When Religion and Health Align

Mobilising Religious Health Assets for Transformation

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Participatory Inquiry on the Interface between Religion and Health: What Does it Achieve, and What Not?

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One way the African Religious Health Assets Programme has sought to undertake research into ‘religious health assets’ (RHAs) is through the development of ‘participatory inquiry,’ an approach that in fact combines several ideas in one. The relevant toolset we call ‘Participatory Inquiry into Religious Health Assets, Networks and Agency,’ or PIRHANA. Here we introduce this research strategy, and ask what it does and does not achieve.

This toolset was used first in research done for the World Health Organization (ARHAP 2006) and since in a range of other international settings. Its value has been repeatedly ratified: it is particularly useful for gathering certain kinds of data, and its participatory richness has noteworthy kick-on effects in bringing key actors together around common concerns.

The PIRHANA toolset can readily be turned into mere technique, and used with a purely instrumental purpose; but then its value is reduced and some of its most important and powerful features undermined. It is therefore critical to understand its theoretical foundations and its practical intentionality.

In what follows, we provide some background to the tool, explore the research concerns that led to its development, and examine its theoretical foundations. Then we outline the tool and its logic. Finally, we ask what the tool achieves and what it does not.
AN HISTORICAL OVERVIEW

PIRHANA was initially developed as a swift way of meeting a research task that ARHAP was asked to undertake by the World Health Organisation (WHO): mapping and assessing religious health assets in Zambia and Lesotho, for a scaled up response to HIV and AIDS. ARHAP researchers already knew that RHAs must be understood as both tangible and intangible, and delineated accordingly. Convinced that underestimating intangible assets is a common error that should not again be repeated, we wanted to do more than map the physical, or tangible, assets that religious entities might bring to health.

Moreover, we were interested in these assets not only from the perspective of those who provide health, but also those who seek it. Already existing data on religious entities in health focused overwhelmingly on providers, especially their facilities, such as hospitals, clinics and dispensaries. Data on health seekers was scarce and largely unconnected to provider data. We sought to bridge what in reality is a unity of practice and behaviour in which, for good or ill, provider and seeker are intimately bound up with each other.

We had a relatively short time span to do the work, and a tight budget. We turned, therefore, to the portfolio of exercises from Participatory Rural Appraisal (PRA) methods that de Gruchy was teaching at the time, in dialogue with Paulo Freire’s (1970) thinking about Dialogical Action, using both Kretzmann & McKnight’s (1993) Asset Based Community Development approach and the ideas of Appreciative Inquiry (Elliot 1999).

The first version of PIRHANA emerged in October 2005, to be piloted on the Zambian Copperbelt in November, using a team led by de Gruchy and Matimelo. Significant new ideas resulted, including adding to the mapping of assets an interest in identifying network relationships (in themselves an important kind of asset or capability that often helps explain the capacity of particular entities), and paying attention to what turns assets-at-rest into value, namely, the agency of human beings acting upon those assets. After reviewing of the pilot, the research team and others produced a second edition used in Lesotho and Zambia in early 2006. After further refining, a full manual emerged that included the ‘dos and don’ts’ discovered through the field work, a version of PIRHANA that had matured to the point where it could be shared more widely.

Driven by growing interest in the toolset, PIRHANA was further evaluated and developed for use with several national Christian Health Associations in Africa, the German Institute for Medical Mission (Difäm) in Tübingen, the Infectious Diseases Institute in Kampala, Uganda, and a major city hospital system at Methodist Le Bonheur Healthcare, Memphis, Tennessee. Later, a modified version—PIRHANA-E (‘empowerment’)—designed to be managed by local people without
the need for trained researchers, was used at the hospice in the town of Alice in the Eastern Cape Province of South Africa, with an emphasis on empowerment rather than research. Since then, PIRHANA has been modified in other ways to cope with specific requirements, as in the CHAMP (Community Health Assets Mapping for Partnership) model tested in Memphis and recently (2009) used by the Hospice Palliative Care Association of South Africa at district level.

The PIRHANA toolset, thoughtfully adjusted, seems able to bridge continental and contextual differences, and it has since spread into other contexts with support from ARHAP. Under the right conditions, and with a proper understanding of its deep rationale and theoretical grounds, it can help to make religious health assets visible in multiple and diverse contexts and, more importantly, to generate actionable insights and fruitful connections through its ‘appreciative’ ethos and participatory methodology.

