When Religion and Health Align

Mobilising Religious Health Assets for Transformation

James R Cochrane, Barbara Schmid and Teresa Cutts (editors)
For Steve

On a hot Sunday, on the 21st February 2010, during a much needed family weekend away, Steve de Gruchy, Professor of Theology and Development at the University of KwaZulu-Natal in Pietermaritzburg, South Africa, tragically drowned in a river rafting accident. One of the founding members of the African Religious Health Assets Programme, his loss is great. In gratitude for the vital contribution he made to the work it represents, we dedicate this collection to his memory. Having lived a full and rich life with a deep grasp of how to celebrate it, Steve is now our ancestor, whom we feel sure, would declare: ‘Mourn as you must, but now live as you should.’
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and Teresa Cutts (editors)

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Jim Cochrane
(lead editor)
About the Contributors

**Christoph Benn** is a physician with special training in tropical medicine and public health, with several years of experience in Tanzania. He also holds a master’s degree in religious studies and social ethics, and has worked with the German Institute for Medical Mission (Difäm). He is currently the Director of External Relations and Partnerships at the Global Fund to Fight AIDS, Tuberculosis and Malaria in Geneva.

**John Blevins** is on the faculty of the Rollins School of Public Health in the Hubert Department of Global Health at Emory University, and part of the Interfaith Health Program and the Religion and Public Health Collaborative there. He combines practical theology with social theory and he has worked as a chaplain, pastoral counsellor, and health educator, mostly in clinical and community-based programs. His research focuses on cultural factors that influence public health initiatives, including religious belief and practice, particularly in the context of sexual health and HIV prevention and treatment in the United States, Kenya, and Zambia.

**Tali Cassidy**, with an honours degree in social anthropology, is currently completing her MPH at the University of Cape Town. During this time she has worked as a research assistant for the African Religious Health Assets Programme (ARHAP).

**James (Jim) R. Cochrane**, one of ARHAP’s founders, is Professor in religious studies at the University of Cape Town. He holds a PhD and has a master’s degree in theology from Chicago Theological Seminary, from which he also has a DDiv honoris causa. He is Co-Director of the International Religious Health Assets Programme (IRHAP, successor to ARHAP) in the School of Public Health and Family Medicine, also Senior Research Associate there, and Director of the Research Institute on Christianity and Society in Africa at UCT. His work over the years has been focused on religion in society and public life.

**Teresa Cutts** is Director of Research for Innovation at the Center of Excellence in Faith and Health at Methodist LeBonheur Healthcare in Memphis, TN. Here she is the academic liaison to its international global faith health partners and leads the evaluation efforts of the Congregational Health Network, integrated health, community health assets mapping, and clergy/congregational training work. She has a PhD in psychology, and holds adjunct faculty appointments at the University of Tennessee College of Medicine, University of Memphis School of Public Health and Memphis Theological Seminary, as well as a Visiting
Scholar position at University of Cape Town’s School of Public Health and Family Medicine.

**Frank Dimmock**, with an MPH from Tulane, was recently awarded an honorary doctorate from Davidson College and has been a missionary of the Presbyterian Church (USA) to east and southern Africa for the past thirty years. He and his family currently live in Lesotho, while he travels throughout Africa as a public health consultant. He has also been active in the establishment of health and orphan care networks and with the support and establishment of Christian Health Associations throughout the continent.

**Geoff Foster** works as a paediatrician in Zimbabwe, and founded Family AIDS Caring Trust in 1987, one of Africa’s first AIDS organizations. His main area of research focuses on orphans and vulnerable children. He was a co-chair of the Joint Learning Initiative on Children and AIDS, and a founding editor of Vulnerable Children and Youth Studies.

**Lucy Gilson** is Professor in the School of Public Health and Family Medicine at the University of Cape Town and the London School of Hygiene and Tropical Medicine, UK, and an honorary professor at the University of the Witwatersrand. She is also Co-Director of the International Religious Health Assets Programme hub at UCT. She has a PhD from the University of London and specializes in health policy and systems research. She works and lives in South Africa, and has a particular interest in exploring the role of health systems as part of the texture of people’s lives—both as safety nets in times of illness and as resources for individual and societal well-being and value.

