Conflict, Epidemic And Faith Communities: The Reconfiguration Of Church-State Relations During The Fight Against Covid-19 In North-Eastern DR Congo

Sadiki Kangamina
Université Anglicane au Congo
Jean-Benoit Falisse (jb.falisse@ed.ac.uk)
University of Edinburgh
Amuda Baba
Université Anglicane au Congo
Liz Grant
University of Edinburgh
Nigel Pearson
Independent consultant
Yossa Way
Université Anglicane au Congo
Emma Wild-Wood
University of Edinburgh

Research Article

Keywords: DRC, religion, conflict, Covid-19, health system, faith-based health provision, Ebola

Posted Date: March 7th, 2022

DOI: https://doi.org/10.21203/rs.3.rs-1409568/v1

Abstract

Background: understanding and improving access to essential services in (post)-conflict settings requires paying particular attention to the actors who occupy the space left ‘empty’ by weak or deficient State institutions. Religious institutions often play a fundamental role among these actors and typically benefit from high trust capital, a rare resource in so-called ‘fragile’ States. While part of the literature has looked at the role faith organisations can play to mobilise and sensitise communities during emergencies, our focus is on a different, essential dimension: the reconfiguration of the relationship between religion and health authorities impelled by health crises.

Methods: we analyse observations, interviews, and focus group discussions with 21 leaders from eight different religious categories in Ituri province in 2020-2021.

Results: we show how faith institutions handled the Covid-19 lockdown period, notably by using and redeploying structures at the grassroots level but also by responding to health authorities’ call for support. New actors usually not associated with the health system, such as revivalist churches, got involved. The closure of worship places during the lockdown shocked all faith leaders; some saw it as a test of faith while others criticised inconsistent State measures, but, ultimately, most were inclined to follow and support health authorities. Such experience was, however, often one of frustration and feeling unheard. The interviewed religious leaders, especially those whose congregations were not previously involved in healthcare provision, felt that they were doing a favour to the State and the health authorities. Such service is at the level of community-level awareness-raising, but also, crucially, leaders were aware that by publicly committing themselves against Covid-19, they were participating in an effort to depoliticise Covid-19 in a context where the response to past epidemics, especially Ebola, is highly contentious.

Conclusions: in the short run, depoliticization may help address health emergencies, but in the longer run and in the absence of a credible space for discussion, it may affect the constructive criticism of health system responses and health system strengthening. The faith leaders’ frustration with the ‘collaboration’ with health authorities (especially for the new actors) also limits its long-term potential.

Introduction

Understanding and improving access to essential services in conflict and post-conflict settings requires paying particular attention to the actors who occupy the space left ‘empty’ by weak or deficient State institutions [1]. Among these actors, religious communities and institutions often play a fundamental role in organising care [2] and raising awareness of health issues [3]. Their role is potentially even more critical during humanitarian crises, including epidemics [4, 5], not least because populations living in so-called fragile’ settings typically trust religious actors more than State actors [6, 7]. Yet the role of religious denominations in contexts marked by both the Covid-19 pandemic and armed conflict has received only limited attention [8]. Many frameworks developed to address Covid-19 in conflict settings barely mention

religious communities and institutions [9]. The few that do tend to limit their role to community mobilisation [10]. However, the Covid-19 pandemic, an event that mobilised the whole of society, reveals much more about the relationship between State, religion and health. This article goes beyond the oft-documented instrumentalization of churches for public health purposes. It discusses a more fundamental and general dynamic: the relationship between religious denominations, the State, and health authorities in a fragile context marked by a general mobilisation to fight an epidemic. How did religious denominations experience the Covid-19 pandemic and the State-led response? What does it tell us about the (re-)configuration of religion-health authority relations in so-called 'fragile' contexts?

Our focus is on faith communities in the city of Bunia and the town of Kasenyi, in the north-eastern Ituri province of the Democratic Republic of Congo (DRC) and, to a lesser extent, the town of Oicha in the north of the neighbouring province of North Kivu. The region is one of the most troubled in the country, at least since the end of the brutal regime of President Mobutu and the first Congo war (1996–1997): armed groups abound in the region and have committed numerous abuses against the civilian population, including massacring, looting, and sacking villages. The repeated cycles of Ebola, cholera, and bubonic plague epidemics, and more recently, Covid-19, only added to these scourges. Religious denominations play a particular role in this context; the Catholic Church and Protestant churches manage many health structures and even have a predominant place in managing certain health districts. Our article shows how the Covid-19 measures pushed other denominational actors typically more distant from the health system –revivalist churches and Muslims, among others– to become involved in health. The experience is often marred with frustration. We also document how entire faith communities, rather than just leaders, engage with the health system, which is a novelty for most, including the Catholic and Protestant churches.

The following section presents the context of Ituri and the debates around the involvement of religious denominations in health. We then introduce our methods, which are based mainly on interviews with key informants and field observations, before presenting our main findings.

Context

Security, health and religious situation in Ituri

Eastern DRC has been plagued by significant and repeated violence for over 25 years. It comes against the backdrop of a brutal colonial and dictatorial past [11]. The northeast, the northern part of North Kivu province and Ituri province, is possibly the most affected of all areas. The conflict has intensified since December 2017 and pits, among others, a particularly violent armed group, the ADF (Allied Democratic Forces), against the regular army. The situation is made substantially more complex, with probably more than 130 armed groups active in the region [12]. Many socio-economic tensions also crystallise around ethnic identities, for example, between Hema and Lendu or between Hema and Bira. In May 2021, the President of the Republic declared a ‘state of siege’ (*état de siège*) and handed over the administration of

Ituri and North Kivu to the army and the police. At the time of writing, the violence had not ceased. The situation of instability and violence has had a tragic incidence on the lives of the region's inhabitants. More than 1.7 million people –just under 50% of the population– were forcibly displaced in Ituri in June 2021, according to the Danish Refugee Council. The economy, based mainly on agriculture and livestock, is being destroyed, and poverty is rising in the region. Every single part of society appears affected by the situation; interpersonal trust and trust in State institutions are, unsurprisingly, extremely low [13].

The effects of the conflict on health are devastating. The already fragile and under-resourced local health system in Ituri [14] has also had to deal with a significant Ebola outbreak in 2019–2020 and a bubonic plague outbreak even more recently. Instability and violence undoubtedly aggravated the Ebola epidemic [12], and the regional health crisis in general. On the ground, the Ebola response suffered from a severe lack of confidence from the population, with many people decrying the 'Ebola business' of the State and international aid agencies [15].

