

A Famine of the Words of the Lord in the Land: *A Critical View of Global Pandemics* *from a Public Health Practitioner*

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The time is surely coming, says the Lord God, when I will send a famine on the land; not a famine of bread, or a thirst for water, but of hearing the words of the Lord.
Amos 8:11¹

Introduction

It is time to take health rights as seriously as other human rights, and that intellectual recognition is only a necessary first step toward pragmatic solidarity, that is, toward taking a stand by the side of those who suffer most from an increasingly harsh “new world order.”²

With this exhortation, Paul Farmer concludes his 2005 work *Pathologies of Power*, a plea from a person who has brought health and hope to some of the poorest people in the world. The reality of the Human Immunodeficiency Virus (HIV)/Acquired Immunodeficiency Syndrome (AIDS) presents a startling world view, now thirty years into the epidemic. Even though the twenty-first-century church lives in the context of this pandemic, it rarely finds its way into the church’s conversations.

The 2008 Campbell Scholars Seminar at Columbia Theological Seminary addressed the question of the response of the church living in the reality of pandemics. We explored reasons for the famine of “the words of the Lord” in our churches and found three broad barriers to discussion and response. First, churches may lack information on the causes of HIV, the communities most affected, and ways of responding. Second, the famine of the words of the Lord may be due to lack of commitment to addressing potentially controversial topics such as human sexuality. Finally, churches may be reluctant to speak and respond due to perceived lack of access to resources and materials for discussion. This article is in response to this famine of “the word of the Lord” and is intended to be a help to preachers who take up the challenge of preaching to address the HIV pandemic.

A global pandemic (from the Greek *pan*, “all” and *demos*, “people”) is a disease that spreads through human populations across a large region, a continent, or even worldwide. Generally, the term pandemic is reserved for infectious diseases in which one person can infect another. A pandemic can start when three conditions have been met: a disease new to the population emerges, the agent infects humans, causing serious illness, and the agent spreads easily and sustainably among humans.³

I first provide a brief look at a past pandemic and the role of the church during a terrifying period. Second, I discuss principles of public health relevant to HIV and epidemiology, the basic science of public health. Third, I provide recent estimates of the burden of HIV in the world. Fourth, I present an argument for the social construc-

tion of disease to inform the church's response. Finally, I present a framework for the church's considered and committed response to world pandemics as a people of God.

The Church and the Bubonic Plague

In the 1340s, the bubonic plague arrived in Eurasia. Increasing population, migration of people from forests into towns with little infrastructure for sanitation and an imbalance between food and population created an environment where rats could thrive and harbor the plague bacillus, *Y. Pestis*.⁴ Despite the size of the countries affected and the slowness of travel, the plague claimed a third of the population of Europe and up to 60% of the population in other regions. Called the Great Mortality by Europeans, the Black Death produced more mortality than can be attributed to two world wars and the 2.8 million deaths from AIDS to date. The Plague produced one of the most horrific examples of anti-Semitism in European History. In the general population collapse of the Middle Ages, the Jews suffered disproportionately (being blamed for the problem and suffering stigma), even though they were usually more prosperous and better educated than their Christian neighbors.⁵

Epidemiology and Public Health

Public Health is the science and art of preventing disease and injury, prolonging life, and promoting health through organized efforts and informed choices of society, public and private organizations, communities, and individuals. *Epidemiology*, the basic science of public health, is the study of factors affecting the health and wellbeing of populations. Epidemiologists may draw on a number of other scientific disciplines such as biology, sociology, and economics in understanding disease processes and social determinants of health.

Public health activities are responsible for the eradication of polio from the globe, the reduction in morbidity (illness) due to measles and other vaccine-preventable diseases, safe food and water, the reduction of dental cavities due to water fluoridation, the decline in tobacco use, the reduction in birth defects due to fortification of flour with folic acid, and preventing mortality from breast and cervical cancer by increasing screening throughout the United States. These population health successes are due to basic tasks of epidemiology: public health surveillance, outbreak investigation, designed studies, program implementation, and evaluation.

Public Health Surveillance is the ongoing systematic collection, analysis, and dissemination of health data to those who need to have them. The final link in the surveillance chain is the application of these data to disease prevention and injury control. Today, in the United States, surveillance applies to approximately 100 infectious diseases and adverse health events of noninfectious etiology at the local, state, and national levels. Global surveillance is conducted by the World Health Organization and UNAIDS.

