94(11): 1884-1893. www.ncbi.nlm.nih.gov/pmc/articles/PMC1448555/.
[4] World health Organisation: www.who.int.
[5] Kurian. M. 'Transformation of Mission and Healing in the 20th Century,' Oct 2015 *Ecumenical Review*, forthcoming.
[6] World health Organisation. 2009. www.who.int/csr/don/2009_06_09/en.

described by *Médecin Sans Frontières* as 'the worst in years'.[7] In addition to suffering, cholera is well known for causing widespread fear and, as in most epidemics, common rumours and beliefs need to be considered and not underestimated or overlooked. In this case, religious believers had both negative and positive responses. A large sect (Johanne Masowe) resisted the community health educators during the outbreak and many infected members failed to seek treatment. Others sought treatment secretly from cholera treatment camps and were reported to have repented afterwards to the sect leaders.[8] In this crisis, as in other similar health challenges, many Pentecostal and other 'tent ministries' promoted 'divine healings' and encouraged adherents to put their faith in God and not in medications. Whilst miracles may happen, blind faith that is not supported by scientific proof is very dangerous, particularly in epidemics, and where people have ceased treatment, it has cost many their lives.[9]

On the other hand, leading Christian denominations supported health education campaigns by devoting Sunday worship time to health education. The priests and pastors ensured no crowding in pew benches, the 'Peace sign' was replaced by a non-touch gesture, and the common communion cup was removed. Community volunteers were trained, creating volunteer networks, and church assets (church halls, schools and health institutions) were made freely available, especially for health education purposes. By involving the communities to be proactively engaged, and to assume some responsibility, they were empowered, not only to deal with cholera but future epidemics as well.

When drugs were in critical supply, the Ecumenical Pharmaceutical Network in Kenya facilitated supplies to be trucked across Africa to the Zimbabwe Church Health Association – in solidarity.[10]

HIV and AIDS

Coming to terms with HIV and AIDS and the resulting impact, and developing appropriate effective responses was a hard learning curve, especially for faith-based responders. HIV challenged the way we think and operate, and our traditional way of dealing with contentious or challenging issues. It flourished in a milieu of stigma and discrimination, increasing the isolation and suffering of those living with the disease.[11] In the early days of the epidemic, the mid-1980s to the late 1990s, the faith community was seen to be negative, especially where attitudes, based on fear, ignorance and prejudice, led to harsh moral judgements on those affected. It was accused of obstructing the efforts of the secular world in the area of prevention and of reducing issues of HIV to simplistic moral pronouncements, making churches places of exclusion rather than places of refuge and solace. Whilst in many instances these accusations were justified, it was not always or everywhere. Many congregations and parishes were at the forefront of care and support. A great number of these initiatives did not wait for funding in order to begin; they just responded and demonstrated real compassion in a world of deep suffering.

Theological reflection has been extensive, revisiting many of the beliefs of the time, re-examining interpretations of scripture in the era of HIV as to whether they were life-affirming or life-threatening. The faith community was the first to initiate home-based care initiatives and support groups and community care-givers, described by UNAIDS as 'the backbone of effective HIV care and support programmes'.[12] It

[7] Naafs. Jolanda 'Cholera in Zimbabwe. Kept quiet, not solved.' www.globalmedicine.nl 2009.
[8] Mukuruva. C.T; Community-based Emergency Management: A *Case Study* on a *Cholera Outbreak in Zimbabwe*: a Thesis Submitted to for the Degree of Master of Public Health (MPH), *2012*. http://aut.researchgateway.ac.nz/bitstream/handle/10292/4681/MukuruvaCT.pdf?sequence=6.
[9] Chitando, Ezra and Charles Klagba. Eds., *In the Name of Jesus! Healing in the Age of HIV*. WCC, 2013.
[10] Ecumenical Pharmaceutical Network. Annual Report 2009.
[11] Susan Parry, '*Beacons of Hope. HIC Competent Churches: a framework for Action*.' Geneva. World Council of Churches Publication (2008).
[12] UNAIDS. www.unaids.org/en/resources/presscentre/featurestories/2013/september/20130909caregivers.

also purposely and meaningfully involved people living with HIV, particularly religious leaders living with HIV, to confront stigma and inform responses. The church has also been in the forefront of addressing many of the social determinants that drive the epidemic as well as involvement in advocacy for access to services and treatment, including the neglected area of treatment for children.[13]

