Arhap
African Religious Health Assets Programme

ARHAP International Colloquium

Case Study Focus

Papers & Proceedings

WILLOW PARK, GAUTENG
SOUTH AFRICA

July 2005

Programme

Wed 13 July

18h00 Registration
18h30 Dinner, welcome and opening address

- Tinyiko Maluleke (UNISA): *Welcome*
- Jim Cochrane (UCT): *Reconceptualising Religion and Public Health: the African Religious Health Assets Programme*

Thu 14 July

8h30 - 10h30 ARHAP Case Study #1: *Masangane (Eastern Cape, RSA)*

11h00-13h00 ARHAP Case Study #2: *Lesotho (national)*

LUNCH

14h00-16h00 ARHAP Case Study #3: *Zambia (Copperbelt)*

16h30-18h00 Work-in-Progress Reports

- Frank Dimmock (Malawi): *Resilience in Malawian Children Affected by AIDS*
- Sophie Chirongoma (Zimbabwe): *The Role of Faith Communities as Care-Givers in the face of Poverty and HIV/AIDS in Contemporary Zimbabwe*
- Evelyn Vera (Lesotho): *The Role of Faith in Decision Making for Health Providers*
- Liz Thomas (Wits & MRC, South Africa): *Faith Based Responses to HIV/AIDS – From Policy to Action*

20h00 DINNER

Plenary Paper 1:

- Nancy Ammerman (Boston U): *Methods and Concepts for Assessing the Religious Health Assets of Religious Gatherings in Africa*

Fri 15 July

8h30-10h00 Plenary Paper 2

- Deb McFarland: *On Economics and Ethics in Public Health*

10h30-12h45 Case studies

- Lauren Graham (Wits) & Jill Olivier (UCT): *ARHAP Literature Review*
- Johannah Keikelame (UCT/Global Health Forum): *Actions Taken by South African FBOs to Address HIV/AIDS Stigma and Discrimination*

LUNCH

14h30-18h00 Other Case Studies

- Peter Okaalet (MAP International): *Transforming Communities Through Promoting MA/PGD in Pastoral Care & HIV/AIDS Programme*
- Christo Greyling & Japé Heath (WorldVision): *Positive Faith in Action Against AIDS Related Stigma and Discrimination*
- Masheti Wangoyi (TICH): *Institutionalized Practices in FBOs and their Influence on HIV Prevention, Care & Social Action*
- Helen Ji (Emory Zambia): *A Quantitative Evaluation of the Impact of Religious Leaders in the Promotion of Couples Voluntary Counselling and Testing in Lusaka, Zambia*

DINNER

Evening Free for Fun .....

Sat 16 July

9h00-13h00 Facilitated working session:
Drawing conclusions for ARHAP

13h00 LUNCH and goodbye

Contents

Introduction

ARHAP seeks to develop a systematic knowledge base of religious health assets in sub-Saharan Africa; thus to assist in aligning and enhancing the work of both religious health leaders and public policy makers in their collaborative effort to meet the challenge of disease, e.g. HIV/AIDS; and hence to promote sustainable health, especially for those who live in poverty or under marginal conditions.

The Colloquium

For three years ARHAP partner organizations have worked on the concept of religious health assets. Religious leaders, health professionals, and agencies in southern Africa face health challenges and new expectations that are without precedent. With the catastrophic impact of HIV/AIDS, the capacities of religious communities regarding health are being studied for the first time in a generation or more. ARHAP has begun to move into this gap, by 1) undertaking some large scale mapping and by 2) providing conceptual clarification about how religious networks in Africa are assets for the health of their communities.

The Colloquium focuses on the second task, first by introducing case studies currently underway or about to be launched under the auspices of ARHAP. To supplement this, others were also invited to report on work they are doing that matches the goals and perspectives outlined in a *Framing Document* prepared for this Colloquium (see below).

In this report on the Colloquium we include material that may be of interest to others, specifically, plenary addresses, a final summing up of the Colloquium, and brief summaries of selected presentations and key discussions. Other contributions that were important to participants but that are either not available or still in development, have been left out.

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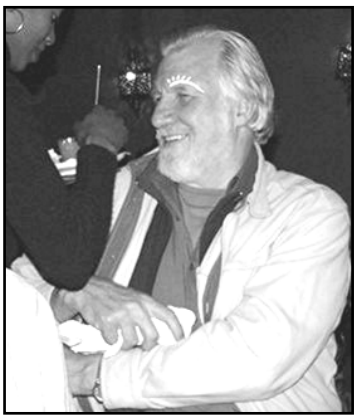
Keynote Address

Reconceptualizing Religion and Public Health

Jim Cochrane

University of Cape Town



First, I wish to thank my good friend and colleague, Prof Tinyiko Maluleke, Dean of the Faculty of Religion and Theology at the University of South Africa, for co-hosting this event here near Pretoria (Tshwane). We have a deep commitment to maximizing the resources we have in this part of Africa, to establishing collaborative partnerships in the tasks we have taken on, to strengthening synergies and each other in the process, to learning from anyone willing to teach us, and so to building the capacity that will help us to contribute to the shaping of a better society and a better world. Prof Maluleke's presence is important to us for these reasons, and we thank him for joining with us and being with us.

Second, I welcome you all in the name of my ARHAP colleagues. This is a diverse group of people, in respect of places of origin, activities and disciplines, expertise and wisdom, sources of insight and understanding. We are very grateful to you for being here, for making this colloquium what it is intended to be. I will say more of that later.

Third, ARHAP has one of those very rare relationships with a funder in which the funder's personnel are real partners, people who want to participate in the thinking, the learning and the work of the project, and who thus go well beyond merely providing money. These are partners who are willing to be guided by us, to listen to us, to act in accordance with what we perceive to be important rather than on what they have pre-defined as the conditionalities of funding out of another context or with a different agenda. I am speaking of the Vesper Society, who have been with us from the outset, and who have made this colloquium and the presence of many of you here possible. In particular I want to acknowledge Vesper's President, Mary Baich, and Financial Officer, Rich Watson, who are with us again.

Fourth … and this is a very important fourth … I want to make special mention of one person who is the rock that stands behind this event, without whom, quite literally, it would never have taken place or have been put together as well as I think it will turn out to be. I speak, of course, of Barbara Schmid, my colleague at the University of Cape Town. Several of us, in South Africa and in the USA, have put many hours into getting to this point, but she is the key person above all, and it is an honour and a privilege to publicly declare this.

Now to the substance of this meeting. I begin with apologies to George Lucas. A long, long time ago, in a faraway galaxy (country), seeds of destruction were sown that would eventually threaten the health of the Republic. Many brave and bold people would be called on to defend its citizens, as great events unfolded in a drama whose end was difficult to see. A profound challenge lay in the fact that the seeds of destruction

were sown not at a distance, but in their midst, within themselves, generating great "dis-ease". Resources available only to the great and the wealthy, resources worthy of an empire, would be turned towards the disease, often it seemed to little effect; or to effects that were different from those that had been anticipated. Battles would be waged and lost. Fear would spread and trust would be at a premium. The greatest weapons and the most powerful tools would not suffice. For ultimately, the Republic would founder on whether or not its people could trust those powerful others who sought to help them, a trust that would have to be won; or trust themselves, a trust that would require them to break free of unhelpful dependencies. This is where our story begins.

