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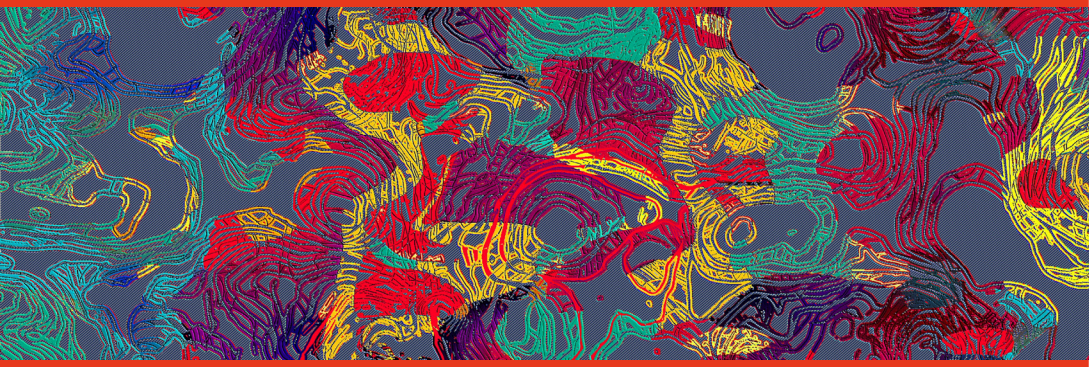
Exploring Religion in Africa 12

Joachim Kügler, Kathrin Gies (Eds.)

THE BIBLE, QURAN, AND COVID-19 VACCINES

Studies on Religion-based Vaccine Perceptions (Africa – Europe – Middle East)



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Volume 37

Exploring Religion in Africa 12

edited by
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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 contextual[2] 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* EKOU'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 *Ifeanyichukwu 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 bought 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 discribe 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.

Acknowledgements

Finally, the editors want to express their deep-felt gratitude to some important people who helped to accomplish this project, first of all the *authors*, who contributed to this volume. Without our authors' dedication to hard work, love of truth, and human dignity; without their interest in the interplay of religion, politics and daily life; and without their intellectual curiosity this volume as well as the whole series of BiAS would not exist. Thanks to you all!

We also want to thank our editorial helpers, *Karelle Eyafa* for her support with French texts, *Paul Rosch* for proof reading, and – again and again – we have to pay our gratitude to *Irene Loch* for her unwavering support. Her patience, scrutiny, and experience in formatting make it so easy to produce one volume after the other! How lucky we are to have her!

Kathrin Gies

1 „*Ich bin JHWH, dein Arzt*“ (Ex 15,26) Krankheit und Heilung im Alten Testament im Kontext der COVID-19-Impfdebatte

Abstract

In the context of the COVID-19 pandemic, vaccinophobia is widespread phenomenon among evangelical Christians in the US, in Brasil and also in Germany – among other countries. Those refusing to be vaccinated refer, inter alia, to the divine self-introduction: “I am YHWH, your doctor.” (Exo 15:26). From an academic point of view, this argumentation disregarding the literary and historical context of the biblical passage, must be questioned. Yet, this issue can be a starting point for asking how illness and disease, healing and recovering are perceived in the Hebrew Bible/ Old Testament. The chapter shows that illness should be regarded as an anthropological phenomenon that should be understood in a literary perspective and on the basis of religious history. Thus, it will become clear, why YHWH is referred to as a doctor without excluding the activity of human healers.

Keywords: COVID-19, Hebrew Bible, Old Testament, YHWH, Disease, Healing, Exo 15:26

Einleitung

Am 9. November 2020 legten das Mainzer Biotechnologieunternehmen BioNTech und sein US-Partner Pfizer eine Studie ihres potenziellen Corona-Impfstoffes vor, der zufolge das Risiko, an COVID-19 zu erkranken, mit der Impfung um mehr als 90 Prozent geringer als ohne Impfung war.[1] Für viele Menschen war diese Meldung das große Hoffnungszei-

[1] Vgl. https://www.zeit.de/wirtschaft/unternehmen/2020-11/corona-impfstoff-biontech-pfizer-usa-zulassungsantrag?utm_referrer=https%3A%2F%2Fwww.google.com%2F (15.12.2022).

chen seit Ausbruch der Pandemie. Jedoch zeigte sich in den folgenden Monaten, dass eine Impfung unter anderem auch in christlichen Kreisen abgelehnt wird. Global betrachtet, ist der Widerstand unter evangelikalen Christen in den USA und in Brasilien besonders groß: Nach einer im Februar 2021 durchgeführten Umfrage wollen sich 30 Prozent aller US-Amerikaner nicht gegen das Corona-Virus impfen lassen. Differenziert man nach religiöser Zugehörigkeit, liegt der Anteil der Impfgegner bei weißen Evangelikalen bei 45 Prozent. Ein Zusammenschluss aus Querdenkern, Coronaleugnern und evangelikalen Christen lässt sich z.B. im März 2022 auch auf Montagsdemos in Deutschland beobachten.[2] Auch wenn die Ablehnung der Impfung gegen COVID-19 auch politisch oder kulturell begründet sein kann, so wird auch biblisch argumentiert: Jesus helfe den Menschen bei einer etwaigen Infektion; Gott sei der beste Arzt.[3]

Tatsächlich lautet eine Selbstvorstellung Gottes im Buch Exodus: „Ich bin JHWH, dein Arzt" (Ex 15,26). Im einem akademisch-theologischen Kontext dürfte klar sein, dass ein Verfahren, das einzelne Sätze aus dem Alten oder Neuen Testament extrahiert und aus dem literarischen und entstehungsgeschichtlichen Kontext isoliert, diese ohne weitere Reflexion in die gegenwärtige Situation überträgt und daraus ethische Forderungen und Verhaltensmaximen ableitet, hermeneutisch fragwürdig ist. Auf die Frage, ob man sich impfen lassen soll oder nicht, bietet die Bibel keine Antwort.

Jedoch kann die Frage nach dem Verhältnis von Impfung und Altem Testament zum Anlass werden, nach den alttestamentlichen Konzepten von Krankheit und Heilung zu fragen. Diese stehen in Zusammenhang mit der alttestamentlichen Anthropologie allgemein und können vor dem Hintergrund von altorientalischen Deutungen von Krankheit und Heilung verstanden werden. Im Folgenden soll daher Krankheit als anthropologisches Phänomen und in religionsgeschichtlicher und alttestamentlicher Perspektive vorgestellt werden, bevor genauer dargelegt wird, welche Vorstellungen dazu führen, dass JHWH als Arzt bezeichnet wird.

[2] Vgl. https://taz.de/Evangelikale-bei-Montagsdemos-in-Verden/!5839321/ (15.12.2022).

[3] Vgl. https://www.dw.com/de/evangelikale-gottes-segen-statt-corona-impfung/a-57113295 (15.12.2022); https://www.sueddeutsche.de/politik/corona-verschwoerungsmythen-martin-fritz-freikirchen-1.5087744 (15.12.2022).

1. Krankheit und Heilung als anthropologisches Thema

Wir erleben Krankheit und Kranksein in unterschiedlichen Dimensionen: Als vorübergehende Schwächung, die unseren Handlungs- und Bewegungsradius einschränkt, aber keine dauerhaften Folgen hat; oder als existentielle Bedrohung, die großes Leid mit sich bringt und im schlimmsten Fall bis zum Tod führen kann. Wir sind mit Diagnosen konfrontiert, die uns selbst betreffen, oder in Sorge um andere, die von Krankheit bedroht sind, und erhoffen Heilung. Krankheiten betreffen Einzelne, für die diese jedoch auch von sozialer Bedeutung sind, oder – was im Westen Europas fast vergessen schien und wie uns die Corona-Pandemie vor Augen führt – sie sind eine kollektive Bedrohung. In jedem Fall führen sie uns die Hinfälligkeit und Schwäche unseres Körpers vor Augen und erinnern an Sterblichkeit und Tod.

Krankheit gehört also zu den Grunderfahrungen des Menschen und damit in den Bereich der Anthropologie. Auf den ersten Blick liegt es daher nahe, Krankheit als „anthropologische Universalie" zu verstehen. Jedoch weist vor allem die historische Anthropologie, die ihre Wurzeln in der zweiten Hälfte des 20. Jahrhunderts hat, darauf hin, dass jedes Nachdenken über den Menschen immer zeit- und kulturgebunden ist (SÜSSMUTH 1984:8). Zwar ist Krankheit ein Phänomen, dass zu allen Zeiten und in allen Gesellschaften zu finden ist. Aber die Vorstellungen vom Menschen und damit auch das Verständnis von Körper, Krankheit und Heilung unterscheiden sich historisch und kulturell. Wie Krankheit individuell erlebt wird, wie mit Krankheit sozial umgegangen wird, wie Krankheit und Heilung symbolisch geordnet werden, ist abhängig von den kulturellen Systemen, in denen die Einzelnen und die sozialen Gemeinschaften enkulturiert sind.

Im Bereich der alttestamentlichen Anthropologie wurden die Grundannahmen der historischen Anthropologie in den letzten Jahrzehnten breit rezipiert. Zu nennen sind insbesondere die Arbeiten von B. Janowski, in denen er einen konstellativen Personbegriff entwirft, mit dem er Spezifika einer Anthropologie des Alten Testaments zu greifen versucht und der auch aufschlussreich im Hinblick auf ein alttestamentliches Verständnis von Krankheit und Heilung ist (vgl. JANOWSKI 2010:64–87).

Moderne Vorstellungen vom Menschen, von dem, was eine Person ist, fußen vor allem auf einer Gegenüberstellung von Innen und Außen, einem inneren Kern der Person, die der Außenwelt gegenübertritt. In alttestamentlicher Perspektive ist der Mensch ein lebendiges Selbst, das aus körperlichen, emotionalen, kognitiven und voluntativen Aspekten gebildet wird und dessen Einheit in diesem komplexen Beziehungsgeflecht besteht. Der Körper wird in seinen Einzelaspekten wahrgenommen; die einzelnen Körperteile sind aber vor allem hinsichtlich ihrer Funktionen von Bedeutung. In ihrem Zusammenwirken bilden die verschiedenen Glieder den Menschen.

Der Einzelne ist nicht in erster Linie ein Individuum, sondern Teil seiner Familie und sozialen Gruppe. Die Person besteht geradezu in ihrer sozialen Identität und versteht sich als in Konstellationen eingebunden. Daher spricht Bernd Janowski in Anschluss an Jan Assmann[4] von einem konstellativen Personbegriff (vgl. JANOWSKI 2009:29): Nichts, was die Ebene der Person, die Leibsphäre, betrifft, bleibt ohne Bedeutung für deren soziale Beziehungen, die Sozialsphäre, und umgekehrt. So zeigt sich Rechtsnot, die auf Ebene der Sozialsphäre besteht, auf der Ebene der Leibsphäre als Kummer oder Trauer. Was auf Ebene der Leibsphäre als Krankheit zu verstehen ist, gilt auf Ebene der Sozialsphäre als Schande.

Der einzelne Mensch ist in die Gemeinschaft eingebunden; Leben ist daher ein konnektives Phänomen.[5] Konnektivität entsteht dadurch, dass die Mitglieder einer Gemeinschaft sich einander solidarisch zeigen. Das für alttestamentliche Texte charakteristische Konzept des Tun-Ergehen-Zusammenhangs bildet dabei den konnektiven Aspekt der Gerechtigkeit: Alles Ergehen wird auf ein vorgängiges Handeln zurückbezogen und als gerecht verstanden. „Die Tat kehrt zum Täter zurück" umschreibt damit das Prinzip der sozialen Konnektivität. Gerechtigkeit ist dann nicht die natürliche Folge der guten Tat, sondern eine Funktion gesellschaftlichen Handelns und des Prinzips der Gegenseitigkeit (vgl. JANOWSKI 2009:30–31).

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4 „Ein Mensch entsteht nach Maßgabe seiner konstellativen Entfaltung in der ‚Mitwelt' seiner Familie, Freunde, Vorgesetzten, Abhängigen. Leben, nach altägyptischer Vorstellung ist ein konnektives Phänomen, und ein im vollen Sinn lebendiger Mensch, ist ein konstellatives Phänomen." (ASSMANN ^{2}2010:75).

5 Das erinnert stark an das afrikanische Ubuntu-Konzept: „Ich bin, weil wir sind". Vgl. dazu MATUTU 2023.

Der Mensch wird also erstens als psychosomatische Einheit verstanden und kann zweitens auch nicht ohne seine Sozialbeziehungen gedacht werden. Vor dem Hintergrund dieses Menschenbildes zeigt sich, dass Krankheit nicht nur allein als körperliches Phänomen verstanden wird, sondern immer den ganzen Menschen betrifft. Krankheit betrifft auch nie nur den einzelnen Menschen, sondern ist ein soziales Ereignis. Sie wird von der Vorstellung her gedeutet, dass alles Ergehen Ausdruck von Gerechtigkeit sein soll. Insofern wird Krankheit weniger als medizinisch-physiologisches Phänomen verstanden, sondern gerät in ihrer existentiellen Bedeutung für die Person als psychosomatische Einheit und in ihrer sozialen Eingebundenheit in den Blick. Zudem werden Krankheit und Heilung im Alten Orient immer religiös gedeutet, auf göttliche Mächte zurückgeführt und im Kontext der Beziehung zu Gott und den Göttern gesehen.

2. Religiöse Deutungen von Krankheit und Heilung im Alten Orient

Krankheit und Heilung sind im Alten Orient konzeptionell in ein religiöses Weltbild eingeordnet. Erkrankt ein Mensch, wird dies auf den Zugriff einer Gottheit, böser Dämonen oder Totengeister zurückgeführt, wobei Dämonen oder Totengeister als Vollstrecker des göttlichen Willens verstanden werden. Krankheit wird also nicht als physiologischer und rein körperlicher Vorgang erfahren, sondern als Zeichen göttlicher Macht und als Ausdruck einer gestörten Beziehung zu einer Gottheit. Der gesunde und funktionsfähige Körper gilt als schöpfungsgemäß und gottgegeben. In logischer Konsequenz muss auch der kranke Körper in Zusammenhang mit der Gottesbeziehung stehen, wobei Krankheit innerhalb des Tun-Ergehen-Zusammenhangs als gerechte Strafe für menschliche Verfehlungen verstanden wird. Zwar ist dann Krankheit durch eine Gottheit oder deren Dämonen verursacht, aber letztlich gründet sie im beabsichtigten oder unabsichtlichen, bewussten oder unbewussten Fehlverhalten des Menschen selbst, der dadurch Gnade und Zuwendung der Gottheit verliert. Dazu zählt z.B. auch die Vernachlässigung der kultischen Versorgung von Göttern oder Familientotengeistern oder das Überschreiten eines Tabus. Das in Form einer Krankheit verhängte Urteil der Gottheiten

gilt aber nicht als unabänderlich, sondern Götter oder Totengeister können zur Revision ihres Urteils angerufen werden oder durch Geschenke, Gebete oder Übergabe eines Stellvertreters, eines Ersatztieres zu Milderung oder Aussetzen der Strafe veranlasst werden (vgl. BERLEJUNG 2010:187–189).

Da also Krankheit immer auch in Verbindung mit der Götterwelt gesehen wird, erfolgt die Behandlung der Krankheit ganzheitlich und umfasst immer magisch-rituelle und medizinisch-therapeutische Aspekte. An Quellen stehen ab dem 3. Jahrtausend v.Chr. pharmazeutisch-medizinische Texte aus Mesopotamien und Ebla (Syrien) zur Verfügung; seit Beginn des 2. Jahrtausend v.Chr. sind diagnostisch-prognostische Texte belegt, die meisten aus dem 1. Jahrtausend v.Chr. Aus Ägypten sind heilkundliche Texte (Rezepte, Prognosen, Sprüche, Abhandlungen über Pflanzen) überliefert. Die Vieldimensionalität von Krankheit spiegelt sich darin, dass für die Behandlung der Krankheit gleich mehrere Spezialisten zuständig sind. In Ägypten wird zwischen Arzt (*swnw*), Priester der Sachmet (der Seuchen- und Kriegsgöttin), Leiter der Selkis (der Skorpiongöttin), Priester des *ḥkꜣ*-Zaubers und Zauberer (*sꜣw*) unterschieden. In Mesopotamien gelten als Experten für den Umgang mit Krankheit der *bārû*, der *āšipu* und der *asû* (vgl. FREY-ANTHES 2007; KAISER 2008:212–245; POMMERENING 2009; BÖCK 2011; BERLEJUNG 2015:26–33).

Auskunft über den weiteren Verlauf der Krankheit und darüber, ob der Erkrankte genesen oder sterben wird, erwartet man in Mesopotamien von den divinatorischen Techniken des *bārû*, des Leberschauers. So wird z.B. der Sonnengott Šamaš anlässlich einer Erkrankung des assyrischen Kronprinzen Assurbanipal befragt:

> „Ich frage dich, Schamasch, großer Herr, ob diese Droge, die jetzt vor deiner großen Gottheit hingelegt ist, und die Assurbanipal, der Kronprinz des Nachfolge Hauses trinken soll – (ob) er durch das Trinken dieser Droge… gerettet <und genesen> wird. Sei anwesend [in diesem Widder], lege eine positive Antwort (in ihn hinein)." (AGS 144 r.8–11, zit. n. KAISER 2008:213)

Die eigentliche Behandlung des Kranken fällt wiederum in den Aufgabenbereich des *āšipu*, des Beschwörers, und des *asû*, des Arztes. Zunächst führt der exorzistische Beschwörer magische Riten durch, die die bösen Geister und göttlich-dämonischen Krankheitsursachen bzw. den Schädigungswillen der Gottheiten beseitigen sollen.

Ein Beispiel für das Handeln des Beschwörers ist ein von ihm durchgeführten Rituals gegen einen Totengeist, der eine Krankheit verursacht hat. Zu Beginn erfolgen Libationen, eine Substitutionsfigur wird angefertigt, und der Sonnengott Šamaš bzw. der Feuergott Girra werden angerufen:

> „Wenn einen Mensch der Totengeist erfasst hat, in (seinem) Leibe sit[zt und nicht weicht] und Geisterschreck i[hn] permanent befällt…

Ritual dafür:

> Bei Einbruch der Dämmerung fegst du den Fußboden, versprengst reines Wasser, stellst ein Räucherbecken mit Wacholder auf. Du libierst Feinbier, mischst Lehm aus der Lehmgrube, Talg (und) Wachs zusammen und fertigst eine Figur des Schreckensgeistes. Dieser setzt du Stierhörner auf, stellst sie vor den Menschen hin. Seinen Namen schreibst du auf die linke Schulter der Figur des Geistes: ‚Schreckensdämon, böse Krankheit, die NN, Sohn des NN, erfasst hat.'
>
> Vor Schamasch hält der Patient diese Figur mit der Linken hoch und knüpft mit seiner Rechten einen Knoten. Beschwörung: ‚Schamasch, dies ist die Figur des Schreckensdämons' lässt du ihn dreimal sagen, dann stellst du sie in einer großen Opferschale ab. Eine Fackel hebst du hoch und zitierst die Beschwörung ‚Girra, du bist unwiderstehlich, bist aggressiv.' dreimal und löst vor ihm den Knoten. Du wirfst dich nieder und wirfst dann die Verbrennungsreste in die Wüste. Dann wird er gesund."
> (VAT 8237, zit. n. Kaiser 2008:214)

Erst nach der Durchführung des Rituals erfolgt die Behandlung durch den Arzt, der vorwiegend auf Medikamente und Rezepturen in Form von Kräutern und Mineralstoffen, zum Teil auch auf animalische Substanzen zurückgreift, Pflaster und Verbände mit Salben anlegt und sogar auch chirurgische Eingriffe vornimmt, um den Kranken zu heilen. Nach erfolgter Genesung, also Wiedergutmachung des Verhältnisses zu den Göttern, werden Dankopfer oder Votivgaben als Dankgaben an die Gottheit dargebracht, der die Heilung zugeschrieben wird. Amulette mit apotropäischer Funktion sollen eine Rückkehr der Krankheit verhindern. Mittels Omina, der Zukunftsdivination soll schon vor Krankheitsausbruch ermittelt werden, welches Schicksal den Menschen erwartet. Physiognomische Omina schließen von der Beschaffenheit des menschlichen Körpers auf künftige Krankheiten, Geburten oder die Art des Todes. Zwar gibt es auch hier rituelle Verfahren als Gegenmittel, aber insgesamt gründen die Omina in deterministischen Vorstellungen und sehen keine Möglichkeit vor, das Unheil abzuwenden (vgl. Berlejung 2010:190–191).

Krankheit ist in altorientalischer Konzeption Ausdruck gestörter Beziehungen zwischen dem Kranken und den Göttern oder Totengeistern. Heilung wird als Wiedergutmachung und Wiederherstellung dieser Beziehungen verstanden. Im Rahmen dieser Vorstellungen wird Krankheit erklärbar und das, was dem Menschen widerfährt, rationalisiert, so dass der Mensch auch im Angesicht der Krankheit handlungsfähig wird. Die Handlungsmöglichkeiten bestehen auf unterschiedlichen Ebenen und beziehen sich auf das individuelle körperliche Wohlergehen genauso wie auf die soziale Eingebundenheit des Menschen, dessen Beziehungen zu anderen Menschen und den Göttern. In diesen Horizont sind auch alttestamentliche Vorstellungen von Krankheit und Heilung einzuordnen.

3. Krankheit und Heilung als die erhoffte Wende in alttestamentlichen Texten

Alttestamentliche Konzeptionen von Körper, Krankheit und Heilung sind ebenso wie deren aus dem alten Ägypten und Mesopotamien bekannte Deutungen in den Kontext einer religiösen Daseinseinordnung und -bewältigung zu stellen. Auch die Texte des Alten Testaments zeigen, dass der Blick auf Krankheit nicht auf physiologische Vorgänge und medizinische Fragen beschränkt ist, sondern der Mensch als psychosomatische Einheit in seinen sozialen Beziehungen und im Kontext seiner Beziehung zu Gott wahrgenommen wird. Der gesunde Körper ist die Voraussetzung für alle sozialen Begegnungen und religiösen Vollzüge. Krankheit wird daher als Störung dieser Beziehungen verstanden. Sie ist körperliche und psychische Schwächung, Kraftlosigkeit, Einschränkung von Vitalität und Verlust von Lebenskraft; sie ist Todesnähe, damit auch Gottferne. Sie ist verbunden mit Einsamkeit, sozialer Ächtung, Anfeindung und kultischer Unreinheit, zerstört so die Beziehungen innerhalb der sozialen Gemeinschaft und verunmöglicht die Gottesbegegnung im Kult.

Mittels Orakeleinholungen (Gen 25,22), Gebeten (1 Kön 8,37–38), Bußriten (2 Sam 12,15–23; Ps 35,13–14) und kultischen Heilpraktiken zur Entsündigung (Ps 51,9) wird gegen sie vorgegangen. Dabei besteht zwischen Krankheit und Heilung eine gewisse Asymmetrie, insofern Heilung immer auf JHWH zurückgeführt wird, während Krankheit als durch JHWH, menschliche Schuld oder das Wirken von Unheilmächten

verursacht gilt. Zwar kommen Priestern (Lev 13–14; Dtn 24,8) und Propheten (2 Kön 5,1–27; Jes 38,1.21 u.a.) diagnostische und therapeutische Kompetenzen zu, möglich wird Heilung aber nur durch JHWH (Ps 147,3). Vor allem die Psalmen verstehen Krankheit als ein Ergriffenwerden vom Tod, während Heilung ein Zurückführen ins Leben ist, wobei allein JHWH der ist, der Leben schafft (vgl. Janowski 2019:177–182).

Die ganzheitliche, körperliche und psychische Dimension der Krankheit und ihre sozialen Auswirkungen zeigt Ps 38 ebenso deutlich wie die Deutung von Krankheit als Folge von Strafe und die Hoffnung auf göttliche Wiederherstellung:

3 Fürwahr, deine Pfeile sind in mich eingedrungen,
und deine Hand hat sich auf mich gelegt.
4 Nichts Gesundes ist an meinem Fleisch wegen deines Grolls,
nichts Heiles an meinen Gebeinen wegen meiner Sünde.
5 Fürwahr, meine Vergehen sind mir über den Kopf gewachsen,
wie eine schwere Last sind sie zu schwer für mich. [...]
12 Die mich lieben und meine Gefährten sind fern meiner Plage,
und die mir nah sind, stehen weit weg von mir.
13 Es legen Schlingen die, die nach meinem Leben trachten,
und die mein Unglück suchen, reden Zerstörung,
und Betrug planen sie den ganzen Tag. [...]
16 Denn auf dich, JHWH, harre ich,
du, du wirst antworten, Herr, mein Gott. (Ps 38,3–5.12–13.16)

Im Mittelpunkt des Gebets steht nicht die Beschreibung einer konkreten Krankheit. Im Gegenteil, es lassen sich keine eindeutigen Symptome ausmachen. Körperliches Leiden geht einher mit Niedergeschlagenheit und Kraftlosigkeit; die sozialen Folgen fallen mit der Verfolgung durch Feinde in eins. Das betende Ich führt seine desolate Situation auf seine eigene Sünde zurück, die es bekennt, ist sich gleichzeitig aber der göttlichen Zuwendung und Heilung gewiss (vgl. Janowski ^{4}2013:177–178).

In Entsprechung zu den altorientalischen Vorstellungen wird Krankheit also der göttlichen Sphäre zugeordnet. Sie ist Ausdruck einer Störung der Beziehung von Mensch und Gott. Vor dem Hintergrund des Tun-Ergehen-Zusammenhangs erscheint Krankheit als göttliche Strafe oder als pädagogisches Mittel für den einzelnen Menschen oder das Volk. Beiden Fällen liegt jedoch die Überzeugung zugrunde, dass die in der Schöpfung durch Gott begründete Ordnung der Welt auf Gerechtigkeit ausgerichtet ist und sein soll. Insofern impliziert die Vorstellung eines

Zusammenhangs von Tun und Ergehen gerade nicht, dass Krankheit ein unumgängliches Schicksal ist, dass – wovon die altorientalischen physiognomischen Omina ausgehen – das Leben determiniert ist, sondern dass dem Menschen mit Umkehr, Reue und Gebet immer Möglichkeiten gegeben sind, das Gottesverhältnis zu erneuern und eine gute Wende herbeizuführen (vgl. BERLEJUNG 2010:205). Dies schließt nicht aus, dass Krankheit als sinnlos und ungerecht empfunden wird. So wehrt sich Ijob gegen jeden Vorwurf, der auf einem Rückschluss von seinem Ergehen auf moralische Verfehlungen beruht (Ijob 16,11–17). Gleichwohl ist es auch Gott, der für seine Erkrankung verantwortlich ist, da er dem Satan freie Hand lässt (vgl. KAISER 2008:236; MÜLLNER 2021:34–35).

Mit der Entwicklung zum Monotheismus gilt Gott als Ursache aller menschlicher Erfahrungen. So kommt es dazu, dass sowohl Krankheit als auch Heilung dem einen Gott zugeordnet werden:

> Seht, jetzt, dass ich, ja, ich es bin,
> und mit mir gibt es keinen Gott.
> Ich töte und mache lebendig,
> ich habe zerschmettert und ich heile,
> und niemand kann aus meiner Hand entrinnen. (Dtn 32,39)

Nicht andere Götter oder Dämonen sind verantwortlich für das körperliche und psychische Leiden, sondern Gott selbst. Wird Krankheit als Folge von Schuld und Verfehlungen innerhalb des Gottesverhältnisses gedeutet, dann kann auch nur Gott von der Krankheit heilen. Theologisch wird dieses Konzept in der Selbstvorstellung „Ich bin JHWH, dein Arzt" (Ex 15,26; vgl. Jes 30,26; Jer 33,6; Hos 6,1) zugespitzt.

4. „Ich bin JHWH, dein Arzt" (Ex 15,26) und die Gabe einer Lebensordnung

Aus religionsgeschichtlicher Perspektive steht die Prädikation JHWHs als Arzt (hebr. רוֹפֵא *rofe'*) an einer langen Entwicklung. Innerhalb eines Götterpantheons wird der höchste Gott als ferner und transzendenter Gott verstanden, während Heilgötter als nahe Götter vorgestellt werden. In den alttestamentlichen Texten lassen sich nur noch wenige Hinweise auf Heilgötter in Israel (2 Kön 1,1–17; 2 Kön 18,4; Num 21,4–9) oder vergöttlichte Ahnen (hebr. רְפָאִים *r^{e}fā'im*) bzw. Hausgötter (hebr. תְּרָפִים *t^{e}rāfim*),

denen die Macht der Heilung zugeschrieben wird, ausmachen. Außerbiblisch sind vor- und nachexilisch Personnamen bezeugt, die aus einem theophoren Element und Derivaten der Wurzel רפא *rāpa'* „heilen" gebildet werden, z.B. *jrpjh* „JHWH heilt" (vgl. auch רְפָאֵל *rᵉfā'el* in 1 Chr 26,7 und רְפָיָהוּ *rᵉfājāh* in Neh 3,9; 1 Chr 3,21 u.ö.) und damit bezeugen, dass JHWH als Familiengott Heilung, Rechtverschaffen und Rettung zugeschrieben wird. Der Aspekt des Rechtverschaffens verweist auf das Verständnis von Krankheit oder Kinderlosigkeit als Strafe, so dass dann die Geburt eines Kindes so verstanden werden kann, dass Gott die Mutter ins Recht setzt (vgl. Gen 30,6) (vgl. Niehr 1991:3–8).

Die forensische Deutung von Krankheit als Strafe führt auch dazu, dass in diesem Rechtsfall der richtende Sonnengott angerufen wird, ohne dass dieser deshalb automatisch ein Heilgott wäre. Die Solarisierung JHWHs führt in Israel dazu, dass JHWH sowohl als Garant der Rechtsordnung fungiert als auch, dass ihm im Bereich der persönlichen Frömmigkeit heilendes Handeln zugeschrieben wird. Als Richtergott ist JHWH sowohl für Krankheit als auch Heilung zuständig: Krankheit ist Ausdruck der Strafe; mit der Heilung wird dem Kranken Recht verschafft. Der nahe und der ferne Gott fallen in eins.

Aus der persönlichen Frömmigkeit wird das Bild von JHWH als Arzt über die Vorstellung vom rettenden Sonnengott auf das Volk als Ganzes übertragen. In der Prophetie bringt das Bild der Krankheit das gestörte Verhältnis von Gott und seinem Volk zum Ausdruck (vgl. Jes 1,5–9; Jer 10,19; Hos 5,13–14). Als Arzt des einzelnen Menschen und als Arzt seines Volkes ist JHWH gleichermaßen für Unheil und Heil verantwortlich (vgl. Dtn 32,39; Jes 57,17–18 u.ö.) (vgl. Niehr 1991:10–12; Lohfink 1988:91–155).

Die Selbstvorstellung „Ich bin JHWH, dein Arzt" (Ex 15,26) ist nicht nur deshalb singulär, weil sich in der Figurenrede JHWH selbst als Heiler bezeichnet. Sie unterscheidet sich von den anderen Texten, die JHWH Heilung zuschreiben, auch dahingehend, dass die Observanz der Gebote als Bedingung und Möglichkeit genannt wird, Israel von den Krankheiten zu verschonen, mit denen das Volk Ägypten geschlagen worden ist:

> „Wenn du willig auf die Stimme JHWHs, deines Gottes, hörst
> und was in seinen Augen recht ist, tust
> und hörst seinen Geboten
> und bewahrst alle seine Satzungen

> – alle Krankheiten, die ich auf Ägypten gelegt habe, dir werde ich sie nicht auferlegen.
> Denn ich bin JHWH, Dein Arzt." (Ex 15,26)

Die Passage gehört in den Kontext der ersten Murr-Erzählung (Ex 15,22–26). Das Volk Israel befindet sich auf dem Weg vom Schilfmeer zum Sinai. Unmittelbar, nachdem das Volk JHWHs Macht und Stärke, die sich in der Rettung vor den Ägyptern zeigt, besungen hat, führt der Wassermangel in der Wüste dazu, dass es sich das erste Mal gegen Mose auflehnt. Zwar gibt es Wasser in Mara, doch dieses ist bitter. JHWH selbst zeigt Mose ein Holz, dass das Wasser süß werden lässt. Mose macht mit diesem Holz das Wasser süß. Wenn die Erzählstimme fortfährt „Dort legte er legte er Ordnung und Recht für es fest, und dort prüfte er es." (Ex 15,25), dann ergibt sich aus dem Kontext nicht Mose, sondern JHWH selbst als Subjekt von Gesetzesgabe und Prüfung (vgl. DOHMEN 2015:381). Die Versorgung in der Wüste, die Ermöglichung von Leben, ist also verknüpft mit der Gabe einer Lebensordnung, womit die Gabe der Tora am Sinai und der Bundesschluss vorweggenommen sind (Ex 19,5–7), und einer Unterweisung über den Zusammenhang von Wohlergeben und der Bindung an Gott. JHWH ist insofern Arzt, als im Bund mit ihm und in der Gabe des Gesetzes Bewahrung vor Sünde und Schuld, die zu Krankheit führen, möglich ist.

Die Rede von JHWH als Arzt ist also Teil einer komplexen metaphorischen Sprache, die religionsgeschichtlich in der Vorstellung wurzelt, dass Krankheit in Zusammenhang mit der Beziehung zu Gott bzw. den Göttern steht und Heilung als Akt des Rechtverschaffens konzipiert wird. Sie ist in der Perspektive des Buches Exodus sowohl mit dem Bundesgedanken als auch der Gabe der Tora als Lebensordnung Israels verknüpft. Sie ist nicht medizinisch, weder was individuelle Erkrankungen noch kollektive Krankheiten betrifft, engzuführen, sondern bringt das Verhältnis JHWHs zu seinem Volk zum Ausdruck.

Wenn die Verfehlungen des Königs Asa von Juda gegenüber JHWH dadurch auf die Spitze getrieben werden, dass er, als er erkrankt, nicht JHWH, sondern die Ärzte aufsucht (2 Chr 16,12), dann wird damit Asa diskreditiert. Daraus kann nicht geschlossen werden, dass die Rede von JHWH als Arzt Formen medizinischer Behandlungen von Krankheiten durch menschliche Ärzte, wie sie aus Ägypten oder Mesopotamien bekannt sind, ausgeschlossen habe, sodass es in Israel keine Ärzte gegeben

habe. Ein Stempelsiegelabdruck aus dem späten 7. bzw. frühen 6. Jh. v.Chr. aus Tell Bêt Mirsim mit der Inschrift „Für Elijahû, den Arzt" verweist vielmehr darauf, dass JHWH-Glaube und eine Tätigkeit als Arzt oder Heiler miteinander vereinbar sind (vgl. Kaiser 2008:222). Dass über medizinische Verfahren in Israel wenig bekannt ist, hängt vielmehr eher damit zusammen, dass die alttestamentlichen Texte eben keine Kompendien antiker Heilkunst sind, sondern Heilung als Heil und Wohlergehen theologisch konzipieren (vgl. Niehr 1991:17; Kaiser 2008:222).

5. Fazit

Zwar ist Krankheit ein universales Phänomen; wie aber Krankheit erlebt und gedeutet wird, ist nicht nur individuell verschieden, sondern auch abhängig davon, wie Körper, Krankheit und Heilung zu verschiedenen Zeiten und in unterschiedlichen Kulturen gedeutet werden. Das alttestamentliche Verständnis von Krankheit und Heilung ist vor dem Hintergrund der Bilder vom Menschen insgesamt zu sehen. So wird der Mensch als psychosomatische Einheit verstanden. Krankheit betrifft immer den ganzen Menschen, wird nicht als rein körperliches Phänomen angesehen, sondern hat immer auch psychische Dimensionen. Da die Person wesentlich ihre soziale Identität ist, der Mensch immer auch in seinen sozialen Beziehungen besteht, hat jede Krankheit Implikationen für die gemeinschaftlichen Vollzüge, in die der Mensch gestellt ist. Im Kontext einer religiösen Weltdeutung werden Krankheit und Heilung im Rahmen der Beziehung zu Gott und den Göttern gedeutet und sind Ausdruck für ein gestörtes bzw. intaktes Gottesverhältnis. Maßnahmen gegen Krankheit umfassen daher immer medizinisch-therapeutische, magisch-rituelle und religiöse Verfahren.

Krankheit als Einbruch des Unerklärbaren wird im Kontext der Vorstellung eines Zusammenhangs von Tun und Ergehen rationalisiert, so dass der Mensch ihr handelnd begegnen kann. Vorausgesetzt ist dabei, dass die Welt als ganze in einer guten Schöpfungsordnung gründet, die auf Gerechtigkeit ausgerichtet ist und in der für den Menschen Gesundheit und Heilsein vorgesehen sind. Innerhalb dieses Rahmens fungiert Gott als Garant von Gerechtigkeit und Ermöglichungsgrund von Heilung und Heil. Wird Krankheit auf ein fehlerhaftes Verhalten des Erkrankten

und daraus resultierend auf eine Störung der Gottesbeziehung zurückgeführt, ist sie kein unausweichliches Schicksal, sondern es eröffnen sich dem Menschen Handlungsoptionen verschiedener Art.

Die Rede von JHWH als Arzt gründet religionsgeschichtlich darin, dass JHWH im Rahmen der persönlichen Frömmigkeit als Familiengott für Heilung, Rechtverschaffen und Rettung zuständig ist und gleichzeitig analog dem richtenden Sonnengott sowohl straft als auch richtend und rettend handelt. Insofern können ihm Krankheit und Heilung gleichermaßen zugeschrieben werden. Die Selbstvorstellung JHWHs als Arzt ist in ihrem literarischen Kontext eng verwoben mit der Befreiung aus Ägypten, der Rettung in der Wüste sowie dem Bundesschluss und der Gabe der Tora als Lebensordnung, die auf ein gutes Leben, also Heilung, zielt. Sie ist nicht auf einen medizinischen Aspekt zu reduzieren, so dass mit der Prädikation JHWHs und nur JHWHs als Arzt medizinische Handlungen ausgeschlossen wären. An diesem komplexen Verständnis von Krankheit und Heilung sind die Argumente zu messen, die mit Bezug auf die Aussage „Ich bin JHWH, dein Arzt" (Ex 15,26) gegen die COVID-19-Impfung vorgebracht werden.

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Assoumou Gilbert Ekou

2 Religion et medecine en Occident medieval : entre pratique cultuelle, savoir et savoir-faire medical (V^E-XIII^E siecles)

Abstract

This contribution focuses on the link between religion and medicine in the Western epoch of the Middle Ages. The author describes the relation between the two cultural sectors of religion and medicine by analysing the medical practices of the pagan polytheistic societies dating from antiquity and those of the Christianised peoples of the West in their fight against diseases from the 5th to the 13th century CE. As can be seen some elements of the privileged relationship of pagan gods as healing authorities were integrated into the religious interpretation of disease and healing among the Christians. The church of the 5th century inherits from the cultic tradition of a religion-based medicine associated with healing gods like Asclepius. This heritage is combined with the religious values of Christianity – especially that of benevolence, hospitality, and charity. These values constituted the basis of the social doctrine of the church and lead to the creation of hospitals in monasteries and other religious institutions. All over the Christian West, the new hospitals became centres of medical studies and training. Under the control of the religious authorities, medicine became something exclusively monastic for a long time. However, in the 13th century it was more and more secularized by the powerful movements of independence, which led to the ascent of medical faculties at medieval universities.

Keywords: Middle Ages, Medieval medicine; healing cult; 5th–13th century CE; hospitals; religion and medicine; monasteries; univeristies

Introduction

Les nombreux fléaux actuels comme la COVID-19 et certaines maladies qui déciment nos sociétés aux croyances multiples, sans véritables remèdes de guérison, entrainent souvent la construction d'un idéal de guérison lié à la religion, avec parfois même des religieux thérapeutes accrédités par les communautés. L'historiographie occidentale médiévale relève bien ce genre de rapport qui entremêle la religion et la médecine, sans aucune illusion de séparation des deux univers. Ce sujet est d'un intérêt scientifique capital car les débats scientifiques en cours sur la problématique du rapport de la religion à la médecine et vice versa sont loin de s'estomper.

Le présent article vise d'abord à analyser le lien entre la religion et la médecine médiévale. Il explique le parallèle entre ces deux pratiques à travers l'étude des pratiques médicales des sociétés polythéistes païennes, et celles des peuples christianisés en Occident, dans leur lutte contre la maladie du V^{e} au XIII^{e} siècle. Il s'agit d'analyser la relation privilégiée de la maladie et du sacré à travers les vertus thérapeutiques des dieux chez les polythéistes et l'interprétation religieuse de la maladie et de sa guérison chez les chrétiens.

Nous montrons par la suite l'origine païenne et antique d'une médecine cultuelle fondée sur les centres thérapeutico-religieux placés sous l'invocation des dieux guérisseurs comme Esculape ou Asclépios (Lanotte, 1998 :7). Le clergé du VI^{e} siècle hérite alors de cette médecine cultuelle et lie ses principes aux valeurs religieuses chrétiennes, notamment la bienveillance et la charité chrétienne, puis la répand en Occident. Ce souci de bienveillance qui fonde et guide la doctrine sociale de l'Église conduit enfin à la création des *hospitales* dans les monastères et autres édifices religieux qui sont des foyers de diffusion de la culture et de la formation médicale. Sous le joug des autorités religieuses, la médecine devient alors conventuelle avant de se laïciser au XIII^{e} siècle en raison des velléités d'indépendances et des difficultés de cohabitations.

L'analyse et l'interprétation des sources comme les textes des historiens du temps, les chroniques, les gestes, les bréviaires, les documents religieux et juridiques, les livres des miracles, ... ont servi à comprendre le sens et le contexte des notions et des faits, puis faire ressortir la conséquence du rapport de la maladie au religieux et au social.

C'est cette dynamique dans l'évolution des rapports entre la religion et la médecine dans la lutte contre les maladies qui fait l'objet de cette étude subdivisée en trois grandes parties. La première porte sur les propriétés curatives des dieux chez les polythéistes et la conception spirituelle de la maladie et sa guérison chez les chrétiens. Quant à la seconde partie, elle analyse le passage des monastères, de la fonction d'assistance à la naissance des hôpitaux. Le dernier centre d'intérêt étudie enfin les difficultés ayant favorisé la laïcisation de la médecine dorénavant sous le joug des autorités religieuses.

1. Dieu et la médecine : des propriétés curatives des dieux chez les polythéistes à la conception chrétienne de la maladie et sa guérison

Au sein de nos sociétés, Dieu a toujours occupé une place de choix dans la médecine. Pour mieux comprendre cette réalité divine dans la médecine en Occident médiéval, cette partie de l'étude analyse les rapports entre les sociétés polythéistes et la médecine au début du Moyen Âge en vue de faire ressortir la place occupée par les dieux dans la médecine. Elle met par ailleurs en exergue, la conception chrétienne de la médecine et la pratique médicale en Occident médiéval, une société dominée par le christianisme.

1.1 Les vertus thérapeutiques des dieux chez les polythéistes

Le cheminement entre la médecine et la religion remonte à l'aube de l'humanité (cf. KORNPROBST, 1957 :14). Déjà dans l'Antiquité, l'histoire du mythe du prêtre-guérisseur, à l'origine de l'influence des grandes familles médicales ayant fondé les écoles de pensée, notamment l'école des Hippocrates Cos, mêle toujours la médecine aux croyances religieuses. Dans la lutte contre la maladie, cette association de la médecine et de la religion se rencontre également dans l'histoire des civilisations de l'Europe occidentale médiévale. Héritières de certaines divinités ou centres de prières spécialisés dans la guérison et la prévention des maladies, ces civilisations polythéistes du temps avaient même des dieux de la médecine. C'est le cas du culte d'Apollon, attesté par les inscriptions d'Avenches, qui montrent bien que des médecins et des professeurs ont bien attesté l'attribut de dieu guérisseur d'Apollon en ces termes : « Aux divinités Augustes, et

au Génie de la colonie des Helvètes, consacré à Apollon, en faveur des médecins et des professeurs ». *Numinibus Aug. et genio col. Hel Apollini sacr. Q. Postum. Hyginus et Postum. Hyginus et Postum. Hermes lib. Medicis et professoribus D.S.D* (HATT, 1983 :186).

Dans les sanctuaires d'Apollon, des prêtres, des médecins et des professeurs étaient associés pour constituer un corps. Ils participaient à un service de la prophétie, de la santé, de la médecine et de l'enseignement, de la thérapeutique et de la chirurgie (HATT 1983 :196). Ce culte d'Apollon, dieu devin et guérisseur, s'est rapidement répandu. La puissance d'Apollon comme guérisseur chez les Leuques (une ancienne tribu gauloise appartenant à la province de Gaule Belgique), était bien connue au V^e^ siècle, en vogue en Germanie, il s'est diffusé dans la Gaule (HATT 1983 :190).

Il y avait bien évidemment des dieux topiques, rattachés à des sanctuaires ou des sites avec pour actions d'offrir des données pour la solution d'un problème. Les actions des divinités métaphysiques vont au-delà des sanctuaires et des régions pour devenir plus général. HATT Jean-Jacques précise à ce sujet que parmi les Mars guérisseurs, Lenus semble avoir joué le premier rôle. Le témoignage d'une épigramme métrique en Grec, traduit en latin, trouvée à Marberg près de Pommern, exprimant la reconnaissance d'une personne que le dieu Lenus Mars avait guérie de ses douleurs et d'une maladie mortelle, est un exemple probant du pouvoir de guérisseur attribué à Lenus Mars (HATT 1983 :195). Les dédicaces au dieu Mars guérisseur se perçoivent également dans les écrits des auteurs (HATT 1983 :194).