What, then, are its deeper rationale and theoretical grounds?

FOUR KEY IDEAS BEHIND PIRHANA

Four key ideas underlie the PIRHANA toolset, some resting on long experiences of working with marginalised communities (see for example, Germond & de Gruchy 1997, Cochrane 1999), and all refined in ARHAP’s theoretical discussions on RHAs.

The first is a focus on both tangible and intangible assets, many of which lie below the radar of public health practitioners. In seeking to ‘make visible the invisible,’ we began with two assumptions later established through empirical research, namely, that: (a) most national health system inventories or ‘maps’ of health facilities were patchy in respect of religiously based or oriented entities, if they were noted at all; (b) a great many religious health programmes or interventions for prevention, treatment, care and support are unknown officially, both to the relevant leadership of religious institutions and to public health officials.

RHAs are complicated things, varying in time and through space, with a mix of tangible and intangible characteristics. The toolset needed to be as sensitive as possible to this complexity. ARHAP researchers thus developed a RHA matrix to discriminate heuristically between tangible and intangible, proximate (direct) and distal (indirect) RHAs (see ARHAP 2006 or, for a more recent version, Cochrane 2009). This helped us visualise the possible range of assets in the field of health and well-being, and to ask of those that are intangible: ‘What are they, how do we ‘map’ them, and how do they function?’

Standard quantitative research tools might enable us to map tangible assets, but the same tools are usually poor at capturing intangible things and their meaning, as given by those who hold them dear. The latter requires qualitative research approaches as well, usually designed as interviews, focus groups and case studies. We sought, therefore, a toolset
that would, on the one hand, allow ordinary people to share how, in their experience, religion contributes to health and well-being, to give us insights into understanding religion as a health asset from their perspective. On the other hand, the data collected also needed to be quantifiable in some way, and hence, relevant to some kind of mapping that would depict the range of phenomena that make up the field of religious assets for health—a field that would, through this process, be defined more clearly than anything else that has been done to date (for some earlier attempts, see Ausherman 1998, Foster 2003, and Green 2003).

Second, we recognised that religion and health are in practice usually deeply intertwined, an insight captured through the innovative introduction of the concept of a *healthworld* (Germond & Cochrane 2010). This idea articulates how ordinary people, out of a taken-for-granted background store of social knowledge, understand health and healing. Healthworlds are rooted in context and culture. African healthworlds regularly emerge from complex, often hybrid religious foundations (Germond & Molapo 2006). The Cartesian paradigm that defines much Western social science, and the biomedical paradigm that dominates much of its health science, are inevitably insensitive, if not allergic, to such realities and their impact on health behaviour. African healthworlds, thus, are impervious and resistant to the tools and methods usually employed in much social research (besides, perhaps, anthropology). Finding a tool to help us overcome some of these antinomies or antagonisms, one more sensitive to this complex reality in Africa, was thus also important.

Third, ARHAP is committed to the *epistemological privilege of those on the margins*, a claim, resting on perspectives in the sociology of knowledge and hermeneutic philosophy, that those who are on the receiving end of power exercised over them have a privileged position in helping us understand that experience. Mapping RHAs and trying to understand how they function must thus begin, first, with ordinary people in local communities, rather than theorists in universities, leaders of relatively powerful institutions, or policy makers in government. It means paying attention to the wisdom of ordinary people, their healthworlds, the health assets they hold, and the ways in which they leverage these through religious sensibilities to navigate contexts of ill-health, disease, and poverty. That, in turn, requires that any research model aimed at mapping and assessing local religious health assets must include the principle of treating its subjects with respect and dignity.

This, however, is not meant merely to reflect a particular *attitude* to ameliorate an otherwise intrinsically disrespectful (objectifying, instrumentalising) engagement with research subjects. It is a principle to be rooted in the *structure* of the research process itself, best described as the difference between an *empowering* and an *extractive* approach to knowledge, foregrounding the former, avoiding the latter. Any
knowledge gained, then, would in principle need to be as available to participants—the research subjects—as to the research team. An open, transparent, and collaborative research process is a sine qua non of such an approach.