**Steve de Gruchy**, Professor at the University of KwaZulu-Natal in Pietermaritzburg, South Africa, was a key member of ARHAP, heading up its Collaborative Centre at the School of Religion and Theology and there. At the time of his tragic drowning in a river accident in 2010, he was Head of the School and, with wide experience in development work in rural and urban areas, a key figure in its programme on Theology and Development. He had a PhD from the University of Western Cape, and had served in numerous positions in church bodies.

**Gary R. Gunderson** is Senior Vice-President of the Faith and Health Division, and Director of the Center of Excellence in Faith and Health, at Methodist LeBonheur Healthcare, Memphis, Tennessee. With a DMin from Emory University, and a DDiv honoris causa from Chicago Theological Seminary, he has authored many articles and books in the faith-health field. Previously, he served as Director of the Interfaith Health Program at the Carter Center and Emory University, and continues to hold an adjunct appointment at Rollins School of Public Health. He is a founding member of ARHAP/IRHAP and a Visiting Professor at University of Cape Town School of Public Health and Family Medicine.
Mimi Kiser is Senior Associate in the Hubert Humphrey Department of Global Health, Rollins School of Public Health, Emory University, Program Director of the Interfaith Health Program, with which she has a long history. Adjunct faculty at Candler School of Theology, she has a DMin from Wesley Theological Seminary as well as an MPH from Emory. Her work is centred on leadership development and community scale capacity building aimed at social change strategies that assure greater health equity.

Katherine Marshall is a Senior Fellow at Georgetown University’s Berkley Center for Religion, Peace, and World Affairs, Visiting Professor in the School of Foreign Service, and Executive Director of the World Faiths Development Dialogue. She has an honorary doctorate from the University of Cambodia. She served for many years as senior advisor for the World Bank on issues of faith and development, and is on the Boards of many NGOs and advisory groups. A key figure in the field, her work focuses on the many facets of faith-inspired institutions engagement on global development.

Sinatra Matimelo is completing his PhD in the School of Religion and Theology at the University of KwaZulu-Natal, and is a long-time participant in ARHAP’s research and participatory training. Previously School Principal of Gateway Christian School in Pietermaritzburg, he currently works as EngageHIV Director for the E3 Initiative for ‘empowering churches to transform communities.’

Sepetla Molapo, from Lesotho, is a long-standing member of ARHAP’s research group, and is completing his PhD in the Department of Sociology at the University of Witwatersrand.

Jill Olivier is the Research Director for the International Religious Health Assets Programme, at the University of Cape Town in the School of Public Health and Family Medicine. She has worked with ARHAP since 2003 and holds an interest in interdisciplinary practice-research.

Gillian Paterson is a writer and consultant on HIV and AIDS, especially in relation to religion. She is Research Fellow at Heythrop College, University of London, from which she has her PhD, and is co-founder of the HIV, AIDS and Religion Collaborative (HARC) research network. She has also written on the history of the Christian Medical Commission and its role in developing the model of primary health care.

Muhammad Khalid Sayed has a master’s of social science, cum laude, in religious studies, from the University of Cape Town, which focuses on the history of Muslim seminaries in the context of political shifts in South Africa, and a Diploma in Arabic Language from the University of Damascus in Syria.
INTRODUCTION

After almost two hundred years of practice in modern public health that has produced an unprecedented body of scientific knowledge about diseases, epidemics, health determinants and the like, the world, its peoples, and its communities still face significant public health challenges. Many experts and policy makers search for effective and durable solutions to the deep question that looms over this enterprise: why do so many people in so many places face so much ill-health when, as never before, the knowledge and the means to deal with it are available?

Asking the question confronts one with the puzzle of public health itself. If, as seems evident, its primary goal is clear and generally valued, if the means, scientific and material, to achieve its end are present to an extent unimaginable even a hundred years ago, and if the collective will of peoples around the globe seeks appropriate action, why are we in a crisis?

One can, of course, answer this question by pointing to the many well-known political, economic, social and cultural determinants that act as impediments to a fully realised goal of health for all. In any particular historical and geographical context the extrinsic ingredients necessary to implementing the ideals of public health—basic matters such as clean water, sanitation, shelter, food security, safety and peace, basic education, decent work, finances, management skills, institutional arrangements, and so on—are fraught with human ambiguity, ideological blindness, resource constraints, hard choices, conflicting ends, and institutional and human failures. Yet, another part of the answer has to do with the intrinsic limitations of public health thinking and practice itself—the limits, if you like, of its reigning paradigm.

