In Search of Common Ground for Interdisciplinary Collaboration and Communication: Mapping the Cultural Politics of Religion and HIV/AIDS in Sub-Saharan Africa

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This thesis is dedicated in memory of Steve de Gruchy, a colleague, teacher and friend, whose laughter and adventurous spirit will be sorely missed, but whose inspiration lives strong.

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Abstract

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Jill Olivier - February 2010

The term interdisciplinary has come into its own in the HIV/AIDS arena. The recognition of HIV/AIDS as a multiplex disease, complexly embedded in the social paradigm has resulted in many calls for interdisciplinary research, and the professionals directly involved in the HIV/AIDS epidemic are also increasingly being pushed into an encounter with each other.

There has also been a substantial increase of attention on religion and religious organisations and their potential for increased intervention in HIV/AIDS. Yet despite more frequent meetings of religious and health professionals, scholars and practitioners, and a stated common purpose, these meetings are more frequently the scene of tension, irritation, miscommunication and resulting breakdown in cooperation and collaboration.

Despite more frequent cases of interdisciplinary research and interdisciplinary research collaboration – there is still surprisingly little analysis of interdisciplinarity in this context, as a methodology or practice. Scholars and practitioners have difficulty in communicating across the disciplinary boundaries that shape religion or public health, themselves shaped by different embodiments of practice, where conflict and contestation, misalignment and contrary ways of working hinder the cooperation and communication necessary to strengthen health systems that are often in crisis or collapsing.

This exploratory study applies a cultural studies and interdisciplinary approach to the discourses that emerge in the discursive gap at the interface of religion and public health, a gap most readily seen in the context of HIV/AIDS and in literature addressing sub-Saharan Africa. The combination of the different, often divergent discursive frameworks of religion and public health, and the idea of the linguistic construction of HIV/AIDS, prompts this theoretical response. The empirical data for developing these theoretical judgements are based on personal involvement in the African Religious Health Assets Programme (ARHAP), an international, multi-institutional research collaborative that is focused on the intersection between religion and public health.

This communication gap between religion and public health has significant implications for the intended recipients of health interventions, and this study provides both reflection and recommendation to improve interdisciplinary communication and practice in this context.

Contents

Selected Acronyms and Abbreviations

ABC	abstinence, be faithful and use condoms
AIC	African initiated church; African independent church
AIDS	acquired immune deficiency syndrome
ARHAP	African Religious Health Assets Programme
ART	antiretroviral therapy
ARV	antiretroviral treatment
ASO	AIDS service organisation
CADRE	Centre for AIDS Development, Research and Evaluation
CBO	community-based organisation
CCIH	Christian Connections for International Health
CDC	United States Centers for Disease Control and Prevention
CHA	Christian Health Association
CHW	community health worker
CIFA	Center for Interfaith Action on Global Poverty
CSG	community support group
DFID	Department for International Development (UK)
DIFAEM [DIFÄM]	German Institute for Medical Mission (Deutsches Institut für ärtzliche Mission)
DRC	The Democratic Republic of Congo
EAA	Ecumenical Advocacy Alliance
EHAIA	Ecumenical HIV/AIDS Alliance (WCC)
FBO	faith-based organisation (faith-based organisation)
FHI	Family Health International
GFATM	Global Fund to fight AIDS, TB and Malaria
GHC	Global Health Council
GIS	geographic information systems
GPA	Global Program on AIDS (WHO)
GPS	global positioning system
HBC	home-based care
HBM	health belief model
HIV	human immunodeficiency virus
IDE	Interdisciplinary education
IDR	interdisciplinary problem-focused research
IDS	interdisciplinary studies
IFDC	Interfaith dialogue and cooperation
IHP	Interfaith Health Program (Emory University)
KAB	Knowledge, attitude, behaviour

KABP	knowledge, attitudes, beliefs and practices
MDG	Millennium Development Goals
MOH	Ministry of Health
MTCT	mother-to-child transmission
NAC	National AIDS Commission/Council
NFBHN	national faith-based health network
NGO	non-governmental organisation
OVC	orphans and vulnerable children
PEPFAR	President's Emergency Plan for AIDS Relief
PGIS	participatory geographic information systems
PHC	primary health care
PIRHANA	Participatory Inquiry into Religious Health Assets, Networks, and Agency
PLWHA	person living with HIV/AIDS
RCC	Roman Catholic Church
RE	religious entity
RHA	religious health asset
RNGO	religious nongovernmental organisation
SA	South Africa
SACBC	South African Catholics Bishops Conference
SAM	Service Availability Mapping (WHO)
SDA	Seventh-day Adventist
SSA	sub-Saharan Africa
STD	sexually transmitted disease
TB	tuberculosis
TBFF	Tony Blair Faith Foundation
UCMB	Uganda Catholic Medical Bureau
UCT	University of Cape Town
UKZN	University of KwaZulu Natal
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	voluntary counselling and testing
WB	The World Bank
WCC	World Council of Churches
WHO	World Health Organisation
WITS	University of the Witwatersrand

Preface. Mapping Religious Health Assets

In January 2006 I was gratefully sitting in the shade on a wooden bench at the back of a community church in Zambia. I was part of a multinational and multidisciplinary team of researchers from different academic institutions conducting participatory workshops as part of a mapping research study for the World Health Organisation (WHO). Through an interdisciplinary research process we were seeking to better understand the contribution of religion and religious entities to health and well-being in the context of HIV/AIDS in Zambia and Lesotho.[1-2] At the start of this study, through a broad literature review, we had argued that while the religious-health infrastructure in Africa appeared to be significant (with a long history and tradition of religious health care and care-giving), there was still a critical lack of systematic research or knowledge that can ultimately guide policy, especially in the sub-Saharan (SSA) region: "The full scope of the religious health system is unknown, and what information there is, remains disparate and often conflicting."[3]

Seeking an answer to these questions and gaps in knowledge had brought us to Zambia that summer, gathering both GIS data and running a series of participatory workshops where we collected the perceptions of community members, religious leaders and health providers about these religious health assets in the context of HIV/AIDS, asking what (if anything) religion contributed to health and HIV/AIDS in their communities. Among a wealth of stories and maps, one narrative, scribbled on the bottom margin my research notebook while sitting on that shady bench, has always stood out for me as representative of a core problem:

> A religious leader stood up and, turning to face the rest of the community, said in a forceful voice: 'religion contributes love,' and sat down, crossing his arms. There was a pause in the discussion. Perhaps not getting the response he had expected, he stood again, and said, 'love is support … and hope,' and sat down … only to leap up to his feet again and, throwing his hands up in the air, but with a questioning lilt to the end of his sentence, said, 'love is home-based care and clinics?' At which point his audience nodded and murmured, 'Amen'.[4]

[1] ARHAP, "Appreciating assets: the contribution of religion to universal access in Africa," (Cape Town: Report for the World Health Organization, African Religious Health Assets Programme, 2006), 8.

[2] A partial glossary is provided in Appendix A. The term "religious entity" seeks to capture the incredibly broad range of religious health assets, incorporating religious facilities, organisations as well as practitioners, both bio-medical and traditional. "HIV/AIDS" captures the broad complex of meaning (epidemics and significations) around the term, recognising that "HIV and AIDS" has gained in popularity in some contexts. I use "interdisciplinary" as the broad overarching term, and then use "multidisciplinary" and "transdisciplinary" to indicate different forms.

[3] ARHAP, "Appreciating assets," 20.

[4] ARHAP, "Appreciating assets." Chapter Four – augmented by author's research observations notes.

The core problem that this narrative represents is a struggle with language and communication at the intersection of religion and public health. This religious leader's battle to mesh different discourses together (for example, love or clinics), had been felt by everyone in that room, participants and researchers.

Moving forward to November 2009, I am now sitting in an air-conditioned conference room filled with selected experts in a meeting convened by the WHO in Geneva (the centre of power in such public health matters). The meeting is titled, *NGO Mapping Standards Describing Religious Health Assets*, and we are intent now on discussing global standards for international mapping and data gathering of religious entities in primary health care (PHC). The invitation states, "The consultation, the first of its kind, will afford an opportunity for WHO to hear from not only the providers of faith based/inspired health services … but also from academic institutions, donors, Member States, development agencies and philanthropy … Against the backdrop of growing demand for scale up of faith based partnership with national governments in primary health care and public health…"[5] Seated at the back of this very different room, I see the same difficulties and concerns being raised as in the community church in Zambia several years prior.

Again, participants wrestled with questions of how to understand the religious response to health and HIV/AIDS and how to map and measure religious health assets (RHAs), commented on how little we still know about these things and how difficult it was to understand what the religious contribution might mean; and how important it was for the faith community to come to the table.[6] On the opening day, several experts spoke of the difficulty of translation across disciplines, knowledges and practices in this field of inquiry. For example, The Joint United Nations Program on HIV/AIDS (UNAIDS) Partnership Advisor, Sally Smith, who has played a pivotal role in building a collaborative network between religious partners in the UNAIDS environment, spoke of the new *UNAIDS Strategic Framework for Partnership with Faith-based Organisations*,[7] concluding her address, saying "UNAIDS has been working with FBOs to enhance communication skills to be able to bridge gaps created when agencies and FBOs speak 'two different languages,'"[8] and spoke of her role in this "…as a process of translation … translation is my work … it is what I do."[9]

[5] WHO-CIFA, "NGO mapping standards describing religious health assets" (Chateau de Bossey Conference Center - Geneva, Switzerland, 10-12 November 2009).

[6] WHO-CIFA, "NGO mapping".

[7] UNAIDS, "Partnership with faith-based organizations: UNAIDS strategic framework," (Geneva: Joint United Nations Programme on HIV/AIDS, 2009).

[8] WHO-CIFA, "NGO mapping".

[9] This quotation is not present in the current draft of this report, but was confirmed in a personal communication, 30 November 2009.

These two brief narratives give evidence of a broad problem, around which a multisectoral and multidisciplinary community of inquiry has emerged over the last decade in various locations, asking the same basic questions: What do religion and religious entities contribute to public health, specifically the fight against HIV/AIDS, and what can we do together based on this knowledge? The two narratives are the book-ends to my personal experience in this community of inquiry, but they are representative of an astounding number of similar meetings, conferences and conversations that occur with increasing frequency. Swirling around these encounters is a substantial amount of literature (institutional and meeting reports, academic research, commentary and media), in which one observes the same conflicting discourses and difficulties with language and the translation of knowledges.

As an emergent community of inquiry around religion and public health, faced with critical concerns and working in a boundary zone between established knowledges, paradigms and perspectives, little has yet been done to step back and map the knowledge and discourses that have emerged within this context. Broadly speaking, this study seeks to do exactly that, to explore this complex and multisectoral community of inquiry with its persistent problems of knowledge, language and (mis)communication, and work to better understand its cultures and discourses of inquiry.

Chapter One. Mapping Complexity, an Interdisciplinary Study about Interdisciplinarity

> *…the first step in this invigorated interest was a meeting with leaders … at Lambeth Palace in London in February 1998 … that meeting – exploratory and private – gave rise to two convictions. First, common interest in fighting poverty was a powerful impetus for collaboration; and second, major efforts to bridge gaps between secular and faith organisations in communication styles as well as practical perspectives were essential if the common interests were to go beyond words.*[10]

At the end of the twentieth century a new conversation had begun between global health, development and religious communities. Searching for new partners in the face of rapidly accumulating global health and development challenges, several powerful institutions and influential individuals began to inquire about religion and religious entities (REs) as possible new partners for collaboration in health and development intervention.[11-12] As the above quote shows, such early meetings explored the potential for collaboration and sought out areas of common interest or common ground. What this example also shows is that right from the start such conversations were hampered by difficulties in communication as significant differences in language and perspectives quickly became apparent.

In the next decade this exploratory conversation broadened significantly and developed into a "community of inquiry": a broad, multisectoral collection of institutions, practitioners, academics and religious leaders, all collaborating and inquiring at the intersection of religion, public health and development. Religious leaders have increasingly been invited to high-level strategy meetings

[10] K. Marshall and M. Van Saanen, *Development and faith: where mind, heart, and soul work together* (Washington: World Bank, 2007), 7-8.

[11] During this study, key terms and concepts are discussed. At this point, however, the term religion here (rather than 'faith', 'religions', or 'spirituality'), is used to broadly describe "the wide variety of comprehensive systems of sacred beliefs and practices, usually (but not always) issuing in religious institutions, groups or organisations that range from fluid to codified, popular to formal, centralised to decentralised, and communal to institutional." ARHAP, "Appreciating assets." In this way, religion is here a sufficiently broad analytic category that recognises that in SSA, religion includes African traditional religions, Islam, Christianity and a wide variety of other identifiable but smaller religious formations. Generally speaking, adherence to Islam is concentrated in North and West Africa, Christianity is more common in Africa south of the equator, and there is widespread belief in African traditional religions See B. Schmid et al., "The contribution of religious entities to health in sub-Saharan Africa," (Cape Town: Study commissioned by Bill and Melinda Gates Foundation. African Religious Health Assets Programme, 2008).

[12] I shall utilize the WHO's 1948 definition of health as "the state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." The definition of the term "public health" is discussed in Chapters Three and Five – however, broadly speaking, public health is defined as "the science and art of promoting health, preventing disease and prolonging life through just and organized efforts of society." See R. Skolnik, *Essentials of global health*, ed. R. Riegelman, Essential public health (Boston: Jones and Bartlett Publishers, 2008).

and consultations;[13] religious engagement in international health and development conferences and gatherings is more apparent;[14] secular international institutions publish new reports on their partnership strategy the religious sector;[15] collaborative networks and facilitating organisations have been formed;[16] new academic programs focusing on the interface between religion and public health have been initiated;[17] and research (whether from academic or institutional sources) that addresses the intersection of religion, public health and development is becoming more readily available.[18]

In the years since the Lambeth conversation described above, there have been a slew of such meetings, consultations and conferences, in different locations and combining different institutions and individuals. In a more recent example, at a meeting exploring the possibility of collaboration on religion and malaria in November 2009, organised by the newly formed Tony Blair Faith Foundation (TBFF) and The Center for Interfaith Action on Global Poverty (CIFA), the following was reported:

> Major funding agencies, governments and faith-based health agencies struggle at times to relate due to their disparity in scale, use of different terminology, and their distinctive approaches. However, the rationale for action of all comes from a common commitment to the well being of communities. Special initiatives are needed to help each to communicate with the other so as to avoid misunderstanding and mistrust … Unless there

[13] For example, a much quoted participation resulted in the statement by faith-based organizations facilitated by the World Council of Churches for the UN Special General Assembly on HIV/AIDS, 25–27 June 2001.

[14] For example, UNAIDS, "First international conference on AIDS and religion," (Dakar, Senegal: UNAIDS, 1997). There are now multiple such conferences and meetings each year and an acknowledged '"faith stream" at the international HIV/AIDS conferences.

[15] See G. Bandy et al., "Building from common foundations: The World Health Organization and faith-based organizations in primary healthcare," ed. T. Karpf and A. Ross (Geneva: World Health Organization (WHO), 2008), GFTAM, "Report on the involvement of faith-based organizations in the Global Fund," (Geneva, Switzerland: The Global Fund to Fight AIDS, Tuberculosis and Malaria, 2008), UNAIDS, "UNAIDS-FBO partnership."

[16] For example, The African Religious Health Assets Programme (ARHAP) http://arhap.uct.ac.za, Christian Connections for International Health (CCIH) http://www.ccih.org, The Tony Blair Faith Foundation (TBFF) http://www.tonyblairfaithfoundation.org, or the Center for Interfaith Action on Global Poverty (CIFA) http://www.cifa.org

[17] For example, university-level interdisciplinary programs specifically focused on the religion-public health interface are being run at the University of Cape Town (UCT, SA), University of KwaZulu Natal (UKZN, SA), Witwatersrand University (Wits, SA), and Emory University (Atlanta, USA). Others are more focused on the interface between development and faith, such as Georgetown University's Berkley Center for Religion, Peace, and World Affairs (Washington, USA), or the Religions and Development International Development Department (RAD) at the University of Birmingham (UK). See http://www.arhap.uct.ac.za

[18] See Chapter Three

> is an understanding of the resonance of terminology, alignment of values is problematic so that discussion short of genuine dialogue readily leads to misunderstandings.[19]

As this extract shows, while these conversations were on slightly different topics and among another group of participants, two main similarities can be seen: an apparent common ground (or commitment) between religious and so-called secular institutions, and a lingering struggle with language and communication. In other words, while there may be more frequent conversation between religious and secular institutions and individuals, communication and partnership continues to be hampered by misunderstandings, frustrations or a "communication gap".

A Communication Gap Most Visible Through the Lens of HIV/AIDS in Sub-Saharan Africa

> *The complex nature and magnitude of the HIV/AIDS epidemics requires a co-ordinated response that is multi-levelled, multi-faceted, and multi-sectoral. A co-ordinated response involves actors from a variety of backgrounds, for example, local and international NGOs, government agencies, and academic institutions.*[20]

This communication gap is most readily seen at the intersection between religion and public health and on the topic of HIV/AIDS in sub-Saharan Africa which has dominated the conversation in this boundary space.[21]

Since the early 1990s, the international response to HIV/AIDS has been characterised by a multisectoral approach.[22] In this context, previously professionally disparate individuals have increasingly been pushed into an encounter with each other in the quest for more effective response and collaboration.

[19] TBFF, "Faith and malaria: towards an integrated solution," in *Faith and Malaria* (Yale University: Tony Blair Faith Foundation, Yale University and Center for Interfaith Action on Global Poverty, 2009), 23.

[20] V. Tallis, "Gender and HIV/AIDS," in *Bridge: Development - Gender* (Institute of Development Studies 2002), 44.

[21] From this point I will be speaking of the intersection between religion and public health, but it should be noted that the boundary between public health and development is increasingly blurred, particularly in the context of HIV/AIDS engagement where poverty becomes a concern of public health, and a "disease" a major concern of development. As noted in a previous literature review, "the field of 'development' … is immensely broad and intersects and overlaps with 'public health' in many places. Clearly, when we are talking about the capacity of religious entities, or of people of faith being challenged to change the world, we are looking at a broad, transversal set of phenomena that cut across issues of concern to development, and public health, practitioners and theorists." J. Olivier et al., "ARHAP literature review: working in a bounded field of unknowing," (Cape Town, South Africa: (ARHAP) African Religious Health Assets Programme, (UCT) University of Cape Town, 2006), 19. "Public health" in this thesis is therefore inclusive of development perspectives and practitioners. See B. Schmid et al., "Understanding religious health assets: health as a lens on religion and development," in *Religion and social development in post-apartheid South Africa: Perspectives for critical engagement*, ed. I. Swart, S. Green, and J. Erasmus (Stellenbosch, South Africa: Sun Media, 2010 [forthcoming]).

[22] See C. O'Manique, *Neoliberalism and AIDS crisis in sub-Saharan Africa*, International Political Economy Series (Hampshire and New York: Palgrave MacMillan, 2004), 153-154.

In the last two decades there has also been a significant increase in the formation and function of civil society groups (internationally and especially in SSA), and this has resulted in a "partnership turn" where civil society organisations are increasingly being recognised as key partners in working relationship with public health institutions and governments.[23] This can be seen in the rapid growth in interfaith-AIDS councils at a national level, and other such representative networks.[24] It can also be seen in the recently released *Partnership with Faith-based Organizations: UNAIDS Strategic Framework*[25] which says, "This strategic framework is the result of stronger partnerships between UNAIDS and FBOs. It is also a demonstration of the commitment of UNAIDS to encourage strong partnerships between UNAIDS, FBOs, governments and other organisations."[26] However, this partnership turn is not without its tensions and difficulties, and as this study will explore, the "communication gap" is also clearly in evidence between partners.

Another key strategy tied to the multisectoral HIV/AIDS response, and relevant to this community of inquiry, is the increased focus on "dialogue" as a communicative strategy seeking to bridge the gaps between partners. However, there is a growing concern that "dialogue" is much more difficult than convening a meeting and getting potential partners to talk to each other. For example, Joy Phumaphi (World Bank) and Lord Carey (World Faiths Development Dialogue) note:

> The World Bank has not traditionally engaged in dialogue with leaders of the major faiths – the worlds of faith and international financial institutions seemed far apart – but today there is broadening recognition that these different voices belong at the same policy table ... We sense a readiness for dialogue and partnership that did not exist in the past … this, for nearly a decade, the World Bank and concerned leaders of world faiths have worked together to seek common understanding of the causes of poverty and how to fight it … a decade of exchanges and partnerships that have marked the effort to bridge what were too often diverging worlds. It recognises the complexity and challenge inherent in dialogue on difficult issues, where conflicting views and areas of uncertainty abound.[27]

[23] Marshall and Van Saanen, *Development and faith*, 12. This is particularly apparent in the significantly increased number of "partnership advisors" visible working at the intersection of religion and public health. See, for example, the professional designations of the following meetings, WHO-CIFA, "NGO mapping", TBFF, "Faith and malaria."

[24] A study addressing partnership on HIV/AIDS between religious and secular stakeholders in SSA, see B. Haddad et al., "The potential and perils of partnership: Christian religious entities and collaborative stakeholders responding to HIV and AIDS in Kenya, Malawi and the DRC," in *Study commissioned by Tearfund and UNAIDS* (Cape Town: Africa Religious Health Assets Programme, 2008).

[25] UNAIDS, "UNAIDS-FBO partnership."

[26] UNAIDS, "UNAIDS-FBO partnership," 7.

[27] Phumaphi and Clifton in Marshall and Van Saanen, *Development and faith*, xii.

As mentioned above, the intersection of religion and public health, particularly in the context of HIV/AIDS has seen a substantial increase in dialogue over the last decade, but this has been hampered by continuing communication gaps and tensions. Indeed, there are some signs that "dialogue fatigue" may be setting in. Banna echoes the feelings expressed by others within this community of inquiry when he says:

> I myself, along with many others, am increasingly weary of hearing of the titles of numerous lectures, meetings and conferences addressing the issue of dialogue. These gatherings can be perceived as being a waste of time, money and effort. Why? Because when we stand here talking and theorising, the public about which we like to speak has not seen nor felt any concrete results. Indeed, whilst we discuss, the feelings of division, stigmatisation and isolation are steadily growing in many parts of the world and none of us is any safer. The world is teeming with people talking about the importance of dialogue and bridge building between and within religions, of the interface of civilisations, of the recognition of each other's cultures and the interaction between ideas and concepts that affect our daily lives.[28]

The notion of "dialogue fatigue" importantly problematizes the assumption that increasing the number of encounters and the number of individuals engaged in conversation automatically results in improved communication and collaboration.[29]

Another factor important to this multisectoral context is an increase in participatory approaches to inquiry and collaboration. Even in the early social response to HIV/AIDS (in the late 1980s and 1990s), attempts were made to bring civil society "around the table," even in the face of a predominantly biomedical response.[30] UNAIDS was seen to have been formed "to be a catalyst of a new alliance of governments, intergovernmental organisations, community-based organisations (CBOs), groups of people living with HIV infection and AIDS, the private sector, and academic and research institutions – in essence, and informal global alliance bound by a common commitment to challenging AIDS."[31] Patton notes in 2003 that, "while HIV *science* is dominated by behavioural and

[28] H.E. Banna, "Conflicting agendas, converging hopes " in *Connecting regions - creating new opportunities: bridging civilisations* (Istanbul, Turkey World Economic Forum, 2006), 1.
[29] The notion of dialogue fatigue will be addressed again later.
[30] See O'Manique, *Neoliberalism*.
[31] Piot in O'Manique, *Neoliberalism*, 60.

biomedical research studies, in the past decade the *practice* of HIV-prevention has been characterised by a slow but steady 'paradigm drift' … towards more participatory approaches."[32]

A participatory approach introduces the final element important to this multisectoral context and that is the way the demands of HIV/AIDS have resulted in a substantial increase in interdisciplinarity. The term "interdisciplinary" has come into its own in the HIV/AIDS era, and particularly so at the intersection of religion and public health.[33] The recognition of HIV/AIDS as a multiplex disease, complexly embedded in the social paradigm has resulted in many calls for inter-, multi-, or trans-disciplinary research.[34] Such research is seen as the avenue to putting aside academic wrangling in a cooperative drive to find the "something missing" from our current knowledge, and as a route to forming over-arching understandings of an epidemic that has stepped out of neat boundaries and invaded every aspect of society. In this context of increased interdisciplinarity, a number of scholars have noted the tensions between the disciplines communicating at the intersection of religion and public health. For example, in 2002, Gunderson says:

> The language of faith-health is just emerging and, at this point, imprecise. We are struggling with and inconveniently *large* amount of relevant knowledge, not too little. The problem is that we are still working out the language about spirituality, health and community inside our various disciplines and are barely at the task of finding powerful language that works across the disciplines ... the big point is that none of us can make sense of the truly important processes of health without trying to take all of the factors into account. It is intellectually irresponsible to ignore the complexity, even though this would make everybody's life much easier. There are a number of critical issues that usually come up in the context of getting the language right. For instance, are the religious words *True* and the health data *Factual*? All of them? Some of them? Which ones? Who decides? Does it matter? Do any of these words really make a difference in how we behave as individuals, leaders, structures and new, as collaboratives?[35]

This extract makes three key points that will be picked up again below. Firstly, a concern for issues of disciplinarity at the intersection of religion and public health raises issues of "truth" and

[32] Emphasis hers, C. Campbell, *Letting them die: Why HIV/AIDS intervention programmes fail*, ed. A.d. Waal and S. Ellis, African Issues (Wetton, South Africa: The International African Institute, 2003), 9.

[33] I use "interdisciplinary" here as a generic term, and define further differences in Chapters Two and Five.

[34] See G. Herdt and S. Lindenbaum, eds., *The time of AIDS: Social analysis, theory and method* (London: Sage Publications, 1992), S. Craddock, "Introduction: Beyond epidemiology: Locating AIDS in Africa," in *HIV and AIDS in Africa: Beyond epidemiology* ed. E. Kalipeni, J.R. Oppong, and J. Ghosh (Oxford: Blackwell, 2004).

[35] G.R. Gunderson, "Concept paper for the design process: The Institute for Public Health and Faith Collaborations," (Atlanta: Interfaith Health Program, 2002), 4.

"evidence" which are prevalent within this community, and which I would argue are best understood through an interdisciplinary (and hermeneutical) lens.[36] Secondly, Gunderson also mentions that we are seeking a powerful language that works across disciplines. Again, this raises the importance of an interdisciplinary perspective, which addresses the formation of disciplinary inter-languages and creoles. Finally, Gunderson argues that it would be irresponsible of us to ignore the inherent complexity of this boundary space between religion and public health, even if that would be easier.

I have taken this need to confront complexity to heart, and have therefore embarked on an interdisciplinary exploration which seeks an *integrated* understanding of these different sectors, groups and individuals coming together in this boundary space. In other words, addressing a convergence of different sectors and interests, academic, institutional, practitioner and community that are all experiencing the same problem, a communication gap, or a problem of communication at the intersection of religion and public health, and particularly in the context of HIV/AIDS. This is the reality of communication and inquiry occurring at the intersection of religion and HIV/AIDS in Africa: more frequently a "messy" intermingling of bodies of knowledge, practices, experts and differing voices. Here, religious entities, "…often operate in a murky interdisciplinary and inter-sectoral manner. The HIV/AIDS epidemic is also a multiplex disease that is as much a disease of development as it is one of public health or biomedicine. It behoves us to remain open to a wide range of influences that might assist in our research trajectory."[37]

However, in order to make this study manageable, I have chosen to focus mainly on the conversation about HIV/AIDS and sub-Saharan Africa (SSA) which has dominated this community of inquiry in the last decade.[38] The reality, however, is that the conversation is a public negotiation *about* SSA that occurs in a transnational space. The community of inquiry at the intersection of religion and public health is of course interested in other health concerns beyond HIV/AIDS, and it is not located in or focused only on SSA. Nevertheless, I apply HIV/AIDS and SSA as delimiting factors, in the understanding that this is a *lens* on the broader transnational community of inquiry.[39]

[36] I make this point since it rules out researching this community of inquiry with a more discipline-specific approach such as intercultural communication analysis or linguistic discourse analysis, since this requires some engagement with hermeneutic and epistemological concerns.

[37] Olivier et al., "ARHAP literature," 20.

[38] Sub-Saharan Africa is the geographic term describing those countries in Africa which are partially of, or lying south of the Sahara desert – inclusive of Southern, East, West and Central Africa, but not North Africa.

[39] For brevity I hereto use "religion and HIV/AIDS" as a shorter form of this topic within a community of inquiry, with the understanding that this indicates "religion, public health, HIV/AIDS in SSA"

The empirical base for this work is supplied by my work with the African Religious Health Assets Programme (ARHAP), an interdisciplinary research collaboration engaged at the intersection of religion and public health with which I am involved, and out of which this study arises.[40] I have been a researcher with ARHAP since 2004 and this has formed the core of my experience within this community of inquiry at the intersection of religion and public health. This thesis is informed by the broader theoretical work of ARHAP, as well as empirical research conducted in three key research projects in which I was a researcher:[41]

> *Appreciating assets: the contribution of religion to universal access in Africa:* A study mapping religious health assets in Zambia and Lesotho in support of Universal Access to HIV/AIDS treatment, care and prevention services, sponsored by the World Health Organisation (2005-2006).[42]
>
> *The contribution of religious entities to health in sub-Saharan Africa*: A landscaping study of health services provided by religious communities in SSA, sponsored by the Bill and Melinda Gates Foundation (2007-2008).[43]
>
> *The potential and perils of partnership*: *Christian religious entities and collaborative stakeholders responding to HIV and AIDS in Kenya, Malawi and the DRC*: A three-country study of collaboration between religious entities and collaborative stakeholders, sponsored by Tearfund and UNAIDS (2007-2008).[44]

These experiences, as well as other more general work with ARHAP, enable me to balance the broad literature review that informs this interdisciplinary study against personal observation, acting as a litmus test and providing a framing narrative.

[40] See acknowledgements. This study is hugely indebted to the numerous conversations and generous intellectual contribution of ARHAP colleagues.

[41] ARHAP provides its own theoretical framework, and emerging culture and discourse. See Chapter Six. Through the ARHAP network I have gained fieldwork experience in Zambia, Malawi, Kenya and the DRC, as well as lesser engagements in research in Uganda, Lesotho, Botswana, South Africa and some peripheral studies in the USA. All these experiences inform this thesis.

[42] ARHAP, "Appreciating assets."

[43] Schmid et al., "Contribution of REs."

[44] Haddad et al., "Potential and perils."

An Interdisciplinary Study about an Interdisciplinary Context

> *Interdisciplinary studies is a process of answering a question, solving a problem, or addressing a topic that is too broad or complex to be dealt with adequately by a single discipline and draws on disciplinary perspectives and integrates their insights to produce a more comprehensive understanding or cognitive advancement.*[45]

In the African academe, HIV/AIDS has become *the* interdisciplinary problem of our time, unsolvable in any single discipline, a complex problem that transcends academic disciplines boundaries. My personal experience of this interdisciplinary focus on HIV/AIDS at the University of Cape Town (UCT) provides a telling illustration. No other problem receives as much interdisciplinary and interdepartmental attention as HIV/AIDS, which is taught across the university, and whose wide impact is shown in a university-published annual bibliography of departmental HIV/AIDS research (no other research is collated in this way).[46] In 2001 a new Masters-level interdisciplinary degree programme was initiated (the *MPhil in HIV/AIDS and Society*) which was based in the Graduate School of Humanities rather than in a specific department, and brought staff and students together from across the university. It was as a student in this degree that I first became concerned about an underlying problematic in the interdisciplinary HIV/AIDS field, namely, an apparent schism between interdisciplinary HIV/AIDS research and the broader scholarship on interdisciplinary theory and practice. For example, while the MPhil included a core course on Interdisciplinary Research Methods, compulsory to all graduate students in the faculty and which addressed a variety of methodologies (quantitative and qualitative), no classes were ever provided on how such approaches could be most effectively integrated.[47] The lecturers that were brought together to provide the students with the core content on HIV/AIDS, provided the students with a fascinating range of multidisciplinary perspectives (from biomedical and statistical models to matters of stigma and gender), but there was no discussion on how these views could be usefully integrated, in research practice or beyond the academe.[48]

With this as my induction into interdisciplinary HIV/AIDS research, I embarked on a systematic review of the literature addressing interdisciplinary research and HIV/AIDS in Africa, and found that

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[45] A.F. Repko, *Interdisciplinary research: process and theory* (Los Angeles: Sage, 2008), 12.

[46] C. Volks, "The role of tertiary institutions in the HIV/AIDS epidemic," in *AIDS in South Africa: A social expression of a pandemic*, ed. K.D. Kauffman and D.L. Lindauer (New York: Palgrave MacMillan, 2004).

[47] Even the current bible of graduate social research in South Africa, does not include the word “interdisciplinary” (or any of its variations) in its index, glossary or contents pages. See E. Babbie and J. Mouton, *The practice of social research*, South African ed. (Cape Town: Oxford University Press South Africa, 2001).

[48] In fact, this course has subsequently suffered a quiet death, first being moved to the Sociology Department for a few years, and then quietly dismembered, showing the difficulties of interdisciplinary higher education (HE) programmes.

this was not a phenomenon particular to this university context, but appeared to be generally pervasive. That is, despite more frequent cases of interdisciplinary research and interdisciplinary research collaboration on HIV/AIDS as a shared problem, and with the majority of social research on HIV/AIDS now declaring itself interdisciplinary, there is astoundingly little analysis of interdisciplinarity in the context of HIV/AIDS as a practice, and little linkage (through citation or otherwise) between this self-proclaimed interdisciplinary research and the literature addressing interdisciplinarity process, integration and theory.

Furthermore, while there are clearly increasing numbers of interdisciplinary collaborative research teams working on HIV/AIDS, there is little assessment of this practice. What this broader schism translates to is few best practice models or teaching material available for the thousands of students and scholars engaged in interdisciplinary HIV/AIDS research. This is not uncommon, as Klein notes that interdisciplinary research frequently lacks reference to the larger body of interdisciplinary scholarship,[49] "There are resources for every stage of [interdisciplinary studies] … Unfortunately, that knowledge is woefully underused. The challenge in the remaining decade of the twentieth century is to make more systematic and productive use of the abundant resources that have emerged in the last two decades."[50] This is a broad challenge which is taken seriously throughout this thesis, and which continues as a general recommendation for further engagement beyond the aegis of this particular study.

With the object of our gaze being such a multiplex community of inquiry, several relevant academic lenses could be applied. For example, a close analysis of a specific meeting or communication situation could be viewed through the perspective of linguistics, social psychology, or anthropology. The cultures present in a particular meeting could be investigated through sociological and anthropological perspectives of intercultural analysis. An analysis of emerging policy could be managed through political studies or public health perspectives. Different religious formations could be analysed through a variety of religious studies and theological frameworks, including sub-disciplinary foci such as religion and development, or religion and culture. The difficulties with discourse and translation (of disciplines) could be viewed through the lens of the social construction of health and illness, or even via the emerging fields of conflict management and inter-religious dialogue. The knowledge (and disciplinary) formations apparent in this community could be analysed through phenomenological and epistemological philosophy. Even then, this listing is not complete, and only reflects the range of fields and methodologies which

[49] J.T. Klein, *Interdisciplinarity: history, theory, and practice* (Detroit, MI: Wayne State University Press, 1990), 122.
[50] Klein, *Interdisciplinarity*, 181.

were found to hold partially-relevant information for an investigation of this community of inquiry, phew of which, however, have yet made a direct contribution to this problem area.

However, these narrower gazes would not (at this time), provide us with the necessary understanding of the complex nature of the object, which exists in a boundary zone between disciplines, influenced by multiple discourses. What is critically missing at this time is broad-gauge scholarship that can assess, or more accurately "take the pulse" of, this emerging community of inquiry thereby providing a perspective to assist those working in this community to better understand its nature, and to improve collaboration and the coordination of action that occurs there. The broad perspective required to view this problem (of a communication gap at the intersection between religion and HIV/AIDS) demands an interdisciplinary research process and design.

> …Ellison with Parker and Campbell discuss the importance of moving from multi-disciplinary syntheses to dedicated inter-disciplinary work – a change in research culture they see as crucial to understanding the biological, social *and* political complexity of HIV/AIDS. Interdisciplinary approaches are required to understand the relationships between the different levels at which HIV/AIDS operates, and to support the development of effective, complex, multi-level, multi-sectoral interventions.[51]

This thesis therefore positions itself in the same "boundary zone" as the object of its investigation, which is not a random exercise, but a necessary path created by the complex concerns of the community of inquiry introduced above.[52]

In *Interdisciplinary Research: Process and Theory*, published in 2008, Repko takes as his battle standard that interdisciplinary studies is itself now a valid academic specialisation in its own right: "Interdisciplinary Studies (IDS) is not a passing fad; it is here to stay. It is a rapidly growing

[51] D. Clarke-Patel, "Foreword," in *Learning from HIV and AIDS*, ed. G.T.H. Ellison, M. Parker, and C. Campbell (Cambridge, United Kingdom: Cambridge University Press, 2003), xiii.

[52] The broad interdisciplinary nature of this study, which crosses several disciplinary territories, brings with it a strong temptation to spend a significant time defending oneself against specialist disciplinary attack seeking greater depth and rigor in specialist areas. Practically, as is typical in broad-gauge scholarship aimed at a diverse audience such as this, there is the added challenge of dealing with concepts and terminology that might require definition and/or discussion for some audiences, but not for others. The temptation here to counter all possible challenges has to be balanced against the practicalities of time and space, and the need to undertake the actual investigation at hand. In addition, because this investigation necessarily includes an intense focus on language and definition, some key terms are not initially dealt with here, since they are deconstructed later in the text. In an attempt to alleviate some of this tension, to simultaneously provide the necessary first explanation, and to streamline the initial theoretical positioning as far as possible, a partial glossary is provided with key concepts and definitions (those that differ from standard usage). See Appendix A.

academic field."[53] This thesis will test this idea, intentionally positioning itself as a specialisation in interdisciplinarity, and seeking to be judged as such. Repko continues, saying that "interdisciplinary studies, like the disciplines, seeks to produce new knowledge, but unlike them, it seeks to accomplish this via the process of integration."[54] Repko argues that interdisciplinary research is better described as a "process" than a "method"[55] which argues for a greater methodological flexibility and self reflexivity. The main method of this interdisciplinary process is integration (or synthesis),[56] built on a broad literature review.[57] This integration is a reiterative process that seeks out relevant insights to the problem, as well as an adequate understanding of these fields and their key concerns and expert theorists.[58]

This is an intentionally (and explicitly) interdisciplinary study which also holds up interdisciplinarity as a focus and uses it as a theoretical foundation.[59] It is my contention that the problem as described above has not been studied before, because of its location in-between spaces, its complex and broad nature, but that it is researchable with application of the right tools and delimiting boundaries. What then are the criteria for success for such an exploratory PHD thesis that seeks "specialisation" in interdisciplinarity? In the framework being developed by those in the emerging field of integrative or interdisciplinary studies, (as represented by Repko and Klein here), success is based on slightly different criteria: less about specialisation or depth in a particular discipline and more about the success of the integrative process. Klein says that depth and rigor are redefined in interdisciplinary studies, "depth in interdisciplinary work derives from competence in pertinent knowledges and approaches (and) rigor derives from attention to integrative process."[60] Rigor becomes "…'a core sense of interdisciplinary rigor' that transcends boundaries to address a particular problem or question by using the most pertinent resources in a continuously integrative manner.[61] Interdisciplinary depth "requires developing adequacy or sufficiency in each discipline relevant to the problem … and involves identifying conflicts between insights and

[53] Repko, *Interdisciplinary research*, 332. This statement is not made without some irony, and indeed the emerging field of interdisciplinary studies is experiencing many of the same tensions as have been felt in cultural studies (introduced below).

[54] Repko, *Interdisciplinary research*, 8.

[55] Repko, *Interdisciplinary research*, 12.

[56] See Repko, *Interdisciplinary research*, 123.

[57] Literature review is an umbrella term that refers to different specialized reviews utilized in each chapter, including context and historical review, integrative review, methodological review, content and theoretical review, and citation analysis.

[58] See Repko, *Interdisciplinary research*, 342 & 336. Burden of comprehension: Having a minimum understanding of each relevant discipline's cognitive map.

[59] Repko ends his book saying, "Finally, there is a need for more research that is explicitly interdisciplinary." Repko, *Interdisciplinary research*, 325.

[60] Klein in Repko, *Interdisciplinary research*, 125.

[61] Klein, *Interdisciplinarity*, 194.

locating their sources, creating common ground, integrating insights, producing an interdisciplinary understanding of the problem, and testing it."[62] Most importantly though, is that interdisciplinary success is also judged on creativity.

> Excellence is measured in terms not of fidelity to disciplinarity but of interdisciplinary originality. Disciplinary accuracy and clarity are important, but the clarity of interdisciplinary communication and the solution of to a problem or the creation of new meaning are of primary importance … interdisciplinary work is most successful when it is most creative; when borders are constructively and constantly engaged...[63]

Mapping Discourse, Power and Knowledge through a Cultural Studies Approach

Returning to the core problem of the communication gap between different discursive worlds on the interface between religion and public health, Marshall and Van Saanen note:

> The picture that emerges is of converging agendas … among the vast array of secular agencies and faith institutions. Common ground lies in deep concern for the suffering of poor people, and frustrations with slow progress on the MDGs. However, relationships among development and faith institutions are far from harmonious. Different languages (of disciplines, not tongues) and complex institutional bureaucracies help keep the two worlds separate. Contentious issues such as HIV/AIDS prevention strategies … divide faith organisations themselves, as well as development and faith institutions.[64]

With this in mind, what becomes necessary for this study is a metatheoretical framework that can adequately integrate issues of language (of disciplines not tongues), communication, different knowledges, as well as conflicting agendas and bureaucracies. The framework chosen for transversing this territory is a cultural studies approach which utilises discourse analytical methods. Cultural studies has emerged as something of a phenomenon in the academe in the last two decades. Deliberately interdisciplinary, cultural studies has generated heated debates on whether it is a new field, an interdiscipline or anti-disciplinary, a network, movement or a discipline.[65]

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[62] Repko, *Interdisciplinary research*, 338. *Adequacy* here is not based on claims of expertise of all the areas crossed, but rather showing a "sufficient understanding of each discipline's cognitive map. The 'burden of comprehension' then having a minimum understanding of each relevant discipline's cognitive map. See Repko, *Interdisciplinary research*, 124.

[63] J.T. Klein, *Crossing boundaries: knowledge, disciplinarities and interdisciplinarities*, ed. E. Messer-Davidow, D.R. Shumway, and D.J. Sylvan, Knowledge: Disciplinarity and Beyond (Charlottesville and London: University Press of Virginia, 1996), 224.See Repko, *Interdisciplinary research*, 298.

[64] Marshall and Van Saanen, *Development and faith*, 4.

[65] Thornton notes, "this new field of enquiry draws from a number of different parent disciplines such as history, literary criticism (with comparative literature, and other variants), anthropology and sociology. The 'field' of cultural studies has not displaced these disciplines but all have had to accommodate it." R. Thornton, "Finding culture," in *Senses of culture: South African culture studies*, ed. S. Nuttall and C. Michaels (Cape Town, South Africa: Oxford University Press, 2000), 33.

Coplan famously writes, "…gone are the empiricist (mis)representations of sociology, the unwarranted authority of synthesising positivist anthropology. I don't make it easy for readers with a particular disciplinary interest to pick out what they think they're looking for. I don't tell you where I'm going or where I've been.[66] This is perhaps too extreme a position for a doctoral thesis,[67] but I do take Davis' example and understand cultural studies to be part social movement, part interdisciplinary studies,[68] with an interest in boundary zones and overarching theory that at the very least challenges disciplinary boundaries and standard knowledge formations. These are all characteristics that make cultural studies a useful vehicle for this exploratory investigation, and which underpins this investigation.

For my purposes, Threadgold best describes the general theoretical assumptions that connect different research activities in this field:

> …a social constructionist view of language; the idea that realities and subjectivities are constructed in and by language; that subjects construct themselves and the worlds they inhabit in their everyday uses of language; that power relations are constructed and deconstructed through these processes; that what we call the social and culture are similarly constructed and deconstructed; that this activity is characterised by narrativity, that changing narratives, telling stories differently, might change the social world and that the goal of work on and with language is a politics committed to social change through what Eco would have called a semiotic labour on and with texts.[69]

This statement connects a cultural studies perspective with much of the discussion above, for example, that we are interested in language which reveals how knowledge is constructed and maintained through power (which is clearly in evidence between the different experts and representatives communicating within this community of inquiry.) I will only briefly define a few of the key terms here (culture, discourse and dominant discourse) to provide some basis for shared understanding, the rest of which will be addressed within the chapters that follow.

See R. Johnson, "What is cultural studies anyway?," in *A cultural studies reader: history, theory, practice*, ed. J. Munns and G. Rajan (London and New York: Longman, 1995 [1983]), I. Smithson, "Introduction: Institutionalizing culture studies," in *English studies: culture studies*, ed. I. Smithson and N. Ruff (Chicago: Illinois University Press, 1994), J. Munns and G. Rajan, eds., *A cultural studies reader: history, theory, practice* (London and New York: Longman, 1995), 575.

[66] S. Nuttall and C.-A. Michael, eds., *Senses of culture: South African culture studies* (Cape Town: Oxford University Press, 2000).

[67] Not to mention that this "antidisciplinary" vision of cultural studies is also being challenged by its rapid growth and institutionalization in universities around the world. See Johnson, "What is cultural studies?," 574.

[68] See I. Davies, *Cultural studies and beyond: fragments of empire* (London: Routledge, 1995), 1. Thornton, "Finding culture," 29.

[69] T. Threadgold, "Cultural studies, critical theory and critical discourse analysis: Histories, remembering and futures," *Linguistik Online* 14 (2003): 1.

The emphasis of cultural studies on narrativity and cultural constructionism has led to a strong tradition of working with "discourse".[70] In fact, in the ways that many cultural studies practitioners utilise the terms, the meaning of culture and discourse have in some senses merged. Abu-Lughod goes as far as to recommend that we replace culture with discourse entirely.[71] While I do agree that the terms have been conflated in popular usage, in this study, I will utilise "culture" as the broader category within which discourse works. In a cultural studies perspective, discourse is then not a "group of signs or a stretch of text,"[72] but is rather "practices that systematically form the objects of which they speak."[73] Stuart Hall, a key figure in cultural studies sees discourse as:

> …a group of statements which provide a language for talking about – i.e. a way of representing – a particular kind of knowledge about a topic. When statements about a topic are made within a particular discourse, the discourse makes it possible to construct the topic in a certain way. It also limits other ways in which the topic can be constructed.[74]

Discourse therefore works within power relations, constructing and limiting what can or cannot be said, or as Foucault says, "we must conceive discourse as a violence that we do to things, or, at all events as a practice we impose upon them."[75] Foucault argued that discourses are produced within power relations, a dominant discourse (that is commonly visible in the public texts) has been made successful by its connection to networks of power, and of particular importance is what Foucault calls "unnoticed power."[76] Burman describes a Foucaultian discourse analysis, saying;

> … discourse work … (explores) how acts of power are performed, and the conditions which allow these acts to work … if, as Foucault (1980) suggests, power is *productive* rather than only repressive, then it becomes an urgent political project to document and theorise the field of action and modes of resistance possible within prevailing social arrangements. For it is attending to such things that change becomes possible … Power … is not the exercise

[70] Discourse (and its analysis) is not merely a method, but a paradigm in its own right, "discourse studies" being even broader than "cultural studies". Teun van Dijk argues that critical discourse studies is "an academic movement of a group of socially and politically committed scholars, or, more individually, a socially critical attitude of doing discourse studies … discourse analysis is *NOT* a method of research, but rather a (cross-) discipline." T.A. Van Dijk, "Critical discourse studies (CDS): A discourse theory (perspective)," (2009), http://www.discourses.org/projects/cda/. See S. Mills, *Discourse: the new critical idiom* (London & New York: Routledge, 1997).

[71] Abu-Lughod in Thornton, "Finding culture," 42.

[72] See Mills, *Discourse*, 17. Discourse studies is an intensely interdisciplinary landscape, including many different styles and methods of 'discourse'. Mills has a particularly useful examination of discourse and the various ways it is utilized in different disciplines and fields.

[73] M. Foucault, *The history of sexuality: An introduction*, vol. 1 (Hammondsworth: Penguin, 1972), 49. See Mills, *Discourse*, 7.

[74] S. Hall, "The West and the rest: discourse and power," in *Formations of modernity*, ed. S. Hall and B. Gieden (Oxford: Oxford University Press, 1992), 290.

[75] See Foucault, *History of sexuality*.

[76] See M. Foucault, *The order of things* (New York: Routledge, 1966).

> of some dramatic force emanating from a single point … Power is, rather a function of a multiplicity of discursive practices that fabricates and positions subjects.[77]

Thornton argues that what is possible is "…an 'uncovering' of hidden relations that have resulted in the 'construction' of some literary text or cultural practice. This uncovering is called 'deconstruction' and attempts to take apart the constructed-ness of culture to show, precisely, its construction in relation to power, and (at least) its potential for hegemony."[78] This then foregrounds the hidden, the tacit and the implicit, seeking discourses that have become naturalised or "common sense." A dominant discourse is therefore powerful in its cultural comfort zone, and the most dominant discourses are the ones assumed as natural or common-sense. Gibbons notes, "What explains the success of any particular discourse of knowledge is its connection with networks of power. In all societies, power-knowledge functions to produce some forms of truth and to disqualify others."[79] Of particular interest then is what dominant discourses are present within the community of inquiry around religion and HIV/AIDS, how they are maintained, what institutions of power they are connected to, and how they impact on collaborative inquiry, for example, shaping discourses, research agendas and ultimately constructing knowledge.[80] Discourses are organised around "… practices of exclusion. Whilst what it is possible to say seems self-evident and natural, this naturalness is a result of what has been excluded, that which is almost unsayable."[81]

Utilising this language, 'miscommunication' is less about specific signs and meaning, and more tied to what Wodak calls "disorders of discourse":

> …the distortion of discourse (in Habermas' sense…) leads to 'disorders of discourse' in actually occurring everyday interaction. Understanding is the exception, misunderstanding and conflict are the rule. The distortions however, are of a quite systematic nature and correspond to more abstract orders of discourse, as described by Foucault … By finding out what power relations are acting on a discourse, one may therefore consider what kind of communication or non-communication they lead to.[82]

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[77] E. Burman et al., "Power and discourse: culture and change in South Africa," in *Culture, power and difference: discourse analysis in South Africa*, ed. A. Levett, et al. (Cape Town: Zed Books, 1997), 2-3.

[78] Thornton, "Finding culture," 41.

[79] M.T. Gibbons, "Introduction: the politics of interpretation," in *Interpreting politics*, ed. M.T. Gibbons (New York: New York University Press, 1987).

[80] See M. Foucault, "The order of discourse," in *Untying the text: a post-structuralist reader*, ed. R.J.C. Young (London and Boston: Routledge & Kegan Paul, 1981).

[81] Mills, *Discourse*, 12.

[82] R. Wodak, *Disorders of discourse* (New York: Addison Wesley Longman, 1996), 15-18.

As noted in Gunderson's commentary above, the communication gaps between disciplines at the intersection of religion and public health are based on different constructions of "truth" in this context coming into conflict. Foucault uses the term *regime of truth,* "…to describe the circular relation between truth, the systems of power that produce and sustain it, and the effects of power that it induces and that it in turn reconfigures. Truth, in this sense, is already power: we can forget the fight for or against a particular truth and instead interrogate the rules at work in a society that distinguishes 'true' representations from 'false' ones."[83]

Working within a framework of cultural studies and discourse, the purpose then is not to uncover the "truth" of particular statements about religion and HIV/AIDS; for example, there is no intention here to draw any conclusions about whether or not religious leaders should be involved in HIV/AIDS prevention, or how effective the religious response to HIV/AIDS has been. Rather, the intention of analysing the dominant discourses circulating in this community inquiry is "to discover the (socio-cultural) support mechanisms which keep it in place."[84] Said differently, it is to interrogate the systems of power which produce and sustain different "truths" within this community of inquiry.[85]

The concepts of discourse and dominant discourses as they are utilised in cultural studies is particularly useful in broad-gauge interdisciplinary studies such as this, as discourse is a concept that usefully crosses over different paradigms and disciplinary boundaries, (one of the reasons it has become so central to cultural studies). As Mill says, "discourse is therefore useful in that it can allow us to analyse similarities across a range of texts as the products of a particular set of power/knowledge relations,"[86] thus allowing for the integration of a variety of texts within one conceptual frame. A cultural studies approach also recognises that there are always a multiplicity of discourses and cultures at play in any given context, and discourses are both the "object and site of struggle"[87] – which is clearly relevant to this community of inquiry with its multiple intersecting voices and agendas.

Discourse analysis (as one of the key methods of this research) almost always adapts a critical perspective on language.[88] Yet it is necessary to make a distinction between the discourse analysis

[83] P. Treichler, *How to have theory in an epidemic: Cultural chronicles of AIDS* (Durham, London: Duke University Press, 1999), 139. See M. Foucault, "The political function of the intellectual," *Radical Philosophy* 17, no. 13-14 (1977).
[84] Mills, *Discourse*, 49.
[85] See Treichler, *How to have theory*, 139.
[86] Mills, *Discourse*, 23.
[87] Mills, *Discourse*, 16.
[88] See A. Jaworski and N. Coupland, "Introduction," in *The discourse reader*, ed. A. Jaworski and N. Coupland (London: Routledge, 1999), 32.

(with a critical perspective) commonly utilised in cultural studies, and the Critical Discourse Analysis (CDA) more commonly utilised by socio-linguists or psychologists, the latter typically being a closer analysis of text and syntax.[89] A useful example is the different level of discourse analysed in HIV/AIDS literature, with my use of critical discourse analysis being closer to the work of authors such as Treichler (who examines the dominant discourses associated with terms such as "Third World AIDS"),[90] than those who look at how discourses of HIV/AIDS impact on individual experiences of the disease.[91] This thesis seeks to present an analysis of broader trends in the public texts, visible in a range of academic publications, research reports, conference papers, meeting reports, as well as so-called "grey" literature such as organisational reports and statements.[92]Cultural studies typically embraces the complexity created by globalisation and the modernisation of communication, resulting in multiple discursive points (or sources).[93]

Cultural studies is inherently interdisciplinary, and there are several areas of overlap between cultural studies and "interdisciplinary studies" (IDS),[94] although they do not necessarily identify the same subject.[95] A focus on IDS brings several additional factors to the metaframework, namely, an interest in disciplinary knowledge formation and formulation (such as Klein's work on boundary crossing), and the focus on epistemology, interdisciplinary research and collaboration praxis. However, these interests fit together surprisingly well when addressing the community of inquiry at the intersection of religion and public health in SSA. There is a tradition of engaging with disciplines as cultures, and of seeking to understand academic discourses,[96] that provides a bridge between these two parts of this metatheoretical framework. In addition, cultural studies has some

[89] See J. Blommaert and C. Bulcaen, "Critical discourse analysis," *Annual Review of Anthropology* 29, no. 1 (2000). I find that Mills provides a useful overview of different styles of discourse and usage of discourse analysis. Mills, *Discourse*.

[90] See Treichler, *How to have theory*.

[91] See A. Strebel, "Putting discourse analysis to work in AIDS prevention," in *Culture, power and difference*, ed. A. Levett, et al. (Cape Town: University of Cape Town Press, 1997). There is significant overlap between these levels of discourse analysis, especially in the HIV/AIDS literature. Both examples providing relevant and useful information, "…the differences between critical discourse analysis and cultural studies in relation to explicitness and replicability are not very great". Threadgold, "Cultural studies," 6.

[92] Again, as mentioned above, the object of this investigation is the discourse of the community of inquiry, rather than that of the voice of "the people" – although some attempt is made to draw in this consideration in the later chapters.

[93] See P. Treichler, "AIDS and HIV infection in the third world: a first world chronicle," in *AIDS: the making of a chronic disease*, ed. E. Fee and D.M. Fox (Berkeley: University of California Press, 1992), 400.

[94] See Repko, *Interdisciplinary research*, S. Nuttall and C. Michael, "Introduction: imagining the present," in *Senses of culture: South African culture studies*, ed. S. Nuttall and C. Michael (Cape Town: Oxford University Press, 2000).

[95] W.P. Germano, "Why interdisciplinarity isn't enough," in *The practice of cultural analysis: exposing interdisciplinary interpretation*, ed. M. Bal (Stanford, California: Stanford University Press, 1999), 331.

[96] See Chapter Five below. An interesting metaphor is presented by T. Becher and P.R. Trowler, *Academic tribes and territories: intellectual enquiry and the cultures of disciplines*, 2nd ed. (Milton Keynes: Society for Research into Higher Education and Open University Press, 1989).

significant interest in engaging with academic disciplines (as knowledge produced through power relations).[97]

While finding this relevant, this investigation does not take an anti-disciplinary stance, (to the contrary, I agree with Repko that the bodies of knowledge that have been built in the disciplines retain their value, and that the disciplines remain foundational to interdisciplinary inquiry),[98] but find this a critical perspective capable of considering the issues of power that influence knowledge and knowledge production through disciplines. A constructivist stance applied to disciplines takes the perspective that Palsson has named the "Epidemiology of Social Theory … what Sperber has called Foucault, Marx and Kuhn's contention that all academic disciplines are shaped by the social context in which they are practiced … the scientific paradigms and conventional standards of scholarship are inevitably rooted in history."[99] This is important later in examining competing constructions of truth in religious and public health discourses.[100]

Both cultural studies and interdisciplinary studies have been critiqued for lacking rigour and critical literacy,[101] and a disciplinary specialist might well find the broad and exploratory nature of this study frustrating. However, as argued above, at this time, broad-gauge interdisciplinary scholarship is *the* most urgently required approach, since it provides much needed perspective to rapidly evolving intersection of religion, public health and HIV/AIDS.

A further critique of both cultural studies and interdisciplinary studies is that such research often reveals more about the researcher than the material being researched.[102] In response both cultural studies and interdisciplinary studies emphasise self-reflexivity as an imperative as well as a tool.[103] In this way, the author intentionally becomes as critically self-exposed and consistently suspicious of his/her influences and motives as possible, allowing readers to build their own understanding of the researcher's position and the research process. In this spirit, perhaps the following list positions me sufficiently at this time: interdisciplinarian, humanities scholar, social scientist, interpretivist, science-friendly, statistics-friendly, female, religiously-undefined, currently HIV-negative, South African… The list could go on of course, and merely represents a commitment to try to be aware of my own power position throughout this project. I do believe that I do not have a

[97] See Munns and Rajan, eds., *Cultural studies*, 657.

[98] See Repko, *Interdisciplinary research*.

[99] G. Pálsson, "Introduction: beyond boundaries," in *Beyond boundaries: understanding, translation, and anthropological discourse*, ed. G. Pálsson (Oxford: Berg, 1993), 39.

[100] See Chapter Five.

[101] See Nuttall and Michael, "Introduction," 16, Klein, *Interdisciplinarity*, 194.

[102] S Blommaert and Bulcaen, "Critical discourse analysis.", Mills, *Discourse*.

[103] See Repko, *Interdisciplinary research*, 137.

particular disciplinary (or cultural) preference for either religious studies or public health, and in this sense, will aspire to a determinedly neutral position throughout this thesis.[104]

The scope of this study is further limited by its bias towards English-language materials, English being the main medium of global health and HIV/AIDS,[105] the language of the bulk of the available literature being collected and analysed,[106] and my first language. In addition, there is a slight bias towards "mainstream" Christian perspectives, reflecting the available secondary literature, which will be managed.[107]

Thesis Organisation

> *…Each case study reveals challenges in bridging divergent approaches and language between secular and faith organisations…*[108]

In what follows, I briefly sketch the structure of the chapters to follow provide the reader with a preliminary map of the themes and arguments that I will revisit in the individual chapters. The entire thesis can be seen as an interdisciplinary project, with separate parts that strive for an integrated cohesion through an iterative spiral rather than a linear progression.[109] Subsequent chapters each apply a slightly different lens onto this community of inquiry using the basic metatheoretical framework described above, but drawing on varying materials and theories.

