When Religion and Health Align

Mobilising Religious Health Assets for Transformation

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Changes in International Thinking on Health Care—The Challenge for Religion

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In 1998, I left institutional life for the shaky freedoms of working freelance. My first proper assignment was from Christian Aid, who asked me to do a piece of research called Churches’ Input to Basic Health and Education in Five Countries of Sub-Saharan Africa, the countries being Ghana, Malawi, Kenya, Tanzania and Zimbabwe.

This research sprang from policy questions that Christian Aid and other development agencies were asking at the time. For decades, they had partnered with grassroots NGOs (religious or otherwise) which operated largely outside formal health and education sectors. If they engaged with health at all, it was as a dimension of under-development, poverty, poor governance, lack of education or the economic and social disempowerment of women and children. This was very much in the spirit of the WHO’s Charter of 1946, which redefined health as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’ (WHO 2006:1; an ongoing debate exists about whether or not to include ‘spiritual’), and with the Alma Ata Declaration (WHO 1978), which reaffirmed health as a basic human right, and stressed the need for social and economic sectors to come within the scope of attaining it.

International policy, in those years, was to encourage governments to take responsibility for the delivery of basic health services to their own people, a process that NGOs were in danger of undermining if they attempted to set up ‘alternative’ systems. Further, in the eighties and nineties, the dominant development paradigm was a secular one, slanted towards the assumption that change happened in spite of organised religion rather than because of it. Governments and international organizations shared this mindset, so that official data on health or education in developing countries would routinely fail to document the contribution of religions (see, for example, the UK’s Department for International Development country reports from the mid-1990s).
As part of my preliminary research for the Christian Aid project, I got hold of the U.K. Department for International Development (DFID) country reports for these five countries. Two of them did not mention religion at all, while the Malawi, Ghana and Kenya reports contained one mention each of the heritage of Christian mission. And yet when I arrived in these countries, it was to find that as many as half of all interfaces with health services took place in faith-owned hospitals or clinics, an observation subsequently confirmed in such studies as the Global Health Council/Catholic joint paper of (2006), and the ARHAP/WHO study, Appreciating Assets: The Contribution of Religion to Universal Access in Africa (de Gruchy et al 2006).

When the Christian Aid report was published, we visited DFID to present them with a copy, and to point out the discrepancy between the facts on the ground and their own country reports. Their jaws dropped: ‘Can this be true?’ they said incredulously, ‘Then how come we didn’t know it? If true, then how embarrassing!’

The version of reality presented in the DFID papers was one that was generally accepted at policy-making level. Governments had no incentive to question it; they were often short of resources to run their own services. Also, many organizations rooted in the faith community are strong in poorer, more deprived, often rural areas. This makes them much less visible, less politically influential than the higher-profile government services (which might also be struggling) centred mostly on cities.

It may be helpful, therefore, to see this ambivalence not as ‘the fault’ of one side or another, but as part of the cultural and ideological context of those decades, linked with a certain embarrassment, in a post-colonial era, about the longstanding alliance between colonialism and Christian mission. Both factors contributed to a feeling that Christian organizations, in particular, should keep a low profile while new governments struggled to build national health infrastructures.

In addition, international organizations and governments had concerns about the way faith related organizations operated. It was assumed that their ‘real’ agenda was to proselytise rather than to provide a professional service; or they were suspected of placing faith (or ‘superstition’) before medically approved therapies and diagnoses; or their ‘constructions’ of disease might be morally rather than epidemiologically-based; or they were believed to have a culture of excluding those who are regarded as socially, morally or religiously ‘different’. All these factors contributed to the fear that a religious orientation might be an excuse for religious services to fail in the task of delivering the kind of professionalism that is expected of secular programs.

In Nairobi, in the late nineties, I met the then Director of WHO for East Africa. ‘Churches,’ he said, ‘are a complete nightmare to work with, because they have so many priorities that have nothing to do with health. For example, you rush to get to a meeting, and you sit down, and
silence falls, and then instead of getting on with the agenda somebody says, "Let us pray". I mean.....", he said.