The threat I speak of is, of course, an alien presence inside the human cell, a parasitic presence. Biologically, the Human Immunodeficiency Virus has lethal implications for human beings, but it also invokes intense culture wars. We know well how it raises powerful questions about sexuality, how it forces us to face multi-dimensional gendered structures of power and control, unsettling the acquired habits of society, and confronting faith based organisations and religion at two of their most vulnerable points.

When we seek at this colloquium to understand, positively, what contributions faith based initiatives or organisations[1] may make to our abilities to confront and combat the threat of HIV/AIDS, then we are simultaneously attempting to tap a vast set of resources – including spiritual, social and material assets – even as we are faced with ironic and difficult to handle reactions from the same religious or faith based bodies.

We all know, for example, of the way in which faith and religion may feed into the problem of stigma, certainly one of the most critical issues to deal with in respect of this disease. We also know that sexuality as an area of human interaction is fraught with taboos, sanctions, and silences, much of it authorized by religious legitimations. I need not mention the problematic patriarchal dimensions of religion and culture, for these too are now well known. Add the deep cultural and religious prejudices about same-sex orientations that infect religious positions, and we are therefore necessarily faced with an ambiguous reality. To this we must further add unavoidable racial and class differences that impact on what is done and what not.

We are dealing, therefore, not just with a virus, but with lifeworlds, within which religious sensibilities, ideas, rituals and behaviour are deeply rooted. No intervention can or should bypass this fact. The extent to which this is understood, to which the strategic or instrumental rationalities that guide most current health interventions are united with the communicative rationalities that govern reception, behaviour, norms and values, to that extent will the success of any intervention be determined. This distinction between strategic or instrumental, and communicative rationalities—drawn

[1] Public health agencies have taken to referring to "faith based organizations" (FBOs) as a focus of interest in leveraging greater social resources for health interventions. While this nomenclature makes some sense, in ARHAP we make the claim that "organizations" (formally constituted bodies such as churches, mosques, religious NGOs) represent only some of the initiatives taken on the basis of faith to intervene in health, and particularly miss those that are more communally based. More generally, then, it makes sense to speak of "faith based initiatives" (FBIs). A further distinction, given recent attention by the National Institutes for Health, is found in those bodies that are the generative frameworks for the commitment, motivation and initiatives that emerge out of faith or religious worldviews. The NIH refers to these as "congregations", but again, this is a linguistically limited term that tends to focus one's attention on religious phenomena familiar to Western societies. We therefore propose to speak rather of "faith forming entities" (FFEs) in this regard. Our distinctions still require full theoretical elaboration (for instance, the term "faith" must itself be defended), and function for the moment heuristically.

as some will know from Jürgen Habermas[2]—is one that illuminates the kind of shift that needs to take place in the relationship between religion and public health.

Despite the ambiguities of religion, culture and science, the crisis introduced by HIV/AIDS pushes all of us beyond what was familiar, away from merely reacting to disease and death, in order to seek and strengthen the healing and life-giving energies resident in our people, communities and societies. For this reason the project that has brought together this colloquium, the African Religious Health Assets Programme, chooses to focus on the positive, in an attempt to contribute to developing the capacity of faith based organisations, of the many people of faith, deep religious commitment and motivation, who wish to make a difference to the situation we find ourselves in, in a way that liberates and heals people.

Of course, HIV/AIDS is not the only crisis which confronts us in the area of health. To confine ourselves to this part of the world, malaria and TB are also great threats. And if one takes a public health view, then so are the environmental conditions of health, deeply affected as they are by impoverishment, alienation, dispossession, violence and trauma, and the inequalities that the current global political economy introduces with still largely negative consequences for most people on this continent.[3]

Indeed, put this way, we may say that public health is generally about creating the conditions of health, and not just about immunizations, antibiotics, anti-retrovirals, and similar clinical interventions, however important these may be. Public health, in this sense, is long-term and not quick-fix in its view, social and not merely physiological in its scale, transformative and not just curative in its ambition. Those are its roots a century or so ago,[4] and those should still be its formative assumptions, though they are often in danger from the strategic-instrumental and technicist-scientific models that de-emphasize the human, the communicative, the social.

The successes of public health as a discipline seem to me to lie in a rich and tightly held dialectic between these two models; and its failures appear to lie in lapses around the second of them in the face of crisis tendencies on the one hand, and political and economic exigencies or system imperatives on the other. The evidence in interventions in Africa around HIV/AIDS appears to support the view that a repetition of the pattern of failure is more likely than not at this point in time, for the same reasons.

If we exclude the systemic roles of 'money' (the economy, specifically so-called "free" markets in our time) and of 'power' (politics, specifically nation-states and transnational corporations in our time), then 'the social' boils down to what happens in the lifeworlds of people, of what happens to these lifeworlds, and how they and the systemic forces are regulated. Here is the location of culture, or of religion.[5]

The social impact of religion, understood as the public expression of religiously framed lifeworld claims, norms and values, must then play a role in a conception of public health. Why do people make certain kinds of choices that seem irrational to the

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[2] Graham Scambler, *Health and Social Change: A Critical Theory*, ed. Tim May, *Issues in Society* (Buckingham and Philadelphia: The Open University Press, 2002), Graham Scambler, ed., *Habermas, Critical Theory and Health* (London & New York: Routledge, 2001).

[3] Paul Farmer, *Pathologies of Power: Health, Human Rights and the New War on the Poor* (Berkeley: University of California Press, 2003), Jim Yong Kim et al., eds., *Dying for Growth: Global Inequality and the Health of the Poor* (Monroe, ME: Common Courage Press, 2000).

[4] Gary Gunderson, *Good News for the Whole Community: Reflections on the History of the First Century of the Social Gospel Movement* (January 28) (1999 [cited 19 July 2002]); available from http://www.ihpnet.org/goodnews.htm.

[5] There is an obvious ambiguity and slipperiness in the terms 'culture' and 'religion', subjects about which a great deal has been written, and to which I pay no further attention here though it is an issue that ARHAP must resolve appropriately to its African context.

biomedical practitioner or Cartesian mind, if not because another kind of rationality is at work? Why do people mix their health-seeking strategies in ways that appear confused or contradictory to the "objective" observer from a public health agency or administration, if not because they trust other ways of understanding causality and responsible behaviour? Why do people resist health interventions that appear to be in their interest according to the (external) intervening actor, if not because their interests are defined differently?

These and similar questions push public health back on itself, back to understanding the social reality within which it locates its sphere of activity and its transformative vision; and this should have implications for public health interventions.