Faith-based health facilities and religious denominations, in general, are on the front line. The Congolese health system gives an important place to religious denominations, which manage dispensaries, hospitals and sometimes even health zones on behalf of the Ministry of Health [16, 17]. These services are open to all who can pay, regardless of religion. The presence of faith-based biomedical services dates back to colonisation: the Catholic and, especially, the Protestant churches [18] were prominent biomedical health care providers, alongside the colonial State and private companies [19]. After independence, the collapse of the Zairian public services from the late 1970s onwards, combined with the structural adjustment policies and then finally the wars of the 1990s, contributed to an even greater focus on health services directly organised by non-profit organisations, including the churches, and the private sector. In 2007, Chand and Patterson (quoted by Widmer et al., 2011) noted that churches run 50% of hospitals and 40% of health zones in the country. Ituri province reflects this situation: Protestant missionaries established the first hospitals in 1919 (in Aru) and then in 1920 (in Rethy), and faith-based facilities continue to imprint the local health system [15]. For instance, the Anglican diocese administers the health zone of Boga, where Bunia –Ituri's provincial capital– is located.

Summarising the religious landscape in the DRC is perhaps even more difficult than explaining its health system. Still, it is essential to note a series of characteristics beyond Protestant and Catholic involvement in health care. There is no reliable data for our field site but, nationally, the population is estimated to be 95.1% Christian, 1.5% Muslim, and 2.5% Indigenous religions [21]. Among Christians, there is a growing number of followers of Pentecostal and so-called 'revivalist' churches [22] who profess faith healing. The Catholic Church has the largest membership and a solid institutional presence on the ground. Membership of a religious congregation, including attendance to services and involvement in other congregation's activities, is an essential social marker. Religious affiliations can be porous and multiple, with some people attending different Christian services [23]. The Catholic Church and, to a lesser extent, the federation of Protestant churches (*Eglise du Christ au Congo*, Congo Christ Church, CCC) are also important political forces. They have played a role in various key episodes in the country's life, from the

fall of Mobutu [24] to the most recent opposition to the appointment of the new president of the independent national electoral commission [25].

The Covid-19 pandemic in DRC and Ituri

At the time of writing, the Covid-19 pandemic appeared to have taken on two distinct faces in the DRC. On the one hand, the number of cases recorded for the country is much lower than in southern Africa (and in Europe and America), with 43,333 cases and 973 deaths recorded as of 7 July 2021. While detection capacity is low there have been no anecdotal reports of very high excess mortality [26]. On the other hand, however, among a more affluent population and the urban 'elite', the picture is more worrying: Covid-19 was reported as the cause of death of nearly 5% of the members of parliament (*députés*) in June 2021 [27]. The Congolese government's response to the pandemic has been based on various elements, two of which should be highlighted: firstly, some of the mechanisms developed in the fight against Ebola, such as the Technical Secretariat of the Response and data sharing and analysis mechanisms, have been 'recycled' in the case of Covid-19 [28]. Secondly, the government has restored to measures similar to those in other countries, and in particular lockdowns.

The Ebola experience has had mixed consequences on attitudes towards Covid-19 (and its 'management'). On the one hand, it may have fuelled the population's fears of a repeated experience of enduring a 'parallel health system' –seen as useless to many but lucrative for very few– and being marginalised in decision-making processes [29]. A WHO report highlighted, for instance, the widespread feeling among the population of being wrongly blamed for the outbreak when many were forced to stay at home without resources or economic opportunities [30]. On the other hand, it is also clear that efforts to contain the Ebola epidemic have normalised certain practices that proved helpful during the Covid-19 pandemic, particularly handwashing. In addition, and we will return to them, some coordination mechanisms involving Protestant and Catholic churches were put place during Ebola and 'recycled' for Covid-19.

Following other countries, President Félix Tshisekedi announced the 'state of emergency' (not to be conflated with the above-mentioned security-related 'state of siege') on 24 March 2020, fourteen days after the first case in the country and two days before the first case in Ituri was announced. Table 1 shows the main measures. The public health restrictions have had clear adverse effects on social and economic life. Existing studies show a significant negative impact on the economy, household income and employment [31]

Table 1
Main measures against Covid-19 in the DRC

19 March – 22 July 2020	**Prohibition of all gatherings, meetings, celebrations of more than 20 people in public places**
16 February 2021 -	**Restriction of all gatherings, meetings, celebrations of more than 100 people in public places**
19 March – 10 August 2020 20 January – 15 February 2021	Closure of schools, universities and higher institutes.
19 March – 22 July 2020	Suspension of all worship
19 March – 22 July 2020	Suspension of sports activities in stadiums and other sports venues
19 March – 22 July 2020	Closing of discos, bars, cafés, terraces and restaurants
19 March – 22 July 2020	Prohibition of mourning in houses.
Source: Coronanet dataset	

Conceptual framework

Our study is in line with the approach proposed by the *Lancet Series on Faith and Health Care* (2015), which suggests a holistic approach to the relationship between health and religion [32]. This moves beyond an approach focused on religion only because religious denominations are involved in health service provision [33] and recognise that faith and faith communities play an undeniable role in health alongside religious institutions. This approach also moves beyond seeing faith as a problem for medicine or, on the contrary, medicine as a problem for faith [34]. Absent from many analyses of the relationship between faith (or simply, religion) and health is the presence of a third actor, the State, or rather the recognition that health and health infrastructures are an eminently political issue [35]. In our study, understanding the relationship between religion and health services (and even more so, health interventions in a pandemic context) also means analysing relationships between faith groups and the State and its institutions. This conceptual framework is fundamental in conflict and post-conflict contexts, which are almost always, and almost by definition, contexts of a deep crisis of confidence in the State, its intentions, and its capacities [36].

Methods

This article is part of an interdisciplinary project involving social sciences, public health and religious studies on the situation of faith communities during the Covid-19 crisis in Ituri and the north of North Kivu province. The project was validated by the ethics committees of the University of Edinburgh and the

Université Anglicane du Congo and funded by an emergency grant from the United Kingdom's Arts and Humanities Research Council (AHRC). Two other articles from this project have been submitted to social science and public health journals. They cover two aspects related to our paper: (1) faith community members' conceptions of Covid-19, its origins, and its meaning [37] and (2) faith community engagement with public health messages about Covid-19 [38]. We will refer to these in due course.