But this is not the full story. In practice, religion had played an important (if under-documented) role in shaping the health ethos and healthcare institutions of the late 20th century. In the late nineties, I was asked to research the history of WCC’s influential Christian Medical Commission (CMC). The Commission had in the 1970s embarked on a structured process of looking at health and health care from a theological and spiritual perspective. The current trend, they said, was for healthcare systems to be linked with the development of high-tech tertiary hospitals offering specialist care to the few. But the urgent need was for person-centred, community-based, low-tech systems of health and healing that would be relevant to the many. In its early documents, the CMC made a powerful case for such a paradigmatic shift in emphasis, which was taken up by the WHO and became the basic philosophical orientation of the primary health care (PHC) movement announced in the Alma Ata Declaration of 1978. It was on this philosophy that WHO based its ground plan for health care for the remainder of the century (Paterson 1998).

In 2008, the WHO celebrated Alma Ata’s 30th anniversary by launching its report, *PHC: Now More than Ever* (WHO 2008). Looking back over the history of PHC, it was clear that despite its strong Christian input, and despite the fact that many religious health organizations did play prophetic roles in developing community-based models of health care, PHC turned out in practice to be an obstinately secular movement; not just because it was wary of organized religion, but because it did not generally recognize the motivational link between health, healing, and the grassroots spirituality of communities and families.

The last five years, though, have seen a paradigm shift in the way religious contributions are evaluated internationally. God, suddenly, is back in the picture. Research (notably by ARHAP) has begun the task of establishing the real extent of religious contributions to health care. Thus, Alma Ata’s 30th birthday provided an opportunity for a re-conceptualisation of PHC in ways that recognize the power of faith, and the potential of organized religion and religion-related social programmes to deliver desired change.

As a result, UN agencies such as UNAIDS, UNICEF, WHO and UNESCO have all been exploring ways in which they can engage more closely with FBOs. This does not necessarily mean they have suddenly seen the light about the value of religion. Rather, it is the fact that additional capacity is urgently needed if the world is to reach targets such as the Millennium Development Goals, or Universal Access by 2020. In addition, there are many places where health services have been weakened by the departure of skilled health professionals for other, wealthier countries. And now it has suddenly dawned on the policy
makers that this extra capacity exists within the long-ignored networks of faith-inspired health assets.

At the launch of the ARHAP WHO report in 2007, Kevin de Cock (2007) said:

Faith-based organizations (FBOs) are a vital part of civil society. Since they provide a substantial proportion of care in developing countries, often reaching vulnerable populations living under adverse conditions, FBOs must be recognized as essential contributors towards universal access efforts.

Of course, he was right. And yet his statement raises further questions. Was it just the quantity of care they provided that made FBOs such ‘essential contributors’? Or was it rather the fact that secular organizations were at some level getting it wrong, that is, they were not being successful in mobilising communities themselves to meet health targets—which in practice is the only way these will ever be met? Perhaps health care delivery cannot be effective unless understandings of health connect with people’s deepest beliefs, their understanding of the meaning of being human in their own contexts, and the meanings implicit in the ‘healthworlds’ they inhabit. What if the time has come to reclaim the concept of ‘spirituality’? What if we were now to re-examine the tendency of international players to treat religion as a problem or source of disharmony?

For the fact is that the majority of the people in this world do have religious faith. Their religious beliefs and practice—though they do sometimes operate as inhibitors of change—are also powerful motivators of human wellbeing and reconciliation. What Kevin de Cock could have said was:

I have become convinced that any movement focused on grassroots meanings of health must take the faith-life of the people seriously. There are messages coming from communities which we need to hear, but to which we in the so-called ‘secular world’ are systemically deaf: that is, either we don’t hear them, we don’t understand the language they are expressed in, or there is no space in our deliberations for them to be articulated.

Well that is what I would have said in his shoes.

