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Perceptions of COVID-19 in faith communities in DR Congo

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ABSTRACT

This article explores the perceptions of COVID-19 among faith communities in north-eastern DR Congo and their intersection with public health responses to disease outbreaks. In a situation of a political and economic insecurity and significant unaddressed health needs, faith communities have a strong trusted public presence and offer resilience in the face of political insecurity, limited state intervention and outbreaks of disease. Semi-structured interviews of members, leaders and medical professionals from seven faith communities in Ituri and North-Kivu were analysed using a thematic framework. The article demonstrates that faith communities and their leaders have a range of opinions on the causes of and responses to COVID-19 that illuminate long term trends in a complex faith-health landscape. It identifies that all faith communities have spiritual responses to disease. Some of those responses cohere with public health messages. Others run counter to them. It argues that understanding the nature, range and variability of these perceptions and their impact on public behaviour is valuable to enable those engaged in public health to work with trusted, resilient communities even where their perceptions of disease are contradictory.



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How do perceptions of COVID-19 in faith communities impact the societies in which those communities are situated? There is within development studies a call to engage in research in understudied populations in the global south and faith communities in order to improve the understanding of resilience and vulnerability to disease worldwide.¹ Scholars of religion have identified in the disruption and suffering caused by the COVID-19 pandemic an opportunity to examine changes in religious practices and the way in

CONTACT Emma Wild-Wood  Emma.wildwood@ed.ac.uk  School of Divinity, University of Edinburgh, New College, Mound Place, Edinburgh, EH1 2LX, UK; Way and Wild-Wood carried out most of the analytical and writing work, and Baba, Way and Kangamina collected, organised and analysed the data. Falisse, Grant and Pearson contributed to the study design and revising the manuscript.

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which religion influences society in a variety of contexts.² From an analysis of Christian nationalism in the USA to a comparison of digitalisation in churches in Asia and Europe, the effects of the pandemic permit evaluations of religious activities and narratives beyond the direct health effects of the virus.³ This article combines the study of religions with development and health studies in an examination of religious communities in north-east Democratic Republic of Congo (henceforth, Congo) to understand common and distinct perceptions about the pandemic, transmission of disease and public health measures. The public and trusted nature of faith communities in Congo and the close association between faith and health provide particular responses to disease that illuminate discourses of public health or governance. Using an approach that resonates with Nancy Ammerman's theorisation of religion as a 'multidimensional social practice' which starts with 'the patterned regularities' of what people do and the 'situated knowledge' that they share,⁴ we examine the shared and contested perceptions of COVID-19 within faith communities in Congo and ask how far these perceptions influence the reception of public health messages in the country. This prior practice influenced perceptions of COVID-19. The article also shows plurality of views and uncertainty about how to regard the arrival of COVID-19. These perceptions are partly a product of mistrust of state and medical authorities and partly a product of distinct beliefs and practices around healing.

The concerns of this article form part of a wider project to engage faith communities in public health and disease prevention. This article arises from preliminary work to understand the situated knowledge of COVID-19 held in faith communities in north-east Congo, through analysing practices, narratives, judgements and spirituality. The regular, public engagement in religious activities in faith communities by a large majority of the population is a significant feature of society and it provides apparatus for responses to disease. The term 'faith communities' is used to include a wider range of practices and association than that denoted by 'religion,' often used for specific institutional and organisational beliefs and practices connected to the supernatural.⁵ By examining different faith groups, we can better understand where COVID-19 lies in the making of meaning in the world, a crucial element for public engagement with communities.⁶

Health provision in Congo engages a range of social forces in complex, connected and complementary ways, and is often religious as it invokes spiritual connection to achieve healing. This means that the realm of the religious often connects the area of health to the concerns of the public.⁷ Much bio-medical provision in Congo – hospitals, clinics, training, and management of health zones – is provided by faith-based organisations who play a significant role in civil society in a state which has withdrawn from effective, country-wide health care.⁸ The relative size and influence of faith based medical provision is apparent in the thirty-six health zones in Ituri. Each zone has a referral hospital. Some 24 of the referral hospitals (two thirds) are run by churches in Ituri. The State manages twelve. Faith communities provide most of health care facilities in rural areas, but they are also prominent providers in the urban areas. There are nineteen of the health training institutes (Diploma to Masters level) that train nurses, midwives, lab technicians, pharmacists. Fourteen of them are provided by Christian churches. Five are government schools. Religious institutions manage the majority of clinics and health facilities in the region, under the supervision of the district health office being managed by the government, through the ministry of health officials. Faith communities

are required to follow the directives developed by the ministry of health, and add guidelines related to the values of their faith.

Nevertheless, biomedical services are often beyond the means of many people. Operating alongside biomedical care are forms of faith-healing and traditional practices of healing that frequently include recourse to the supernatural. Social reasons for disease are commonly given – someone may be accused of spreading sickness for economic or political gain – and a spiritual remedy is required. The biomedical, the spiritual and the social cannot be disentangled, rather they are, in the words of medical anthropologist John Janzen, ‘marshalled together to bring about a coherent, collaborative approach to problem solving, to creating a better world.’⁹ It is this social process of marshalling and cohering in responding to change that makes up the faith-health landscape of Congo into which COVID-19 arrived, accompanied by local and global narratives of its causation and prevention.¹⁰ The public nature of religion and its central role in healing practices challenge interventions based on modern western traditions of individualistic and solely scientific responses, as is increasingly acknowledged by international humanitarian, medical and development organisations who acknowledge the role of traditional practices.¹¹ We refer to ‘faith-health’ practices and narratives to indicate their intertwined nature and to avoid a separation of faith and health. The term ‘faith-health’ is distinct from ‘faith-healing’ which denotes a particular set of practices associated with Pentecostal-Charismatic beliefs. We use ‘landscape’ to signal the complexity of society in which faith-health operates and to recognise the different perspectives that occur as trust and meaning are negotiated in response to changing circumstances. Faith-health practices are entangled with everyday practical affairs, therefore an understanding of social background of Congo is provided below, after an explanation of data collection.