Fourth and finally, it is clearly important that the research provide a strong and persuasive evidence base for public policy, funding priorities, and practical action. Given the human stakes involved in the health crisis in Africa, sloppy or sentimental research to try to prove a point about religion, assets or a particular way of seeing the world is out of place. We wanted a research method and set of tools that would provide some evidence for what has otherwise largely been anecdotal and intuitive information about religious health assets, working on the key hypothesis—a pretty reasonable one—that religion is ubiquitous in the African search for health and healing, and that RHAs are necessary elements in the struggle for health and well-being in Africa. Thus was PIRHANA born.

THE THEORETICAL FOUNDATIONS OF PIRHANA

Each term in PIRHANA (participatory inquiry, religious health assets, networks, and agency) points to a significant theoretical element framing the toolset, first articulated by de Gruchy (2003). If PIRHANA has a theoretical ‘parent’, it would be Paulo Freire’s (1970) understanding of ‘dialogical action.’ Inspiring a generation of people working with those on the margins, dialogical action highlighted the importance of the agency of the poor, the marginalised, or ‘the oppressed’, insisting that teachers (by implication, researchers, academics, activists) respect the capacity of the poor to act in their own right in their struggle for full humanity. This vision and spirit also motivates PIRHANA.

A foregrounding of agency is matched by attentiveness to the assets of the poor, an idea derived from the Asset Based Community Development theory of Kretzmann & McKnight (1993). The theory insists that one cannot build a community on what people do not have. It counters a deficit or needs based approach, which focuses on people’s problems and insufficiencies. To take the agency of ordinary citizens seriously means to work with what they have or know—their ‘assets’—rather than what they lack, at least as one’s basic starting point. These assets include individual gifts and talents, associations, institutions, economic structures and natural resources. The Sustainable Livelihoods Framework also echoes this sensibility in recognising that poor households have a ‘portfolio of possible assets’ from which they can draw for designing livelihood strategies in any given ‘vulnerability context’ (Chambers & Conway 1991, Knutson 2006, Scoones 1998).

PIRHANA is similarly designed to identify assets, in this case religious health assets. Needs will invariably emerge, but the toolset is not designed, in the first instance, for identifying problems and needs.
One key way in which religion is an asset for health is in the networks and ties it represents, commonly called ‘social capital’ (Cochrane 2003, Lin 2001, Smidt 2003). So PIRHANA also aims at identifying networks and pertinent, non-redundant relationships (a redundant relationship being one that links more than one person to the same external body, which carries less social capital than single relationships to multiple other bodies).

PIRHANA also draws on Appreciative Inquiry (AI), an approach to organisational development and community transformation that defines the ‘energy for change’ as located in people’s experience of past successes, linked to current aspirations or dreams of the future (Elliot 1999). Appreciative research crucially means that researchers or facilitators recognise that they are treading on holy ground as they explore the wisdom of people (say, about religion and health). AI adopts the heliotropic principle, where organisations, like plants, ‘move toward what gives them life and energy’ (Elliot 1999: 43), focusing on the good rather than belabouring the bad.

In health, this echoes the idea of salutogenesis stimulated by the work of Aaron Antonovsky (1979, 1987). Here we point to a body of theory focused on what causes life where one would otherwise expect death (see Gunderson & Pray, 2006). While understanding the negative side of religion is necessary to an adequate analysis, the theory emphasises that if we focus primarily on the negative, deficient, threatening or debilitating dimensions of reality, we fail to give attention to the critical capabilities by which people live rather than die. Focusing on what works to promote health is thus part of PIRHANA’s use of an asset-based and appreciative inquiry approach to research.

PIRHANA is centrally a participatory approach. Drawing on other relevant research and action methodologies such as Participatory Rural Appraisal (PRA) to define a range of exercises that enable community members to express their concerns and share their wisdom about their lives, while giving them ownership of that information and an ability to act upon it, the toolset thus includes the following:

i. **Participatory mapping** – participants map their communities, identifying the existing social and religious entities

ii. **Participatory diagramming** – participants produce diagrams of the relationships between religious and health entities

iii. **Participatory indexing** – participants create their own collective definitions of key factors to do with religion, health and well-being

iv. **Participatory ranking** – participants rank the relative strengths and weaknesses of the religious contribution to health and well-being

These exercises are broadly designed to elicit the following information:

a. **Increased understanding** of religion and religious entities, as religious health assets, in the local area/context
b. **Perceived strengths** of the assets
c. **Ties and connections** between identified assets
d. **Changes** of scale, order or character taking place among the assets
e. **Capacity challenges** in relation to the community at large
f. **Actual use** of the assets by people on the ground
g. **Deeper dynamics** in the choices people make about religious health assets as a crucial contribution to understanding what maps at a more general level mean in practice, especially in local communities where policies must be implemented (here we speak of *maps needing to be verified by the people who live on them!*).