One such limit, in our view, is an all too common amnesia about some of the key sources and resources that drove the enterprise from the outset, specifically, the relational, institutional, intellectual and spiritual resources that we can call ‘religious’. The thrust over the last decades of the exemplars public health knowledge—its defining concepts, the models, cases and studies that shape curricula, training, methods, guilds and institutional arrangements—has been to bracket the religious, or more generally, the subjective, largely excluding them
from what counts for the science and polity of public health. Many thinkers and practitioners now realise that this might be an error in need of rectification, but it is by no means clear what that should mean.

This collection of essays is one of a number of emerging attempts to address the issue. Originating from the International Colloquium hosted by the African Religious Health Assets Programme (ARHAP) in Cape Town in July, 2009, now revised and updated, the collection as a whole offers a rich and varied view on current thinking and visioning in the field of religion and public health within which ARHAP has been privileged to play some catalytic role.

While allowing for the ways in which religion can be dangerous to a person’s or community’s health, the essays primarily reflect the somewhat different sensibility that governs the work of ARHAP: Given the vast energies and resources that all kinds of religious entities commit to health—personal, communal and social health—how does one encourage, support and leverage that work for the good of all? What does one need to understand and do in order to align these assets and capacities, both tangible and intangible, with public health institutions and interventions in ways that enhance the mutual goals that undoubtedly do exist? What do religious leaders and public health leaders need to learn about and from each other in this regard?

FROM THE PAST TO THE PRESENT

A bit of history is pertinent here. The story of the rise of modern public health is familiar enough. Though elements of what we now call public health may be traced back a long way (Porter 1994; Rosen 1999), its modern provenance lies more than anything else with the spread of European colonisation, the consequent growth of mercantile capitalism, the increasing inter-territorial spread of people and other creatures carrying illness to new habitats, and the rapid urbanisation and rural disruption occasioned by the industrial revolution. Crises in health associated with such developments found some response in emerging science and technology, most significantly with the rise of germ theory, but the most important challenges needed a public health response.

Industrial capitalism shaped and reshaped both the countryside and the burgeoning cities in ways that made health-at-population-scale a major concern, transcending the capacities of local healers or local health interventions (see, for example, Duffy 1992; McLean 2006). New health threats that came into being revived the nightmare of old ones, such as bubonic plague, in new form—cholera in Europe and the USA most obviously (Johnson 2006, provides a particularly dramatic account of the cholera outbreak in London associated with John Snow’s—and, badly overlooked, the local curate Henry Whitehead’s—contribution to the rise of modern epidemiology). The focus of modern public health on clean water, proper sewage control, unpolluted air, prevention of child labour,
the problems of overcrowding, and similar social and environmental challenges, together with advances in medical science, allowed for the introduction of new policies and practices. Wherever these took root, they fundamentally changed the health profile of populations for the better. The promise was clear and expectations high.

Thus it was that the Twentieth Century saw significant advances in health care and public health, with profound success stories such as a dramatic reduction in polio, the disappearance in some regions of malaria, the discovery of antibiotics, the eradication of smallpox, the birth of primary health care (PHC), and the growth of formal health systems in the new nation states that emerged in the aftermath of the Second World War. It seemed indeed as if the means were at hand—political, material, technological and intellectual—for solving the great problems of public health.

But in our time the grand hopes of public health have been shaken and its promise severely dented. This is not because the advances of the last hundred and fifty years or more are a chimera, but as a result of other factors that have turned out to be far more persistent or unpredictable than had been hoped or anticipated (see, for example, Garrett 2000; Kim et al. 2000; Panos Institute 2003). These include, inter alia, the limited self-interest of nation-states, vast wars and other forms of competition for goods and resources that have harmed millions, the complexity of allocating scarce resources in large scale societies, asymmetric power relations that favour those with greatest leverage in policy and research foci, the particular instrumental and narrow interests of corporations who make health (or its lack) their business, rising inequalities, reductionist forms of knowledge gathered around powerful biomedical, pharmaceutical and technological inventions, and the limits to such science in dealing with the human dimensions of illness and disease.

