When Religion and Health Align

Mobilising Religious Health Assets for Transformation

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## Contents

Acknowledgements xi

About the Contributors xiii

Preface: The Hope of Alignment xvi
   Introduction xvi
   From the Past to the Present xvii
   The African Religious Health Assets Programme (ARHAP) xix
   When Religion and Health Align xxiii

Section 1

Overview and State of the Field

1. The Continued Paradigm Shift in Global Health and the Role of the Faith Community 2
   **Christoph Benn**
   Introduction 2
   Developments in the Last Decade 3
   AIDS as a Catalyst for Equity in Global Health 5
   A Paradigm Shift In Global Health Ethics? 6
   Can the Faith and the Health Communities Find a Common Language? 9
   Conclusion 13

2. Discovering Fire: Changes in International Thinking on Health Care—The Challenge for Religion 16
   **Gillian Paterson**

3. ‘An FB-oh?’: Mapping the Etymology of the Religious Entity Engaged in Health 24
   **Jill Olivier**
   Mapping the ‘Faith-Based Organisation’ Landscape 24
Exploring the Terminological Battlefield: Why Does it Matter? 30
A Clash of Paradigms and Forms of Evidence 32
The Power in Naming 36
Conclusion: Power and Resistance 38

Steve de Gruchy, James R Cochrane, Jill Olivier,
Sinatra Matimelo
An Historical Overview 44
Four Key Ideas Behind PIRHANA 45
The Theoretical Foundations of PIRHANA 47
An Overview of the PIRHANA Tool 50
Technical Research Matters 54
What Does Participatory Inquiry Achieve and What Not? 56
Conclusion 59

5. Boundary Leaders: Seeing and Leading in the Midst of the Whole 62
Mimi Kiser
Institute for Public Health and Faith Collaborations 63
Recognising the Systems Nature of Health Challenges 63
Leadership that Sees the Self in the Whole 66
Liberative Pedagogy 68
Analysis 70

6. Liquid Boundaries: Implications for Leaders Mobilising Religious Health Assets for Transformation 75
Gary Gunderson

Section 2
HIV AND AIDS

7. A Purpose-Driven Response: Building United Action against HIV & AIDS for the Church in Mozambique 86
Geoff Foster, Carina Winberg, Earnest Maswera,
Cynthia Mwase-Kasanda
On Defeated and Contaminated Blood: Understanding the Causes of HIV and AIDS among Indigenes 139
What about Safe Sex? Indigenes on Sex that Involves the Use of Condoms 142
Concluding Remarks 145

Section 3

Practice

11. Trustworthy Intermediaries: Role of Religious Agents on the Boundaries of Public Health 150

James R Cochrane
- Introduction 150
- The Context 151
- The Challenge 152
- Building Trustworthy Intermediaries 155
- Assessing GSOs, and Beyond …. 158
- Conclusion 160

12. The Relevance of Healthworlds to Health System Thinking About Access 164

Lucy Gilson
- Introduction 164
- Understanding Access and Addressing Access Barriers 165
- Unpacking Acceptability 167
- Bridging the Worlds of Patients and Providers: What Role for Trust? 170
- What are the Implications of These Insights for Improving Health Care Access? 173
- To conclude 176


Frank Dimmock with Tali Cassidy
- Introduction 178
- Method of CHAs Study 179
- Historical Background of CHAs 179
14. The Memphis Model: ARHAP Theory Comes to Ground in the Congregational Health Network

*Teresa Cutts*

- Introduction
- The Memphis Landscape
- Theories and the Logic Model
- Covenant Committee Design
- Programme Expansion and Structure
- Evaluation of CHN
- Early Mapping Efforts and Data Snapshots
- Summary and Lessons Learned

15. Frontiers of Public Health and Social Transformation: Faith at the Table

*Katherine Marshall*

- Setting the Scene
- Caveats and Definitions
- Navigating Disconnects and Tensions around Religion and Development
- Trends in International Development, Faith, and Health
- Faith and Health: Moving towards More Concrete Action
- Malaria and Faith – A Case Study
- Ideas on Paths Forward

*Index*
Setting the Scene

For many faith traditions, religion and health are essentially inseparable, tightly linked in teachings and practice. Most religions see care for the sick and suffering as part of their calling; many view spiritual, physical, and mental health in a common frame. Many health care practices and facilities today trace their roots to religious institutions. So it is noteworthy and rather surprising that faith and health have a rather uneasy contemporary relationship.

In the global effort to bridge wide gaps in health care and to meet the unmet health needs of poor people and communities, partnerships with faith institutions offer an important avenue for action. Huge deficits in decent health care are a global challenge, most acute in the world’s poorest countries. Religious actors already do much and could do more in these countries to help meet the challenges of access, improve the quality of care, enhance efforts to prevent disease, and address priority issues like malaria and childhood disease. Their potential roles are multi-layered, from global to regional, national, and local community. Faith institutions play pragmatic and well established roles in providing health care in specific areas (both geographic regions and types of care).

Against this backdrop, there are many areas of synergy, an exciting potential for creative partnerships, and important practical and theoretical lessons to learn. However, overall the current partnership picture is rather murky, and it is not uncommon to find faith actors ignored in analytic reviews and policy consultations. Dialogue and understanding are at best mixed, with more disconnects than connections.

The chapter focuses on how development institutions, developing country governments, and others engage with religion and religious institutions, generally and around global health. The topic has generated intense discussions in the World Bank and the World Health Organization.

1 Insightful comments on earlier drafts from Barbara Schmid, Thomas Bohnett, and Nelle Temple Brown are gratefully acknowledged.
(WHO), and similar debates find echoes in other institutions. Many faith institutions likewise view development approaches with caution or scepticism, concerned above all with the perceived central pursuit of profit and the disruption of traditional communities and values that come with social change. And tensions among some faith groups complicate the picture. The chapter’s discussion highlights the state of dialogue with a view to appreciating hesitations and highlighting areas where better understanding could encourage more fruitful collaboration.

