Rebuilding Trust and Connecting Community: The Role of the Anglican Church of the Province of Central Africa in Malaria Prevention, Treatment, and Eradication

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Malaria continues to be a leading cause of death in sub-Saharan Africa. In the face of widespread state failure to instate productive antimalarial policy, the Church of the Province of Central Africa (CPCA), an evangelical Anglican church spanning Botswana, Malawi, Zambia, and Zimbabwe, has emerged as a particularly effective organization in lowering disease burden. Critically, the failure of state antimalarial policy in Central Africa and the uniquely powerful position of the CPCA has not yet been sufficiently considered from a *biosocial* scope in the literature, incorporating both biological and social factors. A historical analysis of health policy in sub-Saharan Africa reveals colonial medicine campaigns aimed at eradicating diseases using invasive treatments as a potent force behind present-day mistrust in state healthcare. Further, the declining amount of international aid into antimalarial efforts as well as the inefficient allocation of existing funds can be traced back to the neoliberal ideals (e.g. ideals supporting the free market and deregulation) of bureaucratic rationality—the belief in bureaucracy as a rational means of societal organization—championed by the Reagan and Thatcher administrations. These factors contribute to the woefully inadequate provision and distribution of malaria control equipment, including insecticide-treated nets and antimalarial drugs. In contrast, the CPCA has been able to combat malaria on an unprecedented level; capable of reaching thousands of congregants in remote border regions, it has been instrumental in mobilizing volunteers, distributing resources, and educating citizens. The CPCA notably functions as a "local moral world," a group with shared moral experiences and meanings, capable of community-level integration. Its success reaffirms the necessity of faith-based organizations in combating infectious diseases in low-income countries and improving health outcomes.

Introduction

The persistence of malaria as a devastating issue and leading cause of death in many low-income countries, despite being largely treatable with modern medicine, is one of the greatest failures of both regional and global health policy. In 2021, there were an estimated 247 million cases of malaria worldwide and 619,000 malaria deaths; the African region alone was home to 95% of malaria cases and 96% of deaths (WHO, 2023). In contrast, infectious diseases such as malaria are notably missing from the leading causes of death in more affluent countries, establishing malaria as a marker of stark inequality in global health (Farmer et al., 2013). Various faith-based organizations and non-governmental organizations have stepped in to deliver medical care in regional settings. This paper will specifically focus on the role of the Church of the Province of Central Africa (CPCA) as one such faith-based organization, analyzing where and why the CPCA has succeeded in countering a devastating illness that local governments continue to struggle with.

The CPCA, an evangelical Anglican church, has fifteen dioceses (districts) that cover the countries of Botswana, Malawi, Zambia, and Zimbabwe (Steffenson, 2013). With the exception of Botswana, which has been able to consistently maintain malaria incidence at one case per thousand in the past decade (WHO Africa, 2023), all of these countries continue to deal with high rates of malaria prevalence and mortality. Malawi and Zambia both rank in the 20 countries with the world's highest malaria incidence; in 2021, Malawi accounted for 1.7% of global malaria cases and 1.2% of global malaria deaths, while Zambia carried roughly 1.4% of the global malaria case and death burden (USAID President's Malaria Initiative, 2022). Zimbabwe has also struggled with a high malaria burden, regularly receiving hundreds of thousands of cases per annum; just this year, the country recorded 144,508 positive malaria cases by August (Mugarisi, 2023). These countries are all located in the southern sub-Saharan region of Africa, as pictured below:

Figure 1. Map of Sub-Saharan Africa
Note: The Church of the Province of Central Africa spans the southern African countries of Zambia, Botswana, Zimbabwe, and Malawi (Pew Forum on Religion & Public Life, 2010).