Over time, as such factors have complicated or even thwarted the hopes of those who have driven the passionate and compassionate agenda of public health, so too has grown the idea that religion and its institutions and communities of belief are at best irrelevant, at worst an obstacle to health. There can be little doubt that religion can, as some put it, be harmful to health—stigma around HIV associated with religious beliefs or traditions is a case in point, as is the role religion can play in motivating or legitimating violence. If not directly harmful, religion might also interfere with what are regarded as necessary protocols for treating an illness. Antiretroviral drugs for HIV infection, for example, might be rejected because of a belief that faith heals. Or they might be improperly used, perhaps because a particular ‘religious’ (cultural?) value emphasises sharing the drug, perhaps because they are mixed with other ‘traditional’ potions that may inhibit the efficacy of the drug or enhance its negative side effects.
Yet, this is by no means the whole story. Serious challenges now confront public health on several levels—think of the deep human ambiguities around the HIV pandemic, of the need for rapid community responses to new flu strains, of increasingly well documented health disparities, or of the social determinants of ill-health. With this, in the last ten to fifteen years, has come a renewed interest in the potential contribution of religious entities to public health. It is increasingly recognised by major public health agencies and governments that religious entities remain widespread if not ubiquitous, and that they represent multiple assets that need to be better accessed and leveraged for that health of the public.

The growing developmental significance of religious or faith-inspired entities in the global landscape of health is made clear in Christoph Benn’s contribution in this volume. Sitting at the centre of one of the premier international public health agencies, the Global Fund to Fight HIV, TB and Malaria, he is in a particularly advantageous position not only to note this, but also to indicate why a positive assessment of their potential role for the health of the public is both worthwhile and necessary. Benn highlights some ways in which this may be understood from within three religious traditions (Jewish, Islamic and Christian). In an increasingly globalised world where traditional nation-state boundaries no longer match human realities of health, he points out the critical importance of moving from a model of development aid to ‘a still rudimentary but emerging form of a global social security system.’ In effect, as with the origins of modern public health, he once again recognises the critical importance of addressing health holistically, and of paying particular attention, therefore, to the social determinants of health, a theme recently also picked up by the WHO (World Health Organization 2008a).

This is the historical conjuncture that both explains the establishment of the African Religious Health Assets Programme and the reason that its work has gained as much visibility as it has. Those of us who began this work often say, with good reason, that had we attempted it ten years earlier, we would most likely have encountered simple rejection or deafening silence. The times would not have been right.

THE AFRICAN RELIGIOUS HEALTH ASSETS PROGRAMME (ARHAP)

ARHAP was launched in Geneva in December of 2002, with the initial goal of developing a systematic knowledge base of religious health assets (RHAs), in order to help align and enhance the work of religious health leaders, public policy decision-makers and other health workers in their collaborative efforts to meet the major challenges of public health. A transformative agenda has been at the heart of ARHAP’s interests from
the outset, particularly with respect to contributing to the promotion of sustainable health, especially for those who live in poverty or under marginal conditions. Inevitably, this has meant paying close attention to the realities and assets of local communities themselves, above all, though not exclusively, those communities who are most removed from centres of affluence and power.

One of ARHAP’s important contributions is the development of language with which to address this field. Religious health assets (RHAs) are at the core of this work; the term emphasises the focus on assets rather than needs, on building on what is there—and there invariably is much there in even the most marginalised community—rather than paying attention to what may be missing. Many RHAs are tangible, such as facilities and staff; but as crucial are the intangibles like trust or hope—and the way these reinforce what is tangible. Leading Causes of Life (coined by Gary Gunderson) is another phrase arising within ARHAP. It too reflects a switch, starting with life and what is life-giving rather than approaching health from a focus on death.