The project was built on previous research by Congolese and foreign team members on faith and health in the region [39, 40]. Given the health and security situation, most data collection was done closely with researchers linked to the Université Anglicane du Congo and living in Bunia, Oicha, and Kasenyi. This community base was an asset in reaching respondents but may also lead to potential biases (see below). Three types of data collection need to be distinguished.

The first is the observation of the health and security situation during the period from March 2020 to June 2021. Members of the research team took note of developments in local Covid-19 measures as broadcast on local and national radio. They also took note of key developments in the life of faith communities through direct observations in places of worship outside of the lockdown period and via telephone and social media exchanges (WhatsApp and Facebook). These observations were discussed at regular intervals, two to four times a month, with the international researchers and were used to refine the research hypotheses.

The second component was a series of semi-structured qualitative interviews conducted directly face-to-face with 21 religious leaders (interviews, see Table 2), health officials (4 interviews in the Bunia health zone), and members of faith communities (3 focus groups). Most interviews were conducted in December 2020 and February 2021 (with additional interviews with the general population in July 2021). These more in-depth interviews form the core of our analysis.

Table 2
Religious communities covered by the study (with number of interviews)

Communities that manage clinics and hospitals	Communities that do not manage clinics and hospitals
Roman Catholic Church (2)	African and independent churches (Obumu, Chrisco, Combat Spirituel, Independent)
Anglican Church (2)	Revival churches (3)
Sunni mosques (3)	Lam-Te-Kwaro (ancestor worship)
CECA 20 (protestant) : Communauté Évangélique au Centre de l'Afrique (3)	
Other Protestant churches (2)	

Finally, the third part consisted of presenting and discussing our preliminary findings with 11 religious leaders (Catholic, Evangelical, Anglican, Muslim, Pentecostal, Revivalist) on 29 June 2021.

The introduction to the second and third parts of the research emphasised the researchers' religious and medical 'neutrality'. However, the name of their university and the biomedical background of some of them does not exclude that the interviewees were more inclined to make their discourse religiously and 'biomedically' correct. We focused the interviews on lived experiences rather than impressions to ensure data quality. We triangulated the main statements with observations and other sources such as the media.

There exists no precise census of religious denominations in our research area. Still, our selection of religious leaders and the population covers the denominations most visible in the public space. Table 2 distinguishes between two groups, those that have clinics (in each case, we also interviewed the head of the medical service) and those that do not, including the revivalist churches and the ancestor cult, which have developed a strong discourse on faith healing. There is no reliable data on worship attendance, but it is accepted that Catholics make up the majority of the population, followed by Protestant churches. The new (revivalist and independent) churches have a growing audience, while Muslims are a historical minority with a relatively stable membership.

The thematic analysis presented below is based primarily on the transcripts of the interviews and workshop. Passages dealing with the relationship between faith communities (or religion more generally) were systematically identified and then further divided into sub-categories according to the theme. The categories and sub-categories correspond to the sub-sections of the results section. The results were then discussed with the whole team and confronted with observations that added nuance and detail. We indicate either in the text or in square brackets the affiliation of the people quoted and the source (interview or workshop), using the general categories in Table 2. Research participants have agreed to be identifiable.

Main Findings

The first part of this section describes the religious leaders' experience of and reaction to State-imposed Covid-19 measures. Our interviews, workshop, and observations all highlight a sense of shock provoked by the mandatory closure of places of worship –a corollary of the lockdown measure imposed in the DRC (and most countries in the world). We describe how lockdown has been experienced and rationalised by religious leaders and communities. The second part describes the 'coping strategies' put in place by religious groups, while the third returns to the heart of our question: how the relationship between religious groups and health authorities (and the state) has been affected by the pandemic experience.

1. The closure of places of worship: a double bad surprise

The obligation to close places of worship during the first lockdown was unexpected for all religious leaders and their communities. The Anglican Diocesan Medical Service called it "a big surprise because it has not happened for years". Although political and administrative authorities had sometimes coerced

specific) churches to close in the recent past, the compulsory closure of *all* places of worship had not happened before.

The closure generated substantial anxiety among religious communities, especially those whose liturgy and prophetic preaching emphasised the “end times” of the world because of sin. Their initial reaction was fear with the sense that the pandemic and, even more so, the closure of worship places signalled the beginning of this prophecy realising. As an Evangelical leader explained during a workshop:

"A lot of people were talking. Christians were talking a lot; some said this is the end of the world because this was the first time people stopped praying [to be understood as “stopped visiting places of worship”]. It’s something we had never heard before.”

At the same time, it is also evident in our data that religious leaders are aware that they are subject to the temporal power of the government [workshop, Catholic, 1] and that opposing the closure of places of worship was not a choice. The leader of an independent revivalist church in Bunia, the *Ministère Chrétien du Combat Spiritual* (the *Christian Ministry of Spiritual Combat*), explained that: "when the number one in the country says something, we must only submit. We submitted to the demands of the President; everyone prayed at home, everyone was at home." Another workshop participant, a member of an Evangelical church, agreed while also sharing a feeling of incomprehension: "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 things very well.”

Other feelings emerged after initial surprise and fear, ranging from acceptance to outright indignation. Feelings were not consistent along denominational lines. At one end of the spectrum, some leaders described closures as excessive and potentially counterproductive. Their resentment drew on three different arguments.

The first was the depiction of the lockdown (and related closure of places of worship) as an unfounded and disproportionate response, as Covid-19 was not seen as a danger big enough to require such measures. "Some measures are not appropriate, for example, closing churches altogether and encouraging people to pray personally –that was really hard, that was fearmongering" explained an Anglican leader at the workshop.

The second was a criticism of the consistency of the government’s response. Some interviewees called for the closure to apply to all sectors. They pointed out that churches are “places of respect”, unlike markets, which were not closed. "In church, you respect things, but when you get to the market, you are forced in contact with friends, so I found that these measures have not been contextualised to our situation, to our environment here", explained a Catholic priest.

A third argument suggested closure was an attack on the power and value of the Christian faith. “The Church”, explained one Catholic priest,” deplored the closure of the churches because faith cannot be confined". At the Anglican Diocese of Beni, for example, our respondent explained that it was “an

exaggerated measure because it prohibits Christian ceremonies, including various celebrations such as means of intercession", an idea echoed by many of our respondents who emphasised the importance of prayer and God in the fight against Covid-19. A CECA 20 (Evangelical) representative explained that: "in [his faith community] truth, we were astonished. We know that it is God who can solve everything". Another workshop participant, a Catholic priest, explained the reasoning of many leaders:

"When the church is closed, it is the church of God that we pray to [that is closed]. It is God who is above all, and he is the one who can help us fight this scourge, but we are forbidden even to pray..."

