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

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
8. Challenges and Possibilities of Religious Health Assets: Charting an Islamic Response to the HIV and AIDS Pandemic 105

Muhammad Khalid Sayed

Introduction 105
Potential Problems of an Orthodox Islamic Response to HIV and AIDS 107
Islamic Marriage and the Risk to Women of Contracting HIV 108
The ‘Islam-centred’ Response by Positive Muslims to HIV and AIDS 110
Islamic Jurisprudence for an Orthodox-Centred Response Effective Against HIV and AIDS 111
Conclusion 116

9. Tough Negotiations: Religion and Sex in Culture and in Human Lives 118

John Blevins

PIRASH Workshops: The Research Findings of a New Methodological Tool 119
Findings from the Workshops 120
Conclusion from the Workshops and Further Questions 122
Christian Theology and Sexuality 123
Religion, Sexuality and Identity 124
Critiquing Modern Power, Grounded in Social Justice 127
Towards Religious Communities with many Sexual Subjects 129

10. On the Pedagogy of HIV and AIDS: Conversations with Indigenes 135

Sepetla Molapo

Introduction 135
On the Pedagogy of HIV and AIDS: A Brief Overview 136
On Definitions of HIV and AIDS: Indigenes as Adherents of the Dominant HIV and AIDS Pedagogy 138
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

Health Assets: Challenges Facing Christian Health
Associations in the Next Decade 178

Frank Dimmock with Tali Cassidy
Introduction 178
Method of CHAs Study 179
Historical Background of CHAs 179
Function, Mandate and Comparative Advantage of CHAs 182
Current and Future Threats 185
Future Steps and Prospects 186
Conclusion 189

14. The Memphis Model: ARHAP Theory Comes to Ground in the Congregational Health Network 193

Teresa Cutts
Introduction 193
The Memphis Landscape 194
Theories and the Logic Model 195
Covenant Committee Design 199
Programme Expansion and Structure 200
Evaluation of CHN 203
Early Mapping Efforts and Data Snapshots 204
Summary and Lessons Learned 206

Section 4
LOOKING BEYOND AND AHEAD

15. Frontiers of Public Health and Social Transformation: Faith at the Table 212

Katherine Marshall
Setting the Scene 212
Caveats and Definitions 214
Navigating Disconnects and Tensions around Religion and Development 215
Trends in International Development, Faith, and Health 220
Faith and Health: Moving towards More Concrete Action 224
Malaria and Faith – A Case Study 228
Ideas on Paths Forward 231

Index 235
If there is a battle of names, some of them asserting that they are like the truth, others contending that they are not, how or by what criterion are we to decide between them? (Socrates in Plato 1937:678)

Considerable difficulties arise in finding appropriate nomenclature to properly depict the huge variety of health-engaged entities that have a religious aspect to their work or character, commonly identified as the ‘religious sector’ or ‘faith community’. This paper explores conflicts around language and power in the naming and definitional battles that occur within the community inquiry at the intersection of religion and public health, and it considers what this might mean for collaborative communication.

It landscapes the myriad ways in which ‘faith-based organisations’ (FBOs) have been named over the last ten years in the context of public health. The intent is not to ratify certain terms, nor produce new ones. Rather, using the results of an extensive literature review and an analysis of the effects of powerful conflicting discourses, I reflect on how far we have come in the battle to understand religious entities (REs), who or what they are and do, and how we relate to or inquire about them. First, I shall briefly map how various terms have emerged and been utilised in the literature on religion and public health in sub-Saharan Africa (SSA). Then follows an exploration of some of the broader empirical realities revealed by this analysis. Finally, I consider some of the consequences, to chart a way forward more conducive to effective collaborative practice.

**Mapping the ‘Faith-Based Organisation’ Landscape**

The last decade has seen a rapidly emerging ‘community of inquiry’ at the intersection of religion and public health. Those researching and collaborating at this intersection face two main obstacles. First, a significant lack of data and systematic information (mainly a result of secularisation and modernisation perspectives that drew academic and
policy-makers’ attention away from ‘the religious’) has left substantial gaps in our baseline knowledge of religious systems and entities (see Olivier 2010; Olivier et al. 2006). Second, significant differences in language and perspectives at the intersection between religion and public health create a major obstacle, resulting in miscommunication, and demands for translation (see Olivier 2010). As Benn notes (2009:16):

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.

The most overt challenge is the struggle over the naming and definition of the entities scattered across the religious-health landscape. Frequently meetings on religion and health include some discussion of the difficulties of finding accurate language to adequately describe various forms of religion or the frameworks needed to inquire about them. Consider this typical statement from a Center for International and Regional Studies symposium report (CIRS, 2008:5):

...the group focused initially on exploring the significance that should be given to the terms and concepts of ‘faith’, ‘faith-based’, and ‘faith-inspired’, and the significance of describing organisations or communities as Muslim or Islamic, or non-denominational or secular... [and was admonished] to pay special attention to vocabulary and especially terms that may be imbued with western framing and historical legacies.... The crux of the issue lies less in how an individual or an organisation defines their ‘faith’ motivations than on how others interpret and assess its significance. The topic is strewn with pitfalls, and virtually all terms and categories are slippery and problematic.