The core problem this thesis addresses is therefore that in the face of what appears to be a great deal of overt appreciation for interaction and cooperation in the HIV/AIDS industry, and particularly the newly emerging intersection of religion and public health, a large number of the tensions, misunderstandings and problems that occur could be accrued to matters of discourse or interdisciplinary communication. This is not a question of how we communicate messages about religion and HIV/AIDS to "the masses," on which there is already a great deal of research being carried out, but rather how "we professionals" communicate about religion and HIV/AIDS to "each other".

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[104] However difficult or unlikely such a neutral position is in reality. It is also necessary to note that I emerge from a much stronger background in "interpretivist" traditions as opposed to "positivist" traditions – which will be discussed in more detail in the chapters that follow.

[105] The WHO for example conducts most of its business in English. See Treichler, "AIDS in the third world," 389-399.

[106] Some attempts have been made to include other language materials (e.g. French-language materials through the Gates 2008 literature review), and ARHAP workshops are run in local languages and then translated.

[107] These biases reflect an imbalance in the literature that needs correcting.

[108] Marshall and Van Saanen, *Development and faith*, 11.

[109] Similar to the idea of a hermeneutic circle. See Repko, *Interdisciplinary research*, 17, Z. Bauman, *Hermeneutics and social science: Approaches to understanding* (London: Hutchinson & Co, 1978).

The first part of Chapter Two, "Mapping the Cultural Politics of Religion, Public Health and HIV/AIDS in Africa," sketches the context of this intersection between religion and public health, noting the effect of secularization and modernization in making religion invisible to both academic and institutional public health radar. The second part of this chapter introduces another key body of literature, what I have named the "cultural politics of HIV/AIDS." Central to this literature is the conception that HIV/AIDS has been "constructed", and that power influences perceptions and interactions with the pandemic, as well as such related issues as research agendas.[110]

I argue here that there has been a disconnection between these bodies of literature, and what is therefore urgently needed is a complex mapping of the cultural politics of religion and HIV/AIDS in SSA, a project which subsequent chapters undertake. In other words, I argue that it is urgent for us to learn from the significant scholarship on culture, power and HIV/AIDS, and apply this to the community of inquiry at the intersection of religion and public health, considering power impacts on such critical issues as communication or research agendas.

Chapter Three, "Mapping the Religious Response to HIV/AIDS in SSA," begins by continuing the discussion from the previous chapter, this time providing a brief chronicle of the development of the intersection of religion and HIV/AIDS in SSA. The focus of this chapter is on deepening our understanding of the representations of the religious response to HIV/AIDS in SSA; to better understand the way particular assumptions (positive and negative) about the religious response are constructed and maintained. A question that remains begging is what exactly one means by and includes in one's understanding of religion in relation to public health, especially in relation to HIV/AIDS, and in terms of empirical phenomena. This is not self-evident, and a core concern in this chapter is the constructed nature of a "religious" versus a "secular" response, which is a lingering tension throughout this work. What emerges is a context which is home to a particularly powerful set of conflicting discourses which make it remarkably difficult to make any conclusions about the religious response to HIV/AIDS, and especially difficult for policy work. Here I argue that partnerships across the religion and public health interface often run ahead of knowledge, with negative implications for practice.

This discussion is continued in Chapter Four "'An FB-oh?': Mapping the etymology of the religious entity," which focuses on the apparent conflict around language and power expressed in the naming and definition battles that occur between those who are trying to promote the role of religion in public health, with the aim of uncovering their effects on possibilities of collaborative

[110] A social constructionist perspective has been introduced earlier in this chapter – and will be described in more detail in relation to HIV/AIDS in Chapter Two.

communication and action. The issue is tackled by paying attention to discursive patterns of engagement. This chapter emphasises some of the underlying issues of power that (it is argued), sustain the naming and terminological difficulties that are prevalent.

The focus is then turned more directly towards issues of discipline and interdisciplinarity. In Chapter Five, "Mapping the Boundary Between the Academic Tribes of Religion and Public Health," it is questioned how the construction of disciplinary boundaries (or "tribes of religion and public health") affects communication in this field. It is argued here that a significant amount of knowledge about transdisciplinary research and collaboration is not being utilised within this community of inquiry, interrogate underlying tensions in the "translation" metaphor that is so prevalent there, and consider how this affects research agendas and cultures.

In Chapter Six, "Mapping an Interdisciplinary Research Collaboration: The African Religious Health Assets Programme," the focus turns to the empirical base of my investigations, the African Religious Health Assets Programme (ARHAP), and is utilised as a case study for interdisciplinary research collaboration at the intersection of religion and public health. A largely descriptive chapter, it deals with how new language is formed to shape discourses between the "tribes" of religion and of public health, what helps or hinders collaboration, and what this case tells us about strategies of interdisciplinary collaboration and communication more broadly.

The final section, Chapter Seven, "Mapping respectful dialectic" draws the different threads of this together by addressing issues of "dialogue" in practice within this community of inquiry. The concept of "respectful dialogue", as advocated by ARHAP, is argued as necessary for collaboration at the intersection between religion and public health, based on empirical research on HIV/AIDS intervention in SSA. At this point, earlier considerations of power dynamics in the communication process are reintroduced, probing areas of "distorted communication" and considering what this means for the training of "boundary leaders" moving into this community of inquiry, and for "religious-health literacy", two other emerging concerns within this community of inquiry. Gradually, this argument moves towards the proposal of a model of "respectful dialectic," where appreciation of difference is fore-grounded.

Finally, in the conclusion, titled "Towards Common Ground," the insights of the study are summarised, and consideration given towards what this means for communication and collaboration in the community of inquiry concerned with the interface of religion and public health. In closing, this investigation provides some reflection on what these insights mean beyond the topic of HIV/AIDS.

How to Have Theory in an Epidemic

> *Against the urgency of people dying in the streets, what in God's name is the point of cultural studies?*[111]

Finally, there is a danger that this broad and multi-layered problem as described above may appear philosophical, with its interest in discourse, research and discipline a seemingly self-indulgent academic task. A practitioner-colleague working in the field of religion and health once exclaimed during an academic conference, "we don't do discourse in real life!" A sentiment echoed repeatedly in meetings between academics and practitioners at the intersection of religion and public health, and particularly hard-felt when focusing with the realities of HIV/AIDS. A focus on language and social constructivism can certainly be frustrating and distressing in face of the despair and practical demands of the HIV/AIDS epidemic. Marais has also noted, "In such a world, time can seem a luxury, and the rigors of critical enquiry an indulgence."[112] On reflection, I may have been too light-hearted in my introduction, having deliberately avoided making introductory statements about the devastating HIV/AIDS epidemic in Africa, and its accompanying statistics or heart-rending narratives of children living in boxes,[113] nor did I mention that the country which is my home has the highest HIV rates in the world. Treichler has also asked what the place of theory is in the face of the HIV/AIDS epidemic "…to speak of AIDS as a linguistic construction … (may seem) like philosophising in the middle of a war zone." She continues, "but … making sense of AIDS compels us to address questions of signification and representation … Language is not a substitute for reality; it is one of the most significant ways we know reality, experience it, and articulate it; indeed, language plays a powerful role in producing experience and in certifying that experience is 'authentic'."[114]

Instances of speaking past each other, of being silenced, or of miscommunication are perilous in this time of epidemic crisis. Communication is not merely an exchange of information, but lies at the heart of crucial issues of decision-making and implementation. The key questions are therefore: how are religious and health professionals communicating with each other about HIV and AIDS? What attitudes and tensions are revealed by considering the discourse that occurs in collaborative or interdisciplinary spaces? What theories and strategies could be implemented to improve collaboration and cooperative practice?

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[111] Stuart Hall in Treichler, *How to have theory*, 3.

[112] H. Marais, "To the edge: AIDS review 2000," (Pretoria, South Africa: University of Pretoria, 2000). (check PM 2004)

[113] See Chapter Two

[114] Treichler, *How to have theory*, 4.

Renewed cooperation and increased dialogue between religion and public health means nothing if the communication that occurs continues to be filled with misunderstanding and tension. In the desperately urgent context of HIV/AIDS, and in countries where resources are not only scarce but critically needed, every meeting, every instance of miscommunication that either leads to inertia, dialogue fatigue, or non-collaborative practice is a crisis, and an offence. It is precisely in this time of crisis, few resources and the urgent need to "get on with it," that we must acknowledge that every missed opportunity is a disaster. Every meeting that has happened, but has not had significant results, every introduction that has not led to a working relationship, every moment of miscommunication, of being silenced, or speaking past each other like ships in the night is a tragedy.

It is argued in the chapters that follow that in the rush to form new partnerships and collaboration at a number of levels, those working in this community of inquiry (at whatever level and in whatever context) have not paused to consider how our language is constructing what we believe,. We do not adequately understand how our discourse is being shaped or silenced. We have not reflected adequately on how we might converse and collaborate *better,* rather than just *more* – and we have not enough strategies in place to overcome the multiple effects of power forming barriers to communication. It is my contention that perhaps what is needed in this particular war zone *is* some philosophising, or at least a moment of time given to reflection, to apply a critical eye to what we are saying to each other about religion, public health and HIV/AIDS in SSA.

Chapter Two. Mapping the Cultural Politics of Religion, Public Health and HIV/AIDS in Africa

> *…Whitehead recalled the 'calm prophetic' manner in which Snow described the future of their mutual investigation. 'You and I may not live to see the day,' Snow explained to the young curate, 'and my name may be forgotten when it comes; but the time will arrive when great outbreaks of cholera will be things of the past; and it is the knowledge of the way in which the disease is propagated which will cause them to disappear'.*[115]

As John Snow removed the Broad street pump handle in 1854, he could not have known that he was about to become a leading figure in the mythology of modern public health, or that he would later become known as the 'Father of Public Health'.[116] A lot has been written about Snow and that particular cholera outbreak over the last hundred and fifty years, but recently a new account emerged by Steven Johnson called *The Ghost Map*,[117] which details John Snow's journey of scientific inquiry during this period. What is particularly interesting about this version of the John Snow story is the way Johnson weaves the narrative of Dr. Snow's discovery with that of another, much lesser known character, assistant curate Henry Whitehead from St. Luke's church.

Whitehead was making his own inquiry into the cholera outbreak in the Broad street community while he made his rounds among parishioners. *The Ghost Map* tells the story of two separate streams of inquiry, Snow "(drawing) maps in his head, looking for patterns, looking for clues,"[118] and Whitehead "grappling with the theological implications of the outbreak," as well as his personal experiences in the community.[119] Ultimately, however, according to Johnson's account, it was the dialectical relationship between Snow and Whitehead that eventually solved the mystery, a combination of Whitehead's "firsthand knowledge of the neighbourhood"[120] and Snow's biomedical experience and innovation.

This narrative will be addressed again later in this chapter, but of interest right now is the way a religious character has only recently been "rewritten" back into a foundational myth of modern public health, rewritten into the narrative of this most important process of inquiry. The HIV/AIDS pandemic has its own foundational mythology, for example as can be seen in *As the Band Played On,*[121] which chronicles the initial outbreak and inquiry from an American perspective. There is no

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[115] S. Johnson, *The ghost map* (New York: Riverhead Books, 2006), 181.
[116] Or more accurately, the 'Father of Modern Epidemiology' – see http://www.ph.ucla.edu/epi/snow.html
[117] Johnson, *Ghost map*.
[118] Johnson, *Ghost map*, 149.
[119] Johnson, *Ghost map*, 170.
[120] Johnson, *Ghost map*, 53.
[121] R. Shilts, *And the band played on: politics, people, and the AIDS epidemic* (New York: St. Martin's Press, 1987).

And the Band Played On for Africa or for sub-Saharan Africa (SSA). Historians came late into engagement with African AIDS, and historical accounts of HIV/AIDS in Africa have generally come under scrutiny and criticism (and most often self-scrutiny).[122] As Setel notes, "the historical manifestations of STDs and HIV/AIDS are often both ambiguous and diverse, and knowledge of them has been and continues to be limited…"[123] The narratives of African HIV/AIDS has from the start been tied up in North-South dynamics (such as the battles that occurred over whether HIV/AIDS originated in Africa or not, and certain interpretations from within Africa such as the one that AIDS is a bio-weapon from the North).[124] As will be explored in this chapter, the story of religious engagement is glaringly absent from the mainstream chronicle of African HIV/AIDS,[125] only rarely appearing as an occasional religious figure, and never as a part of the narrative surrounding the inquiry and early engagement with the African epidemics.[126] I was intrigued to be told by a colleague working for the Uganda Catholic Medical Bureau (UCMB), in an off-hand comment during a conference tea break, that he was the person who had flown with the first blood samples of the then unknown disease to Paris.[127] I cannot help but wonder if there is not another *Ghost Map* story here as well, a rewriting which includes a narrative of religious engagement in the process of discovery, management and inquiry into HIV/AIDS in Africa, a story in which it seems likely that some religious characters and organisations might have played an important role, even if a dialectical one.

The following chapter provides a swift review of two key thematic areas: the intersection of religion and public health, and the cultural politics of HIV/AIDS. Through this process, I will argue that what is lacking is a complex mapping of the cultural politics of religion and HIV/AIDS in SSA, a project which subsequent chapters undertake. The broad purpose of this chapter is to give a wide-ranging overview, with a medley of concrete examples, of the key concerns and problems facing the community of inquiry at the intersection of religion and HIV/AIDS in SSA. Wodak argues that discourses are essentially historical, that "discourse is not produced and cannot be understood

[122] See E. Fee and D.M. Fox, "Introduction: the contemporary historiography of AIDS," in *AIDS: The making of a chronic disease*, ed. E. Fee and D.M. Fox (Berkeley: University of California Press, 1992), P.W. Setel, "Comparative histories of sexually transmitted diseases and HIV/AIDS in Africa: An introduction," in *Histories of STDs and HIV/AIDS in sub-Saharan Africa*, ed. P.W. Setel, M. Lewis, and M. Lyons (London: Greenwood Press, 1999).

[123] Setel, "Comparative histories," 12.

[124] As many scholars have noted, any such descriptor (North-South, Western-Eastern, developed-developing, first world – third world) is problematic. Where possible I have kept to the North-South distinction, recognizing that it is imprecise.

[125] I use the term "chronicle" in keeping with the work of Paula Treichler's work, which explores the "cultural chronicles of AIDS". See Treichler, *How to have theory*, 4.

[126] I speak here specifically about the broad historical accounts about HIV/AIDS in Africa, and in particular those addressing the stages of inquiry. Obviously there has been ongoing commentary about the religious response to HIV/AIDS in Africa more generally, see Chapter Three for more.

[127] Personal correspondence, Dr Sam Orach, June 2009.

without taking the context into consideration."[128] I endeavour here to provide much of the context in which the discourses analysed in the later chapters are based, and therefore rely on a broad range of literature that is relevant to these two interdisciplinary focus-areas.[129]

Religion and Public Health in Africa: An Emerging Field of Inquiry

> *…what I have tried to show here is how profoundly religion has been intertwined with the public health movement over a long time, as a counter to what one might call a general lapse of memory in the field of public health about this history.*[130]

The intersection of religion and public health is an emerging field of inquiry, and one that has already been subject to a few literature reviews in the last few years.[131] I do not seek here to reiterate these studies, but rather to swiftly lay out some of the key themes as they are relevant to this project. In the first years of the twenty-first century, a realisation has caught the imagination of a number of individuals from a variety of institutions and locations, namely, that there is a significant gap in knowledge between what we know about religion and public health. Several scholars began to ask how this gap had been formed, looking back in history, and seeking to "relearn" what religion had or had not been doing in public health, but also, how this knowledge gap had been created, or the epistemology that resulted in this situation.

Religion and public health have ancient ties, working together on the health of the public long before the current conceptions of modern public health were formed. Lee and Newberg consider the ancient relationship between religion and health as it has "cycled between cooperation and antagonism throughout history ... physicians and other health-care providers have been viewed by religious groups as everything from evil sorcerers to conduits of God's healing powers. Similarly, physicians', scientists', and health-care providers' views of religion have ranged from interest to disinterest to disdain."[132] I do not seek to go into an extended discussion here on when the terms religion and health became separate in Western classification systems.[133] But focusing instead on

[128] Wodak, *Disorders of discourse*, 19.

[129] The narrower focus on SSA is less useful in this chapter which draws in a broader literature which generally speaks of HIV/AIDS in Africa without specifying which countries.

[130] J.R. Cochrane, "Fire from above, fire from below: health, justice and the persistence of the sacred," *Theoria* 116 (2008).

[131] See Cochrane, "Fire from above", J.R. Cochrane, "Religion, public health and a church for the 21st century," *International Review of Mission* 95, no. 376-377 (2006), ARHAP, "Appreciating assets.", Olivier et al., "ARHAP literature.", Schmid et al., "Contribution of REs.", CHART, "The cartography of HIV and AIDS, religion and theology: A partially annotated bibliography," ed. B. Schmid (Pietermaritzburg: The Collaborative for HIV and AIDS, Religion and Theology (CHART) - School of Religion and Theology, University of KwaZulu-Natal, 2009), Cochrane, "Fire from above."

[132] B.Y. Lee and A.B. Newberg, "Religion and health: a review and critical analysis," *Zygon* 40, no. 2 (2005): 443-444.

[133] See Chapter Five for some further discussion on this.

what happened to the way we think about religion and public health, beginning around the time of the Enlightenment, and carried forward under the labels of secularism and modernisation.

> The secularisation thesis suggests, among other things, that as societies develop and modernise they will tend to follow the pattern that developed in Europe during the 20th century where religion has been increasingly relegated to the back seat and seemed to loose its influence in public life. The idea here, that religion will disappear or wither away as the superstition and ignorance that it supposedly represents is eroded by rational thought, is heavily rooted in Enlightenment thinking, by its very nature a backlash against the dominance of the church and theology during the period preceding the Enlightenment.[134]

Modernisation held (and holds) an inherent bias towards religion, where religions were seen as obstacles to progress.[135] "In general, the materialist assumptions of modernisation have been incompatible with religious and spiritual dimensions of society and culture … religion and spirituality have generally been overlooked as positive resources for development, but rather have been viewed as areas of resistance that need to be overcome through creative strategising."[136] Religion was also seen to be opposed to modernity and its connected forms of rationality. Theories and discourses of modernisation had a similar impact, seen in theories and policies of development: that the more developed a nation was, the more technically advanced it was, the less religion would be a factor. It is important to remind ourselves that we are not only speaking of religion in its "mainline" forms, such as Christianity or Islam. Religious forms more easily classified with "traditional culture" were especially hard hit by these modernist perspectives. As Melkote and Steeves say, "through every possible mechanism – economic, political, social, discursive, and spatial – modernisation aimed to replace nearly everything indigenous with imports from the West … this meant a dismantling of most things non-Western including traditional culture. Traditional culture included religion, which often seemed the greatest impediment to progress."[137]

In terms of the different elements of public health, religion was overtly removed from politics as part of the separation of church and state (as religion became held as something private); from a civil society perspective, religious organisations working in health became classified as a subset of non-governmental organisations (NGOs) or civil society; and in academia, as secularisation

[134] Olivier et al., "ARHAP literature."

[135] S.R. Melkote and H.L. Steeves, *Communication for development in the Third World: theory and practice for empowerment* (London: Sage, 2001), 94.

[136] Melkote and Steeves, *Communication for development*, 95.

[137] Melkote and Steeves, *Communication for development*. 94

discourse began to dominate across the human and natural sciences, religion began to be "written out".[138] Religious departments disappeared and were often consumed by others fields such as anthropology and sociology.[139] This all worked to create an inherent bias against religion in many of these fields which lingers today.[140] This was most hard felt in the human sciences, the home of religious studies where, "the negative view prevailed in the social sciences in the second half of the twentieth century, and fundamentally shaped methodologies towards a kind of religion-blindness."[141]

> The influence of the great thinkers of the Enlightenment - and the "masters of suspicion" (Ricoeur) of the Nineteenth Century, Marx, Freud, Nietzsche - led to a founding assumption that has dominated Twentieth Century social science: Because religion is irrational and rationality is the basis of the future, religion as a social reality will decline in modern societies. This assumption became a methodological sine qua non in the social sciences, leading to a generally low level on interest in religion among most social scientists and philosophers.[142]

Beyond the social sciences, the situation was even more extreme, as "religion" was constructed as the binary opposite (antithesis) of "science," a discourse that is remains strong today.[143] O'Connor and Meakes speak of the influences of the scientific revolution, and that the relationship between religion and science has evolved into two forms, "One was a relationship of antagonism where there was open hostility with each seeking to prove the other wrong, while the other was one of separation … in which religion dealt with the spirit and science dealt with the material, with little connection between the two."[144] A number of powerful binary discourses emerged, with science-rationality-progress on the one side, and religion-irrationality-tradition on the other. In these discourses, public health emerged very much on the side of science-rationality-progress. As Peterson and Lupton note, "that both public health and scientific medicine demonstrate a

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[138] See J.R. Cochrane, "Understanding religious health assets for public health systems" (paper presented at the DIFAM Consultation on Religion and Health, Tübingen, Germany, February 2006), Melkote and Steeves, *Communication for development*.

[139] Olivier et al, *ARHAP Review*, 6. See S. Oliver and M. Warrier, eds., *Theology and religious studies: an exploration of disciplinary boundaries* (London and New York: T & T Clark, 2008), M. Warrier, "The disciplines and their boundaries: an introduction," in *Theology and religious studies: an exploration of disciplinary boundaries*, ed. S. Oliver and M. Warrier (London and New York: T & T Clark, 2008).

[140] J. Casanova, *Public religions in the modern world* (Chicago and London: University of Chicago Press, 1994).

[141] Cochrane, "Understanding RHAs", 17.

[142] J.R. Cochrane, "Religion as social capital in the context of health: mapping the field," in *ARHAP: Assets and Agency Colloquium* (Pietermaritzburg, South Africa: African Religious Health Assets Programme, 2003), 42.

[143] See Chapter Five for further discussion of the religion-science discourse.

[144] T.S.J. O'Connor and E. Meakes, "Towards a joint paradigm reconciling faith and research," in *Spirituality and health: multidisciplinary explorations*, ed. A. Meier, T.S.J. O'Connor, and P. Van Katwyk (Waterloo, Canada: Wilfrid Laurier University Press, 2005), 11. We will return to this in Chapter Five

modernist approach is not surprising, given that they emerged at a similar time in history, the post-Enlightenment period, which was characterised by a turning away from the 'superstition' of religion to the power of human thought as a means of control over the vagaries of nature."[145]

Linked to the scientific revolution and the emergence of biomedicine as the dominant force of the modern era,[146] public health rose to become a dominant social, political and academic force. As Cochrane says, "the twentieth century might be called the century of public health. Beginning with vital insights at the end of the nineteenth century on the importance of clean and safe water, of sanitation, of sterilisation, and of population scale interventions in the conditions of ill-health, public health was born."[147] In the 1970s and 1980s public health's successes against the pandemics of infectious diseases, for example 'conquering' smallpox and polio, were applauded as "… grand monuments to the work of public health practitioners and policy makers."[148]

Alongside this process of the burgeoning dominance of modernist science, biomedicine and public health - religion and the public health work of religious communities and organisations disappeared from the sight of public health. This is described in the following quotation from an article written by Donna Coffman:

> Since the last half of the nineteenth century, western societies have been blessed with the miracles of modern medicine. Highly refined surgical techniques, antibiotics, immunisations, and technologies that probe the deepest mysteries of the human body have changed the way we go about curing and healing. Along with skilled, specialised health care professionals these advancements and others have brought us to a time and place in medicine that 150 years ago was unimaginable. However, in the midst of this flood of discovery and progress, a tragedy occurred. Many of the bridges between faith and health were washed out. In the excitement and thrill of the explosion of scientific knowledge, the church relinquished her position as the centre of healing for individuals and communities. The bridges that existed for centuries collapsed in a matter of a few decades. Faith and health were segregated. As we approach a new millennium, many are

[145] A. Petersen and D. Lupton, *The new public health: health and self in the age of risk* (London: Sage Publications, 1996), 6.

[146] Foucault speaks of the overwhelming influence of "biopower," and argues that this has become the "dark, but firm web of our experience." Foucault in D. Armstrong, "Social theorizing about health and illness," in *Handbook of social studies in health and medicine*, ed. G.L. Albrecht, R. Fitzpatrick, and S. Scrimshaw (Beverly Hills, CA: Sage, 2000). See Mills, *Discourse*.

[147] Cochrane, "Religion for the 21st century," 60-61.

[148] Cochrane, "Religion for the 21st century," 61. See R. Detels and L. Breslow, "Current scope and concerns in public health," in *Oxford textbook of public health: the scope of public health*, ed. R. Detels, et al. (New York: Oxford University Press, 1997), 3.

> disillusioned and struggle with a gnawing fear about the state of health care in our country and around the world. In a culture that prizes specialisation, health care (and perhaps life in general) has become very fragmented. We take our bodies to doctors, our souls to church, and our minds to school.[149]

In public health terms, this resulted in religion and religious entities becoming largely invisible in public health literature; or said differently (in public health systems speak), religious facilities became unaligned with national and international health systems and resources.[150]

The Re-emergence of Religion into Public Life

> *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.*[151]

Then, late in the twentieth century, something unexpected happened, contrary to the predictions of modernist and secular theories, religion began to re-emerge into public life on a number of startling fronts.[152-153] There has been great interest in the flourishing of religious movements across the globe (for example, Pentecostal and charismatic varieties of Christianity in SSA, a highly political Islam in North Africa, as well as religious revivals in Asia and the United States).[154] However, in the context of this thesis, of more interest than the burgeoning levels of religiosity is the re-emergence of religion as a valid topic in several public arenas of inquiry. There are a number of elements to this re-emergence relevant to the interface of religion and public health.

The most obvious example of this re-emergence of religion onto public inquiry is linked to the reappearance of religion into the political sphere, challenging the secular-modernist conceptions of separation of religion and state. This political re-emergence can be viewed either positively or negatively, but is strongly visible in many settings. For example, America saw an emergence of right-wing religious voices emerging more strongly into political life, and African nations also saw an emergence of religious discourse (for example, newly elected President Frederick Chiluba

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[149] D.B. Coffman, "Linking faith and health," (2002), http://www.union-psce.edu/news/Publications/archive/LinkingFaithAndHealth.html.

[150] See Schmid et al., "Contribution of REs," 92, ARHAP, "Appreciating assets."

[151] C. Benn, "Why religious health assets matter," in *ARHAP: Assets and Agency Colloquium* (Pietermaritzburg, South Africa: (ARHAP) African Religious Health Assets Programme, 2003), 9.

[152] Cochrane, "Religion as social capital," 42. See J. Derrida and G. Vattimo, *Religion*, Cultural Memory in the Present (Cambridge, UK: Polity Press, 1998).

[153] Note: "Labelling it a 'revival' or 'resurgence' in some ways conveys the misleading impression of a trend that previously existed but that had gone underground, whereas in fact many of today's most visible religious movements have long been publicly active, but have only recently become subject to academic scrutiny." S. Ellis and G. TerHaar, *Worlds of power: religious thought and political practice in Africa* (Johannesburg: Wits University Press, 2001), 5.

[154] See Ellis and TerHaar, *Worlds of power*, 1.

officially declared Zambia to be a Christian nation in December 1991).[155] However, the most obvious re-emergence of religion onto the political stage came after the 11 September 2001 attacks in America, which resulted in a rapid politicisation of religion on a global scale, most often as a political liability, but nevertheless spurring an increase in interest, commentary and inquiry into the role of religion in public life. Baderoon notes how Islam in particular has "entered the gaze of Western media, and therefore public consciousness, in moments of crisis … the vertiginous shift from obscurity to constant presence occurred in a context of perceived threat."[156] Depending on context and perspective, "…the 'resurgence of religion' has been welcomed by many as a means of supplying what they see as a needed moral dimension to secular politics and environmental concerns… (and) regarded by others with alarm as a symptom of growing irrationality and intolerance in everyday life."[157]

Less public, but just as influential has been the re-emergence of religion in academia and scholarship. The most obvious, was the critique (or failure) of the secularisation and modernism theses. As Juergensmeyer says, "Enlightenment and modernity proclaimed the death of religion … now resurgent religious activists have proclaimed the death of secularism."[158] However, it was not only resurgent religious activists, but a broad range of commentators and scholars who have noted that the secularisation thesis had critical flaws, in particular the basic idea that development or modernisation equals secularisation.[159] Berger, a key proponent of the secularisation thesis, admits in 1999 that, "…the assumption that we live in a secularised world is false. The world today … is as furiously religious as it ever was, and in some places more so than ever. This means that a whole body of literature by historians and social scientists loosely labelled 'secularisation theory' is essentially mistaken. In my early work I contributed to this literature."[160]

In the human sciences, alongside this critique of the secularisation thesis (which, at its most basic, says that modernisation leads to a decline in religion), Eurocentric constructions of modernity were increasingly being challenged. Critical theorists began to challenge constructions of traditional cultures or beliefs as "irrational" or "pre-modern," traditional cultures here including "religion". As Melkote and Steeves say, "the dominant paradigm has been criticised for the way it conceptualised

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[155] See P.L. Berger, "The desecularization of the world: a global overview," in *The desecularization of the world: resurgent religion and world politics*, ed. P.L. Berger (Washington D.C.: Ethics and Public Policy Centre, 1999).

[156] G. Baderoon, "Covering the East – veils and masks: orientalism in South African media," in *Shifting selves: Post-apartheid essays on mass media, culture and identity*, ed. H. Wasserman and S. Jacobs (Cape Town: Kwela Books, 2003), 317.

[157] T. Asad, *Formations of the secular: Christianity, Islam, modernity*, Cultural memory in the present (Stanford: Stanford University Press, 2003), 1.

[158] M. Juergensmeyer, *Terror in the mind of God: the global rise of religious violence* (Oxford University Press, 2001), 225.

[159] See Casanova, *Public religions*, Cochrane, "Religion as social capital.", Derrida and Vattimo, *Religion: cultural memory.*

[160] Berger, "Desecularization," 2.

the role of non-Western cultures, especially their religious traditions."[161] All this has led to a revitalisation of scholarship and inquiry into religion in the academe, "hitherto discarded or marginally treated as purely tenacious and atavistic … religion has become an important motif in the scholarly analyses of contemporary issues that shape interpersonal, social, national, and international relations."[162] This is not to say that religion has re-emerged into academia in a blindly positivistic way, to the contrary, it has emerged into a deeply suspicious and antagonistic scholarly environment.[163]

But how did this emergence play out in the chronicle of public health? Putting it bluntly, while religion was re-emerging back into public life, public health was going into crisis.[164] Laurie Garrett eloquently describes the "collapse of global public health" in the 1980s and 1990s, saying "the past decade has witnessed a profound transformation in the challenges to global health; persistent problems have been joined by new scourges in a world that is ever more complex and interdependent.[165] Garrett gives examples such as weakened health systems, increasing environmental loads, increased vulnerability and general failures in public health strategies. She describes the WHO, "once the conscience of global health" as having "lost is way in the 1990s. Demoralised, rife with rumours of corruption, and lacking in leadership, the WHO floundered."[166] Even in the face of scientific and biomedical advances, public health found itself "… (struggling) to maintain respect, funding, and self-definition in the late twentieth century."[167] Over a hundred years after the rise of modern public health, and "its most fundamental objectives are at risk, that public health interventions are failing rather than succeeding, and that public health systems everywhere are in crisis."[168]

Of particular interest was the seeming failure of the primary health care movement (PHC), which had evolved through the participation of religious entities and grew out of the Alma Ata

[161] Melkote and Steeves, *Communication for development*, 201.

[162] U.O. Uzodike and A. Whetho, "In search of a public sphere: mainstreaming religious networks into the African Renaissance agenda," *Politikon* 35, no. 2 (2008): 197.

[163] A basic example can be seen in the flurry of writing from scientists on religion which is mainly evident of extreme reactions and differing interpretations of "religion". See for example the dialectic between "science" Professor Richard Dawkins in his popular book, *The God Delusion,* and Terry Eagleton's review. See R. Dawkins, *The god delusion* (London: Bantam Press, 2006), T. Eagleton, "Lunging, flailing, mispunching," *London Review of Book* 28, no. 20 (2006).

[164] See Cochrane, "Religion for the 21st century."

[165] L. Garrett, *Betrayal of trust: the collapse of global public health* (New York: Hyperion, 2000), 9.

[166] Garrett, *Betrayal*, 9.

[167] Garrett, *Betrayal*, 12.

[168] J.R. Cochrane, "The potential of religious entities for strengthening public health systems in crisis," *The Maghreb Review* 31, no. 1 (2009): 41. See P. Farmer, *Infections and inequalities: the modern plagues* (Berkeley, LA: University of California Press, 1999), Garrett, *Betrayal*, J.Y. Kim et al., eds., *Dying for growth: global inequality and the health of the poor* (Monroe, ME: Common Courage Press, 2000).

Conference in 1978, but ultimately developed a secular ideology.[169] O'Manique describes this failure:

> The PHC approach embodied the ideas that health depended on improving socio-economic conditions and alleviating poverty, and that the process should be community-based and should support health priorities at a local level. The emphasis of health planning shifted from the construction of hospitals to PHC centres, which were to be decentralized, foster local participation, and use appropriate technology. The birth of Alma-Ata, however, was quickly followed by its death barely 2 years later … Although the practice of PHC was rather short-lived, the discourse did not disappear.[170]

Garret describes the status of the public health discipline in the 1990s, saying: "regardless of the mission statements of academic centres, it was clear by the 1990s that public health, as a discipline, was changing rapidly … it was no longer sufficient to prove that a given intervention prevented disease and saved lives: it now had to be done *affordably."*[171]

A significant factor in this was the emergence of HIV/AIDS in the 1980s, which seriously undermined previous confidence (that epidemic disease had been conquered), and emphasised failures of public health strategies as well as severe weaknesses in public health systems, particularly African public health systems. In Africa, it became clear that a price was being paid for a history of inadequate health resources and interventions.[172]

> Africa has 10% of the world's population, 25% of the global disease burden and is home to nearly a third of all people living with HIV and AIDS … Health systems are overstretched and buckling in working against this huge burden of disease while also responding to structural challenges. Health systems are under-resourced … and often having to depend to a large extent on unreliable funding sources; or funds that are designated for vertical programs rather than primary health care. The human resource crisis is severe …[173]

In an echoing of the failure of the secularisation thesis, against all expectations, global public health (backed by modernisation, scientific progress, and development strategies), had apparently not resulted in the improvement of health generally or the strengthening of public health systems as it had foretold.

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[169] See J. Olivier and G. Paterson, "Religion and medicine in the context of HIV and AIDS: a landscaping review," in *The Collaborative for HIV and AIDS, Religion and Theology*, ed. B. Haddad (2010 [forthcoming]).

[170] O'Manique, *Neoliberalism*, 51-52.

[171] Garrett, *Betrayal*, 7.

[172] See Farmer, *Infections*, Kim et al., eds., *Dying for growth*, Setel, "Comparative histories."

[173] Schmid et al., "Contribution of REs," 10.

It is in this context of weakened health systems, lessened public health resources and increased uncertainty that religion has re-emerged onto the radar (or into the discourse) of public health. It is here that the community of inquiry, the object of this study, began to emerge. While the reasoning and specifics of this increased interest will be explored later, it is possible to identify two main areas of interest in the early stages of this inquiry, firstly, the recognition of the importance of religion to individual and community health decisions, and secondly, the possibility of assets held by religious communities that could be leveraged in this context of strained health systems and limited resources.

The first area of interest is tied to the failure of the secularisation thesis, and the renewed realisation that religion remains important to the health of individuals and communities, and in this context, important to their health and interaction with public health. The secularisation thesis is clearly difficult to maintain in face of the visible presence of religion in public and private life today, and once that is recognised, its logical effects on individual and population-scale health. Speaking to the African context, De Gruchy says:

> Though often hidden from Western view, religion is so overwhelmingly significant in the African search for wellbeing, so deeply woven in the rhythms of everyday life, and so deeply entwined in African values, attitudes, perspectives and decision-making frameworks that the inability to understand religion leads to an inability to understand people's lives.[174]

What this means is that for a majority of Africans, their interpretations of life and health would be powerfully religious.[175] The logical corollary of this, is that any public health strategy that did not recognise this, is likely to fail. This drove a renewed discussion that recognised the important role of religion in "… (structuring) human experience, beliefs, values, behaviour, and illness patterns."[176] In 2000 WHO Director General Gro Harlem Brundtland stated, "we must go beyond the traditional health sector - working with people in their homes, their work places, their schools, their community halls and their places of worship,' to confront diseases of poverty."[177]

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[174] S. De Gruchy, "Like housework in the economy: The hidden ubiquity of religion in African wellbeing." (paper presented at the Talk to Religion and Health connection Luncheon, of the Interfaith Health Program of Rollins School of Public Health, Emory University, July 2006), 2.

[175] See C. Benn, "The future role of church related hospitals and health services in developing countries," in *The future role of church related hospitals and health services in developing countries* (Tübingen: German Institute for Medical Mission (DIFAEM) 2002). See Chapter One and glossary for description of what is indicated as inclusive of "religion" in Africa.

[176] D. Luckoff et al., "Toward a more culturally sensitive DSM-IV: Psychoreligious and psychospiritual problems," *Journal of Nervous and Mental Diseases* 180, no. 11 (1992): 673.

[177] Brundtland in R. Martin, "The future of Christian hospitals in developing countries: The call for a new paradigm of ministry," (APHA, 1999), 1.

The second thrust of the renewed interest is based on the discourse that religion holds assets for public health.[178] It has been noted in several texts that since the late 1990s many global health agencies (such as WHO, GFATM, World Bank, UNICEF) began to "…turn to religious bodies who might offer what is otherwise lacking."[179] Both these slightly different interests in religion from a public health perspective will be discussed in more detail in the chapters that follow. Relevant right now, however, is that alongside this new interest in religion from the international public health community, came a startling realisation that due to the effects of modernisation and secularisation on the scholarly community, as described above, little or no information was available to assist this renewed collaboration between religion and public health, and in particular, information relevant to *African* religion and public health. For example, Cochrane says:

> Increasingly, donors, governments, and multilateral institutions, among others, recognise the importance of religious health institutions and networks in combating HIV/AIDS and other health challenges in Africa … Meanwhile, public health agencies are increasingly expecting faith-based groups to play a major role in promoting health and caring for the sick. Despite this, we face a dearth of systematic knowledge of the institutional and structural assets of FBOs. A comprehensive, simple baseline picture of existing FBO facilities in most African countries does not exist, and studies that might help deepen our understanding of the actual and potential contribution to health made by religious institutions or FBOs are rare … Whether one views them with scepticism or anticipation … faith-based organisations and initiatives that affect public health require proper assessment.[180]

From an academic perspective, running a few steps ahead of the inquiry into religion and public health, was a slightly different but related interest in religion and individual health, sometimes named the intersection of "spirituality and health."[181] There are several useful reviews of this body of literature.[182] O'Connor observes that before 1970 there was little research exploring the link

[178] The "assets" language has obvious ties to economics. The use of "religious health assets," coined by ARHAP scholars but which is being utilised more broadly, and which is based on the assets-based development approach as advocated by Kretzmann and McKnight, see J. Kretzmann and J.L. McKnight, *Building communities from the inside out: a path toward finding and mobilizing a community's assets* (Chicago: ACTA Publications, 1993).

[179] Cochrane, "Religion for the 21st century," 61. See Olivier et al., "ARHAP literature," 6-7, Schmid et al., "Contribution of REs."

[180] Cochrane, "Understanding RHAs", 6.

[181] A distinction between 'spirituality and health' and 'religion and public health' is somewhat artificial and there is obvious overlap between the two areas. Nevertheless, this has increasingly become a useful distinction for a number of scholars to assist in mapping knowledge gaps, even it is a distinction that heuristic in nature. See Olivier et al., "ARHAP literature," 1-10.

[182] See H.G.M. Koenig et al., *Handbook of religion and health* (Oxford: Oxford University Press, 2001). Lee and Newberg, "Religion and health." A. Meier et al., eds., *Spirituality and health: multidisciplinary explorations* (Waterloo, Canada:

between spiritual care and health, but that since then, "… the amount of research by health care professionals on spiritual care and health has exploded."[183] Stefanek et al conduct a literature search on both "religion and health" and "spirituality and health" from 1993-2002, and note a 600% increase in publications on spirituality and health over this period.[184] Within the area of spirituality and health is inquiry into the way religion encompasses behavioural, attitudinal, public, and private activities, all of which potentially involve different consequences for health outcomes, and generally covers interests such as coping, psychological well-being and social support, religious-health practices, religious effects on health outcomes, negative effects of religion, and implications for health practice.[185] DeHaven and colleagues describe the decade from the 1990s-2000 as a "faith and health movement,"[186] but this movement is more closely linked with the idea of religion and spirituality, rather than the inquiry into religion and public health which only became visible several years later, and which has a stronger focus on the population scale implications of inquiry between religion and health.

Increased Inquiry at the Intersection of Religion and Public Health

> *Religion is in fact like housework in the economy ... Religion is so overwhelmingly significant in the African search for wellbeing, and yet is conspicuous by its absence in scholarly debates about politics, economics, development, and public health. Because the scholars don't do it … they assume that it is not done at all. And that, if you think about it, is as silly a notion that housework does not contribute to economic life.*[187]

The realisation of this gap in knowledge (on the intersection of religion and public health) has resulted in a bloom of inquiry and publication in this area.[188] But it is important to recognise that this emerging inquiry is situated in the context described above. For example, having been written out of much of the historical narrative of public health (as a result of the modernist and secularisation of social science and public health), there is evidence of emerging "revisionist" historical narratives (or discourses) at the intersection of religion and public health. In other words, there is a trend for authors to look back over the period influenced by modernisation and

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Wilfrid Laurier University Press, 2005). L.H. Powell et al., "Religion and spirituality: Linkages to physical health," *American Journal of Psychology* 58 (2003).

[183] O'Connor in O'Connor and Meakes, "Joint paradigm," 15.

[184] M. Stefanek et al., "Religion, spirituality and cancer: Current status and methodological challenges," *Psycho-oncology* 14, no. 4 (2004): 450.

[185] Koenig et al 2001; See also Peltzer & Koenig 2004, Olivier et al., "ARHAP literature," 18.

[186] Speaking from an American perspective. M. DeHaven et al., "Health programs in faith-based organizations: Are they effective?," *American Journal of Public Health* 94, no. 6 (2004): 25.

[187] De Gruchy, "Like housework in the economy", 1.

[188] The chapter that follows this one reviews the different trends of this emerging research.

secularisation and argue retrospectively that religion *was* significantly involved in public health in a variety of ways. For example, a narrative device is to note that there was significant religious involvement in the development of the WHO Alma Ata, for example, Cochrane notes:

> It is perhaps no surprise, therefore, that the major leap into primary health care in the 1960s, taken up by the World Health Organisation and famously ratified in its Alma Ata Declaration in 1978, also had roots in Christian medical mission work, inspired by the idea of the "barefoot doctor," and catalysed through crucial gatherings hosted by the German Institute for Medical Mission …[189]

Another device is to point to religious figures who were pioneers of the public health movement, for example the key figures of the social gospel movement at the end of the nineteenth century who influenced the emergence of modern public health.[190] Or (the most evident strategy) to point to the long history of religious healthcare in Africa, usually quoting percentages of health sector currently owned by religious communities.[191] Such narrative strategies say more about the current context of inquiry around religion and public health than about the facts of religious involvement. That is, like Johnson's rewriting of the narrative of Dr. Snow's battle with cholera, it is the fact that such a rewriting is necessary that is really of interest here.

In the chapters that follow, we will return to other examples of how the community of inquiry around religion and public health is having to rewrite many such narratives, and so doing, expose the underlying discourses and institutions of power that maintain discourses of modernisation, secularisation and resurging religion. For it should not be thought that there has been a general sea-change in perspective, or that public health (in its various forms) is now completely interested and open to collaboration with religion and religious institutions. "Religionophobia" in the form of doubt, suspicion and negative perceptions of religion and religious involvement in public health continue to linger today,[192] as does "…the belief that religion is derivative (of an economic, political or other social reality) at most, hence illusory or unhelpful and of no relevance to the question of public health or heath care generally, continues to appear in the literature. "[193] In the recent

[189] Cochrane, "Religion for the 21st century," 61. See Olivier and Paterson, "Religion and medicine."

[190] See G. Gunderson, "Good news for the whole community: Reflections on the history of the first century of the social gospel movement" (paper presented at The Earl Lecture, Pacific School of Religion, 1998), Cochrane, "Fire from above.", Cochrane, "Understanding RHAs".

[191] See Chapter Three and Four for further discussion of this device.

[192] See K. Marshall, "Confronting Religionophobia," *Washington Post*, no. August 10 (2009), http: //newsweek.washingtonpost.com/onfaith/georgetown/2009/08/confronting_religionophobia, Cochrane, "Fire from above."

[193] Olivier et al., "ARHAP literature," 11-12.

November 2009 meeting on mapping standards in Geneva, Canon Ted Karpf of the WHO (a key character in the development of the religious-public health conversation) noted:

> There is a great deal moving in the international community on the global health stage. A parallel movement (is) going on among those administering faith health assets, including: faith-based, faith-inspired and faith-related health ministries, health organisations and health services. While it would appear that these separate movements are converging towards a common expression, I regret to tell you that they are not! … there are several of us in the UN and intergovernmental system who have been successful in moving the door ajar…organisations such as UNAIDS, the Global Fund, World Bank, UNFPA, UNDP and WHO have increased their dialogue and begun to deepen their understanding of the faith communities and the health and social services they provide … the fact remains that religious health assets are a 'hard sell' for many who are not often the recipients of their services … simply put, the cultural environment is still hostile towards neutral, and only occasionally welcoming, usually when there are systemic failures or a global health emergency ... [194]

Such negative and resistant perspectives must similarly be understood in the broader context described above, since the inquiry into religion and public health is so clearly influenced by the context (academic, public or otherwise) from which it emerges.

An Emerging Field and Community of Inquiry: Opportunities for Common Ground

It is in this context that a community of inquiry has emerged at the intersection of religion and public health, within which rests the more specific focus on HIV/AIDS in SSA (the object of this thesis). One strategy of assessing the stage (and status) of an emerging field of inquiry is to assess its forms of communication: its publications, journals, and collaborative associations. Applying that lens, the religion-public health community is in its infancy. As mentioned in the introduction, in the last decade, several collaborative bodies have been formed that engage in this inquiry, and a few academic programs have begun with a focus on religion and public health, mainly in South Africa, the USA and the UK. There are no journals dedicated to this inquiry, and the academic publications emerging are dispersed across different disciplinary fields, although few have made it into hallowed journals such as *The Lancet* or *Social Science and Medicine*. What this rapid survey shows is a new but swiftly emerging field of inquiry (certainly not yet an academic interdiscipline, studies area or paradigm), whose individual components are located in different institutions and on

[194] Karpf in WHO-CIFA, "NGO mapping".

different continents. The communication within this group may happen in a church hall in Zambia, a meeting in Geneva, or through written academic dialogue. However, while the number of communicative encounters may be increasing, this does not automatically mean that "communication" is increasing, or said better, this does not mean that communication is *improving*. As was noted in the first chapter, this community of inquiry is frequently faced with problems of miscommunication, and is more frequently characterised by frustrations or problems of translation (of knowledge).

Communication is logically acerbated by the diverse range of actors within this community (scholars of different flavours, public health practitioners and decision-makers, religious leaders), who bring different interests to the table. However, the context described above hints at deeper underlying discourses and perspectives that frame the narrative and logically *must* have some impact on the communication – creating difficulties "of disciplines, not tongues."

Public health has been in crisis, there is also broad movements for change. As stated in a World Bank-WHO document:

> …in many countries, public health is in disarray. It is typically under-funded and poorly staffed, and wrongly regarded as marginally important compared to health care delivery. In practice … public health programs have evolved into a number of uncoordinated vertical programs, each working individually and without an overall understanding of the country's public health needs … Efforts to revitalize public health must not lose sight of the importance of focussing on poverty. Traditionally, public health has aimed to improve the health of the majority, without regard to whether benefits are reaching the poorest sectors of society. The goal of modern public health should be to improve the health of whole populations, with a focus on the poorest groups."[195]

There appears to be a general shift of interest, "… a new interest in the 'quality of care,' 'reciprocity,' 'decent care,' and the social determinants of health, are examples of something in motion."[196] This shift has also heralded an interest in a revitalized PHC movement.[197] This paradigm shift appears to offer a great deal of common ground for religion and public health, with many noting the greater connections within discourse of health, global equity and justice.[198]

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[195] WHO-WB, "Dying for change: poor people's experience of health and ill-health," (Geneva: World Health Organisation and The World Bank, 2002), 24.

[196] Cochrane, "Potential of REs."

[197] See Bandy et al., "Building from common foundations," 1-5.

[198] I will engage with this again in Chapter 6. See C. Benn, "The continued paradigm shift in global health and the role of the faith community," in *ARHAP Conference: When religion and health align - mobilizing religious health assets for*

Christoph Benn (currently with The Global Fund to Fight AIDS, Tuberculosis and Malaria, GFATM), concluded a presentation at the 2003 ARHAP conference with the words:

> We might be at the beginning of a new phase in international health in which FBOs will probably play a major role. Are we at a new *kairos*? We do not know and actually it is not in our hands. But we might experience a new paradigm shift in international health policy with much greater investment in the health of poor people, but based on the experience of the PHC movement emphasizing community participation and ownership.[199]

Six years later, in the 2009 ARHAP conference, Benn looks back at these words and asks, "So, was I right at that time? … What is the vision for the future for religious communities and the world at large?"[200] He concludes by saying, "for me the answer is a clear yes but the big question remains what that would mean for FBOs around the world and how they can and should relate to this new paradigm." He then asks,

> …can the faith and the health communities find a common language? Sometimes the biggest challenge for public health experts, representatives of international organisations and the faith community is the lack of a common language and terminology leading 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.[201]

A number of these issues will be picked up again in the later in this thesis. Of obvious importance is how Benn mentions the lack of common language as hampering the engagement of religious entities in this new paradigm. In the following chapter, this intersection of religion and public health will be examined in the context of the HIV/AIDS in SSA, where more specific examples will be provided. I now turn to the second key area focus-area most relevant to this community of inquiry, the cultural politics of HIV/AIDS.

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transformation (Cape Town, South Africa: African Religious Health Assets Programme, 2009 [forthcoming 2010]), J.R. Cochrane, "The potential of religious entities for strengthening public health systems in crisis," *Maghreb Review*, Special Issue: Health in the Maghreb, the Middle East and Africa (forthcoming), Cochrane, "Religion as social capital.", Cochrane, "Potential of REs."

[199] Benn, "Why religious health assets matter," 11. ("Kairos" here meaning a crisis point, or turning point.)

[200] Benn, "Paradigm shift."

[201] Benn, "Paradigm shift."

The Cultural Politics of HIV/AIDS

> *AIDS has changed much in our lives since then, not only in society but in public health, the university and government policy. It is transforming social science, but only recently have we begun to study these effects on social analysis…the progressive impact of the disease on science and society.*[202]

Does the global HIV/AIDS crisis or its manifestations in sub-Saharan Africa (SSA) require introduction? Perhaps it still does. Even so, I am torn between two ways of introducing the pandemic, a tension that is the consistent focus of this thesis. Starting then with an opening statement more commonly found in public health literature: "sub-Saharan Africa remains the region most heavily affected by HIV. In 2008, sub-Saharan Africa accounted for 67% of HIV infections worldwide, 68% of new HIV infections among adults and 91% of new HIV infections among children. The region also accounted for 72% of the world's AIDS-related deaths in 2008."[203] Now the other kind of introduction, more in the character with the literature emerging from religious authors, a narrative passed on by a colleague:

> I have not even one family in my parish that has so much as one brick in their home, they are so poor. Our community health clinic has been replaced by an AIDS centre. When the mother leading our AIDS care team was diagnosed with AIDS herself, her husband threw her out of the house and away from her children. Her birth family would not take her back, so in a month she died in a box-shelter on the church grounds.[204]

Whichever introduction you find more compelling, both speak to a multiplex disease that has emerged into the private, public, political and academic space as a complex and frequently confounding factor. It is not possible to overstate the direct devastation it has wrought on our families, communities and populations. It has also ripped away the social and theoretical security of a much broader society. As many critics have noted, HIV/AIDS has exposed our weaknesses, travelling down the fault lines of our societies, and exposing our failures to a harsh and uncompromising glare. Peter Piot, Director of The Joint UN Program on HIV/AIDS (UNAIDS) said, "AIDS is travelling along social fault lines and exploiting weakness, hurting both lives and economies'' all over the world."[205] Fineberg agrees, "…more than other diseases, AIDS/HIV has

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[202] G. Herdt, "Introduction," in *The time of AIDS: social analysis, theory and method*, ed. G. Herdt and S. Lindebaum (London: Sage Publications, 1992), 3.

[203] UNAIDS, "AIDS epidemic update: November 2009," (Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS) and World Health Organization (WHO), 2009), 21.

[204] G.R. Gunderson, *Boundary leaders: leadership skills for people of faith* (Minneapolis: Fortress Press, 2004), 1.

[205] Peter Piot Laying waste a continent, news article published in 2003

exposed the 'hidden vulnerabilities in the human condition'."[206] The hidden vulnerabilities exposed have not only been social concerns such as racism, sexism, and economic imbalances, but have also been vulnerabilities in the systems and frameworks we *apply* to such concerns, failures of theory, of public health strategies, of biomedical and social science knowledge, as well as failures of collaboration and empathy with frameworks and perspectives different to our own.[207]

Weeks notes that "…one of the most striking features of AIDS has been the unusual, perhaps unique degree to which the group that was most affected by it took part in all aspects of its management."[208] People living with and affected by HIV/AIDS became involved in the pandemic, and on an unprecedented scale became involved in the critique of the way the disease was being handled by governments, society, and science. Scholars and commentators from a range of disciplines and sectors also took up this task and utilised theories of critical consciousness (such as postmodernism, social/cultural constructionism, post-structuralism, Marxism and feminism) to engage with the pandemic.[209] The literature I have collected under the banner of "the cultural politics of HIV/AIDS" addresses these concerns, critiquing the way the pandemic has emerged, the way it has come to be understood, experienced, communicated and researched. For example, Schoepf argues, "the cultural politics of AIDS are now well understood; their effects were to increase the velocity of the pandemic, rather than to slow it … Common in public health discourse,

[206] Fineberg in Herdt, *Introduction,* 3.

[207] M.C. Bateson and R. Goldsby, *Thinking AIDS: The social response to the biological threat* (New York: Addison-Wesley Publishing, 1988), 4, P. Farmer, "New disorder, old dilemmas: AIDS and anthropology in Haiti," in *The time of AIDS: Social analysis, theory and method*, ed. G. Herdt and S. Lindenbaum (London, New Delhi: Sage Publications, 1992). See Farmer, "New disorder, old dilemmas: AIDS and anthropology in Haiti," 313.

[208] J. Weeks, "AIDS: the intellectual agenda," in *AIDS: social representations, social practices*, ed. P. Aggleton, G. Hart, and P. Davies (New York: The Falmer Press, 1989), 6.

[209] For example, a few of the book collections addressing this are: D. Nelkin et al., eds., *A disease of society: Cultural and institutional responses to AIDS* (New York: Cambridge University Press, 1991), J.R. Oppong and E. Kalipeni, "A cross-cultural perspective on AIDS in Africa: A response to rushing," *African Urban and Rural Studies* 3, no. 2 (1996), Treichler, *How to have theory*, P. Aggleton and P. Davis, eds., *AIDS: individual, cultural and policy dimensions* (London: The Falmer Press, 1990), P. Aggleton et al., eds., *AIDS: social representations, social practices* (New York: The Falmer Press, 1989), P. Aggleton and H. Homans, eds., *Social aspects of AIDS* (London: The Falmer Press, 1988), R.S. Barbour and G. Huby, eds., *Meddling with mythology: AIDS and the social construction of knowledge* (London and New York: Routledge, 1998), J. Baxen and A. Breidlid, eds., *HIV/AIDS in sub-Saharan Africa: understanding the implications of culture and context* (Cape Town: University of Cape Town Press, 2009), V. Berridge and P. Strong, eds., *AIDS and contemporary history* (New York: Cambridge University Press, 1993), T.M. Edgar et al., eds., *Communication perspectives on HIV/AIDS for the 21st century*, LEA's communication series: Health literacy and AIDS treatment and prevention (New York: Lawrence Erlbaum Associates/Taylor & Francis Group, 2008), G.T.H. Ellison et al., eds., *Learning from HIV and AIDS*, The Biosocial Society symposium series (Cambridge, United Kingdom: Cambridge University Press, 2003), E. Fee and D.M. Fox, eds., *AIDS: The making of a chronic disease* (Berkeley: University of California Press, 1992), J. Gow and C. Desmond, eds., *Impacts and interventions: The HIV/AIDS epidemic and the children of South Africa* (Durban, South Africa: University of Natal Press, 2002), Herdt and Lindenbaum, eds., *The time of AIDS: Social analysis, theory and method*, K.R. Hope, ed., *AIDS and development in Africa: a social science perspective* (London and New York: The Haworth Press, 1999), J. Huber and B.E. Schneider, eds., *The social context of AIDS* (Newbur Park, California: Sage Publications, 1992), E. Kalipeni et al., eds., *HIV and AIDS in Africa: Beyond epidemiology* (Oxford: Blackwell, 2004), K.D. Kauffman and D.L. Lindauer, eds., *AIDS in South Africa: A social expression of a pandemic* (New York: Palgrave MacMillan, 2004).

such constructions (of 'risk groups') are part of a 'hegemonic process' that helps dominant groups to maintain, reinforce, reconstruct, and obscure the workings of the established social order."[210]

What links these together is an interest in the way that HIV/AIDS emerges within a social context, the way complex processes and concepts are understood, and the way these conceptions of the disease affect our responses to the pandemic.

> A critical approach to the HIV epidemic requires that the production of health and the production of knowledge become sites of contestation and re-articulation. Epidemic conditions rationalise and augment regulatory power regimes … To open up sites of the production of health to democratic contestation is to allow the re-articulation of how illness and information are managed, crafted, controlled; how identities are fractured or constituted.[211]

Emerging from multiple disciplines, this literature addresses these fault lines and hidden vulnerabilities. Of key interest to most (if not all) these critical commentators has been the role language has played in shaping our experiences and understanding of the HIV/AIDS pandemic. As early as 1988, Sontag famously argued in *AIDS and its Metaphors* that HIV/AIDS should be stripped of its metaphors, saying, "the age-old, seemingly inexorable process whereby diseases acquire meanings (by coming to stand for the deepest fears) and inflect stigma is always worth challenging … but the metaphors cannot be distanced just by abstaining from them. They have to be exposed, criticised, belaboured, used up.[212] Whether or not it is possible to strip disease from its metaphors is a discussion for another day, but Sontag's call, to expose, critique and belabour these metaphors is a mission many others have taken up in the context of HIV/AIDS. Treichler has aptly named this "an epidemic of signification,"[213] observing that the HIV/AIDS epidemic has produced a parallel epidemic of meanings, definitions and attributions.

> For AIDS, where meanings are overwhelming in their sheer volume and often explicitly linked to extreme political agendas, we do not know whose meanings will become 'the official story.' We need *an epidemiology of signification* - a comprehensive mapping and analysis of these multiple meanings … Although the signification process for AIDS is by now

[210] B.G. Schoepf, "AIDS, history and struggles over meaning," in *HIV and AIDS in Africa: Beyond epidemiology* ed. E. Kalipeni, et al. (Oxford: Blackwell, 2004), 16.
[211] E. Reid, "Epidemic logic and its alternatives," in *Experiencing and understanding AIDS in Africa*, ed. C. Becker and J.P. Dozon (Paris: Codesria-Karthala, 1999), 99.
[212] S. Sontag, *Illness as metaphor, and AIDS and its metaphors* (London: Penguin, 1991), 182.
[213] Treichler, *How to have theory*.