The crucial role of the faith-based organisations in the collaborative response is now well recognised and acknowledged. Worldwide, the World Health Organisation estimated in 2004 that one in five organisations engaged in HIV programming is faith-based, and the Catholic Church alone is said to be responsible for providing up to one quarter of that entire care.[14] The extensive networks of support groups and responders to HIV that have been established over the years, are quite unprecedented and the lessons learned have informed responses to other emerging epidemics, such as Ebola.[15]

Ebola

In the initial weeks following the 2014 Ebola outbreak, the lack of accurate information and the media frenzy precipitated fear and panic that resulted in irrational responses and widespread stigma, discrimination and rejection. Mixed responses came from the religious communities, particularly when draconian measures were instituted that conflicted with cultural values, traditions and religious practices. Once they became involved, faith leaders played a transformational role, using every opportunity to raise awareness, de-stigmatise, encourage and accompany communities through the crisis.[16] Their historical continuous presence through war and peace, their accompaniment through significant life events and their voice on behalf of the people earned them the trust and respect of local communities. Throughout the crisis, they continued to provide essential services, particularly in keeping hospitals open to deal with all the non-Ebola cases. Many paid with their lives. A critical role they also played was in promoting the 'safe and dignified burial protocols', and in accompanying the grieving through this process.

In July 2015, the President of Liberia awarded the Liberian Council of Churches the highest distinction: the 'Grand Commander, Order of the Star of Africa' for their sustained response to Ebola through concerted prayer and community action.

The faith leaders played an essential role in social mobilization and behaviour change. However, when the UN agencies arrived, they failed to make use of the capacity or local knowledge of the faith responders until very much later. This delay was costly in terms of lives.

The Way Forward

A number of events are converging at this particular time in history. For a long while, the UN, most international agencies and governments have held preconceptions and prejudices that associate faith-based humanitarian services with proselytization and have failed to engage with them. There is thus an under-appreciation of the extent of the faith-based presence, capacities, local knowledge, socio-cultural

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[13] Caritas. www.caritas.org/what-we-do/health/haart-for-children
Ecumenical Advocacy Alliance: www.e-alliance.ch/en/s/.
[14] Susan Parry, '*Beacons of Hope. HIC Competent Churches: a framework for Action*.' (2008).
Vitillo RJ. Role of faith in the global response to HIV and AIDS. Panel discussion on spirituality, religion and social health – in conjunction with World Health Assembly; May 19th, 2005.
[15] Parry S, '*Ebola and HIV: Faith based response – A presentation of the evidence, lessons learned and recommendations for future action'*. Religion and Sustainable Development Conference: Building Partnerships to end extreme poverty. World Bank, Washington DC, 7th-9th July 2015.
[16] Featherstone. A, '*Keeping the Faith. The role of Faith leaders in the Ebola response*.' Study carried out in Sierra Leone and Liberia for CAFOD, Christian Aid, Islamic Relief and Tearfund (July 2015).

understanding and their links with the community. Moreover, there is a lack of understanding that faith-based organisations provide essential complementary services to governments, and that their non-partisan service is both a *mandate* and an *expression* of their faith, rather than a means to proselytization.[17]

Ebola clearly demonstrated that a technical approach alone will not rapidly and effectively contain a disease that essentially requires behavioural change, and the faith communities are highly effective at community mobilization through their multiple networks and channels.

The World Bank President, Jim Yong Kim, has stated that the eradication of extreme poverty by 2030 will not happen without the involvement of the faith communities and that, further, 'Our alliance with faith leaders to end extreme poverty is rooted in our understanding that we need prophetic voices to inspire us just as we need evidence to guide us.'[18]

The world has recently adopted the Sustainable Development Goals – the 2030 Agenda – which focuses not only on the poor and developing countries but on all countries. There is an energy and enthusiasm to start working now on these goals and to find the most effective way of doing so. 'Faith communities, omnipresent in Africa, can be part of the solution if included as full partners, engaging their powerful communications networks and local knowledge.'[19]

This is thus a *kairos* moment for the church. Secular agencies want to engage but do not know how to, and are trying to overcome some of the barriers that have existed. The faith community is more than civil society. It provides more than health services and humanitarian support. Faith compels us to recognise the dignity of all and treat each with compassionate holistic care and love – it is our mandate – we must simply claim that space.

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[17] Parry S, '*Ebola and HIV: Faith based responses'*.

[18] www.worldbank.org/en/news/speech/2015/04/09/global-faith-leaders-and-world-bank-group-president-jim-yong-kim-on-call-and-commitment-to-end-extreme-poverty.

[19] Marshall K, Smith S, *Religion and Ebola: learning from experience.* The Lancet Faith-based health care. July 2015. Article published on-line July 7, 2015. http://dx.doi.org/10.1016/S0140.6736(15)61082-0.