Like battles inherent in adequately defining ‘religion’ or ‘public health’ (see Olivier 2010), the struggle to find the ‘correct’ language to describe REs has been ongoing. On the academic front, there has been little review of the broader terminological landscape, despite clear evidence of scholars wrestling with different sub-categories (see for instance Berger’s exploration of the ‘religious-NGO’ (2003), or Sider & Unruh’s social service ‘FBO’ varieties (2004)). Significant frustration seems to exist with the lack of shared understanding or common agreement (see Olivier et al. 2006:16).

Without any consensus, the trend is for authors to repeatedly redefine the terms they use. The phrase ‘for the purposes of this discussion/paper/report’ appears regularly, and each interpretation shows personal variation in the use and meaning of the terms. Thus Green (2003:1) begins his report by saying that ‘For the purposes of this discussion
the term FBO refers to organisations of varying sizes and bureaucratic complexity.’ His use of ‘FBO’ encompasses a range of disparate entities, including complex hospital systems, congregations involved in community care, grassroots home-based care groups, individual religious leaders, or youth networks.

Many alternate terms, often differently framed, are used interchangeably in the complex, interdisciplinary engagement and increasing attention given to REs working in health from a variety of sources (public health institutions, academia, the development sector, governments, and REs themselves). Thus, in a landscaping literature review of religious health assets in SSA, over three hundred terms could be discerned to describe REs engaged in health (Schmid et al. 2008). While terms such as ‘nongovernmental organisation’ are generally troubled by a lack of definitional consensus (see Martens 2002), the situation is even more severe for REs as a result of the multi-disciplinary and cross-sectoral slicing that has occurred as the field of interest has rapidly emerged.

Currently there is no consensus on the terminology and definition of REs involved in health, though there is some agreement on the need for a term that encompasses all entities with a religious or faith dimension, and that distinguishes them from secular entities. Here I use the term RE as overarching, with other current front runners being ‘faith-based organisation’ (FBO), ‘faith-inspired organisation’ (FIO), and ‘faith-based initiative’ (FBI). ‘FBO’ is to date by far the most utilised term, even if loosely defined, as a WCC report (Lux & Greenaway 2006:4) demonstrates:

The term FBO is used here to describe a broad range of organisations influenced by faith. FBOs include: religious and religion-based organisations and networks; communities belonging to places of religious worship; specialised religious institutions and religious social service agencies; and registered and unregistered nonprofit institutions that have a religious character or mission. They might be small, grassroots organisations with simple structures and limited personnel or large, global institutions with highly sophisticated bureaucracies, wide networks, substantial financial resources, and significant human capacity.

Perhaps UNAIDS promoted the use of this term in recommending, in 1996, that ‘church-based organisation’ be substituted by ‘faith-based organisation’. It currently holds to that position, stating that ‘Faith-based organisation is the term preferred instead of e.g. church, synagogue, mosque or religious organisation, as it is inclusive (non-judgmental about the validity of any expression of faith) and moves away from historical (and typically European) patterns of thought’ (UNAIDS 2008:8).

Institutions such as the World Bank and Georgetown University’s Berkley Center for Religion, Peace and World Affairs have popularised
the other frontrunner, ‘faith-inspired organisation’ or FIO (see Keough & Marshall 2009). ‘Faith-based initiative’ (FBI) is also popular; its etymology is unclear, but it was likely given momentum by the Bush administration’s Center for Faith-Based and Community Initiatives, now renamed the Center for Faith-Based and Neighborhood Partnerships.

The literature evidences two broad concerns. First, some feel that the term ‘faith’ is more inclusive of non-mainstream or formal groups than the term ‘religious’ (Chambré 2001), while others (including many religious studies scholars) feel that ‘religious’ is more inclusive. Second, in development contexts such as Africa, REs are not always constituted as a form of ‘institution’ or ‘organisation’ (see Thomas et al. 2006:12). Further, in contexts where individuals are relevant (e.g. African traditional healers) and many unaffiliated informal groups work in health, the naming and classification of REs by religious affiliation becomes problematic (ARHAP 2006; Liebowitz 2002; Schmid et al. 2008). Hence ARHAP uses the term ‘religious entity’ to point to the wide variety of forms and functions of entities influenced by religion.

Still, these surface-level concerns do not adequately grasp the struggle and negotiation over language and power that the use of various terms demonstrates. Liebowitz’s (2002:4) definition of ‘FBO’ in his frequently cited study on the religious response to HIV and AIDS in Uganda and South Africa shows some of this tension:

In this paper I define ‘faith-based organisations’ to include both places of worship and their members as well as any organisation affiliated with or controlled by these houses of worship .... Throughout the paper I will use the term ‘religious institution’ and ‘religious organisation’ as substitutes for FBO, realising that such terms are not exactly substitutes.