> very broad - just about everyone, seemingly, has offered 'readings' of what AIDS means…[214]

Many scholars have begun this task, to unpack the epidemic of signification, emerging from a number of disciplines but showing a shared interest in how culture, language, power and knowledge impact on perceptions and experiences of HIV/AIDS. Authors have engaged with the cultural politics at a number of levels, examining how "prevailing public depictions of the disease … impact on individual experience, public views and policy formation."[215] The texts that have been analysed and deconstructed in this project range from media and educational materials to academic literature and children's drawings. Scholars have approached this task of analysing the "epidemiology of signification" from a variety of disciplinary perspectives, and broadly utilised discourse analytical methods to do so.[216] However, a common theme on communication about HIV/AIDS as being of critical importance:

> To believe that information and communication about AIDS will separate fact from fiction and reality from metaphor is to suppress the linguistic complexity of everyday life. Furthermore, to inform is also to perform; to communicate is also to construct and interpret. Information does not simply exist; it issues from and in turn sustains a way of looking at and behaving towards the world; it shapes programmatic agendas and even guides capital investments. Diverse voices, then, represent not diverse accounts of reality but significant points of articulation for ongoing social and cultural struggles.[217]

In unpacking HIV/AIDS as an epidemic of signification, Treichler points out that while HIV/AIDS is a complex cultural phenomenon that produces diversity and contradiction, dominant meanings also emerge, default meanings that can be expressed with little fear of being challenged. These dominant discourses therefore create "preferred readings" of public texts, that is, the reader is not passive, but is positioned at a nexus of various power influences, where a dominant discourse has a greater impact and effect.[218] Dominant discourses that have been unpacked are (for example): biomedical discourses, discourses of gender, discourse of race, medico-moral discourses, and discourses of "African AIDS."[219] These all impact on the constructed meaning of HIV/AIDS.[220]

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[214] Emphasis mine. Treichler, *How to have theory*, 39.

[215] Strebel, "Discourse analysis," 109.

[216] See K. Plummer, "Organizing AIDS," in *Social aspects of AIDS*, ed. P. Aggleton and H. Homans (London: The Falmer Press, 1988), G. Seidel, "The competing discourses of HIV/AIDS in sub-Saharan Africa: Discourses of rights and empowerment vs discourses of control and exclusion," *Social Science & Medicine* 36 (1993), Strebel, "Discourse analysis."

[217] Treichler, "AIDS in the third world," 401.

[218] Treichler, *How to have theory*.

[219] For all see Treichler, *How to have theory*.

By exposing vulnerabilities and gaps in our knowledge, the critical inquiry into HIV/AIDS has become more than an investigation of a specific disease, but has evolved into broader inquiry about the problem complex of self and society, and also the ways we go about researching or inquiring into these problems, with HIV/AIDS as the lens. As HIV/AIDS has exposed fault lines in society (vulnerabilities of the human condition), it has also exposed the fragility and unpreparedness of our systems of enquiry and knowledge formulation. For example Horton and Aggleton question the AIDS research paradigm, "a set of taken-for-granted assumptions concerning the nature and aetiology of AIDS that frames the questions many scientific, medical and social researchers currently ask."[221]

Biomedicine, the powerful institution of modern society, has been shaken through its very public failures; public health (not expecting to see infectious diseases again) was caught unprepared, social science found some of its main theoretical and methodological tools coming under fire (for example, the difficult to acknowledge failures of knowledge-attitude-behaviour models in the context of HIV/AIDS).[222] The modern community of inquiry (academics, researchers and practitioners) suddenly found itself having much in common with Procopius who said about the plague in 430BC, "so it was that in this disease there was no cause which came within the province of human reasoning, for in all cases the issue tended to be something unaccountable."[223]

In fact, from an academic or research perspective, the HIV/AIDS epidemic has shaken the foundations of many theoretical and conceptual paradigms, and has resulted in a substantive amount of critique of the frameworks and methods of inquiry available to interrogate the pandemic. That is, within the cultural politics of HIV/AIDS there has been a strong critique of HIV/AIDS agendas, and specifically, the agendas that impact on research and inquiry.[224] In this sense, HIV/AIDS has been perceived as a lens for examining the broader vulnerabilities and weaknesses of the scholarly production of knowledge, and therefore HIV/AIDS research is relevant beyond the disease-specific aetiology. Critical scholars have considered not only how our systems of inquiry are inadequate, but also how they are frequently complicit in the formulation of harmful

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[220] It is not helpful to review everything that has been said about the cultural politics of HIV/AIDS, since the texts referenced above do extensive work on this already. This is only a broad sketch of a multidisciplinary field of interest.

[221] M. Horton and P. Aggleton, "Perverts, inverts and experts: the cultural production of an AIDS research paradigm," in *AIDS: social representations, social practices*, ed. P. Aggleton, G. Hart, and P. Davies (New York: The Falmer Press, 1989), 74.

[222] C. Patton, "What science knows: formations of AIDS knowledges," in *AIDS: individual, cultural and policy dimensions*, ed. P. Aggleton and P. Davis (London: The Falmer Press, 1990), 2. Patton notes that these failures did not greatly affect the status of biomedicine, which continued to rise.

[223] Procopius, *History of the wars*, trans. H.B. Deuring, vol. 2 (London: Heinemann, 1914), 463.

[224] A particularly useful text addressing this is, Ellison et al., eds., *Learning from HIV and AIDS*. See also P.W. Setel, *A plague of paradoxes. Aids, culture, and demography in Northern Tanzania.* (Chicago: The University of Chicago Press, 1999), Barbour and Huby, eds., *Meddling with mythology: AIDS and the social construction of knowledge*.

constructions of the disease, being tied to dominant discourses (such as race or gender). For example, Fee and Fox say, "AIDS is a particularly good example of the social construction of disease. In the process of defining both the disease and the persons infected, politics and social perceptions have been embedded in scientific and policy constructions of their reality and meaning."[225] Therefore, the critical and self-reflexive tools wielded in the literature addressing the cultural politics of HIV/AIDS address our complicit role as researchers in the production of HIV/AIDS and AIDS-related knowledge.[226]

> The boundaries of what can and cannot be said are shifting and are socially, culturally and historically contingent … The research enterprise is similarly a historical and social product. The boundaries between what research should or should not legitimately and usefully address, together with the professional standards of conduct, shift with the times."[227]

As described in Chapter One, the project of the cultural politics of HIV/AIDS, is less about arriving at a "truth" about HIV/AIDS, and more about critically examining the process and consequences of particular forms of narrative construction of disease, "how narratives perform as well as inform, how information constructs reality."[228] Engaging in the cultural politics of HIV/AIDS means becoming more self-reflective about our forms of knowledge and belief, whether they emerge in the media, literature, policy or scholarship.[229]

This has particular ramifications for inquiring about "African AIDS." One concern that several scholars have noted is the constant tension between African and Western representations of African AIDS. For example Treichler critically deconstructs First World discourse about HIV/AIDS in the Third World showing how it is tied to pre-existing perceptions of race, gender, sexuality.[230] Critically, it has been argued that the African HIV/AIDS pandemic is not just a biomedical problem, but is directly tied to broader concerns, as Setel says:

> AIDS in Kilimanjaro has been an outgrowth of culture, history, demography and political economy. That it has been a disorder of social reproduction … I have argued that AIDS [in Africa] has been a plague of paradoxes, of concentric catastrophes, of disordered relations

[225] Fee and Fox, "Introduction," 9.

[226] See R.S. Barbour and G. Huby, "Introduction: Meddling with mythology," in *Meddling with mythology: AIDS and the social construction of knowledge*, ed. R.S. Barbour and G. Huby (London and New York: Routledge, 1998), 2, Schoepf, "Beyond epidemiology."

[227] Barbour and Huby, "Introduction," 3.

[228] Fee and Fox, "Introduction," 17.

[229] See Fee and Fox, "Introduction," 17.

[230] See Treichler, *How to have theory*.

> of power from the interpersonal to the international, the productive to the reproductive, the societal to the sexual.[231]

It has been noted that the international health community focussed its inquiry almost exclusively on sexuality in the first stages of the epidemic (in the 1980s).[232] In the context of African AIDS, this shifted from a focus on homosexuality and risky behaviour, to a focus on African risk groups and individual sexual behaviour, narratives of "deviant African sexuality," and high risk groups such as sex workers, and truckers dominated the research. These discourses remain evident today, for example, speaking of women in Africa, Soskolne notes: "sadly, constructions of black women's 'out-of-control' and enticingly exotic sexuality still persist, and it is promiscuity that is posited to precipitate the spread of AIDS in Africa … rather than stiflingly oppressive gender relations. This amplifies violent forms of social control … and intensifies their marginalisation, so that black women as the ultimate 'other' …"[233] There has been a welling of such critique, that the drivers of the pandemic in Africa are not individual behaviour, but rather the result of historical and contemporary structural injustice. Many scholars have increasingly argued for the link between African AIDS and poverty, political and economic disenfranchisement and risk.[234]

The dominance of the biomedical model and the way it is articulated through discourses of African AIDS has also been challenged.[235] It has been argued that the biomedical discourse dominated the inquiry into HIV/AIDS from its beginning, permeating academic research, policy decision-making and popular understanding.[236] Packard and Epstein argue that early Western medical research on HIV/AIDS in Africa was based on "cultural assumptions about Africa … (and) the peculiarities of African behaviour."[237] Setel notes the "'competing' or parallel discourses about health and control that AIDS has prompted throughout Africa."[238] Many critiques have arisen arguing that AIDS is much more than a biomedical problem, and demanding increased interrogation of the results of the focus on the biomedical, and for increased attentions to other possible modes of inquiry into and engagement with HIV/AIDS. [239]

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[231] Setel, *Plague of paradoxes*, 236.

[232] Schoepf in Setel, *Plague of paradoxes*, 237.

[233] T. Soskolne, "Moving beyond the margins: A narrative analysis of the life stories of women living with HIV/AIDS in Khayelitsha," (Cape Town: Centre for Social Science Research (CSSR), University of Cape Town, 2003), 3.

[234] See Schoepf in Setel, *Plague of paradoxes*, 237.

[235] See Treichler, *How to have theory*, Seidel, "Competing discourses." See chapter 4 for a further interrogation of this

[236] See Soskolne, "Beyond the margins," 1.

[237] See R.M. Packard and P. Epstein, "Medical research on AIDS in Africa: a historical perspective," in *AIDS: The making of a chronic disease*, ed. E. Fee and D.M. Fox (Berkeley: University of California Press, 1992).

[238] Setel, *Plague of paradoxes*, 7.

[239] See Strebel, "Discourse analysis," 109.

Mapping the Cultural Politics of Religion and HIV/AIDS in SSA

> *The concepts of culture and boundaries – implicit in most discussions of social understanding – have been the subject of much theoretical debate.*[240]

All these issues will be explored in more detail in the chapters that follow, and at this time the brief review above is intended to describe two main concerns. Firstly, it should be clear that this body of literature has great relevance to the community of inquiry at the intersections of religion and public health. This focus-area of the cultural politics of HIV/AIDS raises questions of power, knowledge and holds a strongly critical lens to the processes of inquiry into HIV/AIDS such as research agendas and the formations of knowledge, that contain many hard-earned lessons of the realities of conducting interdisciplinary inquiry into complex problems (health and disease) in a global and multi-power-laden context.

However, placing these two focus-areas alongside one another reveals a strange disjunction between the two, for example there is little shared literature or cross citation between the two. Scholars focusing on the cultural politics of HIV/ADS might occasionally mention religion as a factor influencing other discourses (such as gender, stigma, culture), but rarely in relation to the politics of agenda setting and research agendas.[241] Scholars working at the intersection of religion and public health have similarly generally not tapped into the literature on the cultural politics of HIV/AIDS,[242] particularly in relation to understanding the underlying power relations influencing the *research* into religion and public health.

As mentioned in the introduction to this chapter, there is no *Ghost Map* or *As the Band Played On* for SSA, and certainly none that includes religion in a thoughtful way. As a result of the way religion was written out of the academe, it was also written out of the cultural politics of the *inquiry* into HIV/AIDS. There has been no examination of how the exposed vulnerabilities of our systems of inquiry and knowledge has affected the intersection of religion and HIV/AIDS, for example, considering how discourses and research agendas of religion and HIV/AIDS have been influenced by powerful institutions. This is a significant and potentially dangerous gap in knowledge. While religion is 're-emerging' and 'resurfacing' in a variety of ways, and communities of inquiry are growing, I would argue that we have not applied a sufficiently critical perspective to the community of inquiry itself, and considered the research agendas, the barriers and boundaries

[240] Pálsson, "Introduction," 31.

[241] For example, some scholars note a "medico-moral" discourse. See Strebel, "Discourse analysis."

[242] This statement is specific to these bodies of literature identified. It is clear that many critical perspectives have been applied to religion and HIV/AIDS generally, for example those working on HIV/AIDS and gender, or AIDS in Africa from a theological perspective.

formed by power – that connect and disconnect bodies of knowledge and influence practice. There have been significant lessons learned about interdisciplinary research, research and public health agendas, cultural constructions and collaboration that have not been applied to the intersection of religion and HIV/AIDS.[243] My argument here is that what is significantly lacking is attention to the cultural politics of religion and HIV/AIDS in Africa – a mapping of the inquiry into religion and HIV/AIDS in Africa. The chapters that follow take on this project.

Mapping Complexity and the Search for Common Ground

> *There is an inevitable paradox when talking about interdisciplinarity. Our vocabulary – indeed, our entire logic of classification – predisposes us to think in terms of disciplinarity. This predisposition has created a set of metaphoric structures in the discourse. The dominant discourse – the surface structure – is that of geopolitics. The major activity is dispute over territory, not only in education and research but also on health-care teams, where a patient becomes the 'turf' of specialists.*[244]

This chapter has crossed a broad territory, and concluded by arguing that what is required is a mapping of the cultural politics of religion and HIV/AIDS in Africa. Before moving on to the following chapter, I would like to briefly highlight two key themes that have emerged through the interdisciplinary process of this project, and which (retrospectively) are dominant discourses that cross over the different areas of this research. The first theme is "mapping," and the second is "complexity."

The theme of mapping emerges in an astounding variety of ways, so mapping here is a broad discourse that encompasses several different spatial-mapping elements, whether, practical, narrative (metaphorical) or theoretical.[245] It is not an exaggeration to say that mapping appears in every field of knowledge integrated. In interdisciplinary studies spatial metaphors are commonly used to describe interdisciplinary work, for example, boundary crossing (as the process of moving across knowledge formations), bridge building (as the borrowing of tools and methods from disciplines), and mapping (in this context as the idea of carving up knowledge space).[246] Szostak describes interdisciplinary mapping as using an integrative method to map or display information

[243] See Chapter Five

[244] Klein, *Interdisciplinarity*, 77.

[245] In the term mapping I include all related spatial-discourses such as: participatory mapping, boundary crossing, bridge building, boundary leadership, common ground, boundary zones, border strategies, and related discussions of knowledge formations that utilise a spatial metaphor.

[246] Repko, *Interdisciplinary research*, 23.

that is gathered from a variety of sources.[247] Mapping also emerges in cultural studies literature, for example Jameson notes a "fundamentally spatial dimension of cultural studies."[248] Here maps are often viewed as visual texts and social constructed forms of knowledge. Language and cultures are also described utilising spatial metaphors (such as, language barriers, definitional work, or academic tribes and territories). Pálsson notes that "the concepts of culture and boundaries – implicit in most discussions of social understanding – have been the subject of much theoretical debate."[249]

Overlapping with this are the many ways maps, borders and boundaries have been explored in the cultural politics of HIV/AIDS literature. Here, for example, the boundaries between the self and the Other are deconstructed, and the socio-cultural boundaries impacting on HIV/AIDS are deconstructed.[250] Public health has a rapidly burgeoning interest in mapping,[251] and returning to the *Ghost Map*, John Snow could more properly be considered the Father of Public Health Mapping, following Johnson's account of the importance of Dr Snow's development of public health maps over-shadowing the removal of the pump handle.[252]

The emerging literature on religion and public health is littered with discourse about the need for mapping religious health assets, mapping the religious response, or working in boundary zones.[253] All these themes will be explored in more detail in the chapters that follow, but what emerges is a complex integration of spatial metaphors and discourse. Here, whether mapping knowledge or territory, what is critical is the recognition that maps are neither objects nor objective, but are constructions that have been built and maintained through negotiation, conflict, and power.[254]

> Although maps have long been central to the discourse of geography they are seldom read as 'thick' texts or as a socially constructed form of knowledge … the link is increasingly being made between maps and power … but the particular role of maps, as images with

[247] Szostak in Repko, *Interdisciplinary research*, 23.

[248] F. Jameson, "On 'cultural studies'," in *A cultural studies reader: history, theory, practice*, ed. J. Munns and G. Rajan (London and New York: Longman, 1995 [1992]), 639.

[249] Pálsson, "Introduction," 31.

[250] See E.S. Lieberman, *Boundaries of contagion: how ethnic politics have shaped government responses to AIDS* (Princeton: Princeton University Press, 2009).

[251] See K. O'Neill and J.P. Meert, "Putting people and health needs on the map," (Geneva: World Health Organization, 2007).

[252] See Johnson, *Ghost map*, 194-226.

[253] See ARHAP, "Appreciating assets."

[254] There is a strong tradition of scholars examining the connection between maps and power, for example post-colonial studies concerning creation myths of Africa. See A. Blunt and C. McEwan, eds., *Postcolonial geographies: writing past colonialism* (New York: Continuum, 2002).

historically specific codes, remains largely undifferentiated from the wider geographical discourse in which they are often embedded.[255]

Maps and spatial metaphors are therefore a central theme to this work, and the importance of power-through-mapping a core concern.

"Complexity" is the other theme that is constantly referred to. Complexity is a major concern of interdisciplinary studies, both in terms of integration of theory and practice.[256] Cultural studies is based on a hermeneutic of complexity and instability, built on such concepts as a dialogic idea of culture where "the living utterance … (brushes) up against thousands of living dialogic threads."[257] Scholars engaged in the cultural politics of HIV/AIDS consistently mention the multiplex of conflicting discourses in the HIV/AIDS context, and the tension between complex and stereotyped representations.[258] For example, Treichler has noted that "AIDS is a nexus where multiple meanings, stories and discourses intersect and overlap, reinforce and subvert each other."[259] The intersection of religion and public health is characterised by multiple conflicting perspectives and the need to deal with complexity. All this points to the need to engage with complexity as a discourse in its own right.

The community of inquiry at the intersection of religion and public health is beseiged by complexity. Indeed, tools available to this community and to this study, the frameworks and descriptors necessary to gain and share understanding, are constantly undermined. While this will be more thoroughly discussed in the chapters that follow, briefly here, an example can be seen in the difficulty felt in this study around definition of key terms, which in a more standard study would have been laid out in the opening pages. However, all the main concepts of this study have been problematicized. For example, Threadgold says of cultural studies, critical theory and critical discourse analysis, "of the three key terms … not one is ubiquitously well defined or understood in the same ways, in different national, global, disciplinary or interdisciplinary contexts…"[260] Similarly, Munns and Rajan call cultural studies, "An area of study that defies easy and singular definition."[261] Gudykunst and Ting-Toomey say, "There are many definitions of culture … but to date no

[255] J.B. Harley, "Maps, knowledge, power," in *The iconography of landscape: essays on the symbolic use of representation, design and use of past environments* (Cambridge: Cambridge University Press, 1988), 277.

[256] See Klein 2001, Repko, *Interdisciplinary research*, 158. I do not directly address "complexity theory" here, see J.T. Klein, "Interdisciplinarity and the prospect of complexity: the tests of theory," *Issues in Integrative Studies* 19 (2001).

[257] Thornton, "Finding culture," 47.

[258] See Treichler, "AIDS in the third world."

[259] Treichler, *How to have theory*, 19.

[260] Threadgold, "Cultural studies," 1.

[261] Munns and Rajan, eds., *Cultural studies*, 7.

consensus has emerged on one definition."[262] Mills notes that "discourse as a term is fluid and largely undefined – even within disciplines."[263] Melkote and Steeves: "definitions of development communication vary not only with definitions of the terms that comprise it, but are also complicated by assumptions about related areas of study and practice … the definition and boundaries of all these overlapping interdisciplinary areas have become even more fluid and nebulous in the past decade…"[264] On language ideology, there is apparently: "no single core literature,"[265] the meaning of interdisciplinary studies and interdisciplinarity "continues to be contested by its practitioners and critics."[266] On public health, Garrett notes, "there was no agreement about what constituted 'public health' other than assuring that people were healthy,"[267] and on religion, well, there are many, such as statements that "…no scholarly consensus exists on the meaning of these terms, or on the concept of religion in particular,"[268] but a favourite is Cox who attempts to "recapture" religion from theology and cultural studies by proposing "an entirely new definition of religion."[269]

This is not to argue that definition is not necessary or possible in this particular interdisciplinary endeavour – as with any study, a consistently shared understanding of terms between author and readers is necessary, and some already unpacked above. Indeed, definition of core concepts and terminology are a main focus of this work.

However, what this definitional instability does point to is a broader tension, where, for many scholars, instability and complexity have become the norm as some of the solid boundaries between disciplines have dissolved or become blurred. Klein argued persuasively in 1996 that *"*…interdisciplinarity and boundary crossing has become a defining characteristic of our age," and that interdisciplinarity is as much inside discipline as outside.[270] Interdisciplinary here is therefore not a methodological matter, but rather a situation of increasing cognitive fluidity or boundary

[262] W.B. Gudykunst et al., eds., *Communication in personal relationships across cultures* (Thousand Oaks, California: Sage, 1996), 4.
[263] Mills, *Discourse*, 1-3.
[264] Melkote and Steeves, *Communication for development*, 20.
[265] B.B. Schieffelin et al., eds., *Language ideologies: practice and theory*, vol. 16, Oxford studies in anthropological linguistics (New York: Oxford University Press, 1998).
[266] Repko, *Interdisciplinary research*, 3.
[267] Garrett, *Betrayal*, 8.
[268] Ellis and TerHaar, *Worlds of power*, 3.
[269] Cox in Oliver and Warrier, eds., *Theology and religious studies*, 5.
[270] Klein, *Crossing boundaries*, 1.

crossing between disciplines.[271] Gibbons et al have identified a fundamental change in the ways that scientific, social, and cultural knowledge are being produced.[272]

> …The elemental traits are complexity, hybridity, non-linearity, reflexivity, heterogeneity, and transdisciplinarity. The new mode of production is 'transdisciplinary' in that it contributes theoretical structures, research methods, and modes of practice that are not located on current disciplinary or interdisciplinary maps. One of its effects is to replace or reform established institutions, practices, and policies. Problem contexts are transient and problem solvers mobile. Emerging out of wider societal and cognitive pressures, knowledge is dynamic. It is stimulated by continuous linking and relinking of influences across a dense communication network with feedback loops.[273]

Or, to paraphrase Clifford Geertz, there is something happening to the way we think about the way we think.[274] There is some evidence that those who are engaged in the community of inquiry under discussion are representative of and feel the effects of this increasing cognitive fluidity.

Those working on the cultural politics of HIV/AIDS are generally interdisciplinarians or "undisciplined." For example, a collection of essays on the (history of HIV/AIDS), speaks of the contributors, noting that: "From several telling confessions, it became apparent that few participants felt that they stayed within the boundaries of a single discipline. For example, Berridge: 'I am a mongrel historian'; Abramson (psychology) 'I am not a representative of my discipline'; Gagnon (sociology) 'I work with problems and cross disciplinary boundaries all the time', and Treichler 'as a linguist, I am a person without a field'."[275] As will be discussed in Chapter Six, those engaged in religion and public health are commonly also such interdisciplinarians.

The community of inquiry is therefore inherently complex, giving evidence of multiple discourses emerging in the same space. As discussed above, as a result of globalisation and the nature of this community, transnational communication is the norm here, occurring in meetings in Geneva or in Zambia, on international conference calls, through the sharing of written texts. Any neat and

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[271] Repko, *Interdisciplinary research*, 337.

[272] M. Gibbons et al., eds., *The new production of knowledge: the dynamics of science and research in contemporary societies* (London: Sage Publications, 1994).

[273] J.T. Klein, "Notes toward a social epistemology of transdisciplinarity" (paper presented at the Communication au Premier Congrès Mondial de la Transdisciplinarité, Convento da Arrábida, Portugal, 2-6 Novembre 1994), 2.

[274] To paraphrase Geertz inappropriately. C. Geertz, *Local knowledge: further essays in interpretive anthropology* (New York: Basic Books, 2000 [1983]), 20.

[275] S. Lindenbaum, "Knowledge and action in the shadow of AIDS," in *The time of AIDS: Social analysis, theory and method*, ed. G. Herdt and S. Lindenbaum (London, New Delhi: Sage Publications, 1992), 333.

simplistic categories applied to this community are undermined by its inherent complexity. Klein shows that this is not unique:

> Boundary crossing is not strictly academic. The erosion of older nation states, the globalisation of economic activities, information technologies and networks, international transport of goods and people, and new cultural particularisms have created a 'new constellation' … often dubbed 'postmodernism'. One of its central features is the reversal of the differentiating, strong classificatory dynamic of high modernity and increasing de-differentiation, de-insulation, and hybridisation of cultural categories, identities, and previous certainties … Contests of legitimacy continue, systems of demarcation persist, and regulative and sanctioning mechanisms are still enforced. However, transdisciplinarity, transculturalism, transnationalism have blurred and reordered older binary cultural, social, political, and epistemological distinctions and categories. As older borders and identities have weakened, the need for transdisciplinarity has become greater but, simultaneously, more difficult …[276]

This is important to note, since the "interdisciplinary communication" that is the focus of this thesis clearly does not imply an isolated discourse within an "ivory tower", but rather a complex blend of scholars and researchers from different walks of life, but all engaged in interdisciplinary inquiry.

Any simple solution to the HIV/AIDS pandemic has been challenged. Peter Piot said as he opened the Mexico AIDS Conference in 2008, "Let's never forget that the epidemic could still bring us new surprises – as it has done so many times already. If we are to get ahead of this epidemic, it is time to come to terms with complexity …"[277] AIDS economist Alan Whiteside similarly says that "the AIDS pandemic's impact on the world is extensive, showcases a great complexity, and may require a hawk's expansive visual acuity to fully comprehend."[278] Therefore in trying to better understand and engage with the community of inquiry at the intersection of religion and HIV/AIDS, "complexity" needs to be acknoweledged rather than avoided. *Mapping complexity* therefore becomes an aim of this work, even if such a purpose should lead to slightly less stable and less conclusive ends. In the chapter that follows, the context discussed above is applied to the literature addressing the religious response to HIV/AIDS in SSA, which certainly gives evidence of a complex mapping.

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[276] Klein, "Social epistomology".

[277] P. Piot, "Don't give up the fight!," in *XVIIth International AIDS Conference* (Mexico City, Mexico: UNAIDS, 2008), 2.

[278] Whiteside in Achebe, "Politics of AIDS," 274.

Across these different fields and perspectives, the most common (and complex) spatial metaphor is the search for "common ground." This has already been mentioned above several times, but is worth addressing again here. Common ground is most frequently spoken of in this community of inquiry as shared values, shared goals, or a shared language. Remember, for example, Benn's argument 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."[279] I will be taking these considerations forward in this thesis, but another interpretation, of "interdisciplinary common ground" is useful here, which Repko defines as "One or more theories, concepts, and assumptions by which conflicting insights can be reconciled and integrated. Creating common ground involves bringing out potential commonalities underlying the conflicting disciplinary and theory-based insights so that these can be reconciled and ultimately integrated."[280] Finding common ground is a central aspect to interdisciplinary research, and that "common ground makes integration of conflicting insights possible, and once achieved, enables the development of an interdisciplinary understanding."[281] All these considerations and interpretations are foregrounded in this study, which can broadly be viewed as a search for common ground between religion and public health in the context of HIV/AIDS in SSA.

[279] Benn, "Paradigm shift."
[280] Repko, *Interdisciplinary research*, 343.
[281] Repko, *Interdisciplinary research*, 108.

Chapter Three. Mapping the Religious Response to HIV/AIDS in SSA

> *A fruitful dialogue and as far as possible the integration of paradigms into useful frameworks could help lead us out of the current situation with different explanations contradicting each other.*[282]
>
> *Religion in the AIDS crisis: irrelevance, adversary or ally?* [283]

What has the religious response been to HIV/AIDS in SSA? Has it been full of moralising and stigmatising themes which have persecuted people living with and affected by HIV/AIDS, or the development of a compassionate safe space for those infected and affected by HIV/AIDS to find comfort and support? Have religious entities been involved in response to HIV/AIDS in SSA from the very beginning of the pandemic, or have they only recently woken up to the challenge and responded? What kind of response has this been? Have religious entities been engaged in prevention, care, support, other, or none of these?

It is helpful to pause here and consider your own instinctive responses to these questions, suspecting that many would respond, "well, all of that," but others, based on personal experiences with HIV/AIDS response or with religious involvement in HIV/AIDS would lean towards a more positive or negative view of religious response and engagement. In a brief article in 1999, Garner asked whether religion in the HIV/AIDS crisis is an "irrelevance, adversary or ally."[284] A decade has passed, and despite a burgeoning amount of literature and inquiry, I would argue that his question still remains largely unanswerable - or more accurately, answerable only by negotiation through conflicting knowledge and truths that defy any kind of unified understanding within the community of inquiry at the intersection of religion and public health.

The previous chapter ended by arguing that we are missing a cultural politics of the inquiry into religion and HIV/AIDS in SSA. This chapter seeks to begin to address that need by examining the literature that addresses the religious response to HIV/AIDS in SSA. There is a huge amount of commentary on the religious response to HIV/AIDS, for example that which emerges from religious and theological perspectives, such as statements from religious leaders on the challenge of HIV/AIDS to the church, or individual commentary addressing the religious imperative for involvement in different areas of the HIV/AIDS response.[285] While such literature is clearly

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[282] S. Weinreich and C. Benn, *AIDS - meeting the challenge: data, facts, background* (Geneva: World Council of Churches, 2004), 96.

[283] R.C. Garner, "Religion in the AIDS crisis: irrelevance, adversary or ally?," *AIDS Analysis Africa* 10 (1999): 6.

[284] Garner, "Irrelevance or ally," 6.

[285] Numbering in their hundreds, such statements usually address the role of religious entities in HIV/AIDS, see Olivier et al., "ARHAP literature," 41.

relevant, this chapter focuses on a core group of research reports addressing the religious response to HIV/AIDS in SSA.[286] These reports (academic and institutional) respond to the question, "what has been the religious response to HIV/AIDS in SSA?", and therefore have direct relevance to the community of inquiry seeking to understand and act on such information.[287] By analysing the dominant discourses that emerge out of this literature, I seek to better understand the way particular assumptions about the religious response to HIV/AIDS in SSA are constructed and maintained.[288]

The previous chapter outlined the way the relationship between religion and public health has shifted over the last two decades. The same can be said in the context of HIV/AIDS, where attitudes towards religion and religious entities continue to evolve rapidly. In order to understand the context in which these research materials on the religious response to HIV/AIDS in SSA emerged, it is therefore necessary first to weave the story of HIV/AIDS into the historical narrative provided in previous chapter, so that we might better understand the context of HIV/AIDS inquiry in which these materials evolved.

The following chapter broadly outlines key phases of the international attitude towards the religious response to HIV/AIDS in a chronological style (beginning the process of rewriting religion back into the narrative of the cultural politics of HIV/AIDS), which is seen as a useful arrangement, since the historical perspective is so often missing in this work. However, it is necessary to emphasise that terms such as "phase" or "stage" are not entirely correct, and the chronological style in which this information is arranged is potentially misleading.[289] Treichler calls her work a "set of cultural chronicles," and notes that "no issue in AIDS epidemics is ever fully settled, and no discursive term is ever free of its history…"[290] More accurately then, what is identified here are dominant discourses about religion that have emerged at different times during the HIV/AIDS pandemic (all of which have historical roots in other contexts), and which, once part of the story of HIV/AIDS, continue to play a role, becoming part of the generally accepted narrative. Furthermore, what is represented here can only be seen as taking the pulse of an evolving field of interest,

[286] For literature reviews of these materials, see CHART, "The cartography of HIV and AIDS, religion and theology: A partially annotated bibliography.", Olivier et al., "ARHAP literature."

[287] The materials were collected through standard review techniques, and collected through the search of web-based and academic databases and spiralled out from there. Materials were all individually assessed in terms of relevance, interest, the scarcity of other documentation of its type, and quality (author, publication, etc).

[288] It is important to note that Chapter Five will engage more directly with the issues of disciplinary cultures and boundaries of knowledge within this community of inquiry, that is, the academic production of knowledge, and therefore some of this discussion is referred to the later chapter.

[289] These phases are more appropriately "discourses", emerge as a result of a thematic discourse analysis of the literature named above.

[290] Treichler, *How to have theory*, 4.

especially in the context of HIV/AIDS which is characterised by rapid transformation,[291] and only representative of a few of the range of discourses impacting on this context.

The Early Stages of HIV/AIDS Inquiry: Religion as Irrelevant and an Adversary

> *Response to AIDS is political in Africa as elsewhere. Public health action takes place on a terrain of contested meanings and unequal power, where different forms of knowledge struggle for control.*[292]

In the first decades of the HIV/AIDS pandemic (from the 1960s to the 1980s), international inquiry into the disease was largely blind to religion and religious entities working in health.[293] As discussed in the previous chapter, under the influence of secularisation and modernisation, religious involvement in health care and public health interventions had all but disappeared and the health- and social sciences had become largely "religion-blind." Of course, we can fairly assume that many religious entities (REs) were already partnering with international organisations and governments on health issues other than HIV/AIDS. However, in this period, when the biomedical perspective dominated the inquiry,[294] there was little or no mention made of religion or religious health entities. Instead, REs were assumed to be part of secular civil society or private healthcare categories; in the health sciences religion was mainly considered as one of many cultural factors, or as part of the emerging "spirituality and health" concern of the role of religion in healthcare.[295] Liebowitz, for example, has suggested that the belated consideration of the comparative advantages of a religious engagement in the HIV/AIDS agenda, "may be linked to the fact that religion is relatively less important in many developed countries where AIDS research and policy agendas are driven – in comparison to the developing world where the highest HIV prevalence rates are to be found."[296]

The first appearance of religion in both the international and Africa-focused materials emerges during what Weeks describes as the phases of moral panic and crisis management, when HIV/AIDS

[291] See Fee and Fox, "Introduction," 12.

[292] B.G. Schoepf et al., "Theoretical therapies, remote remedies: SAPs and the political ecology of poverty and health in Africa," in *Dying for growth: global inequality and the health of the poor*, ed. J.Y. Kim, et al. (Maine: Common Courage Press, 2000), 107.

[293] By international inquiry I mean the range of research being carried out by international public health institutions, policy-makers and linked academic research.

[294] See Weeks, "Intellectual agenda," 4, Plummer, "Cold climate," 24.

[295] See Chapter Two and Chapter Four.

[296] Liebowitz in W. Parker and K. Birdsall, "HIV/AIDS, stigma and faith-based organisations: A review," (Centre for AIDS Development, Research and Evaluation and DFID Futures Group MSP, 2005), 17.

began to be described as a "gay plague" (in the USA and internationally), and the marginalisation of risk groups developed into a moral panic.[297]

> From about 1982, AIDS (now identified as a distinctive set of diseases with definable, if as yet not precisely known, causative factors), became the bearer of a number of political, social and moral anxieties, whose origins lay elsewhere … (and) included issues such as 'promiscuity', permissive lifestyles and drug taking … This was the golden period of the New Right and Moral Majority onslaught in the USA, with leading lights claiming to see in AIDS God's or nature's judgement on moral decay … this was the time when people with the disease were blamed for it.[298]

Although Weeks is addressing the North American context, it is relevant that this phase of moral panic brought a specific discourse about religion into the international inquiry, and it is clear that this moral discourse was swiftly visible in materials addressing the African HIV/AIDS pandemic. Seidel describes the emergence of what she names powerful medico-moral discourses, which she sees as being primarily Christian interventions and frequently judgemental (such as those representing AIDS as God's punishment). These medico-moral discourses show a complex weaving of religious and biomedical "truths" as people struggled to understand this known yet devastating phenomenon, often to disastrous effects. Seidel also notes that "medico-moral discourse shares features of the older public health paradigm which created social categories of disease identified with disorder."[299] Green concludes,

> Although FBOs have been encouraged to play a stronger role in HIV prevention in the last several years, a conflict remains in many countries between taking a medical or "realistic" approach to AIDS prevention … and taking a religious or "moral" approach. The popular press and some AIDS literature pit medically enlightened progressives who recognise human behaviour as it actually is against religious conservatives who moralise about how behaviour ought to be.[300]

In reaction against these moral discourses, critical commentary arose within the HIV/AIDS literature which took a strongly adversarial position against religion, describing religion as a barrier to effective HIV/AIDS intervention. Stories of religious leaders shunning people living with and

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[297] Weeks, "Intellectual agenda," 4-5.

[298] Weeks, "Intellectual agenda," 5.

[299] Seidel, "Competing discourses," 178. See Weeks, "Intellectual agenda," 15.

[300] E.C. Green, "Faith-based organizations: contributions to HIV prevention," (Washington DC: US Agency for International Development and The Synergy Project, TvT Associates, Harvard Center for Population and Development Studies, 2003), 19.

affected by HIV/AIDS grew rapidly at this time, and the inquiring gaze towards religion and HIV/AIDS becomes narrow-eyed with suspicion. As Green describes, "many people who worked in HIV prevention believed religious leaders and organisations were intrinsically antagonistic to what they were trying to accomplish."[301] UNAIDS took it a step further and named opposition from religious authorities as "perhaps the greatest obstacle to AIDS prevention activities in many countries."[302]

Significantly, in the 1990s, the main discourses of the international inquiry shifted from a "gay disease," to an "African plague,"[303] as HIV/AIDS was contained in most Western countries (becoming a chronic disease), and continued to grow exponentially in African states (as an epidemic disaster and disease of development.)[304] The previous attitudes mentioned above, of religion as an irrelevance or an adversary was woven into such discourses of African AIDS, and narratives of stigmatising male African religious leaders began to flourish and are still strong today.

The juxtaposition between medical and moral discourses places religion on the side of irrationality and medicine (science) on the side of rationality, as has been done since the time of Enlightenment. What is important to note is that this discourse of "irrational religion" has a particular character in the HIV/AIDS context. In HIV/AIDS research, "rationality" has move from being an epistemological or philosophical concern to a matter of urgent and practical importance. The assumptions of rational behaviour upon which interventions models such as knowledge-attitude-behaviour (KAB) or the health belief model (HBM), were quickly shown to be not entirely adequate for HIV/AIDS response. For example, speaking of behaviour change through communication, Hughes and Malila note, "…divergence between rationality assumed and rationality used … AIDS messages implicitly presuppose an actor whose decision-making practices are premised on a rule-governed and linear version of rationality … assumes actors undifferentiated in their particularities. Actors who are uniformly rational in the sense of assessing and weighing conflicting claims; interpreting scientific evidence; deconstructing ambiguous prescriptions …"[305] Scholars such as Krieger note, for example, that poor women make "irrational"

[301] Green, "Contributions," 4.

[302] E. Pisani, "Acting early to prevent AIDS: the case of Senegal," in *Best Practice Collection* (Geneva: Joint United Nations Programme for HIV/AIDS, 1999).

[303] See Treichler, "AIDS in the third world."

[304] See D.M. Fox, "The politics of HIV infection: 1989-1990 as years of change," in *AIDS: The making of a chronic disease*, ed. E. Fee and D.M. Fox (Berkeley: University of California Press, 1992), 126-128, C.E. Rosenberg, *Explaining epidemics: and other studies in the history of medicine* (Cambridge: Cambridge University Press, 1992).

[305] S. Hughes and I.S. Malila, "Media and the African context of the social construction of HIV/AIDS," in *AIDS and development in Africa: a social science perspective*, ed. K.R. Hope (London and New York: The Haworth Press, 1999), 115.

sexual choices in resource-poor settings, and because of issues of gender-power relations.[306] As an HIV/AIDS research community, we are compelled to reconsider how and why individuals make irrational-seeming choices, and to understand the broader (structural) forces impacting on HIV/AIDS prevention and intervention. However, the literature reviews significantly less understanding of or compelled to work with "religious irrationality" in the context of HIV/AIDS.

To provide a brief example, the most "irrational" seeming religious discourse (to a biomedical and public health perspective) must be the discourse of miracle healing. In Malawi, the national HIV/AIDS policy states that "Government, through the NAC, undertakes to … sensitise religious leaders to HIV/AIDS and discourage them from making false claims of miracle HIV/AIDS cures."[307] A news report from 2008 shows some of this tension, saying: "a pastor in southern Malawi recently hit the headlines when he told five HIV-positive people in his church to stop taking antiretroviral (ARV) medication because they had been treated by prayer … the government has drawn up legislation, currently before parliament, to muzzle anyone claiming they can cure AIDS."[308] Yet during anonymous participatory research in Malawi, the majority of a group of religious HIV/AIDS programme managers expressed an understanding of healing to mean that "God could heal people from HIV infection, and in fact had done so."[309] My interest lies in the fact that belief in miracle cures is pervasive in SSA, and cannot be legislated away as irrational by "muzzling" religious leaders. My concern is that the HIV/AIDS research agenda is being driven from a secular perspective, that is willing to expend energy in attempting to understand why sex workers ("irrationally") have unprotected sex, but are seemingly less willing to try to understand *why* an ("irrational") belief in miracle cures is so pervasive in SSA. And yet we know that religious communities in Africa perceive HIV/AIDS and healing in a complex way. My favourite example is from a community member in Zambia who told us the following story in response to a question about HIV/AIDS and healing:

> As a pastor, we had a patient who was sick, a church member, and we prayed for her for two weeks, and each time there was no improvement. Until one time the spirit of God says, 'can you just ask, if she has eaten anything?' So I asked, 'Madam, have you eaten anything?' And she said, 'how can I get anything?' So the church decided to do something.

[306] See N. Krieger, "Genders, sexes, and health: what are the connections – and why does it matter?," *International Journal of Epidemiology* 32, no. 4 (2003).

[307] NAC, "National HIV/AIDS policy: a call for renewed action," (Lilongwe, Malawi: Office of the President and Cabinet, National AIDS Commission, 2003), 71.

[308] PlusNews, "Malawi: faith can give comfort, but cannot cure AIDS," *PlusNews*, 12 March 2008.

[309] Haddad et al., "Potential and perils," 89.

> In the afternoon they all went and bought her this and that, such as a bag of maize-meal. And the very next morning … she was healed![310]

I will engage with the issue of rationality from a disciplinary perspective again in Chapter Five, but argue here that this is an area that requires a considerable amount of further investigation if common ground is to be found on such topics. In other words, common ground is not forged by broadly declaring one powerful discourse rational, and another irrational and therefore to be silent.

Lingering religionophobia can be spotted throughout the HIV/AIDS literature, tied to discourses of antagonism, and the emergence of religion into public life as a liability (particularly discourses about terrorism and fundamentalism),[311] and continuing discourses of secularisation and modernisation. Concerns and frustrations linger today, for example, towards the detrimental effect of some religious leaders to HIV prevention strategies, the fear that religious organisations may use public funds for prosetylisation or "concern that ideological considerations are replacing sound empirical evidence of effectiveness in delivering health services."[312] All this has fed into a lingering dominant discourse of a negative or detrimental religious response to HIV/AIDS in Africa, a response that has been "worse" than secular responses.

This introduces a core paradox to the literature of the religious response to HIV/AIDS, namely, that it is constructed on the idea that "religion" is a measurable and definable category, which is comparable with a "secular" response.

In my first experience working with an interdisciplinary team of religious studies scholars I became the butt of a joke particular to the religious studies tribe. Busy dividing up the writing of the report glossary, I was told by a senior religious studies professor, "you get to define religion", at which a great chuckle rose from the group around me. What I had unwittingly walked into was the in-house knowledge that defining religion is acknowledged as a difficult if not impossible task, as Simmel notes:

> No light will ever be cast in the sybillic twilight that, for us, surrounds the origin and nature of religion as long as we insist on approaching it as a single problem requiring only a single word for its solution. Thus far no one has been able to offer a definition of religion that is

[310] ARHAP, "Appreciating assets," 68.

[311] See Chapter Two

[312] Breger in S. Woldehanna et al., "Faith in action: examining the role of faith-based organizations in addressing HIV/AIDS - a multi country key informant survey," (Washington, DC: Global Health Council, 2005), 12-13. See J. Liebowitz, "The impact of faith-based organizations on HIV/AIDS prevention and mitigation in Africa," (Health Economics and HIV/AIDS Research Division, University of KwaZulu Natal, 2002).

both precise and sufficiently comprehensive. No one has been able to grasp its ultimate essence.[313]

In fact, the definition of religion is a central concern to the academic study of religion, and there is a great literature engaging in this debate, a great wrestling match between an innumerable range of views, paradigms and boundary-drawing around the term "religion" and its variations.[314] As Cochrane notes, "The idea of 'religion' is notoriously slippery. One of the main problems that scholars of religion deal with is how to define their subject … Complicating matters is the fact the scientific notion of religion - indeed, the very word itself - is bound up with a particular Graeco-Latin conceptual framework not shared by everyone, and with a flawed history in the part of the world influenced most strongly by that heritage (usually called 'the West')."[315] Of relevance to this study is the recognition that religion in SSA gives evidence of a complex pattern of religious beliefs being lived and understood in plural ways, which are not always (or even "mostly") describable through this scientific language.[316] Any simplistic understanding of religion is particularly vulnerable in this context.[317]

The idea of a "religious response to HIV/AIDS" is built on the assumption that "religion" (or its variations) adequately encompasses what we know is a mass of different religious types, categories, entities, traditions and perspectives; and that this is comparable with the normative and somehow featureless "secular" response to HIV/AIDS. To make any conclusion about the religious response to HIV/AIDS assumes that such a generalisation has validity, that it is possible to say the religious response has been good or bad, fast or slow, engaged more in one area than another, as opposed to (good, bad, fast, slow) secular response. The underlying assumption in Garner's question (is religion irrelevant, an adversary, or ally?), is that there is such a thing as "religion" that is assessable and comparable with a "secular" response.

This is a reminder of what Klein identifies as the core paradox of interdisciplinarity, the continuing "…rhetorical opposition of disciplinarity and interdisciplinarity, an oversimplified dichotomy that

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[313] Simmel in A.M. McKinnon, "Sociological definitions, language games and the 'essence' of religion," *Method & Theory in the Study of Religion* 14 (2002): 61.

[314] See J.Z. Smith, "Religion, religions, religious," in *Critical terms for Religious Studies*, ed. M.C. Taylor (Chicago & London: University of Chicago Press, 1998), McKinnon, "The 'essence' of religion."

[315] J.R. Cochrane, "Deliberations on religion and religious health assets," in *ARHAP: International Case Study Colloquium* (Johannesburg, South Africa: African Religious Health Assets Programme, 2005), 20.

[316] Several ARHAP scholars have taken on this project of re-examining religious perceptions of health utilising locally constructed language. See Cochrane, "Religion for the 21st century.", P. Germond and S. Molapo, "In search of bophelo in a time of AIDS: Seeking a coherence of economies of health and economies of salvation " *Journal of Theology for Southern Africa* 126, no. November (2006).

[317] Colleagues at the Interfaith Health Program at Emory University have taken to using the plural form "religions" to indicate this plurality. However, I find this stylistically awkward, and continue to utilise the singular, while emphasising the inherent plurality and complexity of "religion" in any context, and especially in SSA.

obscures the more subtle interactions that do take place."[318] I will return to this in later chapters,[319] but am reminded of this in the oversimplified dichotomy between "religion" and "the secular" which sometimes obscures the more subtle responses to HIV/AIDS that take place. In this context, it is an overwhelmingly secular discourse (and accompanying classification system) that constructs "religion" as a one category in this literature, despite the well acknowledged pluralism of religion. Klein argues, "our vocabulary – indeed, our entire logic of classification – predisposes us to think in terms of disciplinarity. This predisposition has created a set of metaphoric structures in the discourse."[320] In the paradox particular to the intersection of religion and public health, the secular vocabulary predisposes us to construct the religious response to HIV/AIDS as irrelevant, adversarial or an allied Other to the dominant secular perspective (that is, dominant in the global health and HIV/AIDS arenas, not in the community context.) This paradox is not a linguistic or theoretical facade but critically undermines and destabilises all the literature on the religious response to HIV/AIDS.

Consider, for example, the idea that religion and religious entities had an initially poor response to HIV/AIDS, both in terms of inaction and by acting as a barrier to effective intervention. This particular narrative of the religious response began in the earlier stages discussed above, and continues strongly to this day. However, this truth about the religious response was not powered by secular sources alone (such as public health institutions or social science scholars). At this time, alongside the increased interest in religion and religious response (in the late 1990s and early 2000s), a strong narrative device was established, with religious leaders confessing that the faith community had a poor start in responding to HIV/AIDS, and denouncing the early religious response to HIV/AIDS.[321] For example, in 2002, the Pan-African Lutheran Church Leadership said,

> We … publicly confess and acknowledge that we have too often contributed to stigmatisation and discrimination and that our churches have not always been safe or welcome places for people living with or affected by HIV/AIDS … We repent of these sins. We therefore commit ourselves to a faithful and courageous response in breaking the silence, speaking openly and truthfully about human sexuality and HIV/AIDS.[322]

[318] Klein, *Interdisciplinarity*, 105.

[319] See Chapter Five for a linked discussion on these simplified binary constructions,

[320] Klein, *Interdisciplinarity*, 77.

[321] See H.J. Dilger, "Doing better? Religion, the virtue-ethics of development, and the fragmentation of health politics in Tanzania," *Africa Today* 56, no. 1 (2009): 95.

[322] In Dilger, "Doing better," 95.

Another frequently quoted statement is the one made by a select group of religious leaders to the United Nations Special General Assembly on HIV/AIDS, in June 2001:

> FBOs are joining many other actors in the global fight against this devastating pandemic and can offer our specific resources and strengths. At the same time we acknowledge that we have not always responded appropriately to the challenges posed by HIV/AIDS. We deeply regret instances where FBOs have contributed to stigma, fear and misinformation.[323]

Such a confessional discourse is present in a staggering amount of literature in which authors (theologians, religious leaders, and other commentators) admit to weaknesses of religious leadership, stigmatising practices and the inherent weaknesses of religious entities.[324] Dilger notes that this was a particularly *public* confession as religious institutions moved, …away from their former silence about HIV/AIDS issues toward public statements of their willingness to collaborate with other institutions in the fight against HIV/AIDS ... (in) the form of public confessions, which denounced their previous interpretation of the epidemic as evidence of 'sinful' irresponsibility."[325]

The confessional discourse clearly has strong roots in a number of religious traditions.[326] What is of interest right now is the way this confessional discourse legitimates the secular discourse which says "religion" responded poorly to the HIV/AIDS pandemic. Here, religious leaders as experts with authoritative (and communicative) power are strengthening the discourses that speak of a generally negative response (of stigmatising religious leaders as a barrier to prevention and inherent weaknesses that make religious entities poor partners for collaboration). There is rarely a countervailing confessional discourse from global health institutions or the secular community (whatever that is). Furthermore, any one of these religious leaders making these statements know of the diversity that makes up the faith community and which makes any generalisation about "the religious response" at best incomplete, and at worst deliberate fabrication.

Essentially, the confessional discourse of a poor religious response feeds into a power struggle, where the secular dominant discourse has assumed (and been handed) the right to judge the response of the religious Other. Has the religious response been worse than the secular response?

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[323] World Council of Churches, "Increased partnership between faith-based organizations, governments and inter-governmental organisations: Statement by faith-based organizations facilitated by the World Council of Churches for the UN special General Assembly on HIV/AIDS June 25-27, 2001," *International Review of Mission* 90, no. 359 (2001). Quoted most recently in the opening pages of the document: UNAIDS, "UNAIDS-FBO partnership."

[324] See Olivier et al., "ARHAP literature."

[325] Dilger, "Doing better," 95.

[326] Foucault addresses confessional discourse as a particularly powerful discourse strategy, see Wodak, *Disorders of discourse*, 26-27.

Has "religion" responded more inadequately than "public health"? In reality we know that there are a number of institutions (public health, government, or academic) who should be applying a confessional discourse to their response to HIV/AIDS in SSA. While there may be a critical lens applied to these other secular institutions, it is rarely a self-critical and confessional perspective, since this would undermine the power of these institutions. As Treichler says,

> What makes the story [of HIV/AIDS activism] … interesting and important are the ironies and tensions embedded in the process of forging novel scientific, political and moral identities. This is a complicated history in which no party has had all the answers. All players have revised their claims and shifted their positions over time; all have had to wrestle with the unintended consequences of their actions.[327]

I would suggest here that one unintended consequence of a confessional discourse has been to reinforce a stereotyped representation of "religion" as opposite "the secular." Baderoon suggests that "at times of crisis, stereotyped representations may be more popular since they provide frames that are easy to understand and communicate," and such representations draw on the "power of oppositional thinking."[328] In this time of HIV/AIDS crisis, the religious response has emerged as a stereotyped representation, that is constructed in opposition to a secular dominant perspective, strengthens "truths" such as the one that the religious response was *particularly* poor (or particularly good) as compared with the broader HIV/AIDS community. This will be addressed again below in relation to other truths of the religious response to HIV/AIDS.

Renewed Interest in the "Faith Community"

> *Religion can be a force for good or bad in African development, but it can't be ignored.*[329]

In the later years of 1990, a new interest emerged on HIV/AIDS agenda, visible in the discourses of renewed interest in religion and religious entities. As far as can be judged, the literature shows two main reasons for this as it emerged in the HIV/AIDS context, firstly that it made for a more culturally appropriate response and secondly that religious communities potentially held assets that might be useful in partnership.[330] The first reason is powered by the general failure of many HIV/AIDS interventions that were shown to be culturally inappropriate and the growing realisation that religion is important to the lives and health-related decisions of the people most affected by

[327] Treichler, *How to have theory*, 10.

[328] Baderoon, "Covering the East," 317.

[329] Commission-for-Africa, "Our common interest: report of the commission for Africa," (London, UK: Commission for Africa, 2005).

[330] See Haddad et al., "Potential and perils.", Olivier et al., "ARHAP literature."

HIV/AIDS.[331] The second cluster of reasons given for this renewed interest, that religious communities might hold assets for partnership, can be seen to have roots in broader trends in the HIV/AIDS agenda, to now treat HIV/AIDS as a disease of development and society, rather than a medical problem, and a pandemic primarily located in resource-poor settings which are characterised by booming civil society sectors.[332] This generated a strong interest in partnership and multi-sectoral collaboration as visible in the development and public health literature.

This increased interest is visible from a number of global health agencies expressing the desire for increased integration of the response of religious entities within the international response against HIV and AIDS.[333] For example: The World Health Organisation (WHO) stated in its 2004 *World Health Report* that "Faith-based organisations have a crucial role to play in the widespread uptake of HIV/AIDS treatments … (they) could be brought into treatment scale-up in order to combine their comparative advantages."[334] The United Nations Children's Fund (UNICEF) started to look at religious organisations as sites of support for child-headed households as well as for the care of people living with HIV and AIDS.[335] The United States Agency for International Development (USAID) stated in its 2002 policy on AIDS prevention that religious organisations should be engaged in USAID's fight against HIV/AIDS, and established a *Center for Faith-Based and Community Initiatives* in the same year, "to create a level playing field for faith-based and community groups to compete for USAID programs."[336]

This increased interest, however, did not immediately or automatically lead to widespread improved collaboration. As James Wolfensohn, then head of the World Bank, exclaimed, "Half the work in education and health in sub-Saharan Africa is done by the church … but they don't talk to each other, and they don't talk to us."[337] What emerged at this time, and is particularly important to this study, was a strong realisation that integration of responses and collaboration was severely hampered by a lack of basic information about religion and religious entities engaged in health. In other words, this increased interest also highlighted the fact that due to the historical factors described in the previous chapter (secularisation, modernisation, and the general religion-

[331] See Chapter Two.

[332] As discussed in Chapter Two.

[333] See Woldehanna et al., "Faith in action," 12.

[334] WHO, "The World health report 2004: changing history, community participation in public health," (Geneva: World Health Organization, 2004), 46.

[335] UNICEF, "Sharing common goals," *Faith-based organizations and children* (2004), http://www.unicef.org/media_4537.html.

[336] USAID, "USAID's work with faith and community-based organisations," (2004), http://www.usaid.gov/our_work/global_health/aids?TechAreas/community/fbocbofactsheet.html.

[337] Wolfensohn in M. Kitchen, "World must coordinate efforts, end waste, says Wolfensohn," *UN Wire* (2002), http://www.unwire.org/unwire/20021025/29832_story.asp.

blindness of public health inquiry) there was a significant knowledge gap on religion, religious entities, their response and (potential) impact on HIV/AIDS intervention.[338]

The acknowledgement of this gap led to renewed inquiry into the religious response to HIV/AIDS, resulting in a huge literature (academic and grey) emerging on religion and HIV/AIDS generally. This is reflected in the significantly increased focus on religion at each subsequent international HIV/AIDS conference, up to the latest in Mexico (2008) where there was a "faith stream" that could be tracked through the conference topics.[339]

"In the last few years, driven by the HIV/AIDS epidemic, there has been a sudden boom in the reporting of 'faith-based responses' to health crises, with an interesting array of both published and unpublished materials, nearly all of which can be accessed by anyone on the internet."[340] Logic says that a large body of emerging literature addressing one theme of inquiry (the religious response to HIV/AIDS) would mean that more was generally known about the religious response, and more decisions could be made based on this knowledge. That is, if there is a large generation of knowledge, we should be nearer to answering Garner's question, is religion irrelevant, an adversary or an ally in HIV/AIDS response. In terms of the broad literature addressing the religious response to HIV/AIDS (in African and elsewhere) that has blossomed since Garner asked his question, *logic* has little place.

Treichler has demonstrated how inquiry into HIV/AIDS generally has resulted in a huge volume of research and a "wild diversity of AIDS' rapidly multiplying meanings."[341] She begins *How to Have Theory in an Epidemic* with the words, "In multiple, fragmentary, and often contradictory ways, we struggle to achieve some sort of understanding of AIDS, a reality that is frightening, widely publicised, yet finally neither directly nor fully knowable."[342] The materials emerging as a result of inquiry into the religious response to HIV/AIDS in SSA reveals the same volume, wild diversity and rapidly multiplying meanings Treichler indicates, and (arguably) even worse conflict and tension than other areas of HIV/AIDS inquiry. Anyone conducting literature reviews of this material (as a first step in gaining an overarching knowledge of a field of inquiry), swiftly finds that every statement of fact about the religious response to HIV/AIDS in Africa is counter-balanced by another directly contradicting fact.[343] I will not repeat these reviews here, but rather list the main

[338] See Schmid et al., "Contribution of REs."

[339] See EAA, "Report on faith-based involvement in the XVII International AIDS Conference August 2008, Mexico City," (Geneva: Ecumenical Advocacy Alliance 2008), 1.

[340] Olivier et al., "ARHAP literature," 38.

[341] Treichler, *How to have theory*, 315. (check version)

[342] Treichler, *How to have theory*, 11.