Data from surveillance are generally of four types:

1. Risk factors: personal behaviors or societal characteristics that affect risk of disease or injury;
2. Morbidity: existence of a disease. Morbidity can be measured as incidence, the number of new cases of a condition in a given population at a given time, or prevalence, all the cases that exist in a population at a point in time;

3. Disability adjusted life-years: a statistical adjustment that discounts life according to various measures of disability or illness;

4. Mortality: death.

Mortality data may be the most comprehensive source of information across the world. An ambitious project attempts to calculate the global burden of disease and risk factors for 136 diseases and injuries, for seven income/geographic country groups, attributable to 19 risk factors.⁶ This analysis reveals several aspects of interpreting mortality data. It may be instructive to examine a selected subset of these data.

There are many ways to measure mortality. In the U.S., a death certificate is required by law for burial or cremation. So, death certificates are a fairly representative picture of deaths of the U.S. population. However, information on the death certificates may not be accurate. Certain conditions, e.g., diabetes, cancer, or HIV, may cause much morbidity, but not be the ultimate cause of death. Other characteristics listed on the death certificate (e.g., education and race) have been shown to be unreliable; for example, education of decedents tends to be exaggerated, and recorded race (by next of kin or physician) is often different from how the decedent self-classified him or herself.⁷

In some international settings, where death certificates may not be uniformly available, public health workers use verbal autopsies, interviews with family and community members about deaths. When this is not possible, models are developed to predict causes of death from other data sources. Even when models must be used, verbal autopsies are often conducted for certain conditions.

Burden of HIV

From public health data, we learn that in 2009, an estimated 2.6 million people became newly infected with HIV. This is nearly one fifth (19%) fewer than the 3.1 million people newly infected in 1999, and more than one fifth (21%) fewer than the estimated 3.2 million in 1997, the year in which annual new infections peaked. While new infections are declining, there were an estimated 33.3 million people living with HIV at the end of 2009 compared with about 26.2 million in 1999—a 27% increase. The reduction in AIDS-related deaths is due to the significant scale up of antiretroviral therapy over the past few years.

The estimated number of children living with HIV increased to 2.5 million in 2009, 90% of whom live in sub-Saharan Africa where nearly 12 million children under 18 have lost one or both parents to AIDS.⁸ While the proportion of women living with HIV has remained stable (at slightly less than 52% of the global total), the share of infections in heterosexual women is increasing, and, for selected regions, infection is increasing rapidly in people over age 60.⁹ Sub-Saharan Africa bears a disproportionate share of the global burden and has more women than men living with HIV.¹⁰

Since 2001, when the United Nations Declaration of Commitment on HIV/AIDS was signed, the number of people living with HIV in Eastern Europe and Central Asia has increased by more than 150% from 630 000 to 1.6 million in 2007. In Asia, the estimated number of people living with HIV in Viet Nam has more than doubled between 2000 and 2005, and Indonesia has the fastest growing epidemic.

Disease as a Social Construct

Disease is socially produced and distributed. Becoming sick or unhealthy is not

the result of individual misfortune, but rather the consequences of social, political, and economic organizations in society. Because of the complex biomedical issues of HIV, sometimes disfiguring nature of advanced illness, and its association with death, HIV/AIDS might have been stigmatized no matter who was initially infected.¹¹ Stigma represents a deviation from a socially constructed ideal or expectation, such as adhering to an accepted sexual orientation or remaining free from a disfiguring disease.¹² In her essay “Illness as Metaphor,” Susan Sontag explores the social construction of TB, Cancer, and HIV.¹³

Medicalization is a process by which non medical problems get defined as and treated with a medical model. In 1851, Samuel Cartwright described an apparent mental illness that caused slaves to flee captivity. He stated that the illness was caused by masters who “made themselves too familiar with [slaves], treating them as equals” and pointed to the Bible’s call for the slave to be submissive to the master.¹⁴ Cartwright prescribed an intervention: “whipping the devil out of them.”¹⁵ Indeed, the use of race as categorization of human beings has little relevance to illness or prevention, despite the widespread use of categories in medical texts.¹⁶ In the mid-nineteenth century, homosexuality was similarly medicalized.¹⁷

The Voice of the Church regarding pandemics

The notion that pandemics are of no relevance to the local church may be a US-centric phenomenon. Churches provide a substantial portion of medical care in developing countries, often reaching vulnerable populations in adverse conditions. In addition, health, religion, and cultural norms and values define the health-seeking strategies of many people. We articulate here three voices with which the church can speak to pandemics: prophetic, authoritative, and compassionate.

1. Prophetic voice

In public health, it has long been understood that the way to ensure the health of a community is to empower the people of that community. However, the church may not always feel comfortable in that role. During the 2008 Campbell Scholars Seminar, we identified three barriers to the Church’s greater involvement in pandemics: (1) selected interpretations of the Bible; (2) lack of knowledge of the cause of pandemics and effective interventions, and (3) perception that these problems just do not affect church membership. Here, I discuss each of these barriers in light of the Church’s prophetic voice.