I have already hinted at the potential and the ambiguity of religion in this context, and now I have had something to say about public health. Taken together, they point to what might be a mutually fruitful, if not absolutely essential relationship. But, though there are important exceptions, this is a relationship that, in our time, is no longer clear, no longer intelligently understood, whether one thinks of the world of health (which remains dominated by bio-medical and clinical paradigms and an instrumental rationality) or the religious world (which remains dominated by personalist or isolationist paradigms and too easily lapses into irrationality). Without downplaying the importance of bio-medicine, or denying the personal dimensions of faith, or romanticizing Africa or African cultures and experiences, we are convinced that the African context has something to teach both public health leaders and religious leaders.[6]

We are interested in taking into account all of these realities at the same time. This is no mean task. However short we or anyone else may fall, it remains a vital task. The fragmentation of responses to the crises, the insulation and divisiveness of disciplinary specialties, are not a deterrent but the very ground for the attempt.

We have been working at this for some time now. For example, in August 2003 at the University of Natal[7] in Pietermaritzburg, we held our first colloquium on themes of assets and agency,[8] focusing particularly on what we mean by these terms and how this affects our research paradigm and methods.[9] In 2004, at Monkey Valley, Cape Town, a small core group worked on developing a heuristic matrix of 'religious health assets' that has informed our work ever since, together with a model for a research strategy aimed at generating a range of research instruments or tools in four areas of interest, namely: the agency of health-seekers and health providers; material assets of religious or faith-based initiatives in health; the capabilities of local groups, organizations or communities to undergird and sustain such initiatives; and the policy dimensions of aligning religious health assets with public health systems. This clearly signals 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

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[6] This will require emphasizing the role of what we call "boundary leaders", cf. Gary Gunderson, *Boundary Leaders: Leadership Skills for People of Faith* (Minneapolis: Fortress, 2004).

[7] Now joined with the University of Durban-Westville and renamed the University of KwaZulu-Natal.

[8] See ARHAP. *Assets and Agency: Papers and Proceedings of the ARHAP Colloquium*. Pietermaritzburg, RSA, August 2003.

[9] In this context the notion of social capital was also addressed.

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. The danger is losing sight of this larger interest in the detail and daily demands of a large and complex operation. Accordingly, at a workshop in Hout Bay, Cape Town, also in 2004, where one focus was the planning of three to four case studies that would allow us to test and develop our ideas, we also began to face the larger context. 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 as our work continues.

Two further meetings, in 2005, are markers of the way in which ARHAP is unfolding. The first, held in Morija, Lesotho, drew together members of three case study research teams (one each for Lesotho, Zambia and Masangane in the Eastern Cape of South Africa) to compare notes and ideas. At least one major intellectual adventure began to take shape there. This was a confrontation with the linguistic (hence social) limits of our foundational concepts—religion and health. In seSotho (as in isiXhosa and other related African languages), there are no direct equivalents for either term, a fact that clearly complicates the way in which one draws up questionnaires, interviews people, makes judgements about meanings, and conceptualizes what one is researching. As will be demonstrated later in this colloquium, the only appropriate seSotho word is bophelo (impilo in isiXhosa) which, because it combines both our sense of what religion is and what health is (and extends both too), necessarily functions as an epistemological critique of the Cartesian dualism implicit in the disjunction health/religion, and as an philosophical critique of reigning ideas of health and religion.[10] In order to take such insights into account and still be able to work in English, we are currently thinking through the idea of "healthworlds"—a linguistic innovation of our own[11]—to describe what we encounter.

The second of our 2005 meetings, again at Monkey Valley, placed into the centre of our discourse another idea that had been emerging, namely, the notion of "leading causes of life" as crucial to re-visioning public health understandings and interventions,[12] as a quite direct complement to what determines public health discourse at so many levels - the "burden of disease" or "indicators of mortality and morbidity". In fact, we anticipate that this will, and should, be more than complementary, for it is really to change the emphasis of public health discourse. Again, this is work in progress, and I am sure that more will be said about it in this colloquium.

This brief history of key aspects of the intellectual journey that ARHAP has been on and will continue to follow suffices as a summary of where we have arrived at for the moment. But the intellectual work I have been describing has not been done in isolation. We have been working for close on three years now to create the collaborative relationships, the networks and the support structures that are able to give effect to our vision. On the one hand, our attempts to address the issues in the way that we have are met by great resonance from an astonishingly wide range of people and organisations, including key people in agencies such as the World Health Organisation, the Global Fund, the Global Health Council and the Centers for Disease Control and Prevention. Even more so, we have met with enthusiasm and strong interest from colleagues,

[10] See also "ARHAP Case Study #2: Lesotho" on p 68 of this Report.
[11] First introduced by Paul Germond, leader of the Lesotho case study team.
[12] This is another of Gary Gunderson's innovations. See "Listening for an African Heartbeat", p 44.

friends and practitioners in various parts of Africa, as well as in Europe and the USA.

The momentum for this program in terms of the human support it has gained, the needs that it seems to address, and the expectations that it evokes, has been strong. The number and quality of people who have learned of its work and who have become part of it in some co-operative or collaborative way is enormously encouraging. At this point in time, we have some 50 people alone working on the case studies or on individual pieces of research in the programme. There are probably double that number of people who are trying to help in finding support for the programme or who are requesting information, insights and guidance from members of the programme. One indicator of the ability of those who have been involved to impact upon others within the field of public health is the fact that both the World Health Organisation and the Centers for Disease Control and Prevention have overtly begun to use our language.

This all seems very positive, but it is necessary to say that much of our research has only recently begun, and that we are not yet sure of how powerful it will prove to be. Indeed, this case study colloquium has been called precisely in order to allow us to present our work-in-progress so that it may be commented upon, criticized, and constructively developed as far as possible by the considerable expertise of all of those present here, many of whom have been working in this or a related field far longer than we have. We are seeking to expose our work to a wider audience, from a significant range of disciplines and experiences, and we are seeking to do this at a relatively early stage.

There are two reasons for doing this, both of which are essential to this colloquium. The first has to do with the knowledge, insight and understanding that you as participants bring to the field that we are trying to research. We have here intellectuals, leaders and practitioners from a number of contexts and a number of fields. It makes sense to have your input at an early stage, when we may be getting something wrong, or perhaps touching on something right that we have not fully grasped, and for which guidance at this stage would be far more productive than later when we have completed most of the work.

Second, we are strongly cognizant of the fact that our focus on "religious health assets", as they are held by ordinary people, in communities, families and societies, through their faith and a rich religious worldview that they draw on in response to the crises with which they have to deal, is daunting. We are touching on a complex reality, so much so that we speak of our object of investigation rather ironically, but precisely, as "a bounded field of unknowing".[13]

It is important that the work we do does not muddy the waters, and it is important that we enter into this work in a way that supports and sustains those who are facing the brunt of the crises. In many respects, our attempts to focus attention intellectually and scientifically on the significance of religion, of faith and of the role of faith based initiatives, goes counter to the grain in public health, at least in the way in which decisions about resources, access and focus are made. We do not decry the positive (and largely positivist) achievements of statistical data, of economic calculations, of measurements and indicators, of “evidence-based” understanding. These have their place; indeed, the baseline data they provide is vital. Yet we are among those who claim with considerable force that such achievements, philosophically and humanly speaking,

[13] The “bounded field of unknowing” is a phrase positively describing the limitations of knowledge, and the interdisciplinary nature of religion and assets. There is a parameter guiding ARHAP theories, which has taken a grounded theory approach to understanding phenomena.

merely scratch the surface. That they carry the day most of the time is indefensible intellectually and problematic practically.