Au début du Moyen Âge, la pratique de la médecine cultuelle reposait alors sur le culte de certains dieux ayant le pouvoir de guérir que les populations vénéraient. Il s'agit de divinités païennes comme Esculape, Apollon, etc. dont les traces sont perceptibles en Gaule, précisément dans les sources du début du Moyen Âge occidental. Il est indiqué que chez les Gaulois, après le Grand dieu Mercure, Apollon chassait les maladies (AUPERT 1992 :59-75). Léon Vannier met cette fonction divine de la médecine en exergue ; la médecine serait alors une grâce donnée par Dieu dont les fondements ne sont pas les livres académiques mais « *la miséricorde divine et ses dons* » (VANNIER, 1931, cité par KORNPROBST, 1957 :13-16). Il donne ainsi une fonction sacrée à la médecine tout en la considérant comme un sacerdoce (DEMONT, 1999 :367).

Depuis le Moyen âge, la médecine s'est donc identifiée partout à des pratiques magiques et religieuses qui a trait au mystérieux et relève du domaine du spirituel. La pratique médicinale avait alors une profonde interprétation divine ou providentielle de la maladie et sa guérison. Elle est cultuelle, puis repose sur le culte de certains dieux qui possèdent le pouvoir de guérir. Parmi ces des dieux de la santé ou dieux guérisseurs, Esculade apparait bien plus répandu, mais c'est Apollon qui a récupéré les pouvoirs thérapeutiques de la plupart des divinités locales de la Gaule (PIERRE, 1992 :312-333). Dans les écrits, Apollon, dieu guérisseur, encore appelé Belenus en gaulois ou celtique, est aussi identifié avec des divinités romaines (HATT, 1983 :185). Ces divinités païennes de l'époque disposaient de nombreux sanctuaires qui servaient parfois de lieux d'Asile. On comprend alors le développement d'une sorte de mythologie sanitaire au sein de ces sociétés occidentales médiévales qui présentent des dieux aux vertus curatives. Ces dieux ont particulièrement influencé la médecine au Haut Moyen Âge, et chacun semblait manifester la présence divine dans le culte des forces mystérieuse de la nature comme les sources, les lacs, les arbres, les pierres, des montagnes etc. Les guérisons miraculeuses au moyen de l'eau, mentionnées dans le premier livre de Miracula de saint Hubert au IX^{e} siècle, montrent bien ce lien étroit entre les maladies et les croyances religieuses du temps (DESMET, 1998 :16-19).

Le culte des eaux par exemple était une pratique commune chez les Gallo-romains et les Germains (DEYTS, 1986 :24). Les populations paysannes demandaient la guérison de leurs maladies et la fécondité de leurs champs à ces divinités. Toutefois, avec l'avènement du christianisme, l'Église l'avait condamnée à de nombreuses reprises sans pouvoir l'éradiquer. Elle a finalement dû se contenter de christianiser les sources sacrées pour perpétuer le culte. Les vertus thérapeutiques que l'on attribue à l'eau sacrée trouvent leur illustration dans la mythologie celte. Ce culte en Gaule a essentiellement pour objet des divinités guérisseuses. Des cures se faisaient dans ses sanctuaires de l'eau puis servaient de lieux de pèlerinage pour les malades et leurs représentants (DESMET, 1998 :7-21). Une sorte de médicalisation des pratiques thermales se perçoit donc dans les traités qui diffusent des conseils d'utilisation chez les curistes ainsi que la production de règles d'usage du séjour thérapeutique au bain (NICOUD, 2011 :21). La cure des malades dans des locaux particuliers est par exemple mentionnée dans les statuts des hôtels Dieu de Montdidier (1207) et de Paris aux environs de 1220. Cette cure concerne un malade

qui est membre de la confrérie : « *Fratres habeant suam infirmariam et sorores suam, in quibus tempore infirmitatis et minutionis [= signée] diligenter et misericorditer tractentur* » (GRMEK, 1982 :39). Les populations fréquentaient donc les sanctuaires pour demander également la protection de la santé et faire des offrandes aux divinités. Ce culte des sources fut une des religions de la Gaule entière, cf VURPILLOT (2016) pour de plus amples informations sur les sanctuaires des eaux.

Héritée de l'Antiquité, la pratique médicale médiévale occidentale était une médecine empirique fondée sur l'usage d'une abondante pharmacopée, sans véritable base intellectuelle. La conception de la médecine à cette époque est indissociable de la mythologie et du sacré. La thérapeutique était considérée comme un don divin, et la manifestation divine résidait à la fois dans l'origine de la maladie et dans le mécanisme de fonctionnement du remède. Guérir ou soigner revêtait alors un caractère sacré, magique et divin.

Cependant, avec l'installation progressive de la chrétienté en Occident au Moyen Âge, la société confère une place centrale à cette religion. La médecine n'échappe pas à l'évolution chrétienne de la société d'autant plus que le clergé va disposer plus tard des leviers de décisions. Par ailleurs, la tradition médicale laïque ne pourra pas concurrencer les forces chrétiennes (BARIETY & COURY, 1963 :325-400). La dévotion réservée à certains saints pour intervenir dans la guérison des maladies, ainsi que le culte des reliques pour garantir une faculté d'intercession auprès de Dieu et les exorcismes etc., expliquent bien l'orientation de cette médecine portée sur le monde surnaturel, avec une croyance générale aux interventions mystiques ou surnaturelles (cf. MOEGLIN 2000). Les exemples de malades qui vont même séjourner plusieurs mois dans des basiliques, veiller dans des églises en vue de la guérison par des miracles sont légion. Des cierges situés autour de tombeaux de saints guérisseurs, restent allumés des nuits durant, donnant une ambiance mystérieuse propice aux visions. Certains remèdes reposent également sur les tombeaux et ce qui les entoure. Il y a aussi l'invocation de versets bibliques pour surmonter l'épreuve de la maladie. Telle est la conception de la maladie et de sa guérison dans ces civilisations occidentales au début du Haut Moyen Âge.

Toutefois, avec l'avènement du christianisme qui occupe une place centrale au sein de la société médiévale, la médecine n'échappe pas non plus à l'influence de cette religion.

1.2 Conception spirituelle de la maladie et sa guérison chez les chrétiens

La religion et la médecine ont longtemps cheminé étroitement (HELENE-PELAGE, 2015 :23). Elise NEDELEC (2022 :83-100) ne dit pas le contraire quand elle affirme, et je cite : « Le médecin soigne seul Dieu guéri ».

En effet, dans la théologie médiévale, l'être humain est formé de la conjonction d'un corps charnel et périssable, et d'une âme, entité spirituelle et immortelle. Le christianisme fait donc une représentation duelle de la personne humaine : âme et corps (BASCHET, 2000 :3-4,23). La médecine du temps ne déroge donc pas à cette représentation. Cette interface âme/corps, entre le spirituel et le matériel, domine la pensée médiévale de l'ère chrétienne. Il est alors difficile de séparer les événements corporels comme la maladie, de leur signification spirituelle. Pour mieux percevoir le rapport entre la religion et la médecine au sein des sociétés occidentales médiévales dominées par le christianisme, il faut d'abord comprendre la conception de la maladie selon les mentalités des peuples.

En fait, la mentalité médiévale conçoit la maladie comme une punition divine ayant son origine dans les péchés de l'homme. Il y a donc une théorisation des théologiens chrétiens pour faire accepter la maladie. Raison de plus pour Baudri de Bourgueil d'affirmer que « toute maladie du corps est un remède de l'âme ». Plusieurs auteurs influents du temps comme Grégoire le Grand, saint Bernard de Clairvaux et saint François d'Assise ont bien insisté sur ce « bon usage » de la maladie. Ce raisonnement moralisateur a permis à l'Église de prôner une médecine théurgique et faire considérer les soins spirituels comme un moyen indispensable pour combattre la souffrance physique (GRMEK, 1982 :27).

En effet, il est donc impossible de séparer les événements corporels de leur signification spirituelle car le corps et l'âme sont intimement liés et imbriqués. Cette conception des maladies était bien différente chez les médecins de l'Antiquité pour qui toutes les maladies sont somatiques. Selon eux, les maladies de l'âme n'étaient qu'une invention des moralistes. L'ésotérisme y tenait une place importante. On attribuait des vertus thérapeutiques aux amulettes, à certaines pierres, aux sécrétions animales ainsi qu'à certains objets étranges. C'est par ailleurs une médecine par les plantes qui se dégage difficilement de la magie et de la sorcellerie, vers lesquelles se dirigent les malades pour endiguer les terribles épidémies de l'époque.

Au Haut Moyen Âge, avec l'avènement du christianisme, la pratique médicale, un legs de l'Antiquité qui mêle à la fois tradition chrétienne de la charité[1] aux soins des malades, a favorisé la fondation de nombreux lieux d'assistance en Occident.

2. Les monastères au Moyen Âge: de la fonction d'assistance à la naissance des hôpitaux

Dans cette partie, nous montrons comment les édifices religieux ont été utilisés comme des lieux d'assistance et de charité pour enfin occupé les fonctions d'hospice et d'hôpitaux. Les monastères, un legs antique et oriental puis africain, après leur implantation en Occident, ont été transformés du modèle antique à un modèle occidental.

Le clergé occidental lie alors ce legs antique (monastère et médecine cultuelle) aux valeurs chrétiennes de charité et de bienfaisance. La médecine médiévale va donc se renforcer de la culture chrétienne gréco-latine pour développer la médecine conventuelle en Occident.

2.1 La pratique de la médecine couplée à la vie monastique

La médecine du début du Moyen Âge trouve refuge dans les édifices religieux (monastères, abbayes, couvents, etc.) où moines et évêques médecins s'attellent à compiler les manuscrits médicaux de l'Antiquité. Comment cette évolution dynamique de la médecine cultuelle à la médecine conventuelle s'est-elle déroulée au Moyen Âge ? Tout est parti de l'essor sans précédent des monastères au Moyen Âge.

En effet, le monachisme nait par imitation aux actions du Christ à travers son commandement qui dit : « vas, vends tout ce que tu possèdes,

[1] Le christianisme place la charité au centre des œuvres humanitaires. Ces œuvres de charité et de prise en charge des indigents, démunis, pauvres et autres malades ont entrainé la création de fondations ou lieux de prise en charge du prochain. La première fondation caritative de ce genre a été réalisée au IVe siècle par Fabiola, une noble dame romaine. Le premier endroit où l'on soigne, qu'on pourrait bien appeler le premier hôpital cité dans un texte le (*Nosokomeion*, mot grec qui désigne ce qui se rapporte à l'hôpital) remonte au IVe siècle. Le premier auteur qui aborde ce sujet d'hôpital est l'ermite Dalmat saint Jérôme. Il affirme qu'une matrone chrétienne, Fabiola, fonda à Rome vers la fin du IV^{e} siècle, un *Nosokomeion* où elle soignait elle-même les malades, et un praticien, Pammachius, fait construire à Ostie, à la même époque, un *xenodocheion,* un refuge pour les pèlerins, d'où la dénomination des institutions hospitalières.

donne-le aux pauvres et suis-moi » (Marc 10 :21 ; parr Matthieu 19 :21 ; Luc 18 :22). Cela entraine le retrait du monde qui passe par la vie reculée solitaire, à la vie retirée en commun, au sein d'un mur de clôture, avec un complexe de bâtiments et autres espaces dont tous obéissent à un supérieur.

Débuté au IVe siècle en l'Égypte, le monachisme gagne l'Asie Mineure pour ensuite atteindre l'Occident par le Sud de l'Italie dès la seconde moitié du IVe siècle (KAPLAN, PICARD, ZIMMERMANN, 1994 :62-65). C'est par cette même voie de l'Italie du Sud, où toutes les civilisations méditerranéennes se côtoyaient, que le savoir médical des écoles s'est également répandu dans le monde occidental. Au IVe siècle, l'Église se coule tout naturellement dans le moule de la cité antique puis devient le meilleur défenseur de la romanité et le principal appui des royautés barbares. Les religieux s'approprient alors le savoir antique de l'herboristerie en créant des « jardin de simples » comme l'abbaye de Salagon dans le Sud de la France. Au VIe siècle en Occident, la contestation du modèle antique du monachisme et le refus de la culture classique entraine l'apparition d'écoles monastiques qui forment le clergé (KAPLAN, PICARD, ZIMMERMANN, 1994 :85-86).

Le germe de la vie conventuelle en Europe occidentale se situe donc au Mont-Cassin où Saint Benoit de Nursie fonde entre 527 et 530, la maison mère d'un ordre religieux nouveau. Les manuscrits anciens sont conservés dans les monastères hérités de la maison mère du Mont-Cassin, fondée par Saint Benoit de Nursie (480-527). Pendant les premiers siècles du Moyen Âge, et surtout avec la fondation du monastère de Mont Cassin en Italie[2], la médecine conventuelle se développe à travers une formation générale des médecins portée sur les sciences de la nature que sur l'homme. L'Église devient dépositaire du savoir. Ainsi sont cultivées des plantes médicinales dans les *herbularius* ou jardins des simples, situées dans les monastères et cultivées par les moines. On assiste dès lors à l'éclosion des monastères bénédictins créés à distance des cités. À titre d'illustrations, nous avons le monastère bénédictin de Mont Cassin, le

[2] Saint-Benoit fonde le monastère de Mont Cassin au VIe siècle et rédige la *Règle de saint Benoit vers 540*. Cette règle propose un mode de vie autarcique, équilibré entre prière, travail physique et intellectuel et repos. Cette règle bénédictine se diffuse progressivement en Occident et fut imposée à de nombreux monastères. Le monastère de Mont Cassin est l'un des tout premier monastère du Ve siècle, fondé en Occident.

monastère de l'Abbaye Saint Étienne de Marmoutier du VI[e] siècle, le monastère de l'abbaye de Saint-Gall, abbaye bénédictine fondée au VIII[e] siècle, le monastère de Disibodenberg, le monastère de l'abbaye saint Bernard de Clairvaux, les monastères clunisiens et cisterciens etc. Á cette époque, la médecine n'est pas exercée par des personnes à qui cet art est réservé, mais plutôt par des moines formés à la théologie, aux mathématiques, à la botanique, á l'architecture et à la médecine.

Le monastère du Mont-Cassin est à l'origine de l'éclosion des monastères qui drainent dans leur sillon, l'établissement de lieux d'assistance caritative et de soins des malades. Conformément à cette tradition chrétienne, les *hospitale*, les hospices et autres hôpitaux qui pullulent plus tard en Occident, sont alors considérés comme des œuvres majeures d'assistance chrétienne. Les soins et la médecine étaient entre les mains de plusieurs praticiens avec plusieurs types de soins dans l'informelle. Il existe en outre des regroupements purement séculiers dont les membres ne prononcent aucun vœu de vie monastique, mais se consacrent à la visite des malades, prennent soin des orphelins et des enfants trouvés et conduisent aussi les malades à l'hôpital.

La médecine de cette époque, est pratiquée par des clercs comme Boèce (480-524), Isidore de Séville (570-636), plus soucieux d'exercer la charité chrétienne que faire propager la médecine. Un texte de 1181, tiré des Statuts de l'Hôpital de Saint-Jean à Jérusalem, promulgués par Roger de Molins le 15 mars 1181, contient cette belle formule qui va dominer la législation des Institutions hospitalières en Europe tout au long du Moyen Âge :

> « Dans les maisons désignées par le maître de l'Hôpital, lorsque le malade se présentera, voici comment il sera reçu : ayant d'abord confessé ses péchés au prêtre, il sera communié religieusement, puis on le portera au lit, et là, le traitant comme un seigneur, suivant les ressources de la maison, chaque jour, avant le repas des frères, on lui servira charitablement à manger » (Grmek, 1982 :26).

Dans son évolution, la médecine médiévale s'est renforcée de la culture chrétienne. C'est ainsi que la tradition chrétienne de la charité, qui passe également par le soin du prochain et des malades, a favorisé la fondation des *hospitale*, c'est-à-dire des lieux situés à proximité des édifices religieux, où les moines pratiquent l'assistance caritative et le soin des malades,

comme le relèvent les livres des miracles, les traités médicaux, les chroniques, etc. Ces lieux d'assistance aux malades existaient sous différentes appellations avant le Moyen Âge.

Nosokomeion/ nosocomium et *xenodochium* sont les deux termes d'origine orientale qui désignaient en son temps l'institution hospitalière en Orient. *Nosocomium* désignait étymologiquement la maison pour les malades et *xenodochium*, un refuge pour les pèlerins. Mais ces notions se sont par la suite estompées en Occident et ont été supplantées par hospice pour devenir hôpital. L'appellation *xenodochium* supplante le vocable *nosocomium* en Occident à cette époque. Elle sera progressivement remplacée pas hospice, puis hospitale au IX^{e} siècle.

Conformément à la tradition chrétienne, les hôpitaux étaient considérés comme une des œuvres majeures d'assistance chrétienne établis dans l'ombre des couvents, monastères, cathédrales et autres édifices religieux. À titre d'illustration, l'abbaye du Mont Saint-Michel possédait deux infirmeries, une pour les moines et une autre pour les novices ; celle de Cluny en avait trois, la troisième étant pour des laïcs au service du couvent. Le moine Gualbert de l'abbaye de Marchiennes près de Douai, lui-même un moine, devenu paralysé et par manque d'aide professionnelle sur place, a été transféré à l'abbaye d'Anchin pour être soigné au *monachus et benignus medicus*[3].

Au fil du temps, des institutions religieuses se transforment en établissements de soins et d'accueils des malades. Ainsi se sont développés les premiers centres d'accueils d'origines religieuses et aux allures d'hôpitaux pour encadrer les indigents, les pèlerins, les malades, etc.

La charité et la bienveillance, cette doctrine sociale de l'Église catholique, est à l'origine de la naissance de ces centres de prises en charge. Avec l'éclosion des monastères, la médecine conventuelle fut avant tout une œuvre humanitaire admirable. Les praticiens de cette médecine étaient des religieux, laïcs, juifs, chrétiens, nobles, roturiers, etc. La pratique de la médecine sera alors couplée à la vie des monastères et des couvents qui hébergent les malades, les indigents, les pèlerins etc. Ainsi se développent les premiers hôpitaux d'origines religieuses pour encadrer les malades. Les sources relèvent à cet effet que le pronostic médical ainsi que le diagnostic du temps se fondaient sur une mise en parallèle de la

[3] *Acta Sanctorum, Maius,* vol. III, pp. 131-132, cite par GRMEK, 1982 :35.

médecine cultuelle et la médecine raisonnée dans la lutte contre les maladies et les épidémies de peste[4], de lèpre, de tuberculose de typhus, de petite vérole, dysenterie etc. (DURAND, DUPLANTIE, LAROCHE & LAUDY, 2000 :6).

La charité et la bienveillance sont des vertus cardinales éminemment sociales, mentionnées dans les Écritures Saintes. Cette bienveillance divine qui fonde les œuvres de charité des chrétiens, est une voie maitresse de la doctrine sociale de l'Église catholique suivie par les chrétiens du Moyen Âge. C'est dans un souci de charité, de bienveillance et d'assistance que plusieurs hospices, *hopitale* où lieux d'assistance chrétienne sont établis dans l'ombre des édifices religieux pour une prise en charge des malades, des indigents, des pauvres, des pèlerins, etc.

Avec la propagation de l'évangile, le sens chrétien de la charité passe par le soin du prochain et si possible la guérison des malades. Certaines institutions religieuses se transforment alors en établissements de soins et d'accueils aux malades, aux pauvres et autres indigents. Les premiers hôpitaux viennent donc des monastères et la façon dont les moines et les moniales s'occupent des malades, sert de modèle de prise en charge. La médecine cultuelle est la continuation du culte des dieux païens comme Esculape (dieu grec élevé par un centaure administrant des potions bienfaisantes ; il devint rapidement un bienfaiteur universel).

La volonté de créer des hôpitaux vient aussi des ecclésiastiques. Le Concile d'Aix-la-Chapelle de 816 établit que chaque évêché doit avoir des refuges pour les pauvres. Les évêques et les communautés religieuses en fondent effectivement plusieurs dans les siècles qui suivent (DURAND, DUPLANTIE, LAROCHE & LAUDY, 2000 : 47-53). Grâce à l'initiative des souverains ou des municipalités, le nombre des hôpitaux s'est accru sous l'impulsion des Ordres Hospitaliers. Ces derniers ont pendant longtemps assurer les soins et plusieurs d'entre eux se sont spécialisés dans l'activité charitable donnant naissance aux grands ordres hospitaliers à savoir l'ordre des Antonins en 1095, du Saint-Esprit en 1178, de Saint-Lazare en 1187 et les chevaliers Teutonique en 1197.

[4] Les épidémies de peste qui, vague après vague, déferlent sur l'Occident pendant la seconde moitié du XIV[e] siècle et pendant tout le XV[e] siècle perturbent gravement la démographie médicale et avivent les sentiments de responsabilité sociale. Elles conditionnent des remaniements profonds dans l'organisation de la santé publique, notamment l'introduction de la quarantaine et de l'isolement des malades infectieux aigus.

Les Bénédictins (fondés au VI^e siècle) et les Franciscains (fondés au XII^e siècle) s'illustrent dans ces fonctions d'assistance ; sans parler des grandes fondations comme les Hospitaliers du Saint-Esprit à Montpellier, ceux de Saint-Antoine dans l'Isère ou les ordres militaro-hospitaliers comme celui de Saint-Jean. On voit naître aussi des communautés religieuses de femmes vouées aux soins des malades : elles succèdent à l'œuvre des patriciennes romaines et à l'ordre des Diaconesses. Les plus célèbres sont les Augustines de l'Hôtel-Dieu de Paris, fondées au VII^e siècle et réformées au XIII^e siècle. Elles deviennent le modèle des congrégations hospitalières.

Un grand nombre d'hôpitaux encore existant sont fondés au Moyen Âge, comme l'Hôtel-Dieu de Lyon, l'Hôtel-Dieu de Paris, l'Hôpital du St-Esprit, et encore l'Hôpital d'York, le St. Bartholomew et le St. Thomas à Londres. En 651, à Paris, l'hôtel Dieu[5], près de Notre Dame, accueillent les pauvres, malades ou non, il est ouvert aux malades en 829.

On constate alors une transformation de l'hôpital, lieu charitable en un lieu de soins. Une véritable révolution s'opère ainsi : les hôpitaux, qui, au départ, sont de simples lieux de refuge, deviennent plus tard de véritables lieux où l'on soigne les malades.

En outre, avec l'expansion du christianisme, la médecine savante, détenue par le clergé, se pratique dans les monastères. La médecine laïque et profane des premiers siècles du Moyen Âge était moins bien structurée. Elle avait une pratique médicale empirique, populaire et informelle, héritée de l'Antiquité. Bien avant la mainmise des religieux sur la pratique de cette médecine, il y avait des soignants associés aux monastères, ainsi que des soignants laïcs. Ces différents soignants étaient des hommes et des femmes, des laïcs, des moines ou des membres du clergé séculier. Dans

[5] Au temps de la médecine scolastique, le plus important établissement hospitalier français était l'Hôtel-Dieu de Paris. Né d'une initiative religieuse, il n'était au départ, et pour longtemps, qu'une « émanation spirituelle et temporelle de l'Évêché de Paris ». Il grandit à l'ombre de Notre-Dame. Pendant tout le Moyen Âge, il garda son caractère d'asile polyvalent, mais assez tôt on y fit aménager des lieux séparés pour les vrais malades. Ainsi le roi Philippe Auguste créa encore des salles et l'infirmerie pour les grands malades. L'Hôtel-Dieu tendait à s'organiser dès le début du XIII^e siècle en tant que maison de soins. Toutefois, ces premiers Statuts datant du 1217 sont muets à ce sujet. Les soins des malades restent jusqu'à la fin du Moyen Âge confiés essentiellement à quelques religieux et religieuses. Toutefois, le corps médical laïc y entre officiellement par une ordonnance du roi Charles IV datée du 16 janvier 1328 qui décide qu'à l'avenir, les malades de l'Hôtel-Dieu doivent être visités par deux chirurgiens jurés au Châtelet, désignés par le roi et rétribués par la recette de la ville de Paris.

son évolution, la médecine transite progressivement vers une médecine conventuelle aux mains des religieux. Après avoir trouvé refuge dans les monastères, la médecine occidentale du Haut Moyen Âge est restée entre les mains des moines et évêques médecins : le médecin était en même temps religieux. C'est ainsi que l'Église va orienter la connaissance médicale vers la formation générale des médecins avec un développement porté plus sur les sciences de la nature que de l'homme. Cette médecine couplée aux apothicaires, perfectionne grandement la connaissance de la botanique. Pour leur savoir médicinal, les moines tiraient leur connaissance de la médecine au travers des copies dans leurs différents monastères, de textes médicaux anciens hérités de l'Antiquité. Ce sont donc les moines et évêques médecins du Haut Moyen Âge qui ont généralement compilés les rares manuscrits médicaux de cette époque (VERGER, 1999 :3-7).

Dans leur organisation, les monastères concourent ainsi à l'essor des hospices et hôpitaux en favorisant l'émergence d'une médecine conventuelle dont la formation est partie des écoles pour se renforcer dans les universités.

2.2 Les religieux et l'essor des foyers de diffusion de la formation médicale

Le système de formation dans les écoles occidentales est un legs de la tradition romaine, avec un enseignement en langue grecque, principalement littéraire pour une formation en grammaire et rhétorique qui s'adresse aux élites sociales se préparant à jouer un rôle politique. Au début du Moyen Âge, surtout avec les peuples germaniques et l'avènement du christianisme en Occident, l'Église reprend ce système de formation à son compte, puis dispense cet enseignement essentiellement aux futurs clercs dans un cadre purement monastique avec le latin qui remplace le Grec. Ainsi, plusieurs écoles monastiques et épiscopales sont fondées sur des bases essentiellement religieuses dans les villes en Italie du Sud et en Gaule.

L'urbanisation favorise le développement remarquable des écoles de façon générale, mais en particulier les écoles épiscopales. Ainsi naît par exemple, l'école de médecine de Salerne qui propulse les autres écoles de médecine et contribue à l'émergence des Universités orientées vers l'étude de la médecine. La première école de Médecine de l'Europe, l'école

de médecine de Salerne est héritière des civilisations méditerranéennes. Historiquement, Salerne est non seulement la première école de médecine fondée en Europe, mais encore la plus importe. L'on ignore la date précise de sa création, les noms de ses fondateurs qui seraient au nombre de quatre : un Latin, un Grec, un Arabe et un Juif. L'on ignore également l'endroit où elle se dressait exactement. Salerne serait un reliquat de la médecine antique à la fois cléricale et laïque (GUITARD, 1958 :308-309). La fusion entre la civilisation gréco-romaine et les sociétés barbares est difficile. La seule unité va venir de la religion qui favorise progressivement la conversion des nouveaux venus. « Ce sont surtout les papes et les ordres monastiques qui sont les principaux facteurs d'une unité d'ailleurs plus axée sur la politique que sur une foi véritable » (DURAND, DUPLANTIE, LAROCHE & LAUDY, 2000 :5). Le clergé met ainsi la main sur la médecine savante aux travers des ouvrages médicaux hérités de l'Antiquité, conservés et recopiés dans les *scriptoria* ou ateliers de copistes des monastères (LANOTTE, 1998 :15). Dans l'ombre de l'église cathédrale, à l'école canoniale, se forment les médecins ; une médecine pratiquée par les membres du clergé selon lesquels le seul médecin était le Christ, lui seul pouvait guérir les malades.

Le savoir médical des écoles se répand en Europe occidentale à partir de l'Italie du Sud, avec des auteurs, traducteurs et intellectuels comme Alcuin, Théodulphe, Paul Diacre, Eginhard, Nithard, Jean Scot Erigène, Hincmar, Raban Maur etc. Le monastère de Mont Cassin, l'un des premiers brillants centres de culture au début du Moyen Âge, regorge bien une école.

Les réformes initiées par Charlemagne au IX^{e} siècle font de l'enseignement un véritable pilier de la formation et de la culture. A partir du cartulaire de Thionville de 805, qui fait clairement mention de l'art de guérir, la science médicale est intégrée dans la formation des élèves.

La renaissance carolingienne vient ainsi donner un nouvel essor à la culture de l'enseignement et à la vie intellectuelle avec *l'Admonitio generalis* de 789 qui exige qu'il y ait des écoles dans chaque évêché. Ce renouveau des lettres et des arts dont les principaux initiateurs sont les clercs, améliore la formation des clercs. L'ordonnance royale de Charlemagne de 789, *Admonitio generalis* (un des plus célèbres cartulaires de Charlemagne), fixe alors la formation de base des clercs et restaure les écoles épiscopales, monastiques et paroissiales.

Les différents conciles du temps sur la vie culturelle et la formation des clercs viennent par ailleurs renforcer la culture de l'enseignement et la vie intellectuelle. C'est ainsi que le troisième concile de Latran de 1179 définit les bases de l'enseignement en occident médiéval.

Toutefois, le fort désir d'autonomie des maitres et étudiants finit par affaiblir les écoles épiscopales et ouvrent la voie aux universités. La présence des écoles de médecine en Occident et la volonté d'indépendance de ces écoles entrainent la création des Universités de médecine notamment celle de Salerne, de Montpellier, de Paris etc.

Bien avant le XI^{e} siècle, l'organisation de la médecine et des soins étaient dans l'informelle. Il existait plusieurs types de soignants (médecins, chirurgiens, barbiers, apothicaires, herboristes, exorcistes, etc.) qui exerçaient à leur façon les fonctions d'un médecin généraliste moderne, sans aucune distinction sémantique entre les différents praticiens. À partir du XI^{e} siècle, nous avons l'émergence d'un corps de praticiens mieux défini, avec la naissance d'institutions médicales spécialisées laïques et religieuses telles que les facultés universitaires ainsi que des programmes d'études structurés comme l'école de Salerne, de Montpellier en 1137, de Bologne fondée vers 1170, celle de Paris en 1200 et Oxford en 1204 (Durand, Duplantie, Laroche & Laudy, 2000 :10-11).

La profession médicale au Moyen Âge s'est appuyée sur certaines bases pour se développer et s'épanouir. Cependant elle a tout de même rencontré un certain nombre de difficultés liées aux menaces sur son libre exercice ainsi que des concurrences inattendues à l'origine de sa laïcisation.

3. La médecine médiévale au confluent des influences religieuses et laïques

En Occident médiéval, religieux et laïcs ont depuis longtemps été opposés aussi bien pour le contrôle du pouvoir politique que pour la pratique médicinale. Cette opposition constatée depuis le Haut Moyen Âge à travers la lutte contre le paganisme et ses relents dans la pratique médicale, a favorisé la volonté d'indépendance des écoles médicale médiévales ; entrainant aussi des situations problématiques à l'origine de la laïcisation de la médecine.

3.1 Difficile cohabitation entre médecins religieux et médecins laïcs

Vers le V^e^ siècle, les écoles de médecine d'Orient quoique divisées en écoles rivales, faisaient bonne figurent. Alexandrie était alors le principal foyer d'enseignement médical entre le V^e^ et le VI^e^ siècles, où de nombreux médecins, quoique divisés en écoles rivales, continuaient la tradition de la médecine savante de l'Antiquité (VERGER, 1999 :3-7). À la fin de l'Antiquité, les monastères sauvent et développent certains éléments de la culture antique, notamment les écoles monastiques qui s'ouvrent à des étudiants autres que des clercs.

La tradition médicale laïque a impulsé la médecine cultuelle avec des divinités aux vertus curatives. Face à la main mise de l'Église de Rome sur la formation culturelle et intellectuelle en Occident, ce legs de l'Antiquité gréco-romaine ne trouvant plus sa place en Occident médiéval, fait place à la médecine conventuelle. C'est dans l'ombre des églises, des monastères et autres couvents que naissent alors les écoles monastiques et épiscopales qui s'approprient les théories médicales antiques et les développent. Religieux et laïcs étaient alors en lutte permanente pour le contrôle de la pratique médicinale.

Aux VIII^e^ et IX^e^ siècles, les monastères deviennent les grands centres de la science et de la culture. Les moines ont le privilège d'exercer la médecine, sauf la pratique de la chirurgie en raison du sang versé, l'obstétrique par pudeur. Certains deviennent de grands médecins (DURAND, DUPLANTIE, LAROCHE & LAUDY, 2000 :32).

En Gaule par exemple, avec l'existence de petites divinités locales qui ont le pouvoir de guérir, la chrétienté, dans sa lutte contre le paganisme, a combattu les divinités de la Gaule. Dans les sources normatives, il est relevé que les fidèles chrétiens se tournaient vers les anciens rites pour une prière non satisfaite. C'est ainsi que toutes les formes païennes de dévotion autour des points d'eau, étaient dénoncées et condamnées par l'Église comme des pratiques superstitieuses (DESMET, 1998 :11). Cette répression des pratiques dites superstitieuses continue jusqu'au XII^e^ siècle comme le relève Dieter Harmening qui montre bien la persistance de ces pratiques[6]. Des objets d'idolâtrie et des lieux de cultes païens sont

[6] L'étude de Dieter HARMENING a montré que les nombreuses condamnations des pratiques cultuelles *ad fontes vel ad petras vel ad arbores* constituent une sorte de *topos* de la

sanctifiés par l'Église, qui les transforme à son compte. C'est la lutte contre des pratiques païennes considérées comme superstitieux. Avec l'ère chrétienne et la lutte contre le paganisme, deux types de praticiens de la médecine cultuelle cohabitent : médecine conventuelle et la médecine raisonnée. Pour encadrer la pratique médicale, certaines mesures sont prises par les autorités religieuses ou laïques. Ainsi, la pratique des femmes et des juifs à la profession médicale est limitée. L'Église veut que les chrétiens ne soient pas traités par des juifs, mais sans grand succès car ces derniers figuraient parmi les plus compétents.

Quant aux femmes, celles dénommées femmes-guérisseuses qui, pendant des siècles, se sont occupées à soigner les gens du peuple car connaissant de nombreuses pratiques de soins, sont considérées comme des sorcières, des démoniaques.

En effet, les autorités religieuses pourchassaient toutes les pratiques et tout savoir suspects de magie ou sorcellerie. Il s'agit des guérisons et conduites tendant à provoquer des résultats extraordinaires sans l'approbation des autorités religieuses (DURAND, DUPLANTIE, LAROCHE & LAUDY, 2000 :44). Et la connaissance du pouvoir et du secret des plantes était par moments considérée comme la sorcellerie. Ceux qui avaient l'art des simples étaient considérés comme des sorciers. Ainsi, femmes guérisseuses et laïcs praticiens de soins sont traqués, pourchassés et persécutés (DURAND, DUPLANTIE, LAROCHE & LAUDY, 2000 :45). C'est le cas de l'abbesse bénédictine allemande Hildegarde de Bingen, poétesse, musicienne, appelée « la sainte guérisseuse », qui avait l'art de la phytothérapie, était considérée comme une sorcière. Les Inquisiteurs réservaient leur plus grande colère pour la sagefemme et affirmaient que : « Les plus grandes injures à la foi, en ce qui concerne l'hérésie des sorcières, sont accomplies par les sages-femmes ; et ceci est clair comme de l'eau de source si l'on prend connaissance des confessions que certaines ont faites avant d'être brûlées » (EHRENREICH & ENGLISH, 1982 :50; cité par DURAND, DUPLANTIE, LAROCHE & LAUDY, 2000 :45). C'est ainsi que les pratiques de soins reconnues par les femmes guérisseuses sont entrées dans la clandestinité pour réapparaître par la suite sous la forme de vocation religieuse et d'amour du prochain mais encadrées par les autorités. Dans

littérature hagiographique et pénitentielle et trouveraient leurs origines dans les sermons de Saint Césaire d'Arles. Pour plus d'informations sur ces dondamnations des pratiques cultuelles, se referer à HARMENING, 1979 :49-75.

les faits, les autorités religieuses récusaient tout savoir acquis par les femmes guérisseuses sans avoir fait d'études médicales déclarées.

À travers les siècles, la connaissance des plantes médicinales, des remèdes végétaux et la médecine raisonnée n'a pas cessé de s'enrichir. Toutefois, les rivalités entre médecins religieux et médecins laïcs étaient aussi récurrentes. Les représentants de la médecine officielle étaient opposés aux praticiens taxés sans aucun titre comme les chirurgiens et les barbiers qui ont tendance à empiéter sur le domaine de la médecine dite officielle (DARRICAUT, 1999 :11).

La bulle du Pape Grégoire IX de 1231 crée une faculté de Médecine à Paris sous le titre de *Saluberrima Facultas Medecinae Parisiensis,* placée sous l'autorité pontificale, et distincte de la faculté des Arts de Paris. L'enseignement se donnait dans des maisons privées ou des églises, voire dans des granges meublées de botte de paille ou de foin. L'organisation progressive des professions va permettre une délimitation des fonctions sans toutefois freiner les conflits. Dès 1271, la faculté de médecine de Paris restreint la compétence des chirurgiens aux seules opérations manuelles et interdit, *a contrario*, aux bacheliers en médecine de pratiquer la chirurgie à partir de 1350, sous serment (DARRICAUT, 1999 :11). En interdisant aux moines médecins de pratiquer la chirurgie, les moines-médecins déchargent les barbiers des couvents d'une partie de leur travail. Ils trouvaient certaines tâches dégradantes sur la chirurgie des barbiers (désigné *rasor et minutor sanguinis*). Le barbier pratiquait la chirurgie courante et la petite chirurgie. Ils saignent et ouvrent les abcès, pensent les plaies, traitent les fractures et luxations, les dentiers aussi pratiquent l'extraction des dents etc. Ces médecins séculiers sont souvent méprisés pour leur ignorance du latin et leur humble condition.

Les difficultés étaient toujours récurrentes. En effet, au sein de l'Université de Bologne créée en 1123, l'enseignement de la médecine y fut inauguré en 1250, avec une orientation chirurgicale de Ugo Borgognone et Guglielmo Salico. Elle fut vite freinée par une bulle du pape Boniface VIII frappant d'excommunication « tout découpeurs de cadavres » pour une étude d'anatomie (BARIETY & COURY, 1963 :325-400).

Dans le reste de la France, la plupart des facultés de médecine se situaient dans le midi de la France. Les médecins du Moyen Âge exclusivement instruits plus aux lettres et à la théologie, étaient surtout victimes de leur immobilisme technique. À la fin du Moyen âge, les médecins doivent

plus leur diplôme à la théologie, l'astronomie, à la botanique qu'à l'art médical proprement parlé.

Au XII^{e} siècle, dans leur organisation, les corps de métiers se regroupent en corporations. En France, ouvriers et patrons se regroupent en corporations avec des ouvriers apprentis et des maitres qui sont des patrons et chaque corporation affiliée à une confrérie, est placée sous la protection d'un saint ou d'une sainte. Saint Luc devient alors le patron de la confrérie des médecins, célébré chaque 18 octobre de chaque année, avec la messe de saint Luc. Au moyen âge, toutes les corporations et corps de métiers se plaçaient sous la protection d'un saint patron, et il était assez naturel que Luc, étant lui-même médecin, soit choisi par les médecins comme leur saint patron.

Dès la création des premières facultés de médecine en France au XIII^{e} siècle, le 18 octobre, jour de la Saint-Luc, était le jour de la rentrée à la faculté de médecine et donnait lieu à des célébrations festives à la faculté de médecine de Paris. Il s'agit de mettre les métiers sous le regard ou le signe et la protection de Dieu (Bariety & Coury, 1963 :325-400). Ce début d'organisation professionnelle des métiers et les conflits liés à l'obligation de posséder un titre universitaire pour exercer la médecine favorisent le contrôle de la corporation puis contribuent à la laïcisation de la médecine.

3.2 La laïcisation de la médecine consacre la scission entre religion et pratique médicale

L'Église de Rome s'insurge contre l'indépendance des écoles et décide de mettre de l'ordre dans les écoles à partir des conciles. Cet effort de l'Église favorise l'apparition des institutions médicales spécialisées telles que les facultés universitaires. De nombreux clercs ont certes mis leur érudition hippocratique au service des malades. Mais l'église de Rome s'émeut de cette prise d'indépendance et remet de l'ordre lors des conciles des XII^{e}–XIII^{e} siècles.

Dans une société dominée par le christianisme, où les forces spirituelles et une partie du pouvoir temporel se concentrent désormais entre les mains de l'Église, la tradition médicale laïque se trouve du coup mise en difficulté. L'indépendance de nombreux clercs médecins laïcs est très vite stoppée par l'Église de Rome, qui, entre les XII^{e} et XIII^{e} siècles, prend

le contrôle à travers les nombreux conciles. Ainsi, la pratique de la médecine est interdite au clergé religieux aux conciles de Clermont de 1130 et de Reims 1131. Sur la base de « *Ecclesia abhorret a sanguine* » signifiant l'Église hait le sang, le concile de Tours de 1163 décrète que la plupart des membres du clergé de l'époque ne peuvent plus pratiquer la chirurgie, reléguant ainsi la pratique de la chirurgie à un rang inférieur pour de nombreuses années. C'est dans ce même contexte que le concile de Latran IV interdit aux prêtres d'exercer la chirurgie. Les religieux assistaient davantage les âmes qu'à secourir les corps. Les monastères ne sont plus désormais les seuls lieux d'étude et de formation médicale. Ceci propulse la profession médicale entre les mains des laïcs à cette époque avec la diffusion de l'enseignement hors des enceintes conventuelles. Le pape Honorius IV dissocie la pratique de la médecine à la religion par une ordonnance du XIII^{e} siècle.

La laïcisation se formalise et la médecine médiévale occidentale devient donc progressivement laïque. Cette laïcisation de la médecine médiévale occidentale entraine la création de plusieurs écoles et universités, des foyers de diffusion et développement des connaissances médicales avec la naissance d'une discipline universitaire. Par exemple en 1216, le Comte Raimond VI de Toulouyse dota sa ville d'une école médicale dont la direction fut confiée à un médecin venu d'Espagne, Lopez Hispanus (BARIETY & COURY, 1963 :325-400). La médecine s'individualise de la pharmacie et s'institutionnalise et celui qui la pratique doit se libérer des autres tâches (JORTIE, 2015 :15-16). En 1258, Louis IX donne un statut aux apothicaires. La création des Universités, avec un enseignement spécifique dans l'art médical, sanctionné par un diplôme, ainsi que la constitution d'associations de métier, sont autant de signes qui marquent la professionnalisation et le désir de qualité des soins. Toutefois, il convient de relever que l'ensemble des praticiens en exercice ne se limiteraient pas aux seuls détenteurs d'un titre.

Les médecins formés dans les Universités partagent avec d'autres praticiens, un marché avec un recours de plus en plus fréquent aux hommes de l'art et la concurrence ecclésiastique diminue, non seulement en raison des interdictions conciliaires, mais aussi parce que ce marché offre des attraits économiques, et la profession médicale tend à se laïciser (NICOUD, 2011 :10-11).

Les associations de métier tendent à se fermer à tous ceux qui n'auraient pas de diplômes, comme le stipule clairement les statuts du collège des médecins de Milan datés de 1385, afin de préserver aussi bien les populations que les hommes de l'art des fraudes dont sont coupables les empiriques et les ignorants (NICOUD, 2011 :12). L'idéal de fermeture du métier à tous les incompétents fait jour et s'étend à d'autres localités comme Florence en 1314, Vérone en 1327, Trévise en 1426 et Parme en 1440. À travers les exclusions, la cohésion du corps se renforce à travers une conscience collective et une identité propre. Les nombreuses législations témoignent de l'intérêt porté à ce corps par les autorités régulières et séculières. La régulation de la pratique médicale s'accompagne aussi de la reconnaissance de capacités particulières dévolues au médecin et les fonctions qui lui sont confiées, faisant de lui un *expertus*.

La justice et les cas de maladies surtout réputées contagieuses, deviennent des lieux de mobilisation de l'avis médical, parce que les doutes et les conflits qu'ils suscitent, justifient un recours à un arbitrage. Plusieurs études ont montré, à partir de la seconde moitié du XIII^{e} siècle, l'intervention de médecins dans des pratiques judiciaires, dans des cas variés (homicides, blessures, empoisonnements, décès inopinés, ...) (NICOUD, 2011 :13).

La présence des infirmeries conventuelles aurait aussi pu aider au développement des hôpitaux médicalisés ouverts à toutes les populations mais cet élan fut interrompu par des décisions prises par la hiérarchie ecclésiastique qui freina l'activité médicale des clercs réguliers pour donner la priorité absolue à l'idéologie du salut. Toutefois, pendant le Haut Moyen Âge, les clercs détenaient pratiquement le monopole du savoir médical ; et ce n'est qu'à partir du XII^{e} siècle qu'il y aura un changement. En 1157, le chapitre général des Cisterciens interdit aux moines qui sont médecins d'aller soigner hors de leur couvent et dès 1130, le concile de Clermont avait défendu aux moines et chanoines réguliers d'étudier la médecine. Le concile de Latran de 1215 va par la suite interdire aux prêtres, diacres et sous-diacres de verser le sang, c'est-à-dire d'exercer la chirurgie (GRMEK, 1982 :37).

La justice a joué un rôle important dans cette laïcisation. On découvre dans certaines sources, des mentions de noms de médecins au service de la justice tels que Ugo Borgognoni da Lucca (1180-1258), Bartolomeo da Varignana décédé après 1321 qui ont contribué à légaliser la laïcisation de la médecine.