In Psalm 31, we read the lament, complaint, and prayer of thanksgiving from a writer afflicted and shamed by society, but trusting in God to deliver him to a safe place. In Luke 13:10-17 we were reminded of the role of the church in making crooked people straight. In Luke 2, we saw the son of God wrapped up (how can God be “wrapped”?) and laid in an unsanitary place. The writer of John 5 tells a story about the challenge of societal neglect: friends outrun the invalid man to the pool, and he has no one to help him into the water. And we see Jesus inverting the social order and helping those with less opportunity. In II Kings 5, a powerful leader of the country receives healing counsel from a servant girl; we listen for the voice of God in unusual places.

Passages in the Bible concerning homosexuality (for example, Genesis 1, 2; Genesis 19; Leviticus 18 and 20) are often cited by the church as an excuse not to accept or minister to people with HIV/AIDS. Biblical scholars have studied the relational

and gender patterns of the ancient Mediterranean world—the world that produced the Bible. In this context, they conclude that the story of Sodom and Gomorrah is not a condemnation of homosexuality, but rather a story about rape and inhospitality. In other biblical texts (Ezekiel 16:49, Luke 17:28-29) Sodom's "sin" is not identified as homosexuality; rather, their sins were pride, failure to help the poor, and lack of hospitality to people different from themselves.

The links among disease and guilt and sin may not be as straightforward as we thought. Often the scriptures deal with disease or disability as an opportunity to show God's power. Consider the story from John 9: As [Jesus] walked along, he saw a man blind from birth. His disciples asked him "Rabbi, who sinned, this man or his parents, that he was born blind? Jesus answered, "Neither this man nor his parents sinned; he was born blind so that God's works might be revealed in him." Here, Jesus makes explicit that there is not a necessary connection between sin and illness. The man was born blind, Jesus tells us, so that God's work might be revealed. Verse 8 deals with stigma and its effects. Those accustomed to seeing (and treating) the man as a blind beggar asked, "Is this the man who used to sit and beg?" Verses 9-17 are interrogations: "How were your eyes opened?" Despite repeated answers, the people, trapped in their social construct of stigma, insist he was born entirely of sin, and in v 34 they finally expel him from the community. The man meets with a fate worse than blindness: the stigma of exclusion.

We do not often hear sermons where Iraq is said to be a punishment for sin or the famine of Darfur is evidence of the sinfulness of the hungry people. Nor do we complain that the United Nations is undermining morality by feeding people. In such situations we do not think, preach, or pray by blaming the victims.

2. Authoritative voice

Through preaching, teaching, and community involvement, church leaders have an opportunity to shape opinion and action. Public health agencies recognize the unique role that the Church can play and have provided guidance on community protection.¹⁸

In the face of surveillance evidence cited above, the claim that the Bible is a barrier to the Church's discussion of the pandemic of HIV loses much of its merit. The HIV pandemic is no longer identified only with homosexual men; the groups most affected throughout the world are women, children, and the elderly. German theologian Paul Tillich challenges us: "Reality itself makes demands and the (theological) method must follow; reality offers itself in different ways, and our cognitive intellect must receive it in different ways."¹⁹

In 1996, a survey of members of the Presbyterian Church USA showed that 25% were *affected* by AIDS in some way (e.g., knew someone).²⁰ Assuming that people who have been affected by AIDS are no more or less likely to be members of the PCUSA in 2008 (compared to 1996), crude calculation shows that the percentage of members of Presbyterian churches *affected* by HIV/AIDS is conservatively 60%. Familiarity with current data on true burden and risk for global pandemics can aid the church to speak with a voice of authority. Every minister in the US has ready access to a local health department with staff trained to assist pastors to deal with these issues.

3. Compassionate voice

Churches are stable, enduring, and often the most trusted institutions in the community. They can be identified with almost every cultural and ethnic group and

frequently serve as a point where large numbers of people regularly congregate. Finally, people often turn to their faith for strength in times of illness and stress.

The impact of Churches in African-American communities in the United States may be even greater than in other ethnic groups. The church has historically been the center of spiritual, social, and political life for African Americans. Public Health has recognized the essential role of the church in African-American communities.²¹

Many public health groups are beginning to develop policies that aid churches in promoting community health. The American Public Health Association's Caucus on Public Health and the Faith Community encourages health and faith partnerships that promote positive health behaviors among members of their congregations as well as individuals in the community. The World Health Organization held a meeting on tobacco and religion to explore the spiritual dimensions of health and ethical values underpinning public health actions.

Faith-based organizations that have developed health ministries are often very successful in providing community health programs. One study²² found eighteen frequently cited church-based health-promotion programs comprised of health screening, health-promotion and disease-prevention events, and risk-reduction programs. The African-American churches represented the largest number of churches included in the study. The study determined that health-promotion activities within faith-based settings are gaining broad-based support from representatives of religious institutions and public health officials.