Other religious leaders, while regretting the closure of places of worship, accepted the necessity of the action. A Muslim leader elaborated: "we respected these measures because it helped us Muslims understand the danger of this disease". These leaders indicated that their congregations had the same mindset. For example, one of the Evangelical leaders explained:

"There were a lot of comments [about closing the church] but those who understood [...] they understood that it is a necessity, to limit the number of people who come to worship to avoid the big crowds that could easily spread disease and gain a lot of people [...] The church understood that this is good."

While the closure was a frustration, such religious leaders also saw it as having a purpose. As a leader of a Protestant church explained: "we were really surprised to have to tell people not to pray [in church], but we accepted for health reasons. However, this does not prevent prayer." The leader of the Rehobot church (revivalist) added: "lockdown cannot affect the Christian life of a Christian [because there is still] family prayer and personal prayer time". The last element is crucial: the dissociation between place of worship (and gathering) and prayer appears to be the element that allows many religious leaders to make peace with church closure. For some communities, especially within the revivalist churches, Covid-19 was sometimes even presented as an opportunity. Indeed, as the leader of one of these churches explained: "in our church, we advise people to make a radical confession", he then continued explaining that the Covid-19 lockdown effectively created conditions more conducive to such confession.

In general, it seems to have taken Covid-19 cases in the community for religious leaders to accept the government's decision (which did not mean they had not already complied with its instructions). For example, the head of the *Christian Spiritual Warfare Ministry* explained:

"When the churches were closed for us, people said, "we have entered hell", but we didn't understand that hell is after some time, when we saw the disease appear in our community, in the neighbourhood. That's when the government was proven right."

This contact with the disease is sometimes not enough. Data from the workshop illustrate how, for some, defiance remained more than a year after the start of the pandemic. They still expressed doubts about the virus' biomedical nature [41], which affected their involvement in the Covid-19 response:

"Although the friend testified, he was a victim of the disease, he also pointed out somewhere when we see all that surrounds Covid-19, we also ask: does Covid-19 really exist? Because lately we have been

following on social networks in Uganda very close to us here next to us, 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, in the coffins they were burying sand, can I really accept that Covid-19 exists?" [Workshop, Independent Church, 3]

These doubts do not mean that the principle of closing places of worship and imposing measures is not respected, but rather that the commitment of some remains superficial and certainly not spontaneous or in line with their perspectives. As we show below, respect for State authority plays an important role.

The second lockdown

The decision not to close churches during the second lockdown was met with relief by many religious leaders, though some suggested that the closure of schools but not places of worship appeared contradictory. One Muslim leader in Kasenyi explained:

"Why only close schools? When the decision came down, we were surprised that the churches continued as normal but not the schools. Why?"

On the Catholic side, at the Brazza church, a leader challenged the coherence of public action:

"Among the various measures recommended by the government in the fight against Covid-19, there are some that are beneficial and others that are not. It's full of contradictions, so without taking into account the consequences in the future, for example, when we have to close the schools, we haven't closed the market."

2. Maintaining faith community during lockdown

Faced with a strict lockdown order, many religious leaders spoke of the need to "continue with their pastoral mission". This protestant pastor continued:

"Some condemn the state, others say that Satanists have prepared some things to destabilise the church, but I also think that the church has also made other arrangements in relation to its life, it can continue to supervise Christians and do other things" [interview, Protestant, 11].

Many churches adapted to the challenges. For example, some mobilised or created "many small cells throughout the city", as [interview, CECA 20, 18]. They explained, "we realised that in the church there are a lot of people capable of running the cells, a lot of people capable of teaching, preaching and taking responsibility". In Catholic churches, prayer groups meeting once or twice a week, the 'living church communities' (*communautés église vivante*), were active before the pandemic and mobilised. Some Protestant churches, such as CECA-20, also had a similarly active network. It was less the case for the Anglican Church, where cells existed in name but were not very active (as the whole congregation would usually meet). These cells were, however, revived with the pandemic. With the pandemic, the cell group

model –typically led by a layperson appointed by the local church committee– was also be taken up by other Protestant churches, such as the *African Inland Church* (AIC), and even by some revivalist churches.

These cells, which are small enough to operate within the Covid-19 rules or work remotely, maintained religious life during the lockdown. They also took an active role in Covid-19 sensitisation, often basing their action on religious ideas, since, as a cell leader explained: "our pastoral mission is also an educational mission". The person in charge of the CECA 20 medical service further developed this point:

"Prayer is good, it is biblical, but the churches must take real, concrete measures and take measures that can save the Christian population, that is to say, teach their population to work, teach the Christian population to take barrier measures specifically within the framework of this disease, which is infectious, and teach Christians also to take responsibility for intervening in some other way."

Cells also played another essential role for churches: they helped collect the offerings that pay the church's running costs and its leaders' salaries (sometimes at the risk of exploiting congregants who are already in precarious situations; [41]). Lockdown disrupted the economic model of churches dependent on offerings from the faithful during worship, but soon offerings were given to cell leaders, who passed them on to church leaders. Other mechanisms, such as donation boxes placed outside churches or even offerings via mobile money, were also implemented.

In some groups (Protestants (CCC), Catholics, and Muslims), community radios were used to encourage offerings (or tithes and thanksgivings) and to explain that they enable religious leaders to pray for the faithful (and, in particular, those who are generous). In addition, the radios were used to keep in touch with the congregation and broadcast awareness messages about Covid-19. In the words of UEA CECA 20: "the Lord gave us the grace to reach as many members as possible through radio RTK [...] spiritually we were always together, the teachings were given through RTK, the worship was done through RTK, that was a great opportunity for us because of the radio". Social media appeared in our research but was cited as a nuisance –a source of 'fake news' that is difficult to combat– more than a useful channel used by churches.

In practice, the army and police did come and check that places of worship were not being used, and our research found no evidence of meetings taking place. Nevertheless, these actions reinforced the idea of churches being coerced, as explained by a representative of an independent church:

"people from the security forces started to chase people, it's like the church leaders have sinned [...] so I think with this, the church leaders just 'consumed' [*consommé*, endured] and accepted, complied with what the government had decreed".