The chapter explores, more specifically, faith-health intersections, especially in Africa. It focuses on contemporary concerns about aid coordination and harmonisation, set within the framework of the Millennium Development Goals (MDGs), especially approaches to poorly performing states and societies in conflict, and challenges of mitigating the impact of economic and social crisis. The central questions are where faith-run and faith-inspired work, in hospitals and clinics and within communities, fits within these aid policy discussions, and what the knowledge, networks, experience, and ethical stance that faith institutions hold can add to international efforts. Global malaria campaigns are explored as an illustration, drawing on the recent review undertaken by Georgetown University’s Berkley Center for Religion, Peace, and World Affairs (Marshall & Bohnett 2009), and the World Faiths Development Dialogue (WFDD).

As to paths forward, the chapter suggests priority areas for attention, notably engaging at country level. It identifies specific obstacles to common engagement on health challenges as well as potential solutions, including addressing (through purposeful dialogue) tough issues where disagreements impede action (like gender relations), and generating and using knowledge more effectively. With practical and creative steps on these fronts, faith voices could contribute more and more effectively to meeting global health challenges. Such engagement also offers the promise of helping make faith-inspired delivery systems more effective and scalable.

My first inspiration to explore questions about religion and health came during brainstorming discussions in 2003 with a Bill and Melinda Gates Foundation team. Their probing questions found no ready answers. What, they asked, do we really know about the health care that faith institutions provide? What practical lessons emerge from their experience? And what are faith institutions’ long term visions and strategies for their contributions to health care?

The answers are complicated by the extraordinary variety of experience among faith traditions and countries, but also by large information gaps. How do different faith traditions (for example Christianity and Islam) approach health care with differing assumptions and ideals? We know far too little about the real size and impact of faith-provided health care, and where and how it differs from ‘secular’ care, public and private. We have even less comparative data about its
quality and impact. And there is little reliable overall data on whether faith-run systems truly reach the poor and excluded, and what we stand to learn from their experience. Set against the enormous roles of faith communities in the history of health care, the future seems unclear.

Addressing these specific knowledge gaps is the essential first stage in understanding the puzzle of disconnects. But it is also useful to situate discussions about religion and health within the broader context of the re-emerging recognition in various disciplines that a set of blinkers have obscured understanding and appreciation of faith’s role in many fields, including the social transformation that development is all about. This is particularly true among international development institutions and the academic programs that prepare many to work in these fields.

The discussion draws on my direct development experience as a World Bank officer, and wide ranging discussions with faith and development leaders and institutions, about many quite different topics, ‘from AIDS to zebras’. The approach is strongly interdisciplinary, and focuses on intersections of different practice communities as well as academic disciplines.

**Caveats and Definitions**

These complex and sensitive topics cannot be explored sensibly without some effort to define terms, and some essential caveats.

Religion and faith make up a huge subject, touching large and complex worlds. The most basic terminology itself is fraught: religion, faith, spirituality, secular, are all contested terms. For some, religion is a straightforward description of institutions and approaches; for others it implies formality in keeping with the word’s Latin root, meaning ‘to bind.’ Religion can also mean simply a broad and intangible set of beliefs. Spirituality can suggest the essence of religious belief and practice, or, alternatively, something apart from organised religion. Faith can imply a set of specific beliefs or convictions, extending well beyond organised religion, or simply a belief in something transcendent. The assumption that believers are organised in formal communities sits uncomfortably for some traditions, even as other believers (some Buddhists, for example) maintain that they do not have ‘faith’ in the commonly understood sense of the word. And while ‘secular’ suggests clarity and virtue for some, in other settings it can imply a godless and by implication valueless approach.

In short, definitions are difficult. This chapter uses faith more readily than religion because it conveys a broader and less formal connotation. The term ‘faith-inspired’ institutions or organisations (as opposed to ‘faith-based’) suggests a wider net than is common, with less assumption of institutional affiliations. But no definition satisfies all concerns. The definition conundrum should never obscure the intrinsic complexity
of the worlds and issues that lie behind the terms (see the chapter by Jill Olivier in this volume for a discussion of the definitional problem).

To complicate the definitional challenges, readers would do well to appreciate how far ‘development’ also refers to a complex world of institutions and ideas, one that is in flux, representing widely different approaches. The tendency to lump development institutions or groups of countries into simplistic baskets (secular versus faith based, north versus south) obscures both the varied actors and approaches at work.

Both thinking and practice about development have changed markedly in recent decades. For example, community engagement and empowerment were barely mentioned two decades ago, but today, for most development institutions, community ‘ownership’ is a moral and ethical imperative, and a key to success in almost any venture. It is not easy to pin down what ‘development’ really means; the concept encompasses broader and broader groups of countries and virtually any topic or sector. At one level, international development is about combating poverty, but in practice, far more than abject poverty is at issue. Development work confronts basic questions about the ideal society and, thus, social justice in its many forms.

Definitions of the basic terminology of health also present definitional challenges. The ARHAP initiative has contributed mightily to elucidating the challenges, especially with its embrace of religious health ‘assets.’ The assets notion makes clear that development actors must confront the full gamut of issues, from organising the most rudimentary forms of health care and defining ‘wellness,’ to grappling with norms of decent care that reflect both international standards and the values of a given community. Even a preliminary exploration highlights how far ideals of equity and compassion can find themselves in a tug of war with technical progress, cost, and standards.

Ethics and values are intertwined in discussions about the roles of faith and development, and nowhere more so than in the area of health care, with its special sensitivities around human dignity and respect for life. Again, caution is advised, particularly in ascribing ethical high ground or even clearly delineated values to any group or faith or secular tradition. Then, what can and should be ascribed to religion really, versus culture? Where does one end and the other begin? Complex realities defy ready categories and boundaries. There are few simple answers in efforts to disentangle the roles of religious beliefs and cultural norms and traditions. But, challenging though they may be, posing the questions offers an array of insights as well as practical experience and ideas.

**Navigating Disconnects and Tensions Around Religion and Development**

Links between global health and faith are usefully explored in the context of a broader and fairly recent resurgence of interest in how development
and religion are, and should be, related. International affairs actors generally, and the development community more specifically, are considering, in diverse ways, their relationships with religion, from both practical and theoretical perspectives. Faith inspired actors and institutions, for their part, are rethinking relationships with many public programs and institutions.