Data collection

The project investigated perspectives of COVID-19 within seven faith communities to provide a representative sample of religious affiliation in the region. It built on prior research on faith and health in the area,¹² including a workshop of church and medical leaders in Aru.¹³ The evolution of the local Covid-19 measures as broadcast on local and national radio and the information and rumour spread on social media outlets was noted. Some observation of community faith life was possible in religious events after the strict lockdown was lifted in August 2020. A series of 58 face-to-face, semi-structured qualitative interviews with local faith and health figures – ministers, priests, and lay preachers, health authorities, medical staff, most of whom were men – was carried out in April-May 2020, and December 2020-February 2021 (group A).¹⁴ A participative workshop with eleven faith leaders was organised on 29 June 2021 (group B). In July 2021, 23 faith community members of different genders, ages and societal positions were interviewed to check leadership views with the wider population (group C). As detailed below, differences were more noticeable between faith communities than between genders or members and leaders. Interview data was collected from the towns of Bunia, Beni and Kasenyi, using researchers located in the towns who followed social distance measures when speaking with people. Regional insecurity limited travel, prohibited research in rural areas and reduced the data collection in Beni. Researchers often relied on password-protected Whatsapp to communicate research.

Responses were anonymised and quotations below are identified using groups or with general descriptors in order to protect the identity of individuals. Analysis was organised through a thematic framework: perceptions of a/ existence, b/prevention, c/ transmission, d/ government messaging on COVID-19, e/lockdown and f/ relationship between COVID 19 and faith.

Of the seven faith communities, three run clinics and hospitals and have been authorised by the government to run health districts (*zones de santé*) in Ituri and Nord-Kivu. They are the Roman Catholic Church, the largest Christian denomination in Congo, and two members of the Protestant association, l'Eglise du Christ au Congo (ECC), the Anglican Church (CAC) and the Communauté Evangelique au Centre de l'Afrique (CECA 20). Muslim representatives of the three Sunni mosques in the towns were included, as were two Christian communities that focus on faith healing: Chrisco, an African Initiated or Independent Church, and the Armée du Seigneur a member of the organisation Eglises du Réveil au Congo (ERC). A religious community of the Alur ethnic group known as Lam-Te-Kwaro represented communities who recourse to ancestor veneration as part of their response to disease. Faith leaders were often expected to have a public view on the nature of COVID-19 and the appropriate response to it, although some were uncertain about the guidance they should give.

Those who carried out the research were employed by or connected with the Anglican University of Congo and the ECC. This gave them a trusted base in society, but it also positioned them within the range of faith-health beliefs in ways that may have influenced the data. Although the researchers were alert to the subjectivities they brought to the project, many interviewees tended to talk of opinions that might run contrary to public health advice as those held by 'others' and not the interviewees themselves, or to tentatively explore more than one view during the interview. This exploration of different views adds to the qualitative richness of the data but means that the statistics mentioned below can only be indicative. It also suggests, as scholars have seen elsewhere, that expectations of 'correct' bio-medical discourses may intrude on responses.¹⁵ To understand the background to this research, the context of north-east Congo is explained before exploring the perceptions of COVID-19 within Congo's faith-health landscape.

Congo, COVID-19 and faith-health practices in an insecure context

Religious affiliation in north-east Congo

The research was carried out in the provinces of Ituri and Nord-Kivu that border Uganda to east and Sudan to the North. The provinces have a similar religious demographic to the rest of Congo: an estimate of approximately 10% Muslim, 10% Indigenous Religion and 80% Christian.¹⁶ Explaining these shared and contested perceptions illuminates the role of disease and the role of faith communities in the faith-health landscape of Congo. The Catholic Church has a large membership and institutional presence. There are many Protestant and Pentecostal churches. In Bunia alone (population estimate of 366,000 in 2012), there are twenty-one denominations affiliated with the Protestant group of churches, the Eglise du Christ au Congo. There are also twenty-one members of the Pentecostal Eglise de Réveil au Congo but most have a small membership. There are thirteen local independent churches with no recognised legal status and six independent churches with international connections (mainly Kenya and Uganda).¹⁷ Unlike other parts of Africa, the

Pentecostal churches in Ituri have yet to have strong networks into the state or with external groups. Muslim adherence centres around a single town mosque in the Sunni tradition. Participation in indigenous religious practices remains strong in some areas. While many healers prefer to act alone, there is a branch of Association Nationale des Guérisseurs du Congo (ANAGECO) in Bunia, the capital of Ituri, which represents indigenous healers that seek official recognition. Many people have multiple religious affiliations of different sorts and some change affiliation over the course of their lives.¹⁸ Although there is some correlation between affiliation to a faith community and assent to its official position or that of its local leader, it cannot be assumed. Regular attendance or even membership of one community may confer status or social interaction rather than being an indication of a shared knowledge and practice about disease, including COVID-19. Faith-based hospitals, clinics and health zones support the state's bio-medical provision, which is poorly funded and access is limited to those who can pay for treatment or receive care via their employer. Bio-medical assistance is unaffordable for many whose source of income is affected by chronic and multi-faceted insecurity.

Insecurity and disease in north-east Congo

The arrival of COVID-19 comes against the background of long-term, but increasing violence that, since 1996, neither the regular army nor the United Nations peacekeeping mission seem able to prevent. During the pandemic, the activities of least six armed groups have often been a more pressing threat than COVID-19.¹⁹ Armed conflicts and on-going violent attacks upon civilians have caused internal displacement to larger towns and significant loss of life. From July to December 2020 at least 647 civilians were killed in Ituri.²⁰ In the province of Ituri 1.7 million of the population of 5 million people are displaced, unrooted by the insecurity and violence.²¹ Armed groups are often involved in human rights abuses, extortion, customs fraud, the misuse of natural resources and deforestation, or their activities provide a cover for others to act in this way.²² Women and girls are particularly affected by sexual violence. On 6 May 2021, President Tshisekedi placed Ituri and Nord Kivu under military governance in order to impose peace on the region. A number of pitched battles in the southern part of Ituri increased the civilian death toll still further and the trust of the population in a government solution diminished. Instability and under investment also reduces agricultural productivity and contributes to health, education and economic insecurities. Malaria and cholera are endemic in Congo. Measles has killed 6,500 people since 2019 and between 2018 and 2020 Ebola killed 2,250 people. Levels of infant mortality, malnutrition and access to clean water remain concerning.²³ In north-eastern Congo state authority or legitimacy is limited and there is little comprehensive basic service provision. The state may appear absent but it is better understood as one of the key players among many actors involved in governance.²⁴ In this situation, as has been seen in humanitarian crises, the beliefs, practices and social welfare provided by faith communities support resilience among their members.²⁵ In a previous article we discussed the intersection of conflict and health in church state relations.²⁶ We noted that faith leaders considered they were 'depoliticising' COVID-19 (a work that faith leaders consider to be key after the popular criticism levelled at the health response to Ebola²⁷). They did this by working with government authorities to comply with public health measures to ensure short-term positive health outcomes. However, they felt undervalued by those same

authorities. A state-focussed view is not always able to appreciate the resilience found in other aspects of society, like faith communities and the civic role they play.