Similarly, the idea of a healthworld, elaborated by two of ARHAP’s researchers (Germond and Cochrane 2010), designates the complex web of elements that shape how health and well-being is understood, relationally rather than atomistically, ecologically rather than reductionistically. Healthworlds are particular to a person’s history, context and situation, and any one healthworld expresses the perceptions of a person in relation to their interaction with the world around them, affecting behaviour and action. Sepetla Molapo’s exploration of the multi-layered understandings of HIV and AIDS among migrant mineworkers illustrates the complexity of their particular healthworld, located as it is between traditional and modern paradigms. He addresses the complex relationship between the mind and the body, between history and the contexts of ideas that play a crucial role in defining what constitutes modern knowledge. Also dealing with healthworlds, Lucy Gilson applies the concept to health systems thinking in her elaboration of the notion of access (see below).

Besides inventing language to capture insights arising from its work, since its launch ARHAP has also been engaged in a number of breakthrough studies. Its first extended research project focused on understanding a comprehensive, integrated programme around HIV and AIDS begun by a Moravian Church pastor in a deep rural part of the Eastern Cape of South Africa (Thomas et al. 2006). The study concluded that public health policy leaders and decision-makers need to take greater cognisance of the critical role that a faith dimension can have on treatment, especially the value for ‘clients’ of the integration of the faith component into treatment and support group activities. Also important is the potential partnership between such faith-inspired entities and the state for strengthening community health systems. Masangane, for example, has made a key contribution to such time-intensive aspects
of an anti-retroviral treatment (ART) programme as treatment literacy, stabilisation on treatment, maintaining support groups, and monitoring adherence. It has used its locally rooted infrastructure, influence and respect to address the vexed issue of stigma and to mobilise for treatment when the state was not responding adequately—though ARHAP is careful to note that such religious assets for health should in no way be seen or treated as a substitute for what the state and the public health system should and could do.

Subsequently, the WHO commissioned ARHAP, in its partnership with Emory University, to undertake a study of religious health assets in Lesotho and Zambia. Whereas anecdotal evidence and stray studies suggested that there might be some value in working with religious entities engaged in one or more activities around HIV and AIDS, the WHO wanted a more systematic insight into the range and size of such activities, as well as a deeper grasp of their nature. ARHAP’s study identifies and documents RHAs in four sentinel sites in Zambia and three in Lesotho, probing not only their number, location, range of activities, scope and scale, but critically, also the often hidden dynamics that give them their energy and explain their origin and potential for alignment with formal public health systems (African Religious Health Assets Programme 2006).

Key to ARHAP’s methodology in this study, alongside standard survey questionnaires and GIS mapping, was a uniquely engineered and theorized set of tools, drawn from asset based community development, sustainable livelihoods, appreciative inquiry, participatory or rapid rural appraisal, action research, and Freireian pedagogical theories. Called Participatory Inquiry into Religious Health Assets, Networks and Agency, or PIRHANA, its logic, toolset and character are described in in the essay by Steve de Gruchy et al. A landmark study, the first of its kind for the WHO, the Report was publicly launched by the WHO in the Washington National Cathedral.

At this conference, among others, was a representative of the Bill and Melinda Gates Foundation, who then commissioned a second study by ARHAP. Now the focus was on health services provided by religious communities, institutions and networks to vulnerable populations in resource-poor areas in sub-Saharan Africa (SSA), with Uganda, Mali and Zambia as case studies. The aims were to describe the services provided, their ‘comparative advantage’, what networks and collaborative activities existed among each other and with public health systems, and how best the funding of these services might take place to accelerate, scale up and sustain access to effective services, and/or encourage policy and resource advocacy among and in African countries (Schmid et al. 2008).

Among its several findings were that national faith based health networks play a crucial role in enabling facility based services, though they often have a contested place within national health systems; that faith-based health services work under severe constraints, especially
regarding their workforce, but at the same time, a wide range of non-facility-based services in response to immediate local needs are provided by religious entities, playing a very important role within these constraints; that mixing of multiple healing modalities (African traditional, bio-medical, faith healing, alternative therapies) is a common reality across SSA with mostly very little mutual acknowledgement and collaboration; and that while the important potential of religious leaders for health promotion has been channelled into some creative initiatives, it is generally underutilised. One particularly interesting dimension of the study was the construction of ten country profiles (Mali, Ghana, Nigeria, Senegal in West Africa; the Democratic Republic of the Congo in Central Africa; Lesotho, Zambia, Malawi in Southern Africa; and Kenya and Uganda in East Africa) providing an overview of what the Report calls their ‘religion-health landscape’.