Obviously relationships and arrangements vary widely from region to region, country to country, and even within countries. What is different today is that, within many global and national institutions, often implicit assumptions that relegated religion to a largely private sphere have come under challenge. International relations departments at universities, diplomatic services, private companies, and civil society institutions (inter alia) are rethinking how religion fits into their worldviews and their programs (See for example, Albright 2007, Berger 1999 and Casanova 1994).

The upsurge of interest in religion and development to some degree reflects a positive recognition of potential synergies and common concerns among religious and secular organisations that work on international development. Above all, this turns on their shared focus on serving poor and marginalised people and communities.

Many development actors are impressed by the vast webs of connections and facilities that religious institutions have in communities, and by the polling data that highlight high levels of trust in religious leaders (see Narayan, Patel et al. 2000, Narayan, Chambers et al. 2000 and Narayan & Petesch 2002; also see the studies by the Pew Forum and the Latinobarometro) compared with other categories (politicians, military, NGOs – see Marshall & Marsh 2002). And the tangible evidence of religions’ historic and contemporary engagement on social services and helping those who are poor and suffering has persuaded many to take a serious and constructive look at what they do and why. Many who work in secular development organisations are significantly motivated by religious faith and many staff of faith inspired organisations share common experience with their colleagues in secular organisations. There are bridges linking the worlds.

A darker and more skeptical side to the new interest in religion and development, however, should also be recognised. Many discussions on the topic are permeated with uneasy or negative perceptions of religion—whether it is a principled expectation that religion is private and does not belong in the public sphere (for example, the French commitment to laïcité), or associations that link religion to violence and social tension (accentuated post September 11, 2001).

Where health is concerned, fraught debates about reproductive care drew religion directly into the fray, especially during international conferences in Cairo, Beijing, and Mexico City; they exacerbated impressions in some quarters that religion and development have fatal
incompatibilities. And, from the faith side, many have approached the encounter with development institutions with highly negative images.

Largely reflecting personal leadership by its then president, James D. Wolfensohn, the World Bank found itself 12 years ago (in 1998) to be a pioneer in considering ways to engage religious leaders and institutions more actively in development debates. Since then a wider set of global institutions has entered the arena, including many parts of the United Nations system and bilateral development agencies (British DfID, Dutch and Swiss Aid, USAID for example). An interagency effort led by the United Nations Population Fund (UNFPA) has led to the creation of a network of faith-based organisations and to an August 2009 Forum with faith-based organisations (UNFPA website). WHO undertook a pioneering review of the ethical foundations for Decent Care involving an interfaith group (Karpf, Ferguson, Swift & Lazarus 2008). In this broader trend towards engagement, the World Bank’s journey serves as a pertinent ‘case study,’ with the issues raised there an illustration and a caution (see Marshall 2008 for a fuller discussion of these debates).

Briefly, the journey involved a purposeful effort to engage faith leaders from nine different faith traditions in dialogue about development approaches and strategies. Led by Wolfensohn and former Archbishop of Canterbury, George Carey, five high level meetings of leaders from both faith and development institutions inspired probing and forthright discussions of common purpose and differing strategies and perspectives.

A specific outcome of the World Bank’s entry into the field was the establishment of the World Faiths Development Dialogue, a small non-governmental organisation whose mission is to help bridge gulfs between development and religion (WFDD website). A small unit within the World Bank itself has pursued a range of work, focused particularly on service delivery (Development Dialogue website). Examples of WFDD’s work are explorations of understandings of poverty in different religious traditions, work on HIV/AIDS, and probing the roles that faith institutions can play in the evolving Poverty Reduction Strategy Paper process. Current focus topics include faith roles on tuberculosis, maternal mortality, and agriculture.

Early discussions (in 1999-2000) within the World Bank about working with religions sparked an unanticipated flurry of criticism and tension. Briefly and schematically, religion was seen as divisive and prone to conflict, reopening fraught debates about separation of church and state and inviting tensions and jealousies among different religious groups and denominations. An important concern in some discussions was a concern that a purposeful faith engagement was likely to favour Christian groups over other faith traditions because they were far better represented among the faith-inspired groups with which development agencies came in contact (such as Catholic Relief Services, World Vision, Tearfund). Many, it transpired, viewed religion as largely opposed to
modernisation, patriarchal in attitude and structure, and rarely amenable to social change. Thus there were doubts that religion could truly be a force for positive and sustainable development. And many questioned its importance and priority. Some simply concluded that religion was too complicated to deal with, too likely to generate controversy, and thus was best left to its own, presumably private, sphere.

A striking feature of discussions within the World Bank, an institution that prides itself on careful analysis and objectivity, has been the often personal and emotional tone of discussions about religion’s roles. The topic elicited strong views that made analytic discussion rather difficult. In some respects the discussions paralleled early discussions about the role of gender in development where, again, personal views and experience tended to colour and impede sober reflection and analysis. In that case, the pivot for change was the availability of solid evidence, for example on the remarkable benefits of educating girls. Over a period of time many doubts were dispelled and the tenor of debate changed. Solid evidence as a foundation for policy reflection, especially on sensitive topics, is vital.

In the early explorations about religion and development, health care was a logical place to start. The long history of engagement and obvious presence of faith health care suggested ample potential for partnership, and health was a particular focus for the World Bank and other development institutions. The experience of religion in relation to the HIV pandemic was significant and eventually opened doors and minds (Marshall & Keough 2007). Sometimes rocky relationships between secular and faith actors as they came to terms with HIV and AIDS illustrated graphically that, while religion could be ‘part of the problem’ (fostering stigma and oversimplifying a complex medical and social phenomenon), it also needed to be ‘part of the solution’ in changing norms and providing essential care and help. Experience put a spotlight on an extraordinary range of roles played by faith actors, from home visit programs, pastoral care, and meeting needs of orphans and families, to shaping overall social attitudes and public advocacy and sitting on the cutting edge of ARV therapy. The HIV and AIDS challenge obliged many skeptics within global health circles (UNICEF and UNAIDS, for example), as well as within the large faith-inspired organisations like CARITAS Internationalis and World Vision, to confront the pitfalls of fragmented efforts, the yawning gaps in evaluation of ongoing programs, and discordant messages and programs and to look to more positive synergies.