Crucially, the model is not primarily about a series of exercises. These must be framed within the approach of dialogical action, requiring a dialogical relationship with the research subjects, and include the following principles (Chambers, 1992):

*Facilitating—they do it:* facilitating investigation, analysis, presentation and learning by people themselves so that they present and own the outcomes, and learn. It means ‘handing over the stick’ (or pen or chalk)—while an outsider might start a process, she or he then sits back or walks away, without interviewing or interrupting.

*Self-critical awareness and responsibility:* facilitators continuously examine their behaviour and try to do better. This includes embracing error—welcoming error as an opportunity to do better—and accepting personal responsibility for judgements made at all times, without vesting responsibility in a manual or a rigid set of rules.

*Sharing:* of information and ideas between participants, between them and facilitators, and between different facilitators; sharing field camps, training and experiences between different organisations.

These various theoretical strands are congruent with one another. All emphasise a research and practice paradigm that stands somewhat against the many standard, reigning models and methods that are expert driven, top down, based on needs or deficits, externally or exogenously determined (even if ‘subjects’ are ‘consulted’), and empiricist. Such ‘standard’ models and methods do have value within limits, but those limits have shown themselves to be considerable as development practices or interventions based upon them continue to fail.

Heron & Reason (1997; see also Reason, 1994) also speak of a participative or participatory inquiry paradigm, built on a very similar set of foundations. Attentiveness to religion and religious experience is missing in their work, though it is not hostile to religion. As with our own approach, all such theories reflect an awareness of power in relation to knowledge and seek to take into account the (asymmetric) power dynamics that lie at the heart of research on human subjects. The PIRHANA toolset requires a high level of awareness of these issues, specifically on the part
of the researchers or facilitators, including the fact that they themselves, by virtue of their training and perceived authority in their research or facilitation engagement, invariably introduce asymmetric power relations.

PIRHANA is thus clearly misused if it is understood merely as a set of technical exercises or methods for gathering data. It will fail, in the hands of whoever uses it mechanically, either to generate reliable data or to achieve much for those who are asked to participate in its exercises. ARHAP will not vouch for it under those circumstances. The PIRHANA process should thus only be conducted by those who understand its foundations and have received training in its approach.

AN OVERVIEW OF THE PIRHANA TOOL

We can now introduce the toolset itself (for the full manual, see www.arhap.uct.ac.za). At its heart is a one-day workshop. This is not a stand-alone, in-out event, but crucially, the midpoint in a significantly longer and more extensive participatory research and empowerment process. There are three steps to this process: (1) preparing the workshop, (2) running the workshop, and (3) valuing the workshop.

We begin by making some important statements about steps one and three. The first step, the *sine qua non* of all that follows, is vital. It establishes the appreciative milieu within which the workshop will take place, and it helps identify the participants in the workshop through stratified purposive sampling, which should include people from religious and health environments. The third step is no less crucial for long term impact, being necessary to both facilitators/researchers and participants in building on the knowledge that has emerged, and making use of it in ways (not predetermined) that emerge in the engagement. Valuing the results and experience of the workshop itself should not be confused with evaluating it, a wholly different interest with a different purpose.

PIRHANA is designed a little differently for participants at two different levels of inquiry, namely, (i) health providers, and (ii) health seekers. For a full picture of a local or regional setting, it is best to undertake research at both levels. There is an important reason for this difference.

Regarding providers, we know that religion motivates some people to offer health care, and that they do so in various ways either individually or through organisations. PIRHANA helps identify and understand the kinds of work done, and the relationships and activities, central to this work. Health here is understood very broadly: a pastor or community activist could be understood as a health provider.

Regarding health seekers, we know that religion, broadly defined, widely shapes the way that ordinary people engage in the search for health and well-being. We are interested in how they understand the
relationship between religion and health, which religious people, groups and institutions they consider to be ‘strong assets,’ and why.