The myriad reasons why governmental health policy in sub-Saharan Africa has largely failed to control or eliminate malaria has been the subject of extensive scholarly work. This research has centered around three main causes: the first is the rise of antimalarial drug resistance against chloroquine and sulfadoxine-pyrimethamine in the late 20th century (Takala-Harrison & Leufer, 2015). The additional causes are a misallocation of meager funds that has led to low-cost efficacy for health policy and a lack of primary infrastructure to distribute resources like insecticide-treated nets (ITNs) and indoor residual sprays (IRS) (Kouyaté et al., 2007; Mtalimanja et al., 2022). The scientific consensus is that the historical and present-day inability for African governments to counter malaria does not stem from a lack of effective treatment options, but rather a lack of funding and infrastructure to manufacture and distribute treatment. For example, the recently developed drug Coartem faces severe supply-side problems, when it could have the possibility to save millions of lives. That is, there is a notable shortage of Coartem to distribute to affected individuals due to a severe lack of global investment into its production (Robertson et al., 2018). This is an important contributing factor to the continued devastating impacts of malaria in the Central African region.

However, it is evident that this wealth of existing scholarly research regarding the failures of anti-malaria policy in Central Africa lacks a sufficient biosocial scope, integrating both biological and social factors. For instance, little analysis has been conducted to link the idea of coloniality to present-day mistrust of the state medical system, which is a major impediment to the distribution of health knowledge and treatment. Beyond coloniality, there has been insufficient research regarding the influence of neoliberalism (e.g. ideals supporting the free market and deregulation) and the "affordability"-focused selective primary health care movement on anti-malaria health policy in Central Africa. Definitionally, neoliberalism supports the notion that health is a commodity that ought to be delivered in a market rather than a right for all that the government should provide. Funding from Western sources is critical for malaria interventions in Africa, to the point where about a third of the world's money spent on malaria comes from the United States (Robertson et al., 2018); research findings have pointed towards a lack of funding from foreign donors as a major reason behind ineffective governmental malaria response. However, existing research has not interrogated the cause of this financial situation. This paper will analyze the structural problems with anti-malaria policy funding in relation to the rise of neoliberalism and the push for "affordability" in the mid-20th century; it will draw on Keshavjee and Farmer's historical characterization of the transformation of healthcare to a privatized neoliberal apparatus guided by the priorities of foreign donors (Keshavjee, 2014; Farmer, 2013).

Regardless of the underlying reason, in the face of widespread state failure in combating malaria, the Church of the Province of Central Africa has emerged as a powerful regional force that is dedicated to using community-level interventions to promote health. For the past decade, they have been instrumental in distributing education, health knowledge, and hundreds of thousands of antimalarial insecticide-treated mosquito nets to rural communities. In particular, they have worked with the Cross-Border Malaria Initiative to reach remote communities in Zambia that border Angola and Namibia; these border regions are known for having the highest malaria burden, while also often being the last places to receive support fighting illness (Christian Aid, 2012). With regard to other health interventions, the Anglican church is most well-known for its role in combating HIV/AIDS in South Africa; indeed, the church's response to the HIV/AIDS crisis in South Africa has many parallels to its ongoing malaria response, especially with regards to the way it uses community integration as a mechanism for treatment (Madlala & Khanyile, 2023).

This paper will thus firstly focus on an analysis of the historical factors that have led to the current structural issues within the governments of Central African countries. It will ask two questions: **(1)** What role has colonialism played in the loss of trust in state medical systems in Central Africa? **(2)** How has neoliberalism, bureaucratic rationality, and the "affordability" movement contributed to failure in state medical systems to adequately counter malaria? Subsequently, this paper will discuss the role of the CPCA in the region as a provider of equitable and accessible care for malaria. It will analyze the role of religion and community-level engagement in municipal health systems, and ask a final question: **(3)** How can the CPCA continue to deliver care through the local moral world of religion?

Background: Colonial Medicine & Loss of Trust

"Mistrust does not form in a vacuum"
— Eugene Richardson, Epidemic Illusions

Colonial Medical Campaigns in sub-Saharan Africa

In order to properly interrogate why church-affiliated institutions such as the CPCA have become so essential to the facilitation of malaria control, it is important to analyze how colonial legacies have contributed to the loss of trust in state mechanisms for medical care. As Eugene Richardson writes in his book Epidemic Illusions, the hierarchical orders imposed by European colonialism continue to shape populations' dispositions towards medicine and health care. As a result, they should be taken into consideration as a causal factor in how populations respond to antimalarial efforts (Richardson, 2020). Indeed, the practices of colonial medicine that facilitated the expansion of French, English, Belgian, and other European settlements in Western and Central Africa left a notable residue of resentment behind them. They often involved campaigns to prevent the spread of infectious diseases like smallpox, sleeping sickness, and tuberculosis; these campaigns would force vaccinations and invasive treatments upon indigenous populations. As a result, these campaigns can be seen as potent examples of Foucault's theory of biopower, where Western imperial powers used colonial medical institutions to establish control over the health and social welfare of colonized populations (Farmer, 2013).