A third major study, commissioned by Tearfund and UNAIDS, on ‘the potential and perils of partnership’, sought to understand the nature and extent of collaboration between religious entities (specifically Christian, in this case) and their collaborative stakeholders (donors, governments and interfaith bodies) in three African countries: Malawi, Kenya and the Democratic Republic of the Congo. Its primary goals were to contribute to strengthening such collaboration, increasing mutual respect and understanding between religious entities, governments and donors in three countries, and ensuring that a significant long-term contribution would be made to national AIDS plans through effective multisectoral collaboration (Haddad, Olivier, and De Gruchy 2008). The study was located within the framework of the Three Ones policy promoted by UNAIDS, the principles of which include one agreed action framework, one national coordinating authority, and one monitoring and evaluation system.

Among the findings of this study, made public at the International AIDS Conference in Mexico in July 2008, one suggested that the implementation of the Three Ones principles must be understood as a development strategy, and not simply a response to a medical problem; another that the framework in itself does not promote better collaboration between government, donors, and religious entities, and that the most important element in that regard is trust, clearly not something always easily established or maintained. A further noteworthy finding was that religious entities need to acknowledge their conservative belief systems as being a hindrance to an effective collaboration and be willing to build a contextual theological response that recognises poverty as a key driver of the HIV and AIDS epidemic.

One particularly powerful application of much that has been learned through ARHAP has taken place in Memphis, Tennessee, where a joint team has carried out a RHA mapping project under the auspices of Methodist LeBonheur Healthcare. Developing a modified version of PIRHANA aimed at Community Health Assets Mapping for Partnership
(CHAMP), and linking this to the establishment of an innovative Congregational Health Network, this major health facility with its several hospitals and multiple clinics has embarked on significant community health strengthening strategies, resting deeply on trust-centred relationships and partnerships. In her essay, Teresa Cutts delves more deeply into the key features of this model, which has now attracted the attention of senior government officials in the USA. She describes its development, as well as the context, personalities and convictions that shaped it, offering a powerful picture of the ways in which religion can be leveraged to impact on behaviours that make for better health.

In South Africa, the CHAMP model has been further developed for the national Hospice Palliative Care Association (HPCA), where new challenges associated particularly with HIV and AIDS have arisen—for example, those with AIDS who come into the hospice frequently do not die once on an ART regime, and those who do sometimes leave children for whom the hospices feel some responsibility. To cope with such changes, a meaningful partnership with community and non-governmental agencies, including often ubiquitous religious entities, and with state health facilities, has become essential.

So successful has the ARHAP CHAMP model been in this case, that the HPCA is now rolling it out across the country to dozens of hospices, while the local health forums that the process has enabled, facilitated by the expertise and professional resources of hospices, are proving to be a particularly powerful means of strengthening local community health systems generally. In this case, the hospices, supported by the national HPCA umbrella body, function as vital local intermediaries or ‘grassroots support organisations’. This theme is explored in the essay by James Cochrane who emphasises the critical role of such intermediaries for both the alignment of public and religious health efforts and the support of community-level responses to current health challenges.

**When Religion and Health Align**

The essays here reflect some of the cutting edges of ARHAP’s work, and that of others in the field with whom ARHAP has found common cause and productive collaborative relationships. ARHAP itself was in fact conceived, established and structured as a managed collaborative, a fluid and flexible body not wholly identified with any one institution, on the grounds that wide-ranging collaboration is required in our time, that we cannot afford to build separate kingdoms in the face of the challenges we all face.

Its exploration of the interface between religion and public health is predicated upon an overt conviction that the task cannot be accomplished solely within any particular disciplinary boundaries, or even by a merely additive assembly of perspectives from multiple disciplines. On the contrary, it seemed vital to comprehend, as far as possible, through
a transdisciplinary orientation, the full complexity of the matter, if any breakthrough insights were to emerge.

We thus spoke of drawing on as wide and rich as possible an array of intellectual resources and practitioner wisdom, utilizing any discipline we could that might be helpful, in order to probe what we originally called a ‘bounded field of unknowing’—bounded because not everything is fitting to the subject and we have some clues about what is, unknowing because so little has been done or published on religion and public health over the last decades. By now we have learned enough to say that we are no longer in a position of ‘unknowing’, even if what we have come to know, as might be expected, has expanded that ‘bounded field’ rather than shrunk it. Many new research questions have arisen that either ARHAP’s members or others are pursuing or see reason to pursue.