In the one-day workshop, the PIRHANA toolset exercises have a logical flow to them, with an integrity that must be respected. Here we look at the logic at each level.

The logic of the Health Seeker Workshop

1. **Step 1: Contextual considerations.** The exercises begin with a deliberate focus on context. Prior to the workshops the research team is led, by key informants, on a focused community orientation walk (also called a transect walk) through a section of the community. In the workshops, participants draw community maps (Exercise 1) on which they identify key religious and social entities and facilities in their community. From insights gained through the transect walk and other preparatory work, the research team are able to dialogue with community members about the context. Information from the maps is used in Exercise 3.

2. **Step 2: Health and well-being within the community context.** Having engaged in conversation about their context, participants are asked in Exercise 2 to identify key factors that (i) contribute to and (ii) undermine health and well-being in the community. These two sets of factors are then integrated, through participatory discussion, by generating a group-identified health and well-being index. The index provides a self-defined picture of what the members of the community perceive to be their key health issues.

3. **Step 3: The contribution of community facilities to community health and well-being.** Exercise 3 combines some of the key social facilities (including religious entities) identified in the maps of Exercise 1 with key factors contributing to health and well-being from Exercise 2. The combination produces a facility/health ranking matrix (x-/y-axes). This two-dimensional tool enables participants to rank the relative contribution of key community facilities against group-identified factors contributing to health and well-being. The result is a picture of the relative contribution of different religious entities to health and well-being.

4. **Step 4: The contribution of religion to health and well-being.** Exercise 4 moves the focus to the perceived contribution of religion to health and well-being. In a participatory process, a religion and health index is created. Factors identified are then synthesised and prioritised, in participatory discussion, into a group-identified set of key religious factors for health, based on joint experiences. The discussion functions as a deliberative, reflexive processing of the participants’ knowledge.
5. **Step 5: The relative contribution of religious entities to health and well-being.** This step mirrors the facility/health ranking matrix (Exercise 3). It links religious entities identified in the transect walk and the community maps (Exercise 1) with the synthesised key religious factors of Exercise 4. In doing so, participants rank the relative contribution of religious entities to the group-identified religious factors. This leads to the creation of a health/religious entity ranking matrix (again x-/y-axes).

6. **Step 6: Identification of exemplar REs and their characteristics.** The previous exercises include a great deal of intensive discussion in small groups and in plenary, so participants are strongly immersed in thinking about the contribution of religion and religious entities to health and well-being, and to the language of Religious Health Assets. By now, a fairly substantial body of data, judgement and communicatively developed opinion is on the table, which feeds into Exercise 6. Here, participants are invited to identify the best examples of Religious Entities contributing to health in their community, and to debate and clarify why these were chosen. The substance is captured to provide a set of group-identified characteristics of exemplar RHAs.

7. **Step 7: Local action.** As a respectful and appreciative research tool, PIRHANA does not end simply by extracting data for the purposes of the research team. Throughout the workshop, participants are also accessing all information acquired by the research team. So the workshop ends with intentional time for participants to talk amongst themselves about what they would like to do with the information they have generated (which usually creates greater awareness of each other’s work and orientation, often, indeed, a first encounter between people who live in the same place doing similar things), and whether they wish to make any local commitment to taking forward the process.

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**The Logic of the Health Provider Workshop**

1. **Step 1: Considerations of context: ‘time.’** The health provider workshop begins with a timeline (visibly inscribed in large scale, often on newsprint, varying from several years to decades depending on context) on which participants inscribe events to do with religion and health in their wider socio-political context. This is important because assets, networks and agency, existing in time, are always in flux in response to changing circumstances. The timeline exercise allows participants and the research team to reflect on the causes and effects of certain events and their wider relationships. It also enables participants to reflect on the wider constraints in which the struggle for health and well-being takes place. In the discussion, the ‘spaces’ in which health and well-being is sought in the community are also brought into focus.
2. **Step 2: The contribution of religious entities to health in the community.** Here participants introduce their organisation by identifying its particular contributions to health care in five possible areas: prevention, treatment, care, support, and other. This also helps to identify those organisations not present in the workshop that are nevertheless significant for community health and well-being, usually known to someone present. In the discussion, the contribution of religious entities to health is identified and examined.