Conclusion

En somme, il faut retenir que le cheminement entre la religion et la médecine dans la lutte contre la maladie à l'époque médiévale est très dynamique. Il s'agit d'un processus dont l'évolution débute avec la place primordiale occupée par Dieu au sein des populations aussi bien polythéistes que chrétiennes en Occident médiéval. Son incidence religieuse, scientifique et socio-culturelle est non négligeable. Elle a permis la survie de la culture médicale antique, l'essor de la médecine par les plantes, l'organisation et l'encadrement de l'assistance ainsi que la prise en charge des malades.

L'essor monastique entraine donc l'évolution de la médecine cultuelle vers une médecine conventuelle. Il importe de préciser que dans la lutte contre la maladie au Moyen Âge, la religion et la médecine ont été bien intriquées. Elles ont plus souvent été associées qu'affrontées.

Les études et la formation étant favorisées par l'Église, les clercs deviennent alors des praticiens puis mettent leurs connaissances au service des malades et de la communauté. Cela contribue à l'essor monastique ainsi qu'à l'essaimage des hôpitaux en Occident médiéval. Les puissants seigneurs et les riches de l'époque contribuent à la création de plusieurs institutions hospitalières, scolaires et universitaires sous la tutelle des autorités aussi bien temporelles que spirituelles.

L'affirmation de la profession médicale et la sécularisation des hôpitaux sont à l'origine du début de la scission entre les corps de métiers notamment le corps médical, le corps apothicaire et la religion. Cette désunion est consécutive aux luttes professionnelles ainsi qu'aux velléités d'indépendance.

Toutefois, la perte de l'Église de l'exclusivité du privilège d'enseigner et l'émergence consécutive des Universités rendent possible la laïcisation de la médecine savante avec une influence capitale sur le sort des hôpitaux. La médecine cesse alors d'être cléricale à partir du XII^{e} siècle tandis que l'hospitalisation demeurait toujours une prérogative de l'Église. Dès le XIII^{e} siècle, les clivages entre les médecins universitaires et non universitaires, entre praticiens organisés en corporation au sein de la profession médicale entrainent la laïcisation véritable de la profession médicale conditionnée par l'idéologie du salut des clercs.

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3 *"...He Spat on His Eyes and Laid His Hands Upon Him"* (Mk 8:23) A Contextual Reading of Mk 8:22-26 amidst COVID-19 Vaccine Hesitancy among Christians in Nigeria

Abstract

Mk 8:22-26 remains one of the two micro-narratives in the synoptic gospels where Jesus applied spittle in healing someone. The man, being healed, was blind. Although Jesus had to apply a second level of healing before the blind man could be healed properly, this incident indicates that Jesus could heal diseases and sickness through other means other than words of mouth. This is some form of encouragement for the use of medicine in curing diseases and sicknesses among Christians. Since the outbreak of COVID-19 pandemic in the world and the subsequent rolling out of its vaccine, it seems that the pandemic has been contained to some point. However, the level of receptiveness of the vaccine among Nigerians has been problematic. This has given rise to what is generally termed COVID-19 vaccine hesitancy among Nigerians of which Christians form a large percentage. Using the historical-critical approach to exegesis, with oral interview serving as a means of data collection, this work studied the micro-narrative of Mk 8:22-26 to relate how it can encourage Christians in Nigeria to be more receptive of COVID-19 vaccine. Findings in the study indicate that by healing a blind man with spittle, a well-known medical practice of the time, Jesus accepts medical processes involved in curing diseases. This means that Christians in Nigeria are encouraged to be receptive of COVID-19 vaccine as a means of preventing COVID-19 related health issues and/or COVID-19 related deaths. It also calls for the re-evaluation of Nigerian Christians' stance on Faith (Religion)–COVID-19 vaccine debate.

Keywords: Mk 8:22-26, Healing, COVID-19, Nigerian Christians, Conspiracy Theories, Vaccine Hesitancy,

Introduction

There are two micro-narratives in Mark where Jesus healed using spittle and the touching of hands. While the first of these narratives is recorded in Mk 7:31-37, our interest in this article is in the second narrative recorded in Mk 8:22-26. In this healing narrative, Mark records that a man probably born blind, from the town of Bethsaida, was brought to Jesus to be healed via touching. Jesus took this blind man out of the town through leading him by hand. He then spat on his eyes, while also putting his hands on him. Then Jesus asked the blind man if he could see. The blind man replied that he sees men, as trees, walking. On this response, Jesus had to perform a second level of healing by touching the man's eyes again, and making him look up. At this second-level healing, the blind man's sight was totally restored. The blind man saw clearly. Jesus therefore sent him away to his house with a charge to neither go into the town nor tell anyone what has happened. The involvement of a second level of healing in the narrative is perplexing. As LATOURELLE (1988:179) puts it 'Historians on the lookout (*sic*) difficulties will find all they want here.' According to PILAND (2016:1) 'A cursory glance reveals that Jesus healed the blind man in two phases, almost as if he was not able to heal him on the second attempt. No doubt this passage has left many Christian Bible readers puzzled, wondering why Jesus did not heal the man all at once, as was his custom.' While this healing narrative has a lot of unanswered questions surrounding why Jesus could not heal the blind man with a first trial, it is mostly the belief of scholars that the narrative is significant in Mark's portrayal of Jesus' disciples and their spiritual perceptions. According to GLENNY & NOBLE (2014:71) 'Interpreters of Mk 8:22-26 have long understood that the blind man of Bethsaida is a kind of analogue for the disciples and their spiritual perceptions or misperceptions.' This kind of interpretation, of course, comes from scholars who propose what has been called the discipleship model in understanding the place of the narrative in the overall plan of the gospel of Mark. Scholars with this kind of an understanding of Mk 8:22-26 are TELFORD (1999), MARCUS (2009:599-602), and LARSEN (2004) whose Christological reading of the text is somehow aligned with a discipleship model of the text. In this Christological reading, LARSEN argues that Mark's main concern has to do with an unveiling of the very nature of Christ.

Our concern in this article goes beyond unravelling the reason for the application of a second level of healing by Jesus before the blind man's sight could be perfectly restored to include what the method of the healing of the blind man by Jesus has for Christians in Nigeria amidst COVID-19 vaccine hesitancy. By implication, we want to re-read the text of Mk 8:22-26 in the context of COVID-19 vaccine hesitancy seen among Christians in Nigeria. That COVID-19 is a reality in Nigeria is not to be doubted. At the height of its ravages in the country in 2020, many lost their lives, and Christians and their churches bore the brunt of COVID-19 in many ways (CHUKWUMA 2021). Churches were closed for a long period in Nigeria, and many Christians were denied the opportunity of worshiping God. Of course, a nation-wide lockdown that lasted for almost three months was invoked by the government of Nigeria at that time. With the massive roll-out of COVID-19 vaccine in Nigeria as from 2021, there were high hopes that a way to contain the devastating effect of the pandemic has been found. However, many Nigerians did not welcome the idea of taking COVID-19 vaccine, including Christians. According to the findings of OLU-ABIODUN, ABIODUN & OKAFOR (2022), the acceptance rate of COVID-19 vaccine in Nigeria is still not encouraging since many Nigerians are unwilling to take the vaccine. Of course, part of the problem, as long as hesitancy for the COVID-19 vaccine by Christians is concerned, is the belief that the pandemic is not real. In May 2020 when the outbreak of COVID-19 was at its zenith in the country, we had an interview with *IP MI-6*, a Catholic Christian, on why she was not observing COVID-19 protocols. Her answer was quite simple: "There is nothing like COVID-19 in Nigeria. The belief in its existence is what the government made up to embezzle money. I do not believe in COVID-19." Thus, the first problem many Christians had in accepting the vaccine was the belief that there was nothing like COVID-19. This kind of belief makes it impossible for many Christians in Nigeria to be receptive of COVID-19 vaccine.

In such a scenario, our aim is to re-read the micro-narrative of Mk 8:22-26 in the context of COVID-19 vaccine hesitancy among Christians in Nigeria. The methodology we apply to this effect is the historical-critical method of exegesis which GORMAN (2006:15) says 'focuses on the origin and development of a text, employing methods designed to uncover these aspects of it.' According to UWAEGBUTE (2022) this type of methodology helps an exegete to pursue a holistic study of biblical texts in the context of their oral histories, source(s), literary criticism, social context (*Sitz im*

Leben), setting, among other related issues that will aid the understanding of biblical texts. Our primary source of data as regards views on COVID-19 hesitancy among Christians in Nigeria is oral interviews. In this sense, we purposively selected some Christians who were interviewed regarding their views on if Christians should be receptive of COVID-19 vaccine. These interviewees cut across denominations and gender. Their age ranges from 25 years to 60 years. They also included clergy and lay-persons as well. The data we got from this source will be presented descriptively in the work.

Setting the Scene: Source, Social Context (*Sitz im Leben*), Setting and Structure of Mk 8:22-26

Source of Mk 8:22-26

That Mk 8:22-26 follows a sequence of a similarly recorded event in Mk 7:31-37 make some scholars think that there is a relationship between the recorded events in the gospel of Mark. These two episodes depict the healing of two people following the same healing method and sequence. Of course, among the synoptic gospels, it is only in Mark that we come across such narratives where Jesus healed with spittle, including the touching of hand on the healed. MUTHIAH (2005) writes about these two micro-narratives:

> Both the passages have verbal similarities and ritualistic actions of spitting and touching and are not recorded by Mt and Lk. Astonishingly, the words used to introduce the scenes (7:32-33a and 8:22-23) and the concluding commands to silence (explicit in 7:36 and implicit in 8:26) are similar.

By this similarity, it is very much the thought of many scholars that these two narratives are of the same source. The source of these narratives, of course, was oral tradition which was circulated among the first hearers of Jesus and handed down to other later disciples. While it is generally believed that the gospel of Mark was the first to have been written, and was used as a source for Matthew and Luke, we do not want to go into the identity of the author of the gospel of Mark. This belonged to a different discussion altogether. Because of the above similarities we have mentioned, a scholar like GUELICH (1989:435) thinks that both episodes were

very likely to have been circulated together in oral tradition which may have concluded with the acclamation of Isa 25:5. This acclamation depicts Jesus' healing ministry as regards the prophet Isaiah's promise of healing ministry, which included the healing of the blind and the deaf.

For MANN (1986:335-336), the similarities of the two healing episodes in Mark show that these were doublets probably referring to the same incidence. We do not agree with MANN's position notwithstanding the similarities in the two healing episodes. While they may have followed the same ritualistic process, the differences in the identity of the healed persons are clear. While one was a deaf-stammerer in Mk 7:31-37, the other was a blind man in Mk 8:22-26. Hence, we agree with TAYLOR (1952:369) that 'in the two Markan stories the differences are far greater, so great in fact as to belong to different incidences.'

What we can therefore make of these discussions is that Mk 8:22-26 has its source as oral tradition about Jesus probably circulated among his earliest followers in Palestine. It was probably part of those oral tradition about Jesus that were preserved as miracle stories. These miracle stories were probably preserved in forms, and were constantly re-told among the earliest followers of Jesus in Palestine. Since it is mostly believed in modern scholarship that the gospel writer of Mark was an author who made use of many sources to compose his gospel, he probably had access to these miracle stories.[1] It was then Mark's role as an evangelist, writing for a particular community which he belonged, to select miracle stories that served his purpose. This becomes likely since it is believed that the understanding of the person of Jesus may have been a problem to the members of Mark's community. This was why the failure of the disciples to grasp Jesus' personality features prominently in the gospel of Mark (CHINWOKWU 2015). Mk 8:22-26 happened to have been one of the miracle stories preserved by Mark to help him deal with the problem of his community's lack of understanding and perception of the person of Jesus.

[1] For a detailed discussion on this, see BURKETT (2002:156).

Social Context (Sitz im Leben)[2] *of Mk 8:22-26*

What were the reasons and the circumstances surrounding the preservation of this micro-narrative in Mark? This is our concern here when we talk about the social context of Mk 8:22-26. It is a well-known fact that the disciples of Jesus in the gospel of Mark are constantly accused by the author of the gospel of their lack of understanding of the person of Jesus. This, sometimes, extends to their lack of faith and what has been technically referred to as the 'blindness' or lack of 'comprehension' among the disciples in the gospel of Mark (CHINWOKWU 2015, NINEHAM 1964:37, 214, 217, RICHARDSON 2012:84, HUR 2019:41-48, PILAND 2016:1, BORING 2006:1-3, AUNE 1987:55, GARLAND 2015:388-437, VOS 1954:75-76).[3] Examples of these accusations in the gospel of Mark abound.[4] From these passages, we get the impression that there may have been a 'crisis of perception' of Jesus' person in the community that the writer of Mark belonged. As believed by many scholars, the gospel writers did not write out of carelessness or just for the fun of writing the life history of Jesus. Many of what they wrote, as much as they were faith lessons, were borne out of problems that the communities that these gospel writers belonged faced. In this case, the writer of Mark probably had the correction of the poor understanding of the person of Jesus in his community in mind when he recorded instances where Jesus rebuked his disciples for their lack of faith and understanding of his person and mission.[5]

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2 We will use both social context and S*itz im Leben* (situation in life) in this work loosely to mean the same thing. This does not mean that we are not aware of the fact that *Sitz im Leben* is a German term that was originally associated with German scholars who pioneered form criticism in the early part of the 20th century with an effort to understanding the forms the gospel traditions took before they were committed into writing.

3 This blindness of the disciples is usually seen as a literary device through which the identity of Jesus as the messiah is kept hidden until the resurrection of Jesus. Of course, William WREDE first popularised this thesis in 1901.

4 Mk 4:40; Mk 6:51–52; Mk 8:4, Mk 8:14–21; Mk 8:33; Mk 9:2–10 and Mk 14:68–72 are very notable here.

5 Our claim here is not that lack of understanding of the person and role of Jesus was the sole problem that both the author of Mark and his community faced. Certainly, other problems that faced the community were also reflected in the gospel of Mark. Discussing this is, however, beyond the remit of the present work.

In this sense, we can say that the social context of Mk 8:22-26 was the problem of lack of understanding of the person and the ministry of Jesus in the community that Mark belonged. This probably was the prevailing atmosphere that led to the preservation of Mk 8:22-26 which foreshadows the blindness of the disciples and the subsequent gradual progression of the apostles' understanding of Jesus. In this sense, we agree with RICHARDSON (2012:84) that "the progressive character of the story of the healing in Mark 8:22-26 is due to St Mark's desire to symbolise the gradual process of the unstopping of the disciples' ears and the opening of their eyes."

Setting of Mk 8:22-26

Mark records the place that the healing of the blind man took place. According to the narrative, it was at the town of Bethsaida that the healing took place. For MUTHIAH (2005),

> [Bethsaida] is a fishing town on the northeast corner of the sea of Galilee and east of the Jordan river. Etymologically, Bethsaida means house of fishermen. It was raised to the honour of a city by the tetrarch Philip and was renamed Bethsaida Julias in honour of the emperor Augustus daughter.

FRANZ (1995) says that another name for Bethsaida in Hebrew is 'house of hunter.' It was certain that Bethsaida was the capital of Gaulanitis. Bethsaida features very well in the life and mission of Jesus in the New Testament. In Jn 1:44, Bethsaida was the home town of apostles Peter, Andrew and Philip. In Lk 9:10-11, Jesus fed the five thousand at a place near Bethsaida. In the woe formula in the Synoptic gospels, Bethsaida is associated with Chorazin (Mt 11:21, Lk 10:13). Even though Bethsaida is depicted in this narrative as a village, it is certain that the palace was a sizable city (HARE 1996:93, ANDERSON 1981:203). Being located at Gaulanitis, a gentile area, did not make Bethsaida to be gentile as regards its inhabitants. On the contrary, it seems that the city was largely Jewish in makeup (HARE 1996:93). This may be why Jesus and even some of his apostles were associated with the city in the New Testament.

The Text of Mk 8:22-26

	Greek Text	Researchers' Translation
22	Καὶ ἔρχονται εἰς Βηθσαϊδάν. Καὶ φέρουσιν αὐτῷ τυφλὸν, καὶ παρακαλοῦσιν αὐτὸν ἵνα αὐτοῦ ἅψηται.	And they came to Bethsaida. And they brought a blind man to him and implored Him to touch him.
23	καὶ ἐπιλαβόμενος τῆς χειρὸς τοῦ τυφλοῦ ἐξήνεγκεν αὐτὸν ἔξω τῆς κώμης, καὶ πτύσας εἰς τὰ ὄμματα αὐτοῦ, ἐπιθεὶς τὰς χεῖρας αὐτῷ, ἐπηρώτα αὐτόν Εἴ τι βλέπεις;	Taking the blind man by the hand, He brought him out of the village, and he spat on his eyes and having laid his hands on him, He asked him, 'Do you see anything?'
24	καὶ ἀναβλέψας ἔλεγεν Βλέπω τοὺς ἀνθρώπους, ὅτι ὡς δένδρα ὁρῶ περιπατοῦντας.	And looking up he said, I see men as trees, walking.
25	εἶτα πάλιν ἐπέθηκεν τὰς χεῖρας ἐπὶ τοὺς ὀφθαλμοὺς αὐτοῦ, καὶ διέβλεψεν καὶ ἀπεκατέστη, καὶ ἐνέβλεπεν τηλαυγῶς ἅπαντα.	Then again He laid His hands on his eyes; and he looked intently and was restored, and began to see everything clearly.
26	καὶ ἀπέστειλεν αὐτὸν εἰς οἶκον αὐτοῦ λέγων Μηδὲ εἰς τὴν κώμην εἰσέλθῃς.[6]	And He sent him to his home, saying. Do not even enter the village

[6] There is a textual problem in the Greek original of the text. It has about four variant readings. This one that we adopted in the text seems to have been the earliest variant in circulation, although believed to be of the Alexandria, Eastern, and Egyptian text-types (Metzger 2002:84). The other variants are nothing more than conflated readings probably based on the first variant. In textual criticism, it is common knowledge that shorter readings are mostly preferable since copyists had tendencies of adding to the texts they are recopying than removing from them. Because these other variants are longer, it is probable that they are later additions to the first variant through which later copyists probably tried to explain the import of the first reading. In this context, we chose the reading that we retained in the text based on our belief that it is the most original reading of all the variants.

Structure of Mk 8:22-26

For the purpose of our exegesis, we will structure Mk 8:22-26 thus:

8:22-23: At Bethsaida, a blind man is brought to Jesus to be healed

8:24-25: Jesus restores the blind man's sight using spittle and the touching of hand

8:26: The blind man is sent to his home with a strict warning not to enter the village

Close Reading of Mk 8:22-26

V 22: At Bethsaida, a Blind Man is brought to Jesus to be healed

This verse tells us that a blind man was brought to Jesus at Bethsaida. Mark does not record the identity of those who brought this blind man. All that the reader is told is that they brought (φέρουσιν) a blind man to Jesus to be healed. Certainly, Jesus was in the company of his disciples. This is why Mark uses the verb indicative present middle ἔρχονται (they came) to show that Jesus was in the company of his disciples. The term ἔρχονται is the plural form of ἔρχομαι which means 'to come'. The people who brought the blind man implored (παρακαλοῦσιν), which according to COLE (2006:1210), implied healing. By implication, they begged Jesus to heal the blind man. This shows that Jesus' fame as a healer had spread to Bethsaida. This was why those who brought the blind man had faith that Jesus could heal him. By using the word ἅψηται (to touch), Mark wanted to show that Jesus' healing methods also included the act of touching of hand. We can see this word being used to mean healing in Mt 9:21, 29, 17:7 and Mk 10:13.

Vv. 24-25: Jesus Restores the Blind Man's Sight Using Spittle and Hand Touching

When they had implored Jesus to heal the blind man, Jesus agreed. He therefore took him by the hand (ἐπιλαβόμενος τῆς χειρὸς) out of the village. While Jesus and his disciples probably were together when Jesus agreed to heal the blind man, it is certain that Jesus alone took the blind man out of the village. Hence, Mark used the aorist middle verb ἐπιλαβόμενος to describe this action. The term ἐπιλαβόμενος is the aorist form of the verb ἐπιλαμβανόμαι which means to grasp, to catch or to take hold of. Why Jesus would take the blind man out of the village before healing him is

linked to his desire to keep his identity secret (CHINWOKWU 2015:63). This is linked with the theory of messianic secret which WREDE (1901) first called attention to. The healing of the blind man when Jesus had taken him out of the village follows the ritualistic process of spitting and the laying of hands probably on the man's eyes. This is the second time Mark would record this ritualistic process. The first of these episodes is seen in Mk 7:31-37 and as we had noted earlier, there seems to have been a relationship between these two healing episodes. According to SABIN (2009:142):

> Like the healing of the deaf-mute at the end of chapter 7, the healing of the blind man here has symbolic significance. Particular elements of that earlier healing are repeated here. In both instances, Mark tell that us that that Jesus took the person aside (7:33; 8:23); in both, Mark indicates a laying of hands (7:32; 8:25); in both Mark says that Jesus used spittle as a means of healing (7:33; 8:23).

As seen in Mark's narrative here, Jesus used two methods of healing: The first was the use of spittle while the second was the laying of hand (on the blind man). It was through these two healing methods that Jesus firstly attempted the healing of the blind man. The laying of hand was Jesus' common means of healing. However, quite unlike Jesus, was the application of spittle as a means of healing the eyes of the blind man. The use of spittle as a healing method was not new in Jewish or Mediterranean medical process of healing. Neither was it a new method of exorcism at the time of Jesus. CHINWOKWU (2015:194) says this on Jesus' healing methods, especially about the use of spittle and the laying of hands:

> The other method used by Jesus was performing a cure by a normal medical means, but with an extra power and authority, which might achieve success where the ordinary doctors had failed. It was not always easy to distinguish in practice between medical and magical or exorcistical techniques: the use of spittle by Jesus, for example, is both a well-attested practice in primitive medicine and also part of the exorcist's ritual when attacking an evil spirit. However, both touching with their hands and applying spittle, which the evangelist recorded were part of Jesus' healing techniques and they were normal medical procedures.

Equally, as COLE (2006:1210) argued, 'In those days saliva was thought to have therapeutic effects.' What we make of this is that at the time of Jesus, the use of saliva to heal was an accepted medical practice. Hence, when Jesus spat on the blind man's eyes, he was making use of a known medical

procedure in curing diseases during his time. It also shows that Jesus believed in medical procedure and encouraged it while curing infirmities. COLE (2006:1210) says further that 'this incidence further suggests that the Lord does sometimes use physical means in the process of divine healing, even though he can also heal without them.'

However, the combination of spittle and the laying of hands on the blind man, seemed not to have been effective at first application. Hence, when Jesus asked him if he could see anything, he looked up and said he saw men, as trees, walking. This shows that the first healing attempt by Jesus was not successful totally. The meaning of the verb ἀναβλέψας (looking up) as it applies to the case of the blind man has been contended by scholars. KLOSTERMANN (1950:77), LOHMEYER (1937:158) and TAYLOR (1952:371) think that the verb simply means 'to look up, or 'to lift one's eyes.' As MUTHIAH (2005) argues, ἀναβλέψας is used in three senses in the New Testament. Firstly, it simply refers to the act of looking up as can be seen in Mk 16:4, Lk 19:5, Lk 21:1). Secondly, it refers to the act of looking up in prayer as seen in Mk 6:41 and Mk 7:34. Thirdly, it is used to refer to the act of regaining of sight, especially when it is used in the context of blindness (cf. Mk 10:51, Mt 11:5, Mt 20:34, Lk 7:22, Lk 18:41-43, Jn 9:11 among others). As the verb is used here, it certainly refers to the act of regaining one's sight. Hence, LAGRANGE (1942:213) is right in saying that the word ἀναβλέψας was used here to refer to the moment the blind man regained his sight.

While we can agree that Mark used ἀναβλέψας to refer to the moment the blind man received his sight, we believe that his sense of recognition and perception was not restored at this point. Hence, DERRETT (1981:36) is right in saying:

> A person who recovers sight after a long interval, and who first sees object inverted, takes time to recover the interpretative power. The interval between darkness and the correct interpretation of an erect image, complete with distance and perspective, is a period of mental confusion with its own frustrations.

The lack of interpretative power, as DERRETT puts it above, leads the blind man to see men walking as trees. Certainly, having not been able to see for a long time, the perceptive and recognitive power of the blind man, had not set in properly. In this case, confusion had to set in, and he saw men as trees, walking. Jesus probably understood this and had to lay his

hands on the eyes of the blind man again. This time, Mark uses the verb διέβλεψεν which means to 'look intently' to described the blind man's action after Jesus had touched his eyes the second time. This time, after he had looked intently, his power of perception and recognition was totally restored; his blindness was gone. He was now able to see things clearly. This two-stage healing, as much as it is perplexing regarding why the man's sight was not restored at first attempt by Jesus, therefore has something to do with optical and cognitive restoration processes. This is not uncommon with the process of sight recovery in modern understanding. In fact, as GLENNY & NOBLE (2014:72) argue correctly,

> By making use of cognitive sciences, we find that the blind man's multiphased restoration of sight is not inconsistent with a modern understanding of the physiological process in question. In fact, if we can assume that this pericope reflects Mark's acquaintance with anecdotal accounts of sight recovery, then the two phases of healing are best interpreted in terms of optical and cognitive restoration, respectively.

V 26:

The Blind Man is sent to His Home with a Strict Warning not to enter the Village

At the restoration of his sight, Jesus sent the blind man home with a strict warning not to enter into the village. According to HARRINGTON (2014:614) "[i]t is another command to silence after a miraculous action on Jesus' part (1:44, 5:43, 7:36)." The act of sending the man home quietly shows that he was not from Bethsaida. He may have come to Bethsaida from his village probably as a blind bagger. Blind beggars were common in Palestine at the time of Jesus, and Jesus had numerous encounters with them. This blind man, probably resided in Bethsaida as a beggar. This was why Jesus sent him home with an instruction not to enter into the village. SHORT (1986:1166) thinks that Jesus did not want others to see the man when he was healed before his family. So, according to SHORT 'Desirous, probably, that the man's relations should know of his cure before other people, Jesus told him to go home, rather than near-by village.' Many scholars think the action of Jesus is linked to his desire to keep his identity secret. This, as we have shown, is called the messianic secret in Mark. While we share this view, we also believe that part of why Jesus sent the man home with a warning not to enter the village may be linked to the fact the He(Jesus) wanted the blind man's family to be able to see the good work God has done for him firstly, before other people. Besides, Jesus

may also be thinking of the distraction such a miraculous healing may generate in the life of the blind man and those who may have witnessed the healing. At least, it seems Jesus was not yet ready for such interruptions to his ministry.[7]

Conclusion of Exegesis

From our reading of the text, we see that Mk 8:22-26 involved a two-stage healing of a blind man. Equally, Jesus made use of some methods of healing which are somehow unconventional to his method of healing. Although unconventional to Jesus' healing method, our exegesis reveals that these healing methods were, in fact, well-known in the medical practice of Jesus' day. By implication, Jesus made use of well-known medical procedure in the process of restoring the blind man's sight. This, therefore, means that Jesus was not antagonistic of the application of medicine in healing diseases. In fact, he encouraged it in our reading of Mk 8:22-26. This shows that Christians are not to reject the uses of medicine in the cure of diseases, as much as faith-healing is also upheld.

The Hermeneutics of Mk 8:22-26 in the Context of COVID-19 Hesitancy among Christians in Nigeria

COVID-19 became a reality in Nigeria in the year 2020. By February of 2020, the first confirmed case of COVID-19 was recorded in the country (Nigerian Centre for Disease Control 2020). Hence, a somewhat distant disease believed to have been a 'white man's' disease became a reality in Nigeria. Amidst the confusion and fear for the diseases, the government of Nigeria imposed a nation-wide lockdown in order to contain the disease. It was still in the same year 2020 that the World Health Organisation declared COVID-19 a pandemic as it had at that time affected almost all countries of the world, leaving behind a huge death toll. The nationwide lockdown meant that religious activities had to cease. By implication, all worship centres were closed down in a bid to try to contain the spread of the virus by the government. As CHUKWUMA (2021) has shown, the church in Nigeria was affected in different capacities. This does not however mean that there were no positive effects of the pandemic on the

[7] For more on this, see CHINWOKWU (2015:67-72).

church in Nigeria. For one, the pandemic and the lockdown in Nigeria, taught Christians that the church can be moved online without a need for physical gathering to worship God. It was still in the year 2020 that scientists developed a vaccine for COVID-19 but there became a mass rollout of different types of COVID-19 vaccine all over the world by 2021 (Olu-Abiodun, Abiodun & Okafor 2022:2). All this was in a bid to mitigate the spread of the virus. As it is, Nigeria keyed into the provision of the vaccine for its citizens. According to Olu-Abiodun, Abiodun & Okafor (2022) as of November 2021, about 6,000,000 people had taken the initial dose of the vaccine while about 3,369,628 had taken the second dose; this brings the number of unvaccinated people in the country as of then to about 200,000,000. As of 2022, a review of the acceptance rate of COVID-19 vaccine based on available studies in Nigeria stood between 20.0% and 58.2% (Olu-Abiodun, Abiodun & Okafor 2022).[8] This tells the fact that acceptance of the vaccine is still a problem among Nigerians.

The main problem, as regards hesitancy in accepting COVID-19 vaccines among Nigerians, is linked to the belief that COVID-19 is a myth. Or, as many Christians saw it, COVID-19 is the anti-Christ. Among many Christians in Nigeria, there was a belief that the outbreak of COVID-19 was a sign of end time. As the findings of Ossai (2021) showed, many Christians interviewed about their perceptions of the pandemic, believed it to be the anti-Christ. Our findings corroborate Ossai's findings and go further to show that Christians, who do not see COVID-19 as the anti-Christ, believe it to be a myth. This was the genesis of the problem as regards why many Christians in Nigeria have come to reject both COVID-19 as a reality, including its vaccine.

During the field work for this study, our findings showed that many Christians have varied views regarding the need for Christians to accept COVID-19 vaccine. Many of the views we sampled on COVID-19 vaccine and why Christians should accept or reject it, were based on conspiracy theories. According to *IP CO-1* (2022 oral interview), there is a view among many Christians in Nigeria that COVID-19 and its vaccine has a link to the anti-Christ. As such, many Christians in the country, believe that taking the vaccine means being part of the anti-Christ. In this regard, many Christians in the country do not want to take the vaccine for the fear

[8] For a breakdown of COVID-19 vaccine acceptance rate based on geo-political zones of Nigeria between 2020 and 2021, see Olu-Abiodun, Abiodun & Okafor (2022:5).

of being part of the anti-Christ. A similar view by *IP EO-2* (2022 oral interview) shows that COVID-19 is a myth in Nigeria. Absurdly, he links COVID-19 to a ploy to overthrow the former president of the United States of America, Donald Trump, since he was a Christian fighting for Christian values. For him, God can heal COVID-19 and in as much as the vaccine does not cure the disease, there is no need for Christians to take it. This relates to the view of *IP NO-8* (2022 oral interview) that COVID-19 is a biological war by China to reduce the population of the world. For him, it was one of the tools the white people used to reduce the population of the blacks all over the world. This tool did not work, according to *IP NO-8*, and they had to resort to COVID-19 vaccine to achieve their aim. Christians in Nigeria, therefore, understood this and decided to reject the vaccine. *IP NO-8* thinks that this accounts for the hesitancy seen among Christians in Nigeria for COVID-19 vaccine. This is similar to the view of *IP AE-3* (2022 oral interview) that there was nothing like COVID-19 in the first place. It was (and still is) a scam. It was a means through which the white people wanted to reduce the population of blacks by deceiving them into accepting COVID-19 vaccine so that they will die *en masse*. In a related view, *IP FE-7* (2022 oral interview) believes that COVID-19 exists but it is not meant to kill Christians. She even cites Exod 15:16 where God promises the people of Israel that he will not visit them with the diseases he afflicted the Egyptians with since he is the Lord that heals. In this sense, Christians are not meant for COVID-19 and COVID-19 is not meant for Christians. In fact in her words "Christians have immunity against COVID-19." For her, this is the reason for vaccination hesitancy among Christians in Nigeria.

Some of those we interviewed, believed in the reality of COVID-19. However, they were on the minority. For example, the view of *IP AO-4* (2022 oral interview) indicates that why there is vaccine hesitancy among Christians in the country is because Church leaders are not promoting the need for the vaccine. According to her, many church leaders in Nigeria discourage Christians from being vaccinated against COVID-19. In this sense, as long as they do not encourage it, many Christians in the country will be hesitant to being vaccinated against COVID-19. This relates to the view of *IP CO-5* (2022 oral interview) that part of the problem is a lack of sensitisation on the need for the vaccine among Christians. He argues that since many of the Christian leaders are not part of the sensitisation

process, many Christians in the country are not properly sensitised about the need to get vaccinated against COVID-19.

What we make of these views is that there is COVID-19 vaccine hesitancy among Christians in Nigeria. While there may be reasons different from the ones we sampled here on why Christians are hesitant in being vaccinated against COVID-19 in Nigeria, the fact remains that Christians in the country are accepting COVID-19 vaccine at a very low rate. In this regard, we will discuss below how our exegesis of Mk 8:22-26 encourages Christians in the country to get vaccinated against COVID-19.

Firstly, the text of Mk 8:22-26 shows that Jesus did not reject the reality of diseases such as blindness that existed in his world. In this text and beyond, where encounters of Jesus with people with infirmities and their subsequent healings are mentioned in Mark, Jesus never doubted the reality of the existence of diseases in Palestine. His acceptance of this fact is to be underscored for a mature approach to acceptance of COVID-19 vaccine by Christians in Nigeria. When, for example, Jesus met the blind man at Bethsaida, he did not ascertain, firstly, if the blind man was truly blind or not. Alternatively, even what was the cause of his blindness was not Jesus' concern. Rather, his concern was how to cure the blind man since he was certain that the man was blind. This is a contrary attitude to that of Nigerian Christians as regards the reality of COVID-19. As we have shown, the denial of the reality of COVID-19 in Nigeria by Christians, is linked to their rejection of its vaccine. Even when there are facts on ground, proven medically, that COVID-19 kills (many Nigerian Christians watched on television how people died of the pandemic in droves in other countries of the world), they still dismissed the reality of the pandemic. Some even went as far as interpreting it to be the anti-Christ. The text of Mk 8:22-26 therefore calls Christians in Nigeria to re-evaluate their faith as regards the religion – health (COVID-19) debate.

Secondly, by making use of a well-known medical procedure of healing diseases in his world, Jesus encourages Christians to accept medical process of curing diseases. If Jesus, with all his healing power as God, could apply spittle in healing a blind man, it means he sanctioned the use of medicine to cure diseases. In fact, it means he supports medical process of curing diseases. This means that in the context of our application of the text, there is a need for Christians in Nigeria to accept medical prescriptions as regards COVID-19. Of course, as of today, there is no known and

acceptable cure for COVID-19; only its prevention method exists. This preventive method is the vaccine which, as we have shown, is being rejected by many Nigerian Christians. In this regard, Mk 8:22-26 teaches Christians in Nigeria that while faith-healing is part of the Christian belief, the application of medicine in curing diseases is equally accepted. The text therefore encourages Nigerian Christians to understand this fact as far as COVID-19 pandemic and its vaccine is concerned.

Thirdly, and in alignment with the above point, our text of study encourages Christians to have themselves vaccinated against COVID-19 since there is nothing wrong for a believing Christian to do so. Our logic here is that since Jesus, in the text of Mk 8:22-26 sanctioned the application of medicine in curing diseases, Jesus sanctioned the acceptance of vaccine as well, which is part of the medical process of combating the pandemic. In this regard, what many Christians should be concerned about is if there are medically proven side effects of having oneself vaccinated against COVID-19. Equally, Christians in Nigeria should also ask if such side effects of the vaccine, even if they exist, are the higher evil as long as being vaccinated against COVID-19 is concerned. As it stands, whatever side effects that Christians in Nigeria claim COVID-19 vaccine has, is based more on 'conspiracy theories' which, in most cases, have not been proven medically. Many of their reasons for rejecting the reality of COVID-19 and its vaccine, as we have seen in our interviews, are based on 'conspiracy theories' and poorly-constructed faith-based reasons rather than medical facts. This is to be discouraged by our exegesis of Mk 8:22-26.

Conclusion

The text of Mk 8:22-26 is very puzzling to many Christians. The application of a two-stage healing process by Jesus, which even included the use of spittle, is even more puzzling to many Christians. The present study 'looked' beyond the nitty-gritty of this two-stage healing to show what the text means for Christians in Nigeria as regards COVID-19 vaccine hesitancy. The study showed that the process of the healing of the bind man at Bethsaida by Jesus followed well-known medical processes of Jesus' time, particularly the use of spittle to cure diseases. This means that Jesus encourages medical process of curing diseases. This therefore should be

an encouragement for Christians in Nigeria in accepting COVID-19 vaccine since all available facts show that the pandemic is real in Nigeria. The text also calls for the re-evaluation of Nigerian Christians' stance on faith (religion) – COVID-19 vaccine debate.

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List of interview partners (IP)

S/N	IP Code	Gender	Denomination/ position
1.	*IP CO-1*	male	Anglican/ clergy
2.	*IP EO-2*	male	Anglican/ clergy
3.	*IP AE-3*	female	Pentecostal/ member
4.	*IP AO-4*	female	Pentecostal / member
5.	*IP CO-5*	male	Roman Catholic/ member
6.	*IP MI-6*	female	Roman Catholic/ member
7.	*IP FE-7*	female	Pentecostal/ member
8.	*IP NO-8*	male	Roman Catholic/ member

Louis Ndekha

4 The Strong, the Weak, and the COVID-19 Vaccine: Reading Romans 14 in Malawi

Abstract

When the COVID-19 pandemic came, it killed millions of people and ravaged national economies, leaving many societies more vulnerable than before the Pandemic. However, beyond economic and social complexities, the Pandemic has also left in its wake religious and theological controversies. For example, in Malawi, the COVID-19 vccine has polarised the religious community, with others accepting it as God-given while others reject it as Satanic. This chapter examines Romans 14:1-12 in the context of the COVID-19 vaccine controversy in Malawi. It argues that in contexts like Malawi, where sharp theological differences over the COVID19 vaccine sub-sist, Paul's representation of weak and strong Christians in Romans 14:1-12 provides a framework through which Christians can negotiate the polar-ising effect of the COVID-19 vaccine. After examining the meaning of Romans 14:1-12 in the context of Paul Greco-Roman auditors, the chapter explores the implications of Paul's 'strong and weak' framework for a local Christians' response to the COVID-19 vaccine controversy in Malawi. Through this analysis, the chapter contributes to the body of knowledge on the effects of the COVID-19 pandemic in Malawi and, by implication, the relationship between religion and health in Africa.

Keywords: Paul, Romans 14, Weak, Strong, COVID-19 Vaccine, Malawi

Introduction

The COVID-19 disease is one of the most complex pandemics the world has ever experienced. Its effects have been widespread and abysmal, affecting nearly all aspects of human existence. The Pandemic has ravaged national economies and left, in its wake, not just economic and social complexities but religious and theological controversies. As religious

communities attempt to cope with the Pandemic, they have developed different and sometimes conflicting perspectives on the meaning of the Pandemic and their appropriate response to it. The chapter examines Romans 14:1-23 in the context of the COVID-19 vaccine controversy in Malawi, where conflicting theological viewpoints on Malawi's COVID-19 vaccine have the potential to affect vaccine uptake. In this chapter, we argue that in a country with a majority Christian population, Paul's representation of the weak and the strong Christians in Romans 14 provides a framework through which Christians in Malawi can negotiate the polarising effect of the COVID-19 vaccine controversy. The application of Paul's approach to conflict resolution in Rom 14 to the Malawi context is made within the broader context of the African philosophy of *ubuntu* which emphasises the importance of community, communion and the common good. Methodologically, our reading of Rom 14:1-23 in Malawi is informed by African Biblical Hermeneutics (ABH), which emphasises the importance of establishing a dialogue between the world of text and that of African readers and, through appropriation, enables the text to solve African problems (Mbengu 2011:4). The chapter has two sections. The first section examines Rom 14:1-23 in its social setting and its implications for Paul's Roman auditors. The second section re-assesses the COVID-19 vaccine theological controversies in Malawi in light of Romans 14:1-23. It is noteworthy that Rom 14:1-23 oscillates between eating and observing special days. This chapter, however, concentrates on the question of abstinence and meat-eating in the Roman church (14:1-4). This choice is based on the supposed correlation between ingestion and vaccine injection in that they involve substance intake into the body.

The Weak and the Strong in the Roman Church

The application of controversial Pauline texts in specific contemporary situations that are equally contentious is always a difficult task. The task becomes more complex when the identity of the weak and strong in Romans 14 remain a subject of heated debate in scholarship. In the literary structure of Paul's letter to the Church in Rome, chapter 14 belongs to the hortatory of the letter 12:1–15:13. The major thematic thrust of the section is Christian living. Two views have, however, dominated the search for the context of the controversy in Romans 14. Most scholars trace the challenge

of the weak and strong in the Roman church to the Jewish-Gentile differences over the observance of Jewish dietary requirements and special holidays. While the specific contexts of the conflict in dietary observance remain elusive, the conflicts likely took place in household contexts where Gentiles and Jews met and shared a common meal (SPITALER 2009:45). It is also likely that, due to the Gentile predominance in the Roman church, more communal meals would have been held in Gentile households. It is therefore expected that concerned with the potential for contamination in the preparation of the meals, especially where the meat came from the pagan temples, the Jews preferred to eat vegetables (YOUNG 2016:55). This suggests the abstainers went to the fellowship gatherings but did not partake in the totality of the ritual meal. By refusing to participate fully in the household meals, 'they spoiled the gathering' (SPITALER 2009:46).

A minority dissenting view holds that, other than viewing the conflict in terms of Jewish-Gentile differences, the designation of weak and strong reflects varying individual tests over what is essential within the Jewish-Gentile mix of the Roman church. In this case, in Rom 14:1-23, Paul is not addressing a particular Jewish-Gentile controversy over food and special days. Instead, the admonitions in chapter 14 are part of Paul's general paraenesis on Christian living traceable from 12:1–15:13 (MORRIS 1988:457). It needs to be noted that there were also strict Gentile non-meeting groups in the Greco-Roman world, such as the Orphics and Pythagoreans (WALTERS & PORTMES 2001:14). This suggests that the Roman situation was more complex than is generally held and that an uncritical ascription of vegetarianism and meat eating to Jews and Gentiles, respectively cannot quickly resolve the matter. As MORTENSEN (2018:329) has argued, it is also possible that Gentile proselytes in Rome continued with their Jewish commitments after accepting Jesus and, therefore, judged non-observant Gentiles. Yet, while the two positions above have merit in themselves, what was at issue in the Roman church, and essential for a contextual reading of Rom 14, was the existence of different preferences (whether group or individual) over what to eat and not to eat and that these differences had the potential for spoiling the fellowship of the church.

The gravity of the lack of fellowship over meals for the Roman community's overall health is underscored by the relationship-building significance of meals in antiquity. Studies in Greco-Roman commensality demonstrate that meals had exclusive or inclusive significance. Meals had

a putative aim of 'making-friends' and determined who was included or excluded from the social group (BRAUN 2007:52). Eating and drinking together was a confirmation of fellowship and mutual social obligation (BRAUN 2007:47).[1] Therefore, if communal meals were a sign of who were friends or foes then, in any communal household context, like that of the Christ-groups in Rome, individual or group preferences were likely to affect community fellowship.

Also pertinent to understanding Romans 14 concerns the reason Paul classifies the faith of the abstainers as weak (v. 14) and that of the meat eaters as strong (v. 1). Such an understanding is important for applying the meaning of the two categories in particular contemporary contexts. Some scholars like REASONER associate the idea of the weak with 'obsessive scrupulousness' (REASONER 1999:54), probably traceable to the meticulous Jewish application of the law. Horace's reference to 'a small man of weakness, one of many' who does not wish to speak on the Sabbath helps to place Paul's reference to the weakness of faith not just in a Jewish context but also in the general concern for ritual purity characteristic of the abstainers.[2] However, what makes the faith strong or weak in the Roman context? BARCLAY rightly argues that the abstainers' faith is weak because it is integrally connected to one particular set of cultural norms, whose removal put it under threat (BARCLAY 2013:202). These are comparable to Cicero's morally weak person, who has an intense belief that something should be avoided when it should actually not be avoided. (Cicero, Tusc. Disp. 4.26. Cf. WITHERINGTON 2004:33). On the other hand, according to BARCLAY, the faith of the strong is strong because they have been able to disassociate their faith in Christ from every norm and value. Thus, for them, eating and drinking are not central to their relationship with Jesus (14:14, 17). These practices were *adiaphora* to their faith and, therefore, matters of preference.

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1 A Pompeian graffiti announcement that 'the man with whom I do not dine is a barbarian to me' (BRAUN 2007:47)

2 Horace in Satires 1.9.68-72 describes an interesting conversation that transpired in Rome and is of relevance to our discussion of Romans 14. One person refuses to talk to another and adds, "Today is the thirtieth sabbath. Would you affront the circumcised Jews?" The other replies, "I have no scruples." The first rejoins, "But I have. I am a somewhat weaker brother, one of the many. I will talk another day." (Cf. WITHERINGTON, 2004:33)

However, from Rom 14:3, 10, it is apparent that for Paul, the problem in the Roman church did not lie in the existence of individual preferences over what to eat or not to eat. The real problem instead lay in the interpersonal attitudes that arose from these divergent tastes. Two key words characterise the respective attitudes of each group toward each other, which Paul admonishes against. The first word is ἐξουθενέω, which means to despise but also carries with it nuances of looking down upon (Lk 18:9), rejecting (Acts 4:11) or disregarding. The second word, κρίνω, has the sense of separating, putting asunder, and distinguishing, which makes it close in meaning to ἀφορίζω, which means 'to mark off by boundaries.' Paul uses the word κρίνω extensively in his discourse against his detractors (1 Cor 3), where he urges them not to judge him but to let God be the judge (1 Cor 4:5). The reference to the problem of interpersonal disparagement and judgement (Rom 14:3) which is also echoed in Lk 6:37-42 mirrors a broken community. Such a community cannot reflect the ethos of a Christian community.