Responses to COVID-19 in Congo

The Democratic Republic of Congo has not recorded high numbers of COVID-19 cases and deaths and, in north-east Congo, the disease was not often regarded by the populations as the most pressing challenge to the well-being of society. This is not to say that the threat of COVID-19 was dismissed. There was a longstanding appreciation of the seriousness of infectious diseases and medical professionals had received training in preventative measures. However, other threats of disease and especially insecurity often seemed more pressing. This had an impact upon the public response to public health measures.

President Felix Tshisekedi announced a state of emergency on 24 March 2020, fourteen days after the first case in the country and two days before the first case was announced in Ituri, warning that the disease could spread rapidly and overwhelm the health system. Following regional Covid measures, markets, schools, universities, churches and mosques have been closed periodically.²⁸ More than 80% of the Congolese population survive through the informal commercial sector that relies on daily human contact and short trajectories of travel, which were restricted to reduce the spread of COVID-19.²⁹ Public health restrictions have had further adverse effects on people's lives, whilst social distancing in large multi-generational households is difficult.

Many people were phlegmatic about COVID-19 as simply the latest infectious disease to arrive in the region. Cholera, malaria and plague are endemic. HIV and AIDS continue to affect lives. Since 2018, there have been serious outbreaks of measles and Ebola in Nord-Kivu and Ituri. Efforts to contain the Ebola outbreak in the northeast of the country had sensibilised many people to the danger of infection and had normalised simple sanitary measures that reduced transmission of Ebola. Respondents said that the experience and knowledge they acquired during Ebola crisis, such as frequent hand washing, helped them in dealing with COVID-19. As one faith leader said, 'during Ebola people had already acquired a new behaviour and Corona came when people were already used to it.' However, Ebola prevention had also created tensions between health service and the population. The international response to Ebola in Nord Kivu had established parallel systems to save lives, but had failed to build trust in the community or gain local knowledge to combat the spread of disease.³⁰ Other practices introduced by COVID-19 such as lockdown, social distancing and face coverings were new and often resented by the people not unlike the Ebola experience.³¹ Resentment developed because of the daily impact on lives while people still felt broadly neglected by the State and other actors with regards to other aspects of their lives. Also, the measures that provided protection against Ebola were less effective against aerosol borne COVID-19.

By 7 July 2021 only 43,333 cases and 973 deaths had been recorded in Congo, although these numbers from the *Secrétariat Technique de la Riposte contre le COVID-19 en RDC* are certainly much lower than actual cases because the capacity for testing is extremely limited. Prominent figures died of COVID-19, including at least 5% of the MPs by June 2021,³² a trend also reported elsewhere in Africa.³³ As the Delta variant entered north-east Congo from Uganda in mid-June 2021, there was still doubt about the

nature of COVID-19, a paucity of available vaccinations and significant vaccine hesitancy in the population. Its arrival caused a regrettable rise in case and deaths and a shift in perception of the nature of disease.

COVID-19 and the faith-health landscape in north-east Congo

The causes and nature of COVID-19 were much discussed in the first year of the pandemic. The following paragraphs present our findings in four broad perceptions regarding the nature and response to COVID-19 from people within faith communities. The four perceptions are set out using terms that were used by some but not all respondents as follows: a/ COVID-19 is a ‘natural’ disease, caused by the transmission of a virus and it requires prayer, biomedical and public health approaches to overcome it; b/ COVID-19 is a supernatural disease, caused by the devil, malign spirits or God. It requires *only* spiritual intervention through prayer, faith-healing practices and exorcism to overcome it; c/ COVID-19 is a fabricated disease, either fictitious, in which case it can be ignored, or man-made, in which case either public health measures or faith healing may be good responses; or d/ COVID-19’s existence or nature is unclear, respondents were unsure or confused by the information available and were unsure how to respond. The categories of perception and the language – ‘spiritual’ or ‘supernatural’ in contra-distinction to ‘natural’ or ‘scientific’ – were not new. Our findings show how narratives about COVID-19’s cause and response were mapped onto pre-existing perceptions of disease. Whether COVID-19 was perceived as having a primary ‘spiritual’ or a ‘natural’ cause or origin or was ‘fabricated’ lay at the centre of initial responses to state preventative measures introduced from March 2020. The extent to which people were ‘unsure’ about COVID-19 influenced how regular or consistent were their actions in response to the disease.

The fifth section of our findings explains the changing reactions to COVID-19 that emerged from collecting data at different points in the year. Our four perceptions should be considered as prominent points of view, around and between which individuals might move as they tested their views and observed the unfolding of the disease. They might, for example, express significant uncertainty about COVID-19’s origins whilst tending towards either a natural, supernatural or fabricated cause. Whilst the cases of COVID-19 remained low many speculated that the disease did not exist or considered it was a western disease and were less likely to alter their behaviour significantly. When cases began to rise, pragmatic responses to the disease superseded speculation about the nature of the disease. At all times, however, almost all informants considered that evoking the spiritual or supernatural in some way was essential for well-being in the face of disease.

COVID-19 is a natural disease

By June 2021 about two-thirds the interviewees accepted, or were open to accepting, a ‘natural’ or bio-medical explanation of the causes COVID-19. Some interviewees were knowledgeable about the causes and measure to prevent the disease: ‘COVID-19 is real, it is a disease, and we have been sensitised a lot about it, through priests and other health technicians.’ Some participants were so concerned to distance themselves from the ‘spiritual’ causation narratives that they emphasised the distinction between

the role of a faith community in providing corporate worship and pastoral care and the role of health services in providing biomedical care. One said, ‘This disease has nothing to do with faith. Faith is something else and so is COVID-19. Despite the fact that we believe in Jesus Christ, we know that this disease is still there.’³⁴ This participant insisted that faith was not diminished by considering that COVID-19 spread through virus transmission and required public health interventions. He defended himself against a view that holding a faith perspective necessarily meant that the disease had spiritual origins. The response to COVID-19 was considered as best situated in the work of health services rather than faith communities. Nevertheless, there was an expectation that faith-based organisations would run health services and that faith leaders would disseminate public health information.

