**Makoka, Mwai**

# Churches and health

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# Churches and Health

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## Biblical reflection: Luke 8:43-48

> [43] Now a woman, having a flow of blood for twelve years, who had spent all her livelihood on physicians and could not be healed by any, [44] came from behind and touched the border of His garment. And immediately her flow of blood stopped.
> [45] And Jesus said, "Who touched Me?"
> When all denied it, Peter and those with him said, "Master, the multitudes throng and press You, and You say, 'Who touched Me?'"
> [46] But Jesus said, "Somebody touched Me, for I perceived power going out from Me." [47] Now when the woman saw that she was not hidden, she came trembling; and falling down before Him, she declared to Him in the presence of all the people the reason she had touched Him and how she was healed immediately.
> [48] And He said to her, "Daughter, be of good cheer; your faith has made you whole. Go in peace."

The story of a woman with an issue of blood for twelve years who was miraculously healed by Jesus is a fitting place to start a discussion of churches and health – or rather, exploring the question, "what role should churches play on health today?" And by today we mean the context of the Sustainable Development Goals, or Agenda 2030.

Who is this woman? We begin by entering into the world of this woman. But before we do so, we need some entry tools. When introducing ourselves nowadays, (or when we are describing someone), we usually refer to name, nationality, age, marital status, qualifications, occupation, number of children that one has, notable people that one is related or connected to and so on.

This woman is not identified by name in the text, but we can still understand a little more about her from the story. If the problem started while in her mid to late 20s, she is probably in her early 40s. There was a lot of stigma and discrimination associated with menstruation in biblical times, (which unfortunately persists today in some cultures and societies). It is likely that she had long been left by her husband (if she had been married)

due to this stigma. There were probably spiritual or socio-cultural explanations to menstrual problems, which perpetuated moralistic/religious condemnation and discrimination against the sufferer. It is also likely that if she had been married, even her own children had abandoned her. She had also been cut off from participating in religious activities, as she was deemed unclean.

Rejected and alone, she "spent all her livelihood on physicians" to no avail. But what constitutes a person's livelihood? It is our income, savings, property and assets. It is also our social network of family, friends and colleagues that we turn to in time of need. In times of illness, these networks support us with financial assistance or soft loans to pay medical bills; food and nursing care (bathing, ablution, feeding, etc.); and also take care of our children and our affairs. Indeed, the largest quantity of nursing care worldwide is provided by family and friends. The woman in this story spent all her livelihood: had borrowed from friends and failed to pay back, received favours and support from friends and family without being able to pay back in cash or in kind. Those who initially cared for her got tired as she was not improving, and they left. Economically, even if she had any strength left, she could not engage in any trade/commerce as no one would buy from her.

Now, what was this woman suffering from? It is easy to see that the biggest pain of this lady is NOT the medical disease itself, but the social rejection, the religious condemnation and the economic marginalisation.

Disclosure: After Jesus' interrogation of who touched him, the woman comes out and "told Him the whole truth". This was a public disclosure of her condition. In telling the whole truth the woman narrated how she had suffered at the hands of the neighbours, the religious establishment and the society at large, how she had lived and suffered as an outcast in her own land and among her own kindred.

Healing vs Cure: The story indicated that the lady was cured from the issue of blood immediately she touched the hem of Jesus' garment, before the conversation. After the conversation, however, Jesus told her that her faith had healed her, or made her whole. He also bid her go in peace – apparently a veiled message to her tormenters, "don't reject her anymore", "don't trouble her any more", or indeed an admonition "did it have to come to this?"

## History of health care in Africa: precolonial, colonial, postcolonial

The modern history of Africa can be subdivided into the precolonial, colonial and postcolonial era. In terms of health care, precolonial times in sub-Saharan Africa were characterised by indigenous and traditional beliefs and practices on causation of disease and illness and healing practices. Contact with western civilisation by way of colonial settlers and missionaries introduced western scientific medicine, and consequently clinics and hospitals. Colonial administrations invested in health care only to the extent that it served their settler populations. Churches and missionaries were left to provide "the human face" of the European settler enterprise, ameliorating its impact and also embodying the gospel mandate of healing the sick. In many countries, there were more colonial government prisons and detention centres than schools and hospitals.

The postcolonial, newly independent governments were either too poor, too preoccupied with consolidating and staying in power, or too oblivious of their social responsibilities to invest in health. The churches thus, continued to provide health care, with no recourse in those countries where the missionary footprint was weak on health. The new economic world order championed through the World Bank structural adjustment programme did not help much for developing countries to emerge and provide holistic health care to their populations.