[343] Schmid et al., "Contribution of REs." See Chapter Four.

statements (discourses) that can be made in the broad literature addressing the religious response, that is the statements or conclusions that are generally prefaced with the such statements as "there is little doubt," or "it is generally accepted," or those that in academic papers are unreferenced statements of fact.[344]

On the timing of the religious response

- Religious entities are not engaged in the HIV/AIDS response at all
- have hesitantly and belatedly responded (is newly involved)
- have always been engaged (but unrecognised)

On the level of religious response

- religious entities are fully engaged
- have recently increased their response (responding to need or increased funding)

On the nature of the religious response

- religious entities are involved in all areas providing a continuum of care (prevention, care, support, treatment)
- are involved more in some areas than others (for example, focused more on orphans and vulnerable children and care)
- are uninvolved in certain areas (such as advocacy and prevention)

On the reasons for engaging (or not engaging) with religious communities

- including religion is part of a cultural appropriate response to HIV/AIDS
- is the reason for culturally inappropriate behaviour
- is an increased risk factor
- is a decreased risk factor
- have a key role in prevention, (through moral teachings and behaviour change)

[344] I have not referenced all the text from which these statements emerge, as the referencing takes up an obstructive amount of space. In the discussion that follows, I will tie specific statements to texts. This tabulation is intended primarily to introduce the reader to the wildly divergent views in this field. For collations of these texts, see the following literature reviews I have conducted (and/or co-authored): Haddad et al., "Potential and perils.", J. Olivier, "Religion and policy in the context of HIV and AIDS: a rapidly shifting landscape," in *The Collaborative for HIV and AIDS, Religion and Theology*, ed. B. Haddad (2010 [forthcoming]), Olivier et al., "ARHAP literature.", Olivier and Paterson, "Religion and medicine.", Schmid et al., "Contribution of REs.", ARHAP, "Appreciating assets."

- has no role in prevention, (because of moral teachings and as an obstacle to behaviour change)
- Religious leaders are an obstacle to HIV prevention
- Religious leaders are a key tool in HIV prevention
- contributes to stigma and discrimination (for example, HIV/AIDS as a punishment from God)
- mitigates stigma and discrimination (for example, through compassionate care)
- Religion impacts on health and HIV/AIDS
- Religion does not impact on health and HIV/AIDS
- Hold unique assets that can be leveraged for HIV/AIDS intervention (such as reach, trust)
- Hold unique liabilities that make them inappropriate for intervention (for example they are weak, unstable)
- Religious entities are comparatively better than secular organisations (for example have 'value-added', 'comparative advantage' or provide 'special care)
- Religious entities are comparatively weaker than secular organisations (for example in the area of documentation and evaluation).

On collaborative response to HIV/AIDS

- The faith community is working together
- There is interfaith competition, dispute and suspicion
- Religious entities are not working with governments
- Religious entities are working well with governments

This crude listing shows just some of the main facts about the religious response to HIV/AIDS in Africa upon which critical decisions must be made. It is obvious that, based on this literature, any position or conclusions about the general religious response to HIV/AIDS is possible or defensible. More to the point, these conflicting facts about the religious response to HIV/AIDS in Africa do not only appear in different literature, but are more likely to appear in the same text. All such statements come up against the paradox discussed above: all these truths about the religious response rely on accepting that religion is a contained category on which such statements can be made against a secular norm. Such a number of conflicting dominant discourses or truths about the religious response to HIV/AIDS are a result of religion not having a specific meaning or

definition. This paradox is played out at a number of other levels, for example, in comparing the religious response of faith-based organisations (FBOs) to that of non-governmental organisations (NGOs). Parker and Birdsall say, "Observers are largely in agreement that early on in the epidemic FBOs constituted 'part of the problem' rather than 'part of the solution'."[345] Yet the term FBO is not explained, and in fact, such statements are made "true" by the fact that 'FBO' has many meanings.[346]

In her unpacking of the epidemic of signification, Treichler points out that while HIV/AIDS is a complex cultural phenomenon that produces diversity and contradiction, dominant meanings also emerge, or default meanings that can be expressed with little fear of being challenged. In the literature and discourses of the religious response to HIV/AIDS, the dominant meanings are also reflective of the wild diversity mentioned above. In the literature addressing the religious response to HIV/AIDS however, I would argue that dominant meanings are indeed present, and are also in direct opposition with other (equally powerful) dominant. This is demonstrated by considering one such case of opposing truths about the religious response: that religious leaders can/have been both a main obstacle and a key tool in HIV prevention. Imagine yourself a policy-maker that must decide whether or not to include religious leaders' in HIV/AIDS prevention strategies in SSA based on the available literature addressing the religious response to HIV/AIDS. Consider the following extract from Kauffman:

> President Abdou Diouf of Senegal was an early advocate of marshalling government resources, religious organisations and civil society to effect a change in behaviour. One of the most dramatic steps taken by President Diouf was to enlist the support of religious groups in Senegal to help promote practices that would reduce the spread of the virus. This is in stark contrast to the response of religious leaders in other African countries who continue to preach that using birth control, including condoms, is a sin.[347]

Kauffman's account is not unique, and is shown here as an example of many similar such utterances. On the surface, there are two main ideas about religious leaders. Firstly, that in Senegal, their involvement was a critical component of the success story, and secondly, that "usually" (in other African countries) religious leaders are significant barriers to HIV prevention. In this example, both positive and negative views of the involvement of religious leaders in HIV/AIDS

[345] Parker and Birdsall, "Stigma and FBOs," 12-13.

[346] I will pick this up again later as the main focus of Chapter Four.

[347] K.D. Kauffman, "Why is South Africa the HIV capital of the world? An institutional analysis of the spread of a virus," in *AIDS in South Africa: A social expression of a pandemic*, ed. K.D. Kauffman and D.L. Lindauer (New York: Palgrave MacMillan, 2004), 25.

are supported. In the early years of 2000, the two "success stories" of Uganda and Senegal became powerful parts of the African AIDS mythology. Public health institutions (international and governmental) utilised this as proof that a targeted intervention and multisectoral approach had worked. Religious institutions utilised this as validation and acknowledgement of their important role in public life.[348] Such success stories gave impetus to the discourses of renewed interest in religion and religious entities engagement in HIV/AIDS.[349]

The negative perceptions of religious leaders' involvement also continued to be powered by both public health and religious institutions (as mentioned above). The result is two directly opposing, equally powerful truths about religious leaders involvement in HIV/AIDS (aptly shown by Forsyth, who states, "Religious leaders have historically tended to represent the best and the worst of humanity during epidemics"[350]). What is interesting from a discursive perspective is how, although Kauffman's narrative is an academic text, neither of the two statements about religious leaders are referenced. Both positive and negative views of religious leaders' involvement in HIV prevention have become so naturalised that they have become undeniable facts. This is the case now in most literature addressing the religious response to HIV/AIDS, where it is no longer deemed necessary to connect such statements to their discursive roots.[351] In reality, the literature depicting the stigmatising religious leaders was originally based on anecdote, and now it is not even deemed necessary to connect to that. Several empirical studies have shown results which suggest that the response of religious leaders is variable. In a survey of religious leaders, Haddad noted that "a key debate raging within HIV/AIDS activist circles concerns the extent to which faith-based organisations are fuelling stigma and discrimination"[352] and found that "…more people believed that ministers believed that AIDS is a punishment from God than actually was the case…"[353] Hattas also concludes in her study of community responses to HIV/AIDS in South Africa that, "The findings of the study suggest that there is no single response to the way in which religious leaders and healers understand and respond to HIV/AIDS. Responses showed agreement and disagreement

[348] For example, in the same 2001 statement to the UN, religious leaders said, "Countries such as Senegal, Uganda, and Thailand which have involved religious leaders early on in the planning and implementation of national AIDS strategies have seen dramatic changes in the course of the epidemic." WCC, "Statement by faith-based organizations facilitated by the World Council of Churches for the UN Special General Assembly on HIV/AIDS June 25-27, 2001," *International Review of Mission* 90 (2001): 473.

[349] See Liebowitz, "Impact of FBOs," 21.

[350] S. Forsythe, "Infectious diseases: historical lessons for the age of AIDS," *AIDS Analysis Africa* 10, no. 3 (1999): 13.

[351] I am not making a judgement on whether this discourse is true or not, but rather of the discourse trends in this literature.

[352] B. Haddad, "We pray but we cannot heal: theological challenges posed by the HIV/AIDS crisis," *Journal of Theology for Southern Africa* 125, no. July (2006): 80.

[353] Haddad, "We pray but we cannot heal," 82.

both in within and across religions…"[354] Of course I do not mean to say here that there are no stigmatising religious leaders (indeed I have witnesses this behaviour myself), but looking at the literature, which is characterised by both a lack of basic evidence and the lack of a nuanced theory to apply to "religion" in the context of HIV/AIDS, a stereotypical stigmatising male religious leader has been constructed as the norm, and can be spoken of without fear of rebuttal or need for contextual specificity.[355] Speaking of the construction of the discourse of "the West and the Rest," Hall says:

> …For simplification is precisely what this discourse itself *does*. It represents what are in fact very differentiated … as homogeneous … And it asserts that these different cultures are united by one thing: *the fact that they are all different from the Rest …* In short, the discourse, as a 'system of representation', represents the world as divided according to a simple dichotomy – the West/the Rest. This is what makes the discourse of the W and the R so destructive – it draws crude and simplistic distinctions and constructs an over-simplified conception of 'difference'.[356]

Religion (and religious leaders) in the context of HIV/AIDS in SSA is similarly constructed in an over-simplified way, based on a conceptual of difference (as irrational, non-science). I will return to this in the chapters that follow.

The discourse of renewed interest has another discursive tactic, that of invoking the "faith community" (or its variations such as church or religious sector) as the body responding to HIV/AIDS.

> The AIDS pandemic demands a more effective response. The church in Africa offers much but needs help. International development agencies and the church need to work together. However, they must address their differences and suspicions if they are to achieve more in the response to AIDS.[357]

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[354] A. Hattas, "Examining religious leaders' and traditional healers' responses to HIV/AIDS in a modern community," in *HIV/AIDS in sub-Saharan Africa: understanding the implications of culture and context*, ed. J. Baxen and A. Breidlid (Cape Town: University of Cape Town Press, 2009), 51.

[355] Treichler, "AIDS in the third world," 385. As Treichler says, "if we relinquish the compulsion to separate true representations of AIDS from false ones and concentrate instead on the process and consequences of representation and discursive production, we can begin to sort out how particular versions of truth are produced and sustained, and what cultural work they do in given contexts. Such an approach … raises questions not so much about truth as about power and representation."

[356] Hall, "The West and the rest: discourse and power," 280.

[357] N. Taylor, "Working together? Challenges and opportunities for international development agencies and the church in the response to AIDS in Africa," in *HIV and AIDS briefing paper 7* (Teddington, UK: Tearfund 2006).

Again, this raises critical questions. Do we judge the timeliness, strengths or weaknesses of the "faith community's response to HIV/AIDS" in comparison with that of the "secular community"? What does that tell us? And underlying such questions is the basic question of who is this faith community? Defining the faith community has been a problem long before HIV/AIDS intervention.[358] Again, the discourse of the faith community's response to HIV/AIDS in Africa is constructed on the idea that an assessment can be made of a faith community, that it is a measurable category, about which generalisations (of size, success or action) can be made. This discourse is powered both from within the faith community, framed by discourses of ecumenism and interfaith collaboration that has grown substantially (beyond the HIV/AIDS arena), and there are clear advantages for such a grouping, increasing advocacy and bargaining power. The idea of a faith community is a particularly seductive discourse, an idea of a community united by faith, or a sector working with common ideals and values, and a significant amount of advocacy work continues to go into "uniting the faith community around HIV/AIDS."[359] On the other side, national and international institutions (such as the WHO or governments), also push this discourse of a faith community forward, as it is obviously much more desirable to collaborate with a single body (for example through a single interfaith HIV/AIDS council), rather than with a fragmented, diverse and complex range of voices.

Those working within the community of inquiry are well aware that the faith community is filled with diverse and sometimes conflicting institutions and actors.[360] As mentioned earlier, HIV/AIDS exposes fault lines in our society, and indeed it has exposed the fault lines and vulnerabilities of the faith community. A simple example is found in asking various religious leaders who is included in the faith community. Most frequently, in SSA, the faith community (as a collaborative relationship around HIV/AIDS) consists of the mainstream Christian religious groups, only infrequently are other faiths such as Islamic groups included, rarely are traditional religious leaders or healers included, and even within Christian groups there are often histories of conflict and confrontation which prevents collaboration.[361] This "faith community" in different locations includes and excludes a different range of faiths (denominations) and cultures.

Treichler argues that deeply entrenched institutional agendas and cultural precedents in the First World prevent us from hearing the story of AIDS in the Third World as a complex narrative, and that a consequence of this cultural imperialism is that very simple generalisations about the

[358] See J.D. Gruchy et al., "Faith, struggle and reconciliation," in *Facing the truth: South African faith communities and the TRC*, ed. J.R. Cochrane, J. De Gruchy, and S. Martin (Cape Town: David Philip Publishers, 1999), 32.
[359] For example the efforts by WCC, WCRP or WFDD on interfaith collaboration around HIV/AIDS.
[360] See UNFPA 'Interagency report',17. As of course is the world of "public health".
[361] See Haddad et al., "Potential and perils."

epidemic may be accepted as "the truth about AIDS," with few efforts made to unravel their diverse and often contradictory claims.[362] Similarly, power dynamics prevent us from dealing with the complexity we know underlies the faith community. Discourses of the faith community are linked to several powerful institutions, and works to hide or mask the diversity beneath this discourse. That is, the dominant meaning (or idea) about the faith community within the community of inquiry at the intersection of religion and public health is that this community should be grouped as a category opposite the secular, and that it can be communicated with by connecting with selected representatives.

Such generalisations and simplifications have generally flourished in the literature addressing the religious response. It is not incomprehensible that given the significant gaps in knowledge in this area, generalisations and stereotyped representations of the religious response flourish. Said differently, while an underlying complexity can be acknowledged, given the lack of basic information, there is little as yet that can be done, particularly at a policy level, to engage with this diversity.

Demands for "Real Research" and Mapping of the Religious Response to HIV/AIDS in Africa

> *…the strengths of church health services are perceived, especially by donors, as being a capacity for efficient and ethical use of resources; a commitment to quality or care even with limited resources; a sympathy with, and support from, the local community … there is little hard evidence that church health services are more efficient, and higher quality differences may be the result of higher resource levels, including subsidised staff.*[363]

This struggle to make decisions based on this conflicting and problematic body of literature describing the religious response to HIV/AIDS has resulted in several calls for a different kind of research. The next phase of this chronicle reflects this frustration, as many public health institutions began to demand "real" research about the religious response to HIV/AIDS. This observation was made not only of religious organisations in SSA, but on an international scale, as Luker says, "although (churches) are major institutions in Papua New Guinea and other Pacific Island countries, very little secular analysis of their contemporary social capacities and roles is available."[364] It is this "secular analysis" that is seen to be missing - analytical assessments of religious organisations and their activities that could be utilised to inform the HIV and AIDS-related

[362] Treichler, "AIDS in the third world," 377.

[363] A. Green, Shaw, J., Dimmock, F. and Conn, C., "A shared mission? Changing relationships between government and church health services in Africa," *International Journal of Health Planning and Management* 17 (2002).

[364] V. Luker, "Civil society, social capital and the churches: HIV/AIDS in Papua New Guinea," in *Techreport* (State Society and Governance in Melanesia Project (RSPAS), ANU, 2004).

policy and practice.[365] There has subsequently been a flurry of research in this area, sponsored not only by religious organisations, but also by international health and development organisations, such as the Global Health Council, WHO, UNICEF and WCRP, UNAIDS and Tearfund, The Bill and Melinda Gates Foundation, and NIH-sponsored research.[366] These calls for research have resulted in a number of studies that have attempted to both summarise the broader literature addressing the religious response to HIV/AIDS in SSA, and conduct empirical fieldwork to address this gap.[367] Most of these studies are considered to be 'mapping' or 'landscaping' studies which survey the broad literature and introduce empirical research to balance this. Consider the following statements extracted from these studies and calls for research that differentiate them from the broader literature of the religious response (emphasis mine): "…The increasing involvement of FBOs in delivering HIV/AIDS services and prevention activities warrants *a balanced and impartial* examination of their contributions to help optimise their future involvement and collaboration;"[368] "…there has been *no comprehensive, independent assessment* of religious health assets, especially

[365] This will be discussed this in more detail below. See Woldehanna et al., "Faith in action.", B.R. Johnson et al., "Objective hope - Assessing the effectiveness of faith-based organizations: A review of the literature," (Philadelphia: Centre for Research on Religion and Urban Civil Society, 2002).

[366] There is still an incomplete picture as to what has driven this renewed interest. A key area for further research would be to investigate this policy-level landscape and to consider some of the drivers more closely, e.g. whether it was new actors in the field, or new funding strategies. See Woldehanna et al., "Faith in action.", ARHAP, "Appreciating assets."

[367] See S. Maman et al., "The role of religion in HIV-positive women's disclosure experiences and coping strategies in Kinshasa, Democratic Republic of Congo," *Social Science & Medicine* 68, no. 5 (2009), N. Taylor, "DFID, faith and AIDS: A review for the update of taking action," (London: UK Consortium on AIDS and International Development, 2007), S. Chand and J. Patterson, "Faithbased models for improving maternal and newborn health," (Baltimore, USA: USAID-ACCESS, 2007), J. Trinitapoli, "Religious responses to AIDS in sub-Saharan Africa: An examination of religious congregations in rural Malawi," *Review of Religious Research* 47, no. 3 (2006), Taylor, "Working together.", Woldehanna et al., "Faith in action.", S. Parry, "Responses of the Churches to HIV and AIDS in South Africa," (Geneva: (WCC) World Council of Churches, 2005), A. Munro, "The Catholic Church and the provision of antiretroviral treatment," (Pretoria, South Africa: (SACBC) Southern African Catholic Bishops' Conference, 2005), M. de Waal and O. Nakedi, "Turning of the tide: A qualitative study of SACBC funded antiretroviral treatment programmes," ((SACBC) South African Catholics Bishops Conference and The University of Pretoria 2005), K. Birdsall, "Faith-based responses to HIV/AIDS in South Africa: an analysis of the activities of faith-based organisations (FBOs) in the national HIV/AIDS database," (Johannesburg: Centre for AIDS Development, Research and Evaluation 2005), G. Tiendrebeogo et al., "Faith-based responses and opportunities for a multisectoral approach," *Sexual Health Exchange* 1 (2004), J. Liebowitz, "Faith-based organizations and HIV/AIDS in Uganda and KwaZulu-Natal," (Health Economics and HIV/AIDS Research Division, University of KwaZulu Natal, 2004), S. Parry, "Responses of the faith-based organisations to HIV/AIDS in sub-saharan Africa," (Geneva: (WCC) World Council of Churches and (EHAIA) Ecumenical HIV/AIDS Initiative in Africa, 2003), J.A.W. Munene, "A situational analysis of the church's responses to HIV/AIDS," (PACANet Christian HIV/AIDS Country Coordinating Mechanisms in Zambia, Swaziland, Uganda and Namibia, 2003), M. Mulonzya, "The churches confronted with the problem of HIV/AIDS: Analysis of the situation in six countries of Eastern Africa," ((WCC) World Council of Churches and (EHAIA) Ecumenical HIV/AIDS Initiative in Africa, 2003), H. Lusey-Gekawaku, "The churches confronted with the problem of HIV/AIDS: Analysis of the situation in five countries of central Africa," ((WCC) World Council of Churches and (EHAIA) Ecumenical HIV/AIDS Initiative in Africa, 2003), Green, "Contributions.", A. Munro, "Belated, but powerful: The response of the Catholic Church to HIV/AIDS in five southern African countries," (Pretoria, South Africa: Southern African Catholic Bishops' Conference, 2002), Liebowitz, "Impact of FBOs.", E.C. Green, "The impact of religious organisations in promoting HIV prevention," *SAFAIDS News* 10, no. 1 (2002), Schmid et al., "Contribution of REs.", L. Keough and K. Marshall, "Faith communities engage the HIV/AIDS crisis: lessons learned and paths forward," ed. M. Kessler (Washington DC: Georgetown University, Berkley Centre for Religion, Peace and World Affairs, 2007).

[368] See Woldehanna et al., "Faith in action."

in the sub-Saharan region…;"[369] "…there is *little comprehensive data* about the scope and scale of their contribution … In addition not much is known, beyond claims and often repeated statements, about the ways in which such health care is different from services provided in the public health system…This study undertook to expand upon the 'patchy' data about this religious involvement … There is *little data* on the faith-based contribution to health and to date no *comprehensive database* of religious health facilities for SSA exists…;"[370] "Existing analyses of FBO responses to HIV/AIDS are largely *descriptive* and there is a distinct lack of literature that has attempted to *evaluate the impact and effectiveness* of FBOs in relation to AIDS ...;"[371] "This PA calls for studies to examine the extent and nature of religious organisations' involvement in HIV-related activities … *little systematic knowledge* exists concerning how religious organisations, in themselves, influence risk and prevention strategies … *A scientifically-focused knowledge base* will contribute…[372]

I have included these several extracts as this is a central concern to this thesis, and this body of literature are the core focus of the remaining chapters.[373] It is obvious that a trend has emerged in the HIV/AIDS agenda, for a specific kind of inquiry. From the emphasised text, a preference is stated towards research that is "scientific," "impartial," "evidence-based" and "secular." In Chapter Five we will continue discussion of this, but it is worth noting here that the calls for this kind of "real" research makes a value judgement about the different kinds of inquiry and research already available on the religious response.

Yet even within this real research, the conflicting discourses and tensions remain. I will provide one example here. A narrative device in the broader literature on the religious response to HIV/AIDS is to unproblematically list the strengths or weaknesses of the religious response. Such statements frequently appear in the opening paragraphs of such documents, and are usually unreferenced and prefaced by phrases such as "it is clear that," or "it is accepted that," for example:

> We have a unique presence and reach within communities. We have unique structures and programmes that are already in place. We are available. We are reliable. And we are sustainable. We were there long before AIDS came and we will still be there when AIDS goes away.[374]

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[369] ARHAP, "Appreciating assets," 6-7.

[370] Schmid et al., "Contribution of REs," 9-10.

[371] Parker and Birdsall, "Stigma and FBOs," 18.

[372] NIH, "Religious organizations and HIV: June 22, 2004 " National Institutes of Health (NIH), http://grants.nih.gov/grants/guide/pa-files/PA-04-115.html.

[373] This group of literature form the backbone of the remainder of this thesis.

[374] Canon Gideon Byamugisha on the contribution faith based organisations can make in responding to HIV/AIDS in WHO, "Faith-based groups: vital partners in the battle against AIDS," *The '3 by 5' Target Newsletter* 2004, 4.

> REs are providing a huge share of the services in response to the HIV and AIDS pandemic. Faith-based organisations, rooted in local structures, have been and continue to be in an excellent position to mobilise communities to respond to the HIV and AIDS crisis … their long-term presence, broad networks of dedicated volunteers, and well-developed infrastructure are unmatched by any public or private organisation.[375]

This listing of unique and intrinsic strengths of religious entities has become a strong discursive tradition in the literature addressing the religious response. For example, these strengths might be that religious organisations have extensive infrastructure, reach and access; that they are found in inaccessible and rural areas; that they have access to dedicated volunteers and educated leadership; that they have unique credibility and acceptance in communities; that they have well-developed networks extending from international to grassroots communities; or that they have particular resilience and staying power. In contrast to such statements of intrinsic strengths, are similar lists of intrinsic weaknesses or liabilities, which make them poor partners for HIV/AIDS intervention. The weaknesses usually listed are limited resources, limited capacity, limited skills (in particular poor documentation), and such concerns as prosetylisation tendencies.[376] Again, such statements are unreferenced and are usually based on perceptions of public health or development experts.

In the emerging research studies authors must negotiate these opposing discourses. In response to this, a standard stylistic device in this literature is to talk of the positive and negatives, assets and liabilities of religion and religious response to HIV/AIDS. The discourse on the religious response to HIV/AIDS is a site of constantly conflicting and balancing views, as Dilger says, **"**in recent years, relationships among religion, development, and globalisation have been discussed critically with regard to the potentially beneficial as well as detrimental opportunities that the work of faith-based organisations (FBOs) presents in relation to HIV/AIDS.**"**[377] Liebowitz argues that:

> In addition, however, FBOs possess limitations of capacity, resources, and skills. These limitations make them ill suited for certain kinds of HIV/AIDS programming … FBOs also have constraints based on their belief system, leadership, and exclusiveness … FBOs continue to have tremendous potential for HIV/AIDS work as community based

[375] DIFAEM, "Global assessment of faith-based organisations' access to resources for HIV and AIDS response," (German Institute for Medical Mission, 2005).

[376] Summaries of these statements can be found in Haddad et al., "Potential and perils," 25-26, Olivier et al., "ARHAP literature.", Schmid et al., "Contribution of REs," 84-85.

[377] Dilger, "Doing better," 1.

> organisations with high levels of legitimacy amongst their followers and a mandate to be involved in a range of activities at the community level…[378]

After an assessment of this literature, Haddad et al argued that "there has been a recent boom of interest in the potential of religious entities in establishing effective HIV and AIDS interventions. This interest usually reflects a strongly positive attitude towards working with religious entities - and simultaneously some cautionary note, based on perceptions of the potential negative effects of religious messages."[379]

This shows how these studies which seek to assess the religious response have to negotiate the different discourses discussed above, and authors are frequently caught at the conjunction of several opposing discourses, resulting in texts which are less cohesive, and fractured by disjunctions. As Parker and Birdsall say, "because the existing literature is diverse and uneven in focus, findings are not readily summarised."[380] What this points to, is a difficulty to make any clear, pointed conclusions about religion and the religious response to HIV/AIDS, or at least any conclusion that could be summarised in a two-page policy briefing for public health decision-makers.[381]

I argued elsewhere, that these studies have generally suffered from their broad perspective, that is, assessing a religious response at a national or international level has not been able to account for diverse religious and cultural perspectives they seek to incorporate.[382] However, I wonder now if it is indeed the specific locations of these studies (country, region, community) that causes tension, or rather the underlying paradox, that religion and the religious response (and its variations such as faith community) are descriptive titles or discourses rather than categories measurable in any "real research." In other words, there are inherent difficulties and tensions within the basic language we use to inquire about the intersection of religion and HIV/AIDS, and similarly the language we use to form the research agenda for this inquiry.

Partnerships Running Ahead of Knowledge

Seemingly disconnected to these struggles to acquire workable knowledge about the religious response, partnership has been flourishing between religious groups and public health agencies. This can be seen in the significantly increased funding directed towards religious entities working in

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[378] Liebowitz, "FBOs in Uganda and KZN," 24.

[379] Haddad et al., "Potential and perils," 13. See Nigel Taylor, *DFID, Faith and AIDS: A Review for the Update of Taking Action* (London: UK Consortium on AIDS and International Development, 2007).

[380] Parker and Birdsall, "Stigma and FBOs," 18.

[381] See Chapter Five

[382] Schmid et al., "Contribution of REs."

HIV/AIDS in Africa (and elsewhere). An obvious example is the US President's Emergency Plan for AIDS Relief (PEPFAR), launched in 2002, which profiled religious organisations, acknowledged the concept of 'spiritual care' and entailed particular funding in relation to religious activities.[383] The Global Fund to Fight HIV/AIDS, TB and Malaria (GFATM) and the World Bank are also examples of agencies that took the decision to channel funds for health programs to religious organisations as this was seen as a reliable and efficient means to impact on health crises.[384] As described above, there are also many examples of more meetings and consultations including religious entities and religious leaders, more interfaith collaborative groups, such as interfaith-HIV/AIDS organisations, and improved collaboration between religious entities and governments in SSA.[385] It is important to note, that in terms of timing, this increased partnership has run several steps ahead of the attempts to fill the missing knowledge gap. In 2006, after an extensive literature review of this intersection of religion and public health, we argued that,

> A primary conclusion is that there is substantial valuable information out there, but that it is often so dispersed, inconsistent or tucked in unrelated-seeming places that it is not easily gathered or formulated into distinct arguments or conclusions … (and) there is a huge amount of research that still needs doing, very often on vital aspects of public health interventions that are already being acted upon with little to no supporting evidence.[386]

Liebowitz concurs, saying, "…increasing resources are being devoted to supporting FBOs in global campaigns like (GFATM) and (PEPFAR) … Yet remarkably little guidance is available for policy makers on exactly what the strengths of FBOs are, what best practices have allowed specific FBOs to achieve significant successes, and how FBOs can be integrated into broader campaigns for prevention and mitigation…[387] Said differently, enthusiasm for partnership has run ahead of the knowledge of the nature, scope and scale of religious entities and religious response, not to mention their unique characteristics that may demand specific strategy. Despite the increased literature, there is still great uncertainty about the response and role of religion in the HIV/AIDS epidemics. As Gunderson says,

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[383] See PEPFAR, "Working with community-based and faith-based organisations," (Washington, USA: The President's Emergency Plan for AIDS Relief, 2009), J.R. Formicola et al., *Faith-based initiatives and the Bush administration: the good, the bad and the ugly* (Lanham, Maryland: Rowman and Littlefield, 2003).

[384] N. Taylor, "Many clouds, little rain? The Global Fund and local faith-based responses to HIV and AIDS," in *HIV/AIDS Briefing paper 4* (Teddington, UK: Tearfund 2005), N. Taylor, "The warriors and the faithful: The World Bank MAP and local faith-based initiatives in the fight against HIV and AIDS," in *HIV/AIDS Briefing Paper 5* (Teddington, UK: Tearfund, 2005), Taylor, "DFID and faith."

[385] See Haddad et al., "Potential and perils."

[386] Olivier et al., "ARHAP literature," 69. See ARHAP, "Appreciating assets," 6.

[387] Liebowitz, "FBOs in Uganda and KZN," 24.

> The immediate work of scholars in the context of the HIV/AIDS catastrophe is urgent, because patterns of relationship, expectations, institutional development and authority, blame, standards of competence and credibility of all the systems relevant to the health of African communities are being laid down now. This is happening with nearly zero scholarship on the religious health assets about which vast assumptions are being made.[388]

This seeming disconnect between increased partnership and available information will be discussed in more detail below, but it is possible to hypothesise here that this could be a factor in the lingering concerns and frustrations that continue to hamper communication and collaboration between religion and public health (or religious entities and public health institutions) in the context of HIV/AIDS.[389]

Mapping the Complex Religious Response to HIV/AIDS in SSA

> *Knowledge is power, but power is also knowledge. Power decides what is knowledge and what is not knowledge.*[390]

This chapter has worked to show some of the underlying context to any inquiry into religion and HIV/AIDS. It has also shown that the intersection of religion and HIV/AIDS is a particularly complex nexus of powerful and conflicting discourses that work against each other, making it difficult to make any broad conclusions or actions based on this knowledge. My argument is that this intersection demonstrates an *extreme* mixing of discourses and frameworks, which the historical development of the context has made this intersection of discourses a particularly difficult one to negotiate or manage, and that this has resulted in a miscommunication.

Given that this is an emerging field with a history of religion-blindness, there are significant gaps in our knowledge that are most often filled with stereotypes and generalisations about the religious response. All this means that despite a blossoming literature, there is still great uncertainty about the role and response of religion in the HIV/AIDS pandemic. “Vast assumptions” are still being made, and based on the current literature; it is still difficult to ascertain whether religion in HIV/AIDS in Africa is an irrelevance, adversary or an ally. At the same time there has been an increased enthusiasm for partnership with religious entities that has run several steps ahead of the available knowledge, and this has resulted in communication, interaction, and decisions being made on the constructed generalisations about the religious response. The general lack of critical

[388] G. Gunderson, "The least we can do: why an African religious health assets project?," in *Assets and Agency* (Pietermaritzburg, South Africa: African Religious Health Assets Programme, 2003), 17.
[389] See Schmid et al., "Contribution of REs."
[390] Claude Alvares in Melkote and Steeves, *Communication for development*, 71.

information in this context has made it even more important to study discursive practices, since discourse and metaphor have even more power in such contestable space.

The emerging community of inquiry around religion and HIV/AIDS is therefore characterised (and frustrated by) numerous conflicting discourses and clashing bodies of knowledge as a range actors seek to inquire, communicate and collaborate together on the critical issue of health and HIV/AIDS. This diversity makes it a complex category for analysis and for collaboration. In fact, as discussed above, the discourses that support the constructions of particular meanings of "religion" or "secular" public health mask a complex reality. It certainly is more difficult to deal with complexity, to acknowledge the diversity of the religious response to HIV/AIDS, and the diversity of religion and public health. Lindauer argues that as our global interdependence rapidly accelerates.

> …the collaboration and cooperation that will be needed to address the pandemic will have to be built on an appreciation of differences: profound and fundamental differences in health-related beliefs and practices, in the history of economic and social development, in the structures of political systems and their responsiveness to local community needs… (and) uncertainty is inescapable … complexity is often our excuse for leaving problems to the experts and looking the other way … the idea that we are going to find solutions is itself misleading…It is hubris to think that we can win a war against uncertainty, illness and danger.[391]

The argument here is that, given the way current discourses and constructions act as a barrier to improved understanding, it is necessary for us to deal with complexity. That is, the difficulties with the definition of "religion" have long been a problem, but that in this case, it is necessary for us to work with and through that complexity. All these phases or discourses discussed above continue to be seen in the inquiry aimed at religion and HIV/AIDS in SSA today. There is lingering invisibility and antagonism, individuals and institutions are newly interested, there are increasing calls for research and inquiry, and it appears that partnership is still increasing, despite increasingly restrained financial resources. However, in the reports describing the most recent meetings,[392] there are some signs of the beginnings of a new phase, what I will call the emergence of an "adult relationship." Here, partnership with religion and religious entities has lost some of its shiny newness in face of increasing reluctance on the part of international institutions to act without "real evidence", and are no longer willing to act on anecdote that religious entities hold inherent

[391] D.L. Lindauer and D.C. Walsh, "Afterword: challenges and lessons," in *AIDS in South Africa: a social expression of a pandemic*, ed. K.D. Kauffman and D.L. Lindauer (New York: Palgrave MacMillan, 2004), 180-182.
[392] For example, WHO-CIFA, "NGO mapping", TBFF, "Faith and malaria."

strengths, and now require proof (in their own language).[393] For example, representing the World Bank, Quentin Wodon says:

> The World Bank's relationship with FBOs has transitioned from a specific focus on dialogue with faith leaders to more policy-relevant empirical work with FBOs and country teams … Three common assumptions are prevalent with respect to faith-inspired service delivery but have not been proven: FBOs address the needs of the poor more than the public sector; FBOs better target the poor than other providers; FBOs provide better services than public providers.[394]

There is some sense of a loss of patience with the "peculiarities of FBOs" and an increased discourse requiring them to "come to the table."[395] New interests in the role religion and religious entities can play in other public health concerns (such as renewed primary health care, malaria, H1N1, health systems strengthening, or safe water), has begun to shift the attention away from the religious response to HIV/AIDS, and we are yet to see the outcome of such a shift in focus. Yet if HIV/AIDS exposes fault lines, then the inquiry into the religious response to HIV/AIDS has exposed underlying power relations and fundamental problematics in the language and frameworks that the community of inquiry applies to the intersection of religion and public health (the religion-secular dynamic being the most obvious at this time.)

Speaking to the future is particularly perilous in this context. It is entirely possible that dominant perceptions and attitudes towards religion and religious entities might well cycle back to disinterest or antagonism, given the inability to adequately answer (after more than two decades of asking), what the religious response to HIV/AIDS has been in SSA. The community of inquiry at the intersection of religion and public health therefore stands at a critical point, and it behoves "us" to take the pulse of this investigation, and to better understand where we have arrived (the project of this chapter and this thesis generally).

In the next chapter, rather than speaking to the broader literature on the religious response, I will focus specifically on the religious entity or "faith-based organisation" as it is utilised in this literature, continuing some of the discussion introduced above, and addressing the issue of "mapping" the religious response to HIV/AIDS.

[393] See Chapter Five

[394] (emphasis mine) WHO-CIFA, "NGO mapping", 17-18.

[395] See two recent meeting reports WHO-CIFA, "NGO mapping", TBFF, "Faith and malaria."

Chapter Four. "An FB-oh?": Mapping the Etymology of the Religious Entity

> *…to name is to show, to create, to bring into existence…* [396]
>
> *If there is a battle of names, some of them asserting that they are like the truth, others contending that they are, how or by what criterion are we to decide between them? Plato*[397]

There have been considerable difficulties in finding appropriate nomenclature that properly depicts the huge variety of HIV/AIDS-engaged entities that have a religious aspect to their work or character and are commonly grouped as "the religious sector" or the "faith community". In the previous chapter some of the conflicting discourses of the religious response to HIV/AIDS in SSA were explored, providing a few examples. This chapter explores the conflict around language and power more thoroughly by examining the naming and definition battles that occur within this community of inquiry, and by considering what this means for collaborative communication.

There is a substantial body of literature sprawled across several disciplines that addresses naming and definition, and many scholars have noted the way naming is linked to power. Bourdieu has said that even in archaic societies, "the almost magical power of naming and bringing into existence by virtue of naming" was one of the most elementary forms of political power.[398] In *Pedagogy of the Oppressed*, Freire observes that "naming the world is a model for changing the world suggests that the actual impact of our acts of naming may be much greater than we have imagined."[399] A key argument is that using language to name (order and create the world), we alter and create perceptions:[400]

> …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

[396] P. Bourdieu, *On television* (New York: The New Press, 1989), 20.

[397] In A. Shakow and A. Irwin, "Terms reconsidered: decoding development discourse," in *Dying for growth: Global inequality and the health of the poor*, ed. J.Y. Kim, et al. (Maine: Common Courage Press, 2000), 44.

[398] See P. Bourdieu, *Language and symbolic power*, ed. J.B. Thompson, trans. G. Raymond and M. Adamson (Cambridge, Massachusetts: Harvard University Press, 1991), 236.

[399] P. Freire, *Pedagogy of the oppressed* (Harmondsworth: Penguin, 1972), 97.

[400] For example, Umberto Eco, Michel Foucault and Roland Barthes. See C. Armstrong and S.I. Fontaine, "The power of naming: names that create and define the discipline," *WPA: Writing Program Administration* 13, no. 1-2 (1989): 7.

> 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 [401]

This chapter will provide a landscaping of the myriad ways the "faith-based organisation" (FBO) has been named over the last ten years in the context of HIV/AIDS in SSA. The intent here is not to ratify a certain set of terms, or produce new ones (there is enough of that happening already), but rather to use this as an opportunity to reflect on how far we have come in the battle to understand the religious entity (RE), who or what they are, what they do, how "we" relate to them and inquire about them. By examining the etymology and usage of RE terminology, I seek to explore the recent attempts to find new language in the context of a renewed international interest in religious responses to health and HIV/AIDS, consider some of the issues of institutional power that drive these discourses, and reflect on the effects of this on the broader inquiry. This is based on the results of intensive literature review and discourse analysis, through which the effects of conflicting and powerful discourses are observed. In the first part of this chapter I will briefly map the etymology of the FBO, how the various terms have emerged and been utilised in the literature addressing religion and HIV/AIDS in SSA. The remaining half of the chapter will be spent exploring the broader empirical realities this analysis reveals, so that we may consider some of the consequences and chart a way forward that is conducive of more effective collaborative practice.

Mapping the "Faith-Based Organisation" Landscape

> *What is a 'Faith-Based Organisation'? A general term used to refer to religious and religious-based organisations, places of religious worship or congregations, specialised religious institutions, registered and unregistered non-profit institutions that have religious character or missions.* [402]

In the first chapter I noted the language battles common in the community of inquiry at the intersection of religion and HIV/AIDS, which have resulted in miscommunication and demands for translation. The struggles over the naming and definition of the REs scattered across the religious-health landscape is the most overt example of these battles. Every meeting within the community of inquiry at the intersection of religion and HIV/AIDS which I have attended has had some discussion of the difficulties of finding accurate language to adequately describe the forms of religion as well as the frameworks to inquire about them. A rather typical example can be seen in this statement from a symposium report:

[401] Armstrong and Fontaine, "Power of naming," 7-8.
[402] Woldehanna et al., "Faith in action," 10.

> But 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. Discussion built on Patrice Brodeur's opening admonition 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.[403]

Like the battle to adequately define religion or public health, the struggle to find the correct language to describe the religious entity (RE) has been ongoing for some time now. Surprisingly, despite this ongoing discussion, there has been no systematic review of such religious terminology, neither in the broader religion-public health context nor specific to HIV/AIDS,[404] and little progress in settling this matter. In the HIV/AIDS arena there appears to be significant frustration with the lack of shared understanding or consensus. On the literature addressing the religious response to HIV/AIDS, "most reports … make considerable effort to explain just what they mean by whatever terms they have chosen to represent religious entities and actions - however, there appears to be little common agreement…"[405] In this literature on religious response, as a result of the lack of consensus, it has become a trend for authors to redefine the term they have chosen to use in each text. The phrase "for purposes of this discussion/paper/report" appears regularly, and each interpretation shows personal variation in the use and interpretation of these terms.

Green begins his report *Faith-based Organisations: Contributions to HIV Prevention* saying, "For the purposes of this discussion the term FBO refers to organisations of varying sizes and bureaucratic complexity."[406] In this example, the overarching use of FBO is shown, where such terms are expected to encompass 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. There are also many alternate terms that are used interchangeably for this purpose, and that have arisen as a result of the interdisciplinary and complex nature of

[403] CIRS, "Symposium: global development and faith-inspired organizations in the muslim world" (Doha, Qatar, 17 December 2008), 5.

[404] The only systematic review I have encountered is focused specifically on the religious NGO-type entity, rather than the broader range of types and frameworks. See J. Berger, "Religious nongovernmental organizations: an exploratory analysis," *Voluntus: International Journal of Voluntary & Nonprofit Organizations* 14, no. 1 (2003).

[405] Olivier et al., "ARHAP literature," 16.

[406] Green, "Contributions."

engagement with REs working in health, and of the increasing attention on these entities from a variety of sources (such as public health institutions, academia, the development sector, governments and from religious entities themselves), all utilising different frameworks for this description.[407]

As a quick demonstration, during the literature review work completed for a landscaping review of religious health assets in SSA, I collected a terminology database from the relevant literature.[408] From this database, the following alphabetical list shows just some of the terms collected that appeared in the literature specifically addressing religion and HIV/AIDS in SSA, and which broader terms such as FBO are supposed to encompass:

> …body, Christian council, Christian health association, Christian health network, church, church-based organisation, community group, community support group, community-based organisation, congregation, congregational network, denomination, development agency, ecumenical organisation, facility based religious entity, faith-background organisation, faith-based community, faith-based development organisation (FBDO), faith-based group, faith-based initiatives (FBI), faith-based institution, faith-based network (FBN), faith-based organisation (FBO), faith-centred organisation, faith-influenced non-governmental organisation, faith-inspired network, faith-inspired non-governmental organisation, faith-inspired organisation, faith-related organisation, faith-saturated organisation, formal worshipping community, global institution, grassroots organisation, home-based care group, independent faith-influenced non-governmental organisation, informal social group, intermediary, international religious body, inter-religious network, Islamic health network, local faith/religious community, mission hospital, national faith-based health network (NFBHN), non-facility based religious entity, non-governmental organisations (NGO), nonprofit institutions (NPO, registered and unregistered), pharmaceutical organisation, private hospital, private sector, private-not-for-profit, relief agency, religious community, religious coordinating body (RCB), religious entity (RE), religious facility, religious group, religious health network, religious institution, religious leader, religious organisation, religious social service agency, religious umbrella body, religious-based organisation, specialised religious institution, traditional birth attendant group, traditional healers' network, umbrella group, voluntary hospital, voluntary owned agency, women's group , worshiping community, youth group…

[407] This will be discussed in more detail below.

[408] Database of literature collected for Schmid et al., "Contribution of REs." This is only a partial extract. Alternate spelling not included.

This simple listing crudely demonstrates the broad range of types of religious entities, as well as the number of different HIV/AIDS-related services they provide. At this time, there is no consensus on the terminology and definition of REs involved in health and HIV/AIDS, in SSA or internationally. While there is no consensus on a particular term, there is some agreement on the need for a term that encompasses all entities with a religious element (or faith factor), a broad-range classification that is built on a binary split between religious and secular entities.[409] In the overarching usage (for which I use "religious entity"), the current front runners are faith-based organisation (FBO), faith-inspired organisation (FIO), and faith-based initiative (FBI). FBO is by far the most utilised term in the literature addressing religion and HIV/AIDS, even if its definition is varied. For example,

> 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. In some cases they are led by clergy … in other cases laypersons … provide the driving force.[410]

It has been suggested that UNAIDS was a main instigator for the use of this term in the context of HIV/AIDS, when they recommended church-based organisation be substituted by faith-based organisation in 1996. UNAIDS currently holds to that position, stating in the *2008 UNAIDS' Terminology Guide* 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."[411] Another frontrunner is faith-inspired organisation (FIO). This has been popularised by institutions such as the World Bank and seen in reports from Georgetown University's Berkley Center for Religion, Peace and World Affairs.[412] Faith-based initiative (FBI) is also popular, although

[409] See below for further discussion on this.

[410] S. Lux and K. Greenaway, "Scaling up effective partnerships: A guide to working with faith-based organisations in the response to HIV and AIDS," (Church World Service; Ecumenical Advocacy Alliance; Norwegian Church Aid; UNAIDS; World Conference of Religions for Peace 2006), 4.

[411] UNAIDS, "UNAIDS' terminology guidelines," (Geneva: Joint United Nations Programme on HIV/AIDS, 2008), 8.

[412] See L. Keough and K. Marshall, "Faith communities engage the HIV/AIDS crisis," (Georgetown: Georgetown University's Berkley Center for Religion, Peace and World Affairs, 2009).

its etymology is unclear. However it is likely that this use has been given momentum by the US Bush administration's Center for Faith-Based and Community Initiatives.[413]

There are two broad concerns in the literature in relation to these overarching terms. Several authors feel that the term "faith" is more inclusive of non-mainstream or formal groups than the term "religious".[414] However, others (including many religious studies scholars) feel that "religious" has a more inclusive meaning, and is worth keeping in use. The second broad concern expressed is that in contexts such as SSA, "religion or religious entities are not always construed in terms of visible institutions, let alone representative ones."[415] Here terms such as institution and organisation are made problematic in the face of multi-religious contexts (which includes African Traditional Religious and other diverse African religious responses) and informal groups within communities working in health and HIV/AIDS.[416] Hence the decision by some in the ARHAP collaborative to use the term religious entity, which I have adopted here.[417] These concerns illustrate the number of different interests at play, making this more than a terminological exercise, and instead a site of struggle and negotiation. For example, Liebowitz's definition of FBO in his study on the religious response to HIV/AIDS in Uganda and South Africa is frequently cited, and 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.[418]

A few years later, reporting on the same body of research, Liebowitz was using FBO again.[419] This example is in no way an accusation, indeed most authors working at the intersection of religion and HIV/AIDS (myself included) have generally utilised a range of terminologies in different pieces of work engaging with the faith community and the HIV/AIDS-involved religious entity. For example, in the ARHAP reports addressing religious health assets in SSA we alternated between: religious entity, religious organisation and faith-based initiative, in order to adequately define the

[413] The Center for Faith-Based and Community Initiatives is now the Center for Faith-Based and Neighbourhood Partnerships.

[414] See S.M. Chambré, "The changing nature of "faith" in faith-based organisations: secularisation and ecumenicism in four AIDS organisations in New York City," *Social Service Review* September (2001).

[415] E. Thomas et al., "Let us embrace: The role and significance of an integrated faith-based initiative for HIV and AIDS," (Cape Town: African Religious Health Assets Programme, 2006), 12.

[416] See Liebowitz, "Impact of FBOs," 4, Schmid et al., "Contribution of REs.", ARHAP, "Appreciating assets."

[417] Although RE has its limitations as well. See Chapter Six for more on ARHAP's assets-based terminology.

[418] Liebowitz, "Impact of FBOs," 4.

[419] Liebowitz, "FBOs in Uganda and KZN."

different aspects of the REs under investigation.[420] These decisions were made (after much interdisciplinary debate), based on the theoretical framework of each study, the object under investigation, as well as funder and audience requirements, influences felt by all authors working in this context.

However, shifting terminology and definitions between texts is the least extreme example available. More vivid, is the increasingly utilised tactic of authors shifting terminology within texts, utilising different terms interchangeably in the same report or article with little clarity of their different meaning. For example, in 2008, Family Health International used the term FBO in their organisational publications,[421] but their website currently states:

> *Faith-based initiatives* can be pivotal to the success of public health programs throughout the world - especially those concerning reproductive health and HIV/AIDS prevention and care…*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, such as HIV prevention and care, and reproductive health.[422]

This extract shows the general instability and loss of meaning apparent in the terminology landscape around REs working in health and HIV/AIDS. Several authors (and institutions) have attempted to provide typologies for the subcategories below these broad-range terms, although again there is currently no consensus or preference in the literature on the use of any typology in the context of HIV/AIDS. For example, the World Council of Churches (WCC) has differentiated between faith-related organisations, faith-background organisations, faith-centred organisations and faith-saturated organisations.[423] A recent UNFPA inter-agency report uses the term FBO as its overarching term, and then in its appendix differentiates between religious leaders, faith-inspired nongovernmental organisation (including faith-inspired networks, and local faith communities).[424]

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[420] See ARHAP, "Appreciating assets.", Haddad et al., "Potential and perils.", Schmid et al., "Contribution of REs.". See Chapter Six for a further discussion of ARHAP's terminology and definitional work.

[421] W.L. Sachs, *Empowered by faith: Collaborating with faith-based organisations to confront HIV/AIDS* (Arlington, VA.: Family Health International (FHI)/USAID Bureau for Global Health Office of HIV/AIDS, 2008).

[422] *Emphasis mine*. FHI, "Family Health International's experience with faith-based organizations," Family Health International, http: //www.fhi.org/en/Topics/Faith-based+Initiatives+topic+page.htm.

[423] See A. Doupe, "Partnerships between churches and people living with HIV/AIDS organizations," (Geneva, Switzerland: World Council of Churches, 2005).

[424] UNFPA, "Proceeding report: Interagency consultation on faith-based organizations," (New York: United Nations Population Fund, 2008).

In a WCRP-UNICEF report, the sub-categories of FBO are: congregation, religious coordinating bodies (RCBs), non-governmental organisations (NGOs), and community-based organisations (CBOs).[425] In a mapping study of Zambia and Lesotho, ARHAP undertook to develop a more concise typology and provided a detailed multi-level categorisation, differentiating 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.[426]

Assessing the broad literature on religion and HIV/AIDS in SSA, it is possible to identify six main ways that REs are represented in the literature (or six main *discourses* about religious entities engaged in HIV/AIDS). I am not providing an alternate typology here, but rather, by assessing the different typologies as described above as well as the definitions provided at the beginning of each text, it is possible to identify the dominant representations of the RE engaged in HIV/AIDS. None of these labels are discrete or fully adequate and all tend to overlap and relate to another, as will be unpacked below:[427]

1) Faith-forming entities: This is a discourse which includes such terms as congregation, church, local faith community or worshipping community, which are intended to name the sub-category of entities whose primary function is the formation of faith. Some authors have sometimes used faith-forming entity (FFE) to mean those "bodies whose primary focus is worship or some analogous practice, out of which people arise who demonstrate strong and enduring religious commitments, passions and motivations to action."[428]

2) Religious leaders: This discourse includes religious leaders of different religious traditions. Religious leaders are frequently singled out on the religion and HIV/AIDS literature, for example as barriers to HIV/AIDS intervention or as important channels for intervention and collaboration.

3) Religious nongovernmental organisations (RNGOs): There is a strong discourse clustering REs as organisations that are part of civil society but with a religious character. Here, the term FBO and its counterparts are used to describe organisations of the NGO-variety. Berger has conducted an interesting review of RNGOs, saying these are "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

[425] G. Foster, "Study of the response by faith-based organizations to orphans and vulnerable children: Preliminary summary report," (World Conference of Religions for Peace and United Nations Children Fund, 2003).

[426] ARHAP, "Appreciating assets," ch2.

[427] All these representations include both explicit and implied meaning/examples.

[428] ARHAP, "The better words project [draft: report forthcoming]," (Cape Town: African Religious Health Assets Programme, Emory University, 2010).

articulated ideas about the public good at the national or international level."[429] This is the most common meaning given to FBO.[430]

4) Community-based religious entities: A related, but slightly different distinction is frequently made about REs characterised by their location at a community level, including such terms as religious organisations, CBOs, or grassroots groups. This is sometimes explicitly stated, and at other times is implicit, for example when FBOs are listed with CBOs as part of civil society, or in the texts from the various US government-civil society initiatives. For example, the Bush administration and its White House Office of Faith-Based and Community Initiatives does seem to locate FBOs at the community level, as does the Obama administration's White House Office of Faith-Based and Neighborhood Partnerships. PEPFAR materials also support this, talking of the "…development of partnerships with FBOs and CBOs as a key strategy for increasing access to services and building sustainability."[431]

5) Networks: Another main representation emphasises the networking or coordinating character of REs such as a diocese, national fellowships or Christian health associations. A term that is much in use is the religious coordinating body (RCB), as "an intermediary organisations responsible for supervising and coordinating religious activities of congregations; RCB may also supervise and support the health work of congregations."[432] Another emerging term is that put forward by USAID, national faith-based health networks (NFBHNs), as country-level providers of health services, or networks of health service providers such as the Christian Health Associations.[433]

6) Health facilities: The last main discourse is concerned with religious health facilities engaged in HIV/AIDS, and usually inclusive of both standard health facilities (such as hospitals and clinics), as well as community-level health initiatives (such as home-based care groups), although much more is said about the former than the latter.

When speaking of an FBO (or RE as an overarching term, all such representations are implied together, as well as a range of other types that still do not fit into these main representations. Yet no typology has ever reached consensus status, implying an underlying problem. The most recent example of a typology attempting to encompass all religious entities engaged in HIV/AIDS is from the *UNAIDS Strategic Framework for Partnership with Faith-based Organisations* which provides a report of the results of an 18-month consultation process organised by UNAIDS from 2008 to 2009.

[429] Berger, "RNGOs," 16.
[430] See Haddad et al., "Potential and perils.", Dilger, "Doing better," 103.
[431] PEPFAR, "Working with CBOs and FBOs."
[432] ARHAP, "Better words."
[433] Chand and Patterson, "Faithbased models."

In this consultation, terminology was discussed extensively with partners and the report gives the results of this consultation.[434] This document uses FBO as the broad term and the focus of the document is abbreviated to the repeated phrase "UNAIDS-FBO Partnership".[435] However, muddying the waters slightly, 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,"[436] giving the reader pause in wondering what the difference is between an FBO and a religious group, and which one is being addressed here. The UNAIDS-FBO Partnership document then provides four sub-category definitions:[437]

> *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 extract shows some of the tensions and conflicting meanings felt by anyone inquiring into religion and HIV/AIDS. Here, the term FBO is chosen as the broad term, but this description shows some of the critical tension in the broader literature, namely that FBO has been used extensively, both as an overarching term that is meant to address every entity with a religious element, as well as different kinds of underlying subcategories, making it increasingly difficult to make a generalising statement about FBO's response to HIV/AIDS, given the varying meaning given to the

[434] UNAIDS, "UNAIDS-FBO partnership."
[435] See UNAIDS, "UNAIDS-FBO partnership," 5-7.
[436] Emphasis mine. UNAIDS, "UNAIDS-FBO partnership," 4.
[437] UNAIDS, "UNAIDS-FBO partnership," 4-5.

term FBO. In this brief extract, FBO appears in several different ways, as a partner (with religious groups), as a subcategory of a faith community, as a separate subcategory in its own right, and possibly a subcategory of local religious community, leaving the reader uncertain as to what is intended by the use of the term and what conclusions can be made about FBOs after reading the text. Furthermore, 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."

This text shows many of the tensions any author feels in this community of inquiry, in both needing to describe a broad range of "something" with the sensitivity their complexity deserves, but not having adequate language or descriptive frameworks to do so. I will boldly predict that this new typology presented by the UNAIDS-FBO Partnership document is no more likely to be generally taken up than any of the others that are circulating within the community of inquiry (as well as the broader religion-health and religion-development communities) despite the considerable collaborative effort put in to arrive at these definitions. It would appear that the authors suspect the same, as they conclude the above definitional statements with the words, "Each UNAIDS Cosponsor may have reasons for its own specific terminology and engagement. For ease of reference in this framework, the term "faith-based organisations" will generally cover the various categories listed above, except where indicated otherwise."[438] It is acknowledged that institutions such as UNAIDS and such high-level Cosponsors have naming and definitional power. In the context of HIV/AIDS, UNAIDS *should* have a particular authority to name the HIV/AIDS territory and the objects within its landscape. These last two sentences of this extract are particularly telling, showing the conflicting terminology being applied by various global institutions, even within the UN family, and the deep uncertainties that linger, even in such halls of power.

Exploring the Terminological Battlefield: Why does it Matter?

> *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.*[439]

What are possible reasons for this ongoing and increasingly complex terminological and definitional battle? Why has no selection of terms, even those formed through collaborative

[438] UNAIDS, "UNAIDS-FBO partnership," 5.

[439] Stephan Hanmer (UNICEF) in UNFPA, "Proceeding report: Interagency consultation on faith-based organizations," 17.

dialogue, struck the collective imagination of the community of inquiry, or managed to adequately address what we are trying to describe? As described in the preceding chapter, the RE has recently enjoyed a growing popularity and interest at an international and national level. The increased interest has significantly added to the number of individuals and institutions inquiring about REs. At the same time, the previous chapter demonstrated how the basic information or knowledge about religion, REs and their engagement in HIV/AIDS is severely lacking as a result of a number of historical factors. The body of information about REs engaged in HIV/AIDS is famously incomplete and inconsistent.[440] Lacking any consensus about naming and terminology, and faced with critical and significant gaps in knowledge, this increased inquiry has led to the effect described above, where authors differently name and define REs from text to text. However, the increased interest in REs has also resulted in more efforts to understand their complexity.

As the quote from Stephan Hanmer of UNICEF says above, those involved in collaboration and inquiry are aware of this diversity, and are attempting to be sensitive to this. The terminological battles have not arisen from callousness towards the RE, but rather from the increased sensitivity to religion and religious entities. As a quick example, consider 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/AIDS prevention, care and support at the community level."[441] Such listings (and the thousand others like this) are making a point of including FBOs in listings of key stakeholders. Yet, because of the conflict and loss of meaning of such terms as FBO, it has an unintended effect of implying that FBOs are something specific, and different from the other secular organisations listed here (PLWHA, CBOs, NGOs, private voluntary organisations or donors), when in fact, we know that FBOs are all of these, and more.

However, with interest running ahead of information, the willingness to understand the complexity of the faith community is faced with a complete lack of information. This has resulted in a flurry of different definitions and names, all attempting to wrestle with the diversity of the faith community. If HIV/AIDS reveals fault lines, in this case it has revealed the vulnerabilities of knowledge systems, and our current naming and classification strategies.

The previous chapter noted the difficulty of making any broad conclusions about the religious response to HIV/AIDS, both because of the language and the lack of information. This shows up starkly in relation to terminology, where the unregulated use of different terms and definitions is

[440] See ARHAP, "Appreciating assets.", Haddad et al., "Potential and perils.", Schmid et al., "Contribution of REs."
[441] Doupe, "Partnership."

of critical concern. Anyone who has engaged in literature review of the materials addressing religion and HIV/AIDS in SSA encounters these difficulties. Shifts in terminology, and the different meaning given makes longitudinal literature review type research virtually impossible.[442]

One of the most heated battles over broad conclusions or generalisations can be seen in a stylistic tradition that has trickled from public health into the religion and HIV/AIDS literature. This tradition is for authors to quote some percentage of religious response to health or HIV/AIDS as opposed to the secular (or some variation of this) in the opening portions of the text.[443] For example, "The World Health Organisation (WHO) estimates that faith-based groups provide between 30% and 70% of all health care in Africa,"[444] is being regularly cited.[445] However, in the landscaping review of religious health assets in SSA, in attempting to unpack and assess such statements and the data on which they are based, it rapidly became clear that these different statistics were severely undermined by the simple fact that they were all assessing something different, are all based on a different definition of the FBO.