The doubts and questions were, however, not easily dispelled. Concerns centred on reproductive health (especially in relation to the many institutions linked to the Catholic Church), and on gender roles, continue to pose major obstacles. Development institutions have come to accord high priority to gender equality, a goal that features prominently in the Millennium Development Goals. While many faith institutions
profess similar goals, lurking not far below the surface are questions about family planning, gender roles within families, and abortion.

The controversies around these issues contribute to doubts about faith-provided health care in some professional circles. Some even question whether the health care provided by religious groups is evidence based rather than grounded in ‘faith.’ Is there a hidden motivation for this work, notably conversion? Is health care a front for proselytizing?

And the doubts run both ways, with some faith actors sceptical of the motivations and values of development actors and the potential benefits of alliances between development and faith actors. Questions vary widely, from fairly minor quibbles (for example, about the mechanics of cost recovery) to fundamental questioning of the very motivations and legitimacy of development institutions.

An example of the latter is a World Council of Churches critique portraying a ‘neo-liberal project’ behind globalisation and development work; the bones are outlined in a document prepared before a dialogue process with the IMF and the World Bank, titled *Lead us not into Temptation* (WCC 2001). Similar challenges include what are seen as the development paradigm’s perceived focus on material wealth, making of greed a ‘religion,’ its narrow and segmented sectoral focus, subscription to immutable economic ‘theologies,’ and failure to take traditional cultures, including religion, sufficiently into account. Many faith groups are uneasy at what they perceive as far too cosy relationships between development institutions and governments. Not surprisingly, such critiques have contributed to tensions and cramp efforts at dialogue.

In short, despite high level leadership, instances of idyllic partnership and collaboration, and a general trend towards greater understanding, relationships among development and faith institutions remain piecemeal, and they are often characterised by considerable unease and poor mutual knowledge and understanding. This situation applies also to the more specific challenge of linking faith and health.

What emerged from the dialogue process and from internal discussions within the World Bank, was keen awareness that many government officials and development leaders are hesitant to commit themselves to explicit policies for engaging with faith institutions. The complex reasons include concerns about the perceived political stance and role of religious institutions, concern about possible bias towards one group or another that might generate social tensions, and impressions rife within development circles that many faith leaders and institutions oppose modernisation and, particularly, changing gender roles. As a bottom line, the experience highlights why linking religion and development, or religion and health, is far from straightforward. Awareness of continuing doubts and concerns is important in any effort to define constructive paths for engagement. The message that faith work is hugely diverse, with very different approaches and practices, needs to be emphasised. Most important, practical, pragmatic examples are needed
that demonstrate the potential for solid partnership arrangements, meet the demand for solid evidence, and fill knowledge gaps.

**TRENDS IN INTERNATIONAL DEVELOPMENT, FAITH, AND HEALTH**

Four important (and interrelated) changes are reshaping the international development world. All are pertinent for the challenge of exploring more active faith health development partnerships, at global level especially, but also in countries and at sub-national levels. They are: (a) progress towards achieving the Millennium Development Goals and interest in how faith institutions fit within that framework; (b) efforts to reform aid architecture and development finance, including aid harmonisation; (c) the challenges presented by countries that are poorly governed or in conflict; and, (d) responding to the impact of economic and social crisis. Until recently, faith work and roles figured little in analysis and discourse on all four topics, but their contributions are significant on all fronts, and there is mounting interest in exploring them.

**MDGs and Aid for Health**

The MDGs today provide a scaffolding for much international reflection about the strengths and weaknesses of development institutions and assistance. The MDGs set targets, highlight priorities, and represent a covenant that, in theory, assures adequate finance from the ‘international community’ and assurances from poorer country governments on its effective use. As the MDG deadline of 2015 approaches, concerns mount that many goals will not be achieved, and discussion is beginning on ‘what next?’ Notwithstanding considerable cynicism about the significance and impact of the MDGs, they represent a historic effort to corral international efforts for a fundamental human rights cause. They garner considerable focus from world leaders and citizens. And they shape global debates about development.

For the most part, faith institutions were, at best, peripheral to initial creative efforts and debates around the MDGs in the early years. That is not to say that the issues and ideas were not on faith radar screens—indeed, one of the world’s largest faith gatherings took place at the United Nations just before the year 2000 Millennium Summit of world leaders. But its focus was more on peace issues than on concrete plans to combat poverty. Recently, however, the leading UN organisations have begun to see faith institutions as significant partners in working for the MDGs. The most striking illustrations of the changing scene are the commitments of two major global interfaith organisations, the World Conference on Religions for Peace (WCRP), and the Parliament of the World’s Religions, to making the MDGs a centrepiece of their approach and programs (Religions for Peace 2006). Also, the massive public mobilisation for the MDGs around the Gleneagles G8 Summit in 2005 was driven and led in large part by church groups (see Millennium
Project website). Even so, many congregations and communities have only a scant knowledge of the MDGs, and fairly little sense of how faith communities might contribute to their achievement.

Of the eight goals that are the MDG backbone (as well as many of the specific targets that amplify each MDG), three centre on health: Goal 4—cutting child mortality; Goal 5—improving maternal health; and Goal 6—combating HIV/AIDS, malaria, and other diseases. Other goals also have clear links to health, notably ending hunger, promoting gender equality, and working for environmental sustainability. The important eighth goal frames a new approach to partnerships, and highlights the need for better and deeper understanding and cooperation among different actors. The aim of bringing the disciplines of focus, targets, measurement, and deadlines to the broad objectives of fighting poverty is a significant MDG feature, designed to separate the goals from earlier efforts that were long on promise and short on delivery.

In short, in the immensely complex community of development institutions, and specifically programs that support health, the MDGs are a good starting point in trying to trace directions, distinguish wood from trees, and work towards better coordination and coherence. They can be an important focal point for efforts to strengthen faith development links.

This leads directly to the second challenge, which concerns the roles of faith institutions in debates about aid architecture.