Multiple studies have found that these past medical interventions are significantly correlated with lower levels of trust in medicine from present-day citizens. For instance, campaigns aimed at eradicating human African trypanosomiasis in French Equatorial Africa—which included forced lumbar punctures and treatment with aminophenyl arsonic acid—may serve as strong explicating factors for Congolese citizens refusing to seek medical care or accept vaccines during the Ebola outbreak (Richardson, 2020). Similarly, a study examining French colonial medical campaigns for diseases such as sleeping sickness, leprosy, syphilis, and malaria in central Africa (affected regions displayed in **Figure 2**) concluded that areas with higher exposure to these campaigns had reduced trust in medicine and lower vaccination rates.

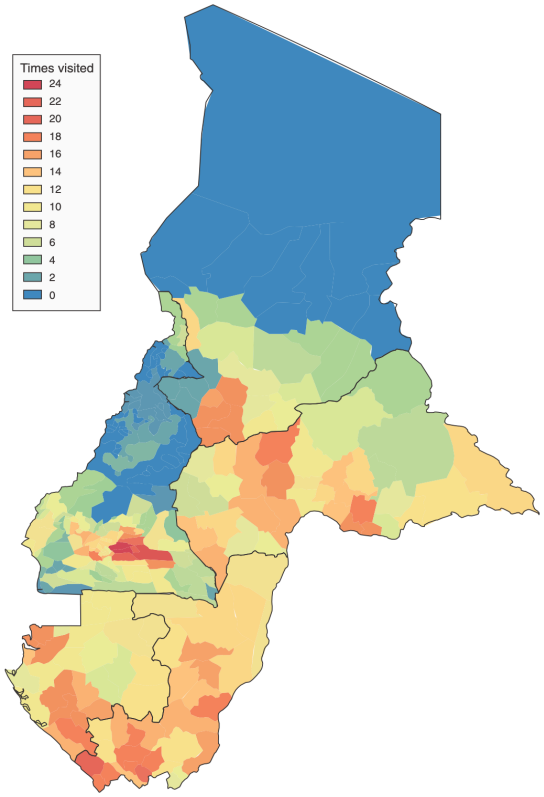

Figure 2. French Colonial Government Medical Campaign Visits in Central Africa Between 1921-1956

Note: A map of Central Africa, in what is present-day Cameroon, Central African Republic, Chad, Republic of Congo, and Gabon. Color-coded by number of visits to indicate regional exposure to French colonial medical campaigns (Lowes & Montero, 2021).

From the years 1921 to 1956, millions of individuals were forced into invasive medical examinations and received injections of medications with severe side effects, including blindness, gangrene, and death. Colonial officers used the drug atoxyl (an arsenic-based drug) that often caused partial or total blindness (in up to 20% of patients). When examining the correlation between medical campaign visits and vaccinations/blood test refusals, there is strong evidence to suggest that the colonial medicine campaigns had negative consequences for vaccinations and consent to a blood test (Lowes & Montero, 2021).

It is important to note that religion too has a deeply controversial history with regards to colonial medicine, with medical missionaries holding up Western civilization and Christianity at large as a solution to illness and a pathway to salvation. Traditional medicine was linked to "heathen" religions, and hospitals became important sites for religious conversion (Farmer et al., 2013). However, in many Central African countries, Christianity has broadly been able to overcome its fraught history of forced religious conversion and invasive medical practices. In fact, many post-colonial scholars and theologians have argued that African theology has been broadly successful in undergoing decolonization and rooting its religious practice in local values (Said, 1976). This idea of community-level integration will be expanded upon later in this paper.