So we are trying to make a case, around the deep-seated desires, fears, expectations, memories, and yes, wisdom, contained in what we commonly call a religious worldview. We will need to be able to demonstrate strongly and persuasively the importance of this dimension of our social reality for public health, well beyond the instrumental approach that is largely dominant at the moment, in which religion and faith based organisations are seen largely as possible strategic outlets for predetermined public health interventions.

That is our grand task, and it is of course not one in which we are alone, though no-one yet, at least in the field within which we are attempting this, has been able to make the case sufficiently. Signs of a paradigm shift may be seen in many quarters, partly impelled by the failures of current models, and partly by the collapse of the radical secularization thesis that dominated most of the scientific community, across disciplines, through the twentieth century. Perhaps this shift is an illusion, perhaps not. It is our bet, our gamble, no, our conviction and commitment that this is not so, and that the work we are doing and still hope to do will contribute to that shift, for the sake of the same humane and divine purposes that most of us share, whatever our intellectual paradigm.

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PART ONE
Framing Document

The invitation to contribute to the Colloquium included a Framing Document, written by the three founding members of ARHAP, to indicate some open-ended parameters for our discussion. Not yet published elsewhere, it situates the contributions we have included in this collection, and we make it available here..

Origin of ARHAP

In 2002 a working group met at the Carter Center, Atlanta, under the auspices of its Interfaith Health Program (IHP), to consider a proposal for a global religious health assets initiative. The initiative recognized the general paucity of studies on faith based organizations working in health, both in respect of knowing what is there, and in extensively, intensively and intelligently assessing what faith based initiatives do best, and how, in the face of growing public health crises in many parts of the world.

From that first meeting, the IHP agreed to support a specific, experimental research programme on religious health assets in Africa. Africa became the focus because it offers the possibility of learning a great deal of relevance globally, given major public health challenges, a complex mix of religious traditions in varying contexts, and a wide variety of actors in the field of health. It is also ethically and epistemologically significant to consider Africa as the appropriate initial learning ground for a global project.

ARHAP was formally launched later in the year, in December 2002, at a meeting in Geneva. There it adopted the following vision:

> *The purpose of this programme is to develop a systematic knowledge base of religious health assets in Sub-Saharan Africa to align and enhance the work of religious health leaders and public policy decision-makers in their collaborative effort to meet the challenge of disease, e.g. HIV/AIDS, and to participate in the creation of health, especially for those in poverty.*

Basic Assumptions

Certain assumptions have guided ARHAP from the outset. First, that faith based entities are widely present on the ground in many contexts where health crises are most urgent. Second, that no matter how impoverished, under-resourced or isolated such faith based entities might be, they nevertheless represent or contribute major assets to health in their contexts. Third, that these assets are both tangible and intangible. Fourth, that they have a public impact on health (besides providing particular health services). Fifth, that they need to be understood in relation to each other, as part of a complex and significant social reality. Sixth, that properly assessing, appreciating and enhancing their potential will produce better public health interventions.

In short, we are interested in focusing on what these religious health assets are, how they work, and what potential exists for strengthening them without undermining the very things they offer or destroying them through inappropriate interventions or engagements.

Thus we begin with a positive view of faith based initiatives in health in the first instance, hence our description of them in terms of religious health *assets*, which we understand much more broadly than the more traditional focus on facilities such as hospitals and clinics (see Cochrane below on the RHA Matrix). At the same time, a naive view of the role of religion would undermine our grasp of the necessary social realities; hence we recognize the need to balance the positive with a clear grasp of the limits and possible negative impact of religious traditions or faith based practices in particular contexts.

Accompanying Contributions

The contributions that accompany this introduction, from the three principal initiators and leaders of ARHAP, are intended to clarify its working conceptual framework. It is this framework that will shape the Case Study Colloquium.

We describe below the terms that comprise our framework and approach. They are broad enough to encompass a wide variety of contributions and to facilitate the discovery of meaningful connections between the different disciplinary approaches of participating contributors and the case studies they address. We intend our terms not to impose a particular way of thinking as much as to be suggestive of the kinds of issues to consider as you reflect upon your own work and experience in relation to the goals of our project.

Some Preliminary Definitions

Assets – Assets refer to a range of capabilities, skills, resources, links, associations, organizations and institutions, already present in a local or translocal context, by which people endogenously engage in activities that respond to their experienced situation. 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.

Agency – Agency is the capacity to "do" - to move into action, to utilize the assets one has to seek and achieve desired goals - as affected by social and environmental conditions.

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 and Christianity.

Health – We work with a broad definition of health, along the lines of the Alma Ata definition of the World Health Organization, which locates health in relation to comprehensive well-being. Hence, the personal, communal, social, economic, environmental and spiritual dimensions of health are taken to be interrelated with each other. Moreover, we see health not in terms of the absence of disease or illness, but rather as the dynamic of life, the genesis of energy, agency and relationality.

WHAT IS WORTH KNOWING ABOUT RELIGIOUS HEALTH ASSETS ... IN AFRICA ... AT THIS PARTICULAR TIME

Dr Gary Gunderson
Director, Interfaith Health Program, Rollins School of Public Health, Emory University

Here. In the momentum toward the Colloquium this July, I want to add one more accent to the languages in which we are drawn to speak to each other about what matters most. In the few years in which the group talking about "religious health assets" has grown from a handful to a roomful, we have always sensed that this was re-search in an odd way. It is a return to a search that had been more or less abandoned a generation ago when it appeared to most that there was a very limited institutional future to the role of religious structures in the delivery of health beyond relatively fundamental primary care services.

The last overarching attempt at even enumerating the scale of religious health services—even at the level of hospitals—was done in the 1960's. Dr. Charles Ausherman attempted to update this survey in the late 1990's, mainly to justify investment in building the capacity of religious health networks in women's and children's health initiatives. While unsuccessful at achieving anything like a full enumeration, was able to document that far from disappearing, the number of religious health networks (as he called them) has grown substantially.

Ausherman's seminal work came to the attention of the Interfaith Health Program, but he retired before we were able to figure out how to fund and pursue his broad question. However, in the years since his first contact, the urgency and importance of filling in the gap of understanding has grown more obvious and inescapable, mainly due to the catastrophic scale and scope of the HIV/AIDS phenomenon in Africa. I note this to make the point that the historical roots of my interest in the subject of "religious health assets" are somewhat particular; they come from the controversial end of the possible spectrum of issues in which the tangle of sex, family, stigma, patterns of domination and fear pervade the discourse even among professionals and certainly among religious leaders involved.