**Aid Architecture**

In recent decades, the number of institutions involved in international development work has grown exponentially. The array now includes multilateral and bilateral organisations, members of the UN family, regional organisations, and a plethora of civil society and private sector actors. While the keen interest and human and financial resources that the aid army involves is welcome, awareness has dawned that the situation has become unmanageable. Seen from the perspective of a developing country official, it translates into multiple actors, with very different requirements, demands for attention, rules and regulations, and often dissimilar development objectives. Financing can be erratic, its quirks leading to programs unduly geared to the donor demand of the moment, not to speak of missed opportunities or lower priority spending. Pathologies include poor coordination and inefficiency, with duplication of effort and programs working at cross purposes.

This explains a central focus today on aid harmonisation, with the informal theme of ‘get a grip’ (see Welle, Nicol & Van Steenbergen 2008). Building on the commitment to partnership in MDG 8, and with ambitious meetings in Paris, Rome, and Accra, major institutions and countries have committed themselves to work together to harmonise their policies and procedures, and to ensure that their assistance forms part of programs led by officials of the benefitting country. Together
with the MDG-linked effort to ensure greater accountability for results, the consensus is that assistance should be part of disciplined programs with proper governance, clear monitoring, and defined targets along the way. One result has been a significant shift towards sector programs (as opposed to individual, more specifically designed, projects). Thus, for a specific country, say Malawi, and a particular sector, say health, all donor efforts would be part of a government designed and led health program, with common goals, monitoring systems, reports, and evaluation mechanisms. Another result is sharper focus on long-standing local aid coordination groups, which are generally led by the government.

The aid harmonisation shift is far from perfect and it has significant detractors, especially in countries where some might not fully support the government’s leadership. Indeed, there are those who argue that a decentralised, ‘let a thousand flowers bloom’ approach encourages entrepreneurship and innovation. But the flaws of uncoordinated aid are glaring and the clear direction of change is towards harmonisation.

For faith institutions, three issues have particular relevance. First, the tendency in most countries and development institutions has been to focus service delivery efforts on public institutions, assuming that private services are largely incompatible with a poverty focus. The emphasis has thus been on public services for health or on public private partnerships where faith institutions are rarely considered as part of the mix. Second, with the shift in focus towards sector programs, smaller actors have more difficulty in making their voice heard, and thus tend to be particularly marginalised. This has obvious relevance for faith institutions, particularly smaller faith-inspired organisations and individual congregation projects.

Finally, with a focus on overall financing of programs, money takes on particular relevance. The picture for faith institutions is complex as many hope for access to the large flows of donor finance that have become available in many countries, packaged through sector programs and administered by the government. Their hopes are often disappointed, in part because of the public sector bias and, in some instances, because of specific reticence to work through organisations with a specific faith affiliation. Bias against faith institutions is not easy to identify in written records, partly because institutions are rarely categorised by a grouping with a ‘faith’ label; this often makes sense given the wide variety of entities but it makes discrimination or simple oblivion rather hard to counter (see Taylor 2005 for an example of an effort to address this approach and possible bias). Further, many governments tend to view faith institutions as suppliers rather than beneficiaries of finance, and are thus reticent to see what they view as ‘their’ funds going to faith groups, especially those with international connections. This complicates the picture still further. The net result is an uneasy focus on finance and the mechanics of applying for funding, debates about degrees of
control, and the pathologies that go with any partnership dominated by unequal power and money.

These discussions take place in parallel with an international debate that reflects mounting concern about the adequacy of global funding for health, about its allocation among specific objectives (HIV and AIDS versus primary care), about a regional (multi-country), internationally driven versus national, country led effort, and about health versus other sectors (infrastructure for example). See Piva & Dodd 2009, Ravishankar, Gubbins et al. 2009 and WHO 2008 a—none of which has more than the barest mention of faith roles). Global financing for health has increased substantially; the recorded external financing—ODA, or Official Development Assistance—for health stood at around US$16.7 billion in 2006, more than double the 2000 estimate of US$6.8 billion. Yet, a large part of the increase has gone to specific HIV/AIDS programs, and fairly little to general, basic health programs. With the economic crisis from 2008, even these levels are in jeopardy, and they still fall far short of what would be needed to meet MDG targets. In short, financing is right in the cauldron of debate about health and development.

Poorly Performing States

The conundrum of providing assistance in very poor countries which are too poorly governed or too embroiled in conflict to use it well, has emerged as a leading issue for the development community. Paul Collier’s (2008) book, *The Bottom Billion*, focuses on these challenges, as does a task force he co-led at the World Bank on the LICUS countries (Low Income Countries under Stress; see IDA 2007). The discussions could presage a paradigm shift, because they suggest new priority and new approaches to development in these challenged states, where health is a major concern. Strikingly, the issue of faith has rarely figured centrally in these discussions. It should, however, since in many of the countries concerned faith institutions are major actors, including often the primary providers of what services are available, as well as leaders in relief efforts. Gradually the important roles that faith institutions play specifically in such contexts and their potential contributions are coming into focus. But a substantial push is needed to move them onto the core agenda.

Social and Economic Crisis

Countering the impact of the current global economic and financial crisis on poor communities is another important development topic. It is increasingly well understood that during periods of economic crisis or downturn, it is poor communities that suffer most, but efforts to address their needs are generally too little and too late. Faith institutions should have important insights and potentially central roles, since they are present in virtually all poor communities and are on the front lines in providing help at critical times. Several health-related
impacts of economic crises are well understood, at least at a theoretical level. Households lose jobs and income, which affects nutrition and expenditures on health care. Many are pushed into extreme poverty by catastrophic health events. The vulnerable are most affected, including women, children, the poor, and informal sector workers, who constitute a large percentage of workers in developing countries. The World Bank indicates, for example, that over 1 million excess infant deaths may have occurred in the developing world during 1980-2004 in countries experiencing economic contractions of 10% or higher. Real government spending on health care declines as revenues contract, currency devaluation, and external aid flows dwindle. The lowest income countries with weaker fiscal positions show the largest negative effects.

Past crises suggest lessons about how to protect health outcomes and reduce financial risk. Broad-brush strategies to maintain overall levels of government health spending have generally failed to protect access and quality of services for the poor. More significant is assuring supplies of essential health commodities in the face of worsening exchange rates. Focused efforts to sustain the supply of lower level services, combined with targeted demand-side approaches, like conditional cash transfers, work better than broader sectoral approaches.

