When Religion and Health Align

Mobilising Religious Health Assets for Transformation

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CHAPTER ONE

The Continued Paradigm Shift in Global Health and the Role of the Faith Community

Christoph Benn
Global Fund to Fight AIDS, TB and Malaria

INTRODUCTION

In the eight years since the African Religious Health Assets Programme (ARHAP) was launched there have been many remarkable developments. Without any doubt, ARHAP has contributed to a much broader recognition of the role that faith communities around the world have been playing in international health. Among many other things, ARHAP has conducted a major mapping exercise on the share of faith communities in the provision of health care with support from WHO (ARHAP 2006). The data of this study showed that about 40-70% of institutional health care, particularly in Africa, is being provided by FBOs. This finding is now widely reported and was quoted recently in a landmark article on ‘Positive Synergies’ in The Lancet (WHO 2009a: 2140).

FBOs are acknowledged as vital partners by governments, UN organisations and foundations. Early suspicions by some NGOs that FBOs were too different to be included in their networks have been overcome and FBO representatives are now regularly invited as part of civil society delegations to the boards of UNAIDS, the Global Fund and other international bodies. FBOs are deeply involved in international conferences, particularly on HIV and AIDS. International organisations such as UNAIDS and the World Bank regularly seek dialogue with major faiths.

ARHAP has greatly contributed to this very welcome development and has clearly met its key objectives. This leads to the question of what the role of the faith community in international health will be in the future. How can ARHAP, among others, contribute to provide data and analyses that will help to guide future policy development? How can we together not only maintain the fruitful cooperation between faith and the global health community but also promote it in a way that it can serve even better the health of the people?
Before I turn to these questions, I want to review developments since the creation of ARHAP. My keynote address at the first ARHAP Colloquium in 2003 concluded with the following statement (Benn 2003:11):

We might be at the beginning of a new phase in international health in which FBOs will probably play a major role. Are we at a new *kairos*? We do not know and actually, it is not in our hands. But we might experience a new paradigm shift in international health policy with much greater investment in the health of poor people, but based on the experience of the PHC [Primary Health Care] movement emphasizing community participation and ownership.

So, was I right at that time? Have we really experienced a *kairos*, a paradigm shift in international health policy? This is the first question I will address before turning to the more important questions: What are the next steps? What is the vision for the future for religious communities and the world at large?

**DEVELOPMENTS IN THE LAST DECADE**

*Increase in Resources*

The first obvious paradigm shift has been in the volume of resources allocated to health in poorer countries. Over the last two decades, and particularly over the last seven years, we have seen an unprecedented increase in resources for global health. According to a recent article published in *The Lancet*, development aid for health increased four-fold from US$ 5.6 billion in 1990 to 21.8 billion in 2007 (Ravishankar et al. 2009:2117). It will be even larger this year (2009). Most of this increase was due to a few major so-called Global Health Initiatives: the World Bank Multi-country HIV/AIDS Program for Africa, the US bilateral programme PEPFAR, the Global Alliance for Vaccines and Immunization (GAVI) and The Global Fund to Fight AIDS, Tuberculosis & Malaria (GFATM).

Most of the resources have supported programmes targeted at infectious diseases, in particular HIV and AIDS. But it has not been confined to the disease that clearly galvanised political attention. Malaria and tuberculosis, child illnesses and health system support have benefitted as well in a major way. Even resources to reduce maternal mortality aimed at providing comprehensive maternal and childcare have increased, although not in proportion to the importance of this cause (Ravishankar et al. 2009:2117). We have made good progress on Millennium Development Goal 6 (Combat HIV/AIDS, malaria and other diseases), reasonable progress on MDG 4 (Reduce child mortality), but very little progress on MDG 5 (Improve maternal health). I would agree with many who argue strongly that maternal health needs to receive
more political attention and financial resources in the future (for more details, see http://www.un.org/millenniumgoals).

Faith-based organisations (FBOs) have also benefited from this increase in the availability of resources. PEPFAR, in particular, has had a strong emphasis on supporting FBOs, but the World Bank and the Global Fund have also channelled considerable amounts of money to FBOs. Leaving open the question of whether FBOs have received enough resources and if not, what the obstacles might be, it is evident that there are numerous examples of considerable resource flows to and through FBOs.

