



Joachim Kügler & Kathrin Gies

□ **INTRODUCTION:
FAITH, DISEASE, HEALING, AND
COVID-19 VACCINES**

This Volume and its Predecessors at BiAS

As it is not the first time that a BiAS volume is dealing with COVID-19, the editors feel a certain obligation to explain the difference between their new volume and the preceding ones.

BiAS 31/ ERA 8 (COVID-19: African Women and the Will to Survive),¹ edited by Helen A. LABEODAN, Rosemary AMENGA-ETEGO, Johanna STIEBERT, and Mark S. AIDOO in 2021, specifically focused on women's experiences. The volume tried to offer theological responses to the COVID-19 outbreak in a feminist/womanist perspective. It reflected on the pandemic mainly under the aspects of social injustices and gendered inequalities.

BiAS 36/ ERA 11 (Religion and Health in a COVID-19 Context), edited in 2023 by Molly MANYONGANISE, then a Humboldt guest-researcher at Bamberg University, focuses on experiences from her home country Zimbabwe concerning the precarious relationship between religions and health in COVID-19 times. The volume is not limited to Christendom, but looks at African Traditional Religion and Islam as well.

This multi-religious approach of BiAS 36 is shared by this volume of BiAS 37. However, we do not have any limitation to a specific country here – not even to the African continent. This has to do with the workshop “COVID-19 and Religion” (November 2021, University of Bamberg), which gave the impulse for BiAS 36 as well as for this volume. Due to the international as well as the multi-religious character of the workshop it was necessary to find a stage for those contributions which did not focus

¹ A detailed bibliography containing all the volumes previously issued in the BiAS series is given at the end of this volume.

on Zimbabwe. Furthermore, BiAS 37 differs from MANYONGANISE's volume by focusing very much on the vaccination debate. Other hygienic topics like physical distancing, masks and more are not in the centre of this volume's focus.

A short overview of the content of BiAS 37

This multi-lingual volume starts with two general contributions that deliver basic information on the relation between biblical respectively Christian tradition and the issue of disease and healing.

The contribution of *Kathrin GIES* (chapter 1) starts with the use of biblical texts like Exo 15:26 by Christian fundamentalists in Germany (and elsewhere) to campaign against COVID-19 vaccination. She challenges this sort of ideological use of biblical texts and tries to show that a contextual² reading of Scripture does not support vaccinophobia or other extremist rejection of medical knowledge and treatment. Embedded in a holistic anthropology, Exo 15:26 and other biblical texts do not teach a strict alternative between faith and medicine. Instead, biblical tradition knows to combine medical treatment with trusting in God as the original source of all healing.

Although the rejection of scientific medicine has some tradition in a number of Christian churches and movements since the 19th century, it should be clear that earlier Christendom, always had found a way to combine faith and medical knowledge. *Assoumou Gilbert EKO*'s French written contribution (chapter 2) shows this for the medieval epoch in Europe. He analyses how – from the 5th to the 13th century – religious centres like monasteries not only adopted medical knowledge of non-Christian origin but also combined it with characteristic theological values of their faith. Thus, the newly invented hospitals in monasteries became places of innovation in medical theory and practical treatment. Despite some restrictions for the clergy, a general rejection of medical innovation never existed. The church's fight against some forms of healing has more to do with the attempt to exclude other healing agents challenging the power of

² Here, the term "contextual" does not only refer to relate Scripture with the lives of recent readers but also relating it with the religious, cultural, and socio-religious conditions of those who created biblical texts expressing the Word of God for their time.

the clergy. This may lead to the question if this is true only for the medieval church or if the fear of losing power also motivates religious players of today when they oppose vaccination as diabolic. Several of the following chapters may remind the reader of this question.

The next two contributions bring biblical texts into the debate by exegetical analysis and by contextualizing them with recent African debates in times of the pandemics.

Kingsley Ikechukwu UWAEGBUTE and *Ifeanyiichukwu Abednego ISIWU* do this for Nigeria with a miracle story in the gospel of Mark. They thoroughly discuss how Mk 8:22-26 is related to ancient medical knowledge, portraying Jesus using human medical practises of his time, instead of simply acting in divine authority. In the Nigerian context of scepticism against vaccination, the Gospel's portray of Jesus could be a remedy against a religious ideology among Christians who put their hope exclusively into super-natural healing. Thus, this chapter may help to remember Christian churches of a basic theological truth. If God incarnated in Jesus to heal and teach in a human way, could the same God not also heal today through human medicine of any kind? If 'everything is possible with God' (cf. Mt 19:26; Lk 1:37; Mk 10:27 among others), why should the Almighty refrain from modern medicine and heal through prophets, evangelists and pastors only?