We have come a long way, in a short time, but we are not there yet. Being ‘flavour of the month’ is a heart-warming experience, especially after decades out in the cold. But that warm, cosy feeling should not blind a faith group or organization to the urgent and fundamental challenges this new acceptability presents. For the temptation is to allow ourselves to be co-opted into national and international systems, where we provide ‘more of the same’, with whatever is distinctive in our contribution being downgraded to a matter of ‘style’—what the Ugandan theologian Emanuel Katongole calls ‘the post-modern celebration of
difference, which at the same time renders difference ineffectual or inconsequential’ (Katongole 2000:243.)

Now, of course, professional standards should not be watered down. It is ‘value-added’ we are talking about, not ‘value-instead-of’. But I think it is also of huge importance that we do not collaborate in a process by which religion is warmly congratulated for filling the gaps left by others, while allowing its distinctive contribution to be made invisible. The question is: what is that distinctive contribution? It is a question that should be foremost in our minds as we increasingly take our place at the not-so-round tables around which international conversations about health take place.

This is not a question that any person or organization can answer for another. The answer depends on how I see my vocation or you see yours, how I or you or we are called to respond to the particular context in which we find ourselves. ‘The place God calls you to,’ says Frederick Buechner, ‘is the place where your deepest gladness meets the world’s deepest need’ (Buechner 1993:95). Where we find that place depends on who I am (or who we are as a community or organization) and what I/we are called to become. We must be the change we want to see in the world, claimed Gandhi. But Buechner and Gandhi were both clear that the answer, for each of us, will be different, and that arriving at this answer involves a process of loving and systematic discernment.

This came to me forcibly a couple of years back. I was one of a team of consultants who were reviewing HIV and AIDS work supported by a group of Northern mission agencies, with India, Bangladesh, Kenya, and Swaziland as our target countries. We were introduced to some fine examples of orphan-care, education of youth, home-based care and so on. In some cases, leaders started out with little knowledge about AIDS; they were just eager to ‘do something’ if only they could figure out what. Of course the availability of financial support for HIV work also made it attractive; in fact funding for other work might have been dependent on the application including ‘an HIV component’.

So when a local government health service suggested that they might start a voluntary counselling and testing (VCT) centre, or run an antiretroviral distribution service, they took up the suggestion. Here was something that was clearly useful, visible, would benefit the community, and would receive funding. A semi-official status would increase the church’s status in its own environment. It was easy to quantify what had been achieved—even if this was often numbers of people treated at the centre, rather than numbers who were healthy as a result. And the project itself could be kept separate from congregations, thus avoiding the uncomfortable challenge of addressing stigma, discrimination and exclusion at that level.

In the course of this evaluation, we came across a number of such examples. For instance, some of the church-related VCT centres we visited had almost given up on the counselling element because so
few people wanted to be counsellors. Instead, they focussed on the testing service, which was externally funded and easy to monitor. Again, Christian and Muslim groups have made a huge contribution to home-based care, especially in Africa. But on several occasions in the course of this review, we encountered volunteers who were so afraid of the stigma of being associated with people with HIV or AIDS that they did not dare tell neighbours or members of their congregations that they were doing this work.

Further, a great deal was said by leaders about the role of religion in relation to ‘vulnerable populations’; but in the course of this evaluation, we did not see a single African church or FBO which was working with people engaged in commercial sex work or with injecting drug users. Nor did there seem to be any discussion going on about the possibility that there might be individuals in their own congregations who were engaged in transactional sex or other kinds of concurrent sexual relations. I am not suggesting that this is universally true; indeed, I know it is not. What I am saying is that we, as a team, did not find evidence of such work in Africa, among this particular group of faith-inspired partner organizations. We did, however, encounter a number of innovative examples of work with sex workers and substance abusers among the Asian organizations we reviewed.