This element is essential and explains the 'acceptance' of the closure of places of worship described in the previous section and work with the government described in the next section. The idea of enduring – i.e. being subjected to the (health) authorities rather than feeling fully responsible and involved– is fundamental. We will come back to it.

3. A change in the relationship between the health system and religious denominations?

Business as usual

For the four denominations who also provide medical services –Muslims, CECA20, the Anglican Church through its Medical Service and the Catholic Church through Caritas– medical work in times of Covid-19 was a natural extension of their important role in the public health system in Ituri. “The church has always worked alongside the health system [government] to help the population", explained the Caritas official in Bunia. Interviews with health officials confirm this impression: "[with Covid-19] nothing has changed regarding the church health structures" for an official in the Bunia health zone. Covid-19 is neither the biggest problem nor the most urgent one for these faith-based health facilities. It is easy for the health facilities to follow the protocol of the health authorities - which, unlike other issues such as family planning, is not subject to any controversy or difficulty.

In addition to this role, local leaders of these four faith groups explained that they sought to prevent and reduce the burden of Covid-19 beyond their own health facilities by working with their faith communities. They explained that they provided handwashing facilities for their followers and raised awareness of anti-Covid-19 behaviours. For example, one Muslim leader explained that "yet not enough is being done here [against Covid-19], so the religious authority is going to get involved, I know that it is listened to a lot, it is listened to in the city as well as in the territory [in rural areas]”. There was coherence in the discourse of each of the four largely biomedical service providers, which centred on the relation between faith, respect for the Covid-19 measures, and respect for the authorities. The person in charge of the Medical Service of the Anglican Diocese of Beni explained: “Our church has contributed to raising awareness about respect for the barrier measures, encouraging the faithful to remain in the faith and to respect the national authority”. In practice, anti-Covid-19 messages are relayed by religious leaders but also often integrated into worship: "in every prayer, even if it is only for a few minutes, we tell our faithful about some of the measures decreed by the Congolese government, concerning Covid-19, and also practising it" [interview, Muslim, 1]. However, this does not happen without clashes; we have already explained the confusion in relation to the rationale behind Covid-19 measures, and a representative of the Catholic Church did not hesitate to report that he sometimes felt "betrayed by the government, which is supposed to make things clear to people".

New actors

The majority of religious leaders interviewed said that they had worked in line with the message of the health authorities, and the same four measures were described as the core of their communication efforts towards the public: wearing masks, hand washing, checking temperature, and physical and social distancing. Except for the mask, these measures are similar to those during the Ebola epidemic.

On the side of religious leaders whose denominations do not organise biomedical services, there is an awareness of playing an important role and somehow doing the State and the authorities a service in the fight against Covid-19. This idea is visible in the Protestant churches, as, for example, at the *Christian Ministry of Spiritual Warfare*: "the role [of the church] was just to keep reminding Christians not to forget that there is a measure that was taken by the government and that Christians must respect". In the same vein, a CCC official explained that the church must "also help people to understand and [...] and put into practice the measures taken by the state".

The anti-Covid-19 measures are also used by some religious leaders, in particular revivalist leaders, to convey a message: the need to follow the rules –including those of the government–to stay on the right moral and religious path. A Muslim leader developed this idea: "the main thing is to teach the government to teach people to be serious in life, to fear sin because sin attracts all sorts of diseases". At Chrisco, an independent church, the same approach is rephrased in biblical terms: "The Bible also says that we must know how to render to others what belongs to them and also render to God what is God's! For we must respect the authorities in our country if the church is to move forward". Thus, faith organisations are presented as a model of civic-mindedness, crucial in times of pandemics. In the words of the head of the medical service of the Anglican diocese of Beni: "the role of the church is to be a model of respect for the barrier measures, the measures given by the Ministry of Public Health".

Depoliticising the discontent

This task of promotion is not necessarily easy. Previous research has already highlighted the extent to which there is a distrust of the State and politics in the region, which is seen as an important part of acute security and health problems [6, 42]. As the Comico representative in Bunia explained: "to convince them [the population/congregation], we say my dear, this [respecting the Covid-19 measures] is not political. Don't call it politics, it's too hard; there are already cases when you go to the different hospitals". For these religious leaders, working to promote the government's measures means first of all "depoliticising" the issue and showing that the pandemic affects everyone, which is far from easy in a context where the disease is only slightly visible and where some in the congregation are in clear opposition to the government. Anecdotal interviews with members of religious communities of different genders, ages and social positions confirm a general discourse towards the State and health authorities that are often more critical than that of their religious leaders. "The corona of 2021, which corona?" was the answer given by a leader of a Protestant church in Bunia (without a medical service) at the time of the workshop. This depoliticization is all the more necessary because here too, there is a feeling that the State is not fulfilling its part of the contract: "I think the religious have done their part, but the government had not organised training as such" explained a pastor of a Protestant church without a medical service.

Among religious leaders, the feeling that the authorities have not well supported them –that awareness-raising has not been accompanied by the means to take care of the sick and suspected cases– is widespread. It is indeed easy to understand, given the means available on the ground. It raises the fundamental question of the value of awareness-raising when the means to fight against Covid-19

(screening, treatment, and vaccines) are minimal. Religious leaders are then left with an impression of powerlessness, as a CECA representative explained:

"All religious denominations are also struggling in this sense [awareness raising]. Because even to relay, to popularise, it is as if we are sending people to hell. You popularise but without really accompanying them in the consequences of the measures."

At a different level, there was also a general impression that religious leaders had worked to spread a message that they did not, in fact, fully understand when the (perceived) low prevalence of the virus during the period under study required significant persuasion efforts. The workshop revealed significant misunderstandings about Covid-19, which religious leaders were aware of, as a CCC pastor explained:

"We must first clarify [that the government gives quality information to religious leaders] so that people understand the information, the origin of the disease and the medicines that can cure the disease. [Otherwise] these are confusing things."

Another participant in our workshop, still affiliated with the CCC, agreed:

"We need to have a clear message about the origin of the disease, the mode of transmission, and as there is no disease yet what we can do to prevent ourselves but also to see how to protect others. And also show the danger, that is to say, the seriousness of the disease. You know, at one time there was Ebola and people were talking about it. When they also saw […] where we were housing the sick, people really felt that the disease exists. That is to say, we must have a message that removes this ambiguity, the somewhat obscure things about the disease. And then maybe the population can understand."