The voice and witness of faith communities as to what is happening on the ground as an economic crisis works its way through a society can help policy makers to understand crisis impact better than admittedly partial and often untimely data, pointing to specific areas where interventions are needed. They can also, if well orchestrated and tuned, help in advocacy, and thus mobilise and direct resources to the communities that need them. This knowledge and advocacy role, both in crisis contingency planning and in crisis response, is an important potential area for collaboration.

FAITH AND HEALTH: MOVING TOWARDS MORE CONCRETE ACTION

The ARHAP venture has highlighted the multifaceted nature of religious roles in health and their breadth and significance. They extend far beyond the hospital and clinic networks run by religious bodies, with particularly important impact at the community level. Faith communities thus have enormous, if very diverse, experience and knowledge to contribute to global health and development debates. However, tacit assumptions within the broad international health community that modern health care is a public responsibility, driven by science, and with declining roles for faith, have contributed to blind spots and antagonisms. The potential for partnerships with faith communities on health, and to meeting agreed public health goals is largely untapped.

The previous discussion sketched some obstacles to partnership, as well as more propitious signs of potential interest in expanding
partnerships among different public and private actors, including faith institutions. Three priority obstacles stand in the way of forward movement. Imperfect knowledge about what faith institutions actually do heightens the blinker tendencies. In this context of poor data and knowledge, well publicised areas where faith-inspired health care is damaging (Christian faith-healing applied to children, imams opposing vaccinations or mosquito nets, stigmatisation and exclusion of minorities) accentuate currents of thought which assume that faith-run health care is anachronistic. And tensions around the highly sensitive topics of gender and reproduction have spill-over effects far beyond the specific issues at hand.

So what can be done to bring greater clarity and a constructive, action-focused approach?

The gaps in knowledge and understanding are complex but surely amenable to action (ARHAP’s work forms a critical part, as do efforts led by WHO’s partnership team). Broadly, contemporary roles of faith-run health facilities are poorly known and understood in many countries, and the aggregate picture is partial and rather confusing, despite their significant presence and deep historic roots in many parts of the globe. Knowledge gaps are accentuated by the way these systems operate, by data collection conventions, and, in some settings, by historical church-state tensions. The growing roles of secular medical practices have exacerbated discontinuities among actors in some settings. Many faith run systems have been buffeted by political forces and successive financial crises. As an example, African countries like Mozambique have seen a long series of abrupt changes involving nationalisation of church-run facilities, then renegotiated church-state arrangements, repeated several times (Keough & Van Saanen 2007). Important, if widely different, traditional medicine practices also enter the diverse services, beliefs, and institutions that represent the health world of many a poor community.

One observer aptly described contemporary faith-run health systems as a galaxy, thus a bewildering array of large and small, close and distant, clearly visible and unseen. Most health care systems serving poor communities are decentralised. Day-to-day management—including fundraising and financial administration—is often centred in each clinic or hospital. The largest single faith-run system—the Catholic Church—includes countless kinds of facilities, many run by religious orders, others initiated directly by bishops (who have ultimate responsibility within their diocese), Catholic NGOs (like Caritas Internationalis, a confederation of relief, development, and social service groups), or movements (like the Community of Sant’Egidio, a lay Catholic group whose fundamental work is with the very poor). The result is that in many countries what have evolved are either quite separate, disarticulated systems or complex, hybrid systems. Changes in religious profiles as well as interfaith or interdenominational tensions shape these often highly decentralised and quite dynamic health systems.
In short, there are many reasons for the complexities of faith health arrangements which, in turn, largely explain gaps in understanding and weak tools for engaging with many institutions. Yet they represent important assets, both in the service and care they provide, and in their knowledge and understanding of communities and their needs.

A first challenge is to clarify the picture, with better knowledge grounded in practical realities; here ARHAP is at the leading edge. What we have now is patchy knowledge, patchier assessment, and thus little sense of aggregate impact. This first order work is termed ‘mapping’, with different associated meanings.

Mapping can range from a basic journalist’s report on what, where, with what, how much, and why on one hand, to elaborate GIS-based physical inventories, bolstered by ‘ground truthing’ based on investigation and dialogue with people and institutions. There are many basic questions to address under this ‘mapping’ umbrella, ranging from how many and what kinds of facilities are present, to staff and their training and incentives, patients treated, diseases that are the focus, and care beyond facilities (home and community based care). More sophisticated GIS mapping can guide both programming (linking population to facilities and topography, for example) and aid coordination. New uses of GIS, in cooperation with Google Earth, following the Haiti earthquake in January 2010, point to powerful new ways to use technology to benefit development and health programs.

Mapping work done by various organisations to date highlights the complexity of the health picture. Faith linked health care is an elaborate mosaic, complicated further by the interaction of formal and community health dimensions. Simple numbers and descriptions can be highly deceptive. There are situations where the picture is fairly straightforward with well-understood and established roles (notably several models of agreement with Christian Health Associations in Africa—see the chapter by F. Dimmock in this volume.). However, in many places the situation is quite dynamic and fluid, and different observers might describe realities quite differently. To take just one example, the changes that anecdotal evidence suggests may be occurring on health fronts linked to the growth of Pentecostal congregations are poorly understood.

Getting the descriptive facts straight is thus far from a simple challenge. But beyond the basics are the important questions of quality and impact. Is the presumption, often advanced by faith advocates, that faith run care is usually better quality borne out by evidence? How is quality measured? Does a second presumption, that faith linked health reaches the poor better than other systems, hold true? What is the aggregate impact of faith-linked health on its own and of the de facto hybrid systems in operation? Is it making a dent or a difference? How well do the plethora of complex partnerships and hybrid systems involving faith and public systems work? And what does the future of
health systems look like? What could and should be the roles of faith-linked health systems in 10, in 50 years? All these questions beg for investigation and dialogue about the implications of answers.