All these examples raise important questions about the distinctive contributions that faith-inspired organisations can make to the overall response to the HIV pandemic (and by implication to other health-related questions). Naturally, it is not that it is wrong to do testing or to run care programs. But in each of these three cases, it seemed to the evaluation team that the partners had, for understandable reasons, turned away from the really distinctive contribution that their faith orientation might have led them to make, from the place, that is, ‘where our deep gladness meets the world’s deep need’.

In 2008, as a member of Affirm Facilitation Associates, I was asked to write a paper for UNAIDS. It was a background for a consultation between FBOs and international organizations that was designed to develop a strategic approach to greater collaboration on HIV and AIDS (see UNAIDS 2010 for final paper). I kept being told: ‘What you are writing is an FBO paper, not a UN paper. If FBOs don’t learn to use UN concepts and language, they will not be “heard” in UN circles.’ And naturally, I wrote it the way I was asked to; they were paying me, after all. And it is, of course, important to speak in terms which will be heard and understood by ‘all’, or at least the ‘all’ with whom one is currently trying to communicate.

My concern here is that we do not throw out the baby with the bathwater. For with language goes meaning. We do actually have understandings and values to contribute. And we must be careful not to allow these values and meanings to be drowned out in the effort to
make our message fit within the corridors of secular power. Differences of meaning and discourse will not be reconciled by simply ignoring them.

I have been working recently with an urban family medicine programme in Vellore in South India, where they are struggling to implement the kind of revitalised vision of PHC that emerged from Alma Ata’s 30th anniversary. Here, the day-to-day faith of the people, who are mainly Hindu or Muslim, is raising specifically faith-related questions about what constitutes health and enhances life in particular contexts, developing ways of working that chime with the forces of life that exist within actual communities, and communicating them to those who make the policies, rather than the other way round (Paterson, Bhattacharji, John, and Nagarajan 2008). Now many of the issues we face in this regard are common to all religions. However, I am a Christian theologian, I have worked mainly with Christian churches and organizations, and I speak as a Christian. So now, finally, I am going to risk saying what I actually think might be a specifically Christian theological basis for the ‘distinctive contribution’ of the religious sector to health.

First, in Christianity, there is something foundational about the idea of justice—a principle also present in other religions. Issues of unjust distribution, lack of access and the prioritisation of the vulnerable (too easy to overlook in dialogues about health care) are very important contributions we bring to the table.

A second, distinctively religious contribution to healing is a belief in salvation, redemption, reconciliation, and the promise that we are not stuck forever with the consequences of personal or structural sin and failure. This means that we do not need to carry the burden of what has happened to us or what we have done, however dreadful the present circumstances may be, or however much of a mess we feel we have made of our lives.

A third uniquely religious message is the message of God’s love for individual men, women and children, and God’s non-judgemental acceptance of each one of us as we are: a vitally important message for people or communities who feel excluded, rejected, powerless or of no importance.

Fourth, those who claim to be followers of an itinerant carpenter, healer and preacher with a particular commitment to the poor and marginalised, should be careful to see that the institutions they build are biased (like Jesus’ ministry) towards service to the excluded and marginalised, not towards the rich; a conviction also held by other faiths.

Fifth, as people of faith, we live in the eschatological context of a story of hope, where the resurrection is our ultimate truth and not the crucifixion: a truth that puts the experience of sickness, suffering and pain into a much broader perspective, enabling us to see it ‘under the aspect of eternity’ and not merely our own, finite, limited existence.

And finally, love, the greatest of all these contributions. As followers of Christ, we may well be motivated by duty, or fear, or a longing for
fame or fortune. We are, after all, human. But if these are the primary theological justifications for our work, we have missed the point. That driving force must—ultimately—be love, both for God, and for other people. And love, we are told, is the most powerful force on earth. The challenge is summed up by the French philosopher, Teilhard de Chardin (1975:87):

The day will come when, after harnessing the ether, the winds, the tides, gravitation, we shall harness for God the energies of love. And on that day, for the second time in the history of the world, humankind will have discovered fire.

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