Impact on Diseases

But more important than the increase in resources is the question: did the money have any impact on the diseases? Do people live longer and have they been protected from premature and preventable illness and death? The answer is a qualified yes.

Millions of children have been vaccinated, helping to decrease child mortality. HIV prevalence rates have stabilised in many countries, and mortality from AIDS is going down quite dramatically in a number of countries such as Ethiopia, Malawi and Rwanda. Tuberculosis incidence is going down particularly in the most populous countries in Asia (UNAIDS & WHO 2009; WHO, 2009b; WHO, 2009c). For me the most amazing and dramatic impact has been demonstrated on malaria morbidity and mortality. With very simple health technology—long-lasting impregnated mosquito nets, and effective therapy using artemisinine-based combination therapy (ACT)—malaria cases and mortality have plummeted in many African countries. In Eritrea, Burundi, Tanzania and Kenya mortality from malaria has decreased by 50% to 80% plus (WHO 2008b). One of the most successful programmes supported by the Global Fund is a multi-country programme covering the border area between Mozambique, Swaziland and South Africa. Here malaria incidence dropped by 87-96% (GFATM 2009:64, fig. 34). For anybody who has been working in public health these results are just amazing and would have been completely unimaginable just a few years ago.

Let me add a personal example to illustrate the change that has occurred over the last years. I used to work at the Bulongwa Lutheran Hospital in Tanzania in the late eighties and early nineties. It was the time of implementing Primary Health Care (PHC), but also the early phase of the HIV epidemic in East Africa.

Like many others, I experienced the strength of the principles of PHC, such as community participation, commitment to equity, and health promotion. But because of the philosophy of self-reliance, communities could not afford even the cheapest of all health interventions: the distribution of mosquito nets. And PHC was completely incapable of recognising the emergence of HIV and AIDS, much less coping with its devastating consequences. As a young doctor, I experienced the deaths
5Paradigm Shift in Global Health and the Faith Community

of so many young people. Like others, I felt helpless at the injustice of the world standing by apparently not concerned with millions of people dying in poor countries.

This has changed dramatically. When I returned to Tanzania in 2008, I saw the sea change that has happened. There are now 170,000 people receiving antiretroviral treatment, which is about 30% of all patients requiring this life-saving intervention. There is a very effective national malaria programme, with mosquito nets being available in most communities. Malaria, which used to be the number one killer of Tanzanian children, is on the retreat. And very importantly, finally something is being done about the tragedy of children who have lost their parents, mainly because of AIDS. Many districts now have comprehensive programmes for orphans and vulnerable children, providing them with shelter, education, food and basic health care.

Tanzania is just one of many countries that have seen these changes. For me there can be no doubt that we have seen amazing progress in access to vital health and social services over the last few years, at a pace never seen before.

AIDS as a Catalyst for Equity in Global Health

If we conclude, then, that a paradigm shift has occurred in the provision of health services in the developing world we have to ask ourselves: why has this happened? The driving force for this paradigm shift has been the global response to AIDS, and South Africa has played a crucial role in it.

HIV has, for the first time in medical history, brought about a solidarity movement between those affected by the disease in rich countries and those in poorer nations. The reality of differential treatment for people in countries with sophisticated health systems, and those who are unfortunate enough to have been born in countries with more rudimentary health services, had never been challenged. But AIDS activists refused to accept ‘business as usual’. Still one of the best expressions of this extraordinary shift in attitude is the statement of Justice Edwin Cameron (2000) at the AIDS Conference in Durban in 2000:

I stand before you because I am able to purchase health and vigour. I am here because I can pay for life itself. To me this seems a shocking and monstrous iniquity of very considerable proportions—that, simply because of relative affluence, I should be living when others have died. … our overriding and immediate commitment should be to find ways to make accessible for the poor what is within reach of the affluent.

Of course, Zackie Achmat and the Treatment Action Campaign (TAC) he led are other outstanding examples of this movement that began to change the way we think about justice, health and solidarity at the beginning of this century.
We easily forget how extraordinary this change has been. Just imagine a person suffering from kidney disease standing up at an international conference to demand the same access to treatment for his fellow sufferers in Zimbabwe or Bangladesh. Alternatively, imagine a woman in London who owes her life and that of her newborn child to a successful Caesarean section saying, ‘I want the same right to lifesaving obstetric care for the 500,000 women who die in childbirth every year.’ Are not these preventable and tragic deaths of countless women as monstrous an inequity as the inaccessibility of antiretroviral drugs has been? But have we heard this cry?