> …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. This severely limits the ability to speak to the 'percentage' of FBOs working in health … 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'. A recommendation here would be for a clear set of indicators and measures to be clarified and put in place to begin to assess the faith-based communities' presence in the national health system(s).[446]

This frustration is equally felt in HIV/AIDS-specific literature. Compare, for example, the two statements: "religious entities in many African countries provide between 30 and 50% of institutional health care … It is estimated that the Roman Catholic Church alone provides 25% of all HIV/AIDS care…[447] to the statement by CAFOD that "around 40% of HIV and AIDS initiatives across

[442] See Schmid et al., "Contribution of REs."
[443] See Olivier et al., "ARHAP literature," 33-35.
[444] UNAIDS, "UNAIDS-FBO partnership," 8.
[445] See Schmid et al., "Contribution of REs."
[446] Schmid et al., "Contribution of REs," 47.
[447] Benn, "Why religious health assets matter."

Africa are supported by the Catholic Church."[448] Little secondary data is available to assess such statements, for example to balance the HIV/AIDS response of the Catholic Church against the actions of other religious groups or against the secular response. Even when more specific terminology is used, wildly different figures are reported. This suggests firstly that there is still a critical lack of information available, and secondly, that these statistics are based on different definitions of what they are assessing, that is on differently named parts of the faith community, and making it impossible to reconcile the different available data.[449] The implications of this are significant, consider, for example, that given the lack of clarity, it is still not yet known whether the contribution of REs to health care in SSA is underestimated (because the terminology is not sensitive enough to capture the range of activities); or overestimated.[450]

This struggle over statistics, which, at this time, is actually a battle over naming and terminology, has severe consequences for the HIV/AIDS sector generally and for the community of inquiry at the intersection of religion and HIV/AIDS specifically. I have witnessed and been part of heated verbal battles where different percentages are quoted and argued over. Such percentage statements have critical consequences in the world of public health, where the fact that a certain percentage of the religious response is being enacted by the faith community, at its most basic level, argues for greater support and attention being given to that sector. Doyal says, "health statistics are especially vulnerable to bureaucratic manipulation because of their political and economic implications … furthermore, the very terms in which the statistics are formulated tend to obscure both the nature of disease in a living population and the means by which it might be eradicated."[451] I will return to this at a later stage in this discussion, but the point at this time is simple, such battles over percentages reveal much more about broad attitudes, positions and opinions, since the underlying evidence is missing or subject to different definitions (or indicators). Said more simply, at this time, it is possible to vigorously argue with supporting literature that FBOs have provided *any* percentage of HIV/AIDS care in SSA since the term FBO is mostly arbitrary and devoid of specific meaning, just as the term "care" has different meaning in different HIV/AIDS contexts of inquiry. Consider the following statement from the WHO's 2004 World Health Report:

> Faith-based organisations have a crucial role to play in the widespread uptake of HIV/AIDS treatments, because of their influence within communities and their reach in rural and

[448] CAFOD, "Review of the year 2005-2006," (London: Catholic Agency for Overseas Development, 2006).

[449] I do not use the term impossible lightly. See Schmid et al., "Contribution of REs," ch4. for further discussion of this.

[450] See Schmid et al., "Contribution of REs." – a key area for further research is an assessment of such statements to better understand their meaning and institutional interests, as well as the broader "mapping" of REs engaged in health and HIV/AIDS (see Chapter Six).

[451] L. Doyal, *The political economy of health* (London: Pluto Press, 1987), 97.

> remote areas. Together with religious institutions, faith-based organisations are central to efforts to reduce stigma and discrimination. They account for around 20% of the total number of agencies working to combat HIV/AIDS. They are well positioned to offer psychosocial, moral and spiritual support to people in difficult circumstances, and they now have a growing role in treatment scale-up.[452]

The assessment that religious institutions and faith-based organisations together account for around 20% of the total agencies working to combat HIV/AIDS is fascinating. What do they mean by agencies? Are they indicating RNGOs, or faith-forming entities? Organisations or faith-forming entities with no buildings? Health facilities or international development agencies? In the context of religion and HIV/AIDS, such terminology is as yet unclear.

Treichler argues that numbers have a particular power and centrality to the construction of HIV/AIDS. She says that without the authority of the statistical method, "the epidemic as a global issue could not be articulated at all. Yet while this First World numerical chronicle of global AIDS may appear to be unfolding smoothly as our knowledge grows, in fact it is problematic … Given the statistics cited above, how can it be that the most fundamental meaning of the narrative remains contested?"[453] Treichler continues by suggesting that in the face of the "overwhelming difficulty of even characterising the diversity of the epidemic, let alone containing it," statistical measures may offer us the "illusion of control."[454] I am struck by the parallels of this observation to the problem of naming religious entities and its relation to the authority of numbers. It has been noted above that generalisations about religious entities (or any of its sub-categories) are problematic, in that they mask the inherent diversity of the "faith community". In the same way, given the complete absence of basic "data" one which to base such statistics about the faith community, such percentage statements, and the broad generalising terminology in which such statements are based, act primarily as an illusion of control over the wild diversity of the faith community. Treichler also argues here that the continued contestation over HIV/AIDS statistics may be as a result of inadequate data or too few studies, or that "…interpretations of the epidemic may be based on divergent and not mutually understandable paradigms and forms of evidence."[455] In the following section, I will seek to consider some of the possible paradigms being applied to the faith community, battling for at least the illusion of control over the construction of religion and HIV/AIDS.

[452] WHO, "World Health '04," 46.
[453] Treichler, "AIDS in the third world," 388-389.
[454] Treichler, "AIDS in the third world," 391.
[455] Treichler, "AIDS in the third world," 388-390.

A Clash of Paradigms and Forms of Evidence

> *Faith-based organisations are organisations that are religious in nature – Wikipedia*[456]
>
> *We also pray with our patients! - Government hospital nurse, Zambia.*[457]

Given the knowledge gap on religion and its associative forms, the naming of religious entities in the context of HIV/AIDS became a new and creative enterprise. Bourdieu says, "throughout our lives, most naming is … coming upon something new and trying to fit it to our previous experiences, deciding whether it belongs under Label A or Label B (but first deciding whether we like it or not. Attraction-repulsion is probably biological) … most often as a subcategory of something for which a name already exists …"[458] In the context of HIV/AIDS, several already existent frameworks (paradigms) impact on the naming and definition of REs. In the following section, I will consider some of the difficulties of mapping REs, by considering some of the main paradigms simultaneously influencing the way REs are named and understood. The main paradigms considered here are public health (seen here in nomenclature of health facilities), development (with nomenclature of NGOs and CBOs), standard assessment perspectives of region, representation and mission, (such as community-national-international, or North-South dynamics), and the religious-secular framework.[459]

Mapping studies of REs in SSA have battled with these questions in recent years and it is helpful to reflect on the steps of a mapping inquiry process as a framework for this discussion. For those used to assessing organisations (NGOs or health facilities) in a Western setting, the most basic way of assessing whether an organisation is religious is by looking at its name or classification in a database or registry. The name is rarely a useful signifier in SSA, as many organisations classified in government registries as secular NGOs have religious names, and equally, organisations registered as religious or faith-based in various databases have no indication of that faith in their name or activities (home-based care groups for example). The next logical step is to then assess religious entities by their presence on such registries and databases. Again, this is less helpful than would be expected since such databases rarely exist in SSA, and if they do, usually only include recognisable subcategories of REs (health facilities in health sector lists and RNGOs in civil society lists). Some FBOs are registered NGOs but many are not and may be supported by their religious community.[460]

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[456] Wikipedia: http: //en.wikipedia.org/wiki/FBO

[457] ARHAP, "Appreciating assets." (original transcripts)

[458] Bourdieu, *Symbolic power*, 140.

[459] It is necessary to point out that the academic disciplinary frameworks will be more closely interrogated in the chapter that follows this one

[460] Lux and Greenaway, "Scaling up," 112.

Furthermore, it has been noted above that given the broad-scale lack of information about religious entities, they are frequently missing from such data sources, and the religious characterisation is rarely clear in such datasets, for example in Uganda, health-providing FBOs are regarded as part of the private-not-for-profit (PNFP) sector.[461]

These examples also show a clash of two main paradigms, namely between development and public health frameworks. In the previous chapters I mentioned the overlap of so-called development and public health sectors in the context of HIV/AIDS. This is particularly evident in the naming and terminology of religious entities engaged in HIV/AIDS in SSA, where different frameworks have been applied to the religious entity. Development nomenclature usually works with terms such as non-governmental organisations and community-based organisations, although there is no fixed nomenclature or typology, and development work is well used to dealing with a number of different entities, for example:

> Non-governmental organisation (NGO) is a catch-all term loosely used to describe a wide spectrum of non-profit organisations working outside government … there are many different typologies and classifications of NGOs. One of the most familiar is distinguishing between specific AIDS NGOs, at times called AIDS Service Organisations (ASOs) and more general development NGOs … This results in diversity, which can make it impractical to compare or apply models from other countries or settings …[462]

As discussed earlier, it is also not possible to pretend that the public health paradigm only provides clear and unambiguous typologies of health facilities, since the public health gaze also falls onto community groups and health initiatives that cross over into what someone might consider to be the development sector. Both these paradigms are therefore already complex and diverse. Nevertheless (speaking in broad terms), it can be argued that inquiry into religion and HIV/AIDS that emerges from a development perspective tends to focus more on RNGOs than on religious health facilities, and inquiry from a public health perspective might be more interested in religious health facilities than RNGOs.[463] Both of these perspectives provide specific tools and measurements for the assessment of these entities, and this is where the difference can be seen more clearly.

[461] See Schmid et al., "Contribution of REs," 73.

[462] See R. Kerkhoven and H. Jackson, "AIDS brief for sectoral planners and managers: NGO sector," in *AIDS Briefs*, ed. A. Whiteside (Durban: USAID, Bureau for Africa, 2005), 1.

[463] Berger for example writes about RNGOs without addressing health facilities at all. Berger, "RNGOs."

Consider, as a demonstration, either of the following statements: "Faith-based organisations - often called FBOs - have been involved in the AIDS response since the earliest days of the epidemic,"[464] or faith-based organisations should be more involved in prevention. Such statements, with the term FBO having lost specific meaning, can be assessed and interpreted differently, depending on the paradigm applied to it. It is indeed probable that religious health facilities (such as mission hospitals) have indeed been involved in HIV/AIDS response from the earliest days, but is this statement true for all RNGOs? Should all religious entities be more involved in prevention? Such generalised statements are constructed or compromised depending on the paradigm applied and the meaning given to FBO.

Development and public health paradigms, both being applied to the naming of religious entities, overlap and clash when applied to the same target. This can be seen in the unclear distinction between civil society and the health sector (or system) response to HIV/AIDS in SSA.[465] In an orderly world, the health sector would consist of precisely named religious health facilities (including identifiable objects such as hospitals, clinics, dispensaries, home-based care groups, public or private sectors),[466] and civil society would consist of identifiable non-governmental organisations and community based organisations.[467] However, this is not an orderly world. Religious non-governmental organisations are running ARV programs, and health facilities are providing developmental outreach into communities.[468] Again, this is not a mere matter of scholarly word play. The development and public health sectors are driven by powerful institutions and power plays a key role in deciding who gets named, noticed and is engaged with. In mapping language, naming and power decides *on whose map* religious entities are placed; and religious entities in turn must decide if it would be to their benefit (or detriment) to be mapped.

An example of the consequences of this can be seen in many national HIV/AIDS strategic policies which can be ranked on a spectrum based on where they place religious entities.[469] On the one end, are policies that do not mention religion at all;[470] then policies that only mention REs (as part of a listing of civil society bodies); then policies that mention REs as part of civil society and

[464] UNAIDS, "UNAIDS partnerships " http://www.unaids.org/en/Partnerships/Civil+society/religionAndAids.asp.

[465] An interesting trend in these two groupings is for religious entities to not be mentioned at all, but instead to be assumed to be part of civil society, non-governmental organisations, or private health sector. See D. Umeh and F. Ejike, "The role of NGOs in HIV/AIDS prevention in Nigeria," *Dialectical Anthropology* 28 (2004).

[466] See Schmid et al., "Contribution of REs.", ARHAP, "Appreciating assets."

[467] PEPFAR, "Working with CBOs and FBOs."

[468] See ARHAP, "Appreciating assets."

[469] See Olivier, "Religion and policy."

[470] Or its associated terms such as faith, spirituality, or FBO. In such policies the positioning of religious entities is implied rather than stated.

religious health facilities as part of the health sector; and, on the opposite end of the spectrum are policies that struggle to engage with contextualized religion and the many religious organisations in a more comprehensive manner, mentioning it in all sectors.[471] ARHAP research suggests that at a national level, two main avenues for collaboration between religious organisations and governments around HIV and AIDS are utilised:

> The first is governments' collaboration with religious health (service) sectors such as national faith-based health networks or the Christian health associations - most commonly managed through Ministries of Health. The second is governments' collaboration with religious entities that are perceived to be part of 'civil society' - this relationship managed (on the governments' side) through national AIDS Commissions or Councils and multisectoral committees …[472]

This research, as well as other secondary literature suggests that in most SSA countries, collaborative relationships between religious health facilities (usually represented through national faith-based health networks, NFBHNs) and governments is usually stronger than the relationship between governments and the "rest" of the REs grouped as part of civil society.[473] The latter (civil society) collaborative route is usually weaker than the more direct relationship the religious health facilities have with the biomedical response group and their representative councils are more commonly the site of internal conflict than the NFBHNs.[474] I will discuss this below in more detail, however at this time, it is possible to suggest that being named has real consequences to such critical issues as representation in the HIV/AIDS community and access to resources.

Anyone unfamiliar with the variety of religious entities in SSA might suggest that this civil society–health sector distinction can be made based on the activities of the entity. Yet several studies have shown that this is not a clearly defined area. In SSA countries there are usually parallel approaches to HIV/AIDS, one approach as a medical problem, and the other as a disease of development.[475] This binary construction reinforces and combines with the constructed difference between civil society and health sector, or development and public health. However, within any of these binary constructions, religious entities are more often outliers than comfortably fitted into such

[471] See Olivier, "Religion and policy."

[472] Haddad et al., "Potential and perils," 29. The DRC, for example, has two different HIV/AIDS coordinating bodies, one for the social response and one for the medical response.

[473] Haddad et al., "Potential and perils.", Schmid et al., "Contribution of REs."

[474] This is anything but a precise division, as many NFBHNs have representation on the national interfaith HIV/AIDS councils. Nevertheless, this division of collaboration appears to be the case across a number of different SSA countries studies. See Haddad et al., "Potential and perils." and Schmid et al., "Contribution of REs."

[475] See Haddad et al., "Potential and perils."

frameworks. For example, there is no neat distinction between those REs who are responding medically or socially to HIV/AIDS. Many of the latter will be running HIV/AIDS programmes that involve ART, or home-based care, but have been grouped with the civil society response due to their perceived nature or their name. Or another example is that an RE collaborating with government as part of civil society, might actually be the coordinating network (denominational body) that "owns" the health facilities who are coordinating via another route. On the other hand, many NFBHNs include members that are not health facilities, but are classified as RNGOs, therefore suggesting that these RNGOs would have a better access to government than other RNGOs in that region, based on their membership in the NFBHN.[476]

In her assessment of RNGOs, Berger 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."[477] In the wake of the increased interest in REs, much of the inquiry has sought to reapply these distinctions of region, representation and mission to REs. Yet, again, few of these tools or perspectives work when applied to REs. Consider the following statement:

> As would be expected, FBOs are differently dispersed across the regions of SSA. For example, in some West African countries such as Mali, FBOs are relatively few, and it appears that in these West African francophone areas, Islam does not tend to manifest in a direct intervention in formal health services, although this is not to say it is not involved in a holistic promotion of health. In comparison, countries in Southern Africa such as Zambia are inundated with a complex range of FBOs, from facility-based health providers to organisations and activities emerging from congregational activities…this variety means that generalisations about 'FBOs in Africa' misrepresent the national and regional variations found on the ground.[478]

Taking this a step further, given the lack of information or shared terminology on REs, generalisations about FBOs across regions is similarly hazardous. That is, what is the value of comparing Mali's (mainly Islamic) forms of engagement in HIV/AIDS with the (mainly Christian)

[476] See the Christian Health Association Platform (CHA) platform for information on the different kinds of formations within CHAs. http://www.africachap.org

[477] Berger, "RNGOs." While I have some concerns with Berger's definition of RNGOs as formal organisations that are different to faith-forming entities and the resultant focus of her article, her work provides a useful contribution to this debate.

[478] Schmid et al., "Contribution of REs," 49.

institutions and organisations in Zambia? Does the result of such comparison not lead to the percentage statements mentioned above, that Mali has a lower percentage of FBOs engaged in HIV/AIDS than Zambia, and carry an inherent bias against informal and unusual religious forms that are not named (or recognizable as) NGOs or health facilities? Again, such statements depend on what the reader understands to be an FBO.

Berger gives the example of the North-South dynamic as a regional categorisations, but given the clearly diverse transnational and transregional ties among religious entities (that is, diverse and unique connections of collaboration, resources, funding or ownership),[479] such a distinction can also be questioned when addressing REs. Berger also suggests that representation (e.g. local, regional, international) is another distinction. Again, this does not fit comfortably onto REs who have a local footprint, a regional network (such as a denomination) and an international connection; or vice versus, international religious entities who run local programs with representation on regional councils.[480]

Indeed, much of the development and health perspectives are based on the constructed idea of the nation-state. "Within this framework, governance largely proceeds through bureaucracies best suited to dealing with organisations or groups in terms of their public presence."[481] However, religious entities often work across national boundaries, representing and collaborating in complex regional and transnational networks that fit poorly into national scale assessments.[482]

Finally, mission (in Berger's sense of the word) is perhaps the most uncomfortable fit for REs, as identifying an RE by its activity is a hazardous activity. Many (if not most) REs in SSA have broad holistic portfolios that simultaneously range across a number of missions, and critically, their primary mission might be religious rather than one recognizable to a development or public health perspective. For example, there are community organisations spontaneously getting together to run HBC and OVC initiatives, faith-forming entities running youth training programs, Muslim communities financially supporting an HIV program in a government hospital, a traditional healer (who is probably also a Christian pastor) running ART and also referring patients to government hospitals.[483] And for all of these, HIV/AIDS care (of whatever flavour) would only be one of many primary activities. Mapping studies have also suggested that religious organisations are often fluid in nature - adapting to the needs around them, and shifting in focus and making it particularly

[479] See Schmid et al., "Contribution of REs," Ch 4.
[480] See Haddad et al., "Potential and perils."
[481] Olivier et al., "ARHAP literature," 37.
[482] See Haddad et al., "Potential and perils."
[483] See Schmid et al., "Contribution of REs.", ARHAP, "Appreciating assets."

difficult to categorise their type or activities,[484] meaning that classification by mission is likely to become swiftly outdated (and challenging our understanding of the role and usefulness of classification and mapping work.)

How do we currently inquire about the element that makes religious entities different to secular organisations? The most basic construction that naming enterprise is based on is the binary division between religious and secular. The overarching terms described above (such as RE, FFO or FFI) rests on the idea that these different entities, can be grouped by a common religious element, whatever their religious tradition or enterprise in health and HIV/AIDS. The broad-scale definitions usually say something like (emphasis mine):

> FBOs…are groups of individuals who *have come together voluntarily* around a stated spiritual or belief system that informs and guides their work together[485]
>
> A faith-based organisation may be defined as a group of individuals *united on the basis* of religious or spiritual beliefs.[486]
>
> …(are) *formed on the basis* of their faith and working, often on social concerns, as a response to their faith.[487]
>
> The term FBO is used here to describe a broad range of organisations *influenced* by faith.[488]

There is little clarity on how the religious factor is defined or measured, these examples show a few of the many different concepts (whether FBOs are influenced by faith, formed by faith, or united by faith). The religious nature of an organisation is particularly difficult to measure or assess using current tools and frameworks of inquiry. There is no secular equivalent that encompasses health facilities, individual leaders, community groups of different forms and civil society organisations; and also no need to measure the nature and level of secularism in an organisation. Said differently, how do we actually know who is faith-based, and by what degree?

I began this section discussing the different methods of naming and classifying REs engaged in HIV/AIDS. Having failed to properly identify REs by their name or classification, the next logical enterprise is to fall back on self-identification. However, in my experience, this is the most

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[484] Schmid et al., "Contribution of REs," 50. See Olivier et al., "ARHAP literature," 40, V. Agadjanian, "Gender, religious involvement, and HIV/AIDS prevention in Mozambique " *Social Science and Medicine* 61, no. 7 (2005): 1529.
[485] Green, "Contributions."
[486] V.C. Carver and B.R. Reinert., "Faith-based organisations," *Encyclopedia of Public Health* (2002), http://www.encyclopedia.com.
[487] Lux and Greenaway, "Scaling up," 112.
[488] Lux and Greenaway, "Scaling up."

troublesome tactic of all, there being many entities the researcher would assume to be religious, who resist being labelled a religious entity or faith-based organisation. For example, the Agha Khan network (a large and power Islamic hospital system and development agency, whose SSA operations are visible in Kenya and Tanzania), stated emphatically that they were *not* an FBO.[489] There are also entities a researcher would assume are secular, who insist they are FBOs, for example, at a workshop mapping religious health assets in Kampala, a member of the Infectious Disease Institute (IDI) insisted, "… but we *are* a faith-based organisation … all organisations in Uganda are faith-based!"[490]

Some studies have attempted to assess FBOs by ownership, for example by which denomination, faith tradition or coordinating network the entity might belong to. This is also hazardous, for example, Kilembe Mines Hospital in Tanzania is owned by a parastatal body but is managed by the Catholic Diocese of Kasese.[491] It is in fact common for health programs and facilities to be owned by more than one network or body, making it increasingly difficult to assess by ownership. There are also entities whose religious identity is unclear and who may not identify themselves as an FBO, but who do state a deep religious belief and intentionality that has caused them to intervene in some activity for health or HIV/AIDS. For example, during the mapping of religious entities involved in HIV/AIDS in Lesotho, a Lesotho team member exclaimed, "community support groups … well, *they* think they are faith-based."[492]

Identification (self or otherwise) as religious or secular is tied in with the organisation's perception of who and what they are, as well as critical challenges such as funding. An obvious example is that different funding opportunities are available to organisations engaged in HIV/AIDS depending on whether or not they are classified as religious (the PEPFAR funding mechanism being the most obvious example of this.) Inversely, some organisations have been 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."[493] Classification as religious or not is therefore not a scholarly pursuit, but critically tied to identity and access to resources.

[489] Agha Khan 2007, personal communication, see Schmid et al., "Contribution of REs."

[490] Unpublished ARHAP workshop report, Uganda, 2007

[491] See Schmid et al., "Contribution of REs," 73.

[492] Lesotho, research team member, 2006 in ARHAP, "Appreciating assets."

[493] Berger, "RNGOs," 17. At the same time, one of the understood strengths of REs is their independence from government or public funding streams, see Schmid et al., "Contribution of REs."

I accidentally encountered a memorandum online, to the Obama-Biden transition project, which is not entirely appropriate to the SSA context, but nonetheless usefully describes the frustrations experienced when trying to work within this religious-secular constructions of organisation:

> Language is one of the many obstacles we face when discussing the Faith-Based and Community Initiative. The term 'faith-based' itself is vague and can obscure certain complex social, legal, and policy issues. Some 'faith-based' organisations are entirely secular in their structure and approach to the provision of services. These groups strictly separate the religious nature of their mission from the services they provide. Other 'faith-based' organisations are expressly sectarian and do not separate the religious nature of their mission from the services they provide. Many exist along a continuum between these points. If we are not careful, under the rubric of 'faith-based', we may confuse these secular but religiously affiliated groups with the others, including pervasively sectarian institutions—ultimately merging the two together and blurring important distinctions.[494]

Secular approaches continue to attempt to quantify and measure the "faith factor" to understand how these entities are different from the secular. For example, several scholars continue to attempt to measure the level of religiosity in relation to HIV/AIDS risk and behaviour.[495] Such studies have been sharply critiqued, most frequently from religious scholars who argue that such studies are compromised by not taking into account religious diversity and multiculturalism (not to mention interpretation), particularly in contexts such as SSA.[496]

> With a few notable exceptions, scholars have not yet moved beyond conceiving religiosity as anything more than membership in a particular group or religious tradition. As more and more studies begin to consider the role of religion in shaping demographic behaviour, the need to treat religion as the multi-dimensional construct it really is becomes more and more evident. A second major drawback … is its reliance on self-reports of sensitive behaviour…[497]

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[494] S. Gutow et al., "Memorandum to the Obama-Biden Transition Project: Improvement of the Faith-Based and Community Initiatives," (Jewish Council for Public Affairs, 2008).

[495] See L. Nicholas and K. Durrhiem, "Religiosity, AIDS and sexuality knowledge, attitudes, beliefs and practices of black South African first-year university students," *Psychological Reports* 77 (1995), K.W. Elifson et al., "Religiosity and HIV risk behaviour involvement among 'at risk' women," *Journal of Religion and Health* 42, no. 1 (2003), J. Zou et al., "Religion and HIV in Tanzania: influence of religious beliefs on HIV stigma, disclosure, and treatment attitudes," *BMC Public Health* 9 (2009).

[496] see Jeavons in Chambré, "Faith in FBOs.", R.A. Jenkins, "Religion and HIV: Implications for research and intervention," *Journal of Social Issues* 51, no. 2 (1995).

[497] J. Trinitapoli, "Religion and HIV status in sub-Saharan Africa: examining influence and pathways," *Review of Religious Research* (2005).

Significantly less is known about measuring religiosity at an organisational level. If you cannot assess something to be an FBO by its name, or its self-report, can you make a judgment based on how much faith it has, that is, how different it is from a secular organisation based on its religiosity?

In the SSA context, we found in landscaping studies that it is difficult if not impossible to cleanly separate out "the religious". We found that a home-care or nursing program might only be named religious if it is a large-scale initiative focused entirely on that aspect. However, if homecare is a task being quietly undertaken by community members at a local level, or religiously-motivated individuals are joining non-faith-based homecare organisations (such as the Hospice), then there is little way to tell whether or not these individuals are motivated by religious doctrines or challenges. This then makes it virtually impossible to affect the policy makers decisions who are providing resources based on evidenced provision of care.[498]

A further complication in this is that these religious entities working in HIV/AIDS are not static; they tend to be fluid and adaptive to their situation and needs,[499] not only in their activities, but also in their religious character. There are few studies that seek to engage with this, but one assessment of the meaning of "faith" in four HIV/AIDS organisations in New York City asks "what is the nature of faith in faith-based organisations?"[500] After an interesting exploration, Chambre concludes that the level or type of faith in an organisation changes over time, and although all continue to honour their religious roots, "…the original meaning of religion has changed. Two organisations became secularized, and the two others incorporated a highly ecumenical and personalized form of faith … the sources of change are more complex than mere receipt of government funds, and they include lack of funding for religious activities, changes in client populations, and shifts in leadership and stakeholders."[501] In its background documentation, ARHAP has argued that

> … most criteria and categories used to study religion look for something quantitatively measurable and 'objectively' present … What is largely missing from most studies … is the dimension of religion that is 'internal' to faith based communities or organisations, an element that explains their motivations, commitments, attitudes, actions and relational or associational strengths on the basis of their own self-understandings and world-views. This dimension is harder to take into account in defining religious health assets, particularly in any way that makes for easy identification, replicability and generalization - the

[498] See Olivier, "Religion and policy.", Schmid et al., "Contribution of REs."
[499] See Schmid et al., "Contribution of REs."
[500] Chambré, "Faith in FBOs," 435.
[501] Chambré, "Faith in FBOs," 435.

requirements of a mapping process that would be useful to policy makers and other decision makers.[502]

There are few available frameworks and measures available that can take this diversity into account.[503] As mentioned in Chapter Two, the majority of the current religion-HIV/AIDS literature addresses either religion as relevant to individual behaviour, or religious organisations. There are therefore few attempts made to cross over between these bodies of literature.[504] Improved processes and theory for naming and defining the religious entity, as well as better conceptualization of the "faith factor" internal to religious entities (which is frequently stated but poorly understood) are of critical importance to the community of inquiry at the intersection of religion and HIV/AIDS, as well as to a broader public. Many critical consequences rest on us getting this right, rather than continuing to debate and struggle against conflicting paradigms and frameworks.

This has briefly shown how the available lenses through which to inquire about REs engaged in HIV/AIDS are inadequate to encompass the variety and unique nature of REs. So far, this discussion has followed how REs are different to secular expectations. There is, however, an even greater concern, namely, that such dominant paradigms and discourses make the community of inquiry blind to a significant part of the faith community, especially those religious entities that do not fit into any of the above schema or frameworks. A number of mapping studies have emerged as a result of the renewed interest in religious organisations and their response to HIV and AIDS - with mapping perceived as a way to make the invisible visible, first locating religious organisations and then assessing their potential.[505] Such studies have tended to "discover" the presence of a number of religious organisations present and working in HIV/AIDS that had not previously known by national and international health institutions.

Interestingly, what has also emerged in these studies have been a mass of smaller community-based religious programs and initiatives - often not of a recognizable NGO or health-facility format, more difficult to measure and understand, and varying considerably in different contexts, frequently responding to need and involved such activities as support of home-based care.[506]

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[502] See ARHAP, "About ARHAP," The African Religious Health Assets Programme, http://www.arhap.uct.ac.za.

[503] See Chapter Six regarding the religious health asset approach.

[504] One brave but not entirely relevant example is from Watt et al who assesses the influence of religion on people living with HIV/AIDS in Tanzania, and concludes that patients' personal faith positively influenced their experiences living with HIV, but that religious organisations had neutral or negative influences. See M.H. Watt et al., "Missed opportunities for religious organizations to support people living with HIV/AIDS: findings from Tanzania," *AIDS Patient Care and STDs* 23, no. 5 (2009).

[505] See ARHAP, "Appreciating assets," 6-27.

[506] See Haddad et al., "Potential and perils.", Schmid et al., "Contribution of REs," 48, ARHAP, "Appreciating assets."

Several scholars and practitioners have noted that in the current inquiry and collaboration there is a significant "missing sector". This sector is differently described as informal, unorganised, non-mainstream, non-facility based, or community-based.[507] There are many examples of this,[508] such as;

> *The hidden religious-health sector…*the extensive operation of small community-based FBO health activities. It has been shown in several studies that facility-based health providing FBOs are overrepresented in comparison with the more amorphous and difficult-to-classify non-facility-based religious entities. That is, there is substantially more information on the more formalised FBOs working in health care, than on the more spontaneous and community-based health efforts of the various religious traditions (e.g. community support groups or traditional healing practices).[509]

It is of course easier to map a hospital than a community-based religious entity that does not have a building or street address. Logically, more is known about the religious response to HIV/AIDS that is done by health facilities, and large-scale religious entities that look like NGOs. The most significant gap in our knowledge is on religious entities that are not so easily named or defined. This bias was shown again in the WHO mapping consultation in Geneva (described in chapter 1), where the initial invitation was to a consultation on *NGO Mapping Standards Describing Religious Health Assets*, but the discussion was actually focused on religious-health facilities (such as hospitals and clinics) that were "measurable" and possible to map utilising the WHO HealthMapper typologies.[510] Discussion of the "other" forms of religious health entities and initiatives was left to be discussed at a later stage.[511] My argument here is that it is not only that religious health facilities are easier to "see" that makes them more mappable, but also that such entities fit more comfortably with current nomenclature and definitions already visible on the public health map. The language of public health makes it easier to map that which looks like what it expects to see; in this case, health facilities with a biomedical-Western character, as I did not see the WHO being interested in mapping the "hospitals" that have been constructed by traditional healers in Zambia for example.[512]

[507] See Schmid et al., "Contribution of REs."

[508] See ARHAP, "Appreciating assets.", Haddad et al., "Potential and perils.", Schmid et al., "Contribution of REs.", Olivier et al., "ARHAP literature.", Parker and Birdsall, "Stigma and FBOs," 11.

[509] Schmid et al., "Contribution of REs," 38. See Foster, "Study of the response," 1.

[510] See Chapter Six for further discussion of this

[511] And there is indeed a continuous discussion of this among some of the participants.

[512] See WHO-CIFA, "NGO mapping".

My suggestion here is that they continue to be "hidden" because of these battles over nomenclature: sometimes being constructed in sameness with secular entities (where differences are masked), and at other times in difference (for example grouped as the faith community), depending on the context. Said differently, this sector is not "hidden", it is "unnamed". In the Geneva mapping standards meeting, Canon Ted Karpf (of the WHO) notes, "…the truth is, if you are not on the map, then in the eyes of the donor and Member states, you do not exist!"[513] 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 those religious entities that are not immediately recognizable as secular organisations such as health facilities and RNGOs.

These REs are all those outliers described above, all the REs who do not get seen through perspectives that are looking for sameness rather than difference. While I agree that community-based and nonfacility-based REs are more frequently part of this group, there are others who are hidden and unnamed. Each of the main representations of REs described above, describe a way of seeing. Those who are looking for Western NGOs will see RNGOs; those looking for secular hospitals and clinics will see religious health facilities; those looking for congregation and churches will see mainstream formal religious groups rather than local religious groups and gathering; those looking for formal networks will see denominations, and complex family and regional networks. All of these represent a lingering bias towards the "informal" religious entity, which is only informal in that it does not look like what we expect to see, or does not fit into what our language causes us to expect to find. Returning to Bourdieu's comment above, these are not being named, as they do not look like anything in our current landscape, and do not have sufficient power or representation to name themselves.

Furthermore, the dominant discourses (such as development, public health and the faith community) actively work to keep them unnamed and hidden. Considering the faith community discourse for example, these informal religious entities are named as part of the faith community (in those broad descriptions that include everything with a faith-factor), but are rarely representative in it.[514] Yet, as described in the previous chapter, the discourse of the faith community is empowered by the generalisations that makes it appear inclusive and representative of all REs, working to mask diversity. Returning to the list of inherent strengths sometimes given to all REs (such as reach, access or trust), we logically know that not all REs have all these strengths, but the discourse of the faith community is strengthened by such generalising discourses. It is my

[513] Karpf in WHO-CIFA, "NGO mapping".
[514] Haddad et al., "Potential and perils."

supposition that these strengths more commonly lie in the hidden and inadequately named religious entities, than in the formal NGOs and health facilities who are struggling to maintain their faith character in the face of modernising forces and outside influences. Yet it benefits the entire faith community to claim these strengths for themselves, simultaneously pushing the generalising discourses and keeping such entities and their variety hidden and unnamed.[515]

The WHO publication *Putting People and Health Needs on the Map*, begins by noting that public health mapping and geographic information systems (GIS) are being used across the globe, "the visualisation of geographically linked information from a wide range of different sources offers fresh insights, increased responsiveness and greater precision in efforts to improve public health."[516] The process and intention to map these REs onto global health maps brings these terminological problems to the surface in a number of ways. As was mentioned in a recent meeting at the interface of religion and public health, "…some of the same challenges in mapping also came up repeatedly, such as reliance on anecdotal evidence, fragmentation and incompleteness of data, differences in language or vernacular, overlaps of data, and difficulties in accessing data that already exist."[517] Differences in language or vernacular are not just a frustrating issue for communication; it also makes the public health mapping of REs difficult if not impossible. The first step to the creation of any public health or GIS database is the creation of a "lexicon" upon which the rest of the program is based, then linking such definitions with signifiers (names) and the symbols that appear on the map.

As we found in ARHAP mapping research (and as discussed above), there is little consensus about such a lexicon for REs.[518] This makes it difficult if not impossible to merge what fragmented data there is together.[519] Mapping is generally described the global health literature as a positive value-free tool to be wielded: "one of the key strengths of public health mapping is the standardisation of disease surveillance data from village level to global level and across diseases … public health mapping tools can be used to analyze health-related data from a wide range of sources, providing a well informed base for decision-making."[520] This outlook is not predisposed to searching for internal faith factors, and is even less concerned with terminology struggles and issues of distorted communication and power through these battles.

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[515] Not wanting to introduce a new theme here, but are "terrorist organizations" FBOs? Are they part of the faith community? Certainly based on the current definitions they are, but the imagined resistance the faith community to agree on this is a reminder of inadequacy of our current naming and definitional frameworks.

[516] O'Neill and Meert, "Putting people on the map," 3.

[517] WHO-CIFA, "NGO mapping".

[518] See ARHAP, "Appreciating assets," Ch2.

[519] See a discussion on this in Schmid et al., "Contribution of REs," Ch4.

[520] O'Neill and Meert, "Putting people on the map," 3.

But naming and mapping brings other tensions and fears to the surface, specifically the fear of REs of being dominated by (secular) government, funders and health institutions. In the ARHAP mapping studies, it was immediately apparent that REs had real and urgent concerns for what the consequences of being mapped by public health might be, and for the power relations inherent in such a mapping process, asking whose map, and what the detrimental effects of being seen on such maps could be.[521] Yet while there is a strong tradition of speaking about the relations of power and mapping in scholarly work,[522] and also in developmental work which has a growing interest in participatory mapping and its power implications,[523] the discourse on mapping REs onto global health maps appears to be largely void of such considerations. I have repeatedly astounded public health practitioners in some meetings within this community of inquiry by saying that we should not take it for granted that REs automatically see the value in being "on the map" (apart from the obvious promises of increased funding), quoting the frequent concerns revealed in our various participatory research settings. It would appear that there is a positivist culture towards mapping within public health that sees mapping as mainly a useful tool, rather than foregrounding the complex implications for those being mapped.[524]

The most obvious example of this is in the ARHAP research in Zambia and Lesotho mapping RHAs for HIV/AIDS intervention that intentionally utilised participatory GIS mapping in order to gain the perspectives of the community, and thereby allowed them to name their own RHAs.[525] The researchers worked fervently to integrate these community-named REs into the typology provided by the WHO HealthMapper (which includes such entities as different levels of hospitals and clinics), and resulted in a unique typology that certainly included health facilities and RNGOs that had not previous been mapped by the WHO, but also included "sites of bophelo", community sites identified as critically important to their health and well-being in the context of HIV/AIDS, that ranged from churches to traditional healer's hospitals, from schools to post offices. While the study was launched with some fanfare by the WHO,[526] Karpf (who had been a main driver behind this research) noted that the study had since not been accepted "in the truest sense" in the global health communities, and he reflected that the reason for this was that "…the descriptions relied on

[521] See Haddad et al., "Potential and perils.", ARHAP, "Appreciating assets."

[522] As discussed in Chapter Two, see Harley, "Maps, knowledge, power."

[523] See R. Chambers, "Participatory mapping and geographic information systems: Whose map? Who is empowered and who disempowered? Who gains and who loses?," *EJISDC* 25, no. 2 (2006), J. Abbot et al., "Participatory GIS: opportunity or oxymoron?," *PLA Notes* 33 (1988).

[524] See Chapter Five for more on the different cultures between religious studies and public health.

[525] See ARHAP, "Appreciating assets," 2.

[526] WHO, "Faith-based organizations play a major role in HIV/AIDS care and treatment in sub-Saharan Africa," *Note for media* (2007), http://www.who.int/hiv/mediacentre/news66/en/print.html.

voices and experiences of local informants … the wisdom of the local people describing their health-seeking behaviours and the responses of the local institutions were the sources of data."[527]

I do not want to get into an extensive discussion about this study or its validity in different sectors, but use this as an example of the exceptional difficulties around the naming and mapping of REs, and the power interplay between community knowledge and global health institutional knowledge. Despite an increased intentionality towards participation and community engagement (such as can be seen in the calls for renewed PHC described in Chapter Two), public health mapping shows us the real difficulties in putting this into practice. Naming an RE in a particular way creates it in a particular way, and then decisions are made based on this representation.

In other places, I have noted the fine line between discourses that describe RHAs as "valuable," and those that describe RHAs as "valued."[528] That is, within the literature addressing the religious response to HIV/AIDS in SSA there is a strong discourse naming REs as an "untapped resource" in the battle against HIV/AIDS. For example, the World Bank says, "the role of African faith-based organisations in combating HIV and AIDS is widely recognised as having growing significance but, at the same time, one which is not fully *exploited*, given the influence and reach of FBOs in African societies."[529] The Zambian national HIV and AIDS strategy similarly states a primary objective as being "to fully *exploit* the potential of faith-based organisations in the fight against HIV/AIDS."[530] This discourse of "exploitation" reveals underlying tensions as felt by religious leaders working in HIV/AIDS in a variety of ways. For example, in the research on collaboration, religious leaders expressed concerns that they felt "used" by the ad hoc way they were being drawn into government HIV/AIDS programs.[531] They also spoke strongly of the feelings of being exploited by some international donors who sought to use their religious communities and programs to raise their own funds, or complete their own agendas.[532]

Paterson warns that religious organisations have begun to be seen as a "…bottomless pit of volunteers, and we need to think about that. FBOs have felt good about being drawn in, and are suddenly part of the solution, but do we want to be regarded in this instrumental way, and should we be thinking through the values we want to bring to the table."[533] More careful consideration is

[527] Karpf in WHO-CIFA, "NGO mapping".

[528] See Olivier, "Religion and policy."

[529] Emphasis mine. World-Bank, "Concept note" (paper presented at the HIV and AIDS workshop for faith-based organisations and national AIDS councils, Accra, Ghana, 2004).

[530] Ministry of Health, *National HIV/AIDS/STI/TB Policy* (Lusaka: Republic of Zambia, Ministry of Health, January 2005), 22.

[531] Haddad et al, *Potentials*, 91.

[532] Haddad et al, *Potentials*, 59.

[533] Gillian Patterson. CHART consultation. 2008

needed about the discourses that name REs as valued or valuable assets. Cochrane and McFarland note that,

> What confounds this potential is that public policy leaders tend to have an instrumental view of RHAs. This elevates technical, ends based goals of the global health agenda that rest on western and secular assumptions and, accordingly, undermines the potential of the contributions that religious health assets might make to public health in Africa … The priorities in global health primarily driven by organisations and institutions external to a country do not necessarily reflect the priorities of communities or even of countries. They are most often developed by those in the dominant North responding to needs in the South as perceived by the North and as assessed by 'objective' evidence. This usually ignores the rich, deeply textured forms of evidence drawn from case studies that take the form of narrative more often than statistics … [534]

I will address some of this again in the next chapter. My immediate concern is that an instrumental approach to naming and defining REs does not adequately take cognisance of the varieties and complexities of the RE.

It is also necessary for us to consider that a consequence of naming REs in an instrumentalist fashion can be to destroy them. Naming a spontaneous community initiative an FBO creates it as such. Consider, for example, an initiative for church members to regularly cycle HIV/AIDS patients to and from the local mission hospital.[535] What would be the impact of naming this an FBO? In many such cases, this spontaneous caring initiative then becomes an RNGO (recognizable as such by Western and development perspectives) and in so doing, you might "kill" the essential nature ("faith factor") that has created this initiative and made it effective (for example, by channelling funds, development staff and requiring structural reporting).

Chambre notes that in the USA, faith-based organisations become more secularized when they become dependent on public funds.[536] We do not yet know enough about this unnamed religious sector in SSA to know what effect funding has on them (apart from what any of us may have experienced in the field). However, we may consider the very real impact of imposing ill-fitting nomenclature from the outside, that is, naming these REs in secular categories that are not able to describe the way REs are different, may be turning these initiatives into what they are named, for

[534] McFarland and Cochrane, *Agency*, 3.
[535] See ARHAP, "Appreciating assets."
[536] Chambré, "Faith in FBOs."

"…to name is to show, to create, to bring into existence.[537] The battles over nomenclature, generalising discourses and the continued failure to name the hidden religious sector puts us at risk of losing that which is valued the most.[538] Naming also makes visible what people may not want visible, especially where visibility might bring a threat from a dominant power.[539]

While it is obvious that REs are also feeling the pressures of a severely resource-constrained environment, and a global economic crisis, it is not enough to assume that naming and mapping is simply a matter of finding the right definition. The argument here is that if REs indeed have particular and unique strengths (as has been strongly suggested), such as a preferential option for the poor, or that they work in places where no other organisations are present, then we critically require strategies that understand and support them in these different activities. Understanding their difference through appropriate naming, rather than forcing them into dominant moulds, is the very first step that is required.

Conclusion: Power and Resistance

While we struggle to understand and assess REs, their "faith factor", and struggle to fit REs into other dominant paradigms, it must be asked why the religious-secular construction is not being questioned. In other words, the religious-secular discourse dominates the entire HIV/AIDS sector and agenda, and the primary skill of this discourse is to make the separation of religious entities and secular entities seem logical and commonplace, even though we continue to battle with the available language, available framework, constant outliers and parts of the "faith community" that do not adequately fit within this binary construction of religious-secular. However, this construction is powered by institutions (both "religious" and "secular") and frames our current investigation, despite this intense struggle happening beneath the surface. All this raises concerns, several of which will be addressed in the chapters that follow. Firstly, it is necessary for us to reflect more intently on how the religious-secular construction has influenced inquiry and the HIV/AIDS agenda. For example, in the midst of advocacy for attention to be paid to the faith community and battles to define and name the FBOs, are we starting to ignore the faith factor in secular organisations?

So far, I have mainly addressed the way powerful discourses (paradigms) may be impacting on the construction of REs in the HIV/AIDS literature. That is, I have mainly focused on power moving in an "outwards" direction, of representations and the imposition of the gaze on REs. Melkote and

[537] Bourdieu, *On television*.

[538] I will return to this below.

[539] See J.C. Scott, *Domination and the arts of resistance: hidden transcripts* (New Haven: Yale University Press, 1991).

Steeves 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"[540] Yet, whether speaking of the way powerful discourses (of development, public health or secularism) go about naming REs, I am not convinced that they are indeed such *pliable* objects to be manipulated. As was discussed above, several attempts have been made to name REs and to apply typologies, numerous meetings and consultations have been held in which language and nomenclature have been discussed and fought over. Yet no particular terminology has risen to dominant status, while those terms that are seen regularly (such as FBO) are still being differently defined. What this suggests is that no dominant institution has sufficient power or authority in this context to name REs.[541] All names and classifications emerging from the dominant discourses have been shown to be problematic, and are engaged in battles with other powerful paradigms. Naming is not a linguistic pastime, but a serious battle to which such institutions (and individuals) bring all their power to bear:

> In the symbolic struggle for the production of common sense or, more precisely, for the monopoly of legitimate *naming* as the official … imposition of the legitimate vision of the social world, agents bring into play the symbolic capital that they have acquired in previous struggles, in particular all the power that they possess over the instituted taxonomies, those inscribed in people's minds or in the objective world, such as qualifications.[542]

In other words, the various institutions (of religion, development, public health and the like) may have some authority to name REs within their own discourse,[543] but do not seem to have the power to make this the dominant framework or discourse in intersecting spaces (such as HIV/AIDS or religion and health). Is this because there are conflicting frameworks, or is something else at work in this context?

Certainly when working to identify and name religious entities, it does appear that for every solution there is an outlier that does not fit, and while the hidden transcript is always more difficult to see or decipher,[544] I do wonder of this might not be an act of resistance on the part of those being named, represented and inquired about. As noted in Chapter one, several critical theorists have noted that even in the face of dominant discourses or power, resistance is not only possible but probable. Is it possible that the objects of our gaze are actively resisting "our" efforts to

[540] Melkote and Steeves, *Communication for development*, 156.
[541] For more an authority and legitimacy to name, see Bourdieu, *Symbolic power*, 239.
[542] Bourdieu, *Symbolic power*, 239.
[543] Although the example of the UNAIDS-FBO Partnership strategy documents throws doubt even on that.
[544] See Scott, *Domination*.

categorize them according to what we know? Is it possible that REs, *especially* those in the hidden religious sector, have some internal power, perhaps developed through decades of being ignored by our academic secular and modernist perspectives, which is resisting our efforts to pigeon-hole them? Perhaps our language 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 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." Many of these questions are unanswerable at this time, although some will be picked up again in the chapters that follow.

In this chapter I have introduced a number of ideas which I have argued impact on the intersection between religion and HIV/AIDS. The continued battle over finding a broad generic term for REs or a sustained and shared set of sub-categories has been unhelpful and has in fact acerbated this lack of knowledge and continued miscommunication and strained collaboration. It has also had real consequences on the inquiry and collaboration at the intersection of religion and HIV/AIDS. However, the battles over naming the RE are clearly less about finding the most fitting terminology, and are more about ill-fitting and competing paradigms and frameworks, showing the vulnerabilities of our current systems of inquiry and knowledge. Dominant discourses empower stereotyping discourses, and make it difficult to name or know the complexities and varieties within the faith community, working 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 religious entities, 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 the conflict and miscommunication, and undermine meaningful engagement (the project of the chapters that follow).

In the next chapter, I will continue much of this discussion, but focus on the intersection of academic and disciplinary cultures coming into confrontation in the community of inquiry into religion and HIV/AIDS. However, to end this chapter, I would like to emphasize, that it is possible to get too caught up in discussions of discourse, complexity and power, and lose sight of some of the basic underlying motives that drive those working in this community of inquiry between religion,

public health and HIV/AIDS. I therefore take the following admonition from Katherine Marshall 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.[545]

[545] K. Marshall, "Faith-based diplomacy," *Washington Post*, no. April (2009), http://newsweek.washingtonpost.com/onfaith/georgetown/2009/04/the_faith_factor.html.

Chapter Five. Mapping the Boundary between the Academic Tribes of Religion and Public Health

> *It does not require Foucauldian analysis to understand that discipline limits discourse. To be part of a discipline means to ask certain questions, to use a particular set of terms, and to study a relatively narrow set of things.*[546]

It is necessary to provide a brief preamble to the next two chapters, as we now shift our attention in a slightly different direction, towards the mapping of *disciplinary* knowledges and meaning that conflict at the intersection of religion and public health. Chapter One addressed the concerning disconnect between interdisciplinary practice and the broader theory and literature of interdisciplinary studies (both in the context of interdisciplinary HIV/AIDS research and at the intersection between religion and public health). The following two chapters seek to more explicitly address this disconnection by beginning the process of integrating such insights as are available in the interdisciplinary studies field to this community of inquiry. This is done in two related parts. Firstly, the boundary between the disciplines of religion and public health are explored (in relation to HIV/AIDS in SSA), and secondly (in Chapter Six), a case study approach is applied to ARHAP, as a demonstration of how such issues impact on interdisciplinary research collaboration in this context.

Introduction: Cultures of Scholarship

> *Scholarship is a special kind of culture – one that selectively but formally carries with it the culture from which it emerged and that does so explicitly in values proclaimed, implicitly in methods used. At the same time, scholarship is also a process for creating culture which, once created, it protectively wraps in a carapace of truth, certified by God or science.*[547]

Scholars have only recently begun to explore the interdisciplinary boundary zone between public health (PH) and religious studies (RS).[548] This exploration has been strongly driven by shared engagement in the problem of HIV/AIDS, and in this context, PH and RS scholars are increasingly being pushed into interdisciplinary encounters with one another.

The broader academic movement towards interdisciplinarity (as the defining characteristic of our time), has also renewed an age-old interest in disciplinarity and disciplinary boundaries, as scholars

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[546] H. Giroux et al., "The need for cultural studies: resisting intellectuals and oppositional public spheres," in *A cultural studies reader: History, theory, practice*, ed. J. Munns and G. Rajan (London and New York: Longman, 1995 [1985]), 649.

[547] Grew in Humphreys, "Interdisciplinarity", 2000.

[548] In this chapter I focus more intently on the *disciplines*, and therefore utilise the "religious studies" (RS), and "public health" (PH) terminology to distinguish this from the broader institutional fields of religion and public health (although as mentioned earlier, there is obvious overlap).

seek to better understand how disciplinary formations (of knowledge) intersect and impact on each other, and what epistemological and genealogical differences construct these boundaries between disciplines and fields.[549] However, a review of this emerging literature shows few references to either RS or PH, and certainly little in relation to their shared boundary.[550] While there are an increasing number of scholars pointing to the lack of knowledge here, as well as the communication difficulties (problems in translation of discipline not tongues), there is little that directly speaks to the interface from a disciplinary perspective.

Clearly the historical development of RS and PH placed them on opposite sides of the academic map (as a result of the secular-gap described in Chapter Two), and gave little reason for reflection on the boundary between them.[551] A further reason that neither RS nor PH appear in texts addressing disciplinary maps and boundaries is, I believe, because neither are straightforward examples of "disciplines" that can be easily applied to arguments about borders and boundaries. Both RS and PH are arguably rather interdisciplines or multidisciplinary fields, both having been especially hard hit by the increased fragmentation of the disciplines, and the increase of sub-specialities. I will provide more description in the body of this chapter; however it is important to note that both PH and RS are more appropriately described as "interdisciplines" than "disciplines". Both are made up of multiple and diverse specialisations, methods and schools of thought, not all of which are bound by common values and attitudes. Typical sub-fields in PH include epidemiology, biostatistics, health services, environmental, social and behavioural health and occupational health;[552] and typical sub-fields of RS include, to name a few, religious sociology, anthropology of religion, comparative religion or theology.[553-554]

Neither are prominently mapped in their current position in the academic landscape because neither are easy to locate, nor is the border between them clearly marked. Adding to the difficulty, there is a huge literature speaking obliquely to elements of this relationship, for example: the

[549] Klein provides a useful overview summary of the various (and often conflicting perspectives) in this "shift". Klein, *Crossing boundaries*.

[550] See E. Messer-Davidow et al., eds., *Knowledges: Historical and critical studies in disciplinarity*, Knowledge, disciplinarity and beyond (Charlottesville and London: University Press of Virginia, 1993), Klein, *Crossing boundaries*, Becher and Trowler, *Academic tribes*, Repko, *Interdisciplinary research*, T.F. Gieryn, *Cultural boundaries of science: credibility on the line* (Chicago: University of Chicago Press, 1999).

[551] The literature assessing disciplinary borders and boundaries commonly speaks of this in geo-spatial terms (of landscape and map). Indeed, the separation of RS and PH is often reflected in a geographic separation on campus, with PH sitting in the health science (hard science) and RS in the humanities (soft science).

[552] See Skolnik, *Public health*.

[553] I acknowledge that this conflation of these different fields into 'religious studies' may be problematic for some. For a fascinating exploration of the different traditions within 'religious studies', see Oliver and Warrier, eds., *Theology and religious studies*.

[554] While this chapter strives to gain some broad understanding of the relation of the fields of RS and PH to each other, a key area for future research would be a more intensive study between specialisations (that are more alike or dissimilar to each other).

debates about religion and science, the sciences and the humanities, genealogical, geographic and epistemological differences, making it a daunting challenge to engage with this particular boundary, and perhaps driving many away from engagement in this topic. With there being a substantial lack of literature directly addressing the relationship between RS and PH, for those scholars working in the revitalised intersection of religion and public health, it is easy to get caught up in these other parallel dialogues such as religion versus science, or science versus humanities, even if they do not precisely describe the RS-PH boundary.[555]

In the preceding chapter, it was suggested that collaborative practice between religion and public health was running several steps ahead of research,[556] and certainly there has been little time for reflection on the nature of the disciplinary relationship between RS and PH in the urgent context of HIV/AIDS. Yet it is critical that time is taken for such reflection, especially given the increasingly urgent interdisciplinary problems such as HIV/AIDS which drive research collaboration forward, and the continually frustrated communication between these disciplines which can be seen in the continuous urgent calls for disciplinary translation.[557] This is a practical frustration in a specific context that is having real consequences on praxis, and therefore demands an attempt at engagement and for solutions, as opposed to a philosophical post-structuralist discussion on whether disciplines are relevant any longer.

Therefore, in keeping with the rest of this study, I find that an appropriate approach to this exploration is to consider the cultural differences between RS and PH as constructed and made visible through the dominant discourses on HIV/AIDS in this community of inquiry. As mentioned, there is a strong precedent for engaging with disciplines as cultures and interrogating their discourses.[558] As Bauer says,

> To speak of disciplines as cultures underscores that the various domains of knowledge differ much more profoundly than just as different 'departments' of knowledge … The metaphor emphasizes that there are rich stories to be told about the disciplines; that it should not be taken for granted that they all have the same cognitive goals, let alone the same values - albeit they all claim to be engaged in 'the search for truth.' The metaphor

[555] As will be discussed in more detail below.

[556] See Chapter Three

[557] See Marshall and Van Saanen, *Development and faith*, 4.

[558] There is a broad literature here on didactics, disciplinary genres and discourses. See H. Bauer, "The antithesis: disciplines as cultures," *Social Epistemology* 4, no. 2 (1990).

> emphasizes that cooperation among the disciplines…should not be assumed to be natural; and that interdisciplinary activity faces difficulties on more scores than one.[559]

For this enquiry, I found the perspective advanced by Becher (and later Becher and Trowler) in *Academic Tribes and Territories* to be useful.[560] Becher and Trowler also base their approach on the realisation that "…it becomes quite perilous to make generalising statements about practices among academics in particular specialisms…" arguing that "the 'special' significance of disciplinary knowledge has been diminished … (but) has not disappeared…"[561] Their approach is to examine the disciplines from a cultural perspective, to enquire into "the nature of the linkages between academic cultures (the 'tribes') and disciplinary knowledge (their 'territories')."[562] They acknowledge the diversity and variety within the disciplines, but take the position that it is possible to analyze the relationship between distinctive cultures within academic communities (what they call academic tribes), and academic ideas (their territories).[563] While "mapping the variegated territory of academic knowledge and in exploring the diverse characteristics of those who inhabit and cultivate it,"[564] Becher and Trowler also note that "some of the most interesting features of the investigation lay in the comparisons and contrasts between different groups."[565] In their mapping, they foreground the importance of language and communication, saying:

> It is, however, through the medium of language that some of the more fundamental distinctions emerge. A detailed analysis of disciplinary discourse … can help not only to bring out characteristic cultural features of disciplines but also highlight various aspects of the knowledge domains to which they relate … the professional language and literature of a disciplinary group play a key role in establishing its cultural identity.[566]

Of course, several other scholars have noted the way language (discourse) plays a critical role in forging and maintaining membership of a particular disciplinary tribe.[567] Academic writing "styles" are hard-earned discourses won through a process of induction and shaping by the powerful

[559] Bauer, "The antithesis," 221.
[560] Becher and Trowler, *Academic tribes*, ix.
[561] Becher and Trowler, *Academic tribes*, xiv.
[562] Becher and Trowler, *Academic tribes*, xiv.
[563] Becher and Trowler, *Academic tribes*, 23. They also argue here that both disciplinary epistemology and the phenomenology of that knowledge are important and (in practice) are inseparably intertwined with academic cultures.
[564] He notes that he owes much to Clifford Geertz who discussed an enthnography of the disciplines in 1976. See Becher and Trowler, *Academic tribes*, ix.
[565] Becher and Trowler, *Academic tribes*, x.
[566] Becher and Trowler, *Academic tribes*, 46.
[567] See Wodak, *Disorders of discourse*.

disciplinary institution (tribe) into which the scholar is part.[568] The scholar proves her/his literacy in a number of ways (such as learning, writing, publication, degree-progression), and results in an ability to recognise and utilize the correct discourse applicable to a specific disciplinary situation.[569]

In the following chapter, I push Becher and Trowler's tribal metaphor a little further, and seek to examine the academic tribe (the community of inquiry whose village is positioned at the boundary of RS and PH and are engaged in HIV/AIDS research), and consider the sometimes conflicting cultures of RS and PH within this tribe by focusing on the discourse and communication between them.[570] Like Becher and Trowler, I rely on a combination of first-hand experience working within this tribe as well as a diverse collection of second-hand literature.[571] The purpose here being to deconstruct a few of the key cultural elements influencing the interdisciplinary relationship and communication, rather than a lengthy discussion of every epistemological and methodological difference between them, a more detailed project that will have to follow this one.