A common response by global health professionals to those who make a case for a ‘faith sector’ is that what is needed is a neutral approach, which would include faith-inspired work as part of broader civil society. All circumstances being equal, indeed a strategic approach that includes faith organisations but offers them no special treatment makes sense in most circumstances, the more so given how diverse faith work is, and the tensions among competing faith groups that might arise if one was favoured over others. But all things are not equal, and with poor knowledge and inadequate policy instruments and approaches, concerted efforts to understand, appreciate, and engage faith work is much needed in many situations. A better understanding would help dispel myths about general faith-linked health care, help in enhancing the impact of care that is delivered, and ensure that efforts are focused on the best quality services. In some cases, a multi-faith approach may be appropriate to help in reducing competition and overlap and to help also in addressing potential interreligious tensions.

There are thus strong prima facie arguments that more attention is warranted to harnessing the experience of faith-inspired health institutions and approaches, and that more purposeful efforts should be made to engage them more effectively in public health development efforts in poorer countries. That suggests, in the first instance, a ‘seat at the policy table,’ as well as exploring ways to assure adequate funding of high quality work. This engagement can occur at many levels, global to community, but the arguments for local focus are most straightforward and compelling.

Much the same can be said of the roles of faith entities in global health. Historically the World Council of Churches, the Vatican, and many faith inspired organisations have been prime advocates for giving priority to health and to policy approaches geared to poorer communities, like primary health care and response to community needs. While indeed there is growing recognition that religious institutions are important players (witness the example of malaria, discussed below), engagement is still partial and piecemeal.

Faith leaders, institutions, and communities already play significant roles in global health architecture, as advocates for increased support and better quality assistance for health, through their direct engagement in service delivery, and by engaging communities in the social and practical changes that can improve lives. The three, often viewed separately, are linked. The credible witness that faith communities can bring, their communication of moral issues, and the capacity to articulate them, are grounded in experience in communities. ‘Prophetic voice’ on policy is informed by experience with service delivery.
MALARIA AND FAITH – A CASE STUDY

The past two years have seen intensive efforts to engage faith institutions more actively in the renewed global campaign against malaria. Tellingly, President Obama specifically cited malaria and faith in two important 2009 speeches on global issues (in Cairo and in Accra). Malaria, a major killer that was for too long neglected, demands the resources of a coordinated campaign in a ‘big push’ if real progress is to be made towards the ultimate goal of eradication. Malaria also offers a challenge that is eminently feasible: it can be eradicated. It is also one that can be readily communicated to citizens worldwide. Thus a global malaria alliance (Roll Back Malaria) has taken on the challenge of translating promises into practice (Roll Back Malaria Partnership. 2008, WHO 2008b). For similar reasons, the Tony Blair Faiths Foundation, the Center for Interfaith Action on Global Poverty, and WFDD have made interfaith action on malaria a centrepiece for their organisational strategies. The constellations seem to be aligned for action.

What does this focus on faith and interfaith engagement on malaria suggest for the broader issues around faith and health? Above all, it offers examples of the potential force of combining advocacy with service delivery and wisdom about communities. It has helped materially to bring the assets of faith communities to the attention of global leaders. And it shows that the complexities of working with the ‘galaxy’ of institutions can be surmounted with rigorous analytic work, and purposeful efforts to construct appropriate partnership arrangements that build on the comparative advantages of different actors.

Malaria kills nearly one million people per year, almost all in developing countries. For decades, funding levels for malaria prevention and control were manifestly insufficient. A sober assessment of progress in combating the disease, culminating in 2000, suggested that ground was being lost, with resistant strains of malaria underscoring the potentially devastating consequences. A major global campaign was launched, capturing the attention and imagination of a wide range of actors, including health specialists, private business, politicians, and celebrities. Campaign planning also highlighted weaknesses of government health systems in malaria endemic countries. So new kinds of partnership were called for.

It is against this backdrop that a quite unprecedented effort was born to engage faith leaders in the global health campaign to combat malaria. Recognition that health care services funded by or associated with faith-inspired institutions deliver a substantial portion of health care in malaria endemic countries, prompted questions about how to scale up their involvement with global malaria prevention and control campaigns and increase their effectiveness and impact.

In order to help translate this general insight into specifics, Berkley Center and WFDD researchers undertook a review in 2008 exploring
both actual work by faith institutions on malaria, issues arising, and potential areas for action (Marshall & Bohnett 2009). The review involved interviews with some 40 development practitioners from faith-inspired development organisations. The report also reviewed the current malaria funding, research, and policy landscape.

A first finding was a near-total absence of relevant data. There is no precise knowledge about the extent or effectiveness of the development-related services provided by faith-inspired organisations, including those directed to malaria prevention or treatment.

In the interviews, leaders and practitioners stressed that, because of their unique characteristics, faith-inspired healthcare providers are in an advantageous position to deliver malaria-related services and education. They are particularly well-positioned for community-level activities, such as promoting and monitoring net use, encouraging positive sanitary practices, monitoring levels of illness, and preparing for indoor residual spraying campaigns. Kevin Starace, senior malaria advisor for the UN Foundation (which recently initiated a program to scale up the involvement of several U.S.-based faith-inspired development organisations in malaria prevention), highlighted the unique characteristics of faith-inspired organisations:

Three come to mind. One is, they’re usually in places that no one else is; they have extraordinary access to places that others don’t. Two, they usually are responsible for, or can tap into, the most powerful vehicle, which is word of mouth…. Behavior-change communication and marketing and communication are core competencies that NGOs claim to have, but it’s faith-inspired organizations that really have it. That’s a huge advantage, …. Third, is the ability to work together with other faith-inspired organizations; this can enable them to tap into a fairly extensive network. (Interview with Kevin Starace, November 13, 2008.)

Rev. Larry Dean Smith of Saddleback Church—a U.S.-based evangelical church recently engaged by Rwanda’s President Paul Kagame to execute a major program training local pastors on health promotion—said: ‘Just seeing the church as a building is helpful. When you’re thinking about delivering some of these health care messages, you don’t have to go build another building. And you can’t build the network they have.’ (Interview with Larry Dean Smith, November 7, 2008.)