Members of those churches that have medical services – the Roman Catholic Church and the Anglican and CECA 20 – were likely to emphasise the viral transmission of COVID-19, bio-medical treatments and compliance with government public health messaging to combat the disease. This perspective is connected to the role of these faith communities in providing health and well-being, enhancing the social good and expressing a desire to contribute to state building.³⁵ They aid the Congolese state to deliver health services because they believe it is part of their mission to serve the population through health care.³⁶ As such they conform to a desire to ameliorate health, ‘through the application of modern, scientific medicine and rational administration.’³⁷ When churches were open, they were likely to provide washing stations outside church buildings and recommend the wearing of face-coverings to protect against Covid-19. Faith leaders used public worship services to encourage observance of public health advice.

Others went further than government expectations. The Catholic Churches often used their Base Christian communities which meet once a week as a means of educating and encouraging their members about Covid-19. The large central CECA 20 church in Bunia brought its health care professionals to the front of church during one service for prayer. This latter example indicates that a ‘natural’ understanding of COVID-19 and an encouragement of social protection measures were accompanied by a spiritual remedy. Faith communities that propounded a natural perspective actually encouraged an integrated mixture of medical and faith practices that they understand to be holistic and uncontroversial: a symbiotic relationship between health care and faith, based on the conviction that it is God who heals and the medical personnel are finite servants of an all-powerful God. There was an expectation that supplication to Almighty God for protection from the disease was vital in mitigating against transmission. One informant expressed it thus:

... it is the Ministry of Public Health which declared that it is disease ... as in the case of any disease, it is necessary to pray. During Ebola outbreak [and] Cholera, we were praying, but it is up to the Ministry of Health for treatment and control of this disease.³⁸

Alongside this view, participants insisted that people needed to keep their faith in God, ‘because what is true is that there is nothing that God cannot do ... what we need to do is only to keep faith.’³⁹ Here the porous nature of the first category of findings is apparent. Whilst some informants wanted to make a clear distinction between ‘natural’ and ‘supernatural’ causes of disease and a public health response, all who considered that they held a ‘natural’ view insisted on God’s omnipotence in the face of disease. One participant from the ECC for example, had no doubt that COVID-19 was a real virus and he rejected

the notion that COVID 19 has a ‘supernatural satanic origin.’ He did this, however, because COVID-19’s impact was too powerful to be that of the devil. Rather, he said, ‘It is God who is all-powerful. God has power over diseases that are bacteriological,’ so, maybe, he mused, ‘God intended to remind men or God punishes.’ If this is the case, he continued, ‘closing the church is not a good solution. Maybe we open the church with barrier measures. We multiply sessions so that God can also intervene because he is sovereign over everything.’ For him, the fact that God was more powerful than the virus meant that spiritual interventions were required alongside public health interventions.

Generally speaking, faith leaders in these organisations considered that they had distinct roles in the combatting of disease. They, along with all faithful people, should pray for God’s intervention and care, whilst medical professionals diagnosed, advised and cured. The leaders of these faith communities also identified a moral responsibility to guide members with good advice on how to avoid transmission. One leader said the following:

The main church role during the lockdown is on raising people’s awareness on COVID-19, insisting on preventative measures, through radio but also different church groups. Through telephone, I kept on preaching to people at the same time.⁴⁰

Whilst another reported that:

Just after the service, the Imam regularly speaks about the preventative measures developed by the government, and the importance for us to comply with these measures.⁴¹

Faith leaders shared their knowledge of virus transmission. Where possible they discussed the matter with medical professionals who are members of their communities. Those leaders who had a public presence used the Radio Tangazeni Kristo (RTK), a well-known radio station in Ituri and Nord-Kivu, to communicate.⁴² Preaching and advice on COVID-19 was part of the public discourse from the start of the pandemic.

Much religious practice in Congo is corporate, shared and in person. There is only limited access to the digital platforms that supported faith communities in other parts of the world during the pandemic. The Catholic Church quickly restricted the celebration of mass and the closing of churches from March to August 2020, as it had done in previous Ebola outbreaks.⁴³ Some faith leaders perceived positively the government decision on lockdown, as the government has the responsibility to care for the population health, ‘... as far as we are concerned, after explanations, and understanding, we realise that it was important, to save people, and the humanity.’ Some faith leaders encouraged people to regard the lockdown as an opportunity to intensify household prayer, ‘it gives us much time for family prayer, and also personal prayer, just because you have nothing else to do.’ Nevertheless, there was profound public resentment over the closing of religious buildings, ‘... we know that there are many people who gather in the markets. But the churches were closed, and that created issues between the Christians and the government ...’⁴⁴

Such was the concern for the socio-spiritual interaction afforded by worship in public buildings that, during the subsequent lockdown in December 2020-February 2021, religious buildings remained open, ‘... schools are closed, but faith communities are allowed to operate, with observance of social distancing... face masks...’ Wide spread

recognition of the importance of collective faith events meant that they were permitted to operate with some moderate restrictions.

The understanding that COVID-19 was a natural disease was likely to encourage leaders of faith communities to exhibit strong to moderate compliance with public health advice from the provincial governors' offices. Hand-washing stations were provided before services. Some churches invested in thermometers, hand sanitiser and sold single-use face-coverings, although their representatives worried about the expense of these items and observed that not all their members used them. In the focus group, a representative of a mosque pointed out that the ritual washing before prayers meant Muslims were already exceeding health advice on some points, although collective prayers at distance had been more challenging to implement. However, some faith leaders were critical of the provincial government for failing to engage faith leaders in the communication of its public health messaging and thus, missing an opportunity to reach a large proportion of the population, 'The government did not organise training as such, it may have been for health workers, but we clerics did not have training on this problem of Covid.' They considered that they were simply being blindly compliant with government orders in announcing the restriction and lamented the lack of preparation and information:

The religious leaders were there and the message came to them without having the training. Because they needed training, information, training. So quite simply, 'There is a disease, we have to confine people'. How can we do that? The leaders have not been trained.⁴⁵

Another pastor from the ECC took the criticism further, saying that the provincial government were under informed, unprepared and over hasty:

... even the government didn't understand the thing it was giving measures to. There was no time for meetings or sensitisation to make people or the church or the communities understand that this is what exists. Even now, there is no organisation from the government.