I ask this question here because I believe it is a key question for the faith community. While Christians and other people of faith are now strong partners in the global efforts to demand equity in global health, we have to admit that they were not the avant-garde of the movement. Maybe it is time now to mobilise our communities, congregations, churches and other religious places around the world for a new way of thinking about inequities and social justice in a globalised world.

**A Paradigm Shift In Global Health Ethics?**

Alongside this paradigm shift in the provision of resources for health there has also been a new way of thinking about the concepts concerning health and development. Let me mention three paradigm shifts.

*From charity to health as a human right*

For decades, development aid for health had been understood as a form of charity. Valuable contributions and enormous sacrifices have been made by countless people motivated to such acts of charity by their religious faith. The recently published Encyclical Letter, *Caritas in Veritate*, strongly emphasises this virtue, stating, ‘Charity is at the heart of the Church’s social doctrine’ (Benedict XVI 2009:2). It defines charity as love, a love that extends even beyond the demands of justice. The secular international community, however, defines charity as a voluntary act of benevolence offered by someone in a position of power to somebody less powerful, without any obligation incurred or duty attached.

Public health organisations and, in particular, the AIDS solidarity movement use a different concept, that of rights and obligations. It is based on the understanding that all human beings are of equal value and that those who have greater means have a duty to be in solidarity with those who are less fortunate. Equitable access to treatment is understood as a basic human right, as stated in Article 25 of the Declaration of Human Rights: ‘Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family’ (UN 1948). This was further specified by the International Covenant on Economic, Social and Cultural Rights (UN 1966: Art. 12):
The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. The steps to be taken ... [include] The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

The implementation of this right to health has mostly been regarded as unrealistic, but the global AIDS movement has changed this paradigm completely. Access to treatment for a life threatening disease is now regarded as an entitlement and not as discretionary spending. The big question now is, will we be able to extend this entitlement beyond the disease that triggered this new paradigm? More and more policy makers and researchers seem to come to this conclusion. As Ooms & Hammonds (2008:157) expressed in a recent article:

It [The right to health] should not remain the exception applicable only to the fight against AIDS, tuberculosis and malaria. It should become the standard for global health aid and for other global aid to realize essential social rights whenever the aim of sustainability at the national level is unrealistic.

From Sustainability as Self-Sufficiency to Long-Term Global Solidarity

For decades, sustainability was defined as achieving self-sufficiency in a short period. Aid was provided under the condition that the recipient would cover the running costs and be able to sustain the programme over time. This was particularly true in health, where donors might have been prepared to support investments in health infrastructure and equipment, but not in salaries, maintenance and the provision of drugs—except for the cheapest versions. This has resulted in countless hospitals and clinics lacking appropriate staff, effective drugs and functioning technology.

When the global community decided to provide antiretroviral drugs to people living with AIDS it was perfectly understood that this was an investment in life-long treatment that could not be abandoned at any given time, and that some of the poorest countries were unlikely to become self-sufficient and take over the costs for that treatment within the foreseeable future. ARV treatment was understood as a global subsidy that could only be financed through global solidarity until poorer countries had developed economically to a point where they would be able to sustain the programmes themselves. The definition of sustainability had changed to mean sustainable international solidarity (Ooms & Hammonds 2008: 157). There was a need to make sure that global solidarity in health was not dependent on individual political leaders or short-term priorities but had a solid foundation with predictable funding for as long as it was required.

It was for this purpose that the Global Fund to Fight AIDS, Tuberculosis & Malaria was created as an institution that would provide
significant amounts of resources over a long period of time—minimising as much as possible the risk of diminishing resources. The Global Fund functions basically as a global pool of resources contributed by a large number of countries, private foundations, private corporations, consumers and innovative finance mechanisms, making it less vulnerable to changing political priorities in any given country or corporation. Even in the current unprecedented global economic crisis, no donor so far has announced that they would not honour their commitments or reduce their contributions. In fact, several large donors including the US, Japan and the United Kingdom increased their annual contributions in 2009 and we are confident that a number of new donor countries will contribute for the first time in 2010.