In a later report on the same body of research, Liebowitz (2004) uses ‘FBO’ again. This slipperiness is common among authors who utilise various terminologies in differing pieces of work as theoretical frameworks, or funder and audience requirements, change. ARHAP, for example, has shifted in various reports between religious entity, religious organisation, and faith-based initiative in order adequately to define different aspects of REs under investigation (see ARHAP 2006; Haddad et al. 2008; Schmid et al. 2008; for a further analysis of these shifts, see Olivier 2010).

More striking is the tactic of interchangeably shifting terminology in the same report or article, with little clarity of its different meanings, illustrating the general instability and loss of meaning apparent in the terminology landscape. For example, Family Health International use the term ‘FBO’ in organisational publications (see Sachs 2008), while their website (2009) moves from one term to another:

*Faith-based initiatives* can be pivotal to the success of public health programs .... *Religious institutions* such as churches, mosques, temples,
and synagogues are found in nearly all communities worldwide. Also, in many countries, faith-based institutions are the largest, most stable, and most extensively disbursed nongovernmental organisations. For all of these reasons, it can be extremely helpful to involve faith-based groups in public health initiatives.

Typologies exist for subcategories of these broad-range terms, but again there is currently no consensus or preference in the literature. The World Council of Churches differentiates between faith-related organisations, faith-background organisations, faith-centred organisations and faith-saturated organisations (Doupe 2005). While a recent UNFPA (2008) inter-agency report adopts FBO as the overarching term, its appendix differentiates between religious leaders, faith-inspired NGOs (including faith-inspired networks), and local faith communities. A WCRP-UNICEF report (Foster 2003) has as sub-categories of FBOs: congregation, religious coordinating bodies (RCBs), non-governmental organisations (NGOs), and community-based organisations (CBOs). ARHAP (2006), in its mapping study in Zambia and Lesotho, following the WHO Services Availability Mapping Survey (SAMS) model, provided a detailed multi-level categorisation that differentiates between the type of RE (congregation, clinic, support group), its primary activity, its geographic reach (local up to international), and the time it has been active.

Within the variety of strategies available for differentiating between REs engaged in health (according to criteria such as nature, size, function, formalisation, location or degree of religious involvement), the literature on religion and health in SSA allows us to identify six main subcategories, what I would call the dominant representations, each reflecting six main discourses, none entirely discrete or fully adequate and all tending to overlap with one another:

1) Faith-forming entities: their primary function is the formation of faith or worship, including congregations, churches, local faith or worshipping communities (see ARHAP 2010).

2 Religious leaders: of different religious traditions, groups or institutions.

3) Religious nongovernmental organisations (RNGOs): part of civil society but with a religious character. ‘FBO’ and counterparts are frequently used in this context. Berger (2003:16), reviewing RNGOs, calls them ‘formal organisations whose identity and mission are self-consciously derived from the teachings of one or more religious or spiritual traditions and which operate on a non-profit, independent, voluntary basis to promote and realise collectively articulated ideas about the public good at the national or international level.’ This is the most common meaning given to ‘FBO’ (see Dilger 2009; Haddad et al. 2008).

4) Community-based religious entities: a related, slightly different distinction around the location of REs at community level, analogous to CBOs
or grassroots groups. Sometimes explicitly stated, at other times it is implicit (when FBOs are listed with CBOs as part of civil society, or in the texts from the various US government-civil society initiatives). Thus, both the Bush and the Obama administrations refer to the ‘… development of partnerships with FBOs and CBOs as a key strategy for increasing access to services and building sustainability’ (PEPFAR 2009:1).

5) Networks: emphasising the linking or coordinating character of REs (e.g. diocesan or national religious health associations). A much used term is religious coordinating body: ‘intermediary organisations responsible for supervising and coordinating religious activities of congregations; RCBs may also supervise and support the health work of congregations’ (ARHAP 2011, forthcoming). USAID refers to national faith-based health networks (NFBHNs), as country-level providers of health services, or networks of religious health service providers (see Chand & Patterson 2007).

6) Health facilities: focusing on religious health facilities, usually meaning both standard health facilities (hospitals, clinics, dispensaries), and community-level health initiatives (such as home-based care groups), with much more said about the former than the latter.