The same respondent then criticised the response from faith communities,

All the religious people were afraid of is: the Bible tells us to respect the established authorities and they gave orders, we should also follow it because it is the word of God. But we didn't understand exactly what the thing was.⁴⁶

Included in the criticism above is the suggestion that some Christian churches unquestioningly follow a well-known biblical injunction to respect authority (Romans 13:1-7). The issue of fear appeared in another criticism, this time directed at faith leaders who either provoked too much fear, or not enough caution: 'some created fear and they exaggerated, and I also saw others, and they neglected even the disease ... they ignored, even refused, these barrier measures,' said one respondent. A Catholic focus group participant picked up the theme:

[faith leaders] should not see themselves as being [subjected to the decisions of the government, but they should work closely together to give the true message of the government ... They are called to represent the government but they don't know how they are going to represent that government because even what is in their heads is incomplete ... they have to work closely together and it's also up to the government to help them to do their best.

Collaboration with government to support health measures gained significant approval at the leaders' workshop.

Not all members of Catholic or ECC churches were convinced of the natural origins of COVID-19, nor did they follow the guidance given in church. Some were persuaded by or open to 'supernatural' arguments. One Catholic priest made a distinction between leaders and members: 'the religious leaders were really involved in respecting the containment measures despite the fact that there was discontent among the 'faithful' who 'come with information picked up from social networks and that makes us really uncomfortable. Yet some faith leaders also admitted to wavering in their views in the face of the circulation of conflicting information. Before examining the uncertainty around COVID-19, the perceptions of COVID-19 as a 'supernatural' and 'fabricated' disease will be explained.

COVID-19 is a supernatural disease

About 15% of respondents spoke about the disease as 'supernatural' 'spiritual' or 'evil.' This is a significantly smaller number than those who spoke about COVID-19 being a natural disease. They said that its origins did not lie in the biology of natural illness. It could not be explained by science. It was a disease caused by supernatural powers. These powers might be God, the devil, spirits or ancestors. Some with a supernatural view of COVID-19, considered that it signalled the end of the world, a warning or a fulfilment of prophecy: a Muslim representative in group B said, 'in the Qur'an, we are informed that such thing as outbreaks, pandemics will happen ... even the prophet has spoken about that in the Qur'an, that such thing will happen.' Others said that supernatural powers acted in this way to mete out punishment. The punishment on Europeans and Americans, who appeared to be suffering most from the virus at the time of interview, seemed justifiable: '... this disease appeared in order to reduce the number of white people ... this disease is God's plan to confuse westerners.'⁴⁷ As COVID-19 caused disruption across Europe and the Americas, there seemed to be compelling circumstantial evidence that judgement had finally fallen upon the western world for its arrogance and misuse of power. For those open to spiritual causes, the closing of religious buildings from March to August 2020 was not simply an attack on religious freedom. It could be seen as evidence that COVID-19 was an attack of the devil, '... it was about 666, and Satanists are preparing something to destabilize faith communities.'⁴⁸ This perception of threat could cause significant anxiety.

In this study, the view that COVID-19 is a supernatural disease and *only* requires a spiritual response was more likely to come from members of Independent Churches, Pentecostal/Charismatic Churches and indigenous communities. It was certainly not limited to them. Their faith healing practices have also influenced some Protestant and Catholic members and congregations. There is significant diversity in belief and practice among these three groups in Congo, as there is in similar groups elsewhere in Africa. Some Pentecostal churches have been at the forefront of bio-medical and public health responses to disease, including COVID-19.⁴⁹

Broadly speaking, faith healing demands that God's spirit be in the person carrying out the healing, who must be spiritually prepared and experienced.⁵⁰ There is, therefore, a close relationship between healing and spiritual leadership. Faith healers are often supportive of bio-medical practices for some diseases. There is a difference of opinion about which diseases are properly the domain of the medical professional and which fall to the faith professional, but faith healers who entirely reject bio-medical practices are in the

minority.⁵¹ Most Christian faith healing traditions in North-east Congo are critical of indigenous African healing practices even where their practices appear to borrow from indigenous traditions. They may support the use of herbal medicine but, generally, they consider indigenous practices to be harmful. Faith healers diagnose illness emanating from ancestors, from deliberate and supernatural malevolence (witchcraft), from God or from spirits. They are likely to attack and exorcise ancestors or spirits to achieve wellness for those seeking healing. Indigenous healers are likely to identify illness and misfortune arising from the neglect of ancestors or spirits, sometimes caused by social discord. They prescribe certain practices and herbs as a means to wellness.

Both faith healers and indigenous healers attend to the spiritual causes of disease. As a leader of Lam te Kwaro observed, 'there are some illnesses which are supernatural things, which seem complicated, and to which religious combat provides a solution.' The curative or protective responses are distinct:⁵² indigenous communities are likely to seek to restore relationships with ancestors or spirits, often associated with the natural world; faith-healers are likely to conduct prayers for healing through laying on hands, or perform exorcisms of spirits. Both sets of faith communities consider that bio-medicine is inadequate because it does not look for the spiritual causes of disease.

Some respondents were willing to countenance public health measures whilst prioritising spiritual responses. However, their situated knowledge made faith leaders likely to doubt official public health messaging and to articulate more acutely their lack of involvement in government decisions. A pastor in the ECC said, 'The government must also involve religious leaders ... If there is a problem that affects physical health, those who see spiritual health should also be interested in order to get things on track.'

A pastor from a revival church also called for greater co-operation from government to, 'gain the trust of the people in change. So that they in turn preach very well so that the faithful also manage to understand.' These faith leaders were likely to consider public health advice misguided or wilfully negligent when it restricted people from attending to those spiritual causes. The banning of collective worship denied people the corporate performance of faith healing or combating the devil or demons in spiritual warfare. In the opinion of many who held a supernatural view about COVID-19's causation, a mechanism for combating COVID-19 was not permitted by a government who failed to understand the spiritual origins of the disease. Following government public health advice was restricting the very activities that would address the problem.

Our findings illuminate the respondents' definition of 'natural' or 'supernatural' disease and their appropriate responses. The two categories are not mutually exclusive: those who considered that COVID-19 was caused by a virus often claimed that God, as the creator of everything, had influence over viruses; those who considered the causes of COVID-19 to be 'natural' assumed that some spiritual response was required alongside biomedical care. Some who thought COVID-19 was supernaturally caused looked only for spiritual responses. Some of those who considered that the disease was supernatural were willing to revise their view or take a mixed approach in their response to disease. There was another possibility that a few respondents put forward: COVID-19 was a deliberately fabricated disease.