In chapter 4 of this volume, *Louis NDEKHA* analyses chapter 14 of Paul's Letter to the Romans and contextualises the Apostle's speaking of "strong" and "weak" among the Christians in Rome with the situation in Malawi. Understanding the Roman debate as focusing on what to eat and what not, he explains the position of the Apostle as a pastoral one which primarily is aiming at Christian unity. Although Paul, from his theological point of view, would clearly opt for the position of the "strong" ones, he does not join any party. Instead, Paul insists on a relationship which disputable matters should not touch or endanger. Mutual respect and tolerance among Christians are of highest importance as they reflect God's relationship with each group. NDEKHA then relates Paul's message – resonating well with the African tradition of *ubuntu* – to the Malawi context of vaccination dispute. He argues that the mutual respect between those churches rejecting vaccines as danger for their faith and those who have no problem with it, should provide the ethical framework for Christians in Malawi to moderate the dividing effects of the debate.

The following chapter (5), contributed by *Lovejoy* CHABATA, takes his starting point from the biblical text Jeremiah 8:22, where the desperate prophet asks why there is no balm in Gilead, no doctor to heal the wounds of the people? After explaining what is meant with Gilead's balm, the contribution offers a comparative study on how the biblical balm is equivalent with the Zimbabwean *zumbani* herb, which is used in African traditional medicine. The thesis is that *zumbani* with its acknowledged medical effects can be a real help in the fight against infections. As a local contribution to public health, *zumbani* definitely can strengthen African identity and self-esteem. Although it may also be used as an icon of post-colonial independency from Western domination by medical science, there should not be an excluding alternative that forces to opt for vaccines or *zumbani*. Instead, CHABATA proposes a holistic approach to future pandemics – an approach that unites different religions, social groups, and knowledge systems into one effective strategy for public health as the common good.

Although the following three chapters (6-8) show the important role of Scripture in shaping Christian discussions, they do not focus on the analysis of specific biblical texts. Instead, *Francis* MACHINGURA describes in several articles, each one written with a different co-author (*Show* CHIBANGO, *Cecil Samuel* KALIZI, and *Beatrice* TARINGA), the landscape of the fierce battle which religion and vaccine were fighting against each other in times of the COVID-19 pandemic. Using qualitative methods of empirical research, they come to fascinating and quite surprising results. For example, their data show that the armies fighting this war are far from being monolithic blocks. Not only, that different churches have completely different attitudes towards the relationship between faith and vaccination, even within one and the same church or religious movement, there are believers who do not simply follow their religious leaders without thinking. Instead, they make their own decisions, accept individual responsibility for their health, and take control over their own body.

Molly MANYONGANISE completes this part of the volume by focusing on the fundamental question of how African Christendom constructs the relationship between religion and science. In her chapter (9) she analyses the experiences with the COVID-19 pandemics and comes to proposing a profound revision of the religion–science relationship. Especially prophetic claims of knowing everything better than others brought illness and even death to so many of the followers. From a sociological point of view,

MANYONGANISE concludes in her final analysis that Africa should rethink the Freedom of Religion and Belief in the context of pandemics. She calls for more academic research and public debate on how messaging on public health issues can be centralised and restricted to qualified personnel.

With the last two chapters (10 and 11) we leave the religio-cultural area of Christendom and broaden the horizon by looking to another major religion, as these two chapters deal with Islam and Islamic reactions to COVID-19 pandemic and the religion's influence on vaccine perceptions.

In chapter 10, *Younes NOURBAKHSH* and *Kobra SAHRAGARD* present results from their qualitative empirical research, which they did among Islamic women in Iran, the centre of Shia community. They not only describe how COVID-19 and the necessary public health measures changed the religious behaviour of women. They also analyse how personal religion (i.e. religious education, religious feelings, and religious reasoning) and crises interacted with each other. Their religious belief not only helped women to cope with the extreme challenges of the crisis, many of them also felt that the crisis strengthened their faith. Many women were able to transform their personal religion and revising their reception of the individual and societal role of religion. Under the influence of the Corona crisis, Iranian women learned to combine religion, philanthropy, and human rights. Thus, their religious behaviour has turned to humanization or civilization (e.g. by charity work), the consequences of which will be of importance for the further development of Iranian society.

The final chapter (11), written by *Joachim KÜGLER*, turns to the Islamic world of West Africa by giving a voice to Sunni Muslims in Ivory Coast. The qualitative empirical research focuses on the extent of anti-vaccine attitude and the reasons for it. The rather small study uses a standardised questionnaire and addresses different social groups. The differences in attitudes toward vaccination between academic professionals, journalists, religious experts, and ordinary people are remarkable. Especially the last and biggest group shows a huge extent of vaccine scepticism. It is, however, obvious that religion does not play the dominant role for anti-vaccine attitudes. Even where religious motives are important for rejecting COVID-19 vaccines, there is a remarkable difference to vaccinophobia among certain Christian movements as Ivorian Muslims show no apocalyptic fever.

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