When using FBO (or RE) as an overarching term, all such representations are implied together, though still with a lack of consensus in meaning. The most recent example is the UNAIDS Strategic Framework for Partnership with Faith-based Organisations (2009), reporting on the results of an 18-month consultation process reporting on the results of an 18-month consultation process during which terminology was discussed extensively with UNAIDS partners. It uses FBO as the broad term, frequently repeating the phrase, ‘UNAIDS-FBO Partnership’ (ibid:5-7). Yet muddying the waters, the opening pages define partnership as ‘… a structured and ongoing relationship between partners, in this case faith-based organisations and religious groups, to ensure delivery on commitments to universal access within the context of the AIDS response’ (ibid:4, emphasis mine). What, we might wonder, is the difference between an FBO and a religious group? In a lengthy extract worth considering (ibid:4-5), the report lists four subcategories of FBOs:

* Faith-based communities: ... In UNAIDS’ experience, it is possible to distinguish these communities based on the way that they operate, at three main levels: 1. Informal social groups or local faith communities ... 2. Formal worshipping communities with an organised hierarchy and leadership ... 3. Independent faith-influenced non-governmental organisations .... These also include faith-linked networks ....

* Faith-based organisations: ... are defined as faith-influenced non-governmental organisations. They are often structured around development and/or relief service delivery programmes and are sometimes run simultaneously at the national, regional and international levels.
Religious leaders: … are national or global religious leaders who have important roles within faith communities.

Local religious communities: … include informal and formal worshiping communities. Differences from faith-based organisations can be blurred, however, with many local faith communities running HIV-related activities or projects as an integral part of daily life.

This illustrates the conundrum felt by anyone inquiring into religion and health: FBO is used both as an overarching term meant to address every entity with a religious dimension, and to describe different kinds of underlying subcategories. It appears in several different ways: a partner (with religious groups), a subcategory of a faith community, a separate subcategory in its own right, and possibly, a subcategory of local religious community. Complicating things further, faith-influenced nongovernmental organisations (FINGOs?) are included both as a part of faith-based communities if they are ‘independent,’ and possibly as part of a local religious community, although the authors admit that ‘differences from faith-based organisations can be blurred’ (ibid:5). It becomes increasingly difficult to be sure of what is meant by the term and, hence, to discern a precise generalisable statement about FBO responses to health, or to know what conclusions to draw about FBOs.

The UNAIDS document highlights the tensions inherent in the requirement to describe a broad range of religious entities, with the sensitivity their complexity deserves, without having any adequate language or descriptive frameworks to do so. Its typology, despite the considerable effort put into this document, is no more likely to be taken up generally than any other in current circulation, as the authors seem to suspect in writing that ‘Each UNAIDS Co-sponsor may have reasons for its own specific terminology and engagement’ (UNAIDS 2009:5). A particularly telling sentence—given that institutions such as UNAIDS should have definitional power or some authority to name the HIV and AIDS territory and its objects—this concedes that conflicting terminology will be used, even within the UN, and reflects the deep uncertainties that linger.

**Exploring the Terminological Battlefield: Why Does it Matter?**

What are reasons for this ongoing and increasingly complex struggle? Why have no terms, even those formed through collaborative dialogue, struck the collective imagination of the community of inquiry or managed to adequately address the phenomena?

Benn (2003:9) notes that religious entities have recently attracted growing interest: ‘… for decades [they] were at best tolerated but not actively supported. Now there is almost a competition among big secular donors to fund the best programmes’. This increased interest
has significantly added to the number of individuals and institutions inquiring about REs, even as information and knowledge about REs engaged in health is famously incomplete, inconsistent, and lacking any consensus about naming and terminology.

Increased interest has also resulted in more efforts to understand their complexity. As a UNFPA (2008:17) study notes, ‘The world of faith-based actors is multifaceted, including religious leaders, faith-based organisations, local faith communities, religious congregations and religious institutions. It is important that engagement attempts take into account the varied roles and functions of these different actors.’ Those involved in collaboration and inquiry are aware of this diversity, and are attempting to be sensitive to it, as illustrated in the following description: ‘The CORE Initiative brings together key stakeholders, including PLWHA, CBOs and FBOs, nongovernmental organisations (NGOs), private voluntary organisations, and donors to enable holistic programming and excellence in HIV and AIDS prevention, care and support . . . ’ (Doupe 2005:27). This listing, like many others, pointedly includes FBOs as key stakeholders. But despite the conflict and confusion around terms such as ‘FBO’, it has the unintended effect of implying that FBOs are both something specific, and something different from secular organisations when, in fact, we know that any of the types listed could also be religious entities.