It can be argued that due to the decades of time between the colonial medicine campaigns and the present-day, it is unlikely that it holds such a strong grip in public consciousness. However, the lasting trauma and legacy of colonialism in sub-Sarahan Africa is well-documented. Thus, the context of colonial medicine campaigns with regards to malaria and other infectious diseases may help to explain the rise of church-affiliated institutions within southern sub-Saharan Africa in administering preventative and curative healthcare. It seems logical that religion, which holds weight both in dictating an individual's spiritual beliefs and in forming a strong faith-based community centered around it, would feel more trustworthy in administering medical treatment than the state. This fits into the reality of the present; in Zambia, church-affiliated institutions are responsible for over 50% of the provision of formal health services in rural areas of the country and roughly 30% of the country's overall healthcare (USAID President's Malaria Initiative, 2022).

Background: The Rise of Neoliberalism, Underfunded Medical Systems, & "Cost-Effective" Malaria Control

"Having the idea lying around — and, in this case, endorsed by global health's major donors — keeps the idea alive and adds to its practicability. It becomes 'common sense'"

— Salmaan Keshavjee, Blind Spot

Although academics and epidemiologists alike agree that one of the major problems in the global fight against malaria is a critical lack of international funding towards distributing effective solutions, the root of this problem still remains obscure in academic literature. With that being said, the theory of bureaucratic rationalization may have an important relation to decreased international funding for malaria efforts. Bureaucratic rationality refers to the idea of emphasizing efficiency, calculative measures, and teleological ends in bureaucratic institutions, and has resulted in a system where major health organizations such as the WHO are broadly unwilling to expend significant capital on disease treatment for underprivileged people. This can be illustrated in the way that the WHO's cost-effectiveness analysis declared AIDS too expensive to treat amongst poor Americans (Farmer et al., 2013).

Moreover, in the latter half of the 20th century, this idea of affordability and return on investment as king was bolstered by a new framework of neoliberalism ushered in by the Reagan and Thatcher administrations (Farmer et al., 2013). Over time, the acceptance of neoliberalism by major institutions has transformed healthcare into a privatized apparatus guided by the priorities of foreign donors. For example, policies like the implementation of revolving drug funds in Malawi (i.e. where drugs provided by donors and international agencies would be sold to communities at marked-up prices to support building healthcare infrastructure) only served to support the overwhelming idea that countries should premise their policy decisions around the minimization of public sector health spending (Keshavjee, 2014).

With regards to antimalarial policy in sub-Saharan Africa, bureaucratic rationality and neoliberal ideologies in healthcare have led to two broad outcomes: the first is dwindling amounts of international support into anti-malarial efforts. The second is a misallocation of those funds themselves. As mentioned in the introduction, the vast majority of funding for malaria interventions in Africa comes from Western sources, which has created a dangerous system of overreliance (Robertson et al., 2018). A study in Burkina Faso estimated that 2-3 billion USD of external funds would be necessary to properly scale up the response against malaria in sub-Saharan Africa—which would include investments into insecticide-treated nets and artemisinin combination therapy, the current best treatment option for malaria; however,

investments are only present in the range of 100-200 million USD. The same study cited that loans were similarly hard to acquire even from organizations like the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM), the main external funding body for malaria treatment in sub-Saharan Africa—mostly due to those organizations' own financial problems. It is clear that this critical lack of funding stems in part from a reluctance from international donors to expend large amounts of money, an action that falls in line with neoliberal ideals of minimal government spending and interference.

Furthermore, when funding is present, it is rarely used for the most effective policies on the ground, but rather for the most cost-effective policies—that is, policies that will reduce the most amount of malaria burden for one unit of additional investment towards funding. For instance, a study that tracked malaria health disbursements in Zambia found that mass drug administration was largely cost-effective (Mtalimanja et al., 2022),even though these kinds of policies rarely allow for drugs to be distributed towards the regions with the highest malaria burden in the country, which tend to be rural border areas. Another example of this is the distribution of insecticide-treated nets. Even though ITNs are associated with a 50% reduction in malaria morbidity and a 20% reduction of all-cause mortality in children, insecticide-treated net coverage in young children still remains unacceptably low in sub-Saharan Africa.