It is striking that although he would typically identify with the strong (Rom 15: 1), in resolving the community challenges rocking the Roman church, Paul sides with neither group. He, instead, takes a third route. His argument is that inter-communal relationships should not be determined by disputable matters (διαλογισμῶ) (14:1b). In other words, among the Roman Christians, matters of diet (or calendar) cannot be part of the criterion for defining the structure of the assembly (MORTENSEN, 1918:331). Where the matter cannot be sorted through an objective criterion, the antidote is mutual respect and tolerance among the members. The basis of this mutuality is derived from each group's relationship with God: God has accepted both the weak and the strong (14:3). The Greek word used is προσλαμβάνω, meaning to accept or take along. It suggests that God takes seriously both those who hedge their faith with norms and practices and those who do not see the need to hedge their faith.

The rhetorical question in v. 4, 'who are you to judge?' emphasises the pointlessness of judging each other, especially if the Lord will ἵστημι (uphold) every respective orientation. In this case, instead of name-calling, each group should be confirmed in their minds the rightness of their action. They should, therefore, not change or be pressured to change because of other peoples' preferences (v. 5b). The reason for the maintenance of the status quo is because each of them eats 'unto the Lord to

whom they are both responsible (v. 6-8). Yet the more significant burden of responsibility to ensure peace and protection of the weak lies with the strong (v. 1). This is because their ability to disassociate their faith in Christ from every norm and value (BARCLAY 2013:202) implies that they would rarely be affected by the action and judgmental attitude of the abstainers. Yet, on the other hand, because their faith is integrally connected to a set of cultural norms, questioning and despising the practices of the weak and requiring a possible change of their behaviour would threaten their faith (Barclay 2013:202). Because of the delicate nature of the Roman community, the best attitude for each Christian should be one of pursuance of what makes for peace and mutual upbringing (v. 18-19). Each group should avoid practices that would endanger the other's faith.

Reading Romans 14 in Malawi

A responsible contextual reading of Rom 14 requires an adequate understanding of the social context of its contemporary Malawian audience and their possible continuities with the text's audience. This understanding helps to create a dialogue between the text and the African context and, through appropriation, establishes how the text can help solve particular African problems (MBENGU 2011:14). Malawi is a Southern African country that shares borders with Mozambique, Tanzania, and Zambia. The country's religious demography portrays a Christian concentration of 77.3% (NSO 1918). The majority of Malawian Christians belong to the mainline churches, while 7.6% belong to the Pentecostal brand of Christianity (US State Department 2019). While the mainline churches portray a balanced theological outlook on social reality, the Pentecostals are usually theologically radical. For example, the Pentecostal response to witchcraft is typically dramatic. In many cases, it involves vehement exorcisms and the burning of charms (VAN DER MEER 2011).

On the other hand, the mainline theological response to witchcraft is usually low-key and nonchalant. In addition, most Pentecostal Christians display the endemic belief that demonic forces are at work at every level of society (ENGLUND 2007:478). This perception makes its members suspicious of any strange phenomena. These characteristics identify the Pentecostals with the conscientious members of the Roman church concerned with anything associated with spiritual contamination, notably the

food pollution of idol feasts (WITHERINGTON 2004:332). Therefore, although the Pentecostals are a minority, their fervent approach to spirituality and preoccupation with the nitty-gritties of faith characterise them as the most conspicuous and outspoken section of the Christian community whose theological pronouncements have a significant impact on public perceptions and attitudes.

Another inherent characteristic of Malawian religious cosmology, and perhaps African Christianity in general, is the intricate relationship between faith and sacred spaces. Faith finds its explicit expression in spatial contexts. As a result of this understanding, faithful attendance of worship in designated religious spaces is a demonstration of faith (TENGATENGA 2021). Since the gathered community is of paramount importance, anything that would negate individual presence in sacred spaces is subject to be branded demonic and anti-Christian. While this perception is endemic to the Malawian church in general Malawi, it is more conspicuous among Pentecostals, where church income and, by implication, the economic rights of the clergy are tied to the church gathering.

Given the above context, the emergence of COVID-19 and the consequent lockdown created a mix of socio-religious challenges that essentially polarised the Christian response to the Pandemic between mainline and Pentecostal churches. At first, since the lockdown distorted the religious cosmology of the Malawian church, both the mainline and Pentecostal churches resented the COVID-19 preventive measures and, in some cases, threatened to disobey (MAWERENGA & KNOETZE 2022:3). After proper coordination with the Malawi Government, the mainline churches eventually towed the conventional line. However, even amidst the confusion brought in by the Pandemic, the theological response of the mainline churches was characteristically moderate, emphasising hope amidst despair. When the COVID-19 vaccine emerged on the scene, the mainline churches encouraged Christians to demonstrate their love of neighbours by being vaccinated (ECM 2021).

However, the Pentecostal response to the lockdown and the COVID-19 vaccine was characterised by active resistance and intentional polemics. To demonstrate dislike of the course of events, the grouping's representatives sued the Government of Malawi and the umbrella body of the mainline churches (Malawi Council of Churches) for accepting extreme COVID-19 measures. In addition, they developed a sustained polemic

against adherence to the COVID-19 measures, the subsequent COVID vaccine and those that subscribed to mainstream thinking. Not only do they interpret the Pandemic as a sign of end time, they brand the vaccine as the mark of the beast in Rev 13:18 (MAWERENGA & KNOETZE 2022:4). Those accepting to be vaccinated are branded as not true Christians but apostates who have no place in the Kingdom of God. At one point, in a viral video clip, a Pentecostal pastor was seen boisterously claiming that a minister in the church of God who contracts COVID-19 was not a real man of God. In a context where several prominent ministers from both the mainline and Pentecostal churches had died of COVID-19, this caused a public uproar.[3]

Rubal KANOZIA and Ritu ARYA argue that religious leaders spreading conspiracy theories can prove detrimental to vaccination campaigns worldwide as these leaders often have ardent followers (KANOZIA & ARYA 2021). This is probably true of Malawi, where, by September 2022, only 11.8 % (2.25m) of the population had been vaccinated. This is against 4.32 million doses made available to the Malawi government. Eventually, most of these expired on the campaign trail and had to be removed. Social, historical, political, and individual factors such as emotions, values, risk perceptions, and knowledge have been known to contribute to the delayed uptake of vaccines (LARSON ET AL. 2014). However, the religious factor, especially in social settings like Malawi, where considerable religious naivety subsists, can potentially affect the COVID-19 vaccine uptake.

It is worth noting that, like in the Roman context, the main problem in Malawi is not the divergent religious views on the COVID-19 vaccine. The real problem lies in the interpersonal judgements over whether to take the vaccine or not and how this has the potential to affect the country's fight against the Pandemic. However, if Paul is to say anything about the Malawian context, one preliminary issue that needs to be established is whether taking the vaccine has any spiritual bearing on what it means to be a Christians. Does taking the vaccine in it any way negate dependence on God? What is the place of medical science in Christian theology? It can be argued that at its basic level, the COVID-19 vaccine is a health issue rather than an economic or religious one. While health issues can be corporate, especially in contexts of infectious diseases like the

[3] This Pentecostal minister was made to make a public apology (by the national leadership of the Pentecostal), which he did.

COVID-19 Pandemic, the decision to take the vaccine is primarily personal. That is why, except in specific situations where public health is a significant concern, taking COVID-19 is voluntary and, therefore, personal. All this makes the theological differences over the COVID-19 vaccine in Malawi as διαλογισμῶ (14:1b) (disputed matter), which cannot be sorted by despising or judging the other but rather by embracing the differences.

Paul's admonition to the Roman church was that as long as the issue of what to eat or not was adiaphora to the Christian faith, then everyone should be confirmed in their minds of the rightness of their position (v. 14b). The validation to maintain status quo is because every Christian, abstainer or meat eater, or in the Malawi context, the anti-vaccine or pro-vaccine, do everything 'unto the Lord' to whom they are also responsible (v. 6-8). It is, therefore, unnecessary in the Malawi context to harangue others into taking one's position on taking or not taking the vaccine. Yet as Paul warns, while individual preferences for what to eat or whether to take the vaccine or not are primary, pursuing what makes for peace and mutual upbringing (14:19) represents the highest form of service to God. The solution Paul offers to the Roman church is for the strong to forgo their preferences in order to build a weaker brother (v. 21). How can Paul's advice apply to the Malawi context where the strong are apparently on the receiving end of judgement? Perhaps here, an appeal needs to be made to Paul's overall message in the chapter, which centres on mutual tolerance and respect among the members.

Thus, in the Malawi context, the solution to Paul's advice would not be for the pro-vaccine Christians to stop getting for the sake of the weaker brother. The answer lies in collective responsibility that ensures the community's general health. The Pauline injunction calls for the contextual application of *ubuntu*, which advocates for the importance of the common good and the values of generosity, hospitality, friendliness, compassion and solidarity (DREYER 2015:196). If one's actions or words are likely to cause another to stumble, either by not taking the vaccine and, therefore, endangering the health of the community or by taking the vaccine and consequently feeling spiritually guilty, then one is not serving the Lord. Thus, Paul's theology of mutuality and tolerance, which resonates with the spirit of *ubuntu* in African culture, provides the theological framework through which the Christian community in Malawi can negotiate the polarising effect of the COVID-19 pandemic and its vaccine.

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Lovejoy Chabata

5 *"Is there no balm in Gilead?"* (Jer 8:22) (is there no *zumbani* in Zimbabwe?)

Christianity and African Traditional Religion and COVID-19 vaccines in Zimbabwe

Abstract

Prophet Jeremiah regrets the lack of the healing balm of Gilead in Judah where his people were perishing from incurable ailments. The balm of Gilead (*commiphora opobalsamum*), like the *zumbani* (*lippia javanica*) of Zimbabwe, was used by traditional herbalists for healing several illnesses and diseases. Zimbabwe's traditional and natural herb, *zumbani*, has been described as 'the wonder herb' (Bhebhe 2021) due to its antioxidant characteristics which are essential for mopping out COVID-19 related toxins in the human body. This article discusses how Christianity and African Traditional Religion (ATR), have espoused use of traditional herbal medicines alongside WHO attested vaccines.

Keywords: COVID-19; African Christianity; vaccination; African Traditional Religion; Jeremiah 8:22; *zumbani*

(1) Introduction

Christianity, African Traditional Religion, and scientific public health institutions in Zimbabwe converged to mitigate the effects of COVID-19 like neighbours joining to put out fire that is about destroy a village. Epistemological and ideological differences that simmered at the onset of the campaign against the insidious effects of the pandemic started to melt away and diminish as people of faith joined forces with government institutions and traditional leaders to rally behind the country's coronavirus vaccination programme (Mambondiyani 2021; Nyathi, 2021). The conundrum and desperation associated with COVID-19 engendered a dire need for strategic synergies between natural sciences, indigenous knowledge systems and faith healing belief. Mavaza (2021) argues that

Zimbabwe's traditional medicine, *zumbani*, assumed the status of a national vaccine for COVID-19. The adoption of *zumbani* as an officially prescribed medicine against the coronavirus fits within the syncretized medicinal trajectory adopted by the World Health Organization in which traditional medicine must be given a chance alongside scientific medicine. The WHO (2013) perceived traditional medicine as 'the sum total of the knowledge, skill and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illnesses.' It is against the backdrop of such a philosophical orientation by the WHO that Zimbabwe's *zumbani* traditional medicine, like the biblical balm of Gilead, won national endorsement as a coronavirus vaccine. Christians and traditional religionists accepted that *zumbani* is endowed with anti-covid oxidants. This chapter takes a keen inquest into how people of faith gave an ear and due credence to indigenous knowledge systems on health in the battle of mitigating the effects of COVID-19. The chapter brings into scrutiny the marriage between traditional epistemologies, scientific knowledge, and Christianity on vaccination with the view to project how future health policies should encapsulate an interfaith and trans-religious response to pandemics.

(2) Problem Statement

The rolling out of COVID-19 vaccines was adversely affected by vaccine hesitancy. The study interrogates the role played by religious groups in Zimbabwe in advancing or derailing the vaccination programme introduced by the Government of Zimbabwe.

(3) Research Aim

The aim of the research is to propose a sustainable, multi-sectoral crises response mechanism that cuts across religious and epistemological diversities.

(4) Research Objectives

To fulfil the above aim, the following objectives were pursued:

- To discourse on the hermeneutical symbiosis between the balm of Gilead and the *zumbani* herb of Zimbabwe as pandemic medicine.
- To investigate how the convergence of indigenous knowledge systems, faith healing and natural scientific knowledge on COVID-19 vaccines portends a culture of epistemological collaboration and toleration in future.
- To design a multi-sectoral response framework for future pandemics and disasters.

(5) Research Questions

The following research questions shall guide this research:

- Why did Prophet Jeremiah refer to the balm of Gilead in Jeremiah 8:22 in the context of the God-fearing people of Israel?
- What is the correlation between the balm of Gilead and the *zumbani* traditional herb in Zimbabwe?
- Was the collaboration and networking among Christians, ATR practitioners and scientific experts on vaccines just a marriage of convenience?
- What cosmological prognosis for future responses to pandemics can be drawn from this study?

(6) Rationale/Justification of Study

This study is justified for the following reasons:

- There has always been a palpable polarization around the subject of healing between the Christian faith and ATR. It is necessary to glean through research, the possibility that ATR and Christianity can collaborate in mitigating the effects of pandemics.
- The study seeks to critically discuss whether the use of natural remedies for pandemics really leads to secularization.
- The findings of this study will be useful to various stakeholders as follows:

– It seeks to vindicate the clarion call by the WHO for the need to blend traditional medicines and scientifically approved vaccines in the quest for preserving soundness of health.
– Health planners and practitioners in government health departments will appreciate the need for inter-epistemological co-operation and synergies in times of crises and disasters.
– The academics will benefit from an enhanced understanding and theology praxis on matters of health and healing.

Methodological Praxis

This study assumes a qualitative analysis that combines Socio-Historical Criticism and Social Scientific Criticism.

Socio-Historical Criticism

EHRMAN (1997:145) defines Socio-Historical Criticism as an exegetical method that focuses on the social context of the world behind the text regardless of whether it is the world referred in the text or the world in which the text was written. Bart avers that biblical texts can precast a futuristic context or the present context in which the text was written. In this chapter, it is assumed that Jeremiah 8:22 has a polyvalent significance beyond prophet Jeremiah's 627–586 BC context. This scholar posits that the world behind Jer 8:22 bears semblance to the *Sitz im Leben* (situation in the life) of the Zimbabwe COVID-19 vaccines milieu. In that regard, *zumbani* herb of Zimbabwe replicates 'the balm of Gilead' of Jeremiah 8:22. CHAMBURUKA (2020:1) argues that Socio-Historical Criticism is a useful tool in studying specific historical and social events, social changes that unfold over time, class conflicts in communities and marginalized groups. The method is pertinent to this study as it allows us to permeate the cultural, cosmological, and historical backgrounds of relations between Christianity and ATR about healing and vaccines. Through Socio-Historical Criticism, we are also able to trace Christianity and ATR changes in inclination and attitudes towards traditional medicine and vaccines.

Social Scientific Criticism

ELLIOT (1993:7) states that Social Scientific Criticism is that phase of the exegetical task which analyses the social and cultural dimensions of the

text and of its environmental context through the utilization of the perspectives, theory, models, and research of the social sciences. Discourses on COVID-19 healing, and vaccines inevitably attract anthropological, sociological, psychological, and religious issues which can only be gleaned through the social scientific lens. BRAY (1996:512) argues that social scientific method impulsively allows modern phenomena to be read back into the ancient world on the assumption that all societies function in one or less similar ways. As we draw parallels between contexts of prophet Jeremiah's balm of Gilead and Zimbabwe's *zumbani* traditional medicines, Social Scientific Criticism enables us to facilitate dialogue between Jeremiah 8:22 and the COVID-19 vaccines *sitz-im-leben* of Zimbabwe.

COVID-19 Vaccines, Balm of Gilead and *zumbani*

The use of natural herbs such as balm and *zumbani* in faith communities as anti-pandemic vaccines raises a polemic on whether certain religious sects are justified in forbidding their followers from taking such herbs. DAFNI & BOCK (2019:2) argue that the use of herbal medicine in faith communities in contemporary times should be discussed in the context of the use of medicinal plants in the world of the Old Testament. Such an approach compels us to interrogate the basis upon which Christianity, itself an offshoot from Judaism, has ambivalence towards use of herbal medicines. Ethnobotanical studies on use of herbs for healing in Bible times and in the Holy Land reveal that balm was used to treat severe sores (Jeremiah 8:22; 46:11; 51:8). DAFNI & BOCK (2019:3) contend that at least one hundred and seventy-six Biblical Medicinal Plants have been discovered of which about one hundred are traceable to the Middle East and the Holy Land. From an Old Testament context, the uptake of herbal medicine assumed some controversies when herbalists or physicians conducted cures which were accompanied by incantations and magic (KRYMOW 2002). Balm was applied on the sick by traditional physicians but the herb features in the list of biblical medical plants. In instances where the herbal medicines were used without invocation of pagan deities, no fears of apostasy and profanity were raised. Balm would even be imported from the Mesopotamian region to cure Israelites when plagues, pestilences or pandemics afflicted them (Genesis 37:25; Genesis 43:11; Ezekiel 27:17). According to evidence from the Old Testament the herb of Balm had na-

tional significance since the time of Israel, the father of the nation of Israel. When Israel and Joseph died, balm was used to embalm their bodies by physicians (Genesis 50:2, 26). In the same vein that balm assumed national importance in Israel, *zumbani* assumed a national significance as a coronavirus vaccine alongside the WHO approved vaccines in Zimbabwe. MOYO (2021) posited that as the world was bracing for vaccination drives to combat COVID-19, Zimbabweans irrespective of religious affiliation latched their hopes on *zumbani*, a woody shrub, to keep the pandemic at bay. Scholars have marvelled at how disparate religions such as Christians and ATR ended up collaborating and accepting both conventional and herbal vaccines (MATIASHE 2021).

GELFAND, MAVI, DRUMMOND & NDEMERA (1985) state that both South Africa and Zimbabwe *zumbani* is used to cleanse demonic spirits by washing the body of the afflicted person by leaf infusion. The *zumbani* herb is traditionally associated with exorcism of evil spirits and witchcraft spells (SHOKO 2007). In Southern Africa generally and in Zimbabwe particularly, African Traditional healers practice herbal healing by combining magical, mythical, spiritual, and scientific activities (ADODO 2010:71). MAROYI (2017) states that in Zimbabwe *zumbani* leaves are used as an infusion to treat people experiencing nightmares, to ward off evil spirits, to protect people from lightning strikes and to safeguard homes from evil apparitions. MAROYI (2017) further points out that in East, Central and Southern Africa, *zumbani* leaf infusions have been very instrumental in treating skin disorders which include rashes, boils, chicken pox, measles, scabies, scratches, and stings.

During the plagues that befell the Holy Land during prophet Jeremiah's time, God's people were so desperate to a point where the prophet asked, 'is there no balm in Gilead? Where is the physician?'. The critical question is YHWH's stance on herbs. Was the God of the Jews, who later also became the God of Christians opposed to medical herbs or rather, he only abhorred the incantations that physicians of Israel muttered as they applied the herbs on their patients? NEMU (2019) contends that the burning of herbal incense and ointment in the Jewish tabernacle to facilitate a direct experience of the Israelite God demonstrates that the God of the Bible loves herbs and is not opposed to their use by his worshippers. ADAMO (2021) argues that the God of the Jews often revealed to his prophets, plants that had medicinal powers as he did in the case of the healing

of King Hezekiah's boil with fig poultice (Isaiah 38:21) as well as the use of a tree to heal the bitter waters at Marah by Moses (Exodus 15:25). BROIDA (2022) argues that although initially there was fear that medical treatments would usurp God's honour as the ultimate healer, in the end, with the influence of Greek philosophy and natural science, physicians were viewed as God's instruments where their skills helped in restoring health.

Is there no balm in Gilead? Is there no physician there? Is there no *zumbani* in Zimbabwe?

Prophet Jeremiah's question in Jeremiah 8:22 brings together three entities to the table of discussion on how the plagued nation of Israel was going to be healed during a devastating pestilence. The three entities were the prophet himself representing the faith community, the physician representing the herbalists/home traditional doctors and the political administration responsible for ensuring availability of balm from Gilead. God's Church represented by the prophet is going through a stand-off with the State. The traditional healers/ herbalists are custodians of the balm. Informed by BRAY's (1996:512) view that modern phenomena can be read back into the ancient world on the assumption that all societies function in more or less similar ways, we argue that Zimbabwean *Sitz im Leben* during COVID-19 vaccination process strikingly replicates the situation in Jeremiah's time. Christian leaders, traditional religious leaders and the government of the day had to put heads together to collectively combat coronavirus. According to GELFAND (1985:3), SHOKO & CHIWARA (2013:217), and CHABATA (2021), the prophetic figure and the traditional seer or spirit medium in Zimbabwe occupy seats of authority and influence in society's interpretation of social and spiritual phenomena. Jeremiah's calls for balm and the physician presents him as a pragmatic prophet who does not claim that only him and his God have answers to pandemic crises.

In a sharp contrast to prophet Jeremiah, Zimbabwe's Prophet Makandiwa reacted to the coronavirus vaccination programme with ambivalence and revulsion. CHABATA (2021) states that Prophet Makandiwa described the WHO as "killer vaccines" which the devil intended to use to wipe out the black race through Bill Gates and Western Scientists. Makandiwa

swore that he was going to defy the government of Zimbabwe's stance to enforce vaccination of the population against the effects of COVID-19. Prophet Makandiwa admonished thousands of his followers at United Family International Church not to be vaccinated as their protection from the deadly pandemic was guaranteed due to his prayers and counsel with God with whom he held direct and physical meetings in heaven. Undoubtedly, Prophet Makandiwa's anti-vaccines pronouncements instilled vaccine hesitancy in his many followers in Zimbabwe and beyond. 'Vaccine hesitancy' refers to the reluctancy to accept available vaccines (Mugari & Obioha 2021). Later the prophet u-turned on his stance when he received an avalanche of wide criticism after several of his pastors succumbed to COVID-19. Prophet Makandiwa alleged that God had warned the Christian Churches to intensify their prayers so that the vaccine chips being planted in their bodies would not cause genocidal deaths.

This scholar argues that Prophet Makandiwa's initial position on coronavirus vaccines should be understood in the context of doubts, mistrust, scepticism, and suspicions that characterized the rolling out of the vaccines. As Matiashe (2021) argues, the vaccination campaign could be stalled by a cocktail of problems ranging from insufficient information, misinformation to conspiracy theories around vaccines in Church, ATR, and political circles. In the initial stages of the vaccination program, even politicians were equivocal and cynical about the vaccines with the government of Zimbabwe authorizing traditional herbalists to treat COVID-19 as an alternative to WHO guidelines (Mavhunga 2020). Those who subscribe to ATR philosophy on health and healing have always believed in combining natural, faith and scientific remedies in the event of sicknesses. A popular adage in ATR circles has always been that "God helps those who help themselves". Through the philosophy that God comes to the aid of those that help themselves, (ostensibly drawn from the Bible), many self-professing Christian believers combined homemade traditional herbal remedies with prayers and scientific vaccines such as the Chinese Sinopharm shot. The Zimbabwe Traditional Practitioners Association posited that traditional medicine practice is acceptable to Zimbabweans since it is older than scientific remedies. According to Ozioma & Nwamaka-Chinwe (2019), African traditional medicine continues to be relevant in the face of Western medicine. Ozioma & Nwamaka-Chinwe (2019) argue that the use of African herbal medicine in primary health care systems in Africa continues to be relevant due to its proven efficacy

in curing diseases, be they physical or spiritual. The traditionalists made a point that emergency disease outbreaks such as COVID-19 demand emergency measures which involve all sectors that are into health delivery practices.

The hesitancy associated with juxtaposing traditional medicines with scientific medicines started dissipating in the face of the glaring reality that Africans in general and Zimbabweans in particular, have always mixed faith healing prayers with traditional herbs and modern medicine. The traditional herbs are usually consumed in the form of herbal tea and at times through steaming, itself an African traditional healing ritual. Medical, traditional and faith forms of healing tend to co-exist in most African societies as the afflicted grope for cheapest, fastest, and most affordable solutions to ailments (Togarasei, Mmolai & Kealotswe 2016). With the outbreak of COVID-19 and the consequential life losses that shook the cradles of civilization and hubs of scientific knowledge, pedantry and hubris made way for inter-ideological and inter-epistemological dialogue. The question of where a possible solution for the marauding coronavirus led even the most fastidious and stringent medicine regulatory bodies to reconsider their positions on the use of African traditional medicines. Every possible source of help in mitigating the devastating effects of COVID-19 was worth considering. It was a moment of desperation like prophet Jeremiah's time when incurable ailments plagued the land of Judah to the extent that the prophet ended up calling for the involvement of physicians (traditional healers) and the use of balm. "Is there no balm in Gilead; is there no physician there? Why then is not the health of the daughter of my people restored?" (Jeremiah 8:22). It was against such a background that zumbani herb was considered as a medicine alongside scientific vaccines that were being rolled out in Zimbabwe.

Interfaith Dialogue and Endorsement of Vaccines

It has been established so far that both Christianity and African Traditional Religion adherents got to a point where they all agreed that vaccination was both inevitable and mandatory. Masiyiwa, Chenjerai & Mujuru (2021) noted that even Apostolic religious communities that were infamous for their vaccine hesitancy shifted from their stance and joined other Christian groups to encourage their members to be vaccinated.

UNICEF Zimbabwe (2021) attributes the breakthrough in securing the vaccines buy-in by faith organizations to an interfaith religious dialogue and conference which UNICEF convened in collaboration with Government of Zimbabwe's Ministry of Health and Child Care and in partnership with Apostolic Women Empowerment Trust. The interfaith dialogue comprised faith leaders from prominent religious groups which included Christian, Islamic and the Traditional Religions. Participants at the religious workshop included major ecumenical bodies in the country such as the Zimbabwe Council of Churches, the Evangelical Fellowship of Zimbabwe, the Zimbabwe Catholic Bishops' Conference, the Seventh Day Adventists, the Supreme Council of Islamic Affairs in Zimbabwe, the Zimbabwe National Association of Traditional Healers and *Dare reMweya ne-Vadzimu*.

The interfaith dialogue diffused and debunked the major causes of vaccine hesitancy such as misinformation, distrust; social, religious, and cultural barriers. The interfaith dialogue posted positive results as the faith leaders took upon themselves the burden to educate their followers throughout the country on the importance of taking coronavirus vaccines. UNICEF Zimbabwe continued to facilitate multi-faith dialogues in the country's major cities and countryside. Coupled with the commitment of the Zimbabwe Government to aggressively drive the vaccination programme positive results were realized as statistics of vaccinated people started rising in the country. Vaccination campaigns were scaled up in African Independent White Garment Churches which support the ZANU PF ruling party. A COVID-19 vaccine hesitancy survey preliminary report that was produced by Tozivepi et al. (2020) revealed that there is lack of targeted education, promotional materials and events that focus specifically on Apostolic faith groups. Government of Zimbabwe Mobile Vaccination Teams planned with leaders of Apostolic sects to have their members vaccinated at their shrines during mega conferences (Saunyama 2021). Most of the Apostolic groupings are now affiliates of the Zimbabwe Heads of Christian Denominations where they work alongside the Evangelical Fellowship of Zimbabwe and the Zimbabwe Council of Churches. In some cases, the White Garment Churches' members had to be incentivised to accept vaccines. Mutsaka (2021) reports that some Apostolic sects around Harare had to be promised gifts such as buckets, soap, and free masks for them to agree to be vaccinated. Chingono (2021) argues that old habits die hard in the case of some members of Apostolic sects

who were raised in disdain to medication. Chingono (2021) contends that while some Apostolic members softened up towards coronavirus vaccines there remained a large number who continue to think that the protection of their spiritual prayers is adequate in the face of COVID-19 and any other ailment. Thus, while other Apostolic sects have awakened to the need to transform the indigenous churches to conform to global standards in matters of health, there is still a remnant of those who harbour distrust and suspicion of malice from the "white man's vaccines".

Dzinamarira et al. (2021) argue that although some commendable progress has been made towards integrating Apostolic sects in vaccination programmes, the government of Zimbabwe still needs to work very hard to break theological rigidity on health-related issues. Dzinamarira et al (2021) opine that the health seeking behaviour of members of the Apostolic Faith sects in Zimbabwe remains worrisome as there is still a tendency to stigmatize those that have been vaccinated as weak in the faith. The acceptance of COVID-19 vaccines has remained precarious since some faith communities play to the gallery and pretend to accept vaccination yet in principle, they resist vaccines. There is fear that the leaders of the Charismatic/ Apostolic sects could completely derail the uptake of vaccines due to their domineering and overwhelming influence on their followers. Such a risk can be averted if the members of those congregants are adequately envisioned on the importance of the vaccines for themselves and for future generations. Researchers have therefore emphasized on the need for the circulation educational and promotional materials on the significance of the vaccines in the ugly face of misinformation, misleading theories, myths, and a general lack of understanding of COVID-19 vaccination (Dzinamarira 2021). Some of the misconceptions, myths and fallacies that need to be debunked through a robust educational programme in the Apostolic sects include the belief that God is anti-medicine generally and against vaccines particularly, that vaccines are linked to Satanism, that manufacturers of vaccines have an agenda to decimate African populations and that spiritual prayers are the only solution to health challenges (Mugari & Obioha 2021).

Zimbabwean *zumbani* among COVID-19 vaccines

Zumbani (*lippia javanica*) falls into the category of the WHO traditional medicine definition due to its historical, cultural, and epistemological dimensions. The herb is an embodiment of indigenous knowledge, practices based on theories, native beliefs and experiences, and cultural health cosmologies in Africa generally and in Zimbabwe particularly. Mavaza (2021) argues that *zumbani* is believed to be Africa's wonder medicine. The herb has a nomenclature that has etymological tentacles from the whole region of Southern Africa. Mavaza (2021) lists some of the common names as: fever tea or lemon bush (English); *koorsbossie*, *beulesbossie*, *lemoenbossie* (Afrikaans); *mutswane*, *umsutane* (Swati); *inzinziniba* (Xhosa); *umsuzwane*, *umswazi* (Zulu); *musukudu*, *bokhukwane* (Tswana); *umsuzwane* (Ndebele) and *zumbani* in local Shona. Philologically, the *zumbani* herb got its scientific name *lippia javanica* from two sources. Firstly, lippia derives from Augustin Lippi 1678–1704, a French physician and botanist, natural historian, and traveller of Italian descent. The second part of the name, javanica, emanates from Java because the plant is also found in Java ecology (Mavaza 2021).

The admission of traditional *zumbani* medicine into the category of prescriptive COVID-19 drugs speaks to the need to incorporate indigenous knowledge systems in public health policies. In African Traditional Religion, *zumbani* is also used by traditional healers to exorcise evil spirits (Chitakure 2020). Dried leaves of the *zumbani* herb are burnt on ambers of fire and as the smoke gets emitted the patient kneels in front of the smouldering *zumbani* covered in a blanket. The patient is encouraged to inhale the pungent smoke of the herb which evil spirits cannot withstand as they exit with a deafening scream. *Zumbani* has always been used to cure respiratory diseases among the Bantu speaking people of Southern Africa generally but most eminently among the Shona people of Zimbabwe (Moyo 2021, Matiashe 2021, Mfengu et al. 2021). Mavaza (2021) points out that the most notable traditional uses of *zumbani* in descending order of importance include treatment of colds, cough, fever or malaria, wounds, repelling mosquitoes, diarrhoea, chest pains, bronchitis, and asthma. A concoction of *zumbani* leaves, lemon, honey, guava, and eucalyptus leaves is heated to boiling point and the patient must inhale the steam while covered in a blanket (Marevesa, Mavengano & Nkamta

2021). According to Zibengwa, Mangiza & Muguti (2022) since immemorial times, traditional herbal medicines have been used to cure ailments such as cancer, colds, malaria, nausea, depression, and insomnia. The COVID-19 traits of colds/flu and respiratory complications such as breath difficulties, dry and persistent cough are common to ailments that have been cured with the *zumbani* herb in the past. *Zumbani* leaves contain oxidants that are efficacious in dealing with COVID-19 symptoms. The leaves can be made into tea. Patients can also be treated through a process of steaming called *kunatira* in Shona.

Scientific studies carried out by BMC Complementary Medicine and Therapies to investigate the anti-inflammatory, antioxidant, and anti-asthmatic effects of *zumbani* revealed that the herb is effective in suppressing cell infiltration and their cytokines (Mfengu et al. 2021). *Zumbani* can also reduce inflammation-induced oxidative stress due to phenolic acid content in its leaves. The study showed that if patients take one or two cups of *zumbani* tea per day, they significantly benefit from its anti-inflammatory, antioxidant, and anti-asthmatic properties. The scientific study validated the traditional use of *zumbani* as an efficacious medicine for treatment and prophylaxis for asthma and other airway inflammatory ailments. Thus, most of the COVID-19 related respiratory complications and disorders can be treated using the traditional *zumbani* herb. The BMC Complementary Medicine Study's results corroborate medical doctor Mavaza (2021)'s finding that the *zumbani* herb is famous in Zimbabwe for treating respiratory problems, gastrointestinal diseases, fever, malaria, insect repellent, wounds, injuries, pain, skin infections, ethnoveterinary uses, antiamoebic effects, antidiabetic, antimicrobial, antiplasmodial and pesticidal effects. It is quite refreshing a refreshing and reassuring development that phytochemical and pharmacological studies have validated the efficacy of *zumbani* in treating COVID-19 symptoms. However, there is a clarion call on the need for more clinical tests on the properties of *zumbani*. Given the herb's dual medicinal and nutritional properties, it falls in the category of nutraceutical plants which are rare plant species.

It is important to note that *zumbani* has been accepted as a wonder herb in Zimbabwe and beyond. Mugwara (2021) observes that with increased morbidity and mortality rates due to COVID-19, there has been a frenzied demand for *zumbani* in Zimbabwe. The herb is now sold in most retail shops and supermarkets in the country. People from different walks

of life and religious backgrounds use the herb to treat COVID-19 related ailments. The herb is user friendly in that one can luxuriously drink it as tea with or without milk. It combines well with sugar or honey as sweeteners. Both Christians and non-Christians take *zumbani* tea or use the herb for steaming when they contract colds and fever. Africa University in Zimbabwe embarked on cough drop manufacturing using *zumbani* (Bande 2021). The University, itself a United Methodist Church related institution, has already produced a prototype *zumbani* lozenges with regulated dosage to make consumption safe. The University aims to develop other cough drops with a higher dosage for steaming purposes. Tea manufacturing companies in Zimbabwe have started making *zumbani* tea bags due to the business boom associated with the wonder herb. Poor people in rural communities where the plant grows naturally in forests liberally harvest it for sale in urban areas. Retailers contract poor people in rural areas to harvest and pack the dried plant in fifty-kilogram containers at a fee.

Comparison between *zumbani* and the balm of Gilead

The biblical balm and the Zimbabwean *zumbani* possess some strikingly similar properties. Just as prophet Jeremiah asked, "Is there no balm in Gilead? Is there no physician there? Why then is not the health of the daughter of my people restored?", in this research we also ask, "is there no *zumbani* in Zimbabwe? Is there no traditional healer there? Why then, (with such amazing therapeutic and nutritious properties of *zumbani*), is the health of Zimbabweans not restored?".

*Table: Biblical Balm **vs** Zimbabwe's zumbani (Source: Own design)*

BIBLICAL BALM	**ZIMBABWE *ZUMBANI***
From the mint family of herbs with medicinal properties. (BROIDA 2022)	From Verbenaceae family of herbs. (BHEBHE 2015)
Used for making cough syrups. (DAFNI & BOCK 2019)	Treats coughs, influenza, reduces pain. (MAROYI 2017)
Combines with ingredients such as honey and licoricey to treat chest congestion, coughs, and fevers. (UNDERWOOD 2010)	Treats chest related illnesses, malaria, bronchial problems, and measles cases. (MAREVESA 2021)
Treats bruises, wounds, inflammation, sunburns, and arthritis. (KENNINGTON 2021)	Treats wounds, prevents inflammation, and boosts immune system. (MATIASHE 2021)
Could be used as a preservative; embalming. (DAFNI & BOCK 2019)	Used as a preservative for meats. (MAVAZA 2021)
Used to cure life-threatening illnesses. (KRYMOW 2002)	Drastically reduces morbidity. Cures respiratory complications, opens breathing airways. Treats cancers, asthma, and diabetes. (MAVAZA 2021)
Usable in food, drinks, and tea. (AMIEL ET AL. 2012)	Used as herbal tea; is nutritious. (BANDE 2021)
Had national, spiritual significance. (BROIDA 2022)	Has become the pride and wonder herb for Zimbabwe. (MOYO 2021)

The above table has shown that both the balm of Gilead in Jeremiah 8:22 and the *zumbani* of Zimbabwe belong to traditional medicines that are characterized by cultural, historical, and cosmological characteristics. Both the Christian churches and adherents of African Traditional Religion in Zimbabwe have now reached a consensus that some natural herbs such as *zumbani* have medicinal properties that are essential for the cure of COVID-19 related ailments (BHEBHE 2021).

Research Findings

The findings of this study are:

1. COVID-19 vaccination programme has ushered an ambience of religious tolerance as interfaith groups came together to spearhead the rolling out of vaccines. Traditional religious boundaries had to be broken down as the reality of covid-19 deaths united people of diverse religious persuasions.
2. The Socio-historical study of Jeremiah 8:22 has shown that during health crises indigenous knowledge systems can combine with religious and scientific knowledge systems to proffer sustainable remedies.
3. An all-stakeholder community engagement during a pandemic is necessary in mitigating further losses of human life.
4. A pragmatic prophetic role of the Church to interpret scriptures in a way that does not leave out other members of the community in the process of change is a dire necessity during pandemic situations.
5. An ecumenical and interreligious approach should be taken in dealing with pandemics.
6. Western epistemologies can combine with African cosmologies to usher solutions to teething problems of the world such as pandemics, disasters, global warming, and climate change.
7. The participation of women organizations in organizing interfaith religious dialogue in liaison with UNICEF for vaccination drive demonstrates that women groups are essential partners with men in sustainable development and change.

Recommendations

From the study, the researcher recommends the following:

1. Zimbabwe Government should facilitate the formation of an all-stakeholders Board comprising representatives of all religious formations, medical practitioners, politicians, the youths, sport and arts bodies, women bodies, civil service organizations, parachurch organizations, educational institutions, research bodies and traditional leaders to formulate an effective strategy for driving vaccination programmes now and in the future.

2. Scientific and clinical tests should be intensified on the use and efficacy of traditional herbs.
3. In tandem with United Nations SDG 3 (Good Health and Well-being) all entities involved in health services should be consulted, engaged and workshops conducted to ensure that activities or habits that may jeopardize people's health and well-being are curtailed.
4. African Initiated Churches that are run like cults should be regulated in issues of public health and environmental management so that during pandemics such as COVID-19 they cooperate with vaccination programmes.
5. Misinformation, myths, distrust, and vaccine hesitancy can be redressed if the all-stakeholder health body proposed in (1) above constitutes a communication and Health Education Team that publishes correct information.

Conclusion

The study has shown that religious groups in Zimbabwe initially held beliefs and convictions that undergirded vaccine hesitancy which was very latent when vaccines were introduced. Interreligious dialogue proved very useful and is the way to go if future vaccination programmes are to be successful. A marriage of convenience is necessary between African Traditional Religion and faith-based organizations such as Christianity and Islam if health and life will be preserved.

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Francis Machingura & Show Chibango

6 COVID-19 Vaccination and the Zimbabwe Christian (Evangelical/Pentecostal and Apostolic Sects) Community

Abstract

The year 2019 witnessed an unprecedented rise of the Coronavirus (COVID-19). Millions of people were left stranded as their socio-economic, cultural, religious and political life got affected by lockdowns and restrictions on peoples' movement. The bruises of Coronavirus did not spare the Christian communities as they were equally affected by the novel disease. Various theories and strategies by radical Christians were thrown in the fray to try and resist the COVID-19 vaccine. Some Christians in Zimbabwe linked the vaccination to the satanic mark of the beast or the end of the world as prophesied in the book of Revelation and Daniel. In this paper we used interviews, secondary literature and Focus Group Discussions (FDGs) to come up with a holistic engagement of how Evangelical/Pentecostal and to some extent Apostolic White Garment Christians understood the COVID-19 vaccine.

Keywords: COVID-19 Virus, Vaccination, Pentecostal, Charismatic, Zimbabwe Christians

Introduction

The coronavirus pandemic caught Christians unaware. But the coming of COVID-19 made it difficult for Christians to comprehend let alone adapt to the new normal, as well as positively engage issues to do with the disease. Fear and confusion gripped both the Christian and non-Christian community. A lot of media reports as well as conspiracy theories took the centre stage with regard to the COVID-19 pandemic and vaccines. The pandemic was followed by lockdown restrictions as well arrests for not obeying the set down regulations and the louder calls for the vaccination of all the people. This made it more challenging for Christians who believe

in faith healing other than any other medical interventions. Some radical Evangelical, Pentecostal and African Independent Churches took the radical call by garment for all citizens to be vaccinated as a test of their faith, They regarded faith healing as the solution to the COVID-19 pandemic and not science or any medical intervention.

Various theories were put in motion in as far as COVID-19 vaccination is concerned. Accusations and counter-accusations were made amongst Christians for accepting or not accepting vaccines. Taking or not taking the vaccines became a measurement of one's faith. Some Christians associated vaccination with the mark of the beast or the devil as prophesied in Revelation 13:17. The book of Revelation became so relevant in the face of the pandemic. The context of biblical texts was not taken into consideration. In some circles, the COVID-19 crisis was interpreted as the end of the world. And the COVID-19 vaccine got interpreted by Evangelical/Pentecostal Christians as meant to divert people from following God. However, with the passage of time (as a result of proclamations by the government), vaccines were grudgingly accepted by the Christian fraternity as there were promises that only those fully vaccinated would be allowed to congregate for services. For some Christians, the world was coming to an end with the vaccine taking the mark of a beast as in Revelation 13:17. The belief that coronavirus vaccination was linked to the mark of the beast was reinforced by sentiments issued by the government that one will not get services if they do not produce the vaccination certificate. In several schools, organisations and institutions, there were notices which demanded people to be vaccinated. Some notices read *"No Mask, No Vaccination, No Service"*. The Zimbabwe's Statutory Instrument 119 of 2021 made it compulsory for persons intending to come into the country without valid PCR test and a certificate, not to be allowed in. Those who did were supposed to be quarantined for 10 days at their expense.

The statutory measures were too heavy for the fundamentalist Christians to fathom. They easily associated COVID-19 vaccination with the end times especially the forceful approach by government to make people get vaccinated. Radical Christians remained resolute against vaccination. Cross-border Christians who depended on importing goods for income had no choice save to be vaccinated. However, there are claims that some fundamental Evangelicals/ Pentecostals and White Garment Churches had no choice but to bribe health personnel so as to get the Vaccination

Certificate. Strong shivers were felt by most Christians as they resisted the vaccine as a way of protecting their faith as well as those who believed conspiracy theories that the vaccine was meant to exterminate Africans and make both men and women barren so as to control the growth of the African population before the neo-colonial foreign invasion to control the African populating and their resources. Revelation 13:16–17 became popular amongst Christians because of the jab and the purported mark left by the jab. References were also made to Daniel 2 and 7 which was given similar interpretations as Revelation 13. The other serious conspiracy theory was on the disease's origin and its association with the Chinese nation claimed to be anti-Christian which further complicated the acceptance of vaccinations. China for radical Christians got depicted as anti-Christian and under the influence of the devil whom Jesus describes as "a thief who comes only to steal and kill and destroy; but he had come that people may have life, and have it to the full (John 10:10)". Coronavirus is regarded as that thief or type of infection that affects the respiratory system resulting in the suffocation of an individual and then death.

Coronaviruses are a family of viruses that range from the common cold to *Middle East Respiratory Syndrome* (MERS) coronavirus and *Severe Acute Respiratory Syndrome* (SARS) coronavirus (WHO 2020). Any new coronavirus is called novel and is denoted by nCov. The recently discovered coronavirus is called 2019-nCov. Perlman & Netland (2009) define the 2019 coronavirus disease (COVID-19) as an RNA virus, with a typical crown-like appearance under an electron microscope due to the presence of glycoprotein spikes on its envelope. According to World Health Organization, COVID-19 is an acute respiratory disease which is caused by a newly emerged zoonotic coronavirus. European Centre for Disease Prevention and Control (ECDC 2020) airs out that the modes of transmission of the virus from person to person are coughed droplets, exhaled droplets by infected persons and touching droplet-contaminated surfaces or objects and then touching the eyes, nose or mouth (WHO 2020). As it stands, Coronavirus has no concrete origins. A number of writers have attributed the pandemic to animals that were sold at the market in Wuhan, China in 2019, while others assume that it was man-made. Among some of the animals presumed to have brought the disease are: raccoon dogs, squat doglike mammal used for food and their fur in China (Worobey 2022). There is an analysis that reinforces the suspicion that the pandemic began at the Huanan Seafood Wholesale Market which many of the people had visited

were infected earliest with SARS-CoV-2 (PEKAR 2022). Research conducted through geo-location analyses connecting many of the samples to a section of the market where live animals were sold. The results pointed towards the market as the source of the outbreak (PEKAR 2022). Some evidence points the origin of coronavirus to viral evolution in nature and jumped to people through some unidentified animal host. The exact animal that transmitted the disease to human beings has not been established. Others pointed to bats as possible creatures that transferred the disease to human beings (NIH 2022). As a result, what is clear is that, the source of coronavirus cannot be established with certainty. Religions scholars, Biblicists and faith believers have resorted to religious theories, beliefs and practices to interpret the threats brought by the coming of the coronavirus.