Most basically, this twisting diversity in understanding religious entities in health makes any broad scale or longitudinal assessments difficult if not impossible, and undermines effective policy-work (see Schmid et al. 2008, chap. 4). One heated battle over broad conclusions can be seen in a stylistic tradition that has become entrenched in the religion and health literature, namely, the stating of some percentage of religious response to health. For example, the WHO ‘…estimates that faith-based groups provide between 30% and 70% of all health care in Africa’ (UNAIDS 2009:8), a statement that is regularly cited. But in the review of religious health assets in SSA conducted by ARHAP, which attempted to assess and verify the data on which such statements are based, it rapidly became clear that any such claims are severely undermined simply because they are based on varying definitions of what is counted (Schmid et al. 2008:47):

Due to the disparity in the type of information found in organisational and research databases, comparison of data was done through qualitative methods, rather than quantitative compilation of data ... Not only do these statistics vary from source to source, but it is also difficult to determine what measurement criteria statements are based upon, e.g. statements interchangeably define FBOs as a percentage of ‘health provision’, ‘health infrastructure’, ‘health work’, ‘institutional health care’, ‘health systems’, ‘the national health system (NHS)’ or ‘health care’.
The struggle over statistics, actually a battle over naming and terminology, has severe consequences for the community of inquiry at the intersection of religion and public health. It has critical consequences for public health, where percentages are used to argue for, or against, greater support and attention being given to the ‘religious’ sector. These battles reveal more about broad attitudes towards REs than about measured evidence. Said more simply, it is not possible vigorously to argue, with supporting studies, that FBOs have provided any particular percentage of health-care in SSA, since the term FBO is mostly arbitrary and devoid of specific meaning or, like the term ‘care’, has unlimited meaning in different contexts of inquiry.

A Clash of Paradigms and Forms of Evidence

A substantial body of literature sprawled across several disciplines addresses issues of naming and definition, and many scholars have noted the way naming is linked to power. Bourdieu (1991:236) has said that ‘the almost magical power of naming and bringing into existence by virtue of naming’ is one of the most elementary forms of political power. Armstrong & Fontaine (1989:7-8) persuasively argue that, in using language to name (thus order the world), we alter and create perceptions: … we create the phenomena that we name, imperceptibly shaping the objects we see or the experiences we recall … Once chosen, a name suggests permanence, as if it could lay a claim upon the true nature of an object … (and) when we integrate existing names into our own language, we assimilate with them what they imply about the nature of the phenomena named. But acts of naming do not often occur in isolation. Rather, they take place in a social context. We name the parts of our world within an already existing structure of previously named parts where we, too, have already been named … every act of naming must be viewed as exclusionary as well as creative.

Because mapping studies of REs in SSA have pursued these questions, it is helpful to reflect on the mapping process as a framework for this discussion. The most basic way of determining whether an organisation is religious is by looking at its classification in a database or registry. But the name of an RE is rarely a useful signifier in SSA. Many organisations classified in government registries as secular NGOs have religious names, and many organisations registered as religious or faith-based give no indication of that in their name or activities. Besides, such databases rarely exist in SSA and, if they do, rarely do they adequately register REs engaged in health. For example, in Uganda health-providing FBOs are subsumed under the private-not-for-profit sector (see Schmid et al. 2008, chap. 4).

Development nomenclature generally refers to NGOs and CBOs, with the former as a catch-all term that includes FBOs (see Kerkhoven &
Jackson 2005), while there are no clear and unambiguous typologies of religious health facilities in the public health field. Broadly, inquiry into religion and health from a development perspective tends to focus more on RNGOs without addressing health facilities at all (Berger 2003, for example), while a public health perspective is generally more interested in religious health facilities—with obvious overlap.

An interesting trend is for REs to not be mentioned at all, but to be subsumed under civil society, non-governmental organisations, or the private health sector (see Umeh & Ejike 2004). In an ‘orderly’ world, the health sector would consist of precisely named religious health facilities, and civil society would consist of identifiable NGOs and CBOs. However, a contextualised reality is much messier. RNGOs are running ARV programs, and health facilities are providing developmental outreach into communities (see ARHAP 2006; Schmid et al. 2008). This is not scholarly word play. The development and public health sectors are each driven by their own powerful institutions, and power plays a key role in deciding who gets named and supported. In mapping, the power of naming fixes on whose map REs are placed, while REs in turn must decide if it is to their benefit (or detriment) to be mapped.

An example of the consequences can be seen in many national HIV and AIDS strategic policies, which can be ranked on a spectrum based on where they place REs. On the one end are policies that do not mention religion (or associated terms such as faith, spirituality, FBO) at all, though they may be implied. Then follow policies that mention REs only as one among many civil society bodies, REs as part of civil society and religious health facilities as part of the health sector, and—the opposite end of the spectrum—REs as part of a policy to engage with contextualised religion more comprehensively across all sectors (see Olivier 2011). ARHAP research (Haddad et al. 2008) suggests that at the national level, collaboration between REs and governments on the issue of HIV and AIDS is commonly streamed into two parts. The strongest relationship is between the religious health facility networks (such as NFBHNS or Christian Health Associations) and Ministries of Health, the weaker between those REs which are seen as part of civil society and are thereby incorporated, on the governments’ side, into national AIDS commissions, councils or multi-sectoral committees. Being named as a health-facility or an RNGO has direct consequences to such critical issues as representation and access to government and resources.