COVID-19 is fabricated

A minority of respondents held a view that COVID-19 is fabricated by those who wish to profit from it. These views did not relate directly to faith or faith communities, but they were discussed frequently in interview. Other respondents spoke about these views even when they said that they held different views. The ‘fabrication’ narrative took one of two directions: COVID-19 was either a serious viral disease let loose to harm others, or it was a hoax, intended to cause fear and reduce economic productivity. Some informants were aware of international accusations that China’s authorities had created the disease to destabilise the USA or the world. Others identified a racial motive, ‘[COVID-19] is a white creation,’ said one member of a revival church, who added that white people, ‘want to sell their vaccine to get rich at the expense of others.’ Contrary to the view that white people were being punished, this view considered that they were profiting from COVID-19. Another respondent provided evidence from the Ebola outbreak for the profit motive:

... it is disease which has been created so that people could make more money, as it was the case for Ebola where people have made a lot of money, and they knew that after Ebola, there could be another disease.⁵³

The observation of the benefits of those employed by international organisations to tackle Ebola caused suspicions that the rich and powerful could create or manipulate nefarious opportunities for wealth creation. These suspicions arose through the establishment of a parallel health system to deal with Ebola that failed to engage with local community groups.⁵⁴ Those who considered it likely that COVID-19 or rumours of COVID-19 had been fabricated for the advantage of international or national medical workers were less likely to take advice from these bodies. For some, the closing of religious buildings also led them to ponder who benefited from intruding on their religious freedoms or from preventing the succour they gained from meeting together or from, ‘... churches were not happy as they were closed, as faith cannot be locked down.’⁵⁵ As late as June 2021 a Revival Church leader presented evidence that COVID-19 was a hoax: ‘we have been following on social networks in Uganda ... they were burying sand in coffins so for me who saw that and for those who are in Kampala who testified even that they buried ... sand, can I really accept that COVID-19 exists?’ A Facebook post shared by a friend carried considerable weight when confidence in authorities was low. Some Congolese believed in the existence of COVID-19 but distrusted public health messages, considering them unnecessary fabrications. Taking *kongobololo* (*veronica amygdalina*) was said to provide immunity against the virus. Yet ingesting large quantities of *kongobololo* caused some deaths.⁵⁶ The inability of state authorities to deal with the multiple insecurities in north-east Congo, whilst individuals charged with improving an issue seemed only to benefit themselves was not a new accusation. Nevertheless, the lack of trust in state authorities and, therefore, in the information and instruction they gave about COVID-19 encouraged particular narratives of fabrication in Congo. Those who believed that COVID-19 was fabricated resisted public health measures in, what they regarded as, an appropriate response to fearmongering by those who sought to benefit from imposed restrictions. The research data did not produce conclusive evidence on the impact of the perceptions of fabrication in faith communities, but they may have contributed to a reluctance to use the washing facilities outside religious buildings.

All three broad categories of perception of the nature and causes of COVID-19 – natural, supernatural and fabricated – were in wide circulation. It meant that for some people the discernment of the nature of the disease was not straightforward, nor was an appropriate response. This caused a significant amount of uncertainty about the disease.

Uncertainty about COVID-19

Some people interviewed had clear views about COVID-19. Many individuals said they were unsure what they thought about the nature of COVID-19, the seriousness of its threat and what an appropriate response might be. Some questioned the existence of the disease, although did not insist on its fabrication: ‘It is difficult to say that this disease really exists, whether it is a reality or not.’⁵⁷ Others simply expressed confusion in general terms: ‘I do not understand the real meaning of this disease.’⁵⁸ Even those who had formed an opinion were not always entirely convinced and were willing to test other views.

There appear to be a number of reasons for the uncertainty. First, the three broad categories of perception of COVID-19 were widely known among respondents. They were aware that there was a choice of opinion, and the evidence for one over the other two did not always appear conclusive. Second, limited and conflicting knowledge about COVID-19 caused an atmosphere of uncertainty. Participants said that trustworthy information was lacking or they were undecided about the information they had. Some criticised officials for contributing to the uncertainty, accusing them of a lack clarity or a lack of commitment to apply personally the preventative measures and lead by example, or of profiting from the situation. Third, misinformation or ‘Fake News’ (a term in circulation in English in Congo) spread among the population particularly on Facebook and WhatsApp. Claims about COVID-19 were often generated outside the country by international anti-vax groups and circulated by Congolese people to their networks. Other misinformation was generated at national level. For example, on 10th March 2020, the day when the first national case was announced, false information circulated that the eminent virologist, expert on Ebola and head of the COVID-19 national taskforce, Professor Jean-Jacques Muyembe had said, ‘black skin cannot be infected by coronavirus.’ Swift rebuttals of the claim and evidence of cases in Congo were unable to contain the spread of this piece of misinformation. Spinning on this virtual merry-go-round of propositions about the disease, some people reserved judgement and continued daily life as usual. Many people held lightly to the threats of the pandemic, particularly when there were other much more pressing regional problems that demanded their attention.

COVID-19 and changing perceptions

The four categories of perception set out above overlap one another and are rarely stable. Interviews at different times during the year of research indicated change in the opinions of respondents as the threat of the disease and the severity of public health restrictions waned and waxed. There was little sense of ideology among the majority of the population and people pragmatically chose what seemed to work. There was a multiplicity of views and an uncertainty of the nature and prevention of COVID-19 among a range of faith communities. The notion of plurality, defined as a choice of a range of equally possible alternatives, is not sufficient to explain the multiple views and changes

in opinion.⁵⁹ The influence of a particular bio-medical and public health discourse as being the ‘correct’ way of understanding a health situation is one aspect of the faith-health landscape that has already been mentioned as making certain alternatives more likely to be chosen, or publicly articulated, than others. The shifting rate of transmission of disease and, with it, the change in influence of certain groups also affected perceptions.