It is important to distinguish that the fault for the ongoing spread and devastation of malaria does not lie solely with international donors. Without the existence of Western aid, there would have been substantially less resources devoted to health infrastructure in sub-Saharan Africa. However, the rise of neoliberal ideals that have directly pushed back against global health aid spending has been greatly detrimental to sustained support in the fight against malaria.

Countering Malaria in the 21st Century

In the past decade, antimalarial drug resistance has proven to be a major problem in central and southern Africa. In the past, resistance to chloroquine and sulfadoxine-pyrimethamine—drugs initially used for the treatment of malaria—received late response, meaning that resistance spread globally before there was an opportunity for containment. Recently, however, resistance to the drug artemisinin in Southeast Asia has emerged, which offers an opportunity to proactively avert spread to malaria-endemic Africa; indeed, the Global Plan for Artemisinin Resistance Containment (GPARC) has been established by the World Health Organization for this very purpose (Takala-Harrison & Laufer, 2015). However, continuous investment is necessary to make this plan a reality if artemisinin resistance is indeed conferred upon citizens who are currently dependent on it as a primary source of treatment. With what is already known about global health, this will require a shift in norms surrounding malaria funding and the allocation of funds towards preventing future problems alongside putting out current fires.

Research also suggests that the recent COVID-19 pandemic may have had a significantly detrimental impact on malaria transmission and outbreak. Zimbabwe experienced a significant increase in malaria morbidity and mortality concurrent with detection of the first COVID-19 cases in the country and the resultant efforts to curb the pandemic's spread; the country's total number of malaria cases from January to June of 2020 (221,860) exceeded the expected number by 30,197 cases. Epidemiologists have theorized several reasons for this observation, including disruptions in efforts for malaria prevention and control, limited malaria control equipment, and modification of health-seeking behavior. According to the WHO, less than half of the 22 million insecticide-treated nets that were expected to be distributed globally in 2020 were distributed: less than half of malaria-endemic countries that had planned IRS campaigns in 2020 had completed them. This could also be due to the well-documented economic impact of the pandemic, which would have decreased the amount of health infrastructure spending that was available for antimalarial efforts. With regards to citizen behavior, fear of infection, lockdowns, and other restrictions may have disincentivized access to routine health services (Gavi et al., 2021). Notably, this might also have caused decreased visits to community health facilities or public spaces like schools or churches where malaria education, preventative equipment, and treatment would have been distributed.

Regardless, it is clear that the instability that the pandemic has invited upon countries in sub-Saharan Africa has only exacerbated the problem of malaria, making it even more urgent of an issue to be solved. But with all of the difficulties with instating effective governmental antimalarial policy, the question remains: who is best equipped to solve it?

The Anglican Church of the Province of Central Africa: Waging War Against Infectious Disease

"In the first three gospels, the evangelists focus on the bread and wine, inviting us to know that, as we take, bless, break and share bread, we find ourselves in the presence of Jesus. In the fourth and last gospel, the focus shifts to the basin and the towel — and Jesus' challenge to his disciples and us to kneel with him in serving."
— The Right Reverend William Mchombo

The Church of the Province of Central Africa has long made it clear that its mandate aligns with the provision of aid to the most vulnerable. Like most other Anglican Communion-affiliated organizations, it is committed to addressing development issues such as poverty and health alongside practicing the evangelical Christian faith. In recent years, the bishops of the CPCA have pledged particularly to support efforts to halt the spread of infectious diseases (Steffenson et al., 2013). At first, this was centered around the HIV/AIDS crisis, where they provided important resources for prevention and counseling. Now, their focus has been shifted to countering malaria. It, like many other faith-based organizations, sees infectious diseases like malaria as a piece of the early childhood development and aid for the suffering for which they believe they have a requirement to provide holistic care for: this includes other aspects of their mandate including providing nutrition and access to vaccines (Robertson et al., 2018). However, other aspects of the church's religious mandate—in particular, its promotion of proselytization—may raise concerns. Regardless of the practical antimalarial benefits the CPCA provide, it is important not to forget its evangelical nature, which means it may function as a source of religious coercion.