Several studies show that there is rarely a neat distinction between REs responding medically and those responding socially to HIV and AIDS (see ARHAP 2006, Haddad et al. 2008). Many REs are running programmes that involve ART, or home-based care, but they are regarded as part of a civil society rather than a public health response due to their perceived nature or their name. An RE collaborating with government as part of civil society might be the coordinating network (denominational body) that ‘owns’ the health facilities that are coordinating via another
route. On the other hand, many NFBHNs include members without health facilities that are classified as RNGOs, suggesting that these RNGOs, based on their membership in the NFBHN, would have a better access to government than others.

In her assessment of RNGOs, Berger (2003:19) also notes that ‘academics and practitioners have distinguished between NGOs on the basis of region (e.g., Northern vs. Southern NGOs), representation (e.g., local, regional, international), and mission (e.g., advancement of women, health care, conflict resolution). These categories, however, have failed to grasp an increasingly large contingent of NGOs, which identifies itself in religious terms. Many have sought to reapply these distinctions to REs, but this also does not work easily. For example, in Mali there are few religious health facilities or RNGOs visibly engaged in health, while Zambia is inundated with a complex range of REs (see Schmid et al. 2008). Generalisations about REs across regions are therefore particularly hazardous. Indeed, what is the value of comparing Mali’s (mainly Islamic) forms of community engagement in health with the (mainly Christian) institutions and organisations in Zambia? Does such comparison not lead to questionable statements, such as Mali having a much lower percentage of REs engaged in health than Zambia? Is there an inherent bias against informal and unusual religious forms that are not named (or recognisable as) NGOs or health facilities? Clearly, much depends on what one understands to be an ‘FBO’.

Berger’s North-South categorisation is also made difficult by the diverse transnational and transregional ties among REs, with their unique connections for collaboration, resources, funding or ownership (see Schmid et al. 2008). Geographical representation is another category that does not fit comfortably either with REs who might have a local footprint, a regional network (such as a denomination), and several international connections; nor with international REs who run local programmes represented on regional councils. REs also often work across national boundaries, collaborating in complex regional and transnational networks that fit poorly into national scale assessments (see Haddad et al. 2008).

Finally, mission (in Berger’s sense of the word) is perhaps the most uncomfortable fit for REs; identifying an RE by a specific intentional activity is hazardous. Many, if not most, REs in SSA have broad, holistic portfolios that range across a number of missions. Critically, their primary mission might be religious rather than one recognisable to a development or public health perspective. There are community organisations spontaneously cooperating to run home-based care or orphan and vulnerable children initiatives, faith-forming entities running youth training programs, Muslim communities financially supporting an HIV activity in a government hospital, traditional healers (who might also be Christian pastors) treating people and referring them to government hospitals (see ARHAP 2006; Schmid et al. 2008).
And for all of these, ‘care’ (of whatever flavour) would only be one of many primary activities. Mapping studies also suggest that religious organisations are often fluid in nature, adapting to the needs around them and shifting focus, making it particularly difficult to categorise their type or activities (see Olivier et al. 2006, Schmid et al. 2008).

In sum, the most basic construction upon which the naming enterprise is based is the binary division between religious and secular. The overarching terms described above rest on the idea that different entities can be grouped around a common religious element. Broad-scale definitions usually say something like this: FBOs ‘… [are] formed on the basis of their faith and working, often on social concerns, as a response to their faith’ (Lux & Greenaway 2006:112, emphasis mine).

If one has failed to properly identify REs by their name or classification, the next logical step is to fall back on self-identification. This is often the most problematic tactic of all, there being many entities one would assume to be religious who resist being labelled as such. For example, the Aga Khan Development Network (a large and powerful Islamic hospital system and development agency) states emphatically that it is not an FBO (Schmid et al. 2008; see also http://www.akdn.org/faq.asp). Conversely, other entities one would assume to be secular may insist that they are FBOs: at a workshop on mapping religious health assets in Kampala, a member of the Infectious Disease Institute (IDI) insisted that ‘… we are a faith-based organisation … all organisations in Uganda are faith-based!’ (ARHAP 2007:12). The religious identity of other entities is unclear. They may not identify themselves as an FBO, but they do state a deep religious belief and intentionality that has motivated them to intervene in some activity for health. For example, during mapping in Lesotho, a team member exclaimed that though we might not usually define community support groups as FBOs, ‘… they think they are faith-based!’ (personal notes from research process for ARHAP 2006).

One might seek to assess FBOs by ownership, say, according to which denomination, faith tradition, or coordinating network the entity belongs to. This is also hazardous. For example, Kilembe Mines Hospital in Tanzania is owned by a parastatal body but managed by the Catholic Diocese of Kasese (Schmid et al. 2008). It is in fact common for health programs and facilities to be owned by more than one network or body.