The winds of change on governance and democracy, including representational governments and space for civil society promoted local provision of health care. Many governments are now held accountable for provision of health services, even though some of their service delivery models leave a lot to be desired. All in all, churches have to redefine their space in the health sector in light of new local and global realities.

## Preach, teach and heal

The churches' response to the three-fold calling to "preach, teach and heal" is evident in many parts of the world. Church missions, health facilities and schools continue to witness to the saving grace of the Lord Jesus Christ. More beautiful dimensions are firstly, that many such institutions are now run by local churches with varying support from overseas founding churches and partners. Secondly, there are also indigenous churches,

with no direct link to western missionary investment, that have established health facilities in response to the needs of the local communities that they serve.

## Christian health associations

Missionary doctors in some parts of the world sought to collaborate, share ideas and fellowship. They established national Christian medical associations for these purposes, notably the Christian Medical Association of India in 1905 and the Christian Health Association of Kenya in the 1930s. During the post-independent era, the World Council of Churches (WCC) supported churches and national councils of churches to coordinate and cooperate among themselves on the one hand, and with the newly emerging governments on the otherr.

A story is told of a team of WCC officials that was invited by the Malawi Council of Churches to assess and advise them on how to re-organise their health portfolio. During their visit, three things happened:

**Firstly**, as the duo travelled around visiting mission hospitals and interviewing officials, a bishop of the Roman Catholic Church heard about it and asked them to include hospitals that were under their church.

**Secondly**, they visited the then president, Dr Kamuzu Banda, who coincidentally was a medical doctor himself, and asked him to include the mission health structures as he was organising his Ministry of Health. He replied that his government could not cooperate with people who did not cooperate among themselves.

**Thirdly**, and further to their findings, including the interview with the president, their debriefing at the MCC, the Council resolved to establish a medical association. The Catholic bishops were present at the de-briefing and decided to be part of the association. In this way, the Christian Health Association of Malawi was jointly established in December 1966 by the Malawi Council of Churches and the Episcopal Conference of Malawi. In 1967, a similar association was established in Ghana, and so on. There are currently similar ecumenical networks in many African countries, including Malawi, Ghana, Nigeria, Lesotho, Tanzania Zambia and Zimbabwe.

The main functions of these ecumenical health networks are: i) to promote coordination and collaboration among the churches on health affairs, allowing for joint planning and limiting undue competition and duplication of efforts; ii) to provide a unified voice in negotiation, collaboration and planning with the government. Over time, more functions have been discovered, for example, resource mobilisation and promotion of standards of care.

## African Christian Health Associations Platform

In February 1970, the WCC invited the Christian health coordinators from sub-Saharan Africa to a meeting in Limuru, Kenya and eighteen representatives from twelve African countries attended. Similar conferences were held in February 1972 in Blantyre, Malawi, and in February 1973 in Mombasa, Kenya. These biennial meetings continued, until at the meeting in Bagamoyo, Tanzania in 2007, the participants decided to formalise the forum, taking on the name Africa Christian Health Associations' Platform (ACHAP). ACHAP was registered as an international NGO in Kenya in 2012 and at the time of writing had membership of Christian health associations or similar networks from 28 countries. Collectively the church health system provides over 40% of health care in sub-Saharan Africa.

In terms of institutional mandate, ACHAP is a vehicle to lift up the work of churches on health for joint advocacy within the church community and with governments and development agencies. It also provides an opportunity through which development agencies like WHO, UNICEF and Global Fund among others can reach out to the Christian health providers on a regional scale. Sharing of lessons and experiences among churches of the same or of different denominations across the region is also facilitated. Above all, it is a platform to reflect on our joint calling to the ministry of healing without the denominational encumberments. This is important because "denominationalism" has been a major barrier to the church's mission and any forum to diminish it while elevating the unified calling is worth all the support.

## Ecumenical Pharmaceutical Network

The churches through the WCC's Christian Medical Commission championed the concept of Primary Health Care, which was adopted by UNICEF and WHO in 1975. A Conference on Primary Health Care held in Kazakhstan in September 1978 produced the famous Alma Ata Declaration on Primary Health Care (PHC).