Far from asking safe, if difficult, questions about logistics for the supply of clinical services or the implementation of cost effective medical techniques, my questions were always more fundamental and complex: in what way can we understand religious networks to be assets to promote the health and wholeness of societies facing large scale threats to their survival? I ask about assets partly because the liabilities posed by organized religious communities are so painfully obvious. This only becomes clearer with every passing month as visible in nations and faith groups scattered from Iowa to Iran, Cape Town to Cairo.

Of course, we hardly know enough about the pathological affects of religion. But we certainly know *less* about how they function as assets, especially in the context of such complex developmental phenomenon as HIV/AIDS. This particular virus thrives in the spaces our religious ignorance, hypocrisy, fear, shallowness and laziness. In the space where men and women meet in the continuum of sexuality, experienced and shaped by power, love and physicality that is animal, social and, yes, spiritual, AIDS is the most human virus. And thus it exposes and demands our most basic appreciation of the how religion is part of the human way of living, thriving and adapting: in short, how religion is an asset for health. Although AIDS represents a not-entirely helpful window

in the broad understanding of health and disease, it is an extremely helpful window into the heart of religion. And in the last few years AIDS has garnered investment from governments and new intergovernmental agencies (The Global Fund, for example) that is simply without precedent. Thus it becomes a window on the role of global political and social phenomenon that inevitably include religion functioning as both liability and asset.

My primary interest in religious health assets is practical and programmatic: what do we have to work with and how do we work together with it? This second part of the question tends to be underestimated in terms of difficulty. The fact is that nearly every large-scale health initiative underway in Africa today is a fantastically complex weave of secular and religious resources and people woven from an amazing blend of local, national and international components. Thus, planning and implementing anything in a systematic way depends on appreciating the sociology of the range of assets, many of which (especially those that are religious) understand themselves in terms of a language and myth that may not be an easy fit with observed behavior. Collaboration requires a lot more discernment than one would think. The study of religious health assets, which can be understood as primarily being in the service of helping to align disparate kinds of assets, is difficult.

Figuring out how religious networks are assets for health appropriately demands the most simple (and yet undone) tasks in gaining some appreciation for the tangible stuff religious communities have accumulated and built, e.g. about agencies capable of serving clinical goals or making available the latest medical tools, be they aspirin or antiretroviral therapy. Without apology, I want the map of those assets so that religious and secular leaders at all scales can design and implement programs that offer the mercies of modern medicine.

However, gaining an accurate map of religious health assets tells us little about how to use them. For that we need to understand the connection between the visible tangible assets and the phenomenon, which produces the fruits of faith, conviction and hope. That is a bit much to expect from governmental leaders and technicians, but through ARHAP we seek to help each other to find a way into the vital heart of the religious phenomenon as it lives to evoke, and sustain, the emergence of health in families and communities. From my perspective this moves us toward questions of life, faith and leadership:

- *Life, not disease or pathology*. Religion itself is a language of life, of what contributes to life, of what sustains it in the face of so many things that feed death. At this point, religion pulls the disciplines that think of themselves as "health sciences" toward greater depth than they usually aspire to, since most "health disciplines" spend most of their time analyzing risk vectors and causes of death. Religion answers a more complex and enduring question, the question of life. These are far from unattached to health.

  Indeed, one could—I hope we do—find that the religious phenomenon with its full menu of ritual, symbol, social practice, nuanced and evocative language is fundamental to how the human species lives, even thrives. A weak mammal with many obvious animal vulnerabilities, human religion is part of our adaptive capacity—a vital asset that demands appreciation from multiple linked disciplinary perspectives.

- *Faith, not extrinsic behavior*. If the above is true, religion functions along a continuum that includes both extrinsic and intrinsic aspects and many that are

interwoven. It is worth noting that many extrinsic affects of religion are tightly linked to positive health behaviors and protect against negative ones. So even the "simple" extrinsic religious affect is often a health asset.

But more interesting, to me, at least, is how and where faith is nurtured. Faith, in my tradition being understood as the substance as that which is hoped for but not yet seen, is a crucial adaptive asset when a family or larger scale social entity is faced with an unprecedented challenge or opportunity. Faith makes possible adaptive leaps as it is not surprised by surprise; it anticipates that which may not yet have precedent; it enables action beyond data; imagination not entirely captive to existing technique.

I will not argue against "evidence-based" practice, except to note that it is not entirely adequate to challenges without precedent, such as those we now face in AIDS in Africa. I might even say (perhaps our case studies will illuminate) that evidence is helpful for excellence, but faith for innovation. Faith can also morph toward fantasy, denial of reality and feed delusional behavior. But many anti-colonial revolutionary leaders made reality out of dreams of independence because they had been nurtured (sometimes unintentionally) in faith.

Where is that faith-forming entity or entities today in Africa? Which of its forms produces the kind of faith that contributes to life and the capacity for vital adaptivity?

- *Boundary leaders, not functionaries.* As health is a social phenomenon at every scale, the critical question is about leadership, the locus of intentional adaptive, innovative choice-making that contributes to life. How do social entities, be they congregations, womens' groups, villages, or global agencies move in new directions? How do leaders create new webs of relationships that cross over previous impermeable cultural or political or financial membranes to form new collaborative responses to health risks or opportunities?

  The current move to make ART available to millions of people in Africa should offer an extraordinary number of illuminating case studies of such adaptive leadership at every scale. But it will be important to keep our curiosity alive long enough for the full story to emerge and to protect us from premature clarity about how such leaders are formed, sustained, prepared, protected in webs that allow transformation to happen. I think of these as "boundary leaders" drawn to the spaces between clear lines of authority and control.

  In Africa today there are almost no such lines; yet we find almost every form and scale of human organization operating simultaneously and frequently in some interrelationship. This phenomenon offers up basic religious questions about leadership character, role and identity formation and how all three may be transformed in the context of engaging health challenges and opportunities.

Life, faith and leadership serve for me as framing questions that make me very curious indeed about what might be found through a careful appreciative examination of a small number of well-chosen African cases. The fundamental evocative power of this search carries promise for those of us who live in communities far from Africa, but also face enduring challenges that seem intractable and tempt us toward despair. Thus, I anticipate our time together in July as a time to help each other discover how we might live appropriately in these most curious times.

PUBLIC HEALTH ECONOMICS IN THE STUDY OF RELIGIOUS HEALTH ASSETS

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What follows represents a stream of consciousness rather than a well formulated piece, offered as one dimension of ARHAP's thinking.

Preamble

Public health, like ARHAP, is multi- and interdisciplinary, and is, at its roots, social, economic and political. If done right, public health is a subversive activity. What is public health? It's not an easy question to answer. Most definitions share the premise that the subject of public health is the health of populations—rather than the health of individuals—and that this goal is reached by a generally high level of health throughout society, rather than the best possible health for a few.