All of this is tied in with a body’s perception of whom and what they are, and with critical issues such as funding or other opportunities available to organisations if they are classified as religious (the PEPFAR funding mechanism being the most obvious example). Conversely, some organisations are reluctant to be named as FBOs for fear of ‘potentially negative connotations associated with religious references as well as legal obstacles that arise when applying for public funding’ (Berger 2003:17). Identification is therefore critically tied to identity, and to resources.
THE POWER IN NAMING

Clearly, the available lenses through which to inquire about REs engaged in health are inadequate to encompass the variety and specific nature of REs. But there is an even greater concern, namely, that dominant paradigms and discourses, including that of secularisation, make the community of inquiry blind to a significant part of the faith community, especially REs that do not fit any of the above schema or frameworks.

Yet mapping REs is both of increasing interest to a number of powerful institutions, and a way of making the invisible visible (see ARHAP 2006). Initial studies have ‘discovered’ the presence of a multitude of REs present and working in health not previously recognised by national and international health institutions, especially smaller community-based religious initiatives often not recognisable as NGOs or health-facilities that are difficult to measure and understand, and vary considerably in different contexts (see ARHAP 2006; Haddad et al. 2008; Schmid et al. 2008). This is a significant ‘hidden sector’, differently described as informal, unorganised, non-mainstream, non-facility based, or community-based (Foster 2003; Schmid et al. 2008). These more difficult to name entities remain secondary to the current mapping impetus, which mainly focuses on large-scale REs that look like NGOs or health facilities (see WHO-CIFA 2009). Not only are they less visible but also, arguably, they fit less comfortably with current nomenclature and definitions on the public health map. Said differently, it is easier to map that which looks like what public health language leads one to expect—primarily, health facilities with a Western biomedical character (see WHO-CIFA 2009).

My suggestion is that these other REs remain hidden or unnamed in a large part because of battles over nomenclature. In a mapping standards meeting in Geneva in 2009, Ted Karpf of the WHO noted that ‘… the truth is, if you are not on the map, then in the eyes of the donor and Member states, you do not exist’ (WHO-CIFA 2009). Being named is the first step to getting on such maps of power. Yet, as this discussion has shown, this is not without its lingering difficulties, particularly for REs that are not immediately recognisable as comparative to secular organisations such as health facilities and NGOs.

Each of the main representations of REs described above describes a way of seeing. Those looking for Western NGOs will tend to see R Ngo s; those looking for secular hospitals and clinics will tend to see religious health facilities; those looking for churches will tend to see mainstream congregations; those looking for formal networks will tend to see denominations and the like. All carry a lingering bias against the ‘informal’ RE embedded in a complex weave of local and regional relationships, and which is only informal in so far is it does not look like what we expect to see. Some REs remain unnamed as they have insufficient power or representation to name themselves, and some
dominant discourses actively work to keep them unnamed and hidden
(for a more in-depth discussion on power and representation in the
‘faith community’ see Olivier 2010).

With public health mapping being used with increasing enthusiasm
(see O’Neill & Meert 2007), the intention to map REs onto global health
maps brings these terminological problems to the surface. Differences in
language or vernacular are not just frustrating issues of communication
or discursive frameworks; they also make the public health mapping of
REs difficult, if not impossible. Basic terminology still requires significant
negotiation.

Naming and mapping brings fears to the surface, specifically the fear
of REs of being dominated by (secular) governments, funders and health
institutions. ARHAP’s mapping studies show that REs have real and
urgent concerns for what might result from being mapped onto global
health maps, about the power relations inherent in such a mapping
process, about ‘whose map’ it is, and what the detrimental effects of being
seen on such maps might be (see ARHAP 2006; Haddad et al. 2008). Yet,
despite a strong tradition of speaking about the relations of power and
mapping in scholarly and developmental work and a growing interest
in participatory mapping and its power implications, the discourse on
mapping REs onto global health maps appears to be largely void of such
considerations (see Chambers 2006; Harley 1988). I have astounded
some by suggesting that we should not take it for granted that REs
automatically see the value in being ‘on the map’ (apart from the obvious
hope of increased funding), quoting the frequent concerns revealed in
our various participatory research settings. A largely positivist culture
towards mapping within global health sees it primarily as a useful tool,
rather than foregrounding the complex implications for those being
mapped, particularly felt among REs who have in recent history mainly
worked in isolation from national and international health efforts.

When asked, representatives of REs show a deep awareness of the
potential hazards of being labelled in a particular way, given that
naming has the potential to destroy, or at least divert a local initiative,
perhaps even the spontaneous caring characteristic of so many REs (see
ARHAP 2006). Chambré (2001) also notes that, in the USA at least,
FBOs become more secularised when they become dependent on public
funds, potentially losing some of their key attributes in the process. We
do not yet know enough about this unnamed religious sector in SSA
to know what effect funding has on it. But we should consider the very
real impact of imposing ill-fitting nomenclature from the outside, of
naming REs in secular categories that fail to grasp their character, and
thus turning these initiatives into something they were not—for ‘to name
is to show, to create, to bring into existence’ (Bourdieu 1989:20). The
battles over nomenclature, generalizing discourses, and the continued
failure to name the hidden religious sector, puts us at risk of losing that
which is valued the most—or of endangering what local communities are trying to protect.