3. **Step 3: The contribution of religion to health and well-being.** Drawing on the practical ways in which organisations contribute to health noted in step 2, the next exercise shifts the focus to the perceived contribution of religion to health and well-being. Again, through a participatory process, a religion and health index is created. Indexed factors are synthesised and prioritised through participatory discussion into a group-identified set of key religious factors. In this process, the concept of Religious Health Assets is introduced.

4. **Step 4: Considerations of context: ‘space.’** The health provider-level workshops would also have begun with a community orientation walk or drive around key areas in the region. In the workshop itself, participants undertake a series of exercises that raise contextual matters to the fore. Particularly important is the mapping exercise in which participants use actual maps of the region and the town, provided by the researchers, to identify the presence of health-related entities (both general and religious). This helps to gain a sense of the scale and scope of these entities in the community.

5. **Step 5: RHAs and their relationships.** Through the timeline and mapping exercises, a range of significant religious entities and other health facilities now have been identified. These are used in a spidergram exercise in which participants map the relationships among the entities, enabling them and the researchers to identify the nature, scope and density of these relationships.

6. **Step 6: Characteristics of good practice.** With the data and information from the previous exercises at hand (and fresh in their minds), participants are now asked to identify the characteristics of good practice, and any particular exemplars of this in their community.

7. **Step 7: Local action.** As a respectful and appreciative research tool, PIRHANA does not end with the research team walking away with the data for its own purposes. Throughout all information acquired is being accessed by the participants too. Thus, the workshop ends with intentional time for participants to talk amongst themselves about what they would like to do with the information that they have generated, and to plan any appropriate local action to take forward
the process. At the provider level, it is even more likely that people or groups with similar agendas and concerns who have not previously known of or encountered each other are brought into potentially fruitful relationship.

**Technical Research Matters**

The PIRHANA process depends upon what is done before—preparing for them—and what is done after—valuing them. Understood thus, the total research process has five key objectives.

*Overall Objectives*

The first objective, key to its participatory approach, is to highlight and make visible the knowledge, wisdom and information that belongs, in the first instance (and primarily), to the local community—the participants themselves and their constituencies. This is crucial to empowering the agency of local communities for action and advocacy towards health and well-being.

The second objective is to make Religious Health Assets visible to policy makers in both public health and religious institutions. The participatory process examines and ‘maps’ a range of religious entities that contribute to health and well-being, providing important information for those involved in health planning.

Third, especially if information is drawn from a number of linked, cross-site workshops, the PIRHANA process aims to generate ‘leadership engagement.’ The data can be utilised by leaders in religion and health to leverage existing Religious Health Assets in new, exciting and more productive ways.


Finally, PIRHANA contributes directly to a wider aim, viz. (www.arhap.uct.ac.za):

… to develop a systematic knowledge base of religious health assets (RHAs) in Sub-Saharan Africa to align and enhance the work of religious health leaders, public policy decision-makers and other health workers in their collaborative efforts to meet the challenge of disease such as HIV/AIDS, and to promote sustainable health, especially for those who live in poverty or under marginal conditions.

*Nature of the Research Data*

PIRHANA-based research is an empirical study driven by a participatory, inductive and non-extractive approach. It impacts upon the generation of data in three ways.
First, discourses about religion and health are largely generated ‘from below’ as participants reflect upon these issues in their own context. One might introduce a question about specific topics—TB, AIDS, violence, say—but great care is needed to avoid turning the workshops into interview sessions.

Second, the generation of research data will be uneven across different sites. Using group-identified factors in the exercises generates data that is highly context-specific. While this has obvious weaknesses for quantitative research purposes, considered as a whole it has the extraordinary strength that it offers extensive, relevant data across multiple sites to enable a larger and deeper picture of a particular region or country. Given the limited state of knowledge about RHAs, this is significant.

Finally, the emphasis on participation at both content and process levels means, at times, that particular participants can take hold of discussions, steering them to the detriment of others, or in ways that undo the purpose of the process. Keeping a hand on this requires the research team to both (i) exercise sensitive respect for the participants and (ii) pay attention to the stated research goals. Tensions between these two objectives do arise, and how one handles them affects the nature of the research findings.

Clearly, the PIRHANA exercises are designed to uncover the perceptions of participants about the relationship between religion and religious entities, on the one hand, and health, healing and well-being on the other. This happens in a public manner, that is, in a discursive context of sharing, debate and open (controlled, friendly) interrogation. It opens up a possible charge that the data is anecdotal or highly idiosyncratic rather than reliable. It is thus important to think about the quality of the data that emerges. Our reflections on the process in action suggest that the data can be characterised as follows.