Scholars and practitioners are conflicted about the "reach" or domain of public health. Some prefer a narrow focus on the proximal risk factors for injury and disease. Others prefer a broad focus on the sociocultural foundations of health. Those favoring this latter position see public health as an all-embracing enterprise bonded by the common value of societal wellbeing.

Ultimately, the field is interested in the equitable distribution of social and economic resources because social status, race, and wealth are important influences on the health of populations. The expansive view of public health may well be justified by the importance of culture, poverty, and powerlessness on the health of populations. Yet, to many, this all-embracing notion is troublesome.

First, there is the problem of excessive breadth. The field of public health appears less credible if it appears to overreach. Second, there is the problem of expertise. Finally, there is the problem of political and public support. By espousing controversial issues of economic redistribution and social restructuring, public health risks losing its legitimacy. Public health gains credibility from its adherence to science, and if the field strays too far into political advocacy, it may lose the appearance of objectivity.

I take the more expansive view of public health. If we do not do so, we risk approaching the challenges of the public's health through a technocratic lens, a magic bullet approach. The technocratic approach, I would argue, is what dominates the current global health agenda and priorities. You can see it in the proliferation of global disease elimination and eradication efforts, the focus on distribution of ARV's for AIDS treatment, the search for new drugs, new vaccines. I do not decry these efforts – in fact, I am involved in two of the major disease control global elimination programs, onchocerciasis and lymphatic filariasis – but I do see the global preoccupation with technical fixes as an evasion.

Focusing only on 'science' – with a very narrow definition of what constitutes science – and empirical evidence, public health somehow believes that rational arguments will win the day. Policy will be based on research. No need to engage in the dirty business of

politics or advocacy, much less the fundamental realignment of economic and social power relationships.

If we take the technocratic view of public health, studying religious health assets is not particularly relevant, except as the assets can be used as instruments to implement the technocratic interventions. But if we take the more expansive view of public health, then understanding RHA's is very relevant because they hold a lot of the DNA of communities and social structures.

If the unit of analysis of public health is populations, the unit of analysis of neo-classical economics is the sovereign individual and firm. Needs are expressed as demands and the allocation of resources is arbitrated by the price mechanism through competitive markets. For all kinds of reasons, primarily the public good attributes of public health functions and services, public health doesn't fit easily into the neoclassical model. And that's why I make a distinction between health economics and public health economics.

Health economics generally takes both an individualist and a market approach to health care – certainly this is true in the USA. Most health economists were educated in traditional economics programs and 'discovered' that health and health care do not fit the market model. So the key is to make the health care market work rather than accept that it is different and requires a distinctive approach. Most health economists ignore public health and certainly ignore the concerns of those in resource-poor environments (developing countries).

Public health economics uses the analytical constructs of economics, particularly welfare economics, and the perspective of public health to address issues like the political economy of health and the unique economic aspects of health in developing countries.

A Particular Health Economics View on the Study of RHAs

1. Global public health policy environment and a focus on strengthening health systems

Health systems are most fragile in the countries and regions of the world where the disease burden is greatest. While this may seem self-evident, it is only recently that the global health agenda has turned its attention to strengthening health systems in a meaningful way. The evidence for disease intervention has developed much faster than the evidence base for strengthening health systems and thus most global health programs have elected to go it on their own by developing separate supply chains, distribution mechanisms, monitoring and evaluation, training, etc. The urgency of the task, e.g. to eradicate polio, has taken ascendancy over health systems strengthening. The latter has been seen as a black hole for investment with no clear returns to governments or to external donors and with little or no available evidence to make a strong case.

That is changing. The desire to scale up distribution of ARV's in Africa has brought the fragile state of health system resources – infrastructure, financial and human – into sharp relief. The work of the Global Fund on AIDS, TB and Malaria has also highlighted the need for attention to the health system.

This is all good news. But the shortcoming is that the strategies to strengthen health systems are being spearheaded by the same economists and health services researchers who are committed to a particular brand of investment – e.g., the market for health care and pharmaceuticals. Key strategies are usually privatization, contracts, user fees, use of financial incentives, insurance mechanisms, etc. While these strategies are appropriate

for some health services, they are not appropriate for most public goods. The debate about health systems strengthening is still the purview of the 'experts' and has not yet been opened to the public – communities, civil society, religious structures.

So where do my interests lie? They are shaped by working in strengthening health services and health financing systems in several African countries, including Uganda, DRC, Nigeria, Liberia, Malawi, Burkina Faso, over the last 15+ years, with a focus primarily on community based health financing mechanisms, understanding household behavior in the allocation of scarce resources for seeking health care, policy dialogue at the sub-national and national level around health systems financing decisions. They are also shaped by participation in the Partners for Health Reform Plus, in two global task forces charged with the interaction of specific disease control programs with health systems, and by my knowledge of the players in health systems reform at the global level and in many countries. They are shaped by methodologies for assessing health systems, health services delivery strategies and health financing mechanisms in terms of efficiency, effectiveness and equity.

This experience tells me that health systems reform is a crucial topic these days. And because the assets of religious organizations and institutions are seen as central to strengthening health systems in many countries, I am convinced that this is a critical contextual area of engagement for the study of religious health assets. There is considerable momentum for health systems reform and strengthening. The role and performance of RHA's will be high on everyone's list.

2. Economic Evaluation

At a more micro level, I have conducted many economic evaluations of specific global public health initiatives including immunization programs, malaria, HIV/AIDS, onchocerciasis, lymphatic filariasis, trachoma, and child survival programs. A key component of all these evaluations has been detailed costing of alternative strategies for achieving explicit public health goals. Most donors, bilateral and multilateral, require an economic evaluation as part of the justification for resource allocation. Cost-effectiveness, cost-utility and cost-benefit analyses have become part of a standard tool kit for ministries of health and NGO's.

The cost structures of RHA's are not well known although some comparative work has been done, e.g. costs of government hospitals compared to mission hospitals in Malawi and Lesotho. Less is known about the comparative costs and effectiveness of RHAs, private sector and government facilities/institutions re delivery of public health services and functions. ARHAP can be an impetus for doing appropriate economic evaluations of RHA's, ensuring that the information is fed into the critical policy and decision making groups, and training RHAs to conduct these kinds of analyses with rapid assessment methods and standard protocols.

3. Economic and Financial Meaning of Assets

While we have begun to develop the constructs around the meaning of the term assets, I don't think we have rigorously thought about the meaning of assets from an economic and financial perspective. This is critical if we see assets and RHA's in particular as things that appear on balance sheets, can be leveraged, and are fungible. Economics and accounting have some interesting ways to measure assets, particularly intangible assets that have resonance for the study of religious health assets.

As just one area to think about – in order for assets to be traded or leveraged, there is a need for understanding the ownership of such assets, i.e. are there property rights.