This image offers another perspective on this particular collection of essays, for it represents well what the field has come to look like, and it illustrates some of the most vital issues that need to occupy future work in the field. Because we wish to keep the richness of multiple voices in place as far as possible within the limits we set ourselves, the reader will find a mix of colloquial, theoretical, empirical and narrative materials in the essays. They are collected into five sections: an overview and the state of the field, leadership, HIV and AIDS, practice, and ‘looking beyond and ahead’. Across these sections are several integrating threads: a common focus on the vision of a greater good and on social justice issues, power dynamics and trust; the developmental growth of the field of enquiry around faith and the health of the public, including several indications of the need for authentic humility and self-aware intelligence in knowing how much we still do not know; the importance of further establishing evidence and measuring outcomes in order to advance the field; and, a truly ARHAPian embodiment of an interdisciplinary stew of thinkers, researchers and practitioners.

What, one may ask however, are we actually talking about? Faith-based organisations in health, faith-inspired organisations, religious health assets, religious entities, or any number of other identifiers that define … what? Nomenclature is an issue here, and as Jill Olivier suggests in her piece on this language issue, definition is not simply about the correct or most accurate terms in identifying the phenomena one seeks to understand; it is also about influence and sway in shaping discourses that are always connected to specific interests and the use of or access to multi-layered relations of power and the resources that go along with it. This is as true for a researcher in an academic institution as it is for a corporate manager.

The question of trust also emerges at this point. It may be one of the most crucial issues to consider in relation to the problematic and counter-productive ways in which power often plays itself out in the field of health, both in the broader social environment within which health decisions must be made and within the institutions, guilds and practices
of the health sciences, professional bodies, and corporate and state structures. Lucy Gilson, public health economist and an international leader in exploring questions of trust in relation to health systems, tackles aspects of the relationship between power and trust. She describes these as ‘two sides of the same coin in a relationship,’ in her essay, and uses the concept of ‘healthworld’ as a foil for unpacking the relationship between those who provide health services and those who seek health.

The question of trust is no small one in our time, particularly in the context of widespread inequity and growing inequality so characteristic of our global political economy. Who does one trust? Who is trustworthy? And if trust is so important, what kind of leadership, whether local, regional or international, exhibits it in the turmoil of our turbulent and often fragile social environments? Here we touch upon the nature of leadership in our time. Gary Gunderson has given particular form to how we understand the required kind of role through the notion of ‘boundary leadership’, the theme of his contribution. This key piece is crafted to show what kind of new thinking and leadership skills are needed as the global faith health landscape changes. This is supported by a second contribution on the theme of leadership from Mimi Kiser, who looks at what we might call the deep DNA of this leadership model and how it impacts on what she names ‘limited domain collaboration’, an approach to describing the kinds of trusted relationships that will allow for the existence of the necessary collaborative work in any particular context.

Perhaps an investment in relationships and human resources, especially including such intangible health assets as trust, might yield better outcomes for health in general. Here we might pay attention to Frank Dimmock’s chapter, which takes account of recent developments among the many Christian Health Associations in Africa. They are themselves a historic expression of the impulse that led to the emergence of primary health care through the inspiration they took from the World Council of Churches Christian Medical Commission that contributed so much to the eventual adoption of PHC by the WHO at Alma Ata. They are also a reflection of collaboration across boundaries that once divided them. The potential is there to revitalise PHC for which the WHO is now calling (World Health Organization 2008b), a further dimension of the challenge that lies before those religious institutions and bodies that have oversight or control over health facilities in many parts of the world.

Geoff Foster, in his offering, also deals with the regional religious resources, in his case, those that churches in Mozambique wield as they struggle to respond appropriately to the HIV pandemic. The theme of leadership emerges again, as Foster highlights the need for more effective networking, and offers evidence of a softening of judgmental attitudes of the church leaders as they become aware that they themselves are affected and complicit. The ambiguity of church leadership and responses to health challenges that touch on sensitive issues again comes to the fore in the exploration by John Blevins of how religion relates to
adolescent sexual health. His analysis of the findings of workshops of young people, as well as his analysis of theological reflection in Christian communities, illustrates the power dynamics and the social justice issues that are at play in this context.