Such observations—highlighting how faith-inspired organisations could potentially strengthen malaria prevention or control campaigns—were a recurrent theme in interviews. Another insight was the real potential for damage control. The Democratic Republic of Congo has the highest number of malaria deaths in the world, and a World Bank funded Ministry of Health (MoH) project aimed to distribute two million long-lasting insecticide-treated nets in the Kinshasa region in September 2008. The majority of nets (1.4 million) were distributed
more or less without incident when progress was disrupted by a politically motivated rumour that the nets were poisoned and would kill their users. Remaining nets were only distributed after the MoH engaged local religious leaders to dispel the rumour in their congregations.

The episode highlighted the importance of the non-commodity aspect of bed-net programs, and thereafter protocols surrounding education about bed-net distributions were reviewed. Before, the Kinshasa program had relied heavily on radio and television advertising. Now, there is a clear appreciation that engaging religious leaders in education about bed-nets is crucial, with hundreds of millions of dollars for malaria control in prospect in the years ahead.

The interviews highlighted the challenges that faith-inspired organisations face in terms of operational capacity. Some faith-inspired organisations, like World Vision and Catholic Relief Services (CRS), operate at the highest levels of the development and relief world. These organisations compete for, and are frequently awarded, large grants from the Global Fund and other major funders. Operationally, they closely resemble major development organisations that do not have faith affiliations. Their interventions are not typically dependent on the infrastructure of faith-based health networks in malaria endemic countries, although they do often establish partnerships with local churches or church-affiliated organisations. However, smaller, faith-inspired development organisations in malaria-endemic countries are less well-equipped than CRS and World Vision. They face capacity constraints, especially where classic administrative skills and systems (pretty straightforward, though far from simple to develop) are concerned. Many faith-inspired healthcare providers lack the organisational capacity that would make them eligible to receive funding from global malaria initiatives. This includes the ability to develop project proposals, to assure proper use of funds, and to monitor and evaluate program progress effectively.

Susan Lassen directs malaria programs for U.S.-based Episcopal Relief and Development, which has extensive health programming in malaria-endemic countries. She cited an analogy used by the Gates Foundation: FBOs are ‘like wheelbarrows trying to get onto the interstate’ so, while it is essential to build better ramps, we also need to ‘upgrade the wheelbarrow.’ Lassen commented that this was a good way to frame the challenge: ‘The global health community wants FBOs involved, but FBOs need to professionalise in some ways if they are going to be full partners.’ Country by country capacity assessments, and focused workshops on priority issues in priority regions, are among the ideas that emerged on how to address capacity shortcomings.

An interesting focus in the recent efforts to engage faith communities on malaria is the emphasis on interfaith approaches. The argument is that interfaith alliances could help in forging common cause among diverse communities, thus strengthening bonds that could extend
to other purposes, at the same time that they assure a broad net of organisations engaged in the campaign. The goal is worthy, and in some situations an interfaith approach makes good sense; indeed, failing to ensure strong bridges among different faith actors could well undermine effective action. The difficulty of working through interfaith mechanisms should not, however, be underestimated.

One such effort, the Interreligious Campaign Against Malaria in Mozambique (ICAMM), suggests that these alliances are hardly simple. Mark Webster, international programs vice president for the Adventist Relief and Development Agency (ADRA), the NGO leading the ICAMM coalition in Mozambique, acknowledged that, ‘We also have been caught short in recognizing that there is virtually no interfaith structure to build on, or that could be replicated from national to provincial and district levels. It has to be built from scratch. …. We are still working out how to support the good will on interfaith, and to help build the structures that are needed to move forward.’ (Interview with Mark Webster, November 2008.)

U.S.-based congregations from a range of faith traditions are participating in multi-million dollar malaria bed-net purchase campaigns. The Gates Foundation launched an initiative in 2008 to engage faith-inspired groups to address malaria through fundraising in the U.S. and malaria prevention programming in malaria-endemic countries. Gabrielle Fitzgerald, of the Gates Foundation, observed that faith-inspired groups are ‘very organized, they have a hierarchical model, and they’re used to giving. … Part of this new partnership is not only that these groups are raising money and becoming advocates, but also this is going to enhance their on-the-ground work.’ (Interview with Gabrielle Fitzgerald, December 1, 2008.)

The Berkley/WFDD malaria review identified significant ways in which faith-inspired institutions could enhance global malaria campaigns. What is called for is not vastly different roles for faith-inspired institutions. Rather, there is ample scope to build on existing capacities and activities, prominent among them education and the provision of basic medical services at the local level. However, there is a strong consensus that action is needed to improve the quality and expand the scope of what faith-inspired actors do, and, still more, to integrate much better their activities into larger networks (while being careful to protect their independence as institutions).

**Ideas on Paths Forward**

National, regional, and global healthcare projects and institutions have significant blind spots on roles of faith-inspired institutions. Gaps in awareness, knowledge, and collaborative work—stemming from lack of good data, habits of mind, and different perspectives on ethical issues—have had important consequences. Recent experience and dialogue
suggests that with an aware leadership, institutional openness to new perspectives on all sides, and recognition of shared commitment to a common goal (such as the MDGs or reducing malaria deaths), these barriers can be overcome.

Possible avenues for action include: (a) supporting purposeful efforts to generate better information on faith-run health programs, assets, and policies, and to integrate this information into health sector planning and implementation at community, national, regional, and global levels; (b) creating dialogue processes that might lift barriers to common action by identifying practical areas for common action and increasing understanding even on areas where there must be ‘agreement to disagree’; and, (c) working from both development policy and faith leadership to set concrete objectives that can be communicated, acted upon, and monitored for enhancing health delivery to poor countries and communities. While there is both need and merit in research and attention at the global level, the most productive avenue may well involve a country focus which translates general principles into specific terms lending themselves to concrete action.

The challenges along the path are significant, because what is required is not a single effort but one that engages a wide array of institutions, people and attitudes. By way of conclusion a comment by Mark Webster of ADRA aptly highlights both the strength of faith assets, the reasons why it is so important to focus on communities, and the cultural gaps in communications that we need to surmount:

The faith picture is far more chaotic and organic than the development industry expects and would like it to be. This is true for all communities and community structures, but perhaps even more so for the faith world. Bureaucracies want order and structure. They also want fast results. Moving faster is likely to be less effective in the long term, seen from the community perspective. It is essential to take into account how communities see realities and their priorities. (Interview with Mark Webster, November 2008.)

REFERENCES