A rise in cases and deaths from COVID-19 encouraged immediate action from the population to prevent transmission. As cases and deaths rose, respondents and media outlets were more likely to prioritise a ‘natural’ understanding and adopt public health measures. A shift in explanations was prompted by the immediacy of symptoms identified, lives lost, funerals attended caused a shift in the explanations. Speculation about COVID-19 was possible when it was not the most pressing threat to people. Those who disseminated conspiracy theories or purely spiritual reasons for the disease originally found a ready audience but, by mid-2021, those who provided a scientific explanation of the virus, its symptoms and preventative measures gained a greater hearing. In the face of an immediate threat to life the questions about the nature and causes of COVID-19 decreased in popularity as people sought to protect themselves using social preventative measures. From June 2021 as numbers rose in the Aru area and then spread to the provincial town of Bunia, the social media forums that had shared misinformation now urged ‘Protect yourselves,’ and face coverings became widely adopted. At this point, the uncertainty shifted from the disease itself to the efficacy of the vaccinations. Very few vaccinations were available in Congo and much misinformation circulated about them. President Tshisekedi supported the vaccination campaign but refused to be vaccinated with the AstraZeneca vaccine. Rumours abounded that he had refused all COVID vaccines.⁶⁰ Some medical personnel were hesitant about taking the vaccine. Faith leaders were unsure how best to advise their communities.

The place of COVID-19 in situated faith-health knowledge

A range of perceptions of COVID-19 among people of faith emerges from their ‘multi-dimensional social practice’ and the ‘situated knowledge’ they share. In this range are four broad but significant categories of perception: COVID-19 is a ‘natural,’ ‘supernatural’ or ‘fabricated’ disease and, overlapping with the first three categories, there is uncertainty about COVID-19’s nature and causes. Furthermore, perceptions were neither stable nor absolute. Views changed during the pandemic. The perceptions drew on prior expectations about the nature of disease operating within Congo’s faith-health landscape and were influenced by the extent to which faith communities were involved in bio-medical care. The perceptions influence the reception of public health messages in the country. This is unsurprising in a faith-health landscape that is characterised by a plurality of faith communities, a range of views on disease causation, broad acceptance of different healing options, and a state medical system that is limited and to which access is restricted by financial means. Significant in this landscape is the public and practical nature of religious activity in Congo and the intertwining of elements that elsewhere are separated as either ‘sacred’ or ‘secular.’ Whilst there is a distinction between spiritual and secular in people’s minds, their categorisation occurs in different ways and causes different responses.

COVID-19, like all disease, has an impact that goes far beyond a physical illness. A number of options are circulating in faith communities about the possible nature of disease and its remedy, in which spiritual considerations and collective ritual are important. Our research identified a range of positions where beliefs and practices intersect with health concerns and authority and trust. It identified communities in which certain positions are more likely than others, at least officially. Some faith communities trusted by significant parts of the population do not always follow public health advice because they do not consider it to prevent disease.

The population is accustomed to receiving guidance about well-being from faith leaders. Individuals in a faith community may hold a differing view to the leadership and may change views, or combine different perspectives. Even where this is the case, they expect faith leaders to give trustworthy guidance to help in decision-making about daily survival. The dynamic process of taking into account faith-based guidance in decision-making about daily survival prioritises the pragmatic and efficacious. For some participants, the views they shared were held lightly whilst there seemed to be little immediate threat from COVID-19 and they were cast away in preference of a pragmatic response towards the disease as the delta variant of COVID-19 spread and the need to avoid sickness and death from this particular threat – as opposed to the many others – became more acute.

The study illuminates three important points. First it suggests that perceptions of COVID-19 are largely consonant with perceptions of other diseases in Congo, in terms of causation and necessary response. In other outbreaks of disease like Ebola, there was debate and uncertainty about disease causation, whilst faith communities provided support in response to illness in different ways, through prayer, bio-medical services, exorcisms and spirit mediation. Where there is a difference in perceptions of COVID-19 it is in the pandemic nature of spread, and the spiritual reasons given – punishment of white people, etc. – for why that is so. The faith-health landscape in Congo has not significantly changed as a result of COVID-19, because of a familiarity with disease outbreaks, limited harm from COVID-19 relative to other continents, and because regional insecurity has usually been more pressing. Second, the study shows why it is important to understand these perceptions: meaning-making of disease has an impact on public health action and behaviour. Third, studying faith communities' perceptions of COVID-19 has illuminated longer term trends in the faith-health landscape in Congo. The irruption of COVID-19 has shown the 'situated knowledge' of faith communities expressed in perceptions of disease causation. An appeal to the supernatural is a required response, but there is variation in how the supernatural is evoked. The relationship between faith communities and state apparatus has been illuminated. Many faith communities possess an organisational practice that encourages a strong sense of civic engagement and collective resilience in the face of disease. Faith communities' leaders are – to varying degrees – willing to work with government because they have a strong sense of civic engagement. Many faith leaders transmit government advice and are prepared to support public health messaging. Some critique government practices because they feel that they are treated like tools to be deployed or ignored by the state. Some feel aggrieved that their healing practices are not acknowledged by Ministry of Health systems. In order to participate in supporting civic well-being, however, faith leaders called for proper consultation and preparation so that they could be partners

in helping to combat disease. The participants at the workshop recognised that to achieve this, greater collaboration between faith leaders is required. This may, in turn, require a more thorough mutual appreciation of the range of healing practice offered by the different faith communities.

Conclusion

This study contributes to the discussion on new directions for research prompted by the global pandemic⁶¹ by providing empirically rich data on responses of faith communities to COVID-19. Its findings resonate with research carried out with churches in Nigeria and with World Vision, an international Faith-inspired organisation.⁶² These studies identified faith communities as trusted vehicles of information and support for large sections of society. During the pandemic faith communities continued to operate with the confidence of their members. In north-east Congo, religion is integrated into other aspects of life, particularly narratives and lived-responses to health and disease. The resilience of the population is enhanced through association with a faith community which helps to make meaning of disease and take action in a pandemic. The data showed that among all the faith communities involved in the project there were commonalities in their articulation of the faith-health landscape in which they operated. This included a shared trust in the therapeutic power of collective religious rituals to combat disease and to fortify the faithful to be resilient in the face of adversity. There was a wide-spread and strong orientation towards in-person, collective religious events which meant that the closure of churches caused distress among all groups. In most cases there was an air of watchfulness towards government instructions that appeared to overlook the spiritual and therapeutic influence of faith communities to appeal to powerful spiritual beings in the face of disease. This study has also identified distinctions in explanations of perceptions about COVID-19 and thus differences in the faith-health landscape they described. These distinctions are shaped by – and also shape – civic engagement and relationships to state apparatus, particularly in regard to health care. Contested perceptions of COVID-19 centred on the diagnosis of the disease and an appropriate response to it. The differences are important because they may influence future civic engagement and relationship to governance. Members and leaders from faith groups that supported bio-medical care were more likely to accept a scientific explanation for COVID-19 as a virus transmitted through contact with infected people. For them, prayer remained important alongside public health measures as a way of tackling COVID-19. They could countenance building closure as a temporary measure and consider that prayer in households or small cell groups or via the radio was ethically considerate and equally efficacious as that in religious buildings. Members and leaders that supported faith-healing or indigenous healing practices had limited long-term engagement with state or health authorities. They were more likely to consider that COVID-19 was a spiritual disease, caused by the devil, other malevolent spirits or a flawed relationship with ancestors. Even where they accepted the possibility that COVID-19 was a ‘natural’ disease, they were more likely to consider that a supernatural intervention to tackle COVID-19 was crucial and would have greater efficacy if carried out as a collective event. Thus they considered that closing religious spaces was dangerous because, for them, it reduced the possibility of being resilient in the face of disease. The levels of trust and resilience formed in these faith communities