For example, the Partnership for a Healthy Mississippi, funded by money from the Mississippi tobacco settlement, utilized a network of churches to help change the culture of Mississippi from one of acceptance of tobacco to one that protects youth from detrimental effects. The Partnership found that the churches' organizations were enthusiastic about their role in promoting healthful behaviors, were able to reach a large number of youth who would not otherwise be reached, and were advocates for health policy changes.

Conclusion

A 1988 movie, *Mississippi Burning*, casts two principal characters as FBI men sent from Washington to a fictional County in Mississippi to investigate the reported disappearance of civil rights workers. The story of the inhumanity of racism and the total disregard of one person for another on the basis of a label unfolds against a backdrop of distrust of government and the fierce faith of the oppressed African American Christians in Mississippi. Normalcy is stood on its head in the "successfully segregated" South as we shudder at heroes not cast in our own images. At one point, the grieving mother of a murdered young Black boy groans, "He didn't do anything except be a Negro!" During a particularly horrific scene, when life was being taken as easily as we swat at flies, we hear a superimposed cadence raised by the church choir: "When we all get to heaven, what a day of rejoicing that will be! When we all see Jesus, we'll sing and shout the Victory." A yearning for a better place since current existence is otherwise unendurable.

Later, when sufficient evidence allows trials to be held, one of the leaders of the community hangs himself. In desperation, someone asks, "Why? He didn't *do* anything!" The FBI character portrayed by Gene Hackman replies, "Anyone is guilty who watches this happen and pretends it isn't." We are reminded of Shirley Guthrie's

articulation of basic forms of Sin:

Sin is not just lynching or shooting Negroes or killing six million Jews. It is having contempt for any human being (Matthew 5:21-24). It is not only actively murdering people, but simply letting them starve to death.... The desire to be like God, knowing good and evil, is enmity against our fellowmen... (and) self destructive.²³

Throughout history, pandemics have been responsible for destruction of life and civilizations. To put the HIV epidemic in perspective, a review of selected pandemics in human history shows that the first pandemic threatened across the world in 430 B.C. when typhoid fever spread by the Roman army raged throughout Europe. Colera spread throughout the world beginning in 1816. Influenza continues to be a worldwide threat as the virus continues to develop resistance to vaccines. Now 2011 marks the thirtieth year since HIV was first reported.

The church has a role in response to the HIV pandemic that cannot be supplanted by any government or nongovernmental agency. The admonition to tend to the blind, lame, and weak transcends any political process and change in political administrations. Numerous resources exist for a church committed to examining a prophetic approach to pandemics. First, any church in the United States and in most international countries has access to a health department²⁴ or ministry of health.²⁵ Many of these organizations offer resource persons and materials developed specifically for churches.^{26,27} Many denominations have developed curricula to assist church leaders in introducing discussions of pandemics into theological education, preaching, Christian education, and mission planning.²⁸

The foundation for the church's response to pandemics comes from John 9:39: Jesus says, "I came into this world for judgment so that those who do not see may see, and those who do see may become blind" (NRSV). If the church is to take John 9 seriously, we must unlearn all those things we think we know about the AIDS pandemic, the Bible, and the Church. Just as people must change their behaviors to avoid HIV, church leaders and those of us in the pews must unlearn who we think is HIV+ and why. Paul Tillich has asserted, "God works toward the fulfilment of every creature and toward the bringing together into the unity of his life all who are separated and disrupted."

Gerald P. Jenkins emphasizes: "In Christianity, our relationship to God and our relationship to fellow man [sic] are regarded as inseparable."²⁹ Pandemics are now a part of our world; when we look at people suffering the effects of pandemics, Tillich tells us we find ourselves not apart from, but right in the middle of it.³⁰ Responding to social justice in health is not a liberal or evangelical issue, but a call by God to respond to an urgent human crisis with the healing spirit of Jesus Christ.

Notes

1. We thank Dr. Kathleen O'Connor for suggesting this text as a context for this essay.
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of All Time (New York: HarperCollins, 2005).

5. Norman F. Cantor, *In the Wake of the Plague: The Black Death and the World It Made* (New York: Free Press, 2001), 150.

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10. UNAIDS, 2010 Report on the Global AIDS Epidemic. Available from: http://www.unaids.org/documents/20101123_GlobalReport_Chap2_em.pdf.

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12. Alonzo & Reynolds, 1995, p. 304.

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19. Paul Tillich, *Systematic Theology* (Chicago: University of Chicago Press (1), 1967), 281.

20. <http://www.pcusa.org/presbyterian-panel-survey-february-1966-summary>

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