Naming and mapping is not simply a matter of finding the right definition. If REs indeed have particular and unique strengths, such as a preferential option for the poor or a likelihood of working in places where no other organisations are present (see ARHAP 2006), then we critically require strategies that understand and support them in these different activities. Understanding their difference through appropriate and negotiated naming, rather than forcing them into dominant moulds, is the very first step required.

**CONCLUSION: POWER AND RESISTANCE**

While we struggle to assess and understand REs, it must be asked why the religious-secular construction is not being questioned. It still dominates the faith-health agenda, and the primary impact of this discourse is to make the distinction between REs and secular entities seem logical and commonplace, masking an intense struggle beneath the surface. The religious-secular construction is maintained both by secular-modernist discourses that position the religious as ‘Other’ to the secular norm, as well as religious institutions that, for example, might gain opportunity and therefore power from this construction. Moreover, in the midst of advocacy for attention to be paid to the faith community and battles to define and name the FBOs, ought we not to pay attention to the faith factor in ‘secular’ organisations?

So far, I have addressed the way powerful discourses (paradigms) may be impacting on the construction of REs in the current literature. Melkote & Steeves (2001:156) speak of how the objects of development are ‘inserted into implicit (and explicit) typologies which define a-priori what they are …. Third World countries became pliable objects to be manipulated by the development experts.’ Yet, when considering how powerful institutions through their discourses go about naming REs, it is not entirely convincing that they are such pliable objects to be manipulated. As discussed, several attempts have been made to name REs and to apply new typologies. Numerous meetings and consultations have been held in which language and nomenclature have been discussed and argued over. Yet no particular terminology has risen to dominant status, while many common terms are still differently or poorly defined. This suggests that no dominant institution has sufficient authority to name REs. Said differently, various institutions (of religion, development or public health) may have some authority to name REs within their own discourse (though the example of the UNAIDS-FBO Partnership strategy documents throws doubt even on that), but they do not seem to have the power to establish a consensus that holds in collaborative spaces.

Is this because there are conflicting frameworks, or is something else at work? When working to identify and name REs, it does appear that
for every identification there is an outlier that does not fit, and while the hidden transcript (Scott 1991) is always more difficult to decipher, I wonder if this might not be an act of resistance on the part of those being named, represented and inquired about. Perhaps the objects of our gaze are actively resisting ‘our’ efforts to categorise them according to what we think we know? Perhaps many REs, especially those in the hidden religious sector, have some ability, established through decades of being ignored by academic secular and modernist perspectives, which resists our efforts to pigeon-hole them? Perhaps our communication troubles in the community of inquiry are a result of this resistance to the cultural imperialism (of whatever flavour) we have attempted? Perhaps there are (as yet unseen) benefits to remaining unnamed (indefinable, complex and fluid) that we have not considered in our assumptions that all REs aspire to be named, mapped and supported by ‘us’?

The continued battle over finding a broad generic term for REs or a sustained and shared set of subcategories has been unhelpful and has in fact exacerbated the lack of knowledge, continued miscommunication and strained collaboration at the intersection of religion and public health. Still, the battles over naming REs appear to be less about finding the best terminology, and more about ill-fitting and competing paradigms and frameworks, showing the fragility of our knowledge systems and methods of inquiry. Dominant discourses empower stereotyping discourses, they make it difficult to name or know the complexities and varieties within the faith community, and work to keep the hidden religious sector unnamed and underrepresented.

More consultation and new typologies are therefore not likely to result in improved consensus on this matter, as the inherent instability and conflict in the language we use undermines this dialogue. It is certainly necessary for us to gain more information about REs, and to aspire to greater precision in their naming, to forge new terminologies, typologies and hierarchies that can be understood and shared between the different paradigms and perspectives. But in order to do so, we first need to better understand the manner in which discourses and power perpetuate conflict and miscommunication, and undermine meaningful engagement.

It is, however, possible to get caught up in discussions of discourse, complexity and power, and lose sight of the basic motives that drive those working in this community of inquiry between religion and public health. We might therefore conclude by taking the following admonition from Katherine Marshall (2009:1) seriously:

The array of potential for good is enormous …. That’s not to say that all goes smoothly …. intolerance creeps in all too often, and human capacities for tension, squabbling, and self-aggrandisement are too common. Partnering with faith-inspired organisations is rarely easy, partly because they are not contractors at the beck and call of public
authorities, but complex institutions with an array of objectives. But the complexities should never be allowed to drown out the central message: that a vast array of people and institutions are deeply committed to making a better world. Working together, working through the many issues and different perspectives, offers huge potential for good.

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