Tribal Difference

> *Built on a widening array of disciplines and specialities, [the academic profession hosts tribal] subcultures that speak in strange tongues of econometrics, biochemistry, ethnomethology, and deconstructionism.*[572]

It is possible to argue that PH has a dominant positivist culture and RS a dominant interpretivist culture.[573] Although there is obvious variation within these tribes, it is commonly said that epidemiology and biostatistics are the determining sciences of PH,[574] which are certainly positivist in their epistemology. It has also been argued that PH is still dominated by a modernist agenda and culture: "Public health and scientific medicine are traditionally archetypal modernist institutions … both projects depend on 'science' as the bulwark of their credibility and social standing, and share a similar belief in the powers of rationality and organisation to achieve progress in the fights

[568] See B. Ballard and J. Clanchy, "Literacy in the university: an 'anthropological' approach," in *Literacy by degrees*, ed. G. Taylor, et al. (Milton Keynes, UK & Philadelphia, PA: Society for Research into Higher Education & Open University Press, 1988), Bauer, "The antithesis."

[569] Becher and Trowler, *Academic tribes*, 50.

[570] My use of the "tribal" metaphor is certainly not intended to allude to a depreciative colonial discourse, but rather to a cultural approach to describing and understanding disciplinary differences. Indeed the historical tensions and concerns around a discourse of "tribalism" is in itself useful for considering the tensions and difficulties felt at disciplinary borders.

[571] Becher and Trowler, *Academic tribes*, x.

[572] Clark in Becher and Trowler, *Academic tribes*, 115.

[573] A cultural approach recognises that both RS and PH are made up of multiple subspecialities (cultures). I suggest here that unless specified otherwise, when speaking of RS and PH broadly, I am addressing dominant cultures within each. Others who follow this approach are A. Klamer, "As if economists and their subjects were rational," in *The rhetoric of the human sciences*, ed. J.S. Nelson, A. Megill, and D.N. McCloskey (Madison, Wisconsin: University of Wisconsin Press, 1987), 165. Becher and Trowler, *Academic tribes*.

[574] See Detels and Breslow, "Concerns in public health," 10. The obvious variation being specialisations such as cultural epidemiology.

against illness and disease."[575] Peterson and Lupton note that PH has undergone a series of changes and has in many ways moved beyond these modernist philosophies, but argue that "…while the new public health may draw on a 'postmodernist' type of rhetoric in its claims, it remains at heart a conventionally modernist enterprise."[576] It is interesting to note that HIV/AIDS has strengthened this culture within PH, for example, Berridge argues that HIV/AIDS has brought a revival of public health and with that a focus on epidemiology "as a means for scientific legitimacy."[577] In contrast, RS is dominated by an interpretivist culture,[578] particularly in the context of HIV/AIDS where the vast majority of RS scholarship has engaged with interpreting the pandemic, rather than measuring its impact.[579] Repko describes the difference between positivists and interpretivists:

> …positivists are concerned with establishing causal relationships between social phenomena through direct observation, attempting to develop explanatory, and even predictive, models … the polar opposite of this position is the interpretivist position … a positivist looking for causal relationships will tend to prefer quantitative analysis that are 'objective' and 'generalisable'. By contrast, a writer in the interpretivist camp is concerned with understanding and will, consequently, use qualitative methods to discover meaning that behaviour has for agents.[580]

The positivist and interpretivist difference results in different methodologies, a topic that receives a significant amount of interest within the community of inquiry at the intersection of religion and public health. For example, in a conference presentation titled *Quantiphobia, quantiphilia, narratives and graphs: epistemologies of religion and public health and the two cultures of evidence,*[581] Peter Brown discusses what he calls a very real problem of two cultures in RS and PH which he sees as evidenced in the different attitudes he names "quantiphobia" and "quantiphilia." In this presentation, Brown discusses the different cultural attitudes towards numbers that are visible in RS and PH scholars. He argues that numbers (quantitative culture) is of central importance to PH scholars, and that the PH is based on foundational myths of the triumphs of the

[575] Petersen and Lupton, *New public health*, 6.

[576] Petersen and Lupton, *New public health*, 8.

[577] V. Berridge, "Introduction: AIDS and contemporary history," in *AIDS and contemporary history*, ed. V. Berridge and P. Strong (New York: Cambridge University Press, 1993), 8.

[578] There are obvious variations, especially from such specializations as the sociology of religion. See Warrier, "Introduction."

[579] See Olivier et al., "ARHAP literature."

[580] Repko, *Interdisciplinary research*, 91-93.

[581] See P.J. Brown, "Quantiphobia, quantiphilia, narratives and graphs: epistemologies of religion and public health and the two cultures of evidence " in *Maps and Mazes: Critical Inquiry at the Intersection of Religion and Health* (Emory University, Atlanta: 2007).

statistical method,[582] and that PH scholars have a preoccupation with measurement because "that's how we do our work."[583] The scholars at the RS-PH interface have engaged with this difference in a number of discussions, considering how such differences reflect the underlying differences between positivist sciences and empirical approaches versus interpretivist and theoretical approaches. This discussion has resulted in calls for mixed-method approaches and better definitional work (of operational definitions, measures and indicators).[584]

The calls for better definitional work are a common feature in this community of inquiry.[585] The most obvious example of tension between RS and PH cultures when communicating on the shared problem of HIV/AIDS is the explicit clashing of terminology seen through the different use of discipline-specific jargon that is accepted as natural by either RS or PH scholars. Interdisciplinary research uncovers,

> …deep differences in language, vocabulary, concepts and frameworks that sometimes hamper discourse and obscure common ground. The fundamental terms 'prevention,' 'treatment,' 'care and support' as well as 'spiritual encouragement, knowledge giving, and moral formation' have very different meanings in religious and public health settings, though they contain, within, many of the same ideas and messages. A key recommendation for the future is the creation of a 'shared lexicon' of terms, tools, and methods from both religious and public health disciplines and formal training in 'inter-religious and public health literacy'…[586]

Disciplinary cultures can be seen as distinct from each other by the use of different linguistic styles, including "specialist words carrying particular meanings."[587] As a brief demonstration, in a meeting between RS and PH scholars, during a brief discussion on HIV/AIDS, I wrote down the following terms being passed across the table:[588]

> From the RS scholars: love, hope, healing, holism, belief, values, ideology, symbolism, hermeneutic, belief…

[582] What Brown calls the myth of 'Saint John Snow'. Brown, "Quantiphobia."
[583] Brown, "Quantiphobia."
[584] See Brown, "Quantiphobia."
[585] See the following chapter for a description of this in relation to the ARHAP group. See also TBFF, "Faith and malaria.", WHO-CIFA, "NGO mapping", ARHAP, "Appreciating assets.", Schmid et al., "Contribution of REs.", Haddad et al., "Potential and perils."
[586] ARHAP, "Appreciating assets," 127.
[587] Becher and Trowler, *Academic tribes*, 115.
[588] ARHAP, "Better words."

From the PH scholars: incidence, prevalence, treatment, reliability, evidence, indicator, cost-effectiveness, health services, outcomes, health belief model…

From both: care, trust, health, evidence, impact, correlation, prevention…

This is only one brief example among many which can be seen in such meeting reports as well as in the secondary literature.[589] RS and PH scholars wield different scholarly discourses which contain terms which have specific terms and whose meaning is often not shared. The most interesting part of this example are the terms that are being utilised by both RS and PH scholars, but with obviously different meaning attached. The difficulties felt in interdisciplinary communication between RS and PH, troubled by the need for translation between disciplines, has resulted in many calls for more definitional work.[590] I have several concerns about both the translation metaphor, and the resulting "definitional work" that arises from this[591] - arguing in the next section that the current strategies within the community of inquiry are not adequately taking into account the real cultural differences between RS and PH, or the discursive strategies linked to power that are embedded in any definitional work or attempts at translation (hence the persistent communication gaps in this community). I will unpack this concern in more detail by considering another key cultural difference between RS and PH that impacts on this community of inquiry, namely what I am calling discourses of "certain-authority" and "uncertainty."

Certainty, Authority, Power and Translation

Scientific activity is not 'about nature', it is a fierce fight to construct reality.[592]

Dominated by positivist science, epidemiology and strongly influenced by biomedicine where things need to be "scientifically proven" in a discipline-specific way, PH as a disciplinary culture wields a discourse of certain-authority. This is true even (or particularly) in the case of HIV/AIDS where such certainty has been exposed and shaken, as Treichler describes the discourse of a health policy debate at an HIV/AIDS conference, where "…most speakers were committed to a positivist

[589] See TBFF, "Faith and malaria.", WHO-CIFA, "NGO mapping", ARHAP, "Appreciating assets.", Schmid et al., "Contribution of REs.", Haddad et al., "Potential and perils.", ARHAP, "Better words."

[590] The ARHAP Better Words project has shown how difficult this is in practice, as can be seen in the discussion Chapter Six. See ARHAP, "Better words."

[591] There is little consensus among scholars as to how translation should be conceptualised. The broadest definitions come from a hermeneutic perspective, for example, Gadamer states that "the process of translation comprises in its essence the whole secret of human understanding of the world and of social communication." Gadamer in R. Schulte, "Editorial: translation and reading," *Translation Review* 18 (1985): 1. Other scholars avoid the term translation altogether, substituting 'interpretation' A. Banks and S.P. Banks, "Unexplored barriers: The role of translation in interpersonal communication," in *Cross-cultural interpersonal communication*, ed. S. Ting-Toomey and F. Korzenny (Newburg Park, California: SAGE Publications, 1991), 173. I will continue to use translation here in its broad trans-cultural capacity, rather than the more familiar literal capacity of the term, in keeping with its use in this community of inquiry.

[592] Latour and Woolgar in Treichler, *How to have theory*.

world-view … (and) little uncertainty or scepticism was expressed…"[593] In PH, a discourse of certain-authority is supported by a culture which honours practical solutions and progression. I have always been amused at the way a colleague who is an important public health economist, always signs off her emails with the word "onwards". I have come to realise that this "onwards" attitude can be found in many PH scholars and practitioners, and is reflective of a discourse of practical problem-solving and forward momentum that infuses the PH literature and discourse. As De Gruchy says,

> …the public health model is deeply rooted in the 'myth' of progress beloved of modernity. In the presence of public health colleagues I am often struck by the sheer confidence that they have in their craft; of the ability to make the world a better, safer, healthier place. With the right kinds of drugs, the right kinds of health systems, the right kinds of resources, the right kinds of personnel, and the right kinds of population compliance miracles can be achieved. Perhaps."[594]

The same PH professor told me that PH students are taught from the outset that if they cannot get their point into two pages no policy-maker will ever read it. With this as the standard, most PH writing is stylistically shorter and more direct, stripped of lengthy explanation or interpretation and aimed at a very specific audience who are familiar with the short-hand jargon that is wielded. It manages this by writing into a specific topic, by utilising discourse-specific terminology, and relies on statistical and graphical displays to summarise information.[595]

In contrast, RS scholarship values a discourse of "uncertainty". This is not to suggest that RS *is* more uncertain, but rather that a self-reflexive and hermeneutical style is generally expected as a stylistic component of RS writing and discourse. RS is characterised by epistemological doubt, uncertainty about what "religion" means, how RS is characterised, and hermeneutical interpretation.[596] RS scholars generally take diversity and complexity to be a reality of their object of study, and take values and ideology seriously.[597] RS scholars therefore generally differ from PH

[593] Treichler, *How to have theory*, 209.

[594] S. De Gruchy, "Re-learning our mother tongue? Theology in dialogue with public health," in *American Academy of Religion* (Washington: 2006).

[595] This can be seen in the styles required for publication in public health journals.

[596] See Chapter One, Warrier, "Introduction."

[597] For interest, Cochrane notes importance of paradox to the Christian discourse "…irresolvable riddle as the very location of truth … this essential structure pervades its language and gives it its dialectical character." J.R. Cochrane, *Circles of dignity: Community wisdom and theological reflection* (Minneapolis: Fortress Press, 1999), 141.

scholars over the possibility of attaining a degree of certainty.[598] RS writing is typically lengthier, providing more description and detail, and does not rely on specialised jargon as much as PH does since qualitative research generally carries a greater burden to create and explain new paths of analysis and description, and cannot rely on clearly defined terms and definitions.[599] Put simply, comparing the styles of RS and PH scholars writing on the same HIV/AIDS topic, you are more likely to see PH certainty for two pages and RS uncertainty for 20pages.

These different styles or discourses have a fundamental impact on collaborative research on HIV/AIDS at the intersection of RS and PH. The first point, based on my personal experience in interdisciplinary meetings, is that these different styles can cause intense irritation and frustration in interdisciplinary communication. Even when common ground can be established, such as key HIV/AIDS problems requiring shared investigation, or a shared inclination towards justice and equity in health, differences in discursive styles can be significantly off-putting, and can hamper communication to the point that participants lose sight of more fundamental common ground.

Another point is that in disciplinary dialogue in this boundary zone, a discourse of certain-authority has more power than that of lengthy uncertainty. In the context of HIV/AIDS, the discourse of PH scholarship is more directly linked to institutions of power (biomedicine, global health institutions and the like). PH also gains power from the broader "power and authority of numbers," as mentioned in previous chapters.

In other words, in collaborative communication, PH discourse appears to be more powerful than that of RS not only because of its links to scientific institutions of power, but also because of its narrative authoritative style. Hermeneutics, interpretation and reflection does not fare well when it comes into competition with a discourse of certain-authority. For example, Dubos says that "the more convincing language (precise explanation) of modern science is more appealing than the more complex and obscure holistic/sociological approach."[600] In a community of inquiry commonly seeking practical solutions to complex problems, the voice of certain-authority and practical decision-making can seem more appealing that that of reflexive-uncertainty that is annoyingly making warnings of complexity and creating obstacles to practical solutions. Of course, RS discourse has its own power in certain settings, but I would argue that in this particular community

[598] There are obvious outliers to this argument, for example those scholars based in sociology of religion who apply social science measures (such as religiosity) to society. As mentioned above, I am mainly comparing the *dominant* cultures of RS and PH.

[599] See J. Brannen, ed., *Mixing methods: qualitative and quantitative research* (Aldershot: Avebury, 1992). This does not mean that there is no specialized jargon in RS, but rather that RS scholars need to take more time to write themselves into particular concepts.

[600] R. Dubos, "Mirage of health," in *Health and disease: a reader*, ed. B. Davey, A. Gray, and C. Seale (Buckingham: Open University Press, 1995), 6.

of inquiry, and in this collaborative context, armed with a interpretivist discourse, RS is constantly entering into collaboration from a weaker position, constantly on the "back foot" in these collaborative confrontations and is in many ways having to conform to more authoritative PH discourse.[601]

This can be seen in a number of ways. The most obvious are the calls for "real research" so prevalent in this research setting which was mentioned in previous chapter. In these calls, the literature addressing the religious response to HIV/AIDS (which at the early stages emerged mainly from RS scholars and institutions), is described in a variety of ways: as lacking in depth-analysis, as anecdotal, lacking reliable data, incomparable with secular data and centralised responses to HIV/AIDS, based on qualitative assessment rather than quantitative meta-analysis, lacking independent analysis, unanalytic, unsystematic, not scientifically-focused, and incomprehensive.[602] A previous literature review of the materials addressing the religious response to HIV/AIDS noted, "…it becomes clear that there is a great need for further research into the religious response to HIV/AIDS … in general the quality of the reports on religious responses are 'lacking' in some basic and significant ways that lessen their value to the public health perspective."[603] In hindsight, this statement is rather revealing of the broader power dynamic in this research agenda, namely that the literature on the religious response to HIV/AIDS is uncritically being assessed on its value to the PH perspective. I am not attempting to say that more quantitative and analytical research is not desperately needed, but am concerned with what this discourse about "real research" tells us about the underlying power dynamics influencing interdisciplinary communication between RS and PH. Value-judgements on different styles of research (such as those between quantitative-qualitative or anecdote-fact) have become part of the default discourse within this community of inquiry. It is therefore recommended that for genuine dialogue to be facilitated, and that we at least strive for a more equal power differential within this dialogue, a most basic recognition needs to be articulated that RS scholarship is just as "real" as that of PH, but holds to a different framework of "truth", and accomplishes this utilising a different style.[604]

[601] For example, Ian Linden, a RS scholar described this feeling of always being on the 'back foot' in these interdisciplinary collaborative meetings between RS and PH at the WHO mapping meeting in Geneva, See WHO-CIFA, "NGO mapping".

[602] See Olivier et al., "ARHAP literature," 42-43, Woldehanna et al., "Faith in action," 9, Birdsall, "National database.", NIH, "Religious organizations and HIV: June 22, 2004 ", ARHAP, "Appreciating assets," 6-7, Green, "A shared mission?," 333-335, G. Foster, "Study of the response by faith-based organizations to orphans and vulnerable children," ((WCRP) World Conference of Religions for Peace and (UNICEF) United Nations Children Fund, 2004), Benn, "Why religious health assets matter," 9.

[603] Olivier et al., "ARHAP literature," 42-43.

[604] I will continue this discussion in relation to Habermas's theory of communicative action below.

Another tension can be seen in the ways RS scholars more persistently raise the concern for the diversity and plurality of religion in the context of HIV/AIDS, as opposed to PH scholars, who might recognise plurality, but are driven to find a practical solution (in a two-page policy) past such complexity. As Setel notes, "…of all the hallmark themes of the histories of STDs and AIDS in Africa, ambiguity is perhaps the most dogged and, from a public health perspective, the most pernicious … In the AIDS era, simply identifying the international scope of the epidemic has proved an intractable task, despite the vast resources deployed to confront it."[605] While there may be many calls for more "culturally appropriate" and complex HIV/AIDS knowledge, the dominant PH culture (or discourse) has an inner resistance to pluralist interpretations, and this continues to undermine collaborative communication between RS and PH. As Treichler notes, "statistical knowledge travels well; cultural knowledge does not. A social scientist at the Maternal-Child Health conference asked whether the politics and policies of the AIDS epidemic must inevitably be based on inadequate data. Without 'data' about meaning and representation, the answer is inescapably yes."[606] Consider the following dialogue from a meeting between RS and PH scholars in 2008, dialoguing on whether it was important to consider religious health assets, two PH scholars said:[607]

> …As an instrumentalist intervention … which public policy mainly is, I do not care what they think is good for them … the degree to which it interfaces with what they decide … Unless it is a huge number of people it will not have a social impact … we don't really care … not that we don't *care* … but that we don't … we are looking at the population scale…
>
> If it is 10% that are so conflicted that they won't use ARVs … should I worry, if the other 90% will?

Both these PH scholars show some strain as they attempt to articulate the difference of the perspective to that of the RS scholars across the table. RS interpretations of pluralistic religious worldviews and health behaviour, or culturally appropriate HIV/AIDS programming might be acknowledged as important to PH scholars, but such considerations are still a significant obstacle to the PH discourses of certain-authority and practical problem-solving. Osborn and Ohmans warn ambitious young MPH students that a central myth of global health is that knowing the answers means you can solve the problems: "Americans like to see challenges as problems to be solved … This approach hasn't always worked well in the field of global health. There is probably a special place in heaven (or hell) for people whose clever international health projects didn't quite work

[605] Setel, "Comparative histories," 3-4.
[606] Treichler, *How to have theory*, 234.
[607] ARHAP, "Better words."

out as planned … If a project doesn't fit within a community's culture it may be doomed to fail."[608] This central myth has a real impact on how RS and PH scholars communicate about HIV/AIDS together, where (put crudely), the latter are culturally driven to solve problems, and the former to point out further problems.

The power dynamics at work can also be seen in the calls for more "definitional work" which in this context, most often is described as a need for RS scholars "to be more careful" when using terminology that has been "claimed" by PH, such as "impact".[609] I still wait the day when I will hear a PH scholar be cautioned to be more careful in their use of the term "hope" or "healing" within this community of inquiry. This is a subtle power arrangement and cannot be simplified to a situation of PH scholars forcing RS scholars to make PH discourse normative. Rather, RS scholars are often the ones arguing for the need for care of use in PH terms. The same goes for the definitional work on REs (as described in Chapter Four), which has largely resolved around how similar REs are to already established definitions, or in mapping discussions where RS scholars have attempted to work REs into PH typologies.[610]

Definitional work has a particular prominence in the academic (and interdisciplinary) setting, it is about marking territory, and is the process by which the academic landscape is mapped. As Bourdieu says, "every field is the site of a more or less openly declared struggle for the definition of the legitimate principles of division of the field."[611] Whether mapping knowledge fields or geography, naming and definition is of key importance. Speaking about interdisciplinarity, Klein says, "Names and the classifications they signify represent attempts to stabilize the flux of social life. They even, to an extent, create the realities they purport to represent. Mapping and naming natural or cultural things are important intellectual parts of their institutionalisation…"[612] This struggle is a continuous process, as lines and definitions are contested and redrawn through the act of naming. Klein continues

> The act of naming entails a concurrent process of gathering, sorting, comparing, and contrasting within an evolving view of reality … The classifications embodied in institutions, structures and maps are neither static nor permanent, since people challenge and

[608] G. Osborn and P. Ohmans, *Finding work in global health* (Saint Paul, Minnesota: Health Advocates Press, 2005), 25.
[609] See ARHAP, "Better words."
[610] See Chapter Four
[611] Bourdieu, *Symbolic power*, 242.
[612] Klein, *Crossing boundaries*, 52-53.

> sometimes change even the most hardened designations … Labels are neither meaningless nor arbitrary, but they are malleable.[613]

Definition (in academic discourse) also has critical implications for a scholar's *access*, for example to journals and scholarship generally, and access is not equal to all, even if there is a shared language.[614] This furthers the argument that the translation metaphor, while pervasive, can in some readings imply a straightforward exchange of meaning between two languages. As Sally Smith said, she sees her position with UNAIDS as one to "enhance communication skills to be able to bridge gaps created when agencies and FBOs speak 'two different languages'," [615] which is expressed in many ways throughout the secondary literature. Repko argues that disciplinary bilingualism might be a popular metaphor, but is in fact inappropriate, "(implying) mastery of two complete languages that rarely, if ever, occurs. It glosses over the challenges inherent in integrating the insight from two disciplines using those languages.[616] I agree with this insight, and expanding on it, argue that in this particular context, translation can suggest a process between two systems of meaning, when in fact, this community of inquiry is faced with a *range* of different cultures and challenges (and again, we are caught in a binary process of translation between the religious and the secular).

I am not advocating for us to get rid of the translation metaphor, but only to point out that in this context, translation implies a straightforward process, and glosses over the intense power struggles between multiple interests that are part of communication and definitional work at the intersection between RS and PH. Definitional work is not simply a matter of translating different disciplinary languages, but is embedded in politics of power. A most public example is the continued battle over the WHO's definition of "health", which has undergone repeated efforts by some religious groups to include the word "spirituality", which the WHO has held off. [617] More broadly, in RS and PH literature, the definition of health is a battlefield, with many scholars recognising the overlapping worldviews impacting on an individual or community's perception of health.[618] Treichler argues that

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[613] Klein, *Crossing boundaries*, 52-53.

[614] Mills, *Discourse*, 14-15.

[615] WHO-CIFA, "NGO mapping".

[616] Repko, *Interdisciplinary research*, 335.

[617] See S. Bok, "Rethinking the WHO definition of health," in *Working Paper Series* (Harvard Health Center for Population and Development Studies, 2004).

[618] See C. Allais, ed., *The sociology of health and illness* (Johannesburg: Lexicon, 1995), Aggleton and Davis, eds., *AIDS: individual, cultural and policy dimensions*.

> …a 'definition' is a set of statements with authority putting up the collateral … a definition is a phenomenon of the public sphere that purports to signify what *is* … and is often servicing a policing function. But definitions are not simply neutral labels for things in the world; rather like constructions of 'reality', they represent the outcome of struggle … This general model challenges conventional wisdom about what definitions do, the primacy and superiority of scientific and medical accounts of reality, the privileged status given scientific facts, and the taken-for-granted nature of scientific discovery … some meanings – become official definitions while others do not."[619]

Continuing with the example of the definition of health, the fact that PH scholars' definition of health is empowered by institutions such as the WHO suggest how difficult it is for RS scholars to engage in a meaningful way in "definitional work" in this collaborative space. Definitions are markers of authority and markers of difference, and any simple attempt to re-define a shared, will likely fail if it does not take into recognition the underlying issues of power working to maintain discipline-specific definitions (as markers of disciplinary terrain). A specialised disciplinary definition is not always open to translation and disciplinary discourses work to repel invaders, and are actively defending the tribe against being "lost in translation". The translation metaphor inadequately addresses the issue of power working within this communication between cultures, making genuine communication possible or not.[620]

It is easy to stop here and say, well, PH has more authority on matters of HIV/AIDS. But does it … or *should* it? And is it not important that our persistent struggles with communication at the intersection of religion and public health are in fact struggles over power between cultures? It has been well recognised that cultures under attack tend to be expressed more strongly as a result, either nationalism or religion being easy examples.[621] It is likely that RS scholars, constantly on the back foot in these collaborative situations and constantly being disempowered by an authoritative PH discourse, might strengthen their RS discourse as a form of resistance, making communication even more difficult. There are other similar considerations which I do not have space to explore fully here, for example, it is worth considering whether PH, as a relatively new "interdiscipline" does not have a more authoritative discourse because it is still working to establish its disciplinary territory, making its discourse and boundaries less welcoming of intruders. In complete contrast,

[619] Treichler, *How to have theory*, 327-328.

[620] This statement skips over the work of several critical theorist such as Habermas or Ricoeur on the possibility of communication in power-filled situations. See Chapters Six and Seven for a more detailed discussion on this.

[621] See Munns and Rajan, eds., *Cultural studies*.

RS is such an old discipline that its disciplinary boundaries have been all but washed away over time, making its boundaries significantly more permeable than those of PH.[622]

Finally, a process of translation will not adequately address underlying antagonistic attitudes that are part of both RS and PH cultures, and inhibit collaboration. I am not speaking here of the overt argumentation, but rather covert antagonism that is rarely expressed in writing, but is often observable in collaborative meetings. For example, a RS scholar may sigh at a graphical display of religiosity in a SSA country affecting HIV/AIDS behaviour, or a PH scholar will roll their eyes at a RS scholar's use of the word "impact" in discussing the strengths of the religious response to HIV/AIDS. These rarely result in anyone storming out of a meeting, but may often (in my experience) result in someone turning to check their email, or disengage from the conversation by going to fetch some coffee from the back of the room. As a rule in cultural and intercultural studies, silences are much more difficult to track and asses.[623] Patton notes, "Silence: the unspeakable, the perceived but best not said, the ignored, the space occupied by that which is ignored, the hidden, the safely tucked away, the camouflaged, the safety of camouflage."[624]

These differences are much more difficult to track or assess, but are critical signs of at the heart of the continued miscommunication felt at this intersection.[625] After observing such small signs of a larger problem time and again, I would argue that no unconscientized process of translation will mitigate these cultural differences, no uncritical definition work will bring such frustrations into the open.[626] This is not unique to this particular interdisciplinary context, as Bauer notes (discussing disciplines as cultures generally):

> Things happen in academia that seem inconsistent with the behaviour of people disinterestedly dedicated to the pursuit of truth … when in an interdisciplinary meeting a philosopher confessed to a modicum of cognitive realism, sociologists on the platform and in the audience snickered and agitated their eyebrows … The most appropriate way to understand such events may be through analogy with the mutual ignorance and xenophobia that separate national cultures. Thus naïve occidentals can … pity 'heathens'

[622] Consider the previous example provided of the increasing number of scientists writing on religion.

[623] See B. Heaphy, "Silence and strategy: Researching AIDS/HIV narratives in the flow of power," in *Meddling with mythology: AIDS and the social construction of knowledge*, ed. R. Barbour and G. Huby (1998), 27.

[624] C. Patton, *Inventing AIDS* (London: Routledge, 1990), 129.

[625] I would argue here that an in-depth and close intercultural analysis of a single encounter between RS and PH scholars in this context would be a fruitful project to follow this one.

[626] Freire's dialogical method "conscientization" means an awakening of critical consciousness or awareness, in this case towards different cultures, discourses and power within communication. See K. Kelly and M. Van der Riet, "Participatory research in community settings: processes, methods and challenges," in *Community psychology: Theory, method and practice*, ed. M. Seedat, N. Duncan, and S. Lazarus (Oxford: Oxford University Press, 2001), 183.

> who need salvation: naively, they fail to recognise that their own manners and beliefs, just as much as those of the strangers, are intricately interwoven features of their culture … And just so may naïve mathematicians fail to recognise that methods of research, choice of problems, evaluation of quality and the like *must* be different in social science than in mathematics; so too may naïve sociologists fail to recognise that they themselves are *culturally constrained* from being receptive to realist notions, whereas the culture of philosophers *necessarily* has room for realists as well as non-realists. A one-dimensional view gives scant opportunity for reasoned discourse let alone for reconciliation of different viewpoints.[627]

This explanation importantly describes the importance of recognising and articulating cultural differences at the intersection of RS and PH. A collaborative discourse that constantly places RS scholars on the back foot, making them have to vigorously defend their territory, can only hinder collaboration in the context of HIV/AIDS. As Ellison says there is "…a lamentable lack of synergy between different disciplines, and a tendency for disdain from those who see themselves as central to mobilising research and policy on HIV/AIDS from those who see themselves at the periphery (whether involuntarily or willingly)."[628] It is important that we take better care in considering how different disciplinary cultures are placed at the centre or periphery of the different HIV/AIDS-related discourses, and what impact this has on communication and collaboration, who is silenced, and how is why.

A Babel of Authoritative Voices: The Construction of Difference

> *…And they said, Go to, let us build us a city, and a tower, whose top may reach unto heaven; and let us make us a name, lest we be scattered abroad upon the face of the whole earth. And the Lord came down to see the city and the tower, which the children of men built. And the Lord said, Behold, the people is one, and they have all one language; and this they begin to do: and now nothing will be restrained from them, which they have imagined to do. Go to, let us go down, and there confound their language, that they may not understand one another's speech. Genesis 11:1-9 (King James version)*

In the face of a lack of literature directly addressing the disciplinary boundary between religion and public health, scholars working in this boundary zone are faced instead with a Babel of related

[627] Bauer, "The antithesis," 222.

[628] G.T.H. Ellison et al., "Introduction. Learning from HIV and AIDS: from multidisciplinarity to interdisciplinarity," in *Learning from HIV and AIDS*, ed. G.T.H. Ellison, M. Parker, and C. Campbell (Cambridge, United Kingdom: Cambridge University Press, 2003), 12.

authoritative voices describing difference between RS and PH. I make this argument after assessing the broad interdisciplinary literature addressing religion and public health, and specifically that addressing HIV/AIDS. In this literature (as in the discussion above), the following binary constructions can be regularly seen:

> religious studies versus public health; religious versus secular; religion versus science; faith versus reason; irrational versus rational; the humanities versus the sciences; theoretical versus empirical; normative versus positivist; interpretivist versus positivist; spiritual care versus biomedical care; complementary medicine versus biomedicine; soft sciences versus hard sciences; humanist versus relativist; subjective versus objective; traditional versus modern; traditional medicine (religion/culture) versus biomedicine; qualitative versus quantitative; the private versus the public; the individual versus the population.

In all these binary constructions, RS and PH are placed on opposite sides of a theoretical chasm. I was caught by Becher's opening remark, that he began his inquiry into academic tribes and territories as a result of a "profound irritation" with: "…a superficial and conceptually flawed polarisation between the worlds of the sciences and the humanities ... (which) triggered off a concern to establish that there are many more numerous and more subtle boundaries than Snow's polemic allowed within the world of scholarly enquiry and many more bridges across what he chose to depict as a grand canyon of the intellect."[629]

After reading into the broad literature which should have been significantly relevant to the interface between religion and public health in the context of HIV/AIDS, I experienced a similar profound irritation with the many polarised views presented, and the depictions of many grand canyons of the intellect. The most vivid example is the material addressing the dialogue on religion and science, which on the outset I had expected to be of particular relevance to this study, especially in view of its recently revitalised nature.[630] On reflection, however, I found this area of investigation to be based on undefined (and largely indefinable) depictions of "religion" and "science",[631] which were largely unhelpful in improving my understanding of interdisciplinary collaboration and communication between RS and PH. For example, consider this statement:

> …Over the course of history, there has been a major divide between science and religion over what constituted truth … the relationship between religion and science quickly

[629] Becher and Trowler, *Academic tribes*, ix.

[630] As mentioned in Chapter One, there has been a recent increase in the number of scientists publishing on religion and religious responses to this.

[631] See M. Stenmark, *How to relate science and religion: a multidimensional model* (Grand Rapids: W.B. Eerdmans Publishing Company, 2004), 9.

> developed into two forms. One was a relationship of antagonism where there was open hostility with each seeking to prove the other wrong, while the other was one of separation, a type of peaceful coexistence, in which religion dealt with the spirit and science dealt with the material, with little connection between the two.[632]

How helpful is this in understanding the disciplinary relationship between RS and PH? Is RS then supposed to deal with the spirit and PH the material? In my mind, Carvahlo is perhaps correct in wondering if "…the science-religion field is closed in terms of its audience, and such a notion may make the scholars in the science-religion arena suspect that the field is dying out or becoming irrelevant to society at large."[633] Certainly, I found the dialogue to be of limited use to the RS-PH interface. Another telling point is how little literature there is which addresses the religion-science interface in the context of HIV/AIDS, given the mass publication of the HIV/AIDS academic industry.[634]

It is possible to spend a lifetime mapping the cultural differences between RS and PH, through the lenses of such binaries. However, I am increasingly concerned that in this approach we perpetuate the power structures that have kept RS and PH on opposite sides of the disciplinary map, and get no closer to practical solutions for improved interdisciplinary collaboration and communication. Indeed, all of these binaries described above have been critically deconstructed in various contexts. In a whirlwind description of several complicated critical analyses: as described above, the religious-secular division has been increasingly challenged. Arms argues that faith and reason might often be "…seen as polar opposites … (however) religion employs logic, albeit according to its own rules and within its own frame of reference."[635] Evink similarly argues that,

> …faith and philosophy are often thought of as forming an opposition, which situates religion, beliefs, and faith on the one side and philosophy, science, knowledge, and reason on the other … in modern times, however, especially in the period of the Enlightenment and onwards, reason and faith are strongly opposed to each other … an opposition which is

[632] Barbour in O'Connor and Meakes, "Joint paradigm," 11.

[633] J.J. Carvalho, "The agenda for religion-and-science: a biologist's perspective on the future of the science-religion dialogue in the twenty-first century," *Zygon: Journal of Religion & Science* 43, no. 1 (2008): 218.

[634] Only a few texts, mainly emerging from a specific issue of the Journal *Zygon,* directly addresses HIV/AIDS in the context of the religion and science debate. See E.W. Gayle, "The new biology and its impact in biomedical strategies against HIV/AIDS," *Zygon* 39, no. 2 (2004), F.M. James, "Is there none left to say anything?," *Zygon* 39, no. 2 (2004), B.A. Strassberg, ""The plague of blood": HIV/AIDS and ethics of the global healthcare challenge," *Zygon* 38, no. 1 (2003).

[635] Arms in Repko, *Interdisciplinary research*, 291. See C.E. Evink, "Jacques Derrida and the faith in philosophy," *The Southern Journal of Philosophy* XLII (2004).

still very influential… Derrida problematises the opposition between faith and reason, as he does all oppositions.[636]

The religion-science division is fundamentally challenged by arguments that RS *is* a science, or that the irrational religion-rational science binary is a problematic construction.[637] Several critical scholars have engaged with the humanities-science division, Kuhn famously arguing that science is not neutral or objective,[638] and is as ideologically influenced as the humanities. The modern-traditional binary has been increasingly challenged, as has the construction of a binary difference between biomedicine and traditional medicine and healing, particularly in the context of HIV/AIDS.[639] Finally, the quantitative-qualitative divide has been deconstructed in a number of ways and been shown to be a misleading distinction.[640]

Yet, no matter these critiques and challenges, these binaries remain powerful constructions, visible within the community of inquiry working at the intersection of RS and PH.[641] Treichler also noted how powerful such binary constructions are in the context of HIV/AIDS. "AIDS exists at a point where many entrenched narratives intersect … It is extremely difficult to resist the lure, familiarity, and ubiquitousness of these discourses … We inherit a series of discursive dichotomies; the discourse of AIDS attaches itself to these other systems of difference and plays itself out there."[642] Treichler continues to identify a number of these, such as first world-third world, self-Other, science-non-science, certainty-uncertainty, or guilty-innocent constructions that remain pervasive in HIV/AIDS discourse.[643]

Others scholars engaged in the cultural politics of HIV/AIDS have noted the interaction between "First World" and "Third World" experiences of the epidemics, and argue that we must pay close attention to the way these natural-seeming binary oppositions are put into work.[644] HIV/AIDS "has highlighted social inequalities and the binary opposites of rich and poor, black and white, first and

[636] Evink, "Jacques Derrida and the faith in philosophy," 314-315.

[637] See Warrier, "Introduction," 3.

[638] Kuhn et al (see Treichler on cultural contruction) that 'science' is not neautral and objective either

[639] See S. Abdool Karim et al., "Bridging the gap: Potential for a health care partnership between African traditional healers and biomedical personnel in South Africa," *South African Medical Journal* 84 (1994).

[640] See M. Hammersley, "Deconstructing the qualitative-quantitative divide," in *Mixing methods: qualitative and quantitative research*, ed. J. Brannen (Aldershot, UK: Avebury, 1992), 39.

[641] See P. Treichler, "AIDS, HIV and the cultural construction of reality," in *The time of AIDS: social analysis, theory and method*, ed. G. Herdt and S. Lindebaum (London: Sage Publications, 1992), 73.

[642] Treichler, *How to have theory*, 35.

[643] Treichler, *How to have theory*, 35.

[644] See B.G. Schoepf, "Women at risk: case studies from Zaire," in *The time of AIDS: social analysis, theory and method*, ed. G. Herdt and S. Lindebaum (London: Sage Publications, 1992), 265, Treichler, *How to have theory*.

third worlds in a terrifying way."[645] All this indicates how such binary constructions govern the way we think about HIV/AIDS. Peter Piot has argued that the new challenge for HIV/AIDS is to:

> …join these efforts into a coherent movement that is able to shift social norms and sexual and drug-use practices. Instead, the demands of these sectors have been competing or contradictory: community versus state, religious versus secular, local versus international, private versus public, and medical versus social. The extent of the pandemic has made the need to overcome these differences in the creation of an effective movement to demand HIV prevention even more compelling.[646]

Returning to the RS-PH interface, I believe that it is necessary for us to consider more carefully how these binary constructions are governing the research agenda and collaborative discourse; and whether there might be a possibility here to work around some of these age-old oppositional forces. Nader notes how these commonly repeated contrasts have the effect of marking difference:

> In demarcating science from other systems of knowledge…(using) a style formed by the very contrasts that bedevil … science/religion, rational/magical, universal/particular, theoretical/practical, developed/underdeveloped – one that fixed hegemonic categories in the popular imagination. These dichotomous categories are powerful mind organisers … A style favoured by contrast includes some things, excludes others and creates hierarchies privileging one form of knowledge over another … contrast also tends to fix a positional superiority in the mind…[647]

Influenced by these slew of binary constructions, the community of inquiry researching HIV/AIDS at the intersection of RS and PH has been constructed as a relationship of *difference*.[648] Interdisciplinary communication is caught up in foregrounding difference rather than similarities or common ground, a modern-day Babel requiring translation. These binary constructions all work together, resulting in RS and PH being discursively pushed apart, with PH inevitably being privileged (as science-reason-positivist-empirical-objective-quantitative-hardscience-rational-modern) and RS helplessly positioned on the opposite side of the academic map (as non-science-faith-irrational-traditional-soft-qualitative-private). Staying with the spatial metaphor, this causes

[645] M. Martin, "HIV/AIDS in South Africa: can the visual arts make a difference?," in *AIDS in South Africa: A social expression of a pandemic*, ed. K.D. Kauffman and D.L. Lindauer (New York: Palgrave MacMillan, 2004), 129.
[646] P. Piot et al., "Coming to terms with complexity: a call to action for HIV prevention," *The Lancet* 372, no. 9641 (2008): 852-853.
[647] L. Nadar, "Introduction," in *Naked science: anthropological inquiry into boundaries, power, and knowledge*, ed. L. Nader (New York: Routledge, 1996), 2.
[648] See Klein, *Crossing boundaries*, 158.

the gap between religion and public health to appear like an ocean, upon which rare islands of common ground are dotted.

Tribal Sameness: Finding Common Ground

> *The search for common ground is the fundamental element of all (interdisciplinary) investigation.*[649]
>
> *…it is an act of faith that there is ground for common cause between religion and public health…we gather together in the search for common cause…*[650]

The constant marking of difference driven by the discourse conventions in our disciplinary language has hindered collaboration in the community of inquiry, and prevented the establishment of common ground from which collaboration can emerge. This is not to argue that an attempt should be made to remove difference, as Klein argues, "disruption and difference play important, productive roles in interdisciplinary work…"[651] However, as Newell says:

> Insights cannot be integrated until common ground among them is first established … the objective of creating common ground is not to eliminate tension altogether between the insights of different disciplines, but to reduce the level of tension. Tensions, even conflict, will remain, reflecting the differing assumptions and epistemologies by which the disciplines and their theories operate.[652]

In this interdisciplinary context, difference has been foregrounded to the detriment of the project of finding common ground. It is significantly more difficult to find discussion of similarity and common ground in the materials emerging in this community of inquiry.[653] I do not speak here of the broad interests such as justice, the eradication of poverty or a shared interest in health and well-being, as mentioned in Chapters One and Two. There are also obviously shared interdisciplinary *problems*, such as poverty, that have given reason for this collaboration in the first place. What has not been adequately addressed is the aspect of disciplinary common ground, or similarities in disciplinary cultures which could enhance interdisciplinary communication, collaboration and even integration. However, as mentioned above, there is little current literature addressing this particular disciplinary boundary, and little integration of the discourse and theory

[649] Kockelmans in Repko, *Interdisciplinary research*, 276.
[650] *Better Words participant. Report forthcoming 2010*
[651] Klein, *Crossing boundaries*, 84.
[652] Newell in Repko, *Interdisciplinary research*, 301.
[653] See the following chapter for ARHAP groups efforts in this regard.

of the broader interdisciplinary studies field into the discourse at the intersection of religion, public health and HIV/AIDS.

Becher notes that it is more useful to compare the discourses and cultures of specialisms than disciplines, especially in our increasingly specialised and fragmented academic context. This could be a much more useful tactic for interdisciplinary engagement between RS and PH. In other words, by shifting the discussion from broadly speaking of RS and PH, to a more focused comparisons between disciplinary specialisms (or subcultures) within RS and PH, more common ground may be found, and the binary constructions discussed above less apparent. Many more similarities can be spotted between the specialisms of RS and PH such as health communication, development theology, comparative religion or cultural epidemiology (to name a few), all having more readily apparent entry points for discussions of similarity, than does that between "RS" and "PH". For example, there are specialisms in both RS and PH who have taken on what I will call a "development perspective" to health, and it would not be an onerous task to outline the similarities emerging from these subcultures.[654]

Focusing on the potential for common ground between specialisms would be a significantly more successful strategy for interdisciplinary communication at the intersection between RS and PH. This is particularly the case considering how RS and PH are similarly fragmented multidisciplines, and both are situated on academic boundaries in that they both have strong connections with institutions outside the academia. In fact, RS and PH could find some common ground in their similar situatedness on the outskirts of the academic map.

Pointing out similarities will have little effect if the power imbalances discussed above are not addressed. That is, unless time is taken to consider power and its effects, RS scholars will remain on the back foot, and scholars from both sides may continue to defensively mark territory through discursive means. Simply pointing out the power imbalances is unlikely to have an effect, nor is pointing fingers at PH scholars as though they are to blame for the dominating actions of their chosen discourse and culture.

Perhaps a more open (confessional) discussion of the shared failures in the context of HIV/AIDS research might create some common ground. And there are many such to work with, such as a shared lack of information, a shared focus on treatment and care at the expense of prevention – and a shared acknowledgement that our disciplinary systems and knowledges have been caught

[654] A quick example is the increased reference to liberation theology in the Health and Development Communication fields. See Melkote and Steeves, *Communication for development*. Or Paul Farmer's discussion of liberation theology in the health context, see P. Farmer, *Pathologies of power: health, human rights and the new war on the poor* (Berkeley: University of California Press, 2003). See Schmid et al., "Understanding RHAs."

unprepared for both the interdisciplinary response to HIV/AIDS *and* the re-engagement of religion and health (so that practice is now running several steps ahead of our scholarly assistance).

Finally, I wonder if there is not a partially hidden shared idealism and hope that can be brought more openly to the surface. Millen argues that in the last few decades:

> …postmodern fashions in the academy have to some degree reinforced the tendency toward moral paralysis and indifference. When understood as a call to radical relativism, postmodern thought has fostered moral resignation … we lose touch with the principle that, while reality is indeed 'complex, contradictory and elusive' certain forms of human experience, above all suffering and death, 'remain incontestably factual' … 'It is not (oppressed people) who have abandoned idealism, universalism, truth and justice. It is those who already enjoy these things who have denounced them on behalf of the others.'[655]

Although RS has been influenced by postmodern perspectives, I believe an argument can be made that, perhaps more than any other humanities and social science cultures, RS retains a strong imperative for such ideals as truth and justice. In the same way, although PH has positivist tendencies, there appears to be a core idealism, an intentionalism to make a difference. The first words of *Finding work in global health* reads, "so you want to go overseas and help people in need … maybe you just know you want to help, somehow."[656] And further down, describing the PHC conference at Alma Ata in 1979, the authors say, "the conference participants, a wonderfully idealistic lot, expressed the belief that health is '… a fundamentally human right' ... rest assured that all but the most cynical of (global health workers) have its noble goals in mind."[657] Perhaps common ground can be found in these ideals, if RS and PH scholars are able to express such ideas in a safe interdisciplinary and collaborative space without being made to feel naïve, or defensive about their disciplinary territory.[658] As Strassberg says, "…an intentionally developed multifaith and multidisciplinary coalition may help us move away from various forms of social speciation and toward sociological mindfulness. This could help us remake the world into one that has more courage to care."[659]

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[655] J.V. Millen et al., "Conclusion: pessimism of the intellect, optimism of the will," in *Dying for growth: global inequality and the health of the poor*, ed. J.Y. Kim, et al. (Maine: Common Courage Press, 2000), 383-384.

[656] Osborn and Ohmans, *Finding work in global health* 1.

[657] Osborn and Ohmans, *Finding work in global health* 35-36.

[658] See Chapter Six for more on this.

[659] Strassberg, "The plague of blood," 169.

Finally, the most obvious area of common ground for RS and PH must be the interdisciplinary problems such as HIV/AIDS on which they are both engaged. Marshall says,

> The diversity of faith traditions, teachings, and communities is remarkable. The central reality is that they matter and need to be studied, debated, and assessed. Harsh polemics may be inevitable where moralities clash and facts are not easy to establish, but they do not help much. What we are after is thoughtful and respectful engagement across different traditions and perceptions of what is happening. The common ground that HIV/AIDS is devastating communities and causing untold suffering calls for working together.[660]

However, as this chapter has explored, sharing a problem and having a common purpose does not automatically lead to shared understanding, collaboration or cooperation. I have argued here that the translation metaphor, in my opinion, does not adequately depict the underlying cultural differences and power that are inhibiting communication and collaboration. Furthermore, while there is certainly a continued need to appreciate difference, it is important that we do not get so caught up in constructing the relationship between RS and PH as different, that we no longer actively search for the similarities and common ground.

Shared problems such as HIV/AIDS demands that we find better ways of working together, that are more effective and more innovative. This means dealing with frustrations and miscommunication, and also working to undermine power structures that keep the interdisciplinary communication stuck in these age-old power relationships.

[660] K. Marshall, "The ABCs of AIDS," *First Things* August/September (2008): 4.

Chapter Six. Mapping Interdisciplinary Research Collaboration: ARHAP

> *Working in the relationships between disciplines, fields of practice, institutional capacities and competencies … is not primarily an intellectual space, but a physical, existential space that is in between all those things we know. The space in which we are trying to do scholarship is filled with haunting ambiguities and confusions in which hope and horror are intermingled.*[661]

Gary Gunderson addressed these words to colloquium of the African Religious Health Assets Programme in 2003, and aptly described my experience in this interdisciplinary interspace between religion and public health. Research at this intersection is unavoidably interdisciplinary. Complex problems such as HIV/AIDS drive scholars and practitioners urgently towards interdisciplinary collaboration, and the historical context of this intersection mean that individuals are stepping into unexplored territory with little available guidance of what interdisciplinary best practice or communication looks like in this boundary zone. The practice of interdisciplinary research (IDR) in this context seems to be particularly fraught with obstacles, conflicts between discourses, cultures and epistemologies. In the previous chapters, I have argued that much of the IDR around HIV/AIDS appears to be suffering from a disconnect between interdisciplinary practice and broader interdisciplinary studies (IDS), knowledge and theory, and this is felt at this intersection of religion and public health as well.

With the rapidly increasing interdisciplinary collaboration at the intersection of religion and PH, and specifically on the topic of HIV/AIDS which has its own interdisciplinary background and impetus, there is an urgent need for research into interdisciplinary *practice,* at a number of levels, from collaborative research to interdisciplinary higher education (HE). Klein argues that we are particularly lacking case studies of interdisciplinary research collaboration: "Rendering the work being done in interdisciplinary fields more explicit is, in fact, the most urgent need in current scholarship. There are very few substantive accounts of individual fields. As a step toward compiling such histories, and thereby coming to understand the 'disciplined' nature of those fields…"[662]

In this chapter, I turn to the empirical base of my investigations, the African Religious Health Assets Programme (ARHAP), and utilise this as a case study for IDR collaboration with the intention of offering this as an insight into the broader collaboration at the intersection of religion and public health.

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[661] Gunderson, "The least we can do," 20.
[662] Klein, *Interdisciplinarity*, 111.

There are a number of areas requiring urgent attention to which the ARHAP experience could be applied (and one of my main recommendations here is that such research be pursued as a matter of urgency). However, given the exploratory nature of this investigation, I will continue to focus primarily on language and communication in the context of IDR collaboration, which many scholars have noted plays a key role in the success or failure of interdisciplinary collaborative efforts.[663] A largely descriptive chapter, I will consider how language shapes collaboration between the tribes of religion and of public health, relying on interdisciplinary team work on HIV/AIDS in SSA as the basis for this discussion. The ARHAP experience is provided here neither to promote nor to criticise this particular collaborative, but is rather offered as an opportunity for considering how the developing ARHAP collaborative experience can better inform the broader community of inquiry at the intersection of religion and public health. My interest is in describing ARHAP's experience, focusing on interdisciplinary communication in particular, and drawing in some of the broader scholarship on IDR practice to inform best practice.[664]

A Note on Terminology: Multi-, Inter-, and Transdisciplinarity

There are great terminological battles over interdisciplinary terminology, as theorists from different disciplines struggle to define a complex array of relations and varieties of scholarly practice, leaving in their wake little consensus around the meaning of the terms such as interdisciplinary or transdisciplinary (and unleashing a swath of alternative prefixes such as cross-, omni-, multi-, peri-, or supradisciplinarity).[665] While I have been utilising the term interdisciplinary as the generic term up to this point, for the purposes of this chapter, in order to speak of the progression of this collaborative project, it is necessary to distinguish between three main terms: multidisciplinary, interdisciplinary and transdisciplinary. Relying on Klein's distinction, in this moment, multidisciplinary is seen as additive rather than integrative, where the disciplines are not changed by the usually limited encounter.[666] In contrast, interdisciplinary signifies "the synthesis of two or more discipline, establishing a new metalevel of discourse, (and) transdisciplinary signifies the interconnectedness of all aspects of reality, transcending the dynamics of a dialectical synthesis to grasp the total dynamics of reality as a whole."[667] In this construction, transdisciplinarity is seen

[663] See J.T. Klein, "Prospects for transdisciplinarity," *Futures* 36, no. 4 (2004): 520.

[664] It is necessary to note that ARHAP is engaged at the intersection between religion and public health broadly and not only on the topic of HIV/AIDS. However, HIV/AIDS has been a central focus, and in keeping with the rest of this thesis, I will mainly utilize the materials addressing HIV/AIDS to maintain some coherence with the other chapters.

[665] For a complete discussion of this, see Klein, *Interdisciplinarity*, 56-62.

[666] See Klein, *Interdisciplinarity*, 56.

[667] Klein, *Interdisciplinarity*, 66.

as an ideal, a "vision of interdisciplinarity penetrating the entire system of science," and is possibly beyond reach in practice.[668]

ARHAP: Is it a Bird or a Plane?

> *…I didn't realise ARHAP was a religion…*[669]

In the five years I have been working with ARHAP, the question I dread and therefore receive the most is: '*what is ARHAP?*' On receiving this question, most "ARHAPians" usually take a deep breath before launching into their personal understanding and description which is typically rather lengthy and somewhat convoluted.[670]

ARHAP is an interdisciplinary, international and intercultural research collaborative. It incorporates scholars, practitioners and intellectuals from a broad range of institutions (including universities from different continents, funding organisations, health organisations, religious entities, and the like). The scholars represent disciplines such as theology, the sociology of religion, public health economics, sociology, medicine, neurology, and psychology (to name only a few), but the common interest is in learning more about the intersection of religion and public health.[671] It has no fixed membership list, and individuals become ARHAPians by way of their own interest and increased engagement with the collaborative. ARHAP was initiated in 2002 under the joint leadership of Dr Gary Gunderson and Prof Deborah McFarland (then both of Emory University, Department of International Health), and Prof James Cochrane of the University of Cape Town (Department of Religious Studies). "It was predicated upon a conviction that faith-based organisations, groups and movements, though playing a significant role in the delivery and promotion of health, are generally not well understood or sufficiently visible to public health systems in most societies."[672]

These individuals, as well as those who subsequently joined and took a leadership role, strategically resisted any inclination for ARHAP to develop into an "organisation", and have held to the conviction that ARHAP is above all a relational network. ARHAP then, in its different guises, is a scholarly research collaboration, a relational network, an information portal, an organising body, a teaching support system, or an IDR team. ARHAP can perhaps be better understood by way of its

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[668] Klein, *Interdisciplinarity*, 66.

[669] K. Marshall, "Frontiers of public health and social transformation: policy and faith" (paper presented at the ARHAP Conference: When religion and health align - mobilizing religious health assets for transformation, Cape Town, South Africa, 13-16 July 2009).

[670] See http://www.arhap.uct.ac.za for a description of the programme and descriptive materials.

[671] I will discuss some of what I see are the underlying unifying values and factors below

[672] ARHAP, "ARHAP: tools workshop report," in *ARHAP: Tools workshop colloquium* (Cape Town, South Africa: (ARHAP) African Religious Health Assets Programme, 2004), 4.

scholarly output.[673] This includes work by individual scholars on a variety of topics at the intersection of religion and public health, but which give evidence of a complex network of cross-citation between individual research interests; large-scale empirical research studies by interdisciplinary teams publishing under ARHAP's name, and resulting in other co-authored texts; graduate student theses; research tools; conference and colloquium papers; as well as other presentations and shared learning opportunities.

ARHAP can also be understood by considering the nature of the organising committee, the carefully named Provisional Integration Team (PIT), which consists of senior staff as well as (intentionally included) graduate students from the Universities of Cape Town, University of KwaZulu Natal, Witwatersrand University, Emory University, Methodist le Bonheur Healthcare, The Vesper Society, as well as a few other specialist individuals who wear many institutional hats. The PIT acts as a steering committee for the organisation of the ARHAP network and for safeguarding the ARHAP culture. Collaboration is described as a set of concentric rings, with the *core team* (the PIT) who have accountability, but is not perceived to be as formal as a "board" in the centre. The next ring closest to the core are those in *collaborative* relationship, working closely with the core without being a core member. Then there are those in *cooperative* relationship, involved in specific projects, followed by those in *conversational* relationships, which means involvement in specific discussions with core members. Finally, the outer ring are those who are in *communication* with the ARHAP group generally, wanting to stay in touch, but not actively involved in any research or collaborative activity.[674]

Klein notes that interdisciplinary dialogue more usually takes places in the "hidden university",[675] or "invisible colleges":

> …(a) subgroup or communications network of scientists who define important problems, interpret seminal work, and link collaborators in a given research area … (or) a community of researchers who are in close personal contact … lacking such visible social and cognitive structures as departments and recognised professional associations, they are defined by 'invisible' patterns of communication: relationships among key productive scholars, conferences, core activities, and vehicles for the diffusion of information. The term can also

[673] For this as well as the descriptive discussion about ARHAP that follows, see ARHAP, "The African Religious Health Assets Programme," ARHAP, http://www.arhap.uct.ac.za.
[674] ARHAP, "Collection of concept papers," in *ARHAP International colloquium 2007* (Monkey Valley Resort, Cape Town, South Africa: 2007), 148.
[675] Klein, *Interdisciplinarity*, 48.

> apply to funded projects and subgroups … (with) an interest in issues with and interdisciplinary component...[676]

ARHAP fits more comfortably in this description of an invisible college than it does an "organisation", and is certainly does not name itself an FBO. ARHAP exemplifies problem-focused IDR, since it is the problem of the lack of information at the intersection between religion and public health that bring these individuals from different disciplines and institutions together into collaboration. ARHAP is also a good example of "boundary scholarship" or "boundary work",[677] since from its outset, ARHAP has spoken of its location in a "…'bounded field of unknowing' … a phrase positively describing the limitations of knowledge, and the interdisciplinary nature of religion and health assets. There is a parameter guiding ARHAP theories, which has taken a grounded theory approach to understanding phenomena."[678]

ARHAP is also an example of international cross-cultural research, in that there is an implicit strategy for communication and sharing of knowledge and resources between Northern and Southern universities and institutions, as well as an expressed need to be cognitive of the inherent power dynamics in relationships. This is in fact why the collaborative was first named the *African* Religious Health Assets Programme, saying, "…without … romanticising Africa or African cultures and experiences, we are convinced that the African context has something to teach both public health leaders and religious leaders."[679] This strategy remains a strong dynamics, for example, there are now strategies that were learned in field research in Zambia and Lesotho being applied by collaborative partners to an extensive hospital system in Memphis, USA.[680] The leaders of the ARHAP collaborative have always foregrounded such issues of power, for example, deliberately emphasising local knowledge and student voices, and strategising to avoid (as far as possible) becoming complicit in the politics driving certain religious, public health or international research agendas.

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[676] Klein, *Interdisciplinarity*, 49.

[677] Klein notes, "border interdisciplinarity … signifies two disciplines that have approached each other to the extent that an overlapping area is created." However as described above, there are more than two disciplines involved here, but it remains a useful descriptor. See Klein, *Interdisciplinarity*, 65.

[678] J.R. Cochrane, "Reconceptualizing religion and public health," in *ARHAP: International Case Study Colloquium* (Johannesburg, South Africa: African Religious Health Assets Programme, 2005), 9. More recently, several ARHAP scholars have noted that as we have learnt more, this phrase is less applicable, see S. De Gruchy, "Concluding remarks" (paper presented at the ARHAP Conference: When religion and health align - mobilizing religious health assets for transformation, Cape Town, South Africa, 13-16 July 2009).

[679] Cochrane, "Reconceptualizing," 7. For a description of the development of this project See Cochrane, "Potential of REs."

[680] See MBH, "Methodist le Bonheur Healthcare," Methodist le Bonheur Healthcare, http://www.methodisthealth.org/portal/site/methodist/.

By now it must be clear why any description of ARHAP is preceded by a deep breath of air as well as some fortitude on the part of the listener. I will be providing more background to ARHAP below, but there is perhaps a further clarification necessary with regard to ARHAP's nature as an interdisciplinary collaborative research project, namely its intentionality towards integration.