Religious Interpretation of COVID-19

Christians explain pandemics that affect the world mainly from a religious or biblical perspective. Diseases are generally explained as curses that came along through the sin of the first man, Adam. When Adam was created, he had no blemish before God; diseases were not part and parcel of humanity. The understanding is that, all forms of disease are a result of sin and disobedience and this includes COVID-19,

> ... because you have done this, cursed are you above all cattle and above all wild animals... (Gen 3:4).

Interestingly Christians take the coming of every disease as communicating something between God and humanity with humanity either obeying or disobeying God is resulting in curse or a blessing. Some believers have ascribed this COVID-19 pandemic as punishment from God for the sins committed, or for disobedience to His word by humanity. Interestingly, there are incurable diseases which were already predicted in the Bible. On most occasions, Evangelical and Apostolic White Garment Churches associate any new disease with disobedience to the laws of God and curses as communication or a message from God to humanity. Thus, the emergency of COVID-19 was something which frightened the Christian community to some extent as even those who got vaccinated unfortunately died.

Moreover, it became complicated for White Garment Churches (Apostolic sects) in Zimbabwe as they do not believe in going to hospitals or consulting medical doctors and any vaccine inventions which they label as foreign and western. Anything western is regarded as meant to dominate Africans. When members of White Garment Churches (Apostolic sects) get sick, they get prayed for at their shrines. To talk about medication and let alone COVID-19 vaccination is regarded as anathema and blasphemous to their God. A number of these members have vowed never to be vaccinated as the idea is taken as foreign and ungodly to them. An interview with one of the respondents, Mr Abureti Gwamakunguwo Gwindingwi (not his real name), said that,

> I would rather die at my shrine rather than going to a hospital to get the vaccination for COVID-19. God's power at our shrine is enough to get us going. It explains why we are still alive right now. Although, the disease killed a lot of people, as you can see here, we were spared. It means that God loves us.

When quizzed about those who die in their church, Mrs Monicah Togarepi Chafuka Machingura (not her real name) went further to say that,

> Death is God's command, you cannot escape death, whether vaccinated or not. So why worry about being vaccinated when we know that God will protect us. After all, 'in everything God works for good to those who love him, who are called according to his purpose' (Romans 8:28).

With such groups of people who do not believe in medical attention when they get sick, it may take time to convince them about vaccination against the coronavirus. To make matters worse, they (White Garment Churches (Apostolic sects) actually boast about their Christian resilience because they do not get their children jabbed/vaccinated for immunisation, believing that God will take care of them. It is unfortunate that this has had negative effects as it risks people as a result of such beliefs and practices. Others think it's ushering in the end time. Interestingly all appeal to the Bible for psychological support and healing in their discourses about God's healing power against every disease.

The Bible and Healing

Generally, people across the religious divide engage the Bible for solutions to whatever challenges of life. Interestingly, the Bible contains a

number of people who suffered different ailments both in the Old and New Testament. The Bible then becomes a source of inspiration, guidance and solace in the face of threats to life. In most of the stories, God is portrayed being at play in bringing smiles to the infected and affected or as a sign of curses against the disobedient. The argument by radical Evangelical/Pentecostal Christians is that, methods of healing that are prescribed in the Bible did not demand injections or jabs or vaccinations but quarantining as in the case of leprosy. As a result, Christians have also focused on the concept of being quarantined because of COVID-19 and how it is perceived or viewed in the Bible. In most cases, leprosy or those perceived to have sinned got quarantined. In this case, when it comes to COVID-19, the infected are medically quarantined in order to contain it. Diseases such as leprosy were contained through quarantine. In the book of Leviticus, those who suffered from leprosy were supposed to live in secluded places so as to contain the spread of the disease as happened with the COVID-19 where those who contracted the disease were supposed to live in secluded places, away from people. The following biblical examples would suffice as examples that are cited to confirm the notion that COVID-19 was a curse from God;

- Miriam, the sister of Moses lived alone for seven days when she got the leprous disease in Numbers 12:10–14;
- We also have Uzziah king of Judah who lived the last part of his life in quarantine when he was smote by leprosy by God (2 Chronicles 26:20–21;
- The four lepers were banned from the city of Samaria and chose to live at the gate of the city (2 Kings 7:3–5); and,
- And Naaman the army commander of the Syrian army who also contracted leprosy (2 Kings 5:14).

All biblical narratives about leprosy called for the infected to be quarantined and secluded from the mainstream society. The same method of quarantining and secluding the infected is applied on COVID-19 victims. The argument on leprosy healing is regarded as having only happened with the intervention of God and not vaccinations. The same assumptions and expectations are then related to COVID-19.

The miraculous power of God is cited as having healed people, for instance, king of Judah, Hezekiah got sick Isaiah 38:1–8. He was healed when the prophet Isaiah came back with the word from the Lord that the

king lived 15 more years. The argument by radical Christians is that, there is no use of jabs as in the case of COVID-19 and modern treatment. However, for the liberal Christians, modern healing is not evil *per se*, since life is preserved. There is several examples of individuals who got healed in the New Testament. Jesus healed all types of infirmities, for instance, he restored the ear of a soldier who had been wounded in the garden of Gethsemane (Luke 22:51); the woman with haemorrhage (Mark 6:21–34) and the paralytic man (Mark 2:12). Moreover, in Acts of Apostles, Peter and other disciples were quite active during the course of their ministry as they also healed a lot of people. At one time, Peter did wonders as shown by the reference below,

> ...and more than ever believers were added to the lord, multitudes both men and women, so that they even carried out the sick into the streets, and laid them on the beds and pallets, that as Peter came by at least his shadow might fall on some of them (Acts 5:15).

At one time Paul did the same,

> ...and God did extraordinary miracles by the hands of Paul, so that handkerchiefs or aprons were carried away from his body to the sick, and diseases left them and the evil spirits came out of them (Acts 19:11–12).

With this in mind, most Evangelical or Pentecostal Christians strongly believe in prayer and faith healing. In some denominations, prayers are assumed as able eradicate any form of disease let alone viruses. Biblical references which were used by these denominations included references such as,

> ...for with God nothing is impossible (Luke 1:37).

The assumptions are that, if people get vaccinated, it's a clear confirmation that God has failed or that believers have lost faith in God. Thus, for Christians to take vaccination jabs is taken as a defeat of their faith. Anything that comes with mandatory tone (Zimbabwean Government) as was the case with COVID-19 vaccinations where people got even arrested for not putting masks was considered as meant to mock God's power, the faith of Christians and had to be resisted. Why do Christians rush to link the vaccinations with the mark of the beast in the book of Revelation? Did they do their homework well enough in as far as the mark of the beast is concerned? But are Christians clear on the context of Revelation 13 in

their denial of the vaccinations equating it with the mark of the beast in Rev 13:16–17 or relating it to the book of Daniel?

Interpretation of Revelation

What is interesting is why and how did Evangelical and Pentecostal Christians find the Book of Revelation predicable about COVID-19 vaccines? Yet on other hand, apocalyptic writings are literatures of protests against oppression. In this case, they are literatures of inspiration against disease and protests against any forms of coercion to take vaccines despite one's religious beliefs. Apocalyptic writings were used as confrontation works of art to take on dictators or any dictatorial tendencies, to embolden the oppressed, for example, Christians standing up against the oppressor and fight for their rights, beliefs and practices. Oppressed people look forward to their total independence and oppression from all forms of evil. The Book of Revelation was written at a time when the Church was undergoing persecution. For GUTHRIE (1987), it is, however, debatable as to which Roman Emperor was persecuting the Church, Nero (60-65 CE), Vespasian (70-80 CE) or Domitian (late 90s CE). The New Testament books clearly show us, from the inception the Church has always been facing all forms of violence: direct violence-torture (the persecutions of Paul against the followers of Jesus, Acts 9:1ff); humiliation (as reported in the Johannine literature), bullying (Acts 7:54–60) from the Roman imperial authorities, for example, Christians being denied access to basic needs (symbolically where no one can buy or sell unless he has the mark in the name of the beast [Rev 13:16–17] or the number [Rev 13:18] of its name) (EHRMAN 1999:63).

The message of end times in several denominations in Zimbabwe must respect the context of the texts in Revelation and Daniel when relating to diseases. Believers seem to have scant knowledge about the context of Revelation and Daniel which is usually associated or related with the end of the world, especially the kingdoms that were prophesied in Daniel 2. The following is a response from Mrs Florence Muchizii (not her real name) in light of the end time message,

> You see my brother; this topic you are bringing is really new to me. We do not know these things. What we know is that there is a 666[1] mark but how

[1] The number "666" refers to Rev 13:18.

> Pastors and teachers of the word brought it up in relation to the vaccine is so confusing and breeds fear. Our pastors do not teach about this topic and when they touch on it; you easily lose sleep. It is also quite unfortunate that they spend a lot of time teaching about money, faith and other subjects leaving out this important topic and number which they always cite whenever there is a crisis or pandemic. Any call for vaccination is associated with the number 666 of the beast. It explains why we have this confusion about COVID-19 vaccination and mark[2] of the beast 666.

It can be deduced that believers are definitely in confusion in relation to COVID-19 vaccinations. It is either that, Pastors themselves are not aware of the topic or they are afraid of losing believers by opting to use the harvest of fear to keep people under the lock and key of their Churches' teachings that generate phobias. It seems the major fear of most Christians was shrouded in mystery and lack of information about COVID-19. Some writers would want to refer to the mark of the beast as related to artificial intelligence characterised by chips being inserted in peoples' bodies connected to their bank details typified as the mark of the beast. Already in some western countries, the chips were tested and have been found to be working (BROOKS 2018).

In as much as this was a good move to protect people from the pandemic by getting them jabbed, there was hesitance or resistance by the majority of the Evangelical/Pentecostal and Apostolic sects' Christians to accept the jab or vaccine which they associate with the mark of the beast as in Revelation 13:17. Most Evangelical/Pentecostal Christians take for a word what was said by prominent preachers against the COVID-19. According to Revelation 13:16, the mark of the beast is to be inserted on the right hand and the forehead which was not the case with COVID-19 where the jab is usually on the left hand and not the forehead. However, the situation was worsened by some companies that demanded vaccination cards for people to get their services. The scenario in Revelation depicts a picture of the devil and his agents forcing people to have the mark of the beast. To reinforce the hesitancy of Christians to take the vaccine was the lockdown that was put forward in the country. People spent more than six months without meeting for Church services. There were restrictions on the number of people who were allowed to attend funerals for the bereaved. Movement from place to place demanded vaccination cards. At the

[2] The "mark of the beast" is mentioned in Rev 13:16–17.

same time, some universities were requesting students to get the jabs so as to into exams rooms. Apart from vaccinations, the population was advised to buy sanitizers as a way of disinfecting hands and building structures. When vaccinations were introduced, the government of Zimbabwe had a target to reach the herd immunity. Unfortunately, the number of those who received the jabs was way below the required target. As we speak to date, the herd immunity has not been reached yet. Initially the vaccinations were meant for those who were above 18 years old. But with the passage of time Centers for Disease Control and Prevention (CDC 2020) introduced vaccines for secondary school going age children who were also included into the fold. Members from the Ministry of Health paid visit to schools and had learners vaccinated *en masse* against the COVID-19 disease. Several schools in different districts had their learners vaccinated at school premises. Unfortunately, social media militated against proper dissemination of information about COVID-19. Conspiracy theories took a toll and generated fear.

WhatsApp and the Harvesting of Fear as well as Acceptance of the Vaccine

The pandemic resulted in a number of strategies that were put in place by the government to contain the disease and which at the same time fed into the phobia theories against the vaccine. National lockdowns made it difficult for Christians to meet and hold services as they used to do. The alternative that was developed was the use of social or online media and in particular WhatsApp online Church services. Pastors and Church leaders would record their sermons and send to their members via WhatsApp groups created for that cause. It also became easy to spread the false gospel about the vaccine by mischievous people. A number of people had challenges accessing or attending such online services. Apart from that, the aged Christians were left out in the whole programme as most of them are not well versed with the technological advancement. It was mostly the young generation that benefited from such facilities and other members who could afford. The majority of the rural folk found it very difficult to have such access. One respondent Mr Gombuzhe Ruvanda Dambashoko (not his real name) argues that,

> The use of WhatsApp for Church services was quite effective during the lockdown period. We were able to be kept afloat as we were strengthened by the word of God. We took our time to pass the message to our elderly Christians through the created online Home Groups. We only had challenges of network as it is not reliable but costly this side. However, a number of our folks were left behind and lost a lot on any information to with COVID-19.

The cost of data bundles was out of reach for many Zimbabweans as most of them were informally employed or unemployed. Silumba & Chibango (2020) note that, the online services relate so well to one's economic and social situation. Some Christians were affected by the national levels of poverty to the extent that they could hardly afford a cell/mobile phone or computer or laptop for online Church services or fellowshipping or worshipping. In Zimbabwe, several ministries were required to show proof of COVID-19 vaccination at their workplaces for admittance. At the same time, the Ministry of Primary and Secondary Education teachers were given deadlines for members to be vaccinated so as to compel all citizens including school going children to be vaccinated. It should be said that in as much as this was a noble move to force members to be vaccinated, it violated Christian members' right to make their own decisions as they were afraid of losing their jobs. With the emphasis that was put on vaccination certificates and results associated thereof, it fed into the mark of the beast conspiracies in disguise. As a result, certain Evangelical/ Pentecostal leaders possibly used the "mark of the beast strategy" as disguise or protest against the vaccine. The other challenge is that, the government at first did not fully involve Churches in the dissemination of information about the vaccine. As a result, most people depended on social media to get information about COVID-19 and the vaccine.

With the passage of time, some Evangelical and Pentecostal Christians began to gradually accept the vaccine as it was the only alternative that would allow them the opportunity to come together again. Pentecostals began to call or plead with their members to be vaccinated against the COVID-19 disease. However, others such as Chang (2019) maintain that the vaccine have nothing to do with the mark of the beast. Research has shown that since time immemorial, whenever a vaccine was invented against any virus, theories on the mark of the beast from some Christian circles would resurface. It is very disturbing to see and hear renowned

pastors and men of the cloth discouraging people to be vaccinated by associating vaccines with the number of the beast 666 (Rev 13:18). This definitely points to misconception that is going around on the Christian circles. Probably, Pastors need to read further about the subject and give people the correct information about the symbolical numbers, colours and beasts enumerated in Revelation and Daniel. In as much as people rely on prayers for their healing, there is need for medical attention as thousands of people succumbed to the pandemic. Everyone in the world, including schools, businesses, companies and Churches need to come together and work as one people whenever there is a virus or disease such as COVID-19. Others thought the COVID-19 ushered or heralded the end time message about the coming of Christ. The Church has passed through various disturbing crises in the past centuries. Signs of the end times include wars, rumours of war, earthquakes, pestilence, famine and chaos, to say the least (Matthew 24:1-14). Verse 7 of the same chapter particularly mentions pestilences (plural) which some associated with the COVID-19 pandemic. Vaccination has no link at all to the mark of the beast in the book of Revelation. Other diseases or pestilences are yet to come in future as happened in the past centuries. These are just signs but it does not mean this is the end of the world, as no one knows except the Father God in Heaven (Matthew 24:36; Mark 13:32). However, taking vaccines against viruses isn't evil or anti-Christian. And COVID-19 vaccine is definitely not the mark of the beast, but is only a vaccine like any other developed in the past for polio, influenza, tetanus, hepatitis, rubella, measles and chicken pox, etc. Any development of vaccines must be understood and embraced positively against any diseases or viruses in future. In fact, Religions or Faiths must embrace science or any scientific discoveries if development in Africa is going to be realised.

Conclusion

Pandemics did not start with COVID-19. In history, we have experienced a number of pandemics that killed thousands as articulated above. Therefore, COVID-19 will pass. Going forward, both Christians and non-Christians should first of all seek relevant knowledge about pandemics before rushing to make conclusions about rejecting vaccines. The government and health officials must raise awareness programmes and workshops that are inclusive of Evangelical-Pentecostal and Apostolic Christian groups whenever there are pandemics.

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Francis Machingura & Cecil Samuel Kalizi

7 Coping with the challenge of COVID-19 pandemic: The Zimbabwean Religious Paradigm

Abstract

A synopsis of religion's response to COVID-19 and related interventions for the period 2019 to 2022 is necessary. This brings in the role that the Church played in fulfilling her missionary role. Religion plays a critical role in national health matters and this is true with regards to COVID-19 as well. The various religious groups involved included Christian Churches, and African Traditional Religious adherents. Religion's response to COVID-19 and remedies were on one hand positive and on the other, negative. There was an interface between political and religious leaders in trying to fight the COVID-19 pandemic. Religious utterances became popular as nations were hard hit by the effects of COVID-19.

Keywords: Religion, COVID-19 Pandemic, African Traditional Religion, Pentecostal and Evangelical Christians

Religion

It is imperative to understand the concept of religion and how it helps or hinders coping with the challenge of COVID-19 within the African context. Coming up with a comprehensive definition of religion is very difficult if not impossible as the attempt by many scholars has proven to be a futile exercise. Ellis & Haar in Kimemia (2016:120) define religion as "a belief in the existence of an invisible world, distinct but not separate from the invisible one, that is home to spiritual beings with effective powers over the material world." The definition is a pointer to diverse religious practices in Africa whether socially and religiously constructed or destructive, well accepted or denigrated. Religion includes such practices sometimes referred to as magic or superstition. Our focus is on Christianity and how the various Christian groups attempted to suppress and fight the COVID-19 disease. It is however important to note that the main religions

in Africa are Christianity, Islam and African Traditional Religion and this chapter draw examples from the three. ASAMOAH-GYADU (2021:158) identifies charismatic Pentecostalism, a form of Christianity that is prevalent in cities, in which prosperity gospel is preached and whose emphasis is the performance of miracles, as growing both numerically and in terms of visibility in Africa. UNICEF (2021) acknowledges the apostolic sects, falling under the domain of Independent or Indigenous African Churches because of their home-grown nature and close identity with African Traditional Religion, as flourishing in Africa. NYATHI (2021) highlights UNICEF's engagement of religious leaders across Islam, Christianity and African Traditional Religion about COVID-19. The insights of ASAMOAH-GYADU (2021:158), UNICEF (2021) and NYATHI (2021) on the religious context in Africa lay a foundation for the discussion of the extent to which religion helps or hinders coping with the challenge of COVID-19 in Africa. The interface between religion's beliefs, practices, rituals and national responses to COVID-19 is central to the discussion in this paper.

COVID-19 Pandemic and its Challenges to the Church

WHO (2022) describes COVID 19 or coronavirus disease as "an infectious disease caused by the SARS-CoV-2 virus". Most of the infected people will experience mild to moderate respiratory illness and recover without treatment. Some will however become seriously ill and require medical treatment. Older people and those suffering from underlying conditions like cardiovascular disease, diabetes, chronic respiratory disease or cancer are more likely to develop serious illness should they get infected with SARS-CoV-2 virus. The disease poses great risk to society because it is highly infectious.

HOBAIKA, MÖLLER & VÖLKEL (2022:6) describe the coronavirus disease as a systemic risk, which is very complex, not limited by any geographic boundaries and causes a looming threat to society's indispensable systems like telecommunication networks, transport, health care, education, provision of basic needs and other critical infrastructure. The World Health Organization declared COVID-19 a public health concern or a pandemic on 11 March 2020 (HUMBE 2022:72). The declaration was in response to the nature of the disease in order to facilitate every stakeholder's response. A pandemic is an epidemic that is experienced the world over

or over a very wide area across international boundaries and affecting many people at a given time and rightly so COVID-19 was declared a pandemic on 11 March 2020 because by then it had spread to 110 countries and areas (HUMBE 2022:7); HOBAIKA, MÖLLER & VÖLKEL (2022:3) observe that a simple handshake could lead to infection, suffering and death and face masks became a must to prevent transmission. Clinics and hospitals were overwhelmed by the huge numbers of people in need of treatment. As at 1 July 2021, according to Johns Hopkins University's coronavirus resource centre, almost four million people had died from COVID-19 while 182 million had been infected globally (HOBAIKA, MÖLLER & VÖLKEL 2022:4). The pandemic having been discovered in Wuhan, China, on 1 December 2019, spread at an alarming rate to bring about the impact stated above. This was due to globalization, a phenomenon that has resulted in an inhibited movement of people and goods throughout the world (PITYANA 2020:333). The challenge was that it was incumbent upon the public to prevent itself from infection by practicing hygienic standards which include washing of hands or use of hand sanitizers regularly, the wearing of face masks covering mouth and nose, abstaining from handshakes, hugs or kisses and maintenance of social distance. Even though Governments were responsible for educating the public, the effectiveness of the information would only be a reality if the public practiced what it was told. PITYANA (2020:335) observes that part of the impact of COVID-19 in Africa was felt through the travel restrictions, curfews, lockdowns, and closure of schools and places of entertainment, worship and sport. The new normal (referring to the restrictions) was not easy for the public as it among other effects impacted negatively on their income as they could not freely engage in their economic activities. According to PITYANA (2020:337) COVID-19 was both a public health crisis and a socio-economic disaster. Besides people dying in millions, the socio-economic and religious lives of the people got affected badly.

Religion was not spared by the imposed restrictions. It is not just the closure of places of worship, but restrictions to movement which resulted in the clergy failing to offer some of their pastoral services like visiting the sick or comforting the bereaved. Accordingly, weddings and funerals were not without restrictions. PITYANA (2020:336) raises very important concerns of the Church during the COVID-19 period, that is, 2020 to 2021. The concerns include issues of conscience around failure to attend Church, "the manner of being church, and the capacity of the Church to

worship and administer the sacraments." Churches being faced with the new normal under the COVID-19 pandemic season, felt they had been paralyzed and robed of their Church hood by failure to meet. Furthermore, they had been robbed of the opportunity to practice their Church rituals, like Holy Communion, from which they draw they identity. The Church's response was therefore mixed as some focused on empowering their members with relevant COVID-19 related information while others focused on spreading theological interpretations of COVID-19 in order to preserve the Church's extinction whilst others focused on the Biblical prophetic solutions to COVID-19.

Religion Helps or Hinders Coping with the Challenge of COVID-19 Pandemic

MANGEYA, JAKAZA & MHUTE (2021:367) perceive religion as an equally formidable force to any government in terms of influencing people's minds, attitudes and behaviours in response to COVID-19. The Church's (believers across the religious divide) influence is such that its adherents can either take seriously or resist government's measures to control the spread of COVID-19 or resist the same. Such is the premise behind the discussion of this chapter. Religion's response to COVID-19 between 2020 and 2021 in Africa demonstrated Africa's potential to either help or hinder coping with the challenge of the pandemic; a phenomenon which provides great lessons for future emergencies. CHITANDO (2022:247) reveals the complex and dynamic nature of the role and impact of religion in the face of any pandemic such as COVID-19. As such there is continuity between positivity and negativity in the responses, a position which warranties such descriptions as "positive while negative" (CHITANDO 2022:247). As a result, religion can either help or hinder any coping strategies with the challenge of COVID-19 pandemic.

CHITANDO (2022:248) claims that one of the areas of response to COVID-19 which probably has not received as much academic attention as it deserves is one of Indigenous Knowledge Systems (IKS) and African Traditional Religions (ATRs) as a result of the already struggling formal health delivery systems, particularly in Zimbabwe. ATRs greatly impacts on how African Christians behave or relate with the Bible. The place of

religions especially ATR got attention during the COVID-19. People resorted to IKS for herbal treatment, a development which saw massive peddling of information about useful herbs and home remedies in response to COVID-19. HUMBE (2022:78) quotes a health official who refused to be admitted in hospital for COVID-19 citing gross incapacities and claiming that it was rare for COVID-19 patients to come out of Zimbabwean hospitals alive. The official reportedly emphasized that Zimbabwean hospitals had become death traps. Even Church leaders (mostly from mainline Churches) also encouraged their members to use traditional herbs, western medicine and strategies to fight the COVID-19 virus. Most people Christians were suspicious of western medicine. Claims by health officials as cited above and other theories (vaccine or western medicine was meant to exterminate Africans) which were peddled on social media platforms strengthened Zimbabweans across the religio-social and cultural and political divide resolved to use herbs and home remedies whenever they were unwell instead of going to formal health delivery institutions. While the medical experts denied the effectiveness of such remedies in treating COVID-19, the general public found them as viable alternatives because of the crisis.

According to HUMBE (2022:81), traditional healers in Zimbabwe claimed that *zumbani* (Lippia javanica), *Mufandichimuka* (Myrothamnus flabellifolius), *Chifumuro* (Dicoma anomala), *Rimiremombe* (Sonchus oleraseus) were effective in managing COVID-19. HUMBE (2022:81) also observes that the majority of Zimbabweans in both urban and rural areas were using herbs and home remedies like *kufukira* (steaming) to manage COVID-19. The stampede for traditional herbs that used to be shunned by Pentecostal and Evangelical Christians as demonic or satanic changed due to social media platforms which had become consultation spaces for survival. Zimbabweans across the Christian divide started planting traditional herbs in their homes; something that was shocking and unheard of particularly Pentecostal or Evangelical Christians let alone African Independent Churches' followers who shun both western medicine and traditional herbs as a sign of total commitment or trust in Christ. Any use of of herbs or western medicine is interpreted as apstacy or lack of faith in God and understanding of God. Apart from treatment, ATR expressed itself by affirming the existence of *Mwari* (Shona Supreme God), *Musikavanhu* (creator of people), *Samasimba* (the Omnipotent one) and *vadzimu* (ancestral spirits) in response to COVID-19, vowing that there

was always a way out (HUMBE 2022:80) hence pragmatic solutions for every challenge. The sacred practitioners interviewed by HUMBE (2022:80) perceived the COVID-19 related suffering through aphorisms such as *vadzimutiringe* (ancestors take care of us), *vadzimu vatirasa* (ancestors have forsaken us), and *vadzimu vadambura mbereko* (ancestral spirits have broken their back sling). The aphorisms were both prayers for help and lamentations and a common way of responding to disaster in ATR.

CHITANDO (2022:249) notes how religion (Christianity and ATR in particular) collaborated with public health and political authorities in spreading relevant messages about COVID-19 and encouraging people to oblige. A good example of such a development is the case of Tanzania where the late former President, John Magufuli, accepted all the WHO recommended guidelines for controlling the spreading of COVID-19 except lockdowns and closure of business (CHITANDO 2022:249). WAGANA (2022:116-117) outlines the measures taken by Tanzania in response to COVID-19 and describes them as friendly in comparison to those of the other Eastern African countries. He further reports that apart from the strong campaign against COVID-19, Tanzania promoted the use of traditional herbs like lemon, ginger, chili pepper, neem tree leaves and such substances as honey. Some of the herbs were boiled and mixed with honey to make syrup which one would drink. Sometimes patients would get steamed using the same substances. WAGANA (2022:117) claims that it is the friendly approach to COVID-19 by Tanzania that allowed religion "precedence and soft entry into the COVID-19 programme" such that religious leaders remained motivated to continue offering prayers for the healing of Tanzania from COVID-19. WAGANA (2022:120) appreciates the full involvement of religious leaders and their institutions as major players in the implementation of the Tanzanian ministry of health issued COVID-19 standard guidelines. It is interesting that religious leaders were actually listed by the Tanzanian health ministry's guidelines for COVID-19 as crucial palliative care providers (WAGANA 2022: 120). This demonstrates the seriousness with which Tanzania perceived religion and how it can be helpful in a nation's response to an emergency. Religion however was still as influential in African nations where it was not accorded the same recognition as in Tanzania.

Religion is often perceived as rigid but CHITANDO (2022:250) underscores the fact that the participation of religion in a systematic working

relationship with public health officials and politicians in the COVID-19 national response mechanisms in Africa, demonstrates "the flexibility, adaptability, and rationality of religion in the face of COVID-19." The above is demonstrated by, for example, the shift from sit in to virtual meetings by different religious groups, even though Pentecostal churches had an edge over other religious groups on this aspect as they were already using digital platforms before COVID-19. NYAWO (2022:143) stresses that irrespective of the different religious understandings of the COVID-19 pandemic, they can be coping mechanisms in light of the stressful circumstances involved. No matter how negative religion's response to COVID-19 may sound, it may be a way of coping. Indeed, there is need for not just religion but the entire society to have coping mechanisms in every crisis. PITYANA (2020) argues that the COVID-19 global situation demanded that religion focuses on the human condition with a view of the deity becoming a reality in a messy world. Religion therefore had to be flexible, adaptable and rational in order to save human lives while continuing to offer services to adherents. Religion had to be relevant in its provision of palliative care and comfort for the bereaved and suffering without risking the lives of the clergy and the needy. Such shift in practice went a long way in strengthening national responses to COVID-19 in Africa.

In several other ways religion hinders coping with COVID-19. The hindrances are mainly due to perceptions and responses to COVID-19. Religion tends to interpret phenomena in tandem with its worldviews and NYAWO (2022:143-146) explores three ways in which the Christian leaders of Eswatini perceived COVID-19. They perceived it as God's punishment for sin, spiritual warfare and fulfilment of end time prophecies. NYAWO (2022:143-144) reports how the government of Eswatini declared a national fast and a day of prayer in which the theme was 'God heal our land'. NYAWO (2022:144) interprets the call for prayer and messages preached by the Christian leaders on the day of prayer to be based on the religious premise that COVID-19 was God's punishment for sin. The interpretation raises a lot of questions. The COVID-19 pandemic is a global phenomenon and yet the people of Eswatini were at home with the interpretation that it was God's punishment for their sin. How are the two reconcilable? The only sensible explanation would arise from the African theologians' theory that the "traditional worldview is irreplaceable, despite having interacted with other worldviews" (NYAWO 2022:148). Traditional worldview

refers to the religion relating to one's indigenous culture and for Africans that is ATR. Turner in NYAWO (2022:148) describes traditional religions in the following words:

> The most basic or fundamental religious forms in the overall religious history of (hu)mankind and that they have preceded and contributed to the other great religious systems…thus they are both primary and prior; they represent a common religious heritage of humanity.

The perception of COVID-19 by the Eswatini government and Christian leaders was therefore influenced by ATR as the traditional worldview even though it was expressed in Christian terms. This thought is buttressed by Sawyer in NYAWO (2022:150) who alleges that ATR perceives sin in the context of community life as opposed to individualism. As a result, it is common for African sacred practitioners to lead their communities to rituals for the purpose of cleansing the land of the effects of sin.

The perception of COVID-19 as God's punishment for sin had serious implications and is bound to hinder coping with the pandemic by creating a sense of hopelessness where people would just pray and wait for God's intervention without taking requisite precautions. The attitude towards COVID-19 by most evangelical or Pentecostal leaders and some Christians is very disturbing and retrogressive. It is a perception that may cause people to wait for their fate without taking practical steps to prevent themselves from infection. It is also a perception that would lead people to defy government's restriction to movement and gatherings with the view that their salvation from COVID-19 is in prayer alone. Such is the attitude demonstrated by some Muslims in South Africa who according to VAHED (2021:2) defied government ban on gatherings and movement by continuing to hold prayers in mosques. VAHED (2021:2) further reports that, after the same Muslims were arrested for breaking the law, they took the government to court challenging the ban on religious gatherings. In Zimbabwe, some Pentecostal and African Independent Churches defied government bans on public gatherings that affected Churches.

Conspiracy theories became the order of the day in some religious circles that the COVID-19 virus was for the rich/ elite people or the virus for white people because of God's anger against them for their sins against God and humanity since time immemorial. While respective African governments were announcing restrictions for the sake of prevent-

ing the spread of COVID-19, some religious people perceived the restrictions as violation of religious activity. This means in some religious sections, rationality around COVID-19 was limited.

Secondly, CHITANDO (2022:251) cites cultural conservatism, resistance to science and COVID-19 prevention strategies as a way of religion hindering coping mechanisms against COVID-19. ASAMOAH-GYADU (2021) analyses some of the Ghanaian Pentecostal charismatic leaders' perception of SARS-CoV-2 virus and the kind of message it communicated to the nation. The perception is painted through the utterances and gestures of Church leaders. ASAMOAH-GYADU (2021:1) reveals the change of meaning of the acronym by some preachers as circulated on WhatsApp to "Christ Overcomes Viruses and Diseases." While the reinterpretation of the acronym above may have been done in good faith, it may give false hope to adherents and cause them to neglect health experts' prescribed day to day precautions, like the use of face masks to prevent the spreading of COVID-19. In the words of Archbishop Duncan-Williams in ASAMOAH-GYADU (2021:4),

> The Coronavirus is a name, a person without body and in the name of Jesus, as we bow our knee and we pray, this plague, pestilence and virus will bow the knee and stand down and go back to where it came from; we find an inclination to the perception of coronavirus as a spirit which can be cast out through prayer.

While prayer is good, the fear is that such prayers may lead adherents to neglect practical preventative mechanisms in the trust that the "spirit of coronavirus" as suggested in Archbishop Duncan-Williams' prayer is cast out. One is convinced it is in support of the above thoughts that MANGEYA, JAKAZA & MHUTE (2021:370) asserts that religion determines how far adherents go to either take risks or exercise caution in matters relating to health or other equally critical matters in life. Prophet Emmanuel Makandiwa of the United International Family Church (UFIC) in MANGEYA, JAKAZA & MHUTE (2021:373) in his emphasis on prayer as the only solution for COVID-19, said the following to his congregation,

> You will not die, because the son is involved in what we are doing... [It is] the freedom that no medication can offer.

Makandiwa publicly condemned the COVID-19 vaccine only to retract his condemnation after some behind the scene engagement with the govern-

ment resonated with what some of the Zimbabwean clergy (mostly Evangelical/Pentecostal and apostolic sects) claimed to be reason behind the COVID-19 virus.[1] Some associated the virus with God's anger towards the high levels of sin or disobedience to God; some even talked about the growing number of homosexuals and lesbians as an invitation of God's wrath in Zimbabwe; some linked the virus to the spilt human blood during Zimbabwe elections and some even talked about than embracing foreign religions if people were going to be spared from the disease and deaths. Makandiwa's position aligns to a category of KIRBY in MANGEYA, JAKAZA & MHUTE's (2021:373) description of Pentecostal charismatic churches which perceived COVID-19 as a spiritual force of evil as opposed to a biomedical disease. Interestingly members and leaders from his Church succumbed to the disease. Critics argue that, religious leaders (Church) are selfish and heartless when it comes to how they use their personal beliefs to become institutional yet risking the lives of people. It is the followers that get risked in public spheres yet they as celebrity pastors are never found staying or interacting in areas where the majority of people are found such as in buses, supermarkets and public schools.

MANGEYA, JAKAZA & MHUTE (2021:376-387) analyse a series of religious messages circulating on social media platforms with the aim of allaying the panic and fear that gripped people during the peak of COVID-19. MANGEYA, JAKAZA & MHUTE (2021:388) believe that the messages created a "discourse of Christian exceptionalism" which effectively gave assurance to Christian believers that they would never be affected by COVID-19. They were messages of hope, like, we should not fear because greater is the one in us than the one in the world; messages founded on the belief that Christians are God's chosen, like, the blood of Jesus in Christians does not get infected with COVID-19; messages which suggest that earthly solutions will not work, a position which tends to under rate health precautions. Messages based on the belief that Christian believers are humans who have been transformed into celestial beings and therefore cannot be affected by COVID-19 (MANGEYA, JAKAZA & MHUTE, 2021:376-387). Believers cited biblical texts that portrayed the COVID-19 virus as one of the demons that needed to be exorcised and Christians were portrayed as victors because of Christ (Revelation 21:4, James

[1] Cf. videos like *www.youtube.com/watch?v=EzWgyD5Nzkg, www.youtube.com/watch?v=Z52OCuo2M0E*, and *www.youtube.com/watch?v=8dpvUQGK-P8*.

5:14-16, 1 Peter 2:24; Matthew 4:23; Matthew 9:35; Luke 6:17-19). All the messages above may have one negative effect or the other on the believers' attitude on COVID-19. All the effects are linked to the tendency to underrate the effect of COVID-19 while portraying the attitude of an invincible nature that is inconsistent with human nature. Furthermore, the attitude promotes recklessness in terms of neglect of the COVID-19 practical preventative measures among Christian believers exposed to such teachings.

Conclusion

The foregoing discussion clearly shows that, religion either helps or hinders strategies coping with the challenges of COVID-19. Religious leaders have a lot of influence on its adherents and the influence is an asset if used positively in national responses to pandemics, like, COVID-19 and other emergencies. However, religion especially Christianity being diverse and complex, it is hardly possible for the entire religious sector to be positive in its response to COVID-19. Furthermore, it is hardly possible for each specific religious Christian grouping to be totally positive in its response to COVID-19. As such the picture of Christian religious response to COVID-19 is a mixture of positive and negative. This calls for a very serious awareness campaign about pandemics among religious groups (especially Pentecostals or apostolic Christian groups), if we are going to ride on religious influence to manage pandemics in Africa. Apart from religion having a huge following in Africa, it has a voice which cuts across the political polarization and therefore it is a major stakeholder that should never be ignored in addressing societal issues.

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8 *Johane Masowe WeChishanu* and United Methodist Church Perceptions to COVID-19 Compliance Strategies

Abstract

While cyclone 'Adai' reconfigured the geographical landscape in a number of Southern African countries, COVID-19 transformed the social, cultural, technological, economic and political terrain world-wide. COVID-19 menace and need for its control, management and containment is well acknowledged globally. Millions have so far succumbed to COVID-19 worldwide. Even the most stubborn communities that always shut their doors against traditional, cultural and religious change seem to be giving in now. World governments responded swiftly and called for multi-stakeholder involvement as COVID-19 scare grip intensified. The COVID-19 culture vocabulary of office out of office, work from home, masking up, social and physical distancing, sanitisation and no movement unless unavoidable emerged and gained prominence. To make matters worse, there were reports of a variety of variants that were not necessarily COVID-19 but COVID-21 especially in African countries and causalities continued to be on the rise. It is against this backdrop that this chapter seeks to uncover comparative perceptions to COVID-19 compliance response strategies by the *Johane Masowe WeChishanu* and United Methodist Churches in Mount Pleasant, Harare. A largely qualitative research approach based on the two cases is used in contacting a mini survey and an in-depth understanding of the resilience strategies adopted by the purposively selected two religious' groups.

***Keywords*:** COVID-19, COVID-19 culture, resilience

Introduction

The chapter is an attempt on reimagining worshipping practices and procedures in the Zimbabwean religious discourse in light of COVID-19 pandemic. It is undoubtedly true that COVID-19 pandemic impacted on the

religious terrain. It transformed the worshipping practices and procedures. While the country had already been geared in the digitisation and had already entered the 4th Industrial revolution, some of the religious groups were yet to fully embrace it. The religious worshipping practices and procedures were still largely convened on a face-to-face basis of interaction in most religious sects. Religion has been a traditional social and cultural system that took care of the masses' physical, psychosocial and spiritual wellbeing. The gatherings provided the congregants with counselling platforms and support systems in times of crises and a general sense of belonging to its members. Churches have generally substituted our traditional and cultural extended family support systems to holistically address human needs. The economic depression in Zimbabwe had pulled people into worshipping that Churches were having overflows. Now it is COVID-19 health guidelines that are pushing the congregants out of churches again. Thus, the chapter sets to explore on how the congregants of the *Johane Masowe WeChishanu* and United Methodist in Mount Pleasant perceived COVID-19 compliance strategies implemented by their leadership and government of Zimbabwe.

Zimbabwe and COVID-19

Zimbabwe's population roughly 85% is membership to either of the Christian religious groups found in Zimbabwe. So, it is through the religious avenue that Zimbabwe may either win or lose the control, management and containment of COVID-19 war. Religion is one of the key variables that need communities to watch out on in terms of its relationship with education, health and wellbeing. However, religion, by virtue of being faith and belief based, tends to be in most cases at loggerheads with science education and biomedical health positions. Religion has come under scholarly scrutiny for its kind of gatekeeping tendencies to biomedical intervention in control, management and containment of epidemics. In Zimbabwe there are religious groups that have their congregants under key and lock to the extent that their health and wellbeing depend on the structurally designed church units. Any biomedical consultation is considered as lack of faith in the ever present and perceived divine healing.

Scholars have different perceptions on the role of Religion in communities' health and well-being globally. It's a paradox of both negative and

positive sentiments as was gathered from the previous works reviewed in this chapter. WHO (2019) explores the role of religion in Communities' health and well-being by designing an assessment tool that provides practical guidance and recommendations to support the special role of religious leaders. Faith based organisations and faith communities play a pivotal role in COVID-19 education preparedness and response. Religious leaders play a major role in saving lives and reducing illnesses related to COVID-19; since they are the primary source of support, comfort, guidance and direct health care and social service for the communities they serve. Religious leaders who are capacitated well provide information that protects their own members and the wider community. Their personal views whether bad or right are more likely to be accepted than views from medical personnel. Religious leaders provide pastoral and spiritual support that is meant to give reassurance, reduce fear and stigma in communities during public health crisis.

SEIFMAN & FORTHOME (2020) noted with concern the negative role played by religion in COVID-19 prevention. They warned that, while scientists work flat out on designing a safe and effective vaccine and therapeutic drugs whereas manufacturers deal with production and distribution strategies; religion can either help or hinder the achievement of prevention goals through their religious beliefs. Vaccine hesitancy is a world problem that is to some extent linked to religion. A major global vaccine hesitancy survey was conducted by a non-profit making United Kingdom Health Research Board in 2018 implicated religion. The survey covered 140 000 participants from 140 countries in which religion had the greatest vaccine hesitancy. The study reported pockets of vaccine doubt (SEIFMAN & FORTHOME, 2020).

Religion provides communities with the ability to cope with the disease, recovery after hospitalisation and a positive attitude in a difficult situation, including health. The pronouncements also are likely to be considered more by congregants and are likely to reduce the likelihood of prevention as was the case with the use of condoms that was considered a sin despite scientists' insistence that they were crucial in preventing HIV/AIDS transmission (SEIFMAN & FORTHOME, 2020). According to these scholars,

> Today there are estimated 42 000 religions globally with others welcoming and others conflicted but supportive while others are resisting on or

> more of the basic scientific and policy prevention pillars which are vaccination, social distancing, limiting crowd size and wearing masks in public. (Seifman & Forthome, 2020)

Thus, to Seifman & Forthome (2020) there are differences in attitude within and between religions which does not warrant a one size fits all kind of guide to the religious groups.

On another note, a summer survey done in America said COVID-19 strengthened religious faith, tightened family bonds among American citizens (Kowalezyk, Roszkwski, Montane, Pawliszak, Tylkowski & Bajek, 2020). People fall back for family, church, friends and co-workers for support and other social networkers in the case of a crisis. In the study about Religion and faith perceptions in a pandemic of COVID-19, Kowalezyk, Roszkwski, Montane, Pawliszak, Tylkowski, & Bajek (2020), revealed that gatherings restrictions to contain the spread of COVID-19 affected complexion of most religions. Another survey revealed that the power of spirituality when death toll rises in the case of the coronavirus pandemic. The Polish Deputy Minister adds that, "Churches are like hospitals for souls. But, is what is good for the soul always good for the body?" Despite the challenges of COVID-19, congregants still longed for the face-to-face gatherings and religious rituals.

There was resistance by apostolic or white garment Church leaders and members to adhere to COVID-19 health guidelines that were noted as congregants resisted social distancing, masking up, and vaccination hesitancy. Some claim that masking up is ineffective and unnecessary as long as one has faith and courage that provides unseen and therefore miraculous protection. They also claim that masking up is bowing to state and limit the divine protection of God. Thus, religions are either following or ignoring the COVID-19 health guidelines. Social Reconstruction theory is a comprehensive description and illustration of how and why a desired change is expected to happen in a particular context. It is a tool of helping identifying the links between a desired change and the sequence that will make it happen. In the preface, George F. McLean in Wamala, Byanihanga, Dalfovo, Kigongo, Mwanahewa & Tusabe (1999) notes that social reconstruction is perhaps the most typical challenge of the present age. The present situation is therefore one in which the people of the world can and must take up creative responsibility for their lives in pre-

sent and in future. There is a shift of paradigms from focusing to government to focusing on people like avoiding power descending from state to that ascending from grassroots often termed as civil society. The 21st century carries both positives and negatives like natural disasters, political, social and economic uncertainties. This demands that participants become active and not passive observers in casting the religious frame of their own that is life-saving.