(a) **It is qualitative data.** ‘Perception’ is the key word. It is important that researchers are aware that they are not getting cold, objective ‘truth.’ PIRHANA primarily produces qualitative data, as it deals largely with the opinions of those who happen to be present in the workshops. Qualitative data, properly controlled, is of course not lacking in value or use. However, PIRHANA actually goes further than this in significant ways.

(b) **It is quantitative data.** The structure of many participatory exercises in PIRHANA means that perceptions are in fact quantified, repeatedly so, with the results that are tested through further debate *in situ*, adding a layer of verification through a process of communicative action that goes beyond individual opinion. Most exercises generate quantitative data in the form of lists and rankings that enable some comparison and contrast across sites, and a growing understanding of religious health assets in Africa.
(c) **It is transparent data.** One exciting thing about a participatory approach to data collection is its relatively transparent character. The perceptions of participants, as noted, are dealt with in an openly peer-reviewed manner, where they can be tested and moderated. Subject to open public scrutiny, this helps to ensure that PIRHANA identifies ‘common knowledge,’ shared by those on the ground rather than the opinions of isolated individuals.

(d) **It is democratic data.** The PIRHANA exercises are generally designed to ensure the democratic participation of each participant. In most exercises, each person has the same ‘power’ to share ideas and insights, though powerful individuals can dominate. While the exercises are carefully designed to avoid this, gender, age and other discrepancies are never absent. Facilitators need to be aware of these at all times.

(e) **It is interpreted data.** A further exciting element is the public nature of the exercises, which make it easy to move from the data itself to the interpretation of the data. As outsiders, researchers are not left in the dark about what the data means, but can test it immediately with participants. Such (appreciative) interpretative interrogation often also leads to open, usually energetic conversation.

(f) **It is appreciated data.** The beauty of PIRHANA is that wisdom and knowledge that is taken for granted (seldom overtly articulated, functioning as background knowledge) by participants is exteriorised via the exercises, and presented in visual manner, through mechanisms such as time-lines, indices, ranking matrices, and spidergrams. Once available in ‘objective’ or overt form, it can be explored in detail. Participants see and experience their opinions and perceptions being appreciated and taken seriously.

(g) **It is empowering data.** Because the data that emerges in the workshops is open, transparent and public, it belongs to the group in an immediate and obvious way, and the appreciative approach enables communities to recognise and acknowledge the wisdom and capacity—the intangible assets—that they have. The workshops always end with an exercise focused on ‘local commitment.’ This reminds us that the first aim of the tool is to empower the agency of local communities in action and advocacy for health and well-being.

**What Does Participatory Inquiry Achieve and What Not?**

Having introduced participatory inquiry and the PIRHANA toolset, we consider the question at the heart of the paper: what does it achieve, and what not? Here we sketch some preliminary answers by way of three themes.
**PIRHANA and its Validity Claims**

In his theory of communicative action, Jürgen Habermas (1984, 1987) suggests that a rational and normative account of the good in social life can be attained through an understanding of the conditions under which communication is intended and expected to be valid for all. This he calls the ‘ideal speech situation,’ which posits four criteria for validity claims: truth, rightness, sincerity and comprehensibility (later he would speak of three, comprehensibility being a requirement of communication rather than a validity claim itself). Concerned about a theory of truth that would enable action towards justice and the good life, he is interested in the relationship between power, theory and action (or praxis).

Similarly, we regard the research approach of PIRHANA to be one that seeks to do valid research within the framework of communicative competence and communicative action. The extent to which it achieves this aim, by virtue of its participatory and appreciative approach, can be monitored, measured, and enhanced.

**PIRHANA Explores the Truth, but not the Whole Truth**

The toolset would fail the courtroom oath to ‘speak the truth, the whole truth and nothing but the truth.’ PIRHANA offers vital insights into RHAs, but it cannot provide ‘the whole truth.’ It deals, after all, with a complex, turbulent terrain, and with entities that are always in motion and never entirely discoverable. It is one research method amongst others with long and honourable pedigrees, and should be used in concert with them. It seeks to get to the ‘heart of the matter’ on at least six key issues (identified earlier as steps 1-6), in an intensive and systematic way. This is its strength. However, it is not designed to explore any one of these issues in ‘complete’ detail, for which one would need a range of other research tools matched to PIRHANA.