ARHAP has from the outset been focused on the boundary between religion and public health. In its initial stages this took the nature of a multidisciplinary project, where the interest was on how to understand one another from different disciplinary perspectives. Rapidly, over the last few years, through interdisciplinary team research and increased collaborative dialogue, this evolved into a more interdisciplinary form, with a distinct language or discourse identifiable as "ARHAPian" (which is the focus of the rest of chapter). However, ARHAP has always shown an intentionalism towards being a transdisciplinary project, in that there has been a drive towards an integrated understanding and essentially, a shared trajectory towards transformative action that is larger than the narrow engagement between disciplinary forms and goes beyond the walls of the academe. That is, there has been an intentionalism from the outset to engage community knowledges, to work at the interface between practitioner and researcher knowledges, and to be a "movement" as much as an interdisciplinary project.[681] Cochrane describes:

> …the broad reach of ARHAP's agenda, one that may be seen as utopian on the one hand, but that also functions in anticipatory fashion to direct our work as it expands, deepens, draws in a wider range of disciplines and partners, and encompasses more of the complexity we are certain resides in the phenomena we seek to understand. The development work that this project has involved, the building of collaborative relationships across intellectual and geographical boundaries, and the lure of exploring various research options and methods, also hides a danger to the originating vision of ARHAP, which includes a specific commitment, a passion if you like, to research that has a transformative effect beyond local contexts and health provision per se … Just how to set a transformative agenda that informs decisions about research is not something that we were able to answer in any simple way, and perhaps the most we can say at this point is that such an agenda is an intrinsic part of our self-understanding that we will need to foreground more and more…[682]

In the first part of this chapter, I will track this progression (from multidisciplinary through interdisciplinary towards transdisciplinary), and then focus more closely on the development of

[681] Cochrane describes this as "an activist intent and a scholarly grounding" See Cochrane, "Potential of REs," 42.
[682] Cochrane, "Reconceptualizing," 7-8.

language and culture specific to ARHAP. Before going forward, however, I believe it is important to emphasise here that this progression of ARHAP, although rapid, has not been without its pitfalls and tensions.

ARHAP colloquia and meetings have continued to show signs of tension as newly introduced individuals struggle to understand ARHAP and its language. For example, a participant responded at the 2007 ARHAP colloquium, "I'm feeling like an anthropologist finding a strange tribe, with a strange language, kept on the outside by the opacity of language. It is a culture shock, forcing me to rethink where I came from and the relevance of what I do…"[683] Every year that I have been a member of the PIT, there have been serious discussion about whether ARHAP has come to the end of its usefulness, and whether or not it should be disbanded, and every year the decision is made to continue on for a while longer.

Each stage of interdisciplinary collaboration has been confounded by serious struggles to remain true to the original vision of an interdisciplinary relational network, but still access funding for core support of the communication hub and for IDR (funders and academic institutions being reluctant to support research, core activities, or a collaborative that is so difficult to define.) ARHAP is not an example of a well-funded IDR institute with strong institutional support. Rather it is an "invisible college" of colleagues being held together *despite* a critical lack of support or recognition from their individual institutions or from the funding community generally.

Yet while ARHAP might not be well-funded, it is certainly well-resourced. As can be seen from the quotations and literature in the preceding chapters, highly profiled scholars and practitioners continue to be engaged, and continue to provide of their unpaid time and energies even without institutional support or immediate academic acclaim. Incredibly busy practitioners, scholars and institutions continue to creatively dip into personal funds to support ARHAP research, gatherings and student development. There is clearly something seen to be worth nurturing and supporting, whether it is the problem being addressed or "something else" holding these diverse individuals and institutions together.

When Katherine Marshall said in the beginning of her address at the 2009 ARHAP conference, that before she attended the conference, she had not realised that ARHAP was a religion, there was some laughter from the audience .[684] But there is also some truth to her statement, in that those who remain engaged in this interdisciplinary collaborative (be they people of faith, agnostics or atheists, theologians or public health economists), tend to be "converted", and express

[683] ARHAP, "ARHAP 2007," 149.
[684] Marshall, "Frontiers of public health".

appreciation of the "something" that holds the collaborative together. Ultimately, what has kept ARHAP together despite these dangers and frustrations is a shared vision. Mary Baich eloquently describes this sense of shared vision she discovered in her first ARHAP meeting:

> From the very beginning at the meeting in Geneva in 2003, I could sense that this activity would be an opportunity of a lifetime. We were each called by invitation to cluster around these exciting ideas of a few people and hints of a proposed journey, that we might do something together … (we) sat attentively listening to Gary and Jim … spin their dreams about the intersection between faith and health, religious health assets and public health systems … it was a most diverse, unconnected sort of conversation ... (but) from the very outset, we were unified around a shared vision, which is one of the success factors for collaborative work … never underestimate the power of a truly collaborative group, especially a group organised around a unique purpose and a shared vision. Other success factors such as concrete, attainable goals and objectives came later.[685]

In this chapter, I will seek to describe the development of the ARHAP collaborative through the lens of interdisciplinary collaboration and communication, so that we might better understand and therefore nurture this interdisciplinary effort that continues to share such vision, and then learn from this for the broader community of inquiry at the intersection of religion and public health.

From Multidisciplinarity through Interdisciplinarity towards Transdisciplinarity

> *Neither the popularity nor the necessity of interdisciplinary research is reflected in the reality of the situation today: shockingly few researchers or institutions have meaningful experience with its actual practice. The reason that such a paradox exists is clear: the practice of interdisciplinarity is difficult and fraught with roadblocks…*[686]

Klein points out that there is nothing inevitable about the progression from multidisciplinarity through interdisciplinarity to transdisciplinarity, and then points to Sverre Sjölander's account of the ten stages in the development of an interdisciplinary project.[687] Klein provides a full description of these steps, which is a long extract, but worth considering in its entirety, as I will then work to match ARHAP's progression against this description.

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[685] M. Baich, "Staying the course: from research to engagement," in *ARHAP Conference: When religion and health align - mobilizing religious health assets for transformation* (Cape Town, South Africa: African Religious Health Assets Programme, 2009), 1-2.

[686] D. Caruso and D. Rhoten, "Lead, follow, get out of the way: sidestepping the barriers to effective practice of interdisciplinarity: a new mechanism for knowledge production and re-integration in the age of information," in *A Hybrid Vigor White Paper* (The Hybrid Vigor Institute, 2001), 2.

[687] S. Sjölander, "Long-term and short-term interdisciplinary work: difficulties, pitfalls, and built-in failures," in *Inter-disciplinarity revisited*, ed. L. Levin and I. Lind (Stockholm: OECD, SNBUC, Linkoping University, 1985).

> At Stage 1 participants often spend their time '*singing the same old songs,*' presenting themselves, their work, and their answers to any conceivable criticism…
>
> At Stage 2 as individuals begin detecting deficiencies in each other's positions, '*everyone on the other side is an idiot'.* Many people quit at this point…
>
> At Stage 3, participants begin '*retreating into abstractions*' in order to find common ground. The more abstract things are, the easier it is to agree…
>
> At Stage 4, '*the definition sickness*' sets in as colleagues ask each other to define technical terms, only to discover that use of more general, philosophical terms varies…
>
> At Stage 5, participants can begin to concentrate on fruitful (but disparate) discussion areas … discussion will … jump from one area to another, like *'jumping the tussocks*' in a quagmire.
>
> At Stage 6 participants may be playing, '*the glass bead game'* ... building on common jargon and common ground…
>
> By Stage 7 '*the great Failure*' often surfaces … participants may despair of their time and effort. Yet when asked to produce … they often find their interest rekindled …
>
> Those who make it to Stage 8 may find themselves wondering '*what's happening to me?*' They have changed more than they may be aware of consciously…
>
> Stage 9 is '*getting to know the enemy*' moving towards more in-depth knowledge of other disciplines…
>
> Stage 10 is '*the real beginning'* reached after long-term work or repeated meetings and often quite productive of results at an astounding rate.[688]

Klein notes that making it to Stage 10 is "neither easy nor inevitable" and in many cases the successes are more likely to be concealed benefits such as "changes in the way individuals work and think."[689] I have provided this entire extract since, even only as a heuristic, I find Sjölander's account to be a useful way of understanding the progression of the ARHAP collaborative. It must first be noted however, as in Chapter Three when describing the "phases" of the development of the religion and HIV/AIDS chronicle, the linear depiction of these stages is somewhat misleading. As mentioned in Chapter One, central to interdisciplinary studies is the concept of the research

[688] Klein, *Interdisciplinarity*, 72.
[689] Klein, *Interdisciplinarity*, 71-72.

spiral, that interdisciplinary progress and integration is not a linear progression, but a reiterative and circular (or more aptly, a spiralling) process. In the case of ARHAP, this is strongly apparent as new members move in and out of the collaborative, new insights are discovered and learnt from, and a shared language is developed and then reassessed.

Nonetheless, it is still useful to consider ARHAP's progression as an interdisciplinary project to gain some sense of its forward development as a collaborative over the last six years. Broadly speaking then, relying on the ARHAP colloquia reports from 2003 to 2009 as well as my general experience in this collaborative as reference: in the early ARHAP meetings and colloquia there were signs of "everyone singing the same song" in that scholars opened themselves up to criticism for embarking on this strange new area (religion and public health) and speaking of RHAs from multidisciplinary backgrounds. For example, the first ARHAP colloquium, titled *Assets and Agency*, shows some signs of different disciplinary perspectives (such development, sustainable livelihoods, social capital, bio-medicine and social science) being applied to the religion-public health interface.[690] A collective theme at this stage was for all involved to argue (from different disciplinary perspectives) that religion was a significant and overlooked factor in relation to public health.

The next stage ("everyone on the other side is an idiot") can be seen in the instances of impatience and frustration between participants (as described in previous chapters), and sometimes resulting in individuals deciding not to engage with the ARHAP collaborative any further. A more subtle version of this can be seen in the PH scholars pointing out the detrimental effects of religion on HIV/AIDS intervention, and of RS scholars pointing out the deficiencies of the PH model in not understanding the complexities of the HIV/AIDS situation.[691]

In 2004 and 2005 colloquia, the next stage ("retreating into abstractions") is visible, as complex models and matrices were designed, and debated, at this stage based on the (often extensive) knowledge and experiences that individuals brought to the collaborative than on grounded empirical or *group* research performed as a collaborative. The ARHAP Suite of Assessment Tools Model (ARHAP-SAT) and the ARHAP Theory Matrix[692] are examples of theoretical abstractions that were a result of participants wrestling with an exceptionally complex problem while searching for common ground. "Again, as with the ARHAP Theory Matrix, the ARHAP-SAT Model is one we envisage developing over time on the back of actual research results and outcomes. It functions in two ways: as a heuristic guide for determining the outlines of a relevant suite of assessment tools

[690] ARHAP, "Assets and agency: papers and proceedings," in *ARHAP: Assets and Agency Colloquium* (Pietermaritzburg, South Africa: (ARHAP) African Religious Health Assets Programme, 2003).
[691] See ARHAP, "ARHAP 2007."
[692] See ARHAP, "ARHAP 2004."

to understand religious health assets; and as a provisional conceptual framework for disaggregating and combining those tools in a theoretically coherent way."[693] The 2005 colloquia showed some of the tensions as in the question and answer sessions, participants began to asked pointed questions of how these abstract models worked "on the ground" in different contexts.[694]

Around this time, the "definition sickness" had begun, with participants enthusiastically tackling different terminology, discovering the different usage of the same terms, and then developing a jargon (such as "intangible religious health assets" or "bophelo").[695] As Sjölander and Klein predict, this jargon indeed proved to be an initial obstacle to some new members, as one new participant said, "I was initially intimidated, but as time went by the language got clearer."[696] From 2007 to 2009, ARHAP began to provide a glossary to colloquia participants describing key terms so as to ease new participants into the discussion.[697]

Stage 5, "jumping the tussocks," can be seen in the 2007 colloquium report which shows fruitful areas of discussion being identified, but also some jumping between areas of interest (for example, the colloquium thematic areas being: religion and health systems alignment, the value added and invisibility of religious health assets, plural health systems, where does religion fit in the political economy of health, leadership engagement, policy formation and development, community leadership and empowerment, possibilities for collaboration). Baich describes the work of the ARHAP collaborative as "…very muddy at first. It lacked clarity and focus and it also took time for the organising work to settle in ... we experienced some false starts and stumbling blocks as we went through the stages of group development."[698]

In the subsequent colloquia, there was evidence of "the glass bead game,"[699] as a common jargon and common ground was clarified. In fact, it was around this time that ARHAP's jargon became more apparent in literature beyond that of the core group, as it increasingly appeared in meeting reports and news articles.[700]

Stage 7, "the great Failure", was experienced at a number of points in this progression, as some participants expressed concern for how much time and effort the collaborative was taking with

[693] ARHAP, "ARHAP 2004," 7.
[694] See ARHAP, "ARHAP: case study focus: papers and proceedings," in *ARHAP: International Case Study Colloquium* (Johannesburg, South Africa: (ARHAP) African Religious Health Assets Programme, 2005).
[695] Discussed in more detail below
[696] Participant response, ARHAP, "ARHAP 2007," 153.
[697] See ARHAP, "ARHAP 2007," 157-164.
[698] Baich, "Staying the course," 2.
[699] *Das Glasperlenspiel*, Herman Hesse.
[700] See WHO-CIFA, "NGO mapping".

little recognition or scholarly reward. Baich describes this in terms of respect and trust within the ARHAP collaborative noting,

> How we treated each other was proportional to how our work flowed. What I mean, is that we were at our best when we respected each other and trusted each other in our work. There were times when lack of communication and individual interests kept us from working well together. We had to recognise when that happened and work to rebuild trust.[701]

At each moment of "great Failure" the decision to continue forward in collaboration was (in my opinion) as a result of two main factors: firstly, at each such point a large-scale interdisciplinary team research project was undertaken which provided further impetus, financial support, as well as opportunities for collaborative members to work closely together (rather than geographically distant, which is the norm for this international network).[702] Secondly, the collaborative relationships and communication network that had been established through considerable attention and effort, continued (and continues) on irrespective of the current financial or institutional status of the programme at large, which in turn generated further collaborative opportunities and energy.

Stage 8 ("what's happening to me?"), is visible as a growing articulation of what it means to be "ARHAPian". Klein notes that this stage is usually felt when collaborative members have to explain themselves to their own discipline or department. A newcomer to the ARHAP group noted in the 2007 colloquium, "The justification of my involvement to my colleagues may be difficult. Other individuals and professionals may not be as forgiving as me."[703] Gary Gunderson began his summary of the 2005 colloquium with the proclamation "you will know the truth, and the truth will make you odd."[704] This growing sense of shared "oddness" reflects an emergent shared culture, or a shared "tribe", that has developed in an interdisciplinary boundary zone and spans disciplinary differences.

In the last two years (2008 to 2009) ARHAP literature has reflected a growing sense of surety in the group culture, in their shared research (increasingly based on knowledge that is still strengthened by the individual experiences, but now also based on a common integrated core), and in the interdisciplinary communication and relational network that holds the collaborative together.

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[701] Baich, "Staying the course," 2-3.

[702] For example the research for the WHO (2005-2006), for The Bill and Melinda Gates Foundation (2007-2008) and for Tearfund and UNAIDS (2008).

[703] Scorgie in ARHAP, "ARHAP 2007," 149.

[704] Gunderson final address. ARHAP, "ARHAP 2005."

Stage 9, "getting to know the enemy", has been a result of a gradual learning process, as scholars from difference disciplines have reached a better understanding of the principles and ways of thinking of scholars on the other side. As a participant of the discussion between RS and PH scholars noted in 2008, "…we have been working from a position where we were on the margin trying to have a perspective and message gain purchase, where it seems to me that we have arrived there. We have to move beyond apology or seeking to show that religion is of significance…"[705]

ARHAP continues to show evidence of all these stages, as new members are brought into the programme and new conversations bring challenging disciplinary perspectives together. There is a definite sense that the core group has in many ways survived these stages and has reached a "the real beginning", when the fruits of long-term efforts are rapidly becoming more evident. Klein notes that reaching Stage 10 "has a lot to do with realising that criteria differ from project to project,"[706] and ARHAP certainly shows a greater sophistication in organising its discussions,[707] and the combination of its interdisciplinary teams, depending on the topics at hand. Publication on ARHAP-related topics has increased significantly from the various ARHAP members over the last two years, and generally ARHAP has begun to feel that, after being out in the snow for some years, its work is being recognised on an international level. When asked what insights he had gained from the ARHAP work, PIT member Frank Dimmock answered, "I was somewhat surprised and certainly thrilled by the attention given by the international community. It was an indication that advocacy efforts, supported by evidence, were paying off … (that) we needed to continue this work, do more and do it better."[708] As mentioned previously, there is some evidence that ARHAP's concepts, language and research tools are being increasingly utilised beyond the core group and that the network continues to grow.[709]

This broad but restricted introduction into the ARHAP interdisciplinary collaborative, has been necessary because, while ARHAP has been an intentionally interdisciplinary collaborative from the beginning with a transdisciplinary and transformative agenda, there has been little opportunity to consider its development in light of the broader interdisciplinary literature such as this one provided by Sjölander. Klein argues that "there is no formula for interdisciplinary work at any stage,

[705] See ARHAP, "Better words," (Cape Town: African Religious Health Assets Programme, Emory University, forthcoming).
[706] Klein, *Interdisciplinarity*, 72.
[707] See for example the different organisation of materials between the 2005, 2007 and 2009 colloquia.
[708] Georgetown-University, "A discussion with Frank Dimmock about his work in Africa in Christian health ministry," Interview Series, no. 31 August (2009), http://berkleycenter.georgetown.edu/interviews/view?author=2357.
[709] For example see the RHA language in use in WHO-CIFA, "NGO mapping". The PIRHANA tool developed for the WHO research in 2006 has been further developed and is now being utilised by a number of different institutions such as some Christian Health Associations, and the Hospice Association of South Africa.

but greater awareness of what the different levels of integration entail will help participants conceptualise both their objectives and the possibility of achieving them."[710] I strongly agree with Klein, and cannot help but wonder what tensions and barriers could have been more rapidly mitigated by the relatively simple strategy of more openly acknowledging within the group that such tensions are an anticipated part of the interdisciplinary collaborative process.

Based on personal experience, I feel that if I had encountered Sjölander's description (or one of the many other more complex models[711]) several years before, and considered such models more actively during this process, that I could have weathered some of the stressful highs and lows of the interdisciplinary collaborative experience with greater aplomb. Of course, as many interdisciplinary studies scholars point out, IDR collaboration is also subject to other factors that are more difficult to manage such as clashing personalities or funding constraints that inhibit the development of the collaborative.[712] Yet it is possible that some of the individuals who began an intense collaboration with the core group, and over time have drifted further out to a communicative relationship, did so as a result of interdisciplinary tension that could have been mitigated by more actively "conscientising" collaborative participants (old and new) to the interdisciplinary strategy and process being undertaken. Furthermore, I believe that further work can be done to anticipate what obstacles the ARHAP collaborative will encounter from this point on, and devise strategies by applying the second-person perspective provided by IDS.[713] This is not to denigrate the instinctive and experience-based interdisciplinary skills of the ARHAP collaborators, to the contrary, most of the individuals drawn to ARHAP are highly skilled and practiced in multi- and interdisciplinary research collaboration, as can be seen from the early commitment to a particular form of interdisciplinary collaboration that has sustained the collaborative through these stages, where many other such programmers have collapsed. Yet that knowledge has been more implicit than explicit (or tacit rather than overt), and has rarely emerged utilising the extensive literature from interdisciplinary studies.

[710] Klein, *Interdisciplinarity*, 73.

[711] See, for example, some of the models described for "transdisciplinary health social science practice" in N. Higginbotham et al., eds., *Health social science : a transdisciplinary and complexity perspective* (Melbourne: Oxford University Press, 2001).

[712] Klein, *Interdisciplinarity*, 122-123.

[713] I do not have the space to continue with this here, but recommend that this is an area for urgent further research.

Developing an ARHAPian Creole

> *…a conscious attempt to integrate material from various fields of knowledge into 'a new, single, intellectually coherent entity' … demands an understanding of the epistemologies and methodologies of other disciplines and, in team effort, requires building a common vocabulary*.[714]

Moving away from the stages of IDR, I turn to a more specific focus on language and communication, which several interdisciplinary scholars have noted is critically important to any interdisciplinary process. From rhetorical and hermeneutical skills, to communicative dynamics in teamwork, language is central to the interdisciplinary project, and communication problems occur in all types of inter- and multidisciplinary collaboration, despite shared resources or shared problems.[715] Duncker describes the development of "interlanguages":

> The construction *of boundary objects* occurs in trading zones to which all participants of the project have access. With the construction of boundary objects, *interlanguages* emerge that allow communication and coordination without fully blown translation. Galison … divides the concept of interlanguages into pidgins and creoles. In the context of multidisciplinary communication … pidgins as basic interlanguages for the sole purpose of facilitating exchange between disciplinarily different groups. Pidgins may be unstable … Creoles play a larger role than facilitating exchange. They cover a wider linguistic area, and they are more complex than pidgins and can serve as 'native' languages (i.e., specific terminology for this intersection of disciplines).[716]

A significant portion of ARHAP's energy has been in spent on language and communication.[717] As Cochrane says, "public health and religious ideals, expressed in a language that joined both, were thus part and parcel of what ARHAP seeks to rediscover."[718] I will not spend significant time describing ARHAP's many linguistic manoeuvres and discussion, but will describe just two of the main terms that have become embedded in ARHAP's discourse: the first, "religious health assets" (RHA) was introduced strategically as a main concept around which the collaboration was built, and the second, "bophelo" emerged as part of the grounded theory approach. These terms have

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[714] Armstrong in Klein, *Interdisciplinarity*, 57.

[715] Klein, "Prospects," 520. See Klein, "Social epistemology", E. Duncker, "Symbolic communication in multidisciplinary cooperations," *Science, Technology, & Human Values* 26, no. 3 (2001): 356.

[716] Emphasis mine. Duncker, "Symbolic communication," 358. For more on interdisciplinary interlanguages and creoles see Klein, "Social epistemology".

[717] For example, reviewing the participant discussions in the various colloquia reports, the issue of language is clearly fore-grounded in every discussion.

[718] Cochrane, "Understanding RHAs".

already been extensively discussed and analyzed by ARHAP scholars,[719] and not wanting to retread that ground, my main interest here is how (using Duncker's terminology) these two terms act as boundary objects in the trading zone between religion and public health,[720] and how they facilitate the emergence of an interlanguage, that enhances communication (without fully blown translation), and has developed into an ARHAP creole.

Cochrane says, "…(ARHAP) was initiated to research and understand … religious health assets to probe how such assets can be drawn into public health systems, and to develop appropriate language for this field."[721] As a boundary object, the construction of the RHA has been particularly successful, becoming part of the natural language within the ARHAP collaborative, visible in the literature, as well as in the broader community of inquiry.[722] I have also witnessed the persuasive power of this boundary object in participatory research meetings in communities in SSA, where we have introduced the term briefly, and not long after have found all participants utilising it enthusiastically. For religious entities and communities, an assets-based approach is seen as a welcome change from liability and needs-focused development.[723] At the level of integration between RS and PH, assets is a concept that allows for engagement from both quantitative and a qualitative perspectives. For ARHAPians, it provides an indication of a broader intention to focus on the strengths of religious communities, rather than on their weaknesses and needs (which has been the main focus of secularization-influenced research prior to this).

The RHA as a boundary object has allowed the ARHAP collaborative to more clearly set the boundaries of the problem they are engaged with and to communicate this problem across disciplinary lines,[724] preventing the collaborative from splitting off in several directions, as this core concept proved to be adequately inclusive and broad enough to incorporate several different research interests. The distinction between tangible and intangible assets has provided an entry point for RS and PH scholars to consider both the more obvious assets (such as health facilities and

[719] I will not provide a theoretical review of these two terms as this has been done extensively by various ARHAP scholars. See Cochrane, "Potential of REs.", Cochrane, "Understanding RHAs", J.R. Cochrane, "Religious health assets in Africa: Seeing healthworlds differently" (paper presented at the American Academy of Religion Annual Meeting, Washington, November 2006), J.R. Cochrane, "Seeing healthworlds differently," *Religion and Theology* 14, no. 1 (2007), Cochrane, "Religion for the 21st century.", Germond and Molapo, "In search of bophelo in a time of AIDS: Seeking a coherence of economies of health and economies of salvation ".

[720] "A boundary object holds different meanings in different social worlds, yet is imbued with enough shared meaning to facilitate its translation across those worlds." McSherry in R. Rorty, "Science as solidarity," in *Commons and borderlands: working papers on interdisciplinarity, accountability and the flow of knowledge*, ed. M. Strathern (Wantage, UK: Sean Kingston Publishing, 2004), 45.

[721] Cochrane, "Religion for the 21st century," 59.

[722] See WHO-CIFA, "NGO mapping".

[723] See Kretzmann and McKnight, *Building communities*, J. Kretzmann and J.L. McKnight, "Assets-based strategies for faith communities," (Asset-Based Community Development Institute of Northwestern University, 2002).

[724] See Repko, *Interdisciplinary research*, 71.

church buildings) as well as the concept that REs and religious communities hold intangible assets (such as faith, hope, love, belonging or resilience).

> ARHAP works on the assumption that what often makes RHAs different from other health associations, institutions or structures lies in what is not visible – the volitional, motivational and mobilising capacities that are rooted in vital affective and symbolic dimensions of religious faith, belief and behaviour.[725]

The concept of the intangible RHA has been significantly useful in describing the "faith factor" to PH scholars and practitioners. Ultimately though, the language of intangible RHAs implies that such assets are quantifiable, and this has become a central challenge as ARHAP moves into "the real beginning", since discovering adequate methods for such measurement that are simultaneously evidence-based and complex enough to handle the insights from an RS perspective, creates a direct confrontation between religious and public health discourses and frameworks.[726]

Klein argues that "one of the lessons from the history of interdisciplinary experiments is that interlanguages develop from acts of integration, not prior to them. Indeed, emergence is one of the core elements of intercommunication."[727] Certainly, the second ARHAP boundary object, that of *bophelo*, is a strong example of an emergent discourse rather than an early strategic decision like RHAs.

Briefly, when an ARHAP team first went to Lesotho in 2004, and began asking communities about religion, health and religious health assets, they were confounded by a basic communication problem, realising that "religion" and "health" did not exist as separate terms in the Sesotho linguistic framework, and were therefore not immediately translatable within the (Western) English discourse in which the questions were being posed (and which are informed by Cartesian and Enlightenment notions of religion and health). In Sesotho, "bophelo" encapsulates the relation between religion and health in a single term, "…there is no differentiation of any significance (which) means that addressing questions of health as if they may be separated from larger religious worldviews is flawed conceptually, and will likely lead to flawed interventions."[728] Health in the Basotho context is a more comprehensive vision of well-being that goes well beyond any

[725] Olivier et al., "ARHAP literature," 11.

[726] The RHA approach has been tied to other linguistic and theoretical developments by ARHAP members, for example the concept of "leading causes of life" as advanced by Gunderson as a strategy to focus on what gives life rather than the dominant public health approaches that focus on the leading causes of death. See G.R. Gunderson and L. Pray, *Leading causes of life* (Memphis, USA: Methodist LeBonheur Healthcare Center of Excellence in Faith and Health, 2006).

[727] Klein, "Social epistemology".

[728] ARHAP, "Appreciating assets," 94-98.

individual person, to incorporate family, community, nation, ancestors and the earth itself, and includes religion within that broad scope. Because of this the team noted that

> …views of health, its character and the related methods for achieving it that most public health policies and biomedical interventions tend to assume or propagate, are frequently dissonant with Basotho views. Because of this, *mis-communication* and hence, misunderstanding, with the consequent likelihood of failed interventions occurs.[729]

Regional variations of bophelo have subsequently been confirmed throughout SSA. Again, I will not engage with this in a great deal more detail, but simply present bophelo here as a boundary object that has emerged into the ARHAP discourse which is now used freely (and seemingly with some relish by non-African scholars), and is tied to number of different conversations within the ARHAP collaborative, such as "healthworlds" and health perceptions.[730]

As boundary objects, both RHAs and bophelo work to create multiple entry points for collaboration and discussion. Of course, both objects continue to be tested and argued as part of a dialectical learning process as the discourse and culture of ARHAP is constructed around such boundary concepts, and the boundaries of ARHAP are constantly redrawn as research interests develop and change.

Creating Common Ground at the Intersection of Religion and Public Health

> *Twining concluded that compatible personalities, common interests, and a common vocabulary were essential for successful interdisciplinary work.*[731]

There are a number of lessons from the ARHAP collaborative experience that could be usefully applied to the broader community of inquiry at the intersection of religion and public health. I will focus here on only three main areas, organised around this argument from Twining, that the essential elements for successfully interdisciplinary team work are compatible personalities, common interests and a common vocabulary.

[729] ARHAP, "Appreciating assets," 94-98.

[730] "…the term 'healthworlds' describes the way in which religion and health are intertwined with each other, impacting on the choices people make about their health." Cochrane, "Religion for the 21st century." See P. Germond and J.R. Cochrane, "Healthworlds: Ontological, anthropological and epistemological challenges on the interface of religion and health," in *Reasons of Faith: Religion in Modern Public Life* (University of Witwatersrand, Johannesburg: (WISER) Wits Institute for Social and Economic Research, 2005), Cochrane, "Potential of REs."

[731] Klein, *Interdisciplinarity*, 185.

A Common Vocabulary

> *Talking together [in the ARHAP colloquium] was an enrichment; yet the rich resource of having people together from many disciplines and with differing capacities was not fully utilized. Interdisciplinary competence must be developed more and more consciously. Give more time for discussion, to engage the issues and insights and bring them down to the ground.*[732]

The previous section has demonstrated the importance the formulation of a common vocabulary is to interdisciplinary collaboration and communication. There are four main lessons that are tied to this concern (which I will unpack): 1) that a common language evolves over time and from sustained collaboration, and is difficult to force through "definitional work"; 2) that a common vocabulary is forged through dialectic and an appreciation of difference, 3) an interdisciplinary intercommunicative action approach is critically important; 4) training for literacy and competence becomes essential.

Firstly, the ARHAP experience has demonstrated the need for *sustained* attention and dialectic on the development of a shared language. Klein says,

> With development, a more stable creole may form … Quality of communication thus becomes an important element … Shared ideas and concepts function, in effect, as 'boundary concepts' with dual capacity … In the work of particular groups, a concept may have both specificity and general meaning that enables connection across heterogeneous groups and sites.[733]

What the ARHAP experience has demonstrated is that short-term "definitional work" is less useful: of the sort frequently mentioned within the discourses of this community of inquiry, where a group of diverse experts meet and redefine certain terms in order to make them more broadly acceptable or inclusive. ARHAP has put considerable energy into the formation of a common vocabulary as an interdisciplinary communicative strategy. Indeed, in the first few years of ARHAP, this definitional work was critical in order to clarify the boundaries of the project and the problems being addressed. For example, in the 2006 report for the WHO, ARHAP authors say, "as with all emerging fields, nomenclature and definition of terms are critical to understanding, replicability, and interpretation of results. The following are offered as the beginning of a new 'lexicon' of

[732] Participant comment, ARHAP, "ARHAP 2007," 153.
[733] Klein, "Social epistemology", 4.

Religious Health Assets, Networks, and Agency."[734] This lexicon was the result of countless conversations, collaborations and dialectical scholarship where terms were introduced, taken up by different scholars within the collaborative (or not), and developed into something new. The ARHAP creole was formed as a result of several years worth of conversations and reiterative thinking as a *few key terms* were re-examined and reworked by different authors.

This key lesson, that a common vocabulary emerges over time as a result of a *sustained dialectical process*, rather than through "definitional work" in which experts sit down and redefine problematic terms, became demonstrated strongly during the ARHAP Better Words project in 2009. Better Words was a research process funded by Emory University under the auspices of their Religion and Health programme and organised by ARHAP, which consisted of a series of workshops held in Johannesburg and Cape Town bringing together RS and PH scholars (from South Africa and the USA). More precisely, it brought together ARHAP members (who were competent in the ARHAP creole) together with a number of scholars who were newcomers to the ARHAP framework. The outcome of these workshops was supposed to be a lexicon based on the discussion:

> …This lexicon, as an outcome of the engagement, brings together a resource that the participants believe will provide a stepping stone for rich and deeper cross disciplinary engagement. The lexicon has been developed to provide a better understanding of the areas of common interest between the disciplines of religion and health and a language of common understanding across the disciplinary boundaries.[735]

I will not describe this particular process or project further, only to say that while it was a fascinating communicative process that produced many useful insights, in my opinion, it has been significantly more difficult to complete the agreed-upon product, a complete new lexicon that adequately "provides a better understanding of the areas of common interest." While there was incredibly rich discussion in the actual workshops, despite the best intentions for this to lead to a transdisciplinary lexicon, the definitional and lexical work afterwards devolved into a multidisciplinary process where most of the different terms were farmed out to suitable scholars for definition (that is, the religious terms to the RS scholars and the public health terms to the PH scholars).[736]

[734] ARHAP, "Appreciating assets," 37.

[735] ARHAP, "Better words," 1.

[736] I am conscious that others in the ARHAP collaborative might not agree that this project "failed" in this way, and present this as my own opinion and reading of this process.

The only terms which showed an integrative perspective were those that had evolved over the long-term ARHAP process (such as religious health assets, bophelo or healthworlds). This particular example demonstrates how difficult it is to force the creation of a common language or vocabulary through "definitional work". Klein reminds us that "ultimately, the domain of interdisciplinarity is the domain of argument. Certain languages are useful, but there is no interdisciplinary Esperanto. Even when established vocabularies are used, they must be shaped to the particularities of the task at hand."[737] Linguistic models cannot be imported, but "evolve in the creation of a trade language … a new first language among a hybrid community of knowers … quality depends on the *richness* of language, not unity or fidelity to a prescribed metalanguage."[738]

This argues that it is important that it is necessary for the broader community of inquiry to strategise for *sustained dialectical communication* if common ground (in this case a common vocabulary), is to be forged. I find that in the intentional drive towards dialogue (of a particular flavour) within the community of inquiry, some appreciation for productive argument, or more appropriately, dialectic is lost. In this community of inquiry, because of the historical context and strongly constructed differences between religion and public health,[739] there is an implicit assumption at play that we are working to *overcome* difference. In contrast, interdisciplinary studies scholars recognise that difference, argument and dialectic are unavoidable, even anticipated. Klein says,

> The reality is that differences matter. Even if negotiated and mediated, differences do not go away – they continue to create 'noise.' Misunderstandings, animosities, and competitions cannot be mitigated or glossed over. They must be taken seriously as attempts are made to spell out differences and their possible consequences. Interdisciplinarity conceived of as communicative action does not trust that everything will work out if everyone will just sit down and talk to each other.[740]

This is a critically important lesson for us to be reminded of within the community of inquiry at the intersection of religion and public health. I will address this issue of difference and dialogue again in Chapter Seven (moving away from the discussion focused mainly on disciplinarity). Repko similarly notes that, "…interdisciplinary studies seeks to integrate knowledge (as it pertains to a particular problem) rather than to unify knowledge … (Integration) confronts differences, looks for

[737] Klein, *Crossing boundaries*, 219.

[738] Klein, *Crossing boundaries*, 220.

[739] As noted in Chapter Five

[740] Klein, *Crossing boundaries*, 221. Klein also provides here a useful description of "interdisciplinary communicative action" in relation to Habermas, describing its particular meaning to interdisciplinary studies.

common ground despite those differences, and, ultimately, produces an interdisciplinary understanding that takes those differences into account."[741] The ARHAP example echoes these statements, showing us that sustained dialectical collaborative conversations, that deal with differences (of perspective, epistemology or personality) in a direct manner, builds common vocabulary and common ground more effectively than polite but short-term definitional-building strategies.

All this points to the importance of a communicative action approach. As mentioned briefly above, ARHAP leaders have consistently foregrounded power dynamics within the collaborative. For example, ARHAP has deliberately worked to balance power in communication by: being conscious of North-South power relations, by foregrounding African scholars, by utilising grounded theory, by working to be as interfaith as possible, by emphasising student voices, by managing tensions between practitioners and academics, by being conscious of gender dynamics, and most importantly, by foregrounding community voices and wisdom, as Cochrane says, "The bias is towards the reconstruction of the political proper 'from below,' through transformative agency exercised via communicative action…[742] Klein says that,

> …transdisciplinarity *implies intercommunicative action*. Transdisciplinary knowledge is the result of intersubjectivity … It is a research process that includes the practical reasoning of individuals with the constraining and affording nature of social, organisational and material contexts … For this reason, transdisciplinary research and practice require close and continuous collaboration during all phases of a research project, what is called "mediation space and time" … or "border work.[743]

I will return to this in Chapter Seven, but the immediate lesson for the broader community of inquiry is that the forging of a common vocabulary is not a simple matter of redefining terms, but is rather a more complex process part of the broader interdisciplinary communicative process, in which power and constraints to communication need to be considered for genuine communication to occur.

All this foregrounds the importance of communicative competence in the interdisciplinary collaborative setting.[744] Repko defines (interdisciplinary) communicative competence as "the

[741] Repko, *Interdisciplinary research*, 20.

[742] J.R. Cochrane, "Health and the uses of religion: recovering the political proper?" (paper presented at the Exploring Religious Spaces in the African State: Development and Politics from Below, University of Edinburgh, Edinburgh, 2008).

[743] R.J. Lawrence and C. Després, "Futures of transdisciplinarity," *Futures* 36, no. 4 (2004): 398.

[744] The phrase "communicative competence" is a clear reference to the work of Jurgen Habermas.

ability to comprehend and translate terminology that is discipline-specific."[745] This is perhaps an inadequately brief definition for a complex and critically important issue, with some IDS scholars arguing that communicative competence is *the* condition for interdisciplinary work.[746] As Vossberg says, "…the unaccountable and often also misunderstandings determine interdisciplinary communication … Consequently, *the development of a communicative competence* in interdisciplinary dialogue is necessary."[747] ARHAP's experience has highlighted the extreme importance of communicative competence amongst its members to facilitate collaboration. This argues for the importance of "boundary leaders" at the intersection of religion and public health for (interdisciplinary) communicative competency, which will be picked up again in Chapter Seven.

Compatible Personalities

I have become comfortable being taken out of my depths.[748]

The next area Twining considers important for successful interdisciplinary collaboration is the need for compatible personalities. While it is obviously more difficult to gain lessons for the broader community of inquiry about the process of developing relationships among difference personalities, there is one main lesson, relating to the character traits of those willingly engaged in the ARHAP collaborative that could prove helpful to the broader community of inquiry.

Consider, briefly, what we might learn from considering the core traits of an "ARHAPian" (those that have willingly taken on the ARHAP tribal culture). Much of ARHAP's discussion has been focused on how to cross the boundaries between religion and public health and how to translate concepts between disciplines (as discussed in previous chapters). Yet there is a key piece missing in this puzzle, and which impacts greatly on the broader community of inquiry. My supposition, is that the individuals drawn into this boundary zone between religion and public health are already inclined towards interdisciplinarity themselves, and that this has particular ramifications for strategising for collaboration in the broader community of inquiry. Mary Baich, says, "for the most part, those who eventually became involved in ARHAP came with years of their own experience in working in collaborative group settings. I think it is safe to say that each of us came with experience working in multidisciplinary settings with issues that were multifactoral."[749] More relevantly, those who became involved in ARHAP not only had *experience* in multidisciplinary

[745] Repko, *Interdisciplinary research*, 337.
[746] See Klein, *Crossing boundaries*, 220.
[747] W. Vosskamp, "Crossing of boundaries: interdisciplinarity as an opportunity for universities in the 1990s," *Issues in Integrative Studies* 12 (1994): 45.
[748] ARHAP, "Better words."
[749] Baich, "Staying the course," 1.

settings, but (I would argue), also had characteristics that made them more inclined towards interdisciplinary and transdisciplinary collaboration.

Repko names fifteen traits and skills common to "interdisciplinarians", the traits being: enterprise, love of learning, reflection, tolerance for ambiguity and paradox in the midst of complexity, receptivity to other disciplines and to the perspectives of those disciplines, willingness to achieve "adequacy" in multiple disciplines, appreciation of diversity, willingness to work with others, and humility; and the skills being an ability to communicate competently, to think abstractly, to think dialectically, to engage in nonlinear thinking, to think creatively, and to think holistically.[750] It is possible to argue that all of the core ARHAP members display all of these traits.[751] I will not expound on each point, but rather focus on just two which have been raised in previous chapters: reflection, and tolerance for ambiguity and paradox in the midst of complexity.

Repko considers *reflection* a key trait of the interdisciplinarian, who is "interested in understanding the knowing process."[752] What is interesting here is that within the ARHAP community, reflection is a key discussion point, as epistemologies and hermeneutics play a substantial role. Repko continues by arguing that *tolerance for ambiguity and paradox in the midst of complexity* is a central trait as:

> Interdisciplinarians accept that sometimes there are irreconcilable differences … they must be able to see all sides of an issue, reconcile conflicting perspectives by creating common ground among them, and live with ambiguity where reconciliation proves impossible … Ambiguity can be unsettling, especially for those who demand quick and clear-cut solutions to problems. Interdisciplinarians know that interdisciplinary understanding is a constant process that never quite achieves a total understanding.[753]

The core ARHAP group is dominated by interdisciplinarians, who find enjoyment and satisfaction in the interdisciplinary enterprise, its risk, learning new perspectives and in its reflection, ambiguity and complexity. As De Gruchy mused in a recent ARHAP conference, perhaps there is a characteristic of people who are able "…to name chaos and uncertainty and be comfortable with it."[754]

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[750] Repko, *Interdisciplinary research*, 42-47.

[751] This supposition is made based on my experience with the ARHAP group, my working in interdisciplinary team research with these individuals, as well as my familiarity with the scholarly outputs of each of the core ARHAP group.

[752] Repko, *Interdisciplinary research*, 42.

[753] Repko, *Interdisciplinary research*, 42-43.

[754] De Gruchy, "Concluding remarks".

Given the inherent complexities and uncertainties of this field of inquiry (as described in the preceding chapters), interdisciplinarians are more likely to arrive here, and to thrive, in comparison with those who have strong single-disciplinary inclinations. This has implications for the broader community of inquiry, as different communication strategies can be implemented to engage those with an interdisciplinary inclination differently from those who are resistant to interdisciplinary method and practice. Klein also speaks of strategies for building a "transdisciplinary attitude," [755] and this could be considered more closely, as having a transdisciplinary attitude certainly makes for easier relations and communication at the intersection of religion and public health. Hubert Markl has emphasised that productive collaboration means "that people do not *have* to talk with one another but rather that they *want* to, and that people know that they have something to share with one another."[756] The ARHAP experience has shown this strongly, that it is not enough to bring individuals together in a meeting to dialogue, but they also have to *want* to communicate.

Common Interests

> *From the earliest conceptions of interdisciplinarity, interdisciplinarians have recognised the need for a common or collaborative language to integrate conflicting disciplinary insights, theories, and concepts … Kockelmans (1979) was the first to use the term common ground, seeing it as a basis for collaborative communication – a common ground … the fundamental element of all interdisciplinary investigation because without it, 'genuine communication between those who participate in the discussion would be impossible.'*[757]

As mentioned above, a sense of shared vision is critically important in creating common ground. ARHAP is representative of a number of disciplinary cultures (not just RS and PH scholars), and one key shared vision around which the collaborative has formed, is that is a concern for health as social justice.[758]

This is expressed in different discourses across ARHAP's literature: as equity, decent care, renewed PHC, health worlds, just health systems, or community participation.[759] This shows the importance of shared concepts above shared terminologies. Social justice is a boundary concept that drawns diverse language together, in other words, the different disciplinary terms are applied, but there is an underlying shared vision.

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[755] Klein, "Social epistemology", 4.

[756] Markl in Vosskamp, "Crossing boundaries," 44.

[757] Repko, *Interdisciplinary research*, 272.

[758] Several of the founding ARHAP members have noted an affiliation with the sentiment expressed in Kim et al., eds., *Dying for growth*.

[759] See Cochrane, "Fire from above," 67.

> Dr. William Foege … has said that public health is the secular arm of theology. In ARHAP we take that formulation seriously. Advancing public health and health systems requires invigorating a language of community, a language that recognises the human interconnection underlying the core social justice values of public health.[760]

What is particularly interesting is that in the ARHAP discourse, a social justice perspective, as common ground, has resulted in calls for the revitalisation of both religion and public health. That is, De Gruchy argues that for religious leaders to gain public health literacy means they will have to "re-learning their mother tongue":

> …the foundational 'doctrine' of public health, that health is rooted in public structures of social justice, and therefore that a commitment to healing is a commitment to engaging in matters to do with access, equity and justice in the economic and political arenas of public life, is at the same time a fundamental theological doctrine. Yet … it is a part of our language that has almost been forgotten. To gain public health literacy may, in this sense, mean re-learning our mother tongue.[761]

Others in turn have argued that "…public health practitioners and theorists have become increasingly aware of the submersion of the founding presuppositions of social justice in their field … (provoking) new attempts to move in another direction.[762] Cochrane also argues that "…one of the disciplines that turns out to be crucial to rethinking health and social justice is religion."[763]

Common ground as a shared interest (or value) in social justice is particularly useful in the context on interdisciplinary communication on HIV/AIDS which has great potential to be divisive (as discussed in the preceding chapters). A justice approach to HIV/AIDS has great potential to act as a firm base for common ground within the community of inquiry at the intersection of religion and public health, as O'Manique points out, "the actual success of the global institutional response to AIDS in Africa … likely lies outside the AIDS-specific multisectoral strategies, but more firmly in the evolution of a just global order."[764] Of course, stating social justice as a common interest and an

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[760] D.A. McFarland and J.R. Cochrane, "The agency of religious health assets in strengthening health systems" (paper presented at the Ethics and Africa Conference, University of Cape Town, May 2006). I find this article a particularly interesting example of interdisciplinary collaboration being co-authored by a professor in a global health department (specialising in public health economics) and a professor in religious studies (specialising in theological hermeneutics and religion and society)

[761] De Gruchy, "Mother tongue," 2.

[762] Cochrane, "Fire from above." Paul Farmer has been influential in arguing for a reassessment of health in terms of social justice. See P. Farmer, "Social inequalities and emerging infectious diseases " *Emerging Infectious Diseases* 2, no. 4 (1996), Farmer, *Infections*, Farmer, *Pathologies of power*.

[763] Cochrane, "Fire from above," 91.

[764] O'Manique, *Neoliberalism*, 176. (Omanique 176)

area of common ground is only the first step. Learning to move forward through effective communication into praxis which is informed by a social justice perspective is then the next challenge for the collaborative, and the community of inquiry as well. Interdisciplinary communication and collaboration remains a useful vehicle for gathering momentum towards such broader aims and intentions.

Towards Interdisciplinary Collaboration

> *At the outset, collaboration was not a stated goal of our way to work together, but in fact, it became the way that we worked together. We believe that for this effort it is the most effective way to work. Collaboration is the most intense partnership type…*[765]

On returning from the 2009 ARHAP Conference in Cape Town, Marshall wrote in a news article that the meeting had brought together "… the kind of motley gathering that does give transformation a chance: ministers, medical doctors, theologians, epidemiologists from all over…"[766]

ARHAP is indeed a deliberately "motley gathering" that has progressed and developed as an interdisciplinary collaborative despite being faced with the same communication gaps and barriers to effective dialogue that are felt in the community of inquiry at the intersection of religion and public health. As Marshall discovered, it is the diversity and complexity of the collaboration between "motley" individuals and perspectives that can provide real transformative power.

Considering this collaboration through the lens of interdisciplinarity provides a useful perspective that has not been adequately addressed, and which could have assisted this collaboration significantly if it had been applied sooner. There are also substantially more areas of investigation that could be of significant use to improving future collaboration and communication. Repko notes that there is an emerging field of inquiry around collaborative research, and this could be usefully applied here.[767]

There are two key lessons from the discussion that should be taken forward into the broader community of inquiry. Firstly, reviewing ARHAP in this way provides an understanding of the importance of taking a long-term view to interdisciplinary collaboration. The real successes of ARHAP have been developed over time, through countless conversations, arguments and discussions, and in the development of relationships. Individual ARHAPians have been transformed by this process, but it has been a subtle and slow transformation which has not received adequate

[765] Baich, "Staying the course."
[766] K. Marshall, "Alliances for health," *Newsweek*, July 2009, 2.
[767] This seems to be emerging from the field of psychology. See Repko, *Interdisciplinary research*.

attention and is a transdisciplinary success that has been somewhat overshadowed by continued barriers and conflicts, which must be recognised as inherent parts of the interdisciplinary process. Duncker notes,

> Longstanding and repeated cooperations … develop hybrid repertoires that have been found to last beyond single projects. This means that with enough time and a sustained multidisciplinary network, multidisciplinary cooperations are more likely to succeed … short-term multidisciplinary cooperations will probably continue to struggle and disappoint. In the light of these experiences, it seems advisable that multidisciplinary cooperations should not be planned as one-off events but need to be embedded in longstanding networks of repeated similarly multidisciplinary cooperations.[768]

Repeated once-off meetings with different collections of individuals, and different institutions, are unlikely to result in effective interdisciplinary cooperation and collaboration. In light of this, and ARHAP's experience, it should be argued that it is important that, rather than a once-off event (in response to whatever immediate need there is, be it malaria or HIV/AIDS), collaboration within the community of inquiry at the intersection of religion and public health be understood as a long-term process.

The second key lesson is the importance of dialectic to the interdisciplinary process, the ARHAP experience giving impetus to the argument that common ground and common language is not developed by glossing over arguments or rapid definitional work, but rather in *appreciating* difference, in constantly interrogating difference through dialectical argument. This will be the focus of Chapter Seven.

[768] Duncker, "Symbolic communication," 382.

Chapter Seven. Mapping Respectful Dialectic

> *There is an abundance of opinion (scholarly and otherwise) but a scarcity of integrative understanding of the many complex problems that bedevil our society and characterise our world. Interdisciplinary study and the integrative process are not about who can win the argument but about who can bring together the best ideas of all stakeholders to get the job done.*[769]

This final chapter begins with a fictional narrative: a story of a meeting held within the community of inquiry at the intersection of religion and public health, constructed as an amalgamation of the many such encounters I have witnessed over the past five years.[770]

A group of experts arrived at a hotel conference room and sat down around a large rectangular table. These experts were representatives of a variety of interests and institutions, all masters of their various discourses with impressive experience in their chosen field of practice. They have been flown to this place with support from (say), a Christian development agency based in London, The Joint United Nations Programme on HIV/AIDS (UNAIDS) and the World Bank. Representatives of the three organisations funding the meeting had provided names of potential participants from their personal networks, and this had been whittled down to the required number by the administration office. The participants' names and organisations were printed on their name tags, which was useful since they had never met each other before, even though they had all been engaged in similar work for some years and had all attended a number of similar meetings in the past few years. On this occasion, they had been brought together for one day to dialogue on what they all agreed was a critical problem worthy of their time and travel away from their homes and work: to inquire about the role of religion and the faith community in HIV/AIDS intervention and to suggest strategies for policy change in Africa and to improve collaboration.

The meeting organisers introduced the plan for the day and informed participants that the person sitting at the back of the room would be taking notes and writing a report of the proceedings which would be available on the organising institution's website. The organiser then asked participants to briefly introduce themselves and to also mention what they had brought to the meeting so that a programme could be compiled for the first half of the morning.

First to stand up was a representative of the UN family (say the WHO), who was based in Geneva. In her introduction, the WHO representative jokingly mentioned that she had also been a religious

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[769] Repko, *Interdisciplinary research*, 277.

[770] The characteristics (organisational, personal, gender) are therefore not representative of any actual person or organisation. This is intended rather as a demonstration which the discussion that follows can interrogate.

leader in a previous career, and had worked for several decades in community health organisations before she had gone to work for the UN. On the table in front of her, she had a draft copy of the speech she could share only verbally with the participants (since it had not yet been cleared by higher powers) and several related research reports from the WHO, UNFPA and UNAIDS publications offices.

Next to stand up was a public health professional and epidemiologist, an American, who was connected to several different research projects in Africa. He did not mention to the group that in his private life, he was a regular member of a religious community, nor did he point out that he had spent much of his professional life actively campaigning against religion, having worked with the CDC on public health campaigns against smallpox and polio in which he felt that religious leaders greatly obstructed otherwise promising intervention plans. On the laptop lying on the desk in front of him were several datasets, most of which did not have any religious-specific measures or indicators, apart from a few that addressed the religious affiliation of some populations in Africa.

Seated next to the epidemiologist was an African religious leader, a powerfully erudite and well-travelled Catholic bishop representing the faith community in Africa, who had conveniently been travelling from Uganda to another meeting in Geneva at the World Council of Churches (WCC), so this meeting had not been far out of his way. He brought with him a sermon he was preparing for his return to his congregation, a draft policy document from his Catholic Bishops Conference on the churches' responsibility in a time of HIV/AIDS and a report on Catholic ARV provision in SSA.

The next person to stand up was a soft-spoken German medical doctor who had worked in African mission hospitals for several decades and currently represented both a Lutheran international agency, and a national faith-based health network which coordinated hundreds of hospitals and clinics. He brought with him a PowerPoint presentation with some graphs showing the range of hospitals and clinics and a report produced by the NFBHN showing the strain religious organisations were under in the current funding situation and human resource crises.

The sixth person to introduce herself was a religious studies scholar from a British university, with a research interest in African indigenous religions and a side interest in liberation theology. She brought with her several nearly finished academic articles on religion and HIV/AIDS which she planned to publish in a religious academic journal. She mentioned that she was involved with several HIV/AIDS programs in SSA, which she visited once a year with postgraduate students so that they could get field experience.

Beside her was the head of the national HIV/AIDS coordinating body of (say) Botswana, who was also an advisor to the Ministry of Health. He brought several policy documents and a national HIV/AIDS assessment report.

The eighth participant was the CEO of a multinational Christian development agency which was running (among other things) HIV/AIDS programs in several SSA countries, and who had brought several glossy copies of research reports published by his organisation which included case study descriptions of different programs engaged in HIV/AIDS work.

The CEO was interested to discover that his multinational agency was running a program in the same village that was the home of the local Zambian community member seated beside him. The community member had been selected by the organisers to represent grassroots community organisations, and she mentioned in her introduction that she was both a religious leader in her community (although she did not mention that her charismatic church group did not have a building in which to congregate), and was part of an initiative being run by her church group that were cycling HIV/AIDS patients to and from the Anglican hospital several miles away, providing food parcels to community members, and visiting the most frail at home. She was on her way back from the international HIV/AIDS conference, where she had been a grassroots representative, and therefore had a poster prepared which included some photographs of an orphan support group in her community and she told the meeting a powerful narrative of hope and horror in her community.

Finally, seated strategically on the opposite side of the table from the bishop, was an Islamic leader from Mali, who briefly introduced himself and mentioned the work that was ongoing to educate religious leaders on HIV/AIDS in his country. He brought with him a booklet that had been published on interpretations of HIV/AIDS according to Islamic law.[771]

Once the introductions were over, the meeting began with several presentations after which the group was encouraged to dialogue respectfully together. During the day there was an exchange of information, and the facilitator was careful to make sure that each participant was given a chance to speak and respond to the others – although not all voices would eventually emerge in the meeting report. Three main topics were discussed: firstly, the need for REs to be better recognised by the global health community, to "get on the map" and "come to the table". Secondly, the need for greater recognition of the valuable assets the faith community were holding and could apply to HIV/AIDS intervention, and thirdly, the need for more culturally sensitive HIV/AIDS interventions

[771] These descriptions are stereotypes and (carefully) not representative of any person I actually know.

that recognised how important religion was to communities in Africa. There were no violent outcries during this meeting. The Islamic leader and Catholic bishop did not argue theology over the table, nor did the epidemiologist and religious studies scholar glare. The community leader did not demand funds from the multinational organisations, and the WHO representative was exceptionally polite and on several occasions asked the opinion of the community member.

There were some obvious problems with the different languages and vocabularies being wielded at the table. The epidemiologist was careful not to raise his eyebrows at the bishop's use of the term impact. The community member was tempted to put up her hand and ask what was meant by religious health asset, but did not, and was relieved when the religious studies scholar did.

The organisers were relieved at how the dialogue had gone, that apart from an obvious difference in vocabulary, had resulted in the group seeming to agree that the role of religious entities in HIV/AIDS was of critical importance and required further engagement and improved collaboration. At the end of the meeting, the bishop was asked by the organisers to give an interfaith prayer of thanksgiving which all the participants respectfully listened to, after which everyone shook hands and some business cards were exchanged. A few weeks later, the meeting organisers published a draft report of the meeting events, emailed it to the participants, posted it on their website and released a few media articles about the meeting.

This meeting has been my metaphor for the community of inquiry that has been the focus of this study. Each time that I have worked to parse out a particular dynamic (between religion and public health, between cultures and disciplines) I have held this meeting in my mind as the litmus test as to whether such a focus had legitimacy in face of the commonstance confrontations of multiple discourses and dynamics, often within the same representative.

Dialogue such as this is occurring with increasing frequency at the intersection of religion and public health, especially in the context of HIV/AIDS, driven by multisectoral and interdisciplinary impetus. With the emergence of religion into public life and into the view of public health, considerable funds and energy have gone into the organisation in such events. Dialogue is a key strategy in this context and looks to increase in importance, for example, the new UNAIDS-FBO Partnership Strategic Framework prioritises dialogue, the first prioritised action being: "UNAIDS partners give priority to facilitation of dialogue between national AIDS authorities, religious leaders, FBOs, local faith communities and networks of people living with HIV on comprehensive

approaches to HIV prevention."[772] These dialogue events have sometimes taken the shape of a conference, sometimes a meeting convened for interdisciplinary research purposes, and at other times as an advocacy process to improve collaboration. Ultimately, however, these meetings have held in common a desire to bring together disparate groups of individuals to dialogue together on religion and public health (and most frequently on HIV/AIDS), and to improve partnership and collaboration.

Based on a review of the meeting reports of some of these events and bolstered by my own experience, it is possible to say that such meetings are generally characterised by "polite dialogue". That is, while an individual might express a view in a different "language," this is not the context in which deep-seated suspicions and distrust are generally aired. In fact, within the community of inquiry at the intersection of religion and public health there is an increasingly evident culture (and discourse) of "polite dialogue". In the last three years, SSA religious leaders (of all varieties) are increasingly being invited to participate in global health meetings, and to be part of government and civil society multisectoral groups.[773] Building on the strong parallel movement towards interfaith dialogue and public health and development strategies that are increasingly focusing on participatory strategies, there is generally a strong intentionality towards participation and dialogue. In the broad secular literature on HIV/AIDS in SSA, religious leaders' opinions are increasingly shown, and case studies profile religious HIV/AIDS programs.[774] The emerging literature speaks of the strengths and assets of REs more than the stereotyped weaknesses, and there is a huge effort and expense being put towards dialogue with REs and religious leaders.

Yet, as discussed in the previous chapters, despite increasingly frequent polite dialogue, miscommunication continues to bedevil the community of inquiry at the intersection of religion and public health, particularly around HIV/AIDS. In Chapter Two it was noted that the religion-public health context was moving from a phase of increased interest, towards a new phase of adult relationship, where the excitement of the new is beginning to show signs of wear, and increasingly pointed questions and demands for "real evidence" are becoming common. I therefore return to my initial concern about the *effectiveness* of the interdisciplinary communication occurring at the intersection of religion and public health in the context of HIV/AIDS, and ask what are the

[772] UNAIDS, "UNAIDS-FBO partnership," 16. Another interesting text is the EAA Pre-conference delegates guide which includes three pages on the importance of dialogue, see EAA, "Faith in action now!," in *Ecumenical Pre-Conference on AIDS* (Mexico City, Mexico: Ecumenical Advocacy Alliance, 2008).

[773] See Haddad et al., "Potential and perils."