We utilised a largely qualitative research approach so as to uncover comparative perceptions to COVID-19 compliance response strategies by the *Johane Masowe WeChishanu* and United Methodist Churches in Mount Pleasant, Harare. The chapter's research design is qualitative, which is influenced by CAMERON's (1963:13) view that 'Not everything that is counted counts, and not everything that counts can be counted.' Thus, though there is numerical represented data, the final emphasis is not quantity based but the quality of worshipping practices, procedures and lived standards. We tried to establish whether the denominational sects are coming head-on or retreating against COVID-19 in a bid to survive in the COVID-19 toxic environment. This is in line with MORGAN & SKLAR's (2012:73) observation that, "proponents of interpretivism argue that human experience can only be understood from the viewpoint of the people themselves." Thus, reality is relative and socially constructed and even context specific. A largely qualitative research approach based on the two purposively selected religious cases is used in contacting a survey and an in-depth understanding of the congregants' perceptions of resilience strategies adopted by the purposively selected two religious' groups. So, it is based on case study, which is "...an intensive, in-depth study of a specific individual, context or situation." (MURRAY & BEGLAR, 2009:48) "...unit of analysis which guides decision on what is to be studied (MAREE, 2007:75) and studies the phenomenon in-situ. The major question remains on how the congregants perceive the COVID-19 health guidelines compliance strategies. There were 45 participants from *Johane Masowe WeChishanu* and United Methodist church from whom a survey questionnaire is administered to 45 participants; 30 participants from a homogenous multiple case study of United Methodist Church (composed of 20 females and 10 males and 15 *Johane Masowe WeChishanu* who are 10 females and 5 males). All the participants were 16 years and above. The study purposively picked up those two cases basing on PUNCH's (1999:162) warning that, "we cannot study everyone, everywhere doing

everything," as the scope maybe too wide for the kind of an in-depth that the study intends to achieve. The participants were reminded not to include any form of identity on the questionnaires for ethical reasons. The mini survey is triangulated with zoom meeting interviews with 5 key informants from each of the religious denominations for an in-depth understanding of their perception of the COVID-19 health guidelines compliance strategies.

Since the data excerpts collected were in ChiShona and the medium of communication for the research study is in English, the research had to adopt literary translation theory to render ChiShona excerpts from ChiShona source language to English target language. Translation is an operation performed on languages, which is a process of substituting a text from one language for a text in another language" (CARTFORD, 1965:1). This is based on the view that "... everything said in one language can be expressed in another on condition that the two languages belong to cultures that have reached a comparative degree of development" (NEWMARK, 1988:6). According to HELDNER (2008:10) "while it seems reasonable to assume a single model applicable to any kind of text would be totally adequate, it should be obvious to anyone that even differences between prose and poetry are important enough to call for more specific models." So, there is a degree of equivalence between the original ChiShona and translated English versions but not that they are the same as sameness in Mathematics. This is unavoidable as confirmed by BOUSHABA (1988:21) that "equivalence in translation cannot be defined in terms of sameness and synonymous but rather creative transposition of the original version." We think translating will go a long way in simplifying things for our readers.

Presentation of Findings

This sub-section now presents, discusses analyses and interprets the data on how the congregants perceive the COVID-19 compliance response strategies by the *Johane Masowe WeChishanu* and United Methodist Churches in Mount Pleasant, Harare. The presentation is covered in the five basic themes that are: Congregants' conception of COVID-19 by the religious groups; COVID-19 health guidelines that congregants are fol-

lowing, religious groups' recommended health guidelines and perceptions of the congregants' recommended guidelines. 45 respondents responded to the questionnaires and there was 100% turn up. All respondents admitted that they have heard and know about COVID-19 pandemicas a killer disease. Though they generally have haze knowledge about its causes and who are likely to get infected by COVID-19; they really know the signs, symptoms and COVID-19 health guidelines for the prevention and containment of the infection from one person to another. On who is likely to get infected, more than half of *Johane Masowe WeChishanu* blamed the victim for lack of faith and being too afraid of the COVID-19 virus unlike the United Methodist participants who just feel that anyone can contract the virus. The views raised are related to what came out through the in-depth interviews given in the five thematic groups below.

Johane Masowe WeChishanu and United Methodist Churches' Congregants' Conception of COVID-19

Upon asked on their understanding of COVID-19, the congregants brought mixed views:

a) Johane Masowe WeChishanu participants Responses:

1) COVID-19 *chirwere chemafemo chinoita munhu atambure kufema*. (COVID-19 is a respiratory condition that causes difficulty in breathing);
2) COVID-19 *chirwere chechikosoro*. (COVID-19 is a condition that induces cough);
3) COVID-19 *chirwere chinobata vanhu vane zvimwe zvirwere*. (COVID-19 is an opportunistic condition that usually infects people with other underlying conditions);
4) COVID-19 *chirwere chemabayo chinouraya munguva pfupi*. (COVID-19 is a condition that usually kills in a short space of time);
5) COVID-19 *iflu inokonzera mabayo*. (COVID-19 is a type of influenza that causes pneumonia);
6) *Vanhu vane zvimwewo zvirwere nechakare*. (Those people that have other underlying health conditions);
7) *Vasinganatsi kuzvipira pakutenda*. (Those that have less faith);

8) *Chirwere chinobata kunyanya vanhu vechikuru vane mamwe makondisheni*. (Usually infects the aged and especially with other underlying conditions);
9) *Dzimwe nguva madhimoni anopa zviratidzo zve* COVID-19 *anodherera vanhu vanotya*. (In other cases, they are demons that displays COVID-19 signs and symptoms and captalises on those who fear it);
10) *Chirwere chinoda kutodzana neflu asi chichiuraya chinonyanya kubata vanogara munzvimbo dzakamanikidzana kunyanya mumadhorobha*. (It is disease that has influenza-like symptoms but it causes death and especially infects that live in congested areas especially in urban areas).

b) United Methodist Participants' Responses:

1) *Takadzidziswa kuti chirwere chinofamba mumhepo*. (We were taught that it is an airborne disease);
2) *Vanhu vanotambidzana chirwere nokufemerana, kuhotsira kana kukosorerana*. (People infect each other through breathing, sneezing and coughing);
3) *Chirwere chinorarama pasimbi, papurasitiki kana paneimwe midziyo kwenguva yakati zvinoita munhu akabata anobva atora utachiwana hwacho*. (The virus survives on surfaces; metals, plastics or any other utensils for some time which when another person gets in contact with contaminated surfaces will be infected with the virus);
4) *Chirwere chinodherera vaya vane zvimwe zvirwere zvinoderedza simba remasoja omuviri*. (It is opportunistic disease that usually affects those that have other underlying health conditions that compromises their immunity);
5) *Samamwe maflu ose chinogona kukonzerwa nekudya, kudya kusingavake muviri uye kutonhorwa*. (Like other influenzas, it is caused by malnutrition through taking the unbalanced diet or subjecting our bodies to the cold weather);
6) *Ichi chirwere chinogona kubata chero munhu anenge asvika pane hutachiwana hwacho hwe* COVID-19. (It is a didease that can infect anyone who will have gotten in contact with the COVID-19 virus);
7) *Chinobata chero munhu asi chinogona kukonzera kurwara zvakanyanya kana kukonzera rufu kune vechikuru kana vaya vanenge vaine dzimwe kondisheni*. (It infects anyone but can cause serious illness or even

death especially to the aged or those that have other underlying health conditions);

8) *Vangava panjodzi huru ndevaya vasingatevedze mitemo yokugara mudzimba kana pasina chakakosha chokufambira, kupfeka masiki, kugedza maoko nekusanitaiza nguva dzose nokukoshesa kutaramukirana zvemita kana kupfuura*. (The people who are at high risk are those that defy the regulations like staying at home when there is nothing compelling them to go out, that do not out on masks, wash hands with soapy water nor sanitise frequently and maintain physical distancing that is a metre and above);

9) *Chero dzimwe nguva vanogara muzvivakwa kana munzvimbo dzakamanikidzana zvekuti vanofemerana, kukosorerana, kuhotsirirana nokugunzvana kana kumhoresana vachibatana maoko vanozviisa panjodzi huru kwazvo*. (Sometimes people live in squashed areas that their breathing, cough, sneezing reaches the next person and getting into physical contact or hand shacking put themselves at high risk);

10) *Vanhu vaye vanoshandira nokugara munzvimbo dzoruzhinji vanogona kubatira nyore sezvo huchigona kubatwa chero nekubata pabatwa nomunhu ane hutachiwana chero iye asati oratidza kurwara*. (Those people who work or stay in public places may contract the infection since the virus can be contracted even through getting into contact with a surface that an infected person has been in contact with even before the person is showing the signs and symptoms).

The *Johane Masowe WeChishanu* and United Methodist participants showed some knowledge about COVID-19; while those from United Methodist Church had programmes whilst those from *Johane Masowe WeChishanu* made no reference to church. From the excerpts above, there are diverse views on who is most likely to contract COVID-19 disease. While the *Johane Masowe WeChishanu* congregants blame the victim and are likely to stigmatise the victims for having sinned against God, the United Methodists feel anyone can contract COVID-19 and are likely to be supportive and sensitive to the victims. The view that religious leadership provide pastoral and spiritual support and reassurance prevent and reduce fear, stigma to communities during public health emergences does come out from the *Johane Masowe WeChishanu*. Above all, how they promote health saving practices (WHO, 2019) contradicts what is coming out from the excerpts above. In other words, there is neither evidence nor countering misinformation nor efforts in reducing and averting fear or

stigma among the congregants. In the excerpts above contrary to WHO (2019) that says, religious leaderships counter misinformation and discourage non-essential gatherings; in this case, it is the opposite as religious leaders can be a source of misinformation or fear. This provides more evidence on the need to empower leadership to foster a life-saving attitude that avoids blaming the victim in cases of crises.

COVID-19 Health Guidelines that Congregants are Following at their Homes

Responses were given on the COVID-19 preventive guidelines that the congregants as follows:

a) Johane Masowe WeChishanu participants' Responses:

1) *Tinofukira nokugeza maoko nesipo nguva dzose, tinopfeka mamasiki asi vamwe vanouya vasina kuchechi vonzi next time ngavauye vakapfeka asi vamwe vanoisa pachirebvu, vamwe pamuromo vasina kuvhara mhuno. Vanodzidziswa asi havateereri.* (We steam and frequently wash hands with soapy water, we mask up, but others come to church unmasked and they are reminded to come masked up the following week, some wrongly wear masks as they drop it to the chin, some cover simply the mouth and leave out the nose. They are taught but they just do not follow instructions);
2) *Tinochengetedza vana kuti vasangofambafamba, tinobika tii yezumbani tichinwa nemhuri dzedu.* (We care for our children so that they do not roam around, we prepare *zumbani* tea and have it with our families);
3) *Tinotobata minamato kuti mhuri dzichengetedzwe kubva ku*COVID-19. (We schedule prayer sessions so that our families are shielded from the COVID-19 pandemic);
4) *Tinopa mhuri kudya kunovaka muviri kwakafanana nebhinzi, maveji nemukaka nguva dzose nokupfeka zvinodziya. Uyewo hameno kuti kune vamwe here vakabaiwa nhomba ye*COVID-19 *iyoyo.* (We provide our families with nutritious foods like beans, vegetables and milk and put on warm clothes. Also, I am unsure if there are others who have been vaccinated for COVID-19);

5) *Isusu hatingofambifambi nokushanyira dzingave hama kana shamwari pasina zvikonzero zvakasimba.* (Ourselves, we do not just pay visits even to our relatives and friends unless there is a compelling reason to).

b) United Methodist Participants' Responses:

1) *Tinogeza maoko nokushandisa sanitaiza nguva dzose.* (We frequently wash our hands and sanitise all times);
2) *Hatifambi kunze kana paine zvakakosha zvatinofambira kana tafamba tinopfeka mamasiki nemazvo, kana kuchechi chaiko tinoita pazoom.* (We do not travel unless there is something compelling us to, if we happen to, we correctly mask up, even church service we remotely contact Sunday services through zoom platforms);
3) *Hatishanyirani nehama dzedu asi tinosangana patekinoloji kana tasangana tinogeza maoko, kusanitaiza, kupfeka masiki nokutaramuka zvemita kana kudarika.* (We do not physically visit our relatives, we meet electronically, if it happens that we meet, we wash our hands, sanitise, mask up and maintain a distance of a metre or above);
4) *Takabaiwa nhomba ye*COVID-19 *kokutanga tichazoendazve kepiri. Taitokurudzirwa nehutungamiriri kuchechi kuti tibaiwe zvibatsiridze kudzivirira chirwere ichi.* (We have been vaccinated for COVID-19 the first dose we will go again for the second dose. We were encouraged by church leadership to be vaccinated to help in controlling the epidemic);
5) *Kana paine ane zviratidzo zve*COVID-19 *tinomhanyira kunotesitiwa nekuzvipatsanura kubva paruzhinji.* (If there are those displaying signs and symptoms of COVID-19 we have to immediately have them tested and self-quarantine).

Basically, though the two groups of participants are aware of the COVID-19 health guidelines, there is a striking difference between the two groups, for example, the *Johane Masowe WeChishanu* are not giving any reference to biomedical approach because of their radical religious beliefs yet the United Methodist participants showed an appreciation of biomedical interventions. The influence of religion on health and well-being is felt in the excerpts. The power religion has can be finely spread in other area of managing, controlling and containment of COVID-19 effectively if religious leaders make pronouncement especially in thwarting vaccine hesitancy, and dealing with stigmatisation. This is so since *Johane*

Masowe WeChishanu religious denominational leadership is mum about vaccination, stigmatisation and reluctant about masking up. This undoubtedly confirms that these religious leaders can help to contain the spread of COVID-19 if they are properly educated or if they were made to appreciate the importance of vaccination or medical or spiritual interventions during any health crisis.

Role of Religion in Management, Controlling and Containment of COVID-19 in Communities

Participants were asked on the roles of the religious group leaders in the management, controlling and containment of COVID-19, the congregants again came with mixed views as indicated below:

a) Johane Masowe WeChishanu participants' Responses:

1) *Kudzidzisa chechi nzira dzokuzvidzivirira kubva ku*COVID-19 *nemamwe matenda angakanganisa vatendi*. (To educate congregants measures to prevent themselves from contracting COVID-19 and other diseases that may disturb their members);
2) *Kukurudzira nekuongorora nhengo dzechechi kana dzichitevedza mitemo yekuzvidzivirira yakatarwa nevezveutano*. (To encourage and assess on whether the congregants are abiding by the set health guidelines);
3) *Kutungamira nhengo mukubata miteuro yokudzinga mamhepo anokonzera* COVID-19. (To lead congregants into following processes and procedures of scheduled prayer sessions to chase away evil spirits that cause COVID-19 infections);
4) *Kutsvaga ruzivo rwenzira dzekudzivirira* COVID-19 *pakati penhengo*. (To source for knowledge and skills in containment and preventing COVID-19 among congregants);
5) *Kunamatira vanenge varwara, kubatsira kudzikamisa hana nokupa tariro kune vanenge vabatwa nechirwere ichi nehama neshamwari dzavo*. (To pray for the sick, to assure and give hope to the infected people and their relatives and loved ones).

b) United Methodist Participants' Responses:

1) *Kutsvaga nyanzvi dzinodzidzisa nhengo nezvedenda iri, kupararira kwaro nokudzivirirwa, zvakafanana nokubairwa nhomba nekushandisa mishonga inodzivirira* COVID-19. (To identify facilitators who foster awareness about COVID-19 disease, modes of spread and containment, like vaccination and other drugs that can be used to combat COVID-19);
2) *Kutsvaga nzira dzokuti vabatsire vanenge varwara, varwarirwa kana kufirwa nedenda irori kuvapa simbiso, tarisiro, uye nemashoko enyaradzo*. (To establish safer strategies of assisting the sick, those caring for sick, those that will have lost relatives and loved ones because of the pandemic, give them assurance and hope, and affording them consoling messages);
3) *Kushanda nevehutano kuona kuti vanenge vachichengeta varwere vaone zvokushandisa zvinovachengetedza*. (To patterner with health personnel and make sure those caring for the sick get the necessary accessories that make them safe during the caring processes and procedures);
4) *Kubatsira nevanenge vafirwa mukuradzika mufi zvine hutano asi zvine chiremerera*. (To assist the bereaved in laying the deceased to rest in safer and dignified way);
5) *Kunamatira chita kuti vatendi vadzivirirwe kubva kumatenda anosanganisa* COVID-19. (To pray that congregants get divine protection from epidemics including COVID-19).

While it is undoubtedly clear from both groups that the religious leaders are centres for health and well-being information, the views coming from the participants show that the *Johane Masowe WeChishanu* feel self-sufficient in talking to their congregants about COVID-19, while the United Methodist Church leadership out-sources resource persons from outside their group to make COVID-19 awareness campaigns.

Upon asked on what are their religious leaders actually say about COVID-19 prevention, treatment and containment among members and non-members, the congregants again came with mixed views:

a) Johane Masowe WeChishanu participants' Responses:

1) *Vanoti zvinoda rudaviro rwakasimba kuitira kuti Mweya mutsvene Gabhurona atichengete nokudzivirirwa newedenga*. (The advice that it

needs strong faith to have the angel Gabhuroni and Heavens divinely protect us);

2) *Vanoti chirwere ichi chiri kuparadza vanotevedza zvenyika ino vanenge vabva pana mweya mutsvene*. (They say the pandemic is destroying those into earthly world and have departed from the Holly spirit);
3) *Vanoti vanotenda chero chakavabata vanoporeswa namweya mutsvene unoera*. (They are saying the believers even if they get infected, they get healed by the Holy Spirit);
4) *Vanoti chakauya kuratidza vanhu ruoko rwaMwari kuti vadzoke pakutenda saka kuchikunda kuva mutsvane*. (They say the pandemic came to show people the existence of God so that they turn back to believing in God, so it can be conqured through being Holy);
5) *Vanoti ngatisose misha yedu neminamato kuitira kuti chirwere ichi chisawana pokupinda napo*. (They say let us fence our homesteads with prayers so that the disease will not get access into our homesteads);
6) *Zvinoita sokuti dzimwe nguva vatungamiriri vedu vave kutya havachina chivimbo nesimba ramweya unoera*. (It appears like our leadership is now hesitant and are no longer confident with the power of the Holy Spirit);
7) *Vamwewo vatungamiri vanenge vatobatwa nemadhimoni okutya* COVID-19, *vachiipa masimba akapfuura aMwari wacho akatoisika*. (Some of the leaders are now possessed by the demons of fearing COVID-19, according it powers that exceed that of God who created it);
8) *Zvoita sokuti zvematongerwo enyika nezvehutano ndizvo izvo tave kunamata zvekuti ndizvo zvave kutonga manamatiro edu*. (It appears like we are now worshipping politics and healthy issues as they are the ones now controlling our actions);
9) *Kufa murau waMwari wekuti kana nguva yakwana haupfuuri chero* COVID-19 *iriko kana isiko kwaifiwa uye kucharamba kuchifiwa*. (Death is God ordained, if it is your turn to die whether COVID-19 is here or not. People have been dying and will continue dying);
10) *Yatititadzisa kuenda kugomo kunotura nhamodzedu kucharara kwatairara tichinamata*. (It has barred us from going for a sleep over in the mountains where we would be praying and presenting our challenges to God);
11) *Hapachina achabatwa musoro achinamatirwa zvekuti hapana madhimoni chaanotya kugara pamunhu*. (No one will lay hands on someone's

head praying for them; thus, demons can stay on a person without fear);

12) *Kusangano kwacho angova mazvake, mumwe uko mumwe uko nemitemo ye*COVID-19, *vanhu vave kutyanana.* (Even at gatherings people are just on their own, with people sparsed to be in sync with COVID-19 physical distancing guideline, people now fear each other);

13) *Mamasiki anotadzisa vanhu kufara uye kuimba zvakanaka vamwe vachibitirirwa, vamwe vanorwara neminhuwi yemasanitaiza, Ah! I basa chairo.* (Masks restrict people from enjoying and singing properly and some will suffocate, some get sick through smelling sanitiser, Ah! It is a challenge);

14) *Ruzhinji rwedu tinorarama nokubata nemaoko edu aya, saka mitemo yezve*COVID-19 *yezvehutano haibvumire kuungana. Saka izvi zvinoderedza kufamba kwezvatinenge tichitengesa.* (A sizeable population of us are self-employed, so the COVID-19 healthy guidelines are against gatherings. This reduces the rate of our sales).

b) United Methodist Participants' Responses:

1) *Vanoti titevedze mitemo yekudzivirira* COVID-19 *yezveutano yokugeza maoko nguva dzose nesipo, kushandisa sanitaiza, kupfeka masiki nokutaramukirana zvemita kana kupfuura.* (They say we have to follow the COVID-19 health guidelines set by health personnel like frequently wash hands with soapy water, sanitise, mask up and maintain physical distancing of a metre and above);

2) *Vanoti tione kuti tabaiwa nhomba ye*COVID-19 *nemhuri dzedu kudzivirira kuzorwarisa kana wabata chirwere ichi.* (They advise that we see to it that we are vaccinated with our families to prevent getting seriously ill in case we are infected by this virus);

3) *Vanoti zviri nane kudzivirira pane kuzoda kuedza kurapa sezvo pasina chati chanatsa kujeka pamarapirwo.* (They are saying it is better to prevent that to try to get treated when it is not yet clear on how it is treated);

4) *Vanoti mweya mutsvene unobatsira vanozvibatsira, saka tinofanira kutevedza mitemo yezveutano yedziviriro.* (They say that the Holy Spirit compliments individual efforts, thus, we should follow the set health precautionary guidelines);

5) *Hanzi kugara tichitora mavitamin 'C' tablets, nokusagara muruzhinji nemunzvimbo dzakamanikidzana dzisingafambe mhepo zvakanaka zvinoderedza mukana wokubata* COVID-19. (They said frequent taking of vitamin 'C' tablets, avoiding getting into congested public places that have poor ventilation helps to reducing the likelihood of contracting COVID-19);
6) *Apa tinozvikoshesa, tinotongotevedza nokuti tose tinoda kurarama hapana anoda kufa, chakakodza nguruve hachizivikanwe.* (We value the advice, we are abiding by them as we all want to live and no one wants to die, we are uncertain of what is helpful);
7) *Hatitombosangane tinotoita sevhisi pamazoom meeting nokuti ndizvo zvinoenderana nemamiriro ezvinhu pane ino nguva.* (We are not meeting physically; we remotely convene our church services through electronic ZOOM platform because that is what is in sync with the health situation at the moment);
8) *Ndinoona sokuti tikanatsa kurongeka tichitevedza nemazvo tinozojaira zvotoita kuti chirwere che*COVID-19 *ichi chirege kupararira zvachose.* (I feel like if we get organised and religiously follow the guidelines we will get used and contain the COVID-19 pandemic fully);
9) *Nguva zhinji panouya zvirwere pokutanga vanhu vanobatira vorwara nokufa vakawanda, asi kana vanhu vajaira votevera dziviriro dzacho nemishonga zvinozongogadzikana.* (The early stage of an outbreak of an epidemic, people contract, get ill and die en-masse, but as people get used to it they follow the precautionary measure and come out with drugs and the situation normalizes);
10) *Shoko rehutungamiriri rakakosha rakafanira kutevedzwa kuti tisazochema tichiti tanga tisingazive, vanotobatsira nokutitsvagira ruzivo.* (The message from leadership is important and has to be adhered to so that we will not regret latter that had we known, they are helping us through sourcing the survival information);
11) *Zvatiomera nokuti tangove munhu ega saka kutandadzana kwaitinyevenutsa pfungwa hakuchina kuruwadzano rwemad-zimai, varume, nevakomana nevasikana nevana hapachina.* (It is a challenge to us as we are individually and on our own, so the leisure that we used to have like women's, men's, boys', girls' and children's fellowship is no more);
12) *Hatichagoni kuita zvirango zvekuunganira anenge chiitiko pamba pake semuchato, rufu, kana mhemberero dzezuva rokuzvarwa.* (We cannot

hold ceremonial rituals for those that may have functions in their homes like weddings, funeral or birthday celebrations);

13) *Makwikwi ataiita ezvigadzirwa akafanana neezvirimwa, zvisonwa, zvirukwa kana zvibikwa ave kunetsa, izvi zvinoderedza mabhizimisi evaitengesa sezvo ongoitwa pama zoom.* (The competitions that we used to hold like Agricultural products, textile outputs, knitting products or catering designs are now difficulty to convene, this reduces the sales as the interactions are now remotely convened through zoom platform);
14) *Zvakatiomera nokuti kupinda chechi sevhisi imari yemabhanduru uye yekutenga tekinoroji kuti tipinde muchechi macho kusiyana nepataingozvifambira netsoka tichienda.* (It is a challenge to us since we need money for WIFI bundles to access a church service and have the technological gadgets to convene church, it is different since we used to walk to church);
15) *Zvinobatsirawo kusunganidza ukama hwemhuri sezvo tave kungoswera tose padzimba.* (It helps in bonding together family members since we spent all the days together).

The excerpts above are evidence of leadership styles influenced by religious beliefs and practices on management, control and containment of COVID-19 to their congregants. As such *Johane Masowe WeChishanu* takes COVID-19 as a spiritual challenge that demands spiritual intervention; this is despite that they know COVID-19 signs and symptoms the same way they are known by United Methodist participants. On the other hand, the United Methodist Church participants are taking it as a biomedical challenge to their spiritual well-being and they are taking a hybrid approach that adopts both biomedical and spiritual approaches. The position religious leaders and each religious group takes is likely to have implication on the members' attitude to the sick, to those that die of COVID-19 and the kind of psycho-socio-spiritual support they may render. While to the *Johane Masowe WeChishanu* the sick and those dying of COVID-19 may be viewed as a sign of weak faith, cowards that fear diseases (COVID-19), punished by God for fearing COVID-19 rather than fearing God and are likely to be stigmatised whereas the United Methodist, the sick are likely to be supported as they have positive attitude towards the sick.

From the first group of participants, the Johane Masowe, there is a radical position where they feel politics and biomedical pronouncements are overriding the power of the Holy Spirit which should not be. Scholars have differences in attitude within and between religions which does not warrant a one size fits all kind of guide to the religious groups. According to the views by congregants in the excerpts above the United Methodists insists on compliance while *Johane Masowe WeChishanu* feel adhering to COVID-19 health guidelines is tantamount to worshipping politics, biomedical specialists and their scientific solutions as well as discoveries rather than standing by their belief in the divine protection of the Holy Spirit.

The Impact of COVID-19 to Worshipping Practices and Procedures

Participants were asked on how COVID-19 has impacted on their worshipping processes and procedure considering that Christian members take physical attendance as critical in one's Christian journey:

a) Johane Masowe WeChishanu participants' Responses:

1) *Yave kuita kuti varege zvimwe zviitwa zvedu zvecharara, zvokurara tichinamata mugomo.* (It made us to contact religious business differently, the sleeping over and worshipping in mountains was abandoned);
2) *Hapachina zvepasika izvo taisiita gore negore muna Nyamavhuvhu tichinosangana nyika yose tichitenderera matunhu kuti gore rino kuHarare, rinouya kuMasvingo. Saka 2020 hatina kusangana vanhu vari kutambura nenhunha dzaida kunogadziriswa ikoko paungano paive pazere maporofita ane simba.* (There is no more Easter celebrations that we used to hold annually in August where members from country wide converge in one province like this year in Harare and the following year in Masvingo. So, 2020 we did not meet, people are suffering with their challenges that were supposed to be solved at the annual conference where there could be powerful prophets);
3) *Vanhu vaisimbundirana zvekuti aive nepfundo pamwoyo aidzoka rapera asi izvozvi vanhu vongosungirira. Hapana kana anoreurura vamwe vanoda maporofita akasimba kuti vanyukurwe muchita vagoreurura.* (People

use to hug each other that help clearing grudges but now people simple keep the grudges. No one repents, some would need strong prophecy to be picked up in the congregation so that they repent);

4) *Pakunamata kwedu hapachina kusununguka nokuti vatendi vave kutyanana, hapana anoziva ane hutachiwana*. (We are no longer freely worshipping as congregants fear each other, no one knows who is a carrier of the virus);
5) *Zvakaoma nyaya dzokubata pamwe neanenge awirwa nedambudziko hapachina, tave kuchema neafirwa pafoni, kuenda pasangano nefoni zvaisabvumirwa. Hapachina kubatana maoko*. (It is now a challenge in helping those who are in challenges, we now mourn with the bereaved remotely through the phone, it used to be prohibited to attend the conference with a phone in possession. We no longer have hand shacks).

b) United Methodist Participants' Responses:

1) *Tekinoroji yave manamatiro matsva apo tinosangana pazoom chechi sevhisi*. (Remotely digitised zoom platform is new way of convening worshipping during church services);
2) *Kunamata kwacho yave mari nemidziyo yezvetekinoroji kuti tipinde pazoom pazviitiko zvose zvekuchechi*. (Worshipping is now cash and technology based to gain access or entry on all church functions/ events);
3) *Zvingave zviitiko zverufu ruzhinji rwobata maoko kubudikidza netekinoroji, zvimwe nemichato, mhemberero dzemazuva okuzvarwa kana nepasika chaiyo*. (It could be a funeral event, many consoles the bereaved remotely through technology, or even wedding events, birthday celebrations and even Passover itself);
4) *Zviremerera zvorufu, michato, mabiko ekuzvarwa kwevana zvaderedzwa sezvo zvave kuiswa pane zvemichina*. (The value of funerals, weddings and the births of children are lost as they are technologically and remotely convened);
5) *Kunamata kwaive mushandirapamwe ave mazvake mazvake uye mumwe nomumwe kwake. Vanhu havachina kubatana. Awirwa nenhamo ndeyake ega. Anofara anongofarawo ega*. (The worshipping processes and procedures that used to be communally convened have now been individualised with each one being on their own. People are no longer united.

When members have been befallen by challenges it is solely theirs alone. Those that are enjoying do so alone as well).

In the excerpts above, participants from both groups *Johane Masowe WeChishanu* and United Methodist Church acknowledged that COVID-19 changed their religious worshipping practices and procedures. It removed the centre pillar of worshipping which are face to face or physical gatherings which left religious rituals and events falluing apart. Close monitoring of members that enabled self-policing is no more.

When participants got asked on what is likely to happen after COVID-19 health scare is over or subjected congregants showed their anxiety and appetite to have physical meetings:

a) Johane Masowe WeChishanu participants' Responses:

1) *Tinobva tazotanga kusangana pakare samazuva ose tichinamata pamwepo nokuenda pacharara* (We resume face to face worshipping sessions and going for sleepover prayer sessions);
2) *Vamwe vanenge vatohedhuka kare nenyaya yekuti hapana anonatsa kuvatarisa nekuvafudza* (Some will have diverted from God as there is no one watching and shepherding them);
3) *Kutenda kwose nezviitiko zveparufu, pamichato nemhemberero zvafumuka zvekuti hazvichina chiremerera. Zvave kuitwa chero nevana vaduku, chero nevatorwa, chero hama nevavakidzani vasipo* (The worshipping, funeral, wedding and birthday celebrations have lost their values and no longer have their diginity);
4) *Chero* COVID-19 *ikazopera hapachina kunamata kwemazvokwadi. Vanhu vave kunamata COVID-19 ndiyo yave kuvaudza zvokuita kwete Mwari.* (Even if COVID-19 goes there is no longer genuine worshipping. People are now worshipping COVID-19 it is now dictating their pace and not God);
5) *Vanhu vanoda kuzodzidziswa patsva kuti kunamata mubatirapamwe kwete mazvake mazvake, okuti munhu mumwe uko mumwe uko.* (People would need to be reschooled again that worshipping is dividual and not individual where each person is on their own).

b) United Methodist Participants' Responses:

1) *Handioni sokuti tichadzokera pamagariro nemanamatiro ataiita. Kwatove netsika itsva yokunamatira pauri nokuti kutya hakuchazoperi. Tsika yokushandira pamwe pakunamata yave kutofa zvamuchose.* (I do not foresee us getting back to our old days standards of living and worshipping. There is now new culture of worshipping wherever you are because we will not get over the fear grip. The culture of communal worshipping has died a natural death);
2) *Pamusoro pemazvake mazvake pavezve netekinoroji yatodziva zvokusangana pauzima zvaiisiita vatendi. Dzemazoom dzakanakira kuti haurasikirwi chero kwauri.* (On top of the individualistic tendency, technology has overtaken physical presence and face to face that congregants used to do. The zoom platform convening church events has an advantage that you will not loose out no matter where you are);
3) *Zvimwewo ndezvekuti vanhu tave kuona zvakanaka kuti tinotepa zviitiko tochengeta zvekuti tinogona kuozoona nenguva dzedu, patinodira kana kusarudza zvikamu zvaunoda uchibvisa zvausingadi.* (Another advantage is that we can tape record the events and we store and later on access them at our own free time, when we feel like to do so, or choose certain parts that we want and discard what we do not want);
4) *Chitori chidzidzo kubva kuCOVID-19 kuti Mwari haanei nekuungana. Tinogona kungonamata chero tiri kwatiri uye chero tiri toga nemhuri dzedu.* (It is a lesson learnt from COVID-19 that God has nothing to do with a group. We can just worship wherever we are and just on our own with our families);
5) *Vamwewo vakanga vasati vanatsa kuita zvetekinoroji vanogona kudzokera asi vamwe zvakatonaka kupinda mutekinoroji uye zvinobata vatendi vakawanda kupfuura zvemagungano. Vatungamiri vakafanira kudzidza kutoshanda nevatendi pamhepo zvichireva kuti chero vasiri vatendi vavo vanogona kunzwawo shoko.* (Maybe those that were not yet fully digitised may get back to the old ways, but as for other it is even good to digitise as that may be accessed by many worshippers that exceeds the face-to-face gatherings. The religious leaders have to learn to work with congregants remotely which may imply that not only their church members can access their church services and ritualistic events).

Both, the *Johane Masowe WeChishanu* and United Methodist Church participants admitted that COVID-19 changed their worshipping styles, rituals, practices and procedures. Church services are now largely remotely convened which makes the majority of members feel distant from the presence of God. They were used to physical interactions. This is due to restrictions in gatherings which was in sync with COVID-19 national health guidelines. KOWALEZYK, ROSZKWSKI, MONTANE, PAWLISZAK, TYLKOWSKI, & BAJEK (2020), revealed that restrictions of gatherings to contain spread of COVID-19 affected religious complexion. Unlike the United Methodist Church participants who are confirming a so far so good attitude, the *Johane Masowe WeChishanu* still felt nostalgia of the golden old days of face-to-face church service interactions and events.

Conclusion

While the impact of COVID-19 on religious practices and procedure is well acknowledged within and across the two religious' sects' purposively sampled participants, the perception of the COVID-19 compliance strategies differed greatly. While the *Johane Masowe WeChishanu* feels that the leaders are succumbing to fear which is compromising their belief in the power of Holy Spirit, the United Methodist congregants' feels that divine protection needs to be complementary with individual efforts through complying with COVID-19 health guidelines. Also, while the Johane Masowe congregants still have nostalgia and wish to go back to face to face gatherings, the United Methodist are anticipating to continue remotely accessing their religious services which they feel are convenient because of the COVID-19 virus. The perceptions seem to be influenced by the groups' understanding of COVID-19 pandemic, that while to the *Johane Masowe WeChishanu* it is generally understood to be demonic, a result of lack of faith and fear, to the United Methodist participants it is like any other pandemics that would be conquered holistically through multistakeholder approach as to have both spiritual and biomedical approaches.

Recommendations

There are three major learning points that emerged from the study. First, basing on the study findings, it should be a lesson to governments and

intervention groups across the globe that they adopt approaches that are inclusive and holistic to benefit individual differences. Second, religious leaders, may have the power to break the myths and speculations about pandemics and health and well-being of their congregants by raising awareness against the COVID-19 virus where possible involve health experts to do the training. In that case, religious leaders need to be empowered through basic health education. Third, religion has power to influence congregants' perceptions of their health and well-being. Having noted these three learning points, it is therefore undoubtedly clear that religion is one of the key factors that community leadership and interventionist organisation should not leave out in dealing with health and well-being, pandemics and community development.

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Molly Manyonganise

9 Prophecy versus Science: The Role of Religiosity in COVID-19 Vaccination in Zimbabwe

Abstract

By 11 Dec. 2020, the Pfizer vaccine against COVID-19 was authorised for emergency use by the Food & Drug Administration in the USA. Other vaccines from different companies were later availed. Of these, Zimbabwe chose to use Sinopharm, then Sinovac from China and later the Johnson & Johnson vaccine. When it was reported that it would be expected that everyone (except those with genuine medical reasons against vaccinations) be vaccinated, responses from religious leaders varied. Of interest is how leaders of New Pentecostal Movements (NPMs) in Zimbabwe deployed prophecy to influence vaccine uptake. The purpose of this paper is to analyse the prophecies given during this period and establish how these shaped people's attitudes towards vaccines. The intention of the paper is to highlight the continued battle for supremacy between religion and science. Data for the paper will be gathered from sermons uploaded on Youtube as well as structured interviews with selected people in Zimbabwe. Secondary sources will be used to support primary data.

Keywords: COVID-19, prophecy, science, vaccine, Zimbabwe

Introduction

The theorisation of religion and science is in itself a daunting task. It goes without saying that there has been a perennial debate on how the two relate. There has been two schools of thought on the subject. One school of thought perceive the two to be antagonists while the other view them as compatible. In 1875, Draper attributed the antagonism between religion and science then to the continuation of a struggle that commenced when Christianity began to attain political power. He argued that the history of science is not a mere record of isolated discoveries, but a narrative of the conflict of two contending powers, that is, the expansive forces of the hu-

man intellect and the compression arising from traditionally faith and human interests. AGAZZI (n.d) traces the origins of the view that science and religion are antagonists to nineteeth century positivism. Propounded by Auguste Comte, positivism celebrated science as the perfect form of knowledge (AGAZZI, n.d) and progress and also maintained that this progress had to be secured by a constant fight against metaphysics and religion (2014:10). For Comte, knowledge reaches maturation after passing through three stages, namely the theological, metaphysical and finally the scientific stage (AGAZZI, 2014:17). For science to advance, KURTZ (2003:11) argues that theology had to be abandoned. MCGRATH (2010:2) argues against the notion that science and religion occupy well-defined domains or areas of competency which do not overlap or intersect. He cautions that neither science nor religion can claim to give a total account of reality. In his analysis, science and religion ought to be viewed as dealing with similar questions but, they obviously operate at different levels and they try to answer these questions in different ways. For him, when taken together, science and religion "can offer a stereoscopic view of reality denied to those who limit themselves to one discipline's perspective on things" (MCGRATH, 2010:2). However, PAUL (2020) note that though there has been a broadening of ideas in the two fields of inquiry, there remain paradoxies inhibiting the synchronisation of religion and science. However, AGAZZI (2014:10) notes that the antagonism may be falling away because there has been a realisation that science and technology cannot tackle present day challenges that the world faces. Hence, science and technology have begun to consider the input from fields such as ethics, philosophy, anthropology etc. Current approaches in science and technology have also begun to make reference to values, human dignity, human rights (AGAZZI, 2014) to mention but a few.

In light of the continued debate on the relationship between science and religion, this chapter seeks to examine how the relationship turned out during the COVID-19 pandemic. The chapter focuses mainly on how religion and vaccine hesitancy particularly the way New Pentecostal Movements in Zimbabwe deployed prophecy to counter scientific advice. It becomes imperative for the chapter to make a discursive analysis of the prophecies in order to establish the way they shaped attitudes towards vaccines. This should enable us in the final analysis to establish how science and religion battled for supremacy in a COVID-19 context in Zimbabwe.

In order to put the discussion into its proper context, a definition of key concepts such as science and religion is necessary.

Defining *Science* and *Religion*

Defining the above concepts is not a straight forward endeavour. Their meanings vary depending on the context in which they are used. In reference to science, LAM (n.d) notes that there is a lot of confusion and misconception concerning science. Up to today, the nature and content of science has not been established. FARA (2015:189) argues that defining science is not straight forward because science is culturally situated and so does not have a permanent or universal meaning. For her, science is not static but changes over time. Furthermore, science brings together a number of disciplines such as the hard sciences (chemistry, physics, biology, and maths) and soft sciences (sociology, philosophy, psychology). While the two categories both refer to science, their methodologies are different. When defining science, MICKENS & PATTERSON (2016:2) say it is the systematic observation, creation, analysis, and modelling of patterns which exists in the physical universe. For them, science provides people with public knowledge which is available to anyone to examine, test, criticise and generalise. For FARA (2015) science is depicted as the rise of reason and emphasis is placed on its supremacy over religion.

Debate about the meaning of religion has been a perennial one. Scholars are not agreed as to what really constitute religion. From CROCKETT's point of view, "scholars simply do not know what religion is in itself, apart from their phenomenological characterisation of it" (1998:4). He further argues that:

> Religion cannot be known immediately as a thing in itself, but also that it is at least partially constructed as an object by the observer, interpreter, or scholar. Any definition of religion must be seen as constructed by human knowing rather than simply given to or imposed upon an observer.

The challenge in this case is in trying to understand religion as both abstract and concrete. In this study, I do not wish to delve into the arguments about the definition of religion except to state that the term has been defined differently in different disciplines. For example, sociologists, psychologists, historians, theologians, phenomenologists, philosophers, etc.,

have provided definitions that speak to their fields of study. Hick Cited in CRAWFORD (2002:3) explains this clearly when he says:

> Religion is one thing to the anthropologist, another to the sociologist, another to the psychologist...another to the Marxist, another to the mystic... As a result, there is a great variety of theories of the nature of religion. There is, consequently, no universally accepted definition of religion, and quite possibly there never will be.

Confronted with this perennial challenge this study adopts a definition which views religion as a set of beliefs and practices that endeavour to fulfil an expectation of a supernatural being.

The definition of the two concepts expose various ways in which they differ. FRAZIER (2003:28) aptly captures the differences when he argues:

> Science (and reason) must not yield any of its own ground. Science is based foremost on evidence, not authority or revelation. In science, nothing is taken on faith, while in religion, faith is at the heart of belief. In science, all knowledge is tentative, continually subject to revision when better explanations and evidence (always aggressively sought) are acquired, religion asserts the presence of unchanging and unchallengeable eternal truths. Science proposes explanations about the natural world and then puts those hypotheses to repeated tests using experiments, observations, and creative and diverse arrays of other methods and strategies. Many religions discourage scepticism or critical examination of cherished precepts. This commitment to test the validity of ideas and claims separate science and religion

KURTZ supports FRAZIER's view when he asserts that the major difference between science and religion lies in their perception of truth. He notes the way science requires an open mind, free inquiry, critical thinking and its willingness to question assumptions. He further argues that "the test of a theory or hypothesis is independent ...of bias, prejudice, faith, or tradition; and it is justified by the universal..., transcending specific cultures and replicable in any and every laboratory in the world" (KURTZ, 2003:13). On the other hand, he argues that "although religions claim to be universal, they have split into contending factions concerning hegemony: they rely on the acceptance of faith in specific revelations and their interpretation by differing prophets, priests, ministers, rabbis, monks or mullahs (KURTZ, 2003:13). CRAWFORD (2002:ix) rejects the view that religion and science are in conflict with each other. He acknowledges that there are

some scientists who contend that religion is grounded in superstition and that it belongs to 'primitive' stages of human development. For this group, science advances and provides remedies for modern problems. However, CRAWFORD also notes that there is another group of scientists, who recognise that religion asks different questions than science. For this group, religion is still useful for living a good life and giving meaning and purpose to existence. Hence, this interplay between science and religion was noticeable during the COVID-19 pandemic.

WHO Guidance on the COVID-19 Pandemic

From the year 2019 to the present, the world continues to grapple with the COVID-19 pandemic and its effects. At its onset, the pandemic ravaged nations with no cure in sight. On 30 January 2020, the World Health Organisation (WHO) Director-General determined that the outbreak of coronavirus disease (COVID-19) constituted a Public Health Emergency of International Concern (WHO, 19 March 2020). There was, therefore, need for individual states to put measures in place for its containment. The WHO suggested quarantine which involved the restriction of movement while the infected were isolated from the rest of the population. Quarantine was to be enforced only as part of a comprehensive package of public health response and containment measures. This also had to be in accordance with Article 3 of 2005 International Health Regulations which recognises the need for respecting human dignity, human rights and fundamental freedoms of persons. In this case, those exposed to infection were to quarantine for 14 days from the day of exposure for monitoring and early detection purposes. As the pandemic progressed, the quarantine rule applied to all travellers entering a particular country. However, at the peak of the pandemic, total lockdowns were imposed world-wide through travel bans and closure of borders. On 14 April 2020, the WHO released it COVID-19 Strategy update. Statistics indicated that by that date, 1.7 million people had been infected and 85 000 had succumbed to the disease (WHO, 14 April 2020). The WHO implored nation-states to control the pandemic by slowing down the transmission and reducing mortality associated with COVID-19 through **(i)** mobilising all sectors and communities to ensure that every sector of government and society takes ownership of and participate in the response and in preventing cases through hand hygiene, respiratory etiquette and individual-level physical distancing, **(ii)**

controlling sporadic cases and clusters and prevent transmission, **(iii)** suppressing community transmission through context-appropriate infection prevention and control measures, and **(iv)** reducing mortality by providing appropriate care for those affected by COVID-19 and developing safe and effective vaccines and therapeutics that can be delivered at scale and that are accessible based on need (WHO, 14 April 2020). Other containment measures such as masking up and sanitisation of hands were added to those that were already in existence. As these were enforced, scientists were working round the clock to come up with a vaccine that would tackle the virus. By 11 Dec. 2020, the Pfizer vaccine was authorised for emergency use by the Food and Drug Administration (FDA) in the United States of America. Other vaccines from different companies were later availed. Hence, in 2021, a number of vaccines were available namely Biontech/Pfizer, Johnson & Johnson, Moderna, Astra Zeneca, Sinopharm, Sinovac among others. The uptake of the vaccines worldwide was initially very slow but gradually improved. Anti-vaccine groups emerged and mobilised people to reject vaccines using various conspiracy theories. In sub-Saharan Africa, religion played a major part in influencing vaccine uptake and Zimbabwe is no exception. In the next section, I turn to examine the COVID-19 situation in Zimbabwe.