While ARHAP is overtly oriented to research religious health assets that are attached to any and all religious traditions, especially important in a diverse global community, much of its work has tended to did focus on Christian communities and their health assets. In part this was always likely, given that most of the areas in which research was undertaken are dominated by Christianity, Zambia being the most obvious example. This bias is also evident in this collection of essays. In this regard Muhammed Khalid Sayed’s discussion of Islamic jurisprudence relevant to aspects of HIV makes an important contribution. He argues that principles of jurisprudence from the works of classical Muslim jurists, rather than general values or calls for a theology of compassion and justice, will influence orthodox religious leaders and hence contribute to mitigating the impact of the pandemic. Sayed discusses some of these principles and their implications for an Islamic response to HIV, arguing that the particular context, and the specific religion, needs to be considered in any assessment of RHAs.

Social justice is another of the integrating threads that runs through many of the chapters. Gillian Paterson is known internationally for her earlier collection of case studies on HIV and AIDS, illustrating women’s stories through the lens of the faith community. In this volume, she offers a personal perspective on the scale and the distinctive contribution of religious entities to health, and the degree to which these have for long been overlooked. She emphasises the centrality of working for justice, especially for those who are poor and marginalised.

Katherine Marshall, well known internationally for her work on religion in development, brings the volume to a fitting close. She sketches faith-health intersections in Africa, paying attention to malaria, HIV and gender against the background of international aid coordination and harmonisation efforts. She highlights the complexity of faith-inspired efforts and the intricate power dynamics at play. Like Benn, she also illustrates how diseases or problems are catalysts or ‘pivots’ to leverage change, particularly the evidence and improved outcomes that spun out of efforts to decrease inequity in education for females. Thus, she ends her essay—and the collection—on a hopeful note.

Building on this, we conclude by noting that ARHAP itself has undergone some transformation. Originally launched at what was always intended as a global initiative, but reflecting a wiser commitment to begin regionally, specifically from within Africa, its work has by now significantly transcended that regional focus. In this respect, ARHAP has served its purpose. In order to reflect the founding intention and the nature of its current work, and honouring the ever-expanding international global faith health work that marks its short history, it is
now renamed the International Religious Health Assets Programme, or IRHAP. It remains collaborative in its ethos, intention, organisation and working style. IRHAP’s hub will also remain in Africa, holding on to those roots, now housed in School of Public Health and Family Medicine at the University of Cape Town, with contributors Jim Cochrane and Lucy Gilson as its co-directors, and Jill Olivier, another contributor, as Research Director, and with support coming from the Gary Gunderson and Teresa Cutts, also contributors to this book, based at the Center of Excellence in Faith and Health and Methodist LeBonheur Healthcare, Memphis, Tennessee.

In furthering its work and the ‘movement’ of which they feel themselves to be a part, IRHAP’s leaders and scholars anticipate that this move will be highly complementary with the burgeoning field of health systems research, in which Lucy Gilson is a key global leader. Supporting the next phase of theoretical and conceptual work that must be undertaken to secure what has been learned and gained in the field of religion and public health, the first full articulation of ARHAP’s driving ideas, together representing something of a shift in paradigms, will also be available from Palgrave McMillan soon, penned by Gary Gunderson and Jim Cochrane (2012).

This collection of essays must therefore be seen as a way-station on a much longer journey, one that in many respects is still very close to its beginning. It is meant, for that reason, to prompt and provoke others to engage with its core concerns. It also reflects the nature of this journey, as one peopled by a wide range of thinkers, actors, practitioners and organisations who, whatever their historical, contextual, disciplinary or practical differences, share some common vision of a world in which health for all becomes something more of a reality than it is. That passion and compassion is not always evident in written chapters in a book, for it rests much more in human encounter than it does in texts as such, but as editors of this book, who know all involved, we know how much it drives the work of those who have graciously contributed their thoughts, their time and their energy to what is written here.

James R Cochrane
Barbara Schmid
Teresa Cutts

References