The problem is more about explaining the logic of the containment and Covid-19 measures than the measures themselves, as handwashing has a direct echo in the scriptures of the Koran and the Bible, as a pastor of an independent church explains:

"Leviticus 13:46: ... This is confinement. He will be confined alone as our pastor Grandpa and his family were confined. ... The others were also affected. If you also read in exodus 30:18–21 you will find there is a problem with hand washing. You have to wash your hands. If you read again Leviticus 13:4–5, it is still the same thing. That is containment. Isaiah 26:20, lockdown always."

Which space for dialogue?

The question these new actors raise is also about the space for interaction between (health) authorities and religious leaders. The data we collected suggests that the space that exists is tenuous. On the one hand, the denominations that have health structures keep their usual contact with the health authorities, who even generally consider them to be "more conscientious" than the State structures (interview health zone, 2). On the other hand, however, direct interactions between other religious leaders and the health system are described as 'normal' and unchanged by health officials who speak of a health system open to all and with its own community participation structures such as community health workers and health

facility committees that allow messages to be relayed. The relationship as described by the few actors in the health system and the 'newcomer' religious denominations is mostly unidirectional. The religious leaders are frustrated that they "cannot really talk" to the authorities. The health system is not, in general, the most open to *bottom-up* initiatives, and this situation is exacerbated in a tense security context, but it is also linked to the fact that these "newcomer" religious denominations have understandings of health that clash with the biomedical health system's [37]:

"I think the situation is there because the religious denominations also see spiritual health, and then the public health ones also see physical health, so they both had to agree. If there is a problem that affects physical health, those who see spiritual health should also be interested in order to put things on track," explains a pastor of a Protestant church without a medical service.

Coordination structures do exist, however, at least on paper, through the coordination platforms set up by humanitarian organisations. The typical example cited is the multi-sectoral structure set up with the Ebola response team, which is chaired by a Catholic priest and aims to create this link but, as one observer of this platform explains: "with Ebola this structure worked very well, because there was a token (*jeton de XXXprésence*) at each meeting; this is not the case with Covid-19". The challenge identified through our interviews seems to be for the space to exist without and beyond aid organisations and the financial incentives they introduce.

Discussion

Our research shows how religious leaders and institutions handled the lockdown period, notably by using and redeploying structures at the grassroots (the cells) but also by responding to the call of the government and health authorities. In general, we find limited opposition to the health authorities in the discourse of religious leaders who describe Covid-19 as an essentially medical problem that requires a response from the whole of society. Therefore, religious leaders seem often inclined to follow public health measures and support government initiatives. These are sometimes embedded in a theological framework that manifests itself in two ways: (1) on the one hand, and for many leaders, following health measures is presented as the right attitude for believers who should follow (health authorities') rules to lead a virtuous life; and (2) on the other hand, and especially for church leaders who profess faith healing, following rules is part of a spiritual test. This adherence to the State's message is interesting because it is not necessarily intuitive. Some churches do not hesitate to enter into frontal opposition with the authorities on health measures they do not like, such as sexual and reproductive health [43]. This does not seem to be the case for Covid-19, which seems to give rise to a general agreement on preventative measures; even if different interpretations of the disease's 'true' origin and nature persist [37]. Again, this is not self-evident; throughout the world, we find examples of collaboration [44] and examples of opposition [45] of faith groups to Covid-19 measures. In an extremely difficult context like Ituri, where conflict is frequent, and health interventions are regularly perceived as politicised [42], it is remarkable that leaders of both the more established and less established religious groups generally choose the path of collaboration rather than opposition –despite significant reservations about the implementation of the

anti-Covid-19 measures we document. An important distinction is, however, to be made between religious leaders who express through the interviews a clear understanding of being subject to the temporal power of the government, and their congregations who are often more willing to be critical –this distinction also points to a potential tension that we have not been able to explore in detail. It would be important to see further studies explore this theme in more depth, as it remains possible that this discourse of 'understanding' of the State's approach despite the constraints is partly a veneer. This is unfortunately a point that we could not explore further due to the difficulty of doing more extensive fieldwork.

The religious leaders we interviewed, especially those whose congregations were not previously involved in healthcare provision, also indicate that they are aware of providing a service, or even doing a favour, to the State and the health authorities. This service is mostly at the level of awareness-raising, which is a widely discussed theme in the literature [46]. However, another potentially more important dynamic in the extremely tense context of Ituri should also be noted: by publicly committing themselves against Covid, religious leaders are participating –and they are aware of this– in an effort to depoliticise Covid-19. Without going too far into the debate on the often necessarily political nature of health [47], it is useful to note that this depoliticization has two potentially contradictory effects. On the one hand, it allows for the achievement of short-term health objectives such as the reduction of the spread of the epidemic through the respect of health measures. On the other hand, it also limits criticism of the political system and the government, which could, in the longer term, bring health benefits. This is not a new dilemma and is often discussed in humanitarian contexts [48, 49]. The more established denominations, mainly the Catholic Church and to a lesser extent the Anglican Church, are used to this constant balancing act between collaborating with State structures by providing services to fill a gap left by a fragile State and criticizing the government, sometimes vehemently. We see with the Covid-19 crisis in Ituri that other actors because they are asked to play a health promotion role, find themselves in a similar position. It is, of course, not insignificant that, in the same way that Anglicans and Catholics are conscious of making up for the State's failures, the 'newcomer' denominations in the field of health also express a conviction that they are doing the work that the State should do. There is, of course, more than one possible position. The Catholic Church, with its large congregation and international support, is both highly critical of the government and involved in many State institutions. The Anglican Church, on the other hand, has a more cautious attitude and is regularly very critical of the government (for example, recently, on the appointment of the president of the CENI) but is not (or hardly) involved in State institutions beyond its teaching and health care activities. The 'newcomers' are reviewing their positioning in this space, having been stung by the mobilisation during Covid. Among them, the Pentecostal churches, traditionally separate and critical of the government, responded to President Tshisekedi's call to participate in the management of the (state) Covid-19 response fund, a call that Anglicans and even Catholics declined [39].