How are property rights, particularly of intangible assets, codified? Are they codified? I haven't developed this line of thinking but I'm wondering if one scholarly contribution that ARHAP might make is to describe and develop methods to define the property rights – physical, financial, human, social – that reside in RHA's, and how these property rights can then be used to further the goals and vision of the RHA's in policy deliberations and decisions.

As a final thought, I have often described the impetus in health care management and financing today as the movement from covenants to contracts. As we move away from trust and implicit forms of accountability and governance to more formal contracts, we lose the grounds of social solidarity that have been the foundation of much health care delivery and financing around the world. I think this has profound implications for the future of global public health. ARHAP can take the lead on describing the implications of this transition, the countervailing principles and strategies to mitigate it and the specific ways to maintain covenants in a contractual climate.

DELIBERATIONS ON RELIGION AND RELIGIOUS HEALTH ASSETS

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"Religion" in Religious Health Assets

The idea of "religion" is notoriously slippery. One of the main problems that scholars of religion deal with is how to define their subject. This is not uncommon for many central concepts in the human and social sciences, of course (and it is more common among the natural scientists than much lay opinion imagines too). 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 (see Derrida and Vattimo 1998), and with a flawed history in the part of the world influenced most strongly by that heritage (usually called "the West").

ARHAP's work is inevitably impacted by this conceptual and historical legacy. This becomes obvious the moment one steps into the African world and discovers, first, that Africans were originally thought by Europeans to have no religion, hence, to not really be human (see Chidester 1996); then later to have a kind of religion after all, but a primitive, hence inferior one. Second, many standard ideas of religion in the West, at least as they have evolved under modernity and the Enlightenment in particular, do not fit African ways of thinking. For example, the theory of secularization has dominated much Western thinking for long, with its view that religion would wither away or be relegated to the private personal realm, and the parallel view that religion reflects a purely anthropomorphic longing born of human unfulfilment or an ideological apparatus legitimizing power. This picture simply does not work in much of Africa (much of the world, one may add).

Two things flow from this for ARHAP. One is a turn to a different view of religion—not a romanticized or anesthetized one, for the negative dimensions of religious life and practice are not trivial—but one that seeks to respect and pay attention to the energizing, transformative, imaginative, relational and transcendent aspects of religion that play such an important role in the way in which the great majority of people deal with daily life and find resources for vitality and healing within them. Hence, using Gary Gunderson's language, we have taken to speaking of how we may discern in religious health assets some of the "leading causes of life".

The second thing that flows from our encounter with religion in Africa is the need to recognize that people deal with health challenges using a mix of strategies that usually includes several worldviews, some of which are almost always religious in character. Another of our colleagues calls this the mix of "healthworlds" that we must take into account in understanding religion and health in Africa. One small, recent study in a black township near Cape Town suggests, for example, that people seeking care for various health needs (physiological, psychological and spiritual) turn differently to "Western medicine", traditional healing and faith healing according to the kind of problem they have, their denominational background and their gender, but always by mixing all three strategies at some point or another (Gwele 2005).

Grasping a Complex Phenomenon

The way in which people seek health, the strategies they use, the religious healthworlds which shape their choices and practices, all have a significant impact, we hypothesize, on how well or badly health interventions from outside (government, international health NGOs, development agencies, etc.) turn out to be. Thus, our interest in religious health assets also has to do with the articulation between public health systems and what people do, influenced by their religious healthworlds, for their health in reality on the ground, where those systems are sometimes weak, ineffectual, counter-productive or simply absent.

The evidence base needed to make a good case for what we are trying to understand, given the deep rooting of religion in culture and human imagination and action, cannot be provided by standard survey tools alone, nor by quantitative methods alone. Nor can that evidence base emerge from rapid assessment alone; and neither can it be framed in terms of one angle of enquiry or "discipline" alone with any hope of grasping the complexity of the phenomenon of religion in the interplay with health. Our metaphor to describe the current state of knowledge about religious health assets (or faith based initiatives in health, as others might say it), is that of "a porous, bounded realm of unknowing."

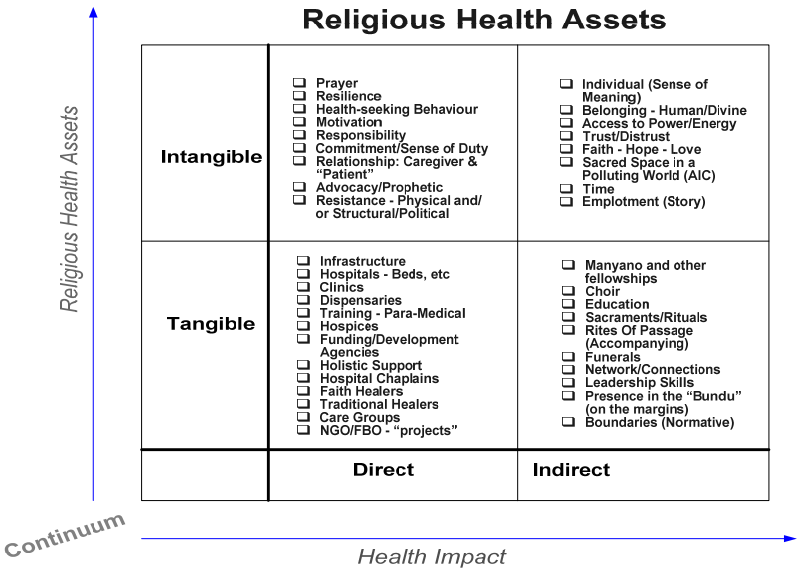
Necessarily then, ARHAP's research design is deliberately complex, cross- and inter-disciplinary. This makes for a more difficult research design, with issues of scope, scale and control over research foci and results being particularly pressing issues. We assume that little is known of what religious health assets are and how they work; that what is known is fragmentary and frequently merely quantitatively empirical. We seek "thick description." This means approaching the "realm of unknowing" from any number of perspectives, or "angles of inquiry", paying attention to both the more readily "countable" or "measurable" aspects of religious health assets at the same time as pushing beyond, or below, the relatively superficial picture that would otherwise result.

The Intangible Force of Religion

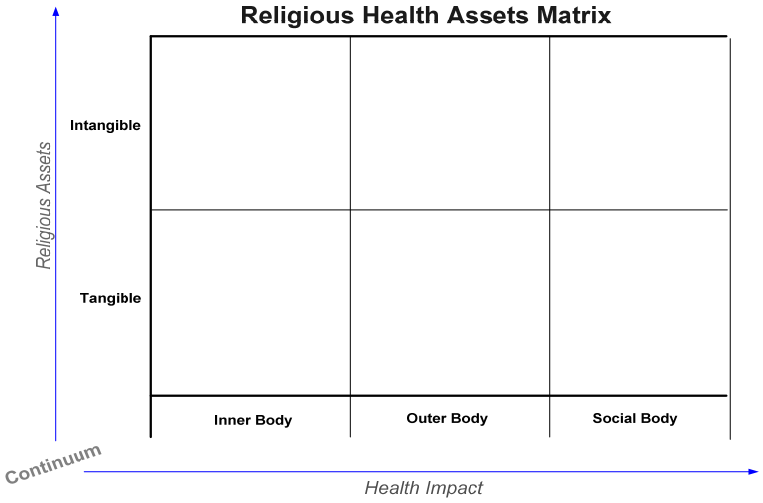
Religions, or religious traditions or worldviews, most often issue in a diversity of functions and structures that can readily be identified—through the way in which they organize sacred spaces, construct ritual performances, identify leadership, or create institutions, and so on. Where such functions and structures are turned directly to the promotion of health or the healing of illness and disease, it is relatively easy to identify what we have called religious health assets (although this is far from saying that the actual identification of such things in Africa is known in any systematic way, or at all, in itself a challenge to be met).