As the person that has been responsible for mobilizing the resources of the Global Fund for the last six years I would not for a second underestimate the challenges the world is facing to secure appropriate funding for health and development, but I am confident that we are in a new era in which politicians do understand that this is no longer about short-term help, but about long-term investment in the health of people.

**From Development Aid to Global Social Security**

This leads me to the last paradigm shift I want to describe. We have observed a gradual shift from development aid to a still rudimentary but emerging form of a global social security system. All developed countries have some form of a social security system, built on the recognition that people face different risks in life and have different means to cope with these risks. Fairness and a sense of equity demand that we do not allow persons who require expensive emergency surgery or treatment for a chronic disease to die or to suffer disproportionately because the treatment is beyond their means. As John Rawls (1971) famously described in his *Theory of Justice*, we all do not know where we will be in the lottery of life before we are born. Therefore, most people would agree that there should be some system that provides us with basic protection when we will need it, and that it is beneficial for all to share the risk and to contribute to a social health insurance to mitigate against these risks.

Rawls deliberately restricted the implications for the allocation of resources outlined in his theory of justice to members of the same community living within the boundaries of a given nation state. But this is, and should be, changing as national boundaries become less relevant in a globalised world. It should not limit our ethical thinking. Only recently have philosophers like Thomas Pogge (2008) applied Rawls’ principles to a universal concept of justice including all people based on the universality of human rights. In a globalised world, we should accept the argument that risks need to be shared more widely, and that a person should not be refused the right to education, food, water or health care just because he or she was born in a country that cannot afford a minimum of social protection.
Therefore, there is now an increasing discussion about creating a Global Health Fund that will provide a minimum package of health services for all. This does not need to be extremely expensive. We do know that for about US$40 per capita a well-functioning PHC system can be financed that will provide a combination of essential preventive and curative services covering more than 90% of health risks. At least half of this would come from domestic budgets anyway, and only a smaller share would have to be subsidised by the international community.

In 2008, the British Prime Minister Gordon Brown, and the President of the World Bank Robert Zoellick, convened a high-level Taskforce on Innovative International Financing for Health Systems. The group presented its report to the G8 Summit in L’Aquila in July 2009 (Taskforce 2009). It argues exactly for this package of essential health interventions that the world can afford if there is sufficient political will.

Some experts argue that The Global Fund to Fight AIDS, Tuberculosis & Malaria might be the nucleus for this new Global Health Fund. Similarly, there is now a discussion about a Global Fund for education promoted, among others, by US Secretary of State Hillary Clinton. The G8 Summit at L’Aquila also proposed a new Global Food Security Fund. What these initiatives have in common is that they incorporate elements of an emerging social security system, building on the domestic resources available in the affected countries, but subsidised by the international community, based on the right to essential protection and moving away from traditional aid in the form of isolated projects.

I hope I have answered the question that I raised a few years ago about whether or not we are experiencing a particular *kairos* and a paradigm shift in international health. For me the answer is a clear ‘yes,’ but the big question remains: what that would mean for FBOs around the world and how they can and should relate to this new paradigm?

**CAN THE FAITH AND THE HEALTH COMMUNITIES FIND A COMMON LANGUAGE?**

Sometimes the biggest challenge for forging collaboration around this theme between public health experts, representatives of international organisations, and the faith community is the lack of a common language and terminology, which often leads to misunderstandings and frustrations.

But I do believe that there is a lot of common ground, and that we should be able to build a joint movement based on shared values and a shared terminology. Let me give you a few examples of where the terminology and the concepts of health and religion might find sufficient common ground, and where I see the need for greater convergence.
All major religions have elaborate teachings on health, healing and wholeness. The Christian faith, for example, recognises that the church has a specific role in healing, originating in Jesus’ call to his disciples to preach the gospel and to heal the sick. Christian theology has developed a holistic view of health, with the task of healing to be entrusted to the whole congregation and not only to the specially trained health professionals (McGilvray 1981). Other major religions also have very distinctive teachings on health, the healing power of rituals, prayer and the religious community.