With that being said, the CPCA has been instrumental in distributing education, health knowledge, and insecticide treated mosquito nets to rural communities along border regions in Zambia through the Cross-Border Malaria Initiative. Border regions are often the most difficult places in which to work and can be the last places to receive help fighting disease. By working through the church in remote communities in Zambia bordering Namibia and Angola the Cross-Border Malaria Initiative

has distributed education and health knowledge in addition to 100,000 insecticide treated mosquito nets (Christian Aid, 2012). Beyond their own initiatives, the CPCA often receives requests from health centers themselves to work together on medical interventions, with governments acknowledging the church's unique power to mobilize thousands of people into actions like cleaning their surroundings to repel mosquitoes. Health centers in Zambia often reach out to religious leaders that have the greatest amount of control over their communities, tasking them with informing communities on using insecticide-treated mosquito nets and spraying their homes. Churches are also asked to bring in staff and volunteers for the government to train as malaria agents, such that they are able to teach congregants about noticing symptoms of malaria and receiving access to treatment—along with encouraging them to go to health centers to begin with (Robertson et al., 2018). The extensive network, resource mobilization, and strong community trust that religious groups command in addressing public health challenges has been studied and documented in other contexts, such as in Nigeria (Alao et al., 2023).

There are other contributing factors to the CPCA's ability to effectively combat malaria. Churches, who are consistently able to attract a wide diversity of devoted congregants, often have access to a much broader range of translators; this allows them to have a unique leg up on state-run health organizations in overcoming language barriers. This is no small benefit to communication, given that in Zambia alone there are seventy-two unique dialects that are spoken. On the other hand, they are often also able to serve as an accurate source for information collection on behalf of the government: for instance, the Christian Council of Churches of Angola found many communities that the government had said had received mosquito nets but actually had not. Lastly, local religious institutions are not necessarily mutually exclusive with international funding; churches can partner with NGOs and foreign governments such that they implement services with external funding. This allows churches to act as a supplement for the government in two important ways—in understanding the spread of an infection, and in treating the infection itself—all the while circumventing the issues of bureaucracy and mistrust endemic to governments that were mentioned earlier.

Religion as a Local Moral World: Community-Level Malaria Prevention & Treatment

"One, they know that they are faithful; they are going to come, and in big numbers. And they will take the messages seriously."
— Reverend Albert Chama, Archbishop and Primate of the CPCA

While the role of the CPCA with regard to healthcare distribution has been discussed, less analysis has been dedicated to the unique sociocultural context of the church that positions it to improve health outcomes far more than the state. This paper will focus on three aspects of the church in this regard: community-level integration, sensitivity to cultural and religious needs, and power in changing beliefs as a local moral world. Firstly, churches are far better at integrating themselves within local communities, where pastors are able to interact with their congregants regularly and form tight, trusting social relationships. The potential positive effects of social participation and community-level involvement have been studied in other contexts.

For instance, a study in Palencia, a town in Guatemala, notes that it has three different spaces for health participation: the municipal-level health commission (i.e. municipal government, health district), the community-level social development councils, and the community health workers (CHW) program. The people in Palencia benefit greatly from this system, which promotes their engagement in health, from participation in planning to the implementation and evaluation of policies, and thus improves the responsiveness of the health system to their needs (Ruano, 2013). Similarly, in Haiti, trained accompagnateurs (community health workers) were the structural backbone of the HIV Equity Initiative, as they were respected in their home communities. It was found that the clinic staff providing psychosocial support and overseeing social projects like housing improvement and potable water projects were effective, both to encourage compliance and to prevent transmission (Behforouz et al., 2004). It should then follow that faith-based organizations would be able to provide better and more holistic care due to being able to directly impact congregants' daily lives by providing sources of food, educational programs, charitable donations, and other integral social services.

Existing research has also supported the idea that healthcare delivery should incorporate local religious practices and beliefs in order to address the cultural contexts of certain areas, which is exactly what the CPCA is able to do. Previous research has emphasized the importance of cultural competence for healthcare providers and systems—i.e. that healthcare professionals work towards understanding and addressing the important cultural, social, and religious needs that patients may have. Without such competence, patients may experience adverse health consequences, receive poor quality care, and be dissatisfied with their treatment (Swihart et al., 2023; Ager & Ager, 2011). For many patients, religion and spirituality are central values to them that cannot be compromised when they are receiving treatment; the CPCA, as a religious organization itself, is thus able to exercise sensitivity with individuals' faith while advocating for effective antimalarial policy.