COVID-19 in Zimbabwe: An Overview

COVID-19 was first detected in China, Wuhan Province in December 2019 (Wang, Gao, Lou & Zhang, 2020; Wu, Chen & Chan, 2020; Zhu, Wei & Niu, 2020; Kumar et al., 2021; Worobey, 2021). As it spread across continents, Africa recorded its first cases in February 2020 (Culliers, 2020; Massinga Loembe, 2020; Osseni, 2020). Zimbabwe recorded its first case and COVID-19 death in March 2020, which led the government to declare its first lockdown on 30 March 2020 and this was punctuated by partial business openings and other lockdowns as the infection cases increased (Chitungo, et al., 2022; Manyonganise, 2022; Sibanda, Muyambo & Chitando, 2022). This has been the experience of Zimbabweans up until March 2022. By 9 October 2022, Zimbabwe had recorded 258000 COVID-19 cases with 5604 deaths. Compared with other countries, the cases are reasonably low. This can be attributed to a number of reasons which are beyond the scope of this study. As alluded to earlier,

vaccines against COVID-19, became available from December 2020 particularly for frontline staff. Zimbabwe chose to use Sinopharm, then Sinovac from China and later the Johnson & Johnson vaccine. Medical scientists had proven the efficacy of vaccines and that vaccination would help prevent hospitalisations and deaths caused by COVID-19 infection. Furthermore, scientists had envisaged that the vaccination of more than half the population would ensure herd immunity (GARCIA & YAP, 2021). Zimbabwe needed to vaccinate sixty percent of the total population (14 million people) to reach herd immunity. When it was reported that it would be expected that everyone (except those with genuine medical reasons against vaccinations) be vaccinated, responses from religious leaders varied. Historically, some religious groups in Zimbabwe shun the conventional health delivery system which they claim, goes against their faith. Apostolic churches such the Johane Marange African Apostolic Church (JMAAC) and the various groups of the Johane Masowe Church (JMC) are known for shying away from hospitals and use of conventional medicine. Hence, in the context of COVID-19 in Africa in general and specifically Zimbabwe, religion and religious leaders played a critical role in shaping attitudes towards the pandemic as well as responses to it. The Zimbabwean health system has deteriorated over the years leading the general public to lose faith in it. This has shaped Zimbabweans' health seeking behaviours where trust is put in religious leaders even for biomedical ailments. The major reason for this is that African Indigenous Religion(s) and some Christian traditions in Africa rely on divination/ prophecy for both diagnosis and prescription of solutions.

Prophecies against Vaccine uptake

Prophecy is a key aspect of Christianity in Africa. It separates mainline Christianity from African Initiated Churches (AICs) and African Pentecostalism. Similar to African forms of divination, AICs and Pentecostal prophets claim to have the ability to predict the future. Religion in Africa is intertwined with health and healing (UKAH, 2020). Hence, even with the availability of hospitals, most Africans still rely on either indigenous healing methods as well as faith healing. Faith healing is practiced by AICs and Pentecostal churches. As a result, some AICs and Pentecostal churches do not allow their members to seek help from hospitals. MASIYIWA, CHENJERAI & MUJURU (2021) spoke to Emmanuel, a member

of the Johane Masowe Chishanu Apostolic Church (JMCAC) who argued that God spoke to their chief prophet a long time ago and told them not to seek medical attention, because they can get protection from all illnesses through prayers and this is what they believe in. Members of JMAAC also subscribe to this notion. The prayers they are told to rely on are often accompanied with prophecies. OMENYO (2011:30) notes that prophecy is the bridge that connects African Indigenous Religion(s) with AICs and African Pentecostalism.

As COVID-19 ravaged the world, self-proclaimed prophets in Africa attempted to explain it. UKAH (2020:452) notes that religious responses to COVID-19 came to the forefront of explanation and analysis because Africans seek understanding and interpretation of the 'why' of the pandemic. The 'spiritual' explanations at times brought the church into conflict with the state. The late 'Prophet' Temitope Joshua (aka TB Joshua), founder of Synagogue Church of All Nations prophesied that the virus would disappear on the 27th of March 2020. He retracted his prophecy by claiming that the Holy Spirit had misled him and that in actual fact, he meant that the virus would disappear in Wuhan, China where it originated from. Even this was also not true. Another Nigerian pastor, Chris Oyakhilome, founder of Christ Embassy Ministries claimed that it was not a virus that was killing people, but the 5G technology. David Oyedepo, founder of Winners Chapel was sceptical about the COVID-19 vaccine. He argued that it was not well tested, hence, he discouraged members of his church from taking the vaccine. He argued:

> They want Africa dead. I heard them say it. When we didn't die as they proposed, they brought out the vaccination scheme. You need to hear their proclamation that Africa will lack spaces to bury corpses (OBADARE, 2022).

These were some of the conspiracy theories that were peddled by church leaders to dissuade their members from cooperating with governments to curb the spread of the virus.

In Zimbabwe, church leaders responded in different ways to the uptake of the vaccine. The most prominent figure who let his thoughts public about the vaccine is 'Prophet' Emmanuel Makandiwa, founder of the United Family International Church (UFIC). To start with, he claimed to have prophesied about the coming of the virus on 20 November 2016, then repeated the prophecy on 7 July 2017. In a YouTube clip played in his

church in March 2020, it showed that he prophesied about a deadly disease that would come from the ocean that would kill millions of people. He indicated how the disease would confound medical personnel. On 1 March 2020, he engaged his church in prayer against the coronavirus. However, he said the prayer would not halt the virus, because it is very aggressive. He promised that God would give power to his people to curse the virus. He instructed his members to take charge against the virus through prayer. From his point of view, if they pray, scientists would find a cure for the virus in already existing medication. He said "It's not about getting the right cure, but allowing God to intervene." He further claimed that God wanted to prove to us that we are not educated. As the clips were being played, the pastors moderating the discussion referred to him as 'the voice of God." On the 17th of March 2020, he said God had shown him that the virus was increasing its speed, but God was also weakening its intensity. When the President of the United States of America, Donald Trump announced that Hydroxycloroquine had been discovered to be effective in curing coronavirus, the UFIC members went into overdrive to celebrate what their 'prophet' had seen before the announcement. Scanning through the comments on social media platforms, one can see how members of the church and other followers from around the world focus on the figure of the prophet. They refer to him as the 'Moses of our time', 'the Seer of our time', 'the Prophet of our time', and 'the Voice'. The general sentiment was that there was no need to fear because the 'Prophet' had enunciated the mind of God.

At the peak of the pandemic, he claimed that the virus was receding but that those who were benefitting financially from it did not want to report it. Like Oyakhilome and Oyedepo, Makandiwa told members of his church not to take the vaccine for various reasons. First, he argued like Chris Oyakhilome that the cause of the virus was the 5G technology; second, he posited that the vaccine was rushed hence, it lacked credibility since its long-term effects were not ascertained; third, he claimed that he had been shown the individuals behind the virus whose intention was to depopulate Africa so that they could recolonise it. In this claim, Makandiwa rubbished the public vaccination of political leaders of Western countries as he told his congregants that they needed to first prove that these leaders were taking the same vaccine as the one they were going to be given. Using the example of the Guyana Massacre of 1978, he

claimed that the vaccines contained poison, which would cause a pandemic. Furthermore, he alleged that the vaccine was the 'mark of the beast' mentioned in the Book of Revelation. From his point of view, the vaccine contained a chip, which would cause everyone to be monitored. This chip would introduce a programme into the human body resulting in the alteration of one's DNA. It was surprising how he blamed previous vaccines as the major cause for Africa's failure to resist the COVID-19 vaccine as he claimed that it is because the DNA of Africans had already been tempered with. In order to buttress his point, he alleged that once that chip is in one's body, then they are controllable and this would remove from the people a desire to worship God. He branded Western political leaders, big pharmaceutical companies and prominent business people from the West as agents of the devil (Fosu-Ankrah & Amoako-Gyampah, 2021). He, therefore, challenged the Zimbabwean state and declared that he and his family were not going to receive the vaccine. In his own words, he said:

> It will come. If they bring it here [vaccine] I will go to jail and my children will go to jail. I am ready for that. You have to drink it yourselves. You want to live. Some of us we have the life already…I will not be forced to take that…I will disobey my government on this one…We are in this world, but we are not of this world… (YouTube, 12 April 2020).

Makandiwa is an influential religious figure in Zimbabwe. He is known for claims to produce miracle babies, and miracle money among others. To his followers, everything he says is the truth and he is their 'spiritual Papa'. Hence, when he spoke of him and his family not taking the vaccine, he should have been talking of members of his church because it encompasses his 'family'. As a result, members of his church and others who do not go to his church but follow his prophecies heeded his call to refrain from vaccination. He had declared that under the doctrine of 'covering' he would cover them with his prayers. At one of the church services before the enforcement of lockdowns, he declared that whosoever was listening to his prayer that particular Sunday was protected from the virus (Fosu-Ankrah & Amoako-Gyampah, 2021). Wanjiru Njiru (2020) notes that such false prophecies offer false hope to people and Sande (2021) is of the view that this can lead church members to conduct their lives recklessly by disregarding public health messages. In the case of Makandiwa, most of his church members believed in his declaration of protection. Like their 'Papa', they also shunned vaccination. I had informal discussions with

some of them who declared that "unless the prophet comes back and says we should get the vaccine, we will not get it." When it became mandatory to access certain places only with proof of vaccination, these members resorted to buying the vaccination cards from unscrupulous health personnel. Some even threatened to quit their jobs if they were going to be forced by their employers to be vaccinated. However, as Zimbabwe entered into the third wave, members of his church also started to succumb to the virus including pastors. He later backtracked on his claims and called on Christians to get vaccinated. He warned his followers not to use his name as a reason for not being vaccinated. Despite his earlier pronouncements on the vaccine, he said he never said there was a chip in the vaccine or that it was the mark of the beast. In fact, for him anyone who thinks that the vaccine would remove God from their lives needed to revisit their theology because it was not biblical. He encouraged his followers to listen to public health officials. He argued:

> As far as the matter is concerned, we have professionals who are dealing with the issue physically, practically. I deal with these issues from a spiritual standpoint. So what the doctors are telling you is what you need to do (KAROMBO, 26 July 2021).

Many people felt that his backtracking had come too late when a lot of people had died. They, however, commended him for doing the right thing. Others felt that there should have been a strong political hand behind his changed attitude. Reference was made to the uneasiness with which he appeared in the video as he broadcast his message. People interpreted this to mean that he had been forced probably by the government to change and announce his stance on vaccination. Some people ridiculed his followers for being dump and being misled by 'false' prophets. It was, however, interesting to note that some of his followers continued to hold on to his initial pronouncements about vaccine. As I discussed with one of them, she said that behind the message by the 'Man of God' on getting vaccinated, they were able to pick that the vaccine remains unsafe for them. Hence, they remained adamant that they would not get vaccinated. Such attitudes buttress UPENIEKS, FORD-ROBERTSON & ROBERTSON's opinion (2022) when they note that religious believers who hold strong beliefs in an engaged God are most likely to distrust the COVID-19 vaccine. DRUCKMAN ET AL. (2021) also argue that those who hold stronger religious beliefs tend to be less scientifically literate and less differential to scien-

tists. They further note that in the context of COVID-19, there was a notable link between the number if misperceptions held and religiosity as well as partisan identity. In this case, the attitude towards the vaccine by some sections of NPMs and Apostolic sects presented a challenge for the government because these brands of Christianity have the majority of followers in Zimbabwe.

On the other hand, there were some prophets in Zimbabwe who used prophecy to enable their members to make sense of the pandemic as well as encourage them to adhere to scientific ways provided by public health personnel. Frahm-Arp (2021) notes the same attitudes among self-proclaimed prophets in the South African context. These prophets like Ian Ndlovu argued that the vaccine was God's way of providing a solution for the virus. Ndlovu rebuked pastors who were commenting on a medical issue as if they were experts in the medical field. He reiterated that vaccines were made by scientists not pastors, hence, any questions regarding vaccines should be directed to scientists. In a YouTube video posted on 16 August 2021, he refuted claims that the vaccines contained the mark of the beast, but said it was God's way of controlling the spread of the virus. He explained that it is God who releases divine knowledge which assists scientists to come up with effective vaccines. Hence, he encouraged his congregants to make personal decisions on whether to get vaccinated and to desist from consulting him because he was not a doctor. Such personal decisions were also notable in some Apostolic sects. For example, Gladys Mapondera, a member of JMAAC in Hurungwe told Apostolic Women Empowerment Trust (AWET) that she chose to be vaccinated because it was a matter of life and death for her and her family. She said "our church doctrine says we don't go to the hospital when [we] are sick or get vaccinated, but with COVID-19 it was a new ball game altogether and I have to take matters into my own hands." For her, she took a personal decision and did not inform church leaders. She said "*ndakati kana ndichifa inini ndinofa ndega, saka vanhu ngatityei chirwere* (I said if I die, I die alone, so people we should fear the disease). Another member of an Apostolic sect interviewed by Masiyiwa, Chenjerai & Mujuru (2021) avered that:

> We understand that there are things that require spiritual guidance and others do not need that guidance. We just have to follow the experts in the field. All coronavirus measures that are being implemented are not to harm us, but to protect us.

Andby Makururu, founder of Johane the Fifth of Africa Apostolic Church was also interviewed by MASIYIWA, CHENJERAI & MUJURU and he indicated that he was pro-vaccine. This is generally a departure from the doctrine of these churches, but personal decisions had to be taken for people to safeguard themselves from infection. In addition, ecumenical bodies in Zimbabwe such as the Zimbabwe Council of Churches (ZCC), the Zimbabwe Catholic Bishops Conference and the Evangelical Fellowship of Zimbabwe played their part in encouraging vaccine uptake. Other leaders of NPMs who did not share Makandiwa's perception also came out and publicly received their jabs in order to encourage people to receive the vaccines. Pastors like Talent Chiwenga openly rebuked Makandiwa and told him not to comment on issues of science. The clash between the men of cloth and the different nature of their views within the broader context of the fight against COVID-19 raises pertinent national issues. Generally, these people are very influential, have a strong loyal constituency of followers, which is easily convinced by their messages. Hence, what they tell their congregants can help stop or increase the spread of the COVID-19 virus.

In order to deal with negative attitudes towards scientific solutions to COVID-19 DRUCKMAN et al (2021) suggest an engagement with opinion leaders such as religious leaders in the relevant communities, as this can assist in combating misperceptions. Having understood the critical role that religion plays in shaping health-seeking behaviour, the United Nations International Children's Emergency Fund (UNICEF) and the Ministry of Health and Child Care (MoHCC), partnered with the Apostolic Women Empowerment Trust (AWET), to create a space for dialogue with interfaith religious leaders from across Zimbabwe so as to leverage support for the COVID-19 vaccine roll out and recovery. Through this engagement, religious leaders noted that the spread of misinformation and uncontrolled information had undermined people's trust in the COVID-19 vaccines. UNICEF (November 2021) noted that collaboration with interfaith and community leaders helped in shifting negative perceptions about the COVID-19 vaccines that had been attributed to widespread misinformation and long-held religious beliefs. Hence, religion need to complement scientific efforts against any pandemic.

Whither Science and Religion?

Scholars of religion and health have noted the continued confrontation between religion and science. Fosu-Ankrah & Amoako-Gyampah (2021) note that the outbreak of COVID-19 in Africa heightened tension between some charismatic Christian leaders and science. In the same vein, writing on Nigeria, Obadare (2022) observes that COVID-19 highlighted the tensions between the needs of religious leaders and the imperatives of public health on the social terrain of a pandemic which affirms certain axioms about state and society relations. Sande (2021) observes how religious perspectives about COVID-19 have emphasised the challenge of the relationship between science and religion and the fluidity of some theologies underpinning forms of Christianity like African Pentecostalism. The above observations paint a gloomy picture on the relationship between science and religion. However, positive responses by another section of the clergy and their members offer hope of collaboration between the two disciplines.

Some scholars have suggested a bridging of the gap between science and religion particularly for the African context. Chabata (2021:274) has called for dialogue between religious and biomedical discourses which for him can yield enormous and sensible results that can transcend hollow dogmatic doctrines of the church. Sande (2021) calls for theological development targeting the nexus between divine healing, science and pandemics. All these are commendable recommendations. I would add to this discussion the need to revisit the concept of Freedom of Religion and Belief (FoRB). Within the Zimbabwean context specifically, religion is not strictly regulated because the constitution stipulates that people have the freedom of religion. There are no set boundaries of how far religion can deviate from government-set programmes meant to save lives. The COVID-19 pandemic laid bare the laxity or the absence of laws that regulate the relationship between religious institutions and the state. The fact that church leaders could comment on scientific issues which they are not knowledgeable of, raises questions about FoRB. I argue that there is need to rethink FoRB in the context of pandemics. While FoRB is a human right, boundaries concerning public health messaging in a pandemic context need to be regulated. Religious leaders need to respect these boundaries in order to avoid misleading their followers which may result in unnecessary loss of life. Manyonganise & Biri (forthcoming) have called on Zimbabwean political leaders to encourage theological training for church

leaders so that in the event of pandemics such as COVID-19, they interpret biblical texts in life-giving ways as well as challenge an overreliance on the spirit. FRAHM-ARP (2021) argues that a pneumatology that disregard the physical realities of a disease and told people to ignore healthcare guidelines would be harmful to followers and place them in danger. Hence, in a pandemic context, religion should function as a social tool to bring cohesion in communities as well as to enable people to derive meaning from situations not to peddle conspiracy theories that discredit science and misinform the public. DRUCKMAN ET AL. (2021) aver that misperception about science are a major concern as they undermine efforts for a healthy and productive society.

Conclusion

The intention of this chapter was to examine the role of religiosity in COVID-19 vaccination in Zimbabwe. It focused on highlighting the role of prophecy in shaping attitudes on vaccine uptake by Christians in Zimbabwe. The chapter noted the centrality of prophecy in AICs and African Pentecostalism specifically in NPMs. In the COVID-19 context in Zimbabwe as in the rest of Africa, the chapter noted how prophecy played a critical role in explaining the pandemic as well as shaping responses to it. Emmanuel Makandiwa was discussed at length because he was very vocal in claiming ownership of a prophecy that had predicted the coming of the virus. He further directed the response of his followers to the uptake of the COVID-19 vaccine through peddling conspiracy theories of how the vaccine had a chip with a mark of the beast mentioned in Revelation 13. Though he later corrected this misinformation, many people in his church had died. The chapter also discussed church leaders who positively influenced vaccine uptake showing that religiosity played an ambivalent role during the COVID-19 pandemic in Zimbabwe. What this shows is a continued conflict between science and religion. The church leaders who spoke on the need for pastors to avoid commenting on issues they are not trained in offer hope of the possibilities of science and religion working hand in hand rather than in confrontation. In the final analysis, the study has called on Zimbabwe and probably Africa to rethink FoRB in the context of pandemics. More research is required on how such concepts can be presented in the Zimbabwe Constitution so that messaging on public health issues is centralised and restricted to qualified personnel.

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Younes Nourbakhsh & Kobra Sahragard

10 The Effect of COVID-19 on Religious Beliefs and Practices of Women in Iran and their Approach to the Vaccine

Abstract

The COVID-19 crisis is a multi-dimensional phenomenon whose effects and consequences can be investigated in various economic, social and cultural fields. The effect of this virus on women and their cultural and religious beliefs and actions is also one of the topics of sociology of religion and sociology of disasters.

The current research has investigated the influence of COVID-19 on the religious beliefs and practices of women in Iran and their approach to the vaccine. This research is a descriptive-analytical qualitative one. The data were collected using in-depth interviews with Iranian women aged 25-60 and were analyzed using thematic analysis. The findings show that the Corona crisis is of high importance; the experience of anxiety and death, the feeling of sadness, religious feelings, religious upbringing, and religious rationality have led to the deepening of religious beliefs and the change of religious behavior in Iranian women. The power of religious feelings has played a prominent role in women's adaptation to the crisis. Regarding the attitude toward the COVID-19 vaccine, one can say that Iranian women had doubts and worries about the unknown consequences of receiving the vaccine. Some considered it ineffective and others preferred traditional medicine as more effective. However, others consider the vaccine the only way to deal with the virus and believe that modern science is more accurate and effective.

Keywords: Women in Iran, Corona, disaster, religious beliefs, vaccine

Introduction

The spread of the corona virus is one of the most important crises of the last century in the world due to the speed of its spread and uncontrollability. Although this crisis is only medical in nature and related to the health

system, it is a multidimensional phenomenon the effects and consequences of which can be investigated in various economic, social and cultural fields. In the economic dimension, the severe recession resulting from the suspension of many economic activities and businesses, in the social and cultural dimension, the isolation resulting from the reduction of social relations, face-to-face meetings, due to home quarantine and the suspension of many religious and social rituals, change in people's lifestyle and cultural consumption are among the changes and consequences that have occurred due to the spread of Corona in the world. In other words, it should be accepted that COVID-19 is not a virus that only infects the body, but beyond the medical issue, it has penetrated all the borders of human life and spread to all the systems and institutions of the societies. On the other hand, it is possible that with the introduction of the vaccine, its medical side is considered to be over, but its effects on social life will not disappear at once. Religion and religiosity is one of the important fields that has been significantly affected by the corona virus. The spread of the corona disease has affected the field of religion in many ways. When crises such as disease and famine or natural disasters occur, the society is pushed towards a new understanding of the world; this disease has greatly aggravated the fear of the death of oneself and loved ones and the anxiety caused by it for humans. Therefore, it can be said that it has created serious questions in the philosophical field. Have so many people suddenly thought about death and the end of their own and others' lives, and has our interaction with people and things ever changed so suddenly? All these issues lead people to reflect and rethink their worldviews and question the hypotheses and ways of life before the global disease.

What made this issue prominent in Iran was, firstly, the beginning of this disease "from the city of Qom" as a symbol of religious life in Iran and the reaction and intervention of a number of religious leaders from Qom to Mashhad in the initial weeks of the virus outbreak, and secondly, there was the suspension of religious and pilgrimage centers and the suspension of religious rituals and the reaction of Iran's religious community to these events. Corona in Iran affected religious rituals and closed or changed them. Different religious interpretations of this disease were presented and created challenges in the society. Places of worship were closed for a long time. In order not to distance people from religion, scholars suggested alternative worships. The media played a greater role in holding

religious ceremonies. Also, virtual processions in religious places provided social and health services to the people and helping those in need also increased at this time compared to the past. General it can be said that new conditions came up in religious rituals which were at the lowest possible level before corona. The corona virus as a disease not only affected religious actions and rituals and caused the closure of religious rituals and temples and shrines, but also brought up new theological interpretations and this created challenges for religious scholars and social policy makers in Iran. Is Corona a sign of God's anger against human sin? Is Corona a collective test from God for humans? Is this compatible with divine mercy and cosmic order? Women's exposure to COVID-19 disease and its mental and social effects were also among the new issues that attracted the attention of the authors of the article; because according to the health guidelines during the outbreak of the corona virus, social distance and home quarantine, it has been acknowledged that the burden of women's caring role has also quadrupled during quarantine. (Labeodan & Olufemi, 2021:15) In this research, we are looking for an answer to this question: What effects has the Corona phenomenon had on the religious values, beliefs and behaviors of women in Iranian society? How did Iranian women face this crisis and what challenges did they face and what religious solutions did they have for it? How did they receive the vaccine? And how willing were they to follow health orders to reduce risk and maintain health? In fact, we want to deal with women's understanding of Corona and religion and see, as Corona changed women's lifestyles, if it affected their religious understanding as well. And what are the consequences of these changes in women's religiosity for Iranian society?

An Overview of the Research Background

With the spread of the corona virus in different parts of the world, studies have been conducted to investigate the effects of the corona virus on the economy, politics, culture and religion in various countries, and here we will review some of them.

The Pew Research Center (2021) has investigated the religiosity of the people of 14 countries during the outbreak of Corona and their family relationships.

> This analysis focuses on views of religious faith and family relationships around the world during the COVID-19 pandemic. It builds on research released in the fall of 2020 about responses in 14 countries to the coronavirus outbreak and U.S. public perceptions of how the pandemic has affected religious beliefs and family situations.

The results of this study show that Americans, more than people in other countries, say that COVID-19 has strengthened their religious faith and made their family ties stronger. (SAHGAL & CONNAUGHTON, 2021:2-3).

Another article titled the role of religion during the crisis of the corona outbreak was done by M.T. JOSEPH (2021).

> This article is an attempt to document the intersectionality of religion with COVID-19. Religion in a general sense is a reservoir of resources to which believers turn, especially in times of crisis. Religion offers explanations as to what is happening and also proposes means of mitigation. This article aims to look for highlights of these two responses from religion in different areas of the world, with a particular focus on India. (JOSEPH, 2021:1-2)

The socio-cultural and religious impact of the spread of Corona in Nigeria (2021) is the title of a research conducted by Nkechi G. ONAH. This research seeks to investigate the impact of the spread of Corona on social-cultural and religious life in Nigeria.

> The article draws data from official documents, interviews, and other relevant materials. Using a descriptive narrative approach, the paper reveals that the family life of Nigerians is disrupted, poverty is exacerbated and gender-based violence is aggravated. The religious life of the people is also affected. The communal religious experience and participation which the people see as essential in their daily lives are also interrupted.

The situation leaves the people in a state of despair. Nkechi G. ONAH says:

> COVID-19 pandemic has impacted religion in Nigeria. Places of worship are shut down while religious activities that will bring people together such as conventions and congregational meetings have been cancelled. Worship is done live on social media, radio and through online television channels but this does not give room for physical interaction with other members of the church. Religious activities bring people together in love and solidarity. It allows people to reach out to members especially the needy and vulnerable groups. This social support is very important in a poverty-ridden country like Nigeria. Studies have shown that communal religious experience is very important in human life (WEINSTOCK 2019)" (Nkechi G. ONAH, 2021:194).

Another study titled "Coronavirus and the Decline of Africa's Collective Values: Religion and Social Media to Rescue" by LANRE-ABASS (2021) was conducted to investigate the socio-economic and psychological consequences of this Corona disease on the African collective value system, especially two approaches to curbing it. This disease examines social distancing and quarantine. LANRE-ABASS says:

> This paper examines the socio-economic and psychological implications of this pandemic on African communal value system particularly social distancing and self-isolation as approaches of containing the pandemic. The paper argues that although these approaches undermine the communal system of living that Africans enjoyed in the past, the need for social distancing and self-isolation becomes imperative when viewed from an Islamic point of view. The paper offers a reconciliation of Islamic social distancing approach with the benefits of the social media as a panacea in handling the gradual decline in African communal system. It recommends that given the spread of the virus, social distancing and self-isolation can both be maintained while at the same time upholding African communal values. (2021: 215)

In Iran, various researches have been conducted regarding the effect of Corona on the educational system of economy and culture. Part of this research is the polls that have been conducted. The results of the latest survey of the Iranian Students' Opinion Center (ISPA) regarding the spread of the Corona virus at the national level and on 24-27 April 2019, show that in response to the question that "How has the importance of religion and God during this period of spread of Corona changed for you compared to before?" 47% of Iranian people said that religion and God are more important to them than before and 48.4% said that there has been no change in this regard. Only 3.5 percent of people said that the importance of religion and God has become less for them than before. This increase of effect was more among women. (ISPA national survey on the spread of the Corona virus, May 10, 2019).

The results of the survey conducted by the Radio and Television Research Center nationally on April 31 and May 1, 2019 also confirm the importance of religion for people during the outbreak of the Corona virus. In this survey, people were asked how effective each of the items is in reducing their anxiety during the Corona outbreak. The findings of the survey indicate that 73.6 percent of the respondents said that prayer is effective in reducing their anxiety. While referring to doctors with 44.2%

and referring to psychologists and psychiatrists with 22.9% are ranked next. As with all surveys and surveys related to religion, here women are more influenced by religion than men. 65.7% of men and 79.7% of women said that prayer greatly reduces anxiety caused by Corona. The least group affected by prayer during the Corona era is students with 55.6 percent, and the highest group is housewives with 81.6 percent (national radio and television survey on the Corona disease, May 2019).

Theoretical reviews

The relationship between gender and religion has long been the focus of sociologists and anthropologists. For example: James FRAZER, a famous anthropologist, shows that even in primitive religions and nations of the East (India) and West (Ancient Greece), the relationship between religion and gender in the form of naming and assigning roles to goddesses is considered (FRAZER, 1922). In studies conducted in many countries, it has been found that women are more religious than men. In this regard, two psychological and sociological approaches can be mentioned. In the psychological explanations of women's religiosity, Freud's theory, deprivation theory, and guilt theory have provided explanations for the differences in women's religiosity. Considering that our approach in this research is sociological, we will explain sociological theories regarding gender differences in religiosity. Social learning theory can be mentioned in the social and sociological explanations. The followers of this theory explain the gender differences and believe that the development of the gender role is influenced by social factors and these social conditions provide children with examples of male and female models who behave differently (such as different gender behaviors). Socialization of girls teaches them to be caring, emotional, submissive, passive and domineering. Because religion encourages these characteristics, women find religion more attractive than men (FURSETH & REPSTAD, 2006). In support of this theory, Landon SCHNABEL argues that gender differences in religiosity are caused by social processes that operate in gendered societies and expect women to assume roles, identities and values related to caring for others. On the contrary, many men develop into self-sufficient, individualistic, strong-willed, and sometimes even aggressive masculinities that are equated with religious bigotry and general intolerance. Apart from distinct social-

ization, people also tend to observe and act on gender norms and stereotypes. For example, women are thought to be more sociable and compassionate, and therefore through social interaction reject those who transgress gender norms. Then these gender processes are compatible with women's greater religiosity and their lower levels of religious prejudices (SCHNABEL, 2018:62). Structural position theories are also among the other theories proposed in this field, they believe that women are more religious than men because of their structural position in society, because women tend to have less participation in the workforce and have more responsibility for raising children, so they have more time for religious activities. Some have also said that women's involvement in raising children leads them to be religiously involved because such activities are related to the well-being of the family. Despite numerous researches that show that women are more active than men in organizing worship, religious activities and religious beliefs, Leventhal believes that these differences exist depending on the culture and tradition of each religion and believes that religious traditions in each religion creates a difference between women and men in terms of religious obligations and duties. For example, Islam and Judaism have fewer religious obligations for women than for men in some aspects. Cult believes that these differences actually have a social origin, and in this way it has explained the gender difference in religiosity. Another theory is the role theory, based on which it can be said that women's gender roles, such as having children and bearing children, women's relatively precarious and dependent position in relation to their fathers, women's love and affection, which are expected from women's roles, and most importantly their dependence on the family system can be an effective factor in their higher religiosity than men. And another theory developed by two sociologists, John P. HOFFMAN and Alan S. MILLER's theory of risk taking explains that men have an innate tendency to take risks and therefore are more inclined to gamble than women to avoid being punished in the afterlife. As a result, men are less religious. Since women are generally more risk-averse, this theory believes that they turn to religion to avoid eternal punishment or to secure a place in heaven (MILLER & HOFFMAN, 1995:72-73). Based on these sociologists' theory, Baylor University sociologist Rodney STARK hypothesizes that men's physiology – specifically their higher testosterone levels – accounts for gender differences in religiosity. His argument is based on what he sees

as growing evidence that testosterone is linked to men's greater willingness to take risks, and argues why men are less religious than women. According to inference, women are more religious because they have less dangerous testosterone (STARK & MILLER, 2002:1419).

On the other hand, people's recourse to religion can be different in disasters and crisis situations, and the amount and type of this recourse is also different between men and women according to gender; "Disaster is an event process that requires the combination of potentially destructive factor(s) resulting from the natural environment, the changed environment or the artificial environment and a population that appears in a socially and economically created vulnerable situation and As a result, a kind of discontinuity is felt in the relatively customary fulfillment of individual and social needs related to material survival, social order and meaning (SMITH & HAFFMAN, 2002:4).

Mikael BARKUN believes that individual disasters provide less opportunity to challenge existing explanations, but when disasters and their consequences are multiple, the inadequacy of traditional methods of explanation becomes evident (BARKUN, 1974:79). Challenging existing methods of explanation in low-consequence disasters or isolated disasters is in many cases neutralized by the inertia of cultural systems: "Cultural systems have inertia; All belief systems tend to preserve themselves as much as possible, even when alternative systems offer better understanding" (BARKUN, 1974:79). Hence, under the initial impact of disaster, victims instinctively seek to explain their plight in terms of pre-existing beliefs, just as we all seek to relate to an unfamiliar stimulus by associating it with the most readily available familiar categories (IBID.). The important point that Mikael BARKUN points out is that if the disaster is limited in terms of scope and time period, ineffective explanations will continue to exist in the corners, but if the disaster expands more and more and in terms of time and space, the scope will continue. In fact, the ineffectiveness of such explanations becomes more apparent (BARKUN, 1974:81).

The more a belief receives the attention and favor of the people of the age, the more power and influence it gains. Sometimes the story is the opposite, and all things go in a certain way, and the set of circumstances is matched in such a way that they destroy the validity of a belief and make it seem unimportant or even deviant and false in the eyes of people. Dis-

aster situation and crisis situation are prone to invalidate beliefs or validate them. We can divide religious beliefs into three categories: untestable, testable, and testable. Because untestable religious beliefs do not have any direct relationship with the affairs of this world and do not require judgment about the affairs of this world or do not require direct intervention in the affairs of this world, they usually do not undergo erosion in a catastrophic situation. Testable religious beliefs are usually not challenged because they can be tested in some way. But the religious beliefs that avoid the test, on the one hand, judging about the affairs of this world, indicate some kind of intervention in the affairs of this world, and on the other hand, the believers of these beliefs are not willing to test them. These types of religious beliefs may rise or decline in a catastrophic social situation. For example, millennial beliefs grow in some catastrophic situations and based on them, millennial movements emerge (Barkun, 1974:164).

Research Method

This research is a descriptive-analytical qualitative research. The data were collected using in-depth interviews with Iranian women and were analyzed and investigated using thematic analysis. Thematic analysis is an analysis based on analytical induction in which the researcher achieves an analytical genealogy through data classification and pattern finding within and outside data (Braun & Clarke, 2013:121). The participants in this study were selected based on theoretical sampling, and according to the quarantine conditions due to the COVID-19 disease; the interviews were conducted in the form of video calls through the WhatsApp virtual network. Interviews were conducted with Iranian women from different parts of the country in the age range of 25-60 years old, working and housewives, single and married. And it continued until theoretical saturation was reached, and finally 19 interviews were conducted. Each interview was between 30 to 45 minutes, all interviews were recorded and then written in detail. For data analysis, thematic analysis was used as a suitable method to obtain the structure of meaning in a set of data that emphasizes the subjective experience of people. After coding and removing duplicate codes, 54 codes were extracted. In this section, the 54 codes or initial concepts identified could be placed in 21 sub-themes, and finally we placed the sub-themes in the heart of 11 main themes.

Findings

The research findings were categorized and analyzed in 11 main themes. In terms of demographic characteristics, women are in the wide age range of 25-60. Married and unmarried women from different cities are included in this survey, and they were employed in various administrative and educational occupations or they were housewives.

The interviewees introduced themselves as believers. Religious beliefs include beliefs related to fundamental ontological issues and the ultimate issues of life that the followers of a religion and ritual believe in those content and concepts. In this research, one of the main themes is "religious beliefs" which has 4 sub-concepts; Belief in monotheism (the oneness of God), resurrection (life after death), prophet-hood (the prophethood of Muhammad (pbuh)) and imamate (twelve infallible imams). They described God as all-powerful, merciful, and considered the Prophet and Imams to be perfect human beings whose behavior is a model for Muslims. They also considered three elements more effective in their "religious education": family, educational institutions and religious studies. The studied women who had a more serious and acute encounter with the corona virus had experienced "anxiety and worry" facing with the disease this disease. The experience of anxiety is the feeling of discomfort, worry or tension that a person presents in response to threatening or stressful situations. Although anxiety is a natural human response to threats, anxiety about COVID-19 seems to be mostly due to the unknown and creating cognitive ambiguity in people about this virus. Fear of this disease, fear of death, spread of false news and rumors, interference in daily plans, regulations, curfew and travel restrictions, reduction of social relations and dozens of other consequences of these conditions threatens the mental health of people in society. The experience of anxiety caused by COVID-19 was not only for the person infected with Corona, but during the spread of this virus, the fear of getting sick, the fear of death, along with the confusion of daily activities, makes healthy people also get involved with the anxiety of this disease (Rubin & Wessely, 2020). These factors can cause a series of symptoms and also serious clinical disorders (Shigemura, et al., 2020), which range from symptoms of feeling fear and worry to clinical stress and anxiety; mental and practical obsessions related to the disease and even signs of post-traumatic stress have been seen in similar conditions (Shultz, Baingana & Neri, 2015). Preliminary data showed

that women accepted more psychological effects of the corona epidemic conditions compared to men, therefore women are at greater risk (Pieh, Budimir & Probst, 2020). According to several studies conducted in Iran, women in Iran felt significantly more anxious when dealing with COVID-19, compared to men. This is also the case in our research. One of the interviewed women clearly expressed her fear of this disease and the fear of the hospital being contaminated:

> It was at the beginning of the New Year 1399 that we got involved as a family. At first it was a minor cold. We were afraid of catching this disease, and they kept telling us not to go to the hospital, because if your illness is not Corona, you will definitely get Corona if you go to the hospital.

Another interviewee (code 18, female, 37 years old, married) also stated in response to the same question:

> In the beginning, at the beginning of the virus outbreak, we were so afraid of catching it that we rarely went out for shopping, and I kept washing everything and anything we bought that could be washed..., it was really a strange fear. We could not go to my mother's house for almost several months, because I was afraid of being a carrier and transferring it to my parents who are very old.

The experience of death and the intensification of grief were among the other issues of the interviewed women, at the same time as the spread of the Corona virus in Iran, the daily deaths caused by it began. The suspension of social rituals related to death caused many survivors to be deprived of holding funerals and burial rituals for their family members and loved ones. In the situation of the spread of Corona, funeral and burial ceremonies were held with the presence of a small number of family members and relatives, and in the case of funeral and memorial ceremonies, which are usually held on the third, seventh, and twentieth days, the physical and public gathering of relatives and acquaintances have been impossible. The situation mentioned about the deaths caused by the corona virus has been worse. The survivors of those who died due to Corona have often been deprived of visiting their loved ones in the hospital, hugging them and saying goodbye to them. Many families do not know how the bodies of their loved ones were washed or bathed. Funeral ceremonies are often not held and burial ceremonies are held in compliance with health protocols and with the presence of a handful of the closest family members. In many cases, religious customs such as the funeral prayer and the last exhortation for these deceased have not been implemented and the holding

of funeral and memorial ceremonies in a physical and collective manner has been completely suspended. In such cases, even close relatives or family members are prohibited from gathering in one place and honoring the memory of the deceased. The situation becomes worse when the survivors of the Corona virus are infected with the virus themselves and go through a period of illness. This is where even wives, children, sisters and brothers cannot hug each other and hold each other's hands. As an example, one of the interviewees (code 3, female, 35 years old, single), in response to the question of whether you lost someone close to you due to corona disease and how you managed it, said:

> I lost my father due to Corona; my illness was also very severe; 20% of my lungs were involved... I was quarantined at home alone for 40 days. I had lost my father and I hadn't seen anyone and only some relatives called me and expressed their condolences. I was so broken down that I couldn't sleep and I cried until morning.

In this research, one of the main themes known to be effective among Iranian women in adapting to the critical conditions of COVID-19 is "religious feelings", which includes two sub-themes of hopefulness and peace and assurance. Emotions are an important aspect of individual and social life and play a significant role in people's lives. According to Vanderle Fran, religious feelings are different from non-religious feelings: First, they have a composite structure and include more than one feeling at the same time. Mixed feelings can be of different nature. They may have the same capacity (both may be pleasant or unpleasant), but equally their capacities may conflict. His description of religious emotions as a mixture of fear and wonder constitutes an example of mixed religious emotions. Second, for our purposes, it is more promising and has more depth of value. So there is a balance between emotional responses and the values that respond to them. (Some values are higher than others and require deeper involvement). Considering that all examples of religious emotions are related to religious values, they are emotions that affect us in a much deeper way. Fear of eternal damnation, religious despair, happiness and hope, the religious joy of feeling loved by God – all are types of general emotions that involve us more than other emotions in connection with religious values (FERRAN, 2019:79). A peculiarity about religious feelings is that, unlike our general emotions, they have more depth and stability. We abandon ourselves to them. We surrender to them. Religious joy is always a deep joy. Religious feelings are emotions with weight. And

one is completely influenced by them. It should also be said that religious feelings intensify, especially in times of crisis, and for this reason, some sociologists consider the changes in societies in the process of modernity, which have increased financial and social security, to reduce the need for religious assurance, and the occurrence of crisis In the societies, they consider it a setback in the religious orientation of the societies (HOLLINGER & MUCKENHUBER, 2019). So it can be acknowledged that religious feelings and beliefs when faced with threatening situations such as illness, war, death of relatives, etc., is an effective way for people to deal with such situations by creating psychological and social support (IMMERZEEL & VAN TUBERGEN, 2011). Analyzing religious feelings according to the dual human need for positive feelings caused by religion in the conditions of suffering and help to overcome the crisis seems necessary (KRYSINSKA, ANDRIESSEN & CORVELEYN, 2014:352). From the texts of the interviews conducted, we extracted the propositions and concepts that indicated religious feelings. For example, one of the interviewees stated in response to the question of how you evaluate yourself from a religious point of view:

> For me, the peace I get in religion is very good, and maybe I can't find this peace in anything else but God. I have to say that this is my personal feeling, those who do not believe in the oneness and power of God live harder.

In response to the same question, another interviewee said:

> I feel God in every moment of my life, and I believe that God will solve every problem. Sometimes when I think about my sister or..., I can see exactly some time later that person contacts me. I believe that this is a non-material action that is going on and the cause of all this is the loving presence of God and God is everywhere.

"Deepening of religious beliefs" is the most important concept that we found in the interviews with Iranian women in the face of the Corona challenge, which has two sub-themes of belief in monotheism and God's power and belief in Ahl al-Bayt (imamate). After conceptualizing the interviews that were conducted with women, we found that the women who had a more serious conflict with it during the outbreak of the Corona virus, their religious beliefs have deepened in terms of belief in monotheism and the power of God and belief in Imamate and Ahl al-Bayt. Women whose belief in God has deepened are those who experienced severe anxiety and sadness during the outbreak of Corona due to acute infection of

themselves or their family members. This feeling or belief made the patient hope for a miracle and healing. The interviewee (code 10, 34 years old, single) answered the question of whether your religious beliefs and beliefs have changed due to the spread of Corona virus or not.

> Well, I really saw a miracle when my brother was hospitalized due to the corona virus, and God gave us a miracle that he came back. It was a really difficult time and God brought him back to us again. This incident made my faith in God and his power stronger and stronger than before.

Also, another interviewee expressed the power of religion in enduring adversities and creating hope in disappointments (code 12, 54 years old, married) in response to the same question:

> I feel that I have become closer to God with this incident, because I had no recourse other than God and the imams in that situation... We asked God for your health, and my infection with Corona made it more tangible for me that a human being with all abilities gets into a state where he can't even blink and I felt how small and weak I was and only God could bring me back to life.

"Religious rationality" is also one of the important concepts extracted in this research. The interviewed women did not see a serious conflict in terms of the ratio of religion and reason. On one hand, they prayed to God for healing and health, and on the other hand, they believed in taking care of medical orders and recipes related to the care of Corona. One of the interviewed women says:

> I believe in the healing power of Imams. The same is true for Corona, but the story of Corona is a little different due to its contagious nature. It is true that Imams have healing power, God himself says that the greatest thing I have given you is reason, and you should use it. When a disease like Corona is highly contagious, then common sense dictates to stay away from the place where there is a gathering, now wherever it is. Whether it is a party hall or a shrine of Ahl al-Bayt.

Also, another interviewee tries to justify the corona bans regarding religious places. She considers answering a prayer to be more of a matter of the heart than a ritual by attending a special place. She said in response to the same question:

> I fully believe in the healing power of imams and for me it is not like I am bound to be present in that place. That is, I appeal to the imam in my heart, and then the place is not important to me, which means it's not the case

> that now that the shrine of Imam Reza or Imam Hossein is closed I can't as for anything from them, or there was no contradiction for me to say that Imam Reza, who was said to heal, is now closed because of Corona.

Among the other main categories extracted in this research, "the change of religious behavior" is under the influence of the spread of the Corona virus, which has a sub-theme of individualization of religious practices and worship among women. Corona has affected religious rituals in Iran. Under the influence of the spread of COVID-19 in Iran, religious gatherings have been cancelled and changed for a long time, congregational prayers and Friday prayers have been suspended, and many mourning rituals of Shia special days in the months of Muharram, Safar and Ramadan were also closed in general. Due to the home quarantine during the outbreak of the Corona virus, the people of Iran did not participate in the traditional religious ceremonies. Scholars proposed alternative forms of worship in order not to distance the people from religion. Also, the media played a greater role in holding religious ceremonies. In this situation, the majority of Iranians performed their religious acts and prayers individually at home. Many religious groups and people who were distributing food offerings in the street spent their offerings to provide health care products for the people in order to prevent the spread of the corona virus and in many mosques and religious groups, they made masks. According to the conducted interviews, we extracted propositions and concepts that indicated the change of religious behavior. For example, one of the interviewees, in response to the question of whether your religious practices changed due to the spread of Corona, said:

> Not only religious ceremonies and pilgrimages, but also parties and everything else were closed. We would go shopping with my husband by car and return early. I used to go to all the ceremonies, especially Ashura and Tasua'a, and I believed in them very much. But during these two years I couldn't go there. We lived in Zanjan for a while, and there was a big celebration in Zanjan Square, which I went in person. But in these two years I watched its live broadcast on TV.