There are considerable apprehensions in the religious community concerning the medicalisation of health. But I do not think that a scientific view of medicine and a holistic understanding of health are in any way mutually exclusive; indeed, they can be complementary. However, I do see the need for religious leaders, in particular, to develop a better understanding of the public health paradigm.

A physician is usually focused on the health of his or her individual patient. Religious leaders have no problem understanding and fully supporting this aspect of the healing ministry. But public health officials have to focus on the health of populations. They are concerned with the incidence of diseases, with interventions to reduce mortality, and with measures to assess the impact on life expectancy. Now Jesus was clearly a healer, but he was hardly a public health official. He was healing individual patients as a sign of the coming Kingdom of God, but he was hardly concerned with the morbidity and mortality rates of the population of Israel in his time. So Christian leaders might be forgiven if they feel that this is a bit outside their mandate.

But I believe that this lack of a common understanding of the concept and principles of public health has negative implications, particularly at this time of unprecedented opportunities in global public health. There are historical reasons for this situation, but it might also be worthwhile to explore whether there have been specific theological arguments supporting an individual approach to health and human well-being.

Churches began to build hospitals and health institutions in the 19th and early 20th century as a response to immediate needs in a given community, but not as part of a national health plan. Specifically, in Africa and Asia, health services were organised by colonial administrations with little interest in the improvement of the health of the whole population. For churches, the provision of health services has sometimes been as much a strategic instrument for expanding the reach of a particular religious group, as it has been an act of charity. The same has probably been true for the establishment of schools and other social institutions. It is now urgent that churches and institutions of other faiths engage both at national and global level in establishing social systems that serve whole populations, regardless of their religious affiliation.
Over the last years, a number of churches and their health institutions have approached me, asking: how can my project or diocese benefit from the Global Fund? The question, unfortunately, is not: how can my church contribute to the wonderful new effort to reduce morbidity and mortality? There is a certain lack of vision here; the mindset is still too narrowly focused on institutional interest, rather than the greater common good. Nevertheless, the question of why the Global Fund does not provide more resources to FBOs is also valid and legitimate, and there are a number of answers.

First, it is not quite accurate that the Global Fund is not providing significant resources for FBOs. It has so far approved about US$16 billion for programmes in 140 countries, and about 5-6% of that amount, approximately US$800 million, has gone to FBOs (Global Fund 2009). This is a considerable amount, though it could be more, given the enormous capacity of FBOs in the provision of health care. Why is it not more?

Second, self-critically, I would say that the processes involved in Global Fund funding are too complex and demanding, particularly for smaller FBOs. We require detailed proposals with indicators and procurement plans, as well as elaborate monitoring and management systems. And this is linked to the need for a different kind of thinking.

Third, many leaders of religious organisations apply for funding for a specific diocese, health centre or health programme of their particular church. They do not yet think of that project as part of a comprehensive national health programme. But the international health community has gone beyond the project approach, beyond well-meaning but limited initiatives. It focuses on the health of populations, and that requires a different approach and vision.

There may be a role for ARHAP in helping religious communities take this step to become part of a broader movement that is already having a significant impact on the health of populations, and that could achieve even more through a close cooperation with the religious sector. Religious communities could benefit from the extensive experience that some FBOs already have in working within the new system. The Churches’ Health Association of Zambia, the Zimbabwe Association of Church-related Hospitals, World Vision, Catholic Relief Services, and many others are already implementing large-scale programmes with financial support from the Global Fund, PEPFAR and others.

Another example is a new partnership between the United Methodist Church, Lutheran World Relief, and the Global Fund, who have agreed to work together on the elimination of malaria. The churches in the US in particular are raising awareness about the disease, but also mobilising resources for national malaria programmes in a number of countries through their related health facilities. The awareness-raising component of this campaign is financed by the Gates Foundation, another example
of the new type of partnership that might be characteristic for this new era.

A good bridge between the more individualistic view of health held by most religious communities and the broader dimension of health might be the report on ‘Social Determinants of Health,’ published by the WHO (2008a):

The Commission takes a holistic view of social determinants of health. The health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, goods, and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of people’s lives – their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities – and their chances of leading a flourishing life. Together, the structural determinants and conditions of daily life constitute the social determinants of health and are responsible for a major part of health inequities between and within countries. The global community can put this right but it will take urgent and sustained action, globally, nationally, and locally.