Lastly, it is important to consider Kleinman's theory of the "local moral world" when considering the role that the CPCA plays in combating malaria. The local moral world can describe a neighborhood, village, hospital, or any other community that has direct influence over someone's moral experience—that is, the shared practices and beliefs over what is at stake in a local setting. In this case, the Church of the Province of Central Africa functions as a local moral world; as a well-respected social institution that commands faith-based credibility, it has the power to change cultural norms around health. This can be immensely impactful, as cultural norms themselves have the capacity to entirely change health outcomes, from garnering support for HIV/AIDS prevention by destigmatizing STDs to increasing the efficacy of treatment programmes for smoking cessation by establishing the harms of smoking (Kleinman, 2010). In this context, the CPCA is able to change cultural norms surrounding malaria prevention and treatment; this means that they are not only able to promote certain practices to repel mosquitoes, but they can in fact encourage congregants to go to health centers by changing norms around trusting state medical systems. This is an important step forward, not only in antimalarial efforts, but in reconstructing trust in government-run medicine as part of the decolonization process in postcolonial countries.

However, this does not indicate that there are not potential issues with faith-based care. Although the Anglican church is well known for its work to destigmatize and treat HIV in South Africa and oppose violence against women in the Democratic Republic of Congo, there are also certain groups who have stigmatizing attitudes towards sexuality and HIV and some who do contribute towards violence against women. Some faith activities can also be a cause of concern if they are done as an alternative to modern medicine: for instance, healing missions for those with disability and long-term illness. At best, these activities are not at all effective; at worst, they can be actively harmful to the practicing person, as is the case with the ingestion of toxic substances as parts of certain

ceremonies (Tomkins et al., 2015). Although the CPCA, which works closely with major antimalarial organizations and state-run infectious disease departments, can largely be held accountable, it is important to note that this is not the case for many other religious organizations within sub-Saharan Africa.

Conclusion: Working Towards a Malaria-Free Future

"Malaria eradication requires a 100% mind-set of success. There are no 70% or 80% or 90% efforts that pass in malaria control and eradication"

— T.K. Naliaka

Ultimately, malaria continues to be a devastating disease and prescient public health issue in much of southern sub-Saharan Africa. This paper analyzes governmental antimalarial policy with a biosocial model rather than a biomedical model, extending beyond surface-level problems such as drug resistance and insufficient distribution first-line treatment to focus on the role of colonialism, bureaucratic rationality, and neoliberalism in state failures to adequately control and eliminate malaria. Notably, historical colonial medical campaigns have significantly contributed to a loss of trust within the medical system in sub-Saharan African countries. Concurrently, an emphasis on neoliberal and "cost-effective" ideologies in global health have resulted in the crucial lack of international funding behind antimalarial efforts and the insufficient allocation of funding towards distribution of the most effective malaria drugs and preventative equipment.

With that being said, this paper emphasizes the immense importance of religion in combating malaria through the current efforts of the Anglican Church of the Province of Central Africa within Botswana, Malawi, Zimbabwe, and Zambia. This analysis, too, requires a biosocial approach: beyond its ability to strengthen medical interventions by being able to more efficiently distribute equipment like insecticide-treated nets, the CPCA holds a unique role in antimalarial efforts due to its social integration within local communities, allowing it to build trust among community members. This positions it to improve health outcomes far more than the state due to it being able to command faith-based power over cultural and moral norms as a potent social institution as well as go beyond providing medical treatment when providing community-level care. If there is one key point that is reinforced by the CPCA's impressive antimalarial efforts in the past decade, it is that religion does not necessarily have to be a force for evil in post-colonial states, but rather, a potent force for good.

Indeed, religion—and especially, religion that has been reclaimed in local contexts—serves as a primary source of faith and hope for citizens in exploited, poverty-stricken countries where the specter of imperialism still looms large. Harnessing that power to fight against the infectious diseases that continue to exist as shameful marks of inequality in global health should not just be a possibility, but an imperative.

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