Indeed, the participatory method of research itself has limitations, as Schönhuth (2002: 152) makes clear in his comments on ethnographic methods and participatory knowledge:

> From my experience, if used in a culturally suitable way, visualizing tools can be extraordinarily useful for the outsider as a means of gaining a quick picture of the local situation and people. Far from being objective, these pictures provide an excellent basis and act as a catalyst for elucidating discussions on local features, local knowledge and local views of reality within homogeneous groups, and between different groups. But as these visualisations are process results, highly situational and context specific, they require interpretation and explanation by knowledgeable experts (i.e. local people and members of the facilitating team). Many participatory approaches such as GRAAP DELTA, SWAP, PRA and others make strong use of the visual principle. Ranking, mapping and modelling draw their theoretical value, among others, from the ‘projective’ element contained in the
visuualisation. The strength of these projective methods depends on weak pre-structuring by the facilitator. However, because of this loose pre-structuring, projective methods need experience, training and theoretical knowledge to be interpreted correctly—a sort of expertise refuted by its proponents in the participatory development context (‘everyone can do it’) but at the same time often very easily missed by participants of RRA/PRA trainings.

This wider interpretive and analytical work requires a theoretical and conceptual ability that cannot normally be expected of local citizens, which is offered by people in the academy. Finding the congruence between participatory research and other ‘ways of knowing’ thus remains a challenge for us all.

**Participatory Inquiry and Action**

A central claim of participatory action research is that its research findings are owned locally and thus able to empower local citizens to undertake local action for change.

The ultimate goal of a collaborative relationship between researchers and participants is structured transformation for the improvement, over a broad front, of the lives of those involved. The outcome of a successful process is not merely a better understanding of a problem, nor even successful action to eliminate it, but raised awareness in people of their abilities and resources to mobilise for social action generally, for empowerment (Bhana 2006: 438).

The development of the PIRHANA toolset rests on such a vision. It seeks to enable discoveries about assets, networks and agency to generate information that can empower local people. The extent to which this actually occurs remains somewhat uncertain. Unable to follow it up, and though we know that the work undertaken for the World Health Organisation has resulted in a few encouraging instances in beneficial new relationships and initiatives, it is quite possible that things return to ‘normal’ soon after the workshop.

It is thus vital for the research to be grounded in the vision and goals of an implementing agency. The WHO, for example, is not that sort of local agency. PIRHANA may thus best be used where there is a partner organisation, agency, or entity rooted in the community that ‘invites’ the research, thus ensuring ongoing energy for the task once the research team has moved on. Such bodies with which we have worked include the Infectious Diseases Institute in Kampa, the Christian Health Associations in Ghana, Kenya, and Malawi, the provincial Department of Social Welfare in Pietermaritzburg, the Hospice Palliative Care Association of South Africa, the Center of Excellence in Faith and Health at Methodist Le Bonheur Healthcare in Memphis, and local health authorities in Atlanta.

How these relationships play out in the PIRHANA process will be a new frontier to explore and monitor, and no doubt, much will be
learned about RHAs and participatory inquiry. Taking this work forward into action, however, could imply that local people are not able to ‘act’ without some outside agency prompting, nurturing and (probably) funding them. We need to be constantly reminded of a central tenet of Asset Based Community Development: that outside assistance is very important, but that there is a world of difference between connecting that assistance to local problems, and connecting it to local assets. The latter strategy is the key to PIRHANA.

CONCLUSION

Early on in the life of ARHAP, Gary Gunderson spoke about ARHAP’s work as a ‘bounded field of unknowing’ on the interface between religion and public health. We knew what the boundaries were, but had little sense of what lay within them. Over the past years, ARHAP has uncovered some of the elements within those boundaries, and we are learning to speak about them with some degree of ‘knowingness.’ While PIRHANA is not the only way we have begun to ‘know,’ it has been a key element in that process.

At the same time, we have not just been learning about the content of the research, namely RHAs, but we have been on a journey to discover the process of researching them. PIRHANA is thus both a tool to uncover data, and in itself, an important focus of reflection and examination. We still have much to learn, and we look forward to the journey.

REFERENCES


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