So let us look at what sustained global action might mean.

**Health and Global Equity**

For me the most important question is whether we will see a greater alignment between religious values and teachings on justice and equity in relation to health. As noted before, I see a gradual movement towards the notion of universal human rights, including the right to health, and an emerging global social security system similar to what many developed countries experienced about a century ago.

Humankind needed thousands of years to accept that our obligations extended beyond the most immediate family, to clans and finally, to nations. The 21st century should see the extension of this concept to include the whole human family on all continents. Individual religious leaders and outstanding individuals motivated by their faith have greatly contributed to that movement, though religious communities generally have not necessarily been in the forefront. Still, I do feel that all major religions, in their core moral teaching, are supportive of this line of argument. Let me give you a few examples, even if that exploration will necessarily be quite cursory and superficial at this point.

For the Jewish faith, life is of supreme value and infinite worth. As a Jewish philosopher expressed it at an international conference (Steinberg 1985:49):

> Since the value of life is infinite and beyond measure, it follows that any part of life is of the same worth. One life is worth as much as a thousand lives – infinity is not increased by multiplying it.
The Muslim faith has a strong notion of brotherhood (ummah). There is a strong inter-dependency between persons, with a complex system of responsibilities and obligations in particular to those who are needy and vulnerable. These obligations to help the sick and the indigent extend beyond the Muslim community (Benn and Hyder 2002:183).

According to Christian scriptures, all human beings are created in the image of God—thus possessing equal value. While Jesus certainly did not develop a theory of distributive justice, we can draw analogies from his teachings and healing ministry that extend to all people, regardless of their faith or ethnic origin, a core message of love that extends beyond justice. Justice gives every person his or her due. Love transcends any narrow concept that limits the benefits of care and justice to a defined group of people.

This is quite clearly expressed in the encyclical letter, Caritas in Veritate (Benedict XVI 2009:6):

*Charity goes beyond justice*, because to love is to give, to offer what is ‘mine’ to the other; but it never lacks justice, which prompts us to give the other what is ‘his’, what is due to him by reason of his being or his acting.

While the Encyclical does not go as far as to argue for a new global social order, it does argue for a clear obligation, for those who have the means, to share in the provision of essential social services (Benedict XVI 2009:60):

In the search for solutions to the current economic crisis, *development aid for poor countries must be considered a valid means of creating wealth for all*. From this perspective, more economically developed nations should do all they can to allocate larger portions of their gross domestic product to development aid, thus respecting the obligations that the international community has undertaken in this regard. One way of doing so is by reviewing their internal social assistance and welfare policies, applying the principle of subsidiarity and creating better integrated welfare systems.

**CONCLUSION**

We have seen an amazing increase of resources for global health, with significant and tangible results that have affected the lives of millions of men, women, children and their communities. We need to make sure that these investments will be sustained, and we need the full support and advocacy of the global faith community for this goal.

The contribution of the faith communities to global health, and the enormous importance of its resources in terms of community support, health facilities and spiritual resources, have been increasingly recognised. We need to work together to make sure that all these resources are employed to maximise the impact on health.
The historic and unique contribution of the global AIDS movement needs to be recognised and, while maintaining the achievements made for people living with and affected by AIDS, the benefits of this movement should be further expanded to other diseases and health problems. As a first step, we need to advocate for a package of essential health accessible to all people in need, regardless of income level or their country of origin. This package needs to be financed with mutual accountability, countries providing a domestic health budget according to their ability, subsidised by the international community. The faith community will be an important provider of this package of health services.

The 21st century should see the establishment of a global social security system that provides all people with a decent standard of health, education, food, water and other basic necessities of life. The current economic crisis that is disproportionately affecting the poorest and most vulnerable should be a reminder of the urgency of a fair system of sharing rights and responsibilities, of protecting people from major risks to their life and well-being. The faith community should be a major voice using all possible means to advocate for equity and health at national and international levels, paving the way for a just world order.

Let me close with a quote from Joel A. Barker (1990) used by former President Nelson Mandela: 'Vision without action is merely a dream. Action without vision just passes the time. Vision with action can change the world.'

REFERENCES


