**Religion & Sustainable Development: Building Partnerships to End Extreme Poverty**

Engaging local faith Communities as partners in responding to public health emergencies

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Communities depend on the institutions in place to understand and explain the emerging realities. In the case of health care these institutions can be the formal health care systems and what is regarded or treated as the informal health care systems. Figures by UNICEF and the World health organisation on Sub-saharan Africa indicate that 47% of mothers give birth with the attention of a skilled attendant. The physician density per 1,000 is below 0.1 and the nurse/midwife density per 1,000 is below 0.2 in many countries. This translates to one doctor for 71,000 people in some countries and one nurse for over 6,000 people.

In such circumstances people have to rely on the local support mechanisms to respond to the challenges they face. These support mechanisms may be built around the worship functions of various faith communities. In the case of churches these can be prayer meetings, regular fellowship meetings and individual engagement in prayer and scriptures. Traditional healers, herbalists and traditional birth attendants also provide information and services to people whom they reach. It is the power of presence-located in a myriad of organisations and networks-that fills the gap left by the inadequacy in presence instructional health care facilities health.

**Challenges**

1. The inadequacy in coverage of formal health care services alienates communities from the state and other responders who arrive at the time of a public health emergency. What complicates the situation is that external responders may arrive in affected communities as if it is an empty space without institutions.
2. People will turn to the institutions or support mechanisms which have always been responsive to their needs. Some of the institutions may not have the competence to handle an emergency like ebola. What determines the nature of the faith response is the immediate or delayed acceptance of evidence.
3. Building trust takes time yet the external responders may not have the time to build the trust.
4. Faith communities are not homogeneous in their interpretation of scriptures in relation to an emerging reality. The designed faith responses may or may not engage the multiple belief systems in place.

**Lessons form the OAIC’s response to HIV and AIDS**

1. Work with faith communities to develop and implement responses from the onset of the emergency. Faith leaders at the local level shouldn’t be treated as mere implementers of what has bee planned somewhere else.
2. Work with faith communities to identify the resources as well as barriers in their theological understanding of the reality at hand. Faith leaders have to take responsibility to give the right information from the pulpit and other communication channels. A statement that is issued collectively by faith leaders will help to provide guidance.
3. Build meaningful partnerships with faith communities during and after the emergency period. Governments and other actors should recognise and work more effectively with the non-institutional health assets.

1. Work beyond the celebration of self-provisioning to building community level participation to engage public institutions for social accountability.