Another interviewee also stated in response to the same question:

> Before Corona, I regularly went to the mosque for noon and evening prayers, I used to offer Iftar to others during Ramadan, but during Corona, I didn't go to mosques and shrines at all, and now I go very rarely. When the Ramadan Quran sessions were canceled, I also read the Quran while watching it on TV.

In addition to the individualization and personalization of religious practices, we also witnessed its medialization. A significant part of the television programs consisted of preaching and religious programs, and by broadcasting limited ceremonies or ceremonies from previous years, it helped people perform religious ceremonies.

Perhaps one of the important themes in this research can be considered as the increase of "attention to human rights". This is the seventh theme that was observed in the findings. By studying the interviews, we extracted concepts that confirm the increasing attention to human rights among Iranian women in the period of the Corona epidemic. This theme includes the sub-concept of public benefit and charity. In a part of the interviews in which women were asked about their religious beliefs and behaviors during the Corona period, they mentioned the increase in helping the needy, respecting the rights of others, and helping charities. An interviewee stated:

> Generally, after the crisis that happened to the family, I changed my mind and come to the conclusion that one's actions are much more important. One's actions, thoughts, and beliefs must be the same; I think that one should try to be kind and help others; that is more effective than, for example, praying 100 raka'ats.

Another interviewee considers serving the people and caring for the needy as religion and states:

> I see God and religion in serving the people. We have many poor people. Especially in this Corona situation, many workers became unemployed and became poor, and they are hungry. I think the cost of these religious places should be spent on these needy people.

Some others even stated that instead of spending money on religious ceremonies, it is more necessary to help the needy and providing the children in school with their needs or medical matters. Here, a kind of secularization of religion can be found. In other words, they did not see religion only in certain customs in a certain place, but consider every human issues and social service to the needy as religion.

"Women's attitude towards the corona virus" is the eighth theme that was investigated. This theme has three sub-categories that express the attitude of women towards the corona virus, some women considered the corona virus to be man-made, some had a natural origin, and some had a

divine attitude towards the emergence of the corona virus. In the following, we have arranged a number of narrations related to each of these concepts. One of the interviewees stated:

> I think the mutations that this virus has are suspicious, and the fact that nature has not been able to eliminate it yet make me think that it has been manipulated. I think these mutations are unnatural, that sometimes it becomes weak and sometimes it becomes strong.

This conspiratorial approach to the corona virus, which considers it to be a product of the laboratories of some major governments in the world, was common for a while, especially at the beginning of the spread of this virus in Iran. The second approach is the natural approach to the virus, which considers it similar to other viruses that have existed in the history of the world with differences. One of the women said:

> These epidemics have always been seen throughout history, and I don't think it's anything strange. And I don't accept many things that have been said.

According to the third approach, Corona is the result of a sin committed by humans, and now, in a way, nature has rebelled against humans and is punishing them. Some religious scholars in Iran also mentioned this concept in their speeches. Some women accepted this approach:

> In my opinion, in the world, there are so many wars, so many sins, so much extravagance in weddings and ceremonies, people who borrowed money for a wedding, how much do they have to spend to make the ceremony elaborate. This is the recompense we have to pay for our being ungrateful.

The ninth theme is that of “women facing the corona vaccine”. With the creation of the first vaccines to deal with the corona virus, there were reactions among the people facing the vaccine, which was accompanied by concern and doubt about its injection. In this research, according to the interviews that were conducted with Iranian women, it was found that they had different opinions regarding the COVID-19 vaccine. Propositions and concepts related to how to face the corona vaccine were extracted, which had two different themes and concepts.

The sub-theme of "doubt and concern about the vaccine and its consequences" is the theme that was extracted according to the conducted interviews. Many women have doubts and worries about the corona vaccine injection. On the one hand, this doubt in Iran was due to the doubt about

the origin of the corona virus, because they saw it as fake, so they considered the vaccine as fake as well. On the other hand, due to the pessimism that exists in Iranian society towards the West, and that the Iranian society was promised the production of a vaccine, people hesitated to use it.

For example, in response to the question of what is your opinion about the corona vaccine and whether you are willing to inject it or not, an interviewee stated:

> It is not known at all what these vaccines are and what effect they are going to have on people's bodies later. However, I took two doses of the Sinopharm vaccine and I am really sorry because after two doses of the vaccine, I got corona again.

Some other women like the rest of Iranian society prefer to use medicinal plants and traditional medicine. Another interviewee stated in response to the same question:

> I generally get along better with herbal medicines. If you ask me for pills now, I don't have any pills at home. I couldn't trust the vaccine either, but finally they told me to receive it and I did. Anyway, this was also a way I tried and the result is not clear yet.

The sub-theme of trust in science is another theme extracted from interviews with Iranian women in the face of the corona vaccine. In response to the question of what do you think about the corona vaccine and are you willing to inject it, some women declared that science has been serving a better life for mankind from the beginning to this day, so they trusted it and were willing to take it easily and so they were vaccinated. The approval of the WHO and the use of many countries also increased the trust among the people, despite this, a part of the society, especially women, could not trust. Proponents of traditional medicine as well as religious healing prescriptions recommended by some religious people, especially in the villages, developed mistrust.

The findings of this research show that the corona crisis, due to its components and extractive effects (experience of anxiety, experience of death and feeling of sadness, religious feelings, religious education, and religious rationality) ultimately leads to the deepening of religious beliefs and changes in religious behavior in Iranian women. It should also be said that the experience of anxiety, the experience of death, and the feeling of sadness have been among the most important factors affecting religious beliefs. In other words, our findings show that women who have

had a more serious encounter with the corona virus, i.e. they themselves or their loved ones had a serious conflict with it, experienced more severe anxiety in interactions with others, and this experience of anxiety and the experience of death and the sadness caused by that crisis has affected their religious beliefs. Our findings show that women who did not experience severe anxiety and sadness did not find a connection between Corona and their religious beliefs, that is, there was no change in their religious beliefs. It should also be added that the theme of religious feelings has played a prominent role in women's adaptation to the experience of anxiety and sadness caused by the corona virus crisis, in other words, women who experienced more anxiety through religious feelings have been able to overcome anxiety. The studied Iranian women, while criticizing the irrational religious prejudices and unconventional behavior of some religious people in response to the closure of religious ceremonies and places, have considered the change in religious behavior as an inevitable necessity in the conditions of the Corona crisis. In other words, under the influence of these conditions, women performed their religious practices individually, away from the crowd and at home. Also, one of the significant points in this field is the increased attention to human rights in women's religious behaviors and practices during the Corona outbreak. Our findings show that during this era, Iranian women were more willing to do charitable and humanitarian acts.

Another finding of this research is the attitudes of Iranian women towards the corona virus, among Iranian women there are three different attitudes towards the origin of the corona virus, some consider it man-made and others consider it natural and like other diseases on earth. But another group has a different attitude towards the origin of the virus and consider it divine and the result of the bad deeds of humans and their ingratitude.

Regarding the exposure of Iranian women to the corona vaccine, it can be said that they had doubts and concerns about receiving the vaccine and its unknown consequences, some considered it ineffective and others were influenced by anti-vaccine advertisements. Traditional medicine has been considered more effective in preventing the corona virus, but some others consider the vaccine to be the only way to deal with the corona virus and believe that modern science is much more accurate and committed

to human health and to stay with their family and loved ones, they have trusted science and are willing to accept the corona vaccine.

Figure No. 1 - The final thematic map shows the relationship between themes and the impact of the Corona crisis on values, religious beliefs and behaviors of Iranian women.

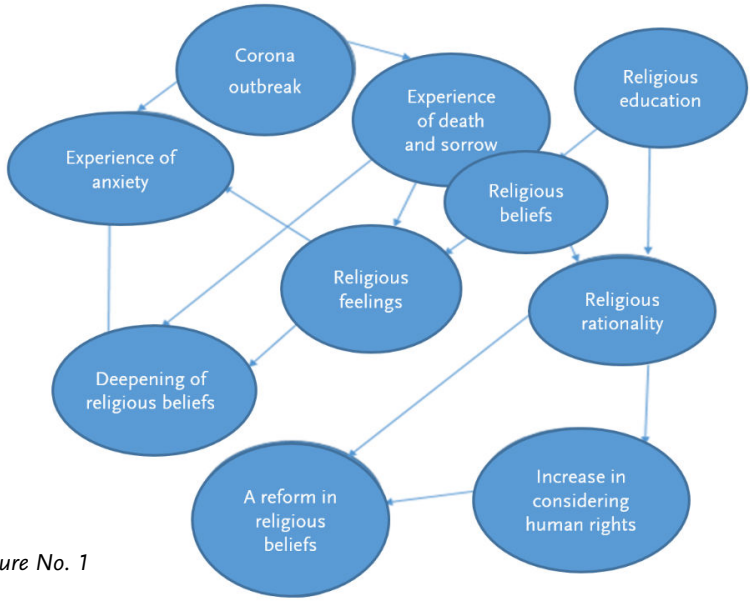

Figure No. 1

In the description of this map, it can be said that the spread of Corona in Iran has had two direct consequences: the experience of anxiety and the experience of death, the feeling of sadness for Iranian women, which, through the components of religious feelings, religious beliefs and religious education, lead to a deepening of beliefs and religious values in women who have been studied in this research. It should also be said that the theme of religious feelings directly played an effective role in controlling women's anxiety during the outbreak of the COVID-19 crisis. On the other hand, the theme of religious rationality, which is influenced by the theme of religious education and religious beliefs, has played an effective role in changing the religious behavior of Iranian women. Also, the theme of increasing attention to human rights as a result of religious education

and religious rationality has also been effective in changing the shape of religious behaviors.

Discussion and Conclusion

The current research was conducted with the aim of investigating the impact of the spread of the disease of COVID-19 on the religious beliefs and practices of women in Iran and their approach to the vaccine. In general, the research results show that the COVID-19 disease has led to the change of women's religious practices and the deepening of their religious beliefs. According to studies in Iran, women felt significantly more anxious compared to COVID-19 (Pieh, Badimir & Probst, 2020). According to the health guidelines during the outbreak of the corona virus; Social distance and home quarantine, it has been acknowledged that the burden of women's caring role has also quadrupled during quarantine (Labeodan & Olufemi, 2021:15). Therefore, it seems that this crisis has resulted in a stronger commitment and moral responsibility for women to fulfill the family, relational, religious and educational needs of their families and take care of them. The findings of our research also show that the experience of anxiety, the experience of death, and the feeling of sadness were among the direct consequences of the spread of Corona on women in Iran. Religious feelings that help women adapt to the problems and anxieties and worries caused by the COVID-19 crisis. In fact, the lived experience of religious feelings such as divine faith and divine help and refuge creates positive emotions and spirits in women. And it reduces the feeling of fear of the death of family members and loved ones and makes family life easier in the high-risk society caused by the spread of the corona virus. From this point of view, religiosity among Iranian women shows more damage than men. The research findings of Lokti et al. (2020) and Chen et al. (2020) confirm the role of religious feelings in increasing life expectancy and reducing anxiety and fear. The findings of M.T. Joseph's research (2021) also show that in India during the Corona outbreak, resorting to religion has relieved their sufferings and pains caused by the Corona calamities. It should also be said that the religious behavior of Iranian women has undergone changes due to the quarantine conditions caused by the spread of Corona. At first, women performed most of their religious practices individually, away from the crowd and at home. This

research is also similar to the findings of other researches mentioned earlier. First, turning to religion was common among Iranian women, as shown in M.T. JOSEPH's research. Second, communal religious experience was a method used by Nkechi G. ONAH's research among Iranian women to face Corona. Thirdly, although social distancing was against Islamic recommendations, this relationship continued by resorting to social media, as LANRE-ABASS's research in Africa also shows, and with the production of religious programs on Iranian television, it is possible to pray and participate virtually in the religious programs.

As BARKUN's research showed, not all religious propositions are affected. In this research, it was found that unassailable beliefs and basic beliefs have not changed, but things have happened in some areas. One of the significant points in this field is the statement of women to increase attention to philanthropy and human rights in their religious behaviors and practices during the Corona outbreak. It seems that this concept is one of the most controversial findings of this research, which can be discussed with the concept of civil or human religion, which was first proposed by Jean-Jacques Rousseau (1712-1778). In general, it can be said that civil religion consists of a set of symbols and rituals that are often connected with religion and cause facilitation and even a kind of awe in the social system. In fact, the main concern of civil religion is to link religious-theological teachings with political-social affairs (ARON, 2007:116). In other words, in this concept, religion is manifested in a civilized form and compatible with the requirements of the new era in the socio-political era. This manifestation is completely in line with the teachings of the new age and in other words, it serves the needs of this age. According to the findings of this research, it seems that under the influence of the spread of Corona, the religious behavior of Iranian women has tended towards humanization or civilization, the consequences and developments of which are debatable for the Iranian society.

One of the characteristics of civil religion is the sanctification of social laws and regulations in order to guarantee their better implementation, so it can be said that unity, harmony and cohesion among social groups is the most important strength of civil religion, whose achievements are the strengthening of organizations and civil and voluntary groups in society. Strengthening groups and organizations in society also leads to strengthening civil society. The strengthening of civil society in the society

has many consequences. The first consequence is that civil society can be assumed to be the gateway to social development. If the civil society is empowered in a society, that society can reach social development sooner and better.

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Appendix

Table 1 - The interviewees' specifications

*	Age	Gender	Marital status	Religion	Education	Profession	Place of living
1	26	Female	Married	Islam-Shia	MA	Housewife	Tehran
2	25	Female	Single	Islam-Shia	BA	Unemployed	Bijar-Kordestan
3	35	Female	Single	Islam-Shia	MA	Teacher	Doodoor-lorestan
4	31	Female	Married	Islam-Shia	Ph.D.	PhD student	Qom
5	30	Female	Single	Islam-Shia	MA	QC Engineer	Boushehr
6	46	Female	Married	Islam-Shia	Diploma	Housewife	Zanjan
7	60	Female	Married	Islam-Shia	MA	Teacher	Tehran
8	28	Female	Single	Islam-Shia	MA	Medicine	Mashhad
9	32	Female	Single	Islam-Shia	MA	Student	Tehran
10	34	Female	Single	Islam-Shia	MA	Teacher	Boroojerd-Lorestan
11	32	Female	Single	Islam-Shia	BA	Teacher	Fouman
12	54	Female	Married	Islam-Shia	BA	Retired teacher	Karaj
13	34	Female	Married	Islam-Shia	MA	Teacher	Khorrama-bad
14	26	Female	Single	Islam-Shia	MA	Corrective movement coach	Karaj
15	51	Female	Married	Islam-Shia	BA	Housewife	Mashhad
16	41	Female	Married	Islam-Shia	Associate degree	Housewife	Kerman
17	38	Female	Married	Islam-Shia	Diploma	Housewife	Kerman
18	37	Female	Married	Islam-Shia	BA	Housewife	Gorgan
19	57	Female	Married	Islam-Shia	BA	Retired clerk	Gorgan

*** The interviewee's code**

*Joachim Kügler**

11 Vaccination Attitudes of Ivorian Muslims: "Islam is not against vaccines – but this is doubtful!"

Abstract

During the COVID-19 pandemic the situation in Ivory Coast was characterized by a deep mistrust against the hygienic measures of the government as well as against the vaccines that were offered as a means to protect oneself against infection with the virus. The chapter focuses on attitudes of Ivorians who define themselves as Muslims toward COVID-19 and tries to find out if they share into the rejection of vaccines and what religion has to do with their attitude. A small study done with qualitative empirical methods, of course, can never be representative for the whole Islamic population in Ivory Coast. Yet, the interviews grant a glimpse into the attitudes toward vaccines and into the relationship between religion, health and politics. The research results in the preliminary impression that socio-cultural and political factors are more important than religion. Significant differences between social groups within the Islamic community become clear.

Keywords: COVID-19, Ivory Coast, Côte d'Ivoire, Islam in Africa, pandemic, disease, healing, religion and science, health and politics

Introduction

In preparation for the workshop "COVID-19 and Religion", which took place in November 2021 at the University of Bamberg the author decided to do some preliminary research among Ivorian Muslims to find out how

* I could not have written this article without the support that I experienced from *Saidou Diallo Mamadou* MSc, Abidjan. He advised in creating the questionnaire, helped in selecting the interviewees and collected the answers. Thank you very much!

far religious attitudes influence the way how the COVID-19 vaccines are conceived.

These interviews on attitudes towards COVID-19 vaccination among Ivorians who identify themselves as Muslims took place at a time when travelling was still restricted and the pandemic was quite far from ending. The general image of Africans' reaction to public health measures in general and to vaccination especially, was mainly influenced by reports on the religious activism initiated by African Christians. Maybe not the majority of Christian religious leaders but those who dominated public discourse in media shaped the image of vaccination as a satanic weapon threatening health and life of African people. The apocalyptic framing of the public discourse about pros and cons of vaccines resulted in an anti-Western, anti-colonial, and anti-scientific war on vaccination.

> Responses to the COVID-19 within this matrix of apocalyptic mind-set sustains the anti-modern harboured perceptions. A further onslaught on humanity as AIDS. Only this time, God has protected Africa from severe COVID-19 casualties. Initially, government officials voiced that COVID-19 is a well-promoted hoax by fake news of prominent western media houses. The late president of Tanzania, John Magufuli, dismissed its actual existence [...] As, however, the pandemic started ravaging Africa and Afro-Americans, perceptions quickly shifted from denial to acceptance. The new realities redirected the attacks on new aims. There was an uproar after some Western doctors suggested COVID-19 vaccines to be tested in Africa. Now, vaccines were seen as racist weapons to kill Africans. The chief justice of South Africa, Mogoeng Mogoeng, echoed prophets like Emmanuel Makandiwa, who declared that the COVID vaccines are the dreaded '666 mark of the beast'. Getting a vaccine shot was perceived as receiving the mark of the beast (Rev 13:16).
>
> Other conspiracy theories promoted [...] declared the protective facemask to be the 'mask of the beast'. The banning from entering supermarkets or public places without a mask is seen as the fulfilment of 'no-one shall be able to sell or buy without the mark of the beast' (Rev 13:17). Plans of having a vaccine certificate for international travel were interpreted as opening a way for the new (satanic) world order. Since world leaders are agents of dark forces controlling the world, the whole pandemic and its vaccines are seen as belonging to the grand scheme of things. The new hybrid apocalyptic worldview, which incorporates indigenous apocalyptic thinking and borrowed Judeo-Christian apocalypticism, transfix many Africans into an apocalyptic appetite that interprets the zeitgeist through apocalyptic glasses. (Nyahuma & Kügler 2021:8)

While the vaccine discussions nourished from Christian traditions were well noted and academically analysed, African Islam seemed to get a bit out of the focus. Sure, there are important contributions like the edited volume focusing on COVID-19 and the Middle East and North Africa (MENA) region, but the chapters do not focus much on religious attitudes. The conclusions show clearly that religion is rather reduced to the group of religious leaders, who are seen as "role models" like sports stars and media representatives among others.

> The pandemic has also put the relationship between religion, science and politics to a renewed test, including the question of whether to comply with or resist governmental measures on religious grounds. Noël van den Heuvel and Ulrike Freitag showed how religious actors were detrimental in developing and sustaining systemic responses to the current crisis in Iran and Saudi Arabia. It has become clear that for a successful reaction to the systemic health crisis, religious leaders are indeed of particular relevance; one might add representatives of other domains as well, whether it be culture and sports, academia and media, or wherever individuals have the chance to serve as role models for the general public. (Hobaika, Möller & Völkel 2022:173)

Religion as a mind-set guiding attitudes, feelings and actions of individuals and groups are not really taken into account. Also the book is not dealing with Africa south of the Sahara.

This clearly is the case in the chapter that Silindiwe Zvingowanisei contributed to BiAS 36 (2023). She discusses responses of Muslims in Zimbabwe to the COVID-19 pandemic. Zvingowanisei argues that Islam has always played a positive role in the domain of health in Zimbabwe. She notes how Muslims (individuals and organisations) have been active in combatting the spread of HIV/AIDS as well as distributing medical treatment to those infected. Zvingowanisei argues that Zimbabwean Muslims complied with COVID-19 protocols of the Zimbabwe government. Thus, she concludes that Muslims showed that they have strong religio-cultural resources that will be helpful in response to future pandemics in Zimbabwe.

> [Zvingowanisei's contribution] foregrounds the role of the Islamic community in promoting public health and human well-being during the COVID-19 pandemic through their cultural identity and other religious resources. [Thus, she] advocates for the inclusion of minority religions such as Islam in post-COVID-19 recovery initiatives and in any other future pandemics. (Zvingowanisei 2023:91)

Although these statements could be rated as speaking a bit *pro domo*, they are confirmed by other authors (e.g. DUBE 2022) too. Anyway, the data base of ZVINGOWANISEI is limited to Zimbabwe and her analysis does not focus on the debate on vaccination. Thus, there is good reason to give Francophone Muslims from West Africa a voice by asking how Ivorians who identify themselves as Muslims use religious patterns to shape their attitudes toward COVID-19 vaccination.

The First Set of Interviews (October 2021)

The first and rather small research campaign started in October 2021 and used a questionnaire that aimed at finding out the general attitude toward COVID-19 vaccines and also to what extent religious motives were involved in this attitude.

The whole group of interviewees comprised 9 persons. Three of them identified themselves as women, six as men. The average age of the three women was 37 years (ranging from 31 to 42 years). The average age of the six men was 29.8 years (ranging from 27 to 35 years).

The interviews went along a short questionnaire, which was read by the interviewer or handed out to the interview partner (IP) so that they could fill in their answers themselves. The questionnaire was, of course, in French, while it is rendered here in English translation also (appendix 1). The interviews took place on locations in several towns and cities in Ivory Coast).

The preliminary results of this first set of interviews in 2021 (FSI 21) can be summed up in the general statement that vaccinophobia is a minority position in the group of interviewees.

Table 1 (FSI 21)

	contra	*pro*	unclear
Women	1	2	
Men	1	4	1

Furthermore, religion seems no obstacle for vaccination. The few IPs that show an attitude against the vaccination give other reasons than religious ones. Their attitude is based on social, cultural or political reasons like a

feeling of losing freedom by being forced by the government, mistrust in the government or in the scientific quality of the vaccine. On the other side, the pro-group mentions religion as a source of motivation to practice social responsibility by protecting human health and life. Thus, the 2021 interviews give the impression that for the majority of Ivorian Muslims their religion not only constitutes no obstacle for vaccination but is, just in the contrary, a motivation to do all possible – including vaccination – to protect health and life of themselves and of others (family and community). Despite the small number of interviews, the results are not irrelevant as they are in accordance with the already mentioned results of other researchers.

Open questions

Although the results of the first set of interviews seem so clear, there are many open questions that cannot be answered by this small set of data. Among these unanswered questions the most thrilling probably are:

1. What is the education level of the interviewees?
2. How intensive is their individual relationship to religion?
3. Does religious preaching/teaching against vaccination exist and how influential is it?

Re-asking the IPs on their professional and educational background

Due to the fact that the interviewer still was in contact with all of the IPs, it was possible to clear at least question #1 in an action of re-asking the IPs on their professional position and their level of formal education.

This re-asking was done in the first week of December 2021 and the result showed a quite high uniformity of the IP-group in this point. The following table gives a short overview over the results:

Table 2 (FSI 21)

Interview Number	Alias	Professional position	Level of formal education
1	M27[1]	Student	Master
2	F31	Student	Master
3	M28	Technician	Bachelor
4	M27	Technician	Bachelor
5	M35	Engineer	Master
6	M29	Engineer	Master
7	F38	MSR[2]	Bachelor
8	M33	Engineer	Master
9	F42	MSR	Bachelor

Table 2 shows that all the members of the first IP group were situated in an academic/ professional context. Thus, the answers of the FSI 21 group refer to only a very small fragment of Islamic population in Ivory Coast. Even if qualitative research never can (or even wants to) achieve representative results, this small sector of society was rather problematic.

Therefore, it appeared necessary to broaden the horizon of the study and get access to IPs from other parts of society.

The second set of interviews (July – August 2022)

The idea of giving a voice to other parts of Islamic population in Ivory Coast was operationalized by shaping three additional groups of IPs.

- The first group was labelled "ordinary people" (OP) and comprised persons that do not define themselves as political or religious experts.

[1] The alias of the IPs are produced by composing age and gender. As alias are repeating in other IP groups, the interview number is then added to clearly identify the specific IP.

[2] Both F39 and F42 give their professional position as "déléguée médicale" which is translated here as "medical sales representative" (=MSR).

- The second group was "religious leaders" (RL), comprising persons that have a religious function of leading, preaching, and teaching in an Islamic community.
- The third group was "journalists" (IJ) and comprised Islamic persons working for media and, therefore, had influence on public opinion.

The "ordinary people" group of IPs (OP)

The questionnaire for the OP group was a slightly extended version of the 2021 questionnaire (appendix 1) as it included elements of the re-asking action mentioned above. This group of IP was the largest one in the second set of interviews. It comprised 14 IPs from different urban areas of Abidjan and different working settings. The age of the IPs ranges from 18 to 40 years with an average of 30.6 years. The following table gives an overview.

Table 3 (OP)

Interview Number	Alias	Occupation	Personal Vaccination attitude
10	M40	Shopkeeper	Negative
11	F31	Housewife	Negative
12	M35	Craftsman	Negative
13	M23	Technician	Negative
14	F28	Housewife	Negative
15	M29	Taxi driver	Negative
16	F18	Shop assistant	Negative
17	M38	Warehouseman	Negative
18	F29	Shop assistant	Negative
19	M34	Electrician	Negative
20	F25	Shop assistant	Negative
21	F29	Housewife	Negative
22	M30	Shopkeeper	Negative
23	M39	Driver	Negative

At the first glance, one can see that we did not find any IP in this group who was *pro* vaccination. What appeared as a minority opinion in the first set of interviews, is here not only the majority. It is the *only* attitude documented. Without any exception, all of the IPs are against vaccination. The reasons given for this attitude mostly are fear of damages caused by the vaccination. This fear often is given as well under "emotional reasons" as under "rational reasons". As there is no IP speaking *pro* vaccination, it is, of course, impossible to say anything about the differences connected with gender or age. The uniformity of the group concerning the negative attitude toward vaccination marks a stunning difference to the 2021 interviews. Due to the character of our data base, it is, however, impossible to thoroughly interpret the reasons for this difference. One can only speculate if it has to do with the different social contexts of the two IP groups or with different perceptions of dangers and risks in a later phase of the pandemic. Anyway, one should always keep in mind that Ivory Coast never saw the high number of casualties that Western countries like Italy, Spain, or USA suffered from.

In spite of the clear differences between the OP group of 2022 and the first IP group of 2021, there is one point that both groups have in common. They do not link religion with a negative attitude toward vaccination. Of course, there is no link between Islam and a positive vaccination attitude as all the IPs in the OP group are showing a *contra* position. Yet, they link their religion with the general responsibility for personal and public health. The OP group is very homogenous in not using their religion as a direct argument for their contra-vaccine-position. None of the IPs states that there is a religious commandment against medical treatment or vaccination in general. Yet, there are links between anti-vaccination attitude and religion. The following table gives an overview:

Table 4 (OP)

Interview Number	Alias	Statement on religious reasons for an attitude against COVID-19 vaccination
10	M40	*L'islam est une religion de vérité* (Islam is a religion of truth)
11	F31	*L'islam est une religion de vérité*
12	M35	*L'islam demande d'être rassuré et convaincu d'une chose avant de la faire* (Islam demands to be sure and convinced of something before doing it)
13	M23	*L'islam demande d'être rassuré et convaincu d'une chose avant de la faire*
14	F28	*L'islam est une religion de vérité*
15	M29	*L'islam recommande d'abandonner tout ce qui n'est pas sûr* (Islam recommends to leave everything aside that is not safe)
16	F18	*L'islam demande la méfiance envers tout ce qui est nouveau* (Islam demands mistrust against everything new)
17	M38	*L'islam est une religion de vérité*
18	F29	*L'islam est une religion de vérité*
19	M34	*L'islam est une religion de vérité*
20	F25	*L'islam est une religion de vérité*
21	F29	*L'islam est une religion de vérité*
22	M30	*L'islam est une religion de vérité*
23	M39	*L'islam est une religion de certitude et non de doute* (Islam is a religion of certainty and not of doubt)

The question concerning "religious reasons" for their attitude often (i.e. in 9/14 cases) is answered by a general, positive statement on Islam. The stereotypic qualification "religion of truth" gives the impression of something learned. Maybe the saying is part of the public discourse among Muslims in Ivory Coast, a pre-defined pattern. In the context of an attitude against COVID-19 vaccination the saying implies that this vaccination is

not true. And indeed the IPs show mistrust against the reliability, effectivity, and harmlessness of the modern vaccines. 4/14 IPs express this uncertainty about the quality of the vaccine by defining a religious tendency to avoid uncertain and doubtful things. Furthermore, one IP – the youngest person in the group – claims that there is a religious motive of rejecting innovation *per se*. As, most probably, even IP 16 (F18) would not reject really everything new, one can understand this utterance as a highly generalized expression of doubts. The IPs 12 (M35), 13 (M23), 15 (M29), and 23 (M39) express the same doubts very clearly.

To sum up, one could say that the members of the OP group show a link between Islam and their rejection of the COVID-19 vaccination. This link has to do with their doubts and mistrust against the quality of the vaccine. Their sceptical attitude seems not to originate directly from religious tradition. Instead, it is obviously used as a secondary confirmation of a negative perception that is informed by other sources. Due to the design of our interviews we cannot say anything about these sources.

It will be very interesting to compare these results with the two other groups, namely religious leaders and journalists.

The IP group of religious leaders/ Imams (RL)

This group of IPs consisted of six men who gave Imam as their profession. A gender mix was not possible in this group as the position of an Imam is clearly gendered as masculine in Ivory Coast. A woman functioning as Imam may be possible nowadays in some Islamic movements in Western countries like USA, France, and UK among others, but would not be acceptable in Ivory Coast – as in most countries[3] – even if the history of Islam obviously did not generally exclude women form this function.

The age of the members of this IP group ranges from 40 to 50 years, with an average of almost 46 years. This means that the RL group is much older than our other IP groups, and also much older than the median age of the Ivorian population, which sits at a bit more than 20 years[4]. Although

[3] For the exceptions in history and present times see the overview at https://en.wikipedia.org/wiki/Women_as_imams.

[4] A median age of 20.3 is given by the CIA's factbook (https://www.cia.gov/the-world-factbook/countries/cote-divoire/#people-and-society) for the whole population of Ivory Coast. See also: https://worldpopulationreview.com/countries/ivory-coast-population.

our IP groups are in no way meant to be representative, this higher average of age is a fact, which could be understood as an expression of a cultural tradition associating higher age with experience and wisdom qualifying for leadership.

The personal position on COVID-19 vaccination is mixed with a tendency to a negative stance. While three members of this IP group are openly against vaccination, the other three say 'yes', but with a lot of fear and doubts. Even with them scepticism prevails.

Due to the pastoral influence of religious leaders on members of their specific congregation, the professional context of their attitude toward vaccination is of high importance. To catch a glimpse into this area two additional questions were added to the questionnaire for this group of IPs – numbered as (5) and (6) in appendix 3. The following table gives an overview of the RL answers.

Table 5 (RL)

Interview Number	Alias	The relevance of COVID-19 vaccination for the religious work
24	M40	Demanding to follow the regulations of state authorities
25	M49	Topic in Friday preaching[5]
26	M45	Topic in Friday preaching
27	M50	Topic in Friday preaching
28	M48	Topic in Friday preaching
29	M43	Topic in Friday preaching

While most IPs of the RL group follow the impetus of the question (5) and simply inform about preaching on the topic of COVID-19 (vaccination), one IP, 24 (M40), already informs on the content of his preaching. He says

[5] According to Islamic tradition the Friday sermon (*Khutbah Jum'ah*) is the most prominent form of public speech. Usually, the Imam leading the prayer is also acting as preacher. The sermon is expected to address religious topics as well as topics concerning political and social developments relevant for the life of the Islamic community. Cf. https://en.wikipedia.org/wiki/Friday_prayer.

that he demands the members of his community to obey to the regulations of the state authorities. Due to the importance of the Friday sermon for the guidance of believers it is of interest to ask about the attitude toward COVID-19 vaccination expressed publicly on these occasions. Having in mind the quite sceptical personal attitudes mentioned above, one might expect to find reflections of these attitudes in the IPs public preaching. However, one cannot expect that the public speaking is simply an unfiltered repetition of the personal view. The religious, social, and political responsibility characterizing contributions to the public discourse will always influence the content.

Table 6 (RL)

Interview Number	Alias	Attitude toward COVID-19 vaccination in public speaking
24	M40	Responsibility of the scientific community to God as the highest authority
25	M49	Respecting public health authorities Trusting in the help of God
26	M45	Respecting public health authorities Trusting in the help of God
27	M50	Respecting public health authorities Trusting in the help of God
28	M48	Respecting public health authorities Trusting in the help of God
29	M43	Respecting public health authorities Trusting in the help of God

The stereotypical character of most of the answers shows clearly that the public speech is more controlled than the personal attitudes. This may not only be true for the Friday sermon itself but also for the interview answers. The public speaking of these religious leaders respects political factors as well as religious ones. While the call for trusting in God pays respect to religious tradition and may serve to strengthen the religious identity of the community, the call for respecting the health regulations of the state remembers the faithful of the duties of citizenship, especially the loyal

obedience to the state authorities. Both calls are very general and do not give any specifications, and it is difficult to say if this is sending a message of its own. One only can ask if the absence of any explanation or argument concerning the health regulations implies any critique of these regulations. Yet, the probability is high that the unspecific call for obedience does not necessarily imply a message of consent with the state's measures – at least if the personal scepticism toward COVID-19 vaccination can be used as an interpretation context for the answer to question (6).

Although our OP group is not identical with the congregation members of our RL group, their anti-vaccination attitude (see above table 3) constitutes a context for a further interpretation, which can claim at least some probability: With some certainty, one can conclude that the audience of the RL group's preaching also is sceptical against vaccination as an element of the public health measures. Thus, the general call for respecting the measures of health authorities can be understood as an act of balancing between the political necessities and obligations on one side, and the expectations of the audience on the other. If an Imam would preach completely against the attitudes of his congregation, he would easily lose his authority. But if he would use his function to publicly speak against regulations of the state, he could easily get into political trouble. Thus, the general call for obedience – without explicitly mentioning vaccination – appears as highly reasonable. In combination with demanding for trusting in God's help, the message is also that beyond the state there still is a higher authority. This is a point that is beyond doubt with IP 24 (M40). He clearly points to this highest authority and warns scientists not to play with human lives.

The IP group of Islamic journalists (IJ)

In times of mass media, the public preaching addressing an audience in face-to-face communication is, of course, not the dominant way of informing and influencing communities. This is true even if the authority of the Friday sermon traditionally is estimated as a very high-ranking one. Therefore, it was interesting to establish an IP group of journalists who define themselves as Muslims. The questionnaire for them was in great parts the same as for the other groups. Yet, we added two questions reflecting their professional context as public communicators – just as we

did with the Imams. In appendix 4 these additional questions are numbered as (5) and (6).

The IJ group consists of six men who define themselves as Muslims and as journalist. The fact that there is no gender diversity in this group cannot be interpreted.

The age of the IPs in this group ranges from 33 to 40 years, with an average of 34.8 years. With this the IJ group is older than the OP group but clearly younger than the RL group.

In the IJ group, the personal attitude toward a vaccination against COVID-19 is characterized by a clear *pro* tendency (see table 7).

Table 7 (IJ)

Interview Number	Alias	Attitude toward COVID-19 vaccination	
		Personal	**Public**
30	M40	*Pro* – with worries	None
31	M35	*Pro*	None
32	M33	*Pro* and *contra*	None
33	M35	*Pro*	None
34	M33	*Pro*	None
35	M33	*Pro*	None

While IP 30 (M40) indicates that his stance *pro* vaccination is accompanied by many worries (« beaucoup d'inquiétudes »), IP 32 (M33) says that he is as well *pro* as *contra*. The other four IPs of the IJ group are stating a clear *pro* attitude. Thus, this group of IPs differs from the OP and the RL group by showing in majority a positive personal attitude toward COVID-19 vaccination. The result is similar to that of the first group of IPs (2021) but even more positive: We have not one clear *contra* position in the IJ group.

The link between the mostly positive personal vaccination attitude and religion is not very clear as the answers are quite stereotypic. 2/6 IPs say that their religion demands to obey the government's regulation. With slight variations, the other 4/6 say that Islam allows everything that is effective and acceptable to protect public health.

Unfortunately, the interviews do not give much information about the link between this personal attitude and the professional communication in public. All of the IPs in the IJ group give a stereotypic answer to question (6) saying that they simply transmit the information given by the ministry of health. This is quite surprising as all of the IPs answer to question (5) that COVID-19 is an important topic that is discussed weekly or even daily. It is a pity that the IPs do not inform us what exactly the point of discussion is. One can only speculate if the transmission of the official information given by the state is an expression of a positive attitude insofar as no scepticism or doubt is expressed.

Conclusion

Although our IP groups show quite different attitudes toward COVID-19 vaccination they have some characteristic in common. The first and most clear is that none of our IP groups showed an explicit link between religion and an anti-vaccination position. Even in the most sceptical group (OP), there is no IP linking religion and vaccinophobia directly. Instead, there is mistrust against the vaccination and this uncertainty is linked with religious tradition. This lack of explicitly religious vaccinophobia marks an impressive difference between our Islamic IP groups and their Christian counterparts mentioned above. While Christian preachers oppose COVID-19 vaccination (and other public health measure) with many religious arguments – even using directly their holy scripture in fight against vaccination, we cannot see anything comparable with Ivorian Muslims. This is even true with the group of religious experts. Although the RL group is quite sceptical they do not indicate that they use their public role to preach against vaccination. If they in fact did, they at least do not admit in the interviews.

The vast majority of the religious leaders and the journalists shows a professional self-understanding that is formatted by loyalty and obedience to the state and its regulations. Although this attitude of loyalty seems quite formal in both cases, both IP groups link their loyalty with a specific concept of their religious tradition. Islam is conceived as a source of obedience and submission to the state's laws in general and to public health regulation specifically.

As our interviews, unfortunately, had no adequate gender diversity, one cannot answer the question if the attitude toward vaccination is influenced by gender aspects.

Concerning other factors like age and educational level, at least some traces can be detected. As the mainly academic group (FSI 21) and the journalist group (IJ) show the most positive personal attitude toward vaccination, one might conclude that higher education reduces anti-vaccination attitudes. This might also be true for younger age, but in this point our results are not a good basis for further conclusions as all our IP groups show a median age that is higher than that of the total population in Ivory Coast.

As to the above mentioned research done with Muslims in other countries, one can say that our results do not speak against the results of prior research – even if our interview design delivers a data base, which is too limited to speak of a confirmation. Yet, it seems obvious that Islamic scepticism against COVID-19 vaccination usually is lacking the religious "apocalyptic fever" that prominent parts of African Christianity show in this point.

Finally, some open questions have to be mentioned. Firstly, what would be the results if Islamic rebellion groups standing beyond the loyalty tradition could be included into research? And secondly, what would be the results, if Islamic population in rural areas would be asked? Thirdly, how would the picture change if online communication via social media would be analysed?

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Appendices

Appendix 1: The first questionnaire (2021)

Questionnaire	**Questionnaire**
Groupe : Personnes islamiques à Côte d'Ivoire	Group: Islamic persons in Ivory Coast
Numéro : / Nom alias : / Date : / Lieu : / Age : / Sexe : / Religion :	Number: / Alias: / Date: / Place: / Age: / Sex: / Religion:
Question : A condition qu'il est possible de recevoir sans problème une vaccination (gratis) contre le coronavirus que serait votre réaction ? Voudriez-vous vous décider en faveur d'une vaccination ? Ou contre ?	*Question*: Supposed that it will be possible to get a (free) vaccination against the corona virus, what will be your reaction? Would you decide for a vaccination? Or against?
Question : Quelles sont les raisons rationnelles en faveur ou contre la vaccination ?	*Question*: What are the rational reasons for or against the vaccination?
Question : Quelles sont les raisons émotionnelles en faveur ou contre la vaccination ?	*Question*: What are the emotional reasons for or against the vaccination?
Question : Quelles sont les raisons religieuses en faveur ou contre la vaccination ?	*Question*: What are the religious reasons for or against the vaccination?
Question : Y-a-t-il quelque chose additionnelle que vous voulez dire sur le thème de vaccination ?	*Question*: Is there something that you would like to add concerning the topic of vaccination?

Appendix 2: The OP questionnaire (2022)

Questionnaire	**Questionnaire**
Groupe : Personnes islamiques à Côte d'Ivoire (population normale/ non-académique)	Group: Islamic persons in Ivory Coast (ordinary people/ non-academic)
Numéro : / Nom alias : / Date : / Lieu : / Age : / Sexe : / Religion : / Occupation :	Number: / Alias: / Date: / Place: / Age: / Sex: / Religion: / Occupation:
Question : A condition qu'il est possible de recevoir sans problème une vaccination (gratis) contre le coronavirus que serait votre réaction ? Voudriez-vous vous décider en faveur d'une vaccination ? Ou contre ?	*Question*: Supposed that it will be possible to get a (free) vaccination against the corona virus, what will be your reaction? Would you decide for a vaccination? Or against?
Question : Quelles sont les raisons rationnelles en faveur ou contre la vaccination ?	*Question*: What are the rational reasons for or against the vaccination?
Question : Quelles sont les raisons émotionnelles en faveur ou contre la vaccination ?	*Question*: What are the emotional reasons for or against the vaccination?
Question : Quelles sont les raisons religieuses en faveur ou contre la vaccination ?	*Question*: What are the religious reasons for or against the vaccination?
Question : Y-a-t-il quelque chose additionnelle que vous voulez dire sur le thème de vaccination ?	*Question*: Is there something that you would like to add concerning the topic of vaccination?

Appendix 3: The RL questionnaire (2022)

(With two added questions)

Questionnaire	**Questionnaire**
Groupe : Personnes islamiques à Côte d'Ivoire (Chefs religieux/ Imams)	Group: Islamic persons in Ivory Coast (religious leaders/ Imams)
Numéro : / Nom alias : / Date : / Lieu : / Age : / Sexe : / Religion : / Occupation :	Number: / Alias: / Date: / Place: / Age: / Sex: / Religion: / Occupation:
Question : A condition qu'il est possible de recevoir sans problème une vaccination (gratis) contre le coronavirus que serait votre réaction ? Voudriez-vous vous décider en faveur d'une vaccination ? Ou contre ?	*Question*: Supposed that it will be possible to get a (free) vaccination against the corona virus, what will be your reaction? Would you decide for a vaccination? Or against?
Question : Quelles sont les raisons rationnelles en faveur ou contre la vaccination ?	*Question*: What are the rational reasons for or against the vaccination?
Question : Quelles sont les raisons émotionnelles en faveur ou contre la vaccination ?	*Question*: What are the emotional reasons for or against the vaccination?
Question : Quelles sont les raisons religieuses en faveur ou contre la vaccination ?	*Question*: What are the religious reasons for or against the vaccination?
(5) Question : Quelle importance avait/ a le thème de vaccination dans votre travail religieux (enseignement, sermons publiques, conversation pastoral individuelle) ?	*(5) Question:* What was/ is the importance of the vaccination topic in your religious work (teaching, public preaching, individual pastoral consulting)?

(6) Question : Voudriez-vous nous dire quelle position en regard de vaccination vous avez pris dans vos déclarations publiques ?	*(6) Question*: Would you please tell us, which position you took concerning the vaccination in your public speaking?
Question : Y-a-t-il quelque chose additionnelle que vous voulez dire sur le thème de vaccination ?	*Question*: Is there something that you would like to add concerning the topic of vaccination?

Appendix 4: The IJ questionnaire (2022)

(With two added questions)

Questionnaire	**Questionnaire**
Groupe : Personnes islamiques à Côte d'Ivoire (journalistes)	Group: Islamic persons in Ivory Coast (journalists)
Numéro : / Nom alias : / Date : / Lieu : / Age : / Sexe : / Religion : / Occupation :	Number: / Alias: / Date: / Place: / Age: / Sex: / Religion: / Occupation:
Question : A condition qu'il est possible de recevoir sans problème une vaccination (gratis) contre le coronavirus que serait votre réaction ? Voudriez-vous vous décider en faveur d'une vaccination ? Ou contre ?	*Question*: Supposed that it will be possible to get a (free) vaccination against the corona virus, what will be your reaction? Would you decide for a vaccination? Or against?
Question : Quelles sont les raisons rationnelles en faveur ou contre la vaccination ?	*Question*: What are the rational reasons for or against the vaccination?
Question : Quelles sont les raisons émotionnelles en faveur ou contre la vaccination ?	*Question*: What are the emotional reasons for or against the vaccination?

Question : Quelles sont les raisons religieuses en faveur ou contre la vaccination ?	*Question*: What are the religious reasons for or against the vaccination?
(5) Question : Quelle importance avait/ a le thème de vaccination dans votre travail comme journalistes ?	*(5) Question:* What was/ is the importance of the vaccination topic in your work as journalist?
(6) Question : Voudriez-vous nous dire quelle position en regard de vaccination vous avez pris dans votre communication journalistique au public ?	*(6) Question*: Would you please tell us, which position you took concerning the vaccination in your journalistic communication in public?
Question : Y-a-t-il quelque chose additionnelle que vous voulez dire sur le thème de vaccination ?	*Question*: Is there something that you would like to add concerning the topic of vaccination?

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