Our analysis shows that the relationship between religious denominations and the State is also at a crossroads at the level of frontline and grassroots actors. On the one hand, there are avenues for inter-faith and inter-sectoral work, such as the platform set up during the Ebola epidemic –although this will probably need to be reviewed as the resources to support it do not exist, and its activity has probably also

been accelerated by generous travel expenses granted to its members, which are the classic pitfall of humanitarian and development aid structures [50]. We explore different avenues for the engagement of faith communities in public health messaging another paper [38] and, therefore, do not dwell on this point. For our analysis of the reconfiguration of religion-State relations, however, it is important to consider the other possible path, which is less productive and sees the frustration of religious leaders – who undoubtedly feel that they have sacrificed a lot– grow as they feel unheard. To address this, the need is not only for a platform for dialogue but also, most probably, for a rethinking of some aspects of health. The place of faith communities in eastern DRC is also intimately linked to the fact that they are for many a space of peace in a context of war, which is often seen as more able than the health system to respond to trauma and mental health problems [51]. The re-establishment of a healing, effective and inclusive health system in a conflict zone like Ituri may also need to incorporate aspects of compassion and listening those religious denominations may help with. Now that the door has been opened with the fight against Ebola and then Covid-19, the question is how to establish real dialogue.

Our research suffers from obvious limitations, notably the fact that it focuses on urban and peri-urban context and is limited to a small number of participants (mostly religious leaders); these methodological limitations are a consequence of the insecure situation in Ituri, but it is also very clear that other fields are barely touched upon by our research and deserve to be explored further. The reaction of religious congregations to the reconfiguration of the relationship between their denomination and the state and, more generally, the tensions between the views of the population and religious leaders, seem to be a priority for future research. Analysis over time of the ongoing reconfiguration and its effects on health, and an in-depth comparison with other contexts that better disentangle contextual and denominational factors, will also be useful.

Conclusion

Our article has focused on the different coping mechanisms developed by religious denominations during the Covid-19-related lockdowns in north-eastern DRC, an area plagued by significant violence. The pandemic led to a general mobilisation of religious authorities who, overall, responded to the authorities' call to play a role in raising awareness and controlling a population (which often has more confidence in them than in the State). This new mobilisation brings new religious actors close to the health system. It forces a political repositioning and a reconfiguration of the relationship between the State (health system) and religious groups. These new actors are also putting forward the desire for a relationship that is not just subordination of the religious to the imperatives of health care but a dialogue that allows the experiences of the faithful in conflict zones to be brought to the fore.

Declarations

Ethics approval and consent to participate

The research was authorised by the ethics committee of the University of Edinburgh's School of Divinity and the Université Anglicane du Congo.

Consent for publication

Not applicable.

Availability of data and materials

The datasets (anonymised interview and focus group discussion transcripts) used and/or analysed during the current study are available from the corresponding author on reasonable request.

Competing interests

The authors declare that they have no competing interests

Funding

This research was funded by a UK Arts and Humanities Research Council (AHRC) grant.
Reference: AH/V007998/1.

Authors' contributions

Conceptualisation, all authors; methodology, all authors; formal analysis, J.-B.F. with S.K. support; investigation, S.K, A.B., Y.W.; data curation, J.-B.F.; writing—original draft preparation J.-B.F. with S.K..; writing—review, interpretation, and editing, all authors. All authors have read and agreed to the final version of the manuscript.

Acknowledgments

None.

References

1. Hill PS, Pavignani E, Michael M, Murru M, Beesley ME. The "empty void" is a crowded space: Health service provision at the margins of fragile and conflict affected states. Confl Health. 2014;8:1–10.
2. Olivier J, Tsimpo C, Gemignani R, Shojo M, Coulombe H, Dimmock F, et al. Understanding the roles of faith-based health-care providers in Africa: Review of the evidence with a focus on magnitude, reach, cost, and satisfaction. Lancet. 2015;386:1765–75.
3. Campbell MK, Hudson MA, Resnicow K, Blakeney N, Paxton A, Baskin M. Church-based health promotion interventions: Evidence and lessons learned. Annu Rev Public Health. 2007;28:213–34.
4. Greyling C, Maulit JA, Parry S, Robinson D, Smith S, Street A, et al. Lessons from the Faith-Driven Response to the West africa Ebola Epidemic†. Rev Faith Int Aff. 2016;14:118–23.

5. Marshall K, Smith S. Religion and Ebola: Learning from experience. Lancet. 2015;386:e24–5.
6. Vinck P, Pham PN, Bindu KK, Bedford J, Nilles EJ. Institutional trust and misinformation in the response to the 2018–19 Ebola outbreak in North Kivu, DR Congo: a population-based survey. Lancet Infect Dis. 2019;19:529–36.
7. Bell C. COVID-19 and Violent Conflict: Responding to Predictable Unpredictability [Internet]. 2021. Available from: https://www.politicalsettlements.org/2020/03/26/covid-19-and-violent-conflict-responding-to-predictable-unpredictability/
8. Barmania S, Reiss MJ. Health promotion perspectives on the COVID-19 pandemic: The importance of religion. Glob Health Promot. 2021;28:15–22.
9. Singh NS, Abrahim O, Altare C, Blanchet K, Favas C, Odlum A, et al. COVID-19 in humanitarian settings: documenting and sharing context-specific programmatic experiences. Confl Health. Conflict and Health; 2020;14:1–9.
10. WHO. World Health Organization strategy for engaging religious leaders, faith-based organizations and faith communities in health emergencies. 2021.
11. Seymour C. Everyday Violence and War in the Kivus, DRC. Childhood, Youth Violence Glob Context. Palgrave Macmillan UK; 2014;153–72.
12. Wells CR, Pandey A, Ndeffo Mbah ML, Gaüzère BA, Malvy D, Singer BH, et al. The exacerbation of Ebola outbreaks by conflict in the Democratic Republic of the Congo. Proc Natl Acad Sci U S A. 2019;116:24366–72.
13. Richardson ET. On the coloniality of global public health. Med Anthropol Theory. 2019;6:101–18.
14. Baba A, Theobald S, Martineau T, Lecturer S, Sabuni P, Nobabo MM, et al. 'Being a midwife is being prepared to help women in very difficult conditions': midwives' experiences of working in the rural and fragile settings of Ituri Province, Democratic Republic of Congo. Rural Remote Health. 2020;20.
15. Tshonda JO. Terre et identités sous tension. 2021.
16. Lindstrom C. Donors and a Predatory State: Struggling with Real Governance. In: De Herdt T, Titeca K, editors. Negot Public Serv Congo. London: Bloomsbury; 2021.
17. Seay LE. Effective responses: Protestants, Catholics and the provision of health care in the post-war Kivus. Rev Afr Polit Econ. 2013;
18. Langhendries M, Hulst R Vander. Gezondheidszorg: het paradepaard van de Belgische kolonisatie? 2020;
19. Kalema E. Religion et médecine au Congo Belge: pratiques et savoirs des assistants médicaux " indigènes" issus de Kisantu (Fomulac) et de leurs patients (1937–1961). ixtheo.de. 2020. p. 1–18.
20. Widmer M, Betran AP, Merialdi M, Requejo J, Karpf T. The role of faith-based organizations in maternal and newborn health care in Africa. Int J Gynecol Obstet. 2011;114:218–22.
21. Johnson T, Zurlo G. World Christian Encyclopedia. 2020;
22. Mufika MB, Henk H(, Stoker) G, Mufika M. Turn the tide on losing members to cults: The challenge of the churches in the Congo. journals.co.za. AOSIS; 2020;54.