In the pursuit of the PHC goal of "Health for All by the Year 2000," the WCC established a Pharmaceutical Action Group (PAG) in 1981 to help promote the availability of essential medicines and supplies in mission hospitals. A number of strategies were employed, including price negotiation with manufacturers and distributors of medicines and diagnostic supplies, establishment of standards for drugs to be available at the different levels of health care and promotion of capacity building on pharmaceuticals. The PAG included technical experts from WHO and UNICEF. The concept of pooled procurement has been adopted by many organisations and countries.

Due to financial and other reasons, the office of the coordinator for PAG was moved to Nairobi, Kenya in 1997. The PAG coordinator organised a meeting in Harare, Zimbabwe, for Church-based organisations that she was supporting, and the participants agreed to become a network, resulting in the establishment of the Ecumenical Pharmaceutical Network (EPN). EPN was registered in Kenya in 2004 and at the time of writing had one hundred and five members (associations, institutions & individuals) from thirty-seven countries in almost all continents.

## EHAIA

The WCC Assembly in Harare, in 1998, was a watershed as far as the churches' response to AIDS was concerned. Since the discovery of AIDS and the reporting of the first cases across many countries, moralisation from the faith community abounded. Stigma and discrimination followed, especially because of the predominantly sexual nature of the transmission of HIV. Churches were part of the problem. They were also part of the solution in that, even before the discovery of anti-retroviral drugs (ARVs), churches were providing health care, including palliative care to the sick and dying. It was a number of years before stigma and discrimination were addressed, at least at institutional levels.

The Harare Assembly mandated the WCC to address HIV & AIDS and an ecumenical programme was established, named Ecumenical HIV & AIDS Initiative in Africa (EHAIA), later extending to the Caribbean and to the Far East, and becoming the Ecumenical HIV & AIDS Initiatives and Advocacy (EHAIA).

EHAIA distinguished itself by venturing into the socio-cultural, religious and moral dimensions of the AIDS epidemic. The first years were spent listening to the voices and issues from the ground and understanding what these meant to the churches.

The remarkable work of EHAIA includes theological discourse on HIV & AIDS, and writing and publishing theological books, covering such pertinent areas as hope, healing, masculinity, and mainstreaming HIV in theology education among others. These have empowered Christians, both as individuals and congregations, to deal with the socio-cultural drivers of HIV & AIDS. Contextual Bible studies have been a tool that has facilitated engagement with difficult socio-cultural and even taboo issues in Africa from a Christian perspective. EHAIA has published over a dozen books and Bible studies, all of which have been distributed for free.

At the end of the day, it is the empowerment that these resources foster that will have a lasting impact. Indeed, these tools have found applicability into spaces heretofore unexpected. The dedicated EHAIA field staff have facilitated workshops with teachers and soldiers on understanding issues of power, culture and sexuality. Following a successful pilot in Cameroon and Nigeria, the EHAIA programme is now extending to in-school youths.

## Health-promoting churches

Now we return to the story with which we started. We saw how ill-health has negative effects beyond the physical and biological dimension of our lives. By the same token, ill-health is also caused or exacerbated by not only physical or biological agents or microorganisms, but by other factors as well. Health is not primarily medical, and so health work is not a preserve for only the medically trained professionals.

Multi-sectoral collaboration was obviously required to restore our dear friend in Luke 8:43-48 to good health: psychosocial support for reintegration into the community, economic empowerment and support, as well as the restoration of broken relationships with family and friends.

The continuum of health, sickness, healing or death encompassing the aspects of health promotion, disease prevention, diagnosis, treatment, control, rehabilitation and/or bereavement demands seamless collaboration among diverse players. Professional health workers and the health facilities play a small, albeit important part in this continuum.

In the same way, the ministry of healing by the church is not only for those Christians who are medically trained. Equally, the ministry of healing is not to be consigned to church hospitals and clinics. Health and healing should be an integral part of the life and witness of the local church.

## Conclusion

In paying tribute to the Rev. Dr Nyambura Njoroge, I close by the story of a hypothetical pastor that we used to talk about, who on delivering the New Year's Eve address provides a "health report" of the congregation: how many births and deaths and so on. S/he continues to provide a breakdown of the deaths by age, gender, cause of death. "What report do we want for next New Year's Eve?" the pastor asks. The following year the congregation goes into action to achieve their desired goal. For Nyambura and I, this dream of health-promoting churches exercised our minds considerably, challenging and inspiring us in equal measure. Its realisation will bring us closer to Jesus' three-fold calling to preach, teach and heal.