were developed in part through spiritual beliefs and practices that run counter to public health messages on disease prevention.

The public and trusted nature of faith communities and the close association between faith and health in Congo mean that faith groups offer opportunities for individual and community resilience in Congo. Yet the plurality of perspectives of COVID-19 expressed in faith communities raises important questions for public health interventions, particularly among those communities whose beliefs and practices contradict the health measures implemented to reduce disease. Recognising the reasons why these communities are trusted by their members and provide them with societal resilience in the face of multiple challenges will facilitate a more responsive approach in the face of future disease outbreaks.

Notes

1. Ansoms et al., “Rural Resilience in the global South”; Ager et al “Local Faith Communities and the Promotion of Resilience.”
2. Baker et al., “Religion in the Age of Social Distancing.”
3. See as examples, Perry et al, “Culture Wars and COVID-19”; and Chow & Kurlburg, “Two or Three Gathered”.
4. Ammerman, “Rethinking Religion”, 14, 37.
5. Goodwin and Kraft, “Mental health and spiritual well-being in humanitarian crises,”6.
6. Igwe, “Religions Responses to the Covid-19 Pandemic in Nigeria,” 106.
7. Prince, “Situating Health and Public in Africa,” 9.
8. Seay, “Effective responses”; Lindstrom, “Donors and a Predatory State,” 78.
9. Janzen, *Health in a Fragile State*, 232.
10. Lee, *Health, Healing and Illness in African Society*.
11. WHO, *Traditional Medicine Strategy*, 11.
12. Falisse et al. “Indigenous Medicine and Biomedical Health”; Way “*La Spiritualité de l’Eglise*”; Wild-Wood, *Migration and Christian Identity*.
13. Wild-Wood, “Faith, Health and Well-being in Ituri”.
14. Baba, “Remote Research Data in DRC.”
15. Schmidt, “Narratives of Spirituality”, 140.
16. Way, “Regard sur les statistiques.” There is little current consensus on religious affiliation. The Pew Research Centre’s *World Christian Database* calculates 1.5% of Muslims (2019).
17. Way, “List des églises identifiés.”
18. Williams, “Multiple religious belonging,” 226.
19. The six groups are the ADF/NALU, the Mai-Mai, the Force de Résistance Patriotique en Ituri (FRPI), the Coopérative de Développement du Congo (CODECO), the Front Patriotique et Intégrationniste du Congo (FPIC) (aka, Chini Ya Kilima), and the Front Populaire d’Autodéfense en Ituri (FPAC/Zaire). *Liberation*, “En République Démocratique du Congo, le contrôle des métaux en mauvaise mine,” 19 July 2019.
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22. UNHCR, “Les flambées de violence déplacent des milliers de personnes dans l’est de la RDC,” 8 May 2020. <https://www.unhcr.org/fr/news/briefing/2020/5/5eb53032a/flambees-violence-deplacent-milliers-personnes-lest-rdc.html> (Accessed 5 February 2021).

23. Baba, "Supporting midwives to improve maternal health."
24. De Herdt and Titeca, "Negotiating Public Services," 6.
25. Ager et al., "Local Faith Communities and the Promotion of Resilience."
26. Kangamina et al., "Conflict, Epidemic and Faith Communities."
27. See for instance, Nyenyzi Bisoka et al., "From Biolegitimacy to Antihumanitarianism."
28. Bashizi et al., "Real governance of the COVID-19."
29. Kuma, "Pauvreté et chômage."
30. Congo Research Group, "Ebola and the DRC," 6.
31. Nyenyzi Bisoka et al., "From Biolegitimacy to Antihumanitarianism."
32. *Reuters*, "COVID-19 kills 32 members of Congo's Parliament" 28 May 2021, <https://www.reuters.com/business/healthcare-pharmaceuticals/covid-19-kills-32-members-congos-parliament-2021-05-28/> (Accessed 26 May 2023).
33. Falisse et al., "African leaders died of COVID-19."
34. Interview from group A.
35. Witter et al., "State-building and human resources for health."
36. Wild-Wood, "Faith, Health and Well-Being in Ituri,"
37. Prince, "Situating Health and Public in Africa," 10.
38. Interview from group A.
39. Interview from group A.
40. Interview from group A.
41. Interview from group B.
42. RTK or "Radio which announces Christ" is run by CECA 20. Other church leaders participate.
43. *Agence Congolais de Presse (ACP)*, "La CENCO exhorte les Congolais au respect des mesures barrière de lute contre COVID-19," 11 January 2021. <https://acp.cd/nation/la-cenco-exhorte-les-congolais-au-respect-des-mesures-barriere-de-lutte-contre-la-covid-19> (Accessed 11 November 2021).
44. Interview from group C.
45. Interview from group B
46. Interview from group B
47. Interview from group A.
48. Interview from group A.
49. Wild-Wood et al., "The Public Role of Churches," 68-69.
50. Boyo et al., "African Christianity and the Intersection."
51. Togarasei et al., "Christian Medical Mission."
52. Matthew et al. "Health and Integrative Wellness."
53. Interview from group A.
54. Vinck et al., "Institutional trust and misinformation," 529; Congo Research Group, "Ebola and the DRC," 4.
55. Interview from group A.
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59. Hsu, "Medical pluralism."
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61. Baker et al., "Religion in the Age of Social Distancing."
62. Igwe, "Religions Responses to the Covid-19 Pandemic in Nigeria," 109; Goodwin and Kraft, "Mental health and spiritual well-being in humanitarian crises," 6.

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