23. Frederiks M, Nagy D. Multiple Religious Belonging and Identity in Contemporary Nigeria: Methodological Reflections for World Christianity. World Christ. 2020. p. 225–50.
24. Nganda AN. Le régime Mobutu à l'épreuve du monde catholique congolais (1965–1997) substitut à l'absence de contre-pouvoir. 2018;
25. Bouvet B. RD-Congo: Malgré le veto de l'Église catholique, élection d'un président contesté à la tête de la commission électorale [Internet]. La Croix. 2021 [cited 2022 Feb 16]. Available from: https://www.la-croix.com/Religion/RD-Congo-Malgre-veto-lEglise-catholique-election-dun-president-conteste-tete-commission-electorale-2021-10-17-1201180950
26. Maeda JM, Nkengasong JN. The puzzle of the COVID-19 pandemic in Africa. Science (80-). 2021;371:27–8.
27. Reuters. Covid-19 kills 32 members of DR Congo's parliament [Internet]. 2021. Available from: https://www.reuters.com/business/healthcare-pharmaceuticals/Covid-19-kills-32-members-congos-parliament- 2021-05-28
28. Al Dahdah M, Falisse J-B, Lurton G. Ignorance et santé globale. Rev d'Anthropologie des Connaissances. 2021;Fortchomin.
29. Mayhew SH, Kyamusugulwa PM, Kihangi Bindu K, Richards P, Kiyungu C, Balabanova D. Responding to the 2018–2020 Ebola Virus Outbreak in the Democratic Republic of the Congo: Rethinking Humanitarian Approaches. Risk Manag Healthc Policy. 2021;Volume 14:1731–47.
30. World Health Organization. Evidence for Contact Tracing Analyses From the Drc Ebola Outbreaks. 2020;
31. Desbureaux S, Kaota A, Lunanga E, Stoop N, Verpoorten M. Covid-19 vs. Ebola: impact on households and SMEs in Nord Kivu, DR Congo. Work Pap IOB (Institute Dev Policy Manag. 2020;
32. Karam A, Clague J, Marshall K, Olivier J. The view from above: Faith and health. Lancet. Elsevier Ltd; 2015;386:e22–4.
33. Summerskill W, Horton R. Faith-based delivery of science-based care. Lancet. Elsevier Ltd; 2015;386:1709–10.
34. Levin J. The discourse on faith and medicine: a tale of two literatures. Theor Med Bioeth. Springer Netherlands; 2018;39:265–82.
35. Benn C. Guest introduction: faith and health in development contexts. Dev Pract. Taylor & Francis; 2017;27:575–9.
36. Hutchison ML, Johnson K. Capacity to trust? institutional capacity, conflict, and political trust in Africa, 2000–2005. J Peace Res. 2011;48:737–52.
37. Way Y, Wild-Wood E, Baba A, Kangamina S, Falisse J-B, Grant L, et al. Perceptions of Covid-19 in faith communities in DR Congo. 2022;
38. Baba A, Grant L, Wild-Wood E, Pearson N, Way Y, Falisse J-B, et al. Engaging faith communities in public health messaging in response to COVID-19: lessons learnt from the pandemic in Ituri, Democratic Republic of Congo. 2022;

39. Wild-Wood E, Way Y. Supporting the Nation in a Time of COVID-19 [Internet]. Christ. Nation Proj. 2021. Available from: https://thechristiannationproject.net/wild-wood-and-way/
40. Falisse J-B, Masino S, Ngenzebuhoro R. Indigenous medicine and biomedical health care in fragile settings: Insights from Burundi. Health Policy Plan. 2018;33:483–93.
41. Wild-Wood E, Grant L, Adedibu B, Barnard A, Ojore A, Way Y. The Public Role of Churches in Early Responses to COVID-19 in Africa: Snapshots from Nigeria, Congo, Kenya and South Africa. Stud World Christ. 2021;27:65–84.
42. Congo Research Group. Rebels, Doctors and Merchants of Violence. How the fight against Ebola became part of the conflict in eastern DRC. 2021.
43. Dumbaugh M, Bapolisi W, Bisimwa G, Mwamini MC, Mommers P, Merten S. Navigating fertility, reproduction and modern contraception in the fragile context of South Kivu, Democratic Republic of Congo: 'Les enfants sont une richesse.' Cult Heal Sex. Taylor & Francis; 2019;21:323–37.
44. Gopez JMW. Building public trust in COVID-19 vaccines through the Catholic Church in the Philippines. J Public Health (Oxf). 2021;43:e330–1.
45. Mukherjee I. COVID-19, cults, and the anti-vax movement. 2021;
46. Tan MM, Musa AF, Su TT. The role of religion in mitigating the COVID-19 pandemic: the Malaysian multi-faith perspectives. Health Promot Int. 2021;
47. Illich I. Medical Nemesis. Lancet. 1974;
48. Barber B. Feeding Refugees, or War? The Dilemma of Humanitarian Aid. Foreign Aff. 1997;76:8.
49. Falisse J-B. Artsen Zonder Grenzen België als apolitieke organisatie. Brood Rozen Tijdschr voor Geschied van Soc Bewegingen. 2011;26–53.
50. Samb OM, Essombe C, Ridde V. Meeting the challenges posed by per diem in development projects in southern countries: A scoping review. Global Health. Globalization and Health; 2020;16:1–11.
51. Gallagher EB, Wadsworth AL, Stratton TD. Religion, spirituality, and mental health. J. Nerv. Ment. Dis. 2002. p. 697–704.