[774] I do not mean to imply that there are no longer volatile confrontations between religious and secular individuals, but that within this community of inquiry, and particularly in the context of collaborative meetings in which public negotiation occurs, there is a strong discourse of polite dialogue.

underlying suspicions and tensions that continue to hamstring even seemingly polite dialogue, and what are strategies for overcoming such obstacles.

The previous two chapters have held to a focus on the academe and on scholarship that, while necessary, did not address the core concern of this thesis, the complex and simultaneous confrontation of multiple cultures and discourses within this community of inquiry. Said differently, while I have worked to parse out some of the different discourse and power elements that occur at such meetings, such as the confrontation between disciplinary cultures, or the battles for power over naming and representation of the religious response to HIV/AIDS, it is necessary to be reminded that in the everyday communication at the intersection of religion and public health, such culture, discourse and powers, come together violently around the same table.[775] It is this intersection of many discourses and cultures that the individual must negotiate, and which polite dialogue covers, and in this context that decisions must be made and collaboration built. In Chapter One I mentioned Wodak's useful discussion of the *Disorders of Discourse*, which

> …result from gaps between distinct and insufficiently coincident cognitive worlds: gulfs that separate insiders from outsiders … and elites from normal citizens uninitiated in the arcana of bureaucratic language. They are traceable not only to the use of unfamiliar professional or technical jargon, but also to the immanent structure of the discourses themselves … the result is a so-called 'frame conflict': worlds of knowledge and interests collide with one another, and those who possess linguistic as well as institutional power invariably prevail.[776]

My interest here is in remapping some of these instances of frame conflict that appear in meetings such as the one described above. In this chapter, I will return to this broader perspective and consider the communication and collaboration that is occurring between the community of inquiry, and the object of their gaze, the religious entities and communities who are receiving such increased interest from the international community.[777] I will address this in two parts. Firstly, I draw in the various threads from the preceding chapters as examples of some of the unspoken "disrespectful dialogue" occurring in such meetings, broadly utilising Habermas' framework of

[775] That is, scholars of different flavours, practitioners of different sectors, community leaders of different sorts, different nationalities and utilizing different information to make their arguments.

[776] Wodak, *Disorders of discourse*, 2.

[777] My intention is to return to my earlier considerations of power dynamics in the communication process, probing differences and suspicions at play in the encounter between the community of inquiry and the objects of inquiry. The goal is not to repeat widely known scholarship on power and knowledge dynamics in research on human subjects (between researcher and the researched), but rather to ask specific questions about how these dynamics affect collaboration at the interface between religion and public health more broadly.

communicative action.[778] I will assess the power dynamics that require consideration if we are to work towards "respectful dialogue" (as communicative action) which much of ARHAP's work has noted is essential.[779] The second part of this chapter will then discuss how we might better equip "boundary leaders" entering this community of inquiry to manage and facilitate such respectful dialogue, ending this chapter with a focus on praxis.[780]

Polite Dialogue and Distorted Communication around the Mapping Table

> *…the large gulf between faith and development worlds in developing countries: in particular, secular and religious organisations simply do not understand their respective vocabularies, networks are feeble, and they tend to expend energy in debates that too often pass like ships in the night…*[781]

When he describes the importance of getting religious entities on the global health map, ARHAP researcher Frank Dimmock likes to use the phrase, "if we are not at the table, we may end up on the menu."[782] What I would argue here is that being, quite literally, at the table (or on the map) does not mean religious entities will no longer get eaten, since even polite dialogue can be distorted communication that governs what can and cannot be said, or what form collaborations take as a result of these meetings.[783] As Romm says (while considering Habermas' communicative action), "…to uncover areas of distorted communication in society. It is necessary to become attuned to the way in which genuine communication (or discourse) is being stifled in society. It is thus crucial to engage in a critique of current meaning-construction in society."[784]

One way of addressing this is to consider the hidden transcripts of such a meeting. As Scott says,

[778] See J. Habermas, *The theory of communicative action: reason and the rationalization of society*, trans. T. McCarthy, vol. 1 (Boston: Beacon Press, 1984), N. Romm, "Critical theory as a way to understand development," in *Reconstruction, development and people*, ed. J.K. Coetzee and J. Graaff (Johannesburg, South Africa: Thomson Publishing, 1996).

[779] See ARHAP, "Appreciating assets.", Haddad et al., "Potential and perils."

[780] The concept of "boundary leaders" has been conceptualised by ARHAPian, Gary Gunderson and further advanced by Mimi Kiser and colleagues at Emory University. See Gunderson, *Boundary leaders*, M. Kiser, "Boundary leaders in a complex world: seeing and leading in 'the whole'," in *When religion and health align: mobilizing religious health assets for transformation* (Cape Town, South Africa: African Religious Health Assets Programme, 2009).

[781] Marshall and Van Saanen, *Development and faith*, 10.

[782] Dimmock in ARHAP, "When religion and health align: mobilizing religious health assets for transformation," (Cape Town, South Africa: African Religious Health Assets Programme, 2009).

[783] I find Romm's reading of Habermas helpful, as she says, for Habermas, communicative discourse "… is distorted in favour of representing the interests of the dominant class … the arguments and viewpoints of the dominant class come to dominate all social conversation. The norms of correct behaviour in these societies thereby already express an unequal relationship between the people, for not all people have participated equally in the construction of these norms." Romm, "Critical theory," 200.

[784] Romm, "Critical theory," 205.

> If we were to proceed in terms of Habermas' analysis of the 'ideal speech situation', the hidden transcript would represent the whole reciprocal conversational reply of the subordinate … Habermas excludes, by definition, all 'strategic' action and dominated discourse from the ideal speech situation, and hence from the search for rational consensus. What domination achieves, in this context, is the fragmentation of discourse…[785]

There are a number of fruitful ways to analyse distorted communication in such a context.[786] However, in keeping with the exploratory pace of this study, I will utilise (as a shortcut) the hidden transcripts identified through ARHAP participatory research, which deliberately created the space for such unspoken tensions to be verbalised in a safe and anonymous research space, and which therefore provides us with some clues as to the discourses hidden in the more common interdisciplinary and multisectoral meetings as described above.[787]

The most obvious distortion is between the powerful community of inquiry (all these public health institutions, academic institutions, governments and powerful individual representatives) and the object of their inquiry, religious communities and religious entities. As many critical theorists have pointed out, no researcher is free of the power implications of this relationship, even those who utilise participatory research methods which attempt to rebalance some of this power.[788]

> Frequent reference to the 'dialogue model' of communication can be found in the participatory development literature which suggests a similarity between concepts of 'participation' and 'dialogue'. 'Dialogue' is seen as a kind of communication context that enables participation. The problem with this model is that it sees dialogue as a 'means' through which participation should proceed, but in reality the community development situation almost implies that at the outset there will be different capacities for engaging in dialogue amongst participants.[789]

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[785] Scott, *Domination*, 38.

[786] As a recommendation (as mentioned previously), it would be exceptionally useful to complete an in-depth analysis of a single meeting such as the one described above, utilizing a close discourse analysis, or applying the lens of intercultural communication analysis to gain a more in-depth understanding of the cultures and power dynamics influencing communication.

[787] In the ARHAP research utilized here, a deliberate strategy of separating out the REs from the health and government partners, and allowing for anonymity, so that discussion could move more freely. This is not to say that such research was not affected by other issues of power, but that it provides useful hints towards transcripts hidden in the other collaborative contexts. See ARHAP, "Appreciating assets," Ch2, Haddad et al., "Potential and perils," Ch1.

[788] See Kelly and Van der Riet, "Participatory research."

[789] Kelly and Van der Riet, "Participatory research," 166.

Whether community voices are brought to the table through the medium of participatory (narrative) research,[790] or whether community representatives are physically brought to the table, the well-acknowledged power structures in place prevent them from speaking or being heard. To clarify the point: while the community of inquiry might politely sit and listen to the community voices present, actually acting on community wisdom remains a challenge.

In mapping religious health assets, the distorted power can clearly be seen in the difficulty of moving this wisdom from the church halls in Zambia to the halls of power in Geneva. Participatory approaches are useful for respecting community wisdom, and for balancing power, but as the description in the Preface and the discussion in Chapter Four showed, as with broader intentions towards social justice, valuing community wisdom remains a challenge. We can politely listen to community voices and allow them to name their religious assets, pointing out different formations for which we do not yet have a name, but if that does not mesh with already established typologies (of powerful global health institutes or of academic definitions), community voices are silenced, and we return to looking for and communicating about what we expect to find.

In describing Habermas' communicative action, Romm argues that "any 'solution' has to be grounded in a respect for the cognitive involvement of all those who will be affected – so that the people concerned do not merely become (or remain) onlookers in the development process."[791] And while this is a sentiment with which many within the community of inquiry agree, in practice, REs remain onlookers as their assets are being charted onto global health maps.

In polite dialogue, the representatives of REs are not speaking of their fears of being treated instrumentally and of being sought out only for the exploitation of their assets.[792] Although they might increasingly be invited to the table, as one participant noted, "FBOs are not given the space to debate things and to participate … So they are sort of relegated to … mopping the floor … We're a sort of a lesser among equals."[793]

In participatory research (when not facing funders and government representatives across the table), religious leaders and RE managers speak of deep fears of being abused by funders, and of distrust and suspicions that could only be disclosed under condition of anonymity, when funding and collaboration are not entailed.[794] This generally remains a hidden transcript in meetings such

[790] Such as ARHAP's which is based on such theories as Freire's dialogic and anti-dialogical action. See Freire, *Pedagogy*.
[791] Romm, "Critical theory," 215.
[792] See Chapter Three
[793] Participant response, Schmid et al., "Contribution of REs," 11.
[794] See Haddad et al., "Potential and perils."

as the one described above, as the risk of offending potential funders (for one thing) hampers communication about real fears and concerns.

REs also do not usually express their fear that they are only invited to the dialogue as tokenistic representatives of the faith community. Tokenistic involvement is not limited to REs but is a growing concern in the HIV/AIDS multisectoral community generally. Tiendrebeogo et al note that religious organisations and leaders contributed to the United Nations General Assembly Special Session on HIV/AIDS, and consider this an indication evidence of their increased engagement at the highest levels.[795] Although it seems that religious leaders are increasingly being invited to multisectoral policy discussions, "little academic research has been undertaken as to the influence of religious leaders on the health-relating policies and consultations that they do attend or advocate for. That is, while there are news articles delineating who is at meetings, and sound bites from religious leaders, there is little academic material on religious leaders' influence on public health policy."[796] In 2008, the *United Nations High-Level Meeting on HIV and AIDS* ended with civil society groups (including religious organisations) complaining over the lack of true partnership with governments in the fight against the epidemic. "The involvement of civil society in official national delegations must be effective, not just tokenistic … real partnership between donors, governments, civil society, UN agencies and affected populations requires a balance of power in making decisions."[797]

As the brief Malawi miracle cure dialogue in Chapter Three shows, REs are unlikely to express their real beliefs (such as the belief that faith can cure HIV/AIDS) in meetings that are dominated by public health discourse and bio-power. They are generally savvy to what is expected of them in such meetings, and are unlikely to express contradictory statements in such a context, or engage in dialectical conversation as to the hermeneutics of "healing". The fact that they generally no longer speak of such fundamentally different knowledges, does not lessen the "frame conflict", but rather transform what were once public transcripts into hidden transcripts, which still continue to have an effect on communication and collaboration even if they are no longer spoken of so loudly.

Similarly, inter-religious conflict is rarely apparent on the surface of these discussions. For example, in Malawi, participants spoke of strong collaboration with government and other faith groups "My response is *very* positive … of course there are differences … but it is a positive approach … we

[795] Tiendrebeogo et al, *Faith-based Responses,* 1-3.

[796] Olivier et al, *ARHAP Review*, 41.

[797] PlusNews, "Greater involvement of civil society has been identified by the UN as a critical strategy to combat AIDS," *PlusNews*, 13 June 2008. See Haddad et al., "Potential and perils," 29-30.

won't fight each other, we work in partnership."[798] However, later in the day, other participatory exercises showed how few were actually working well together, and what tensions (and even suspicions) were prevalent between different REs, especially towards traditional religions, Islamic groups or Pentecostal groups.[799]

I have suggested above that the continued difficulty to find consensus on the FBO terminology is indicative of the power struggles that are ongoing in such polite dialogue. As discussed in Chapter Four, religious leaders and entities rarely openly question the drive towards mapping religious entities on global health maps. Yet in participatory research, REs and religious communities convey a significant apprehension at the underlying intentions for global health mapping. The rapid re-emergence of religion into the public health field of vision has not allayed fears and decades old strategies of working separately from government and secular management. The hidden transcript here emerges as RE's fears that the mapping will expose them in a variety of ways, and they quietly ask "whose map" they are being placed on, and what they mapping will mean for their assets and for their mission. In a safe space, they express sophisticated fears about how being mapped might change them, and what power dynamics lie under mapping and naming.[800]

The broad assumption in the dominant culture of this community of inquiry is that global mapping is an obviously positive strategy that will benefit REs by channelling funds towards them. If you remember, I noted earlier that Karpf said, "…the truth is, if you are not on the map, then in the eyes of the donor and Member states, you do not exist! If you do not exist, you are not accountable or known then invited to the health services table…"[801] Yet Karpf ends this address saying,

> Critical to a more creative and productive WHO-FBO relationship, for attaining MDGs and furthering the public's health, is understanding that the motivations and organisation of FBO religious health assets/religious entities are different than that of WHO. Whereas the delivery of health services is a joint goal, how and why they are attained differ. Mutual understanding of each others' drivers and methods are key to advancing potential for our joint work and building trust.[802]

[798] Haddad et al., "Potential and perils."

[799] Haddad et al., "Potential and perils." See Schmid et al., "Contribution of REs," 113.

[800] See ARHAP, "Appreciating assets.", Haddad et al., "Potential and perils."

[801] Karpf in WHO-CIFA, "NGO mapping".

[802] T. Karpf, "Health mobilization: the urgency to engage religious health assets," in *NGO mapping standards describing religious health assets* (Chateau de Bossey Conference Center - Geneva, Switzerland: World Health Organization (WHO) and the Center for Interfaith Action on Global Poverty (CIFA), 2009).

I cannot agree more, and part of understanding those differences, is striving to hear the hidden transcripts and understanding the motivations and drivers (in this case concerns and suspicions) that are different to those of the WHO.

In ARHAP research, communities have come out strongly saying that what are important to their lives are not only the religious health facilities, but also the multitude of other complex, nameless and poorly understood religious interventions into well-being.[803] Furthermore, communities in SSA perceive REs to be "…contributing to health, well-being, and the struggle against HIV/AIDS in both tangible and intangible ways, and it is this combination that distinguishes them and gives them strength.[804]

Yet in the polite dialogue of the community of inquiry, power pushes us to keep focusing on what is more readily visible, and what is more similar to the secular. Even though religious communities have pointed out the real assets that can be of use for a renewed PHC (for example), and have shown us where the real mixing of tangibles and intangibles lie, where the real list of strengths such as reach, accessibility and trust can be found; because those of us in the community of inquiry continue to struggle to "translate" these lessons into normative approaches, we continue to silence this wisdom.

There are many other obvious examples of power distortions in this context that I have mentioned previously, such as the tension between Northern and Southern institutions and individuals. As mentioned earlier, several scholars have noted the ways our knowledge of African AIDS comes to us through a filter of Western and even colonial presumption "or through highly synthesized and depersonalized cultural representations …"[805] Any discussion on Africa based in Geneva is indicative of such power dynamics and assumptions about knowledge. Another obvious power dynamic that has not been extensively addressed here is that which occurs between genders (certainly an issue in any communication involving male religious leaders). There are also acknowledged power dynamics between practitioners and researchers, with different power flows and knowledges jostling for dominance in this space.

The meeting at the intersection of religion and public health is clearly a point of intersection between a number of dominant discourses and powers which makes it difficult for genuine dialogue, communication and collaboration, since powerful narratives (cultural, institutional or academic) limit what can and cannot be said, making such dialogue polite, but also less effective.

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[803] ARHAP, "Appreciating assets," Ch5.
[804] ARHAP, "Appreciating assets," 126.
[805] Setel, "Comparative histories," 6.

Towards Respectful Dialectic

> *It is incumbent upon religious and public health leaders to undertake respectful dialogue and mutual engagement to make a difference.*[806]

A great deal of energy and expense is being put into increasing polite dialogue, with little more than increased dialogue fatigue to show for these efforts.[807] As I said in the introduction, in this time of crisis, every moment of ineffectual dialogue is a critical problem. My argument here is that polite dialogue does not necessarily lead to improved communication and collaboration. I certainly do not intend that participants be encouraged to start shouting at each other, or violently arguing their point. I do, however, feel a distinction must be made between "polite dialogue" and "respectful dialogue". [808] The ARHAP mapping report, concludes with the following words, arguing for the need for respectful dialogue:

> Our broader work in ARHAP and the findings of this particular research project have reinforced our belief that religious leaders and public health practitioners have a responsibility to engage in *respectful dialogue*. The commitments of the best of religious imagination and of public health policy are to a world in which health and wellbeing are the experience of all, particularly those living on the margins of society, and today this means those infected and affected by HIV/AIDS. This dialogue is therefore essential, not for the sake of polite conversation, but for the sake of decency, universal access and the development of communities … What is clear, however, is that this dialogue needs to be undertaken in a way that is respectful of all partners, *and this does mean dealing with the suspicions on both sides.* Given the way in which religion and health are intertwined in Africa, public health practitioners need to ask: 'How can we expect to understand and help people if we miss the very thing that they consider to be the most important thing in their lives even if it may not be so in our own?' At the same time, religious leaders need to ask: 'How can we expect to make a real difference in the health and wellbeing of our communities, if we do not draw on the wisdom and experience of those dedicated to and

[806] ARHAP, "Appreciating assets," 132.

[807] Referring to the dialogue fatigue mentioned in Chapter One.

[808] I must also acknowledge the work on respectful dialogue by ARHAPian, Steve de Gruchy, which sparked much of my thinking for this chapter. His work on is partially summarized in the brief concept paper: S. De Gruchy, "Taking religion seriously: some thoughts on 'respectful dialogue' between religion and public health in Africa," in *ARHAP International colloquium 2007* (Monkey Valley Resort, Cape Town, South Africa: African Religious Health Assets Programme, 2007).

trained in these fields?' A mutual appreciation of the assets held by both the religious and public health sectors is necessary.[809]

The main differences between polite and respectful dialogue are twofold. Firstly, respectful dialogue carries an intentionality to address communicative power imbalances, since it is clear that keeping fears and suspicions hidden may make for polite dialogue, but does not facilitate genuine communication and improved collaboration and instead results in the much experienced miscommunication, frustration and dialogue fatigue. Secondly, respectful dialogue means directly addressing such concerns and suspicions from both sides, rather than dialoguing them into silence. Respectful dialogue means conversing about difference (or in Karpf's terms, understanding the different motivations and drivers),[810] and a more appropriate phrase is therefore an interdisciplinary communicative strategy of "respectful dialectic", which I will now unpack in more detail.

In Chapter Six the matter of interdisciplinary intercommunicative action was raised. McKay and Romm, when speaking of the possibility of Habermas' utopian ideal of communicative action (as the "ideal speech situation" or the "unlimited community of communication"[811]) argue that "emancipatory potential is enhanced when people strive towards ongoing conversation between alternative positions (rather than striving towards a consensual position).[812] If an unlimited community of communication is a utopian ideal at the intersection of religion and public health (and even more so on the topic of HIV/AIDS in SSA), what McKay and Romm suggest is closer to a strategy for "dialectic" rather than polite dialogue.

Dialectic has been raised several times in preceding chapters. In its most basic understanding, dialectic is a method of argument, a discourse between two or more people who hold different ideas or positions "…and wish to persuade each other. The presupposition of a dialectical argument is that the participants, even if they do not agree, share at least some meanings and principles of inference."[813] I find this a more suitable meaning and strategy for interdisciplinary and multisectoral communication in this particular context than dialogue (of the sort discussed

[809] Emphasis mine. ARHAP, "Appreciating assets," 130-131.

[810] A greater connection can also be made with Inter-religious dialogue, which Peterson notes, "Within theological and religious discourse, the debate around inter-religious dialogue shares the greatest analogy to the practical question of holding together the difference of particularities in the search for common ground with 'the religious other'." Peterson in J.R. Cochrane and B. Klein, *Sameness and difference: Problems and potentials in South African civil society* (Washington D.C.: Center for Philosophy and Values, 2000).

[811] See Habermas, *The theory of communicative action*, Romm, "Critical theory."

[812] Romm, "Critical theory," 201.

[813] Fromkin, *Language*, 56.

above).[814] In this context "respect" means to see the other, to appreciate common ground, to appreciate community wisdom, to be self-reflexive about your own bias and research agendas, and also to give the Other space to speak, even in the face of difference.

There are several reasons why a theory of respectful dialectic is appropriate here. First of all, "…dialectic is *the* interdisciplinary method, since interdisciplinarity is achieved when disciplinary differences are stated, clarified, and then resolved in order to produce a synthesis."[815]

> …Jonathan Broido has demonstrated how the dialectical approach can be a practical methodological heuristic for overcoming 'disciplinary entrenchment' in problem-orientated work … misunderstandings, animosities and competitions are not glossed over or mitigated by this democratic approach. Instead, they are taken seriously as attempts are made to spell out what the differences mean and their possible consequences.[816]

While misunderstandings, animosities and competitions might be inevitable at the intersection of religion and public health, it might also be better managed, not by glossing over difference with polite dialogue, but by taking seriously what these differences mean.

I was interested to see a challenging textual exchange between Katherine Marshall and Edward Green (both well-known figures in the faith-health community) over a report that Marshall's Berkeley group had published called *Faith Communities Engage the HIV/AIDS Crisis*.[817] In a published critique, Green and Ruark argued that the report "betrays a deep ambivalence about whether faith communities, particularly Christian churches, are part of the problem or part of the solution to AIDS",[818] and critiqued the authors for their approach to HIV prevention. Marshall then replied to Green and Ruark saying that *their* article, "…underscores a sad reality in the HIV/AIDS community: that communication and dialogue are ferociously difficult no matter what the intent."[819] And Green then responded to Marshall.[820]

It was not so much the content of their argument that drew my attention so much as the fact that this exchange had happened at all. It brought forward the realisation that such dialectical back and forth, which is the basis of all academic argument and field development is largely missing from the

[814] There are obviously other interpretations of and strategies for "dialogue", such as that by Freire which I will not engage with here. See Freire, *Pedagogy*.
[815] Davis in Klein, *Interdisciplinarity*, 194.
[816] Klein, *Interdisciplinarity*, 194.
[817] See Keough and Marshall, "Faith communities engage."
[818] E.C. Green and A.H. Ruark, "AIDS and the churches: getting the story right " *First Things* (2008).
[819] Marshall, "ABCs," 2.
[820] Green in Marshall, "ABCs," 4.

literature emerging from this community of inquiry at the intersection of religion and public health. That is, while there may be some discussion on the need for real research and such, there is little dialectic evident, where scholars review, critique and defend their work. This begs the question that perhaps we (as a scholarly community) have also become so caught up in politely dialoguing with each other that we have not properly engaged in this traditional form of academic respectful dialectic, which is the basis for academic field development, the corollary of which is that the establishment of religion-public health as an academic "field" has possibly been stunted.

A respectful dialectic does not shy away from complexity. As argued above, complexity is a real factor in this context, and urgently require better ways of dealing with complexity in the context of HIV/AIDS.

> Multidisciplinary syntheses, which combine perspectives from disciplines focusing on different levels, are therefore crucial to understanding the disease in all its complexity. At the same time, explicitly *inter*disciplinary approaches are required to understand the interactions *between* these different levels and to formulate the complex multi-level interventions likely to be most effective *and* acceptable."[821]

The other key element to a respectful dialectic is that it is an ongoing process. It is not going to be solved through a single meeting, or even a series of seminars. It could be useful to tap into the partnership discourse here, which (at least on paper) advocates for long-term relationship building. For example, the UNAIDS FBO-Partnership Strategy says, "On one level, 'partnership' refers to everything that UNAIDS … does. More specifically, a partnership is 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.[822]

What is needed is a sustained dialectical conversation (between partners) in which differences are addressed, but not disrespected. The experience of the ARHAP collaborative has shown that the development of trust (and a shared language) takes time, patience and cannot be forced. Respectful dialectic means taking cognisance of differences in power and culture. This means more consciously planning for the long-term development of this community of inquiry. Rather than a cycling of different individuals into different meetings, it would be useful for some sense of cohesion to be formed – while the intersection of religion and public health might not yet be a "field," it is certainly a "tribe". This also means building on the communicative strengths (and relationships) that have been developed within this community on the topic of HIV/AIDS, and

[821] Ellison et al., "Introduction," 21.
[822] UNAIDS, "UNAIDS-FBO partnership," 4.

transferring that to the other health topics. A process of specialisation in different religious-health topics threatens to fracture the community of inquiry into disconnected islands (religion and HIV/AIDS, religion and malaria, religion and development), and this means losing what collaborative competence we have gained through dialogue and dialectic on religion and HIV/AIDS.

This thesis has spent much of its time discussing such issues as culture, power and theory. I find a useful way to head towards conclusion is to turn towards more overtly practical concerns, in this case, to explore what "respectful dialectic" means for educating and training boundary leaders who are moving into and already engaged within this community of inquiry.

Competent Boundary Leaders

> *The reason I started the Tony Blair Faith Foundation was first of all because I believe that if you are not religiously literate today you cannot understand the world in which we live.*[823]
>
> *The work of boundary leaders is to align the assets of community with the most relevant science and most mature faith.*[824]

There are increasing calls within the community of inquiry for greater engagement in the education and nurturing of individuals who are struggling to work and communicate in this boundary zone on a daily basis.[825] Most recently this concern is being driven within two related discussions: firstly the facilitation of the work of "boundary leaders," and secondly the training of public health scholars or practitioners in religious literacy, and vice versus of religious scholars and leaders in public health literacy. Briefly, boundary leadership in the context of religion and public health is a term first coined by Gary Gunderson, and since has also become a central focus of ARHAP collaborators, such as those at Emory University.[826] Cochrane describes:

> …we include the idea of "boundary leadership," the heart of which is a way of seeing the boundaries where things connect for ill or good and the zones between things that appear disconnected. It points to the critical need for people who influence social networks and institutions across their boundaries and boundary zones and, in the process, form social wholes that allow one to embody new possibilities that lie before us but are not yet in place, people who are able to see new opportunities in the face of acknowledged limitations, and expand positive potentials for greater health and well-being. Boundary

[823] Blair in TBFF, "Faith and malaria," 42.
[824] Gunderson, *Boundary leaders*, 8.
[825] See TBFF, "Faith and malaria.", ARHAP, "Appreciating assets.", Haddad et al., "Potential and perils." Note I do not intend to provide here an a-priori teaching syllabus, but rather address a series of considerations.
[826] See Kiser, "Boundary leaders."

> leadership does not necessarily express unique skills or even unusual leadership practices but, rather, a distinctive way of perceiving reality, including self-perception that unlocks skills and resources able to build something different than that which is failing or stagnating.[827]

As this extract indicates, in their conception of "boundary leadership", both Gunderson and Cochrane are less concerned with the pragmatics of enskilling or training such leaders, and are more concerned with addressing a fundamental way of seeing that these boundary leaders characterise. Here boundary leadership is about imagination, or rather "an ability to cross over and bridge boundaries that otherwise restricts one's options and opportunities for acting and imagining."[828]

In this brief final section of this chapter, I utilise the concept of the "boundary leader" and "religious-health literacy" simply to ground a few practical observations that emerge from the above discussion, as well as to suggest areas for further investigation. While I do not want to abandon the term "boundary leader" entirely, it must be noted that a discussion on skills and training of boundary leaders in some ways flies in the face of Gunderson and Cochrane's views, which address more intrinsic and fundamental issues that I do here. [829]

In the ARHAP research in 2006, and again in 2008, the strong recommendation was made that "given the need for [respectful] dialogue, it is crucial that as a first step religious leaders in Africa gain a basic level of public health 'literacy', and that public health practitioners gain a basic level of religious 'literacy'."[830] The central idea of religious-health literacy is that the theoretical discoveries being made at the intersection of religion and public health be put into praxis to better equip the boundary leaders increasingly working there. In the 2006 report, we recommended that it was urgent to:

> Invest in the development of formal courses and experiences to build religious/inter-religious and public health literacy for the full range of leaders, policy makers, scholars, and practitioners working in the fields of religion, public health, and HIV/AIDS, and especially

[827] Cochrane, "Potential of REs," 9.

[828] Gunderson in Cochrane, "Religion as social capital," 46.

[829] I am also not certain that Cochrane and Gunderson would make the direct link between boundary leadership and religious-health literacy as I have done here. However, at least in the context of this study, it is necessary to consider what interdisciplinary education (IDE) might mean considering the increased calls for literacy training and leadership training within this community of inquiry. For my purposes, religious-health literacy is then tied to boundary leadership, and these slightly different approaches are faced with the same concern, how to facilitate the train, conscientization and enculturation of individuals in ways that can facilitate their crossing of the discursive and knowledge-based boundaries identified throughout this study, and in a manner of respectful dialectic.

[830] ARHAP, "Appreciating assets," 127. See Haddad et al, *Partnership.* 129.

> for those working at the intersection of all three … Develop and make available a 'shared lexicon' and 'knowledge base' of terms, tools, methods, and results drawn from inter-religious and public health disciplines … Provide joint training and orientation for religious and public health workers already in the field and for those to be newly deployed.[831]

Several plans are in process to begin and extend religious-health literacy.[832] I have some concern that, like many other projects in this community of inquiry, the enthusiasm for training on religious-health literacy is running several steps ahead of our knowledge of what this training would most usefully look like or mean. In light of the discussion in the preceding chapters, I will lay out the main considerations that should be taken into account as we move rapidly forward, utilising this both as an opportunity for practical grounding for this discussion, and as a space for consideration of areas requiring further research.

A most logical place to begin for further inquiry would be to initiate a closer investigation of the exceptionally skilled individuals (boundary leaders) already working within this community of inquiry, both at a global or community level. These individuals appear to have particular (interdisciplinary and communicative) skills in being able to switch between discourses with ease, and appear to instinctively negotiate the boundaries that hamper others. Ultimately, we require the constitution of a new profession, for researchers and practitioners who have specific skills for facilitating respectful dialogue at the intersection of religion and public health, particularly in the context of HIV/AIDS. It therefore makes sense to understand the best-practices of those already functioning in this way.[833]

Lacking this, it is still possible to make a number of observations based on the exploration of the chapters preceding this one. There are some obvious first needs in any religious-health literacy training, for example certain information about religion and public health (and HIV/AIDS) as is relevant to specific contexts such as SSA needs to be imparted. A further logical need would be training in mixed method research (boundary leaders who are engaged in inquiry requiring at least a competence in both quantitative and qualitative techniques).

However, I have some concerns that religious-health literacy might be seen by some as *primarily* an exchange of scientific facts (about either religion or public health). For example, in the mapping

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[831] ARHAP, "Appreciating assets," 131.

[832] See M. Kiser, "Boundary leaders: seeing and leading in the midst of 'the whole'" (paper presented at the ARHAP Conference: When religion and health align - mobilizing religious health assets for transformation, Cape Town, South Africa, 13-16 July 2009).

[833] ARHAP work has already identified a number of such "exemplars". There are several intercultural and discourse analytic methods that could be usefully applied to such an end .

research for Tearfund and UNAIDS we found that many collaborative partners felt that religious entities were not engaging in particular HIV/AIDS strategies because they were "ignorant" about scientific HIV/AIDS knowledge, for example, saying: "I think it is mostly a lack of scientific information. When FBO leaders know how HIV and AIDS is spread, they might not consider adultery as the main way it is spread ... Therefore training of the trainers is important in order to pass on the information."[834] Such perceptions of the need to train religious leaders in scientific literacy in such a way is largely "disrespectful" of cultural differences and does not take into account the complex intersection of differing beliefs and knowledges that religious leaders juggle in the HIV/AIDS context. An overly simplistic strategy for imparting scientific knowledge to make religious leaders more scientifically literate would not take into account the clash of cultures as discussed in previous chapters. Claeson et al warn that "scientific literacy" is generally seen in "narrow and technocratic" ways:

> The 'facts' of science, as important as they are, can never be more than tiny pieces of the maps that people devise to guide them in life. Even if we could all magically be made to 'know' the answers to the science pop quiz, the process of our coming to know those 'facts' would entail our embedding them in diverse social, political, moral and metaphysical meanings with which we construct our daily lives. We began by asking how scientific literacy might be defined … we might be struck by the narrowly technocratic nature of the knowledge they regard as relevant. We might wonder whether that knowledge would really be sufficient to enable meaningful public discussion of AIDS … This raises the question of whether it is actually scientists, rather than members of the public, that suffer from illiteracy on the range of considerations that need to be brought to bear on these complex human issues.[835]

Similarly, several scholars have noted the need to expand the method of "health literacy" from a narrow sense (the ability to read health information), to a broader empowerment-focused intervention strategy.[836] Given the argument above, of the need to be more conscientized to the multiple power relations impacting on collaboration within this community of inquiry, religious-health literacy therefore also needs to go beyond training on the meaning of particular terms or methods, to a broader agenda to conscientize these individuals on the distorted power relations

[834] Haddad et al., "Potential and perils," 119.

[835] B. Claeson et al., "Scientific literacy, what it is, why it's important, and why scientists think we don't have it: the case of immunology and the immune system," in *Naked science: anthropological inquiry into boundaries, power, and knowledge*, ed. L. Nader (New York: Routledge, 1996), 115.

[836] See D. Nutbeam, "Health literacy as a public health goal: a challenge for contemporary health education and communication strategies into the 21st century," *Health Promotion International* 15, no. 3 (2000).

within this community of inquiry, so that they might become boundary leaders, and agents for transformation.

ARHAP scholars have argued that "to take forward respectful dialogue means to engender respectful engagement. To do this we recommend that key actors in public health and religion: Build on local wisdom, context, and commitment..."[837] Respectful dialogue (or dialectic) therefore also means drawing community wisdom into policy-level meetings and discussions.[838] Boundary leaders therefore need to be "taught" the value of community wisdom, and "a culture of respect for the involvement of all – including, and indeed especially, the most vulnerable, has to be fostered. In Habermasian terms this means inclusion in the very process of defining social realities."[839]

There are a number of strategies already in place, such as communication for development,[840] or communication for social change,[841] which can be usefully drawn in to religious-health literacy and boundary leadership training. Communication for Development scholars acknowledge that "real change may not be possible unless we address power inequalities between marginalised individuals and groups at the grassroots and those who make policy and aid decisions."[842] Significant work has already gone in to developing communication strategies and techniques to this end (such as development support communication), which could be more properly integrated with literacy training at the intersection of religion and public health.[843-844]

My strongest recommendation is that religious-health literacy training, as well as the education of potential boundary leaders include a more direct connection with interdisciplinary education (IDE), and a greater intentionalism towards training boundary leaders as interdisciplinarians. I see the strategies for religious-health literacy and boundary leadership to be subtly different here, the

[837] ARHAP, "Appreciating assets," 130.

[838] See Cochrane, "Understanding RHAs".

[839] Romm, "Critical theory," 216.

[840] See Melkote and Steeves, *Communication for development*.

[841] See J. Deane, "Communication for social change: Winning the argument, but what about the practice?," (2006), http://webzone.k3.se/projects...

[842] Melkote and Steeves, *Communication for development*, 36.

[843] After some review of literature, I find the area of "health communication" to be less applicable to this context, as it is commonly focused on the transferral or transformation of health information. Communication for Development has a stronger self-reflexive model which critiques its own specialists and the power implications of development communication and work. Interestingly, much Communication for Development materials already pay significant attention to religion and in particular liberation theology, which creates some further common ground and makes this a particularly useful entry-point for religious-health literacy and boundary leadership training. See Melkote and Steeves, *Communication for development*, 39, R.A. Agunga, *Developing the third world: a communication approach* (New York: Nova Science Publishers Inc, 1997).

[844] "Health communication" initially had a narrow focus on interpersonal or mass communication strategies, but "increasingly important element to achieving empowerment of individuals and communities." D. Nutbeam, "Health promotion glossary," *Health Promotion International* 13, no. 4 (1998): 355-356.

former addressing a more multidisciplinary approach, and the latter a transdisciplinary approach, although there is obvious cross-over.

Speaking mainly of the latter, however, I believe it is critical that we embark on a more nuanced contemplation on processes for training interdisciplinary communicative competence.[845] The ARHAP experience has shown us the importance of boundary leaders to be trained as interdisciplinarians and *facilitators* of interdisciplinary and transdisciplinary communication. Again, there is a substantial literature on this within interdisciplinary studies which is not yet being fully utilised in the consideration of religious-health literacy and boundary leadership in this context. A boundary leader who is an "expert interdisciplinarian" would therefore be better able to "integrate the input of others to address an issue, which may include coordinating team members."[846] S/he would also be more comfortable with cognitive decentering,[847] and would be trained to anticipate and to facilitate communication despite uncertainty and the complexity of the problem. As Repko says, "interdisciplinarians value diversity of perspective and seek out conflicting viewpoints with which they disagree. They can live with ideological diversity and tension. They also value ambiguity."[848] Most critically, boundary leaders could be more deliberately trained to be "bridge scientists":

> The concept of a 'bridge scientist' is a good model of the IDR leader. On a multidisciplinary team, a bridge scientist will tend to emphasise problems of language, translating the formulation of a research problem from one monodisciplinary perspective into another. On an interdisciplinary team, the bridge scientist's role extends beyond terminological conflicts to paradigmatic conflicts and different evaluation standards.[849]

Of critical importance is training in "… the art/science of facilitation … (having) the ability to put it all together."[850] Facilitation of interdisciplinary communication (whether in research teams, projects or meetings) is an under-researched and underappreciated area that could be of great value to the improvement of communication in this context.[851] Similarly, there is a significant literature on conflict management (or peace-building techniques), and in particular that addressing

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[845] As mentioned in Chapter Six

[846] Repko, *Interdisciplinary research*, 341.

[847] The intellectual capacity to consider a variety of other perspectives and thus perceive reality more accurately, process information more systematically, and solve problems more efficiently. The term 'decentering' denotes the ability to shift deliberately among alternative perspectives and to bring each to bear upon a complex problem. See Repko, *Interdisciplinary research*, 337.

[848] Repko, *Interdisciplinary research*, 224. Repko 224)

[849] Klein, *Interdisciplinarity*, 131.

[850] Agunga, *Developing the third world*, 12.

[851] See Agunga, *Developing the third world*, 12. "… a new discipline is needed – (a) new professional is needed who can facilitate teamwork in development programming."

inter-religious dialogue which could be more usefully drawn in.[852] Despite a growing culture of polite dialogue within the community of inquiry, in other contexts dialogue between religion and health practitioners can be profoundly antagonistic and conflictual, and there are useful strategies which boundary leaders could apply.

Boundary leaders would also ideally be skilled in managing the interface between research and practice. Again, there is a growing literature on practice-research engagement and training which could be usefully applied.[853]

> Practitioners and researchers at first blush march to very different drums. Stereotypical practitioners are action-orientated, focused on immediate and concrete problems, and concerned with having direct impacts on those problems. Stereotypical researchers are theory-orientated, focused on long-term conceptual issues, and concerned with producing knowledge and conceptual results … these differences set the stage for misunderstandings and poor communications at the practice-research boundary, even when the participants share many concerns and values … (practice-research engagement) brings together reflective practitioners and action-oriented researchers to learn together about issues that are critical to their shared interests in sustainable and just development.[854]

As discussed above, it would be rare for isolated communication to occur only between scholars or between practitioners. More commonly the meetings occurring within this community of inquiry are multisectoral, and the individuals seated at the table wear multiple hats which they sometimes switch from discussion to discussion. In the public health "sectors" there is tension between institutional public health and academic public health, and in the religious sector there is similar tension between religious scholars and religious leaders (although again, these tensions can commonly be found in the same representative). These tensions all play out in the interdisciplinary communicative setting, suggesting that some competence in understanding the epistemologies and disciplinary boundaries of the various disciplines (or tribes) would be a valuable tool for the boundary leader.

Would boundary leaders armed with all these skills be able to mitigate the communication gaps, tensions and suspicions that mingle distressingly in this community of inquiry? Well, it would

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[852] See C.O. Bassey and O. Oshita, eds., *Conflict resolution, identity crisis, and development in Africa* (Lagos: Malthouse Press, 2007), D.G. Ellis, *Transforming conflict: communication and ethnopolitical conflict* (Lanham: Rowman and Littlefield Publishers, 2006), M. Deutsch et al., eds., *The handbook of conflict resolution: theory and practice* (San Francisco: Joeesy-Bass, 2006).

[853] See L.D. Brown, ed., *Practice-research engagement and civil society: In a globalizing world* (Cambridge, USA: The Hauser Center, 2001).

[854] Brown, ed., *Practice-research*, 2.

certainly be a step in the right direction. In the face of all these complexities, tensions and power dynamics, I am warmed by the reminder that even though these issues have undoubtedly hampered collaboration, dialogue (polite or otherwise) has continued, busy individuals have continued to attend meetings, scholars have continued to wrestle in an unbounded field of knowing. If there was no common ground to build from, these efforts would have ended over a decade ago when the need for translation became apparent. Nevertheless, there is still some danger that this underlying common ground is lost in the face of irritations and frustration with language, unless we engage with it more properly.

In closing, I return to the rewriting of the public health foundational myth through Johnson's story of *The Ghost Map* in which the dialectical relationship between Dr. John Snow and assistant curate Henry Whitehead resulted in modern day public health mapping. Johnson says,

> Snow himself was a kind of one-man coffeehouse: one of the primary reasons he was able to cut through the fog of miasma was his multidisciplinary approach, as a practicing physician, mapmaker, inventor, chemist, demographer, and a medical detective. But even with that polymath background, he still needed to draw upon an entirely different set of skills – more social than intellectual – in the form of Henry Whitehead's local knowledge.

This description reminds us how the creative sharing of skills, knowledge and relationship through both dialectical inquiry, communication and the building of relationship can have great effects.

Conclusion. Towards Common Ground

> *Global health seems to have found religion. And religion appears to have found public health. So much for a match made in heaven.*[855]

HIV/AIDS has been a challenge to us in so many ways. It has exposed fault lines in our society, shown us our vulnerabilities and our lack of empathy with each other. It has revealed a range of frailties in how we inquire, communicate and form knowledge. While it can be asked whether it is ethical to theorise in the midst of the pandemic, it must be answered that if we have *not* learnt from this experience it would be disrespectful of the millions of individuals who have lived and coped with HIV or AIDS. As Treichler says, while the global impact may make us feel impotent, precedents are being established in the AIDS arena that will have a much greater impact.[856]

The community of inquiry at the intersection of religion and health has been engaged in HIV/AIDS since the early stages of the epidemic in different forms. This engagement has rapidly accelerated over the last five years. Yet we are still hampered by problems of communication and conflicting agendas. The common ground is clear, although it certainly needs to be better articulated. As this study has shown, HIV/AIDS provides a valuable lens to broader problems. As the community of inquiry at the intersection of religion and public health increasingly turns away from HIV/AIDS towards other health concerns such as Malaria and H1N1, it is desperately urgent that we take the lessons we have learnt in the context of HIV/AIDS and apply them to these new conversations, so that not one more moment is lost to miscommunication, polite dialogue or frustrated silence.

The mere idea of continued dialogue fatigue or miscommunication at the intersection of religion and public health is offensive. It is offensive that we continue to spend critically needed resources on the education and gathering of experts unless, as a most basic measure, such conversation results in collaboration and action that is considerably more valuable to the immediate lives of communities than (say) buying new bicycles would be for the community support group in Zambia who are cycling HIV/AIDS patients to hospital and back.

This study has highlighted several barriers to effective communication, cultural differences and powers that drive discourse and communication in predictable ways and hamper genuine dialogue. Some of these have been unpacked and deconstructed, so that the hidden powers guiding our way of communicating may be more apparent. A significant number of projects for further research have been identified (that will not be repeated here), and there is some urgency to the project of

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[855] D.A. McFarland, "Where does religion fit in the political economy of health?," in *ARHAP International colloquium 2007* (Monkey Valley Resort, Cape Town, South Africa: African Religious Health Assets Programme, 2007), 79.
[856] Treichler, *How to have theory*, 232-234.

reintegrating the broader knowledge and best practice from interdisciplinary studies into these different areas of HIV/AIDS collaboration at the intersection of religion and public health.

This study has also highlighted the inherent complexity of communicating within this community of inquiry, where multiple discourses and cultural politics, powers and agendas impact on a single meeting. Peter Piots' admonition that any simple solution to the HIV/AIDS pandemic must be challenged is worth repeating: "Let's never forget that the epidemic could still bring us new surprises – as it has done so many times already. If we are to get ahead of this epidemic, it is time to come to terms with complexity …"[857] Therefore in trying to better understand and engage with the community of inquiry at the intersection of religion and HIV/AIDS, complexity needs to be embraced rather than feared or ignored.

This study has also shown that there are simultaneously profound differences as well as similarities, and the greatest challenge is in finding a communicative strategy that can simultaneously appreciate difference across boundaries while foregrounding common ground. Speaking of HIV/AIDS in South Africa, Lindauer and Walsh conclude:

> The first lesson is that we are all in this together … The second lesson … paradoxically, is that we are not all in this together … The collaboration and cooperation that will be needed to address the pandemic will have to be built on an appreciation of differences … The third lesson is that uncertainty is inescapable … complexity is often our excuse for leaving problems to the experts … (yet) we know that there are not and will not be simple answers.[858]

Communication is at the heart of this, and our communicative strategy needs to be built on a simultaneous appreciation of common ground, awareness of profound difference, and acceptance of uncertainty. In all the difference pieces of this thesis, the importance of communicating through difference has been emphasised, for in every instance, the differences are profound and inescapable, and it is when they are ignored that real "communication gaps" are formed.

The main challenge then becomes one of dealing with difference in the context of interdisciplinary communication, and what I am suggesting here is a model of respectful dialectic. Creating common ground then becomes a process of focusing on such issues as equity and justice, or the drive for health and well-being, especially in the face of seemingly incommensurable discourses. As Marshall says,

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[857] Piot, "Don't give up the fight!," 2.
[858] Lindauer and Walsh, "Afterward," 180-182.

> …(the conference) on roles of religious NGOs in development work, was testimony to a growing appreciation of the many links and areas of common concern between seemingly separate and contending worlds. We live in dangerous times, with dangerous roads ahead, and such roads are best travelled together by those whose direction and path are essentially the same … This demands urgent new thinking and action by different partners as it casts quite new light on ancient approaches, assumptions and roles.[859]

The community of inquiry at the intersection of religion and public health is a rapidly evolving space in which discourses and cultures shift and overlap. This thesis sought to take the pulse of this community, and to provide a brief moment of reflection as we charge forward into action and dialogue. There is nothing more frustrating than seeing the extensive expertise and goodwill available within this community being frustrated by dialogue fatigue and miscommunication. The intersection between religion and public health, through the lens of HIV/AIDS, offers us a unique opportunity. By being respectful of each other and our differences, we have an opportunity for a more profound relationship between previously disparate institutions and individuals - an opportunity to learn, that can strengthen the new public health, a renewed religious sector, and more importantly a community that willingly and enthusiastically stands in-between.

[859] K. Marshall, "Faith and development: Rethinking development debates " in *Conference on Religious NGOs and Development Institutions* (Oslo, Norway: 2005).

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Appendix A. Glossary

This is a partial glossary of a few term not immediately defined within the text of this study.

Terms are mainly from: the ARHAP collaborative research (see http//www.arhap.uct.ac.za) and from Repko (Interdisciplinary research process and theory, 2008).

acquired immune deficiency syndrome (AIDS) A group of illnesses resulting from an immune system weakened after years of battling HIV.

adequacy (disciplinary) The student or borrower does not claim expertise or professional command of all the disciplines used, but rather acquires a sufficient understanding of each discipline's cognitive map and is thus able to identify the insights, concepts theories, methods necessary to understand a particular problem, process or phenomenon. Minimum understanding of the cognitive map or the defining elements of each of the disciplines, interdisciplines, and schools of thought relevant to a particular problem.

African Religious Health Assets Program (ARHAP) An international research collaboration working at the interface between religion and public health.

appreciative inquiry approach A research attitude of respect for the insights and perspectives of ordinary people, community and religious leaders, and health workers, and in doing this we draw from the approach of appreciative inquiry … The approach of *Appreciative Inquiry*, which is a form of organizational study that selectively seeks to highlight the 'life-giving forces' of the organization's existence, including the unique structure and processes of an organization that makes its very existence possible, and the ideas, beliefs, or values around which the organizing activity takes place.6

assets refer to a range of capabilities, skills, resources, links, associations, organizations and institutions, already present in a context, by which people endogenously engage in activities that respond to their experienced situation.This term refers to a range of capabilities, skills, resources, links, associations, organizations and institutions, already present in a context, by which people endogenously engage in activities that respond to their experienced situation. Assets carry value and may be leveraged to create greater value. Beginning with assets is to set aside the dominant approaches that begin with needs or deficits, so as to make local agency more clearly visible. *Needs*, by contrast, imply that we are seeking to identify and overcome what is found to be lacking. Another common concept, *resources,* as distinct from assets, is more passive; they are there to be *used* rather than leveraged and grown. An asset-based approach takes as its starting point the concern that people and their communities should be viewed as having assets, which can be effectively □obilized or leveraged in order to empower communities, rather than viewing them in terms of deficits, which hamper their development.

assets-based approach An assets-based approach takes as its starting point the concern that people and their communities should be viewed as having assets, which can be effectively mobilised or leveraged in order to empower communities, rather than as having deficits, which hamper their development.

bophelo A Sesotho word, bophelo has a rich lexical range. Its meanings range from biological life (of humans, animals and plants) to the social life of individuals, families, villages and nations. Religion and health are an integral and integrated dimension of the social dimension of bophelo.

boundary crossing A process of moving across knowledge formations for the purpose of achieving an enlarged understanding.

boundary work Occurs as researchers detach a subject or object from existing disciplinary frameworks, fill gaps in knowledge from lack of attention to the category, and if the research attains critical mass, redraw boundaries by constituting new knowledge space and new professional roles.

church Aware of the problematic elements (especially in inter-religious writing), this term has been used as sparingly as possible. However, in the context of this study, the term has occasionally been used to indicate Christian denominational structures at a regional/ national/international level. For example, a localized gathering of congregations of the same nature would be a church – or in terms of such denominational structure as "The Catholic church" or "The Anglican church".

cognitive map A discipline's cognitive map is synonymous with its overall perspective and its defining elements, including its assumptions, epistemology, basic concepts, theories, and research methods.

community of inquiry in the context of this study, the broad range of individuals, institutions and communities interested in learning more about the intersection of religion, public health and HIV/AIDS.

community-based organization (CBO) Generally, a service organization that provides social services to local clients.

complexity As applied to interdisciplinary research, complexity means that the problem has several components and that each component has a different disciplinary character.

congregation A locally organized religious or faith-based entity, meeting regularly for specifically religious purposes, whose primary function is the formation of faith. This term is not intended to indicate only Christian groups but is used to signify all such gatherings of any faith.

creole A new first language among a hybrid community of knowers.

depth (interdisciplinary) To successfully engage in the first half of the interdisciplinary reseach process (i.e. drawing in disciplines and their insights) requires developing adequacy or sufficiency in each discipline relevant to the problem. The depth required for engaging in the second half of the research process (i.e. integrating insights) involves identifying conflicts between insights and locating their sources, creating common ground, integrating insights, producing an interdisciplinary understanding of the problem, and testing it.

dialectic thinking Any systematic reasoning or argument that places opposing ideas side by side for the purpose of seeking to resolve their conflict. It is a method of determining the truth of any asserting by testing it against arguments that might negate it.

disciplinary jargon Terminology unique to a discipline.

faith-based organization or initiative (FBO/I) Faith-based organizations or initiatives are those religious entities that have a more structured nature as well as religious support. This includes initiatives and organizations tied to religious groups (such as mission hospitals or faith-based CBOs and NGOs); as well as community networks.

Geographic Information Systems (GIS) A system of hardware and software used for storage, retrieval, mapping, and analysis of geographic data. This includes spatial features stored in a coordinate, which references a particular place on the earth. Descriptive attributes in tabular form are associated with spatial features. Spatial data and associated attributes in the same coordinate system can then be layered together for mapping and analysis.

global health Considers health problems from a global perspective rather than from the point of an individual country (replacing 'international health')

grounded theory Emergent methodology, or theory developed inductively from a corpus of data. **"**The fundamental theoretical approach that characterizes ARHAP research as a whole is *'grounded theory'.* Given that we are exploring areas with, as yet, little established theory, we intentionally shape our research as a spiral that takes data from the field as centrally important in pointing to appropriate and relevant theory, which means allowing our initial theoretical assumptions to come into question, be adjusted, and conceptually reframed through further analytic reflection upon the data, at which point the spiral begins again. This gives an inductive emphasis to our work. It furthermore sustains our conception of the research study as a collaborative *process* that is guided and adapted by what is learned as we progress."

health system The people, institutions and resources, arranged together in accordance with established policies, to improve the health of the population they serve, while responding to people's legitimate expectations and protecting them against the cost of ill-health through a variety of activities whose primary intent is to improve health. A health system includes all actors, institutions and resources that undertake health actions, where a health action is defined as one where the primary intent is to improve health. Although the defining goal of a health system is to improve population health, other intrinsic goals are to be responsive to the population it serves, determined by the way in which people are treated and the environment in which they are treated, and to ensure that the financial burden of paying for health is fairly distributed across households.

HealthMapper A surveillance, data management and mapping application, developed by WHO and customized specifically for public health users. It aims to address critical surveillance information needs across infectious disease programs at national and global levels.

healthworld Neologism for *bophelo* (Sesotho), *impilo* (isiXhosa), *ubumi* (Bemba) and other African linguistic equivalents, but expressed as a concept argued to be of general significance. Refers to peoples' conceptions of health, as framed by the background store of inherited or socialized knowledge that defines their being in the world. A person's healthworld expresses and guides health-seeking behaviour, choices and actions, in respect of illness or dysfunction in health, towards a *telos* of comprehensive well-being. Culturally and linguistically constituted, spiritual and corporeal, it addresses the condition of the whole body - understood as the ecology of the individual body in relation to the social body under particular material conditions - and thus includes the social and environmental determinants of health.

heuristic An aid to understanding or discovery or learning.

HIV/AIDS For this study the term HIV/AIDS will be used to indicate the complete range of stages of infection, sero-conversion and resulting opportunistic infections associated with the pandemic, as well as the cultural, behavioural, political and spiritual factors impacting on the course of the pandemic. While it is acknowledged that HIV and AIDS are different conditions, for the sake of convenience "HIV/AIDS" will be used instead of "HIV and AIDS". Furthermore, it is also understood that there is not just one epidemic but multiple local and national epidemics with different characteristics and patterns, but at the same time, HIV/AIDS is also a "pandemic" that spans localised and national borders.

institutions (in discourse) as cultures with an emphasis on discourse and power.

intangible religious health assets (See also tangible religious health assets) The volitional, motivational and mobilizing capacities that are rooted in vital affective, symbolic and relational dimensions of religious faith, belief, behavior and ties. Local knowledge, access, reach, participation, trust and accompaniment are just some of these "intangible" religious health assets.

integrative mind-set Cultivating these five qualities of mind 1) seeking what is useful even it it is problematic; 2) thinking inclusively and integratively, not exclusively; 3) being responsive to each perspective but beholden to none; 4) striving for balance among disciplinary perspectives; and 5) maintaining intellectual flexibility.

interdisciplinary An effort or team that draws on insights, concepts, knowledge, or experience from several disciplines.

interdisciplinary common ground One or more theories, concepts, and assumptions by which conflicting insights can be reconciled and integrated. Creating common ground involves bringing out potential commonalities underlying the conflicting disciplinary and theory-based insights so that tehse can be reconciled and ultimately integrated.

interdisciplinary communication Is possible when the partners of cooperation – ie the relevant disciplines or theories – find out that they use the same concepts with different meanings, or that they use different codings (terms, symbol systems), for similar concepts.

interdisciplinary integration The cognitive activity of critically evaluating and creatively combining ideas and knowledge to form a new whole. It requires active triangulation of depth and breadth with disciplinary knowledge. Integrative skills, integrative knowledge, and integrative mind-set.

interdisciplinary studies (IDS) A process of answering a question, solving a problem, or addressing a topic that is too broad or complex to be dealt with adequately by a single discipline and draws on disciplinary perspectives and integrates their insights to produce a more comprehensive understanding or cognitive advancement.

interdiscipline Literally means 'between disciplines', i.e. between the bodies of knowledge defined by the theories and methods of the established disciplines. An interdiscipline often begins as an interdisciplinary field, but over time becomes like a discipline, developing its own perspectives, journals, and professional associations.

multidisciplinarity the placing side by side of insights from two or more disciplines without attempting integration.

paradigm shift A profound and transformative change in the philosophical and theoretical framework that dominates a discipline or approach to knowledge formation.

participatory geographical information systems (PGIS) The adoption of GIS to empower indigenous and local communities through their participation in the data collection, review, and analysis process.

Participatory Inquiry into Religious Health Assets, Networks and Agency (PIRHANA) The Participatory Inquiry into Religious Health Assets, Networks and Agency, is the primary research toolset developed by ARHAP to assess the contribution of religion and religious entities to health and wellbeing in Africa. It is based on a commitment to participatory inquiry, as well as to the framework of assets and agency described above.

problem-focused research Societal/public policy problems necessitate this type of research, which is distinct from what is called basic research or pure theoretical research because it focuses on unresolved societal needs and practical problem solving and emphasizes the pursuit of knowledge, informed action, usefulness, efficiency and practical results.

public health The science and art of promoting health, preventing disease and prolonging life through just and organized efforts of society.

religion A wide variety of comprehensive systems of sacred beliefs and practices, usually (but not always) issuing in religious institutions, groups or organizations that range from fluid to codified, popular to formal, centralized to decentralized, communal to institutional. In Africa, this includes particularly African traditional religions, Islam, Christianity and generally a wide variety of other identifiable religious formations.

religious entity (RE) The term "religious entity" seeks to capture the incredibly broad range of (tangible) RHAs, incorporating religious facilities, organizations as well as practitioners, both bio-medical and traditional. This encompassing term is necessary in order to be able to speak to the more traditional religious entities such as faith-based organizations, as well as those more amorphous entities such as individual traditional healers.

religious health asset (RHA) A religious health asset is an asset located in or held by a religious entity that can be leveraged for the purposes of development or public health. The notion of RHAs captures the basic idea that assets carry value and may be leveraged for greater value. If they are not used, then they remain at rest, but always available for use through some agentive act. We are also using the term broadly to encompass any religion or faith; particularly we include here those assets typical of African religions.

Service Availability Mapping (SAM) Service Availability Mapping (SAM) is a tool developed by WHO to collect and present basic information on health services health infrastructure, human resources and services offered. Its main application is at the subnational or district level, where district health management teams can use the results of the SAM in conjunction with WHO's HealthMapper application, developed by the Public Health Mapping and GIS program, to map and monitor health services. SAM is made up of a survey methodology, remote field data collection devices, and WHO's HealthMapper application

tangible religious health assets (See also intangible religious health assets) The more visible and most studied religious health assets, including facilities, personnel, and activities, sometimes resembling those ofsecular entities. Interwoven with this tangible level, however, are "intangible" religious health assets.

transdisciplinarity the application of theories, concepts, or methods across disciplines and sectors of society by including stakeholders in the public and private domains with the intent of developing and overarching synthesis; 'transdisciplinary' approaches are far more comprehensive in scope and vision, hold out the promise of the kind of 'overarchingsynthesis', are conceptual frameworks that transcend the narrow scope of disciplinary world views.

tribes anthropological metaphor used to describe the disciplines, each having its own culture and language.

voluntary counselling and testing(VCT) Counselling prior to HIV test, testing itself, and post-test counselling conducted when results of the test are given to the patient.