But many religious health assets have to do not with visible institutions, structures or organizations—say, religious hospitals, clinics, dispensaries, hospices, care groups, and so on—but with invisible or intangible realities that nevertheless make a big difference in the way health is perceived, pursued and maintained.

One initial way of capturing this complex reality that we have provisionally adopted is by viewing different kinds of religious realities in relation to their health impact within a heuristic matrix of religious health assets, an array of tangible organizational assets as well as intangible assets with both direct and indirect health affects. This produces a diagram such as the following:



Another possible constellation for a matrix of religious health assets, without any specific identification of particular religious assets for the moment, might look as follows. In this case, instead of "direct" and "indirect" health impacts as the x-axis, the matrix differentiates between mental health ("inner body"), physiological health ("outer body") and public health ("social body"):



The metaphor of "body" is dominant here, but it reflects a meaning of "body" that resists the Cartesian mind-body dualism so characteristic of much Western science. In doing so, it would open up a different view on the relationship between religion and health, one certainly more suited to the African context, though by no means only an African one. Probably the categories for the y-axis would be better formulated in other terms than "tangible" and "intangible" as well in this case, but the diagram is only illustrative here. And these two possible matrices could be supplemented by others.

But the point is clear: We are after ways of understanding religious health assets in all dimensions, even if we are aware that these heuristic tools are merely guides to reflection and research and not a description of the reality itself. Part of what we seek, what is needed, in other words, is a richer conceptual and theoretical framework for

understanding religious health assets than has been available to date.

What Makes the Difference, and Is There One?

On the basis of our current understanding, we suggest that the difference that religion makes to any health practice or institution—if there is a specific difference that marks, say, a faith based organization overtly engaged in health and healing from any other (in itself a focus for research)—will lie at least in how religious faith motivates action, sustains commitment, and enhances a holistic vision of health.

To understand this, however, means to turn to those ideas, practices and arrangements that provide the substrate for motivation, commitment and a comprehensive vision. We have begun to speak of this in terms of 'faith forming entities' (FFEs). Most public health agencies and funders have chosen to speak of "faith based organizations" or FBOs in this context, which implies quite clearly that a visible organization is the touchstone of analysis and policy. But not all religious healthworlds fit this description.

"Faith based entities", we believe, more accurately encompasses the diversity of religious phenomena in Africa that have, or potentially might have, public health impact. The African context highlights other aspects as well, of the nature, function, strengths and operational character of community entities that exist primarily to form faith. Briefly, we suggest, therefore, that:

- FFEs in Africa do not conform to the neat categories of doctrine, structure, organization, most often used by scholars in the western tradition; truncated concepts of these phenomena impoverish and potentially undermine the contributions that such organizations can make to public health and health systems in general.
- they have qualities that are health assets, and these may move from being resting assets to manifesting active agency in contributing to health.
- no-one has a sense of their combined scale and contribution to public health, and they often go unrecognized; and even when they are recognized, they are likely to be misunderstood, sometimes overestimated, and sometimes undervalued in terms of their contribution to health.
- the language of religious studies and the language of public health have few cognates and there are few who are bilingual: What is needed is an interdisciplinary language to develop tighter, empirical, comprehensive and systematic concepts of religious health assets and agency.

This points to an overarching concern in the research we will conduct, namely, the hermeneutic construction of religious worldviews on health, worked out on a comparative basis across the case studies we are pursuing. Behind this approach lie assumptions that, first, attitudes, behavior and actions (e.g. choices about how to deal with health challenges) are framed in the first place by interpretations of the world, of body, of oneself in relation to the other (Cochrane 1993); second, that such interpretations are powerfully religious and fundamental for the great majority of people (Cochrane 1999); and third, that these interpretations are fields of contestation (Comaroff and Comaroff 1991).

Health interventions may be guided by frameworks of interpretation alien to the health-seeker or provider, and may even be seen as hostile and fail to "translate" across

these divides (Bate 1995). Even when the technical intervention is effective in another cultural and religious context it is likely to fail, if not in the short term, then over the long haul. In this sense, good hermeneutic insight and the wisdom to use it have deep developmental implications, for the health sector as much as any other (Benn 2002).

Religion on the Move

When one thinks of religion in any particular context, we commonly imagine that it is bound to and shaped by a local community or institution of some kind, in a way that embodies enduring and durable practices and arrangements in a fixed place. Especially if one thinks of congregations such as those that are normal in the Abrahamic religions.

If this ever was a largely accurate picture of religion, it is certainly not now, in very many places and contexts. Under conditions of contemporary globalization, movement and mobility—whether chosen voluntarily, pressed upon one by circumstances, or forced upon one by others—are as likely to define religious phenomena as are stability and locality (Brettell 2000; Cochrane 2003). A transnational view on religious reality does away with what has been called the dominant "methodological nationalism" of most social sciences (Nina Glick Schiller and Andreas Wimmer, cited in Levitt 2004), in which the nation state is taken as the natural organizing category of social life (Kearney 1999).

We would then need to understand religious health assets as being strongly defined, among other things, by movement, mobility and migration, at least as much as they are defined by stable local groups or communities. The dynamics of migrating ideas, people, resources, finances and structures would become a focus in understanding how religious health assets work, why they work, and where they work. One may intuit that such dynamics will considerably affect patterns of behaviour and the kinds of practices that individuals, groups and communities manifest, with a measurable impact on health, on health seeking strategies, and on health interventions.

Policy Frameworks and Translation

Much health policy in the world is governed by the modern conception of the nation-state. Within this framework, governance largely proceeds through bureaucracies best suited to dealing with organizations or groups in terms of their public presence (Scott 1998). Religion, however, is not always construed in terms of visible institutions, let alone representative ones. In Africa, religion is equally, if not more often, rooted communally (Everett 1999). There are often no clear representative structures or visible institutions given over specifically to religion as if it were an independent social reality or sector.

This directly affects how policies play out in real contexts, and may explain why they often fail. Policies that are not appropriately rooted in local realities, commonly give rise to apathy, passivity or resistance at local level and beyond (Froestad 2002). One dimension of much "local reality" in Africa is the holistic worldview that includes religion and does not separate it out from life or energy producing forces, that is, from health (Smidt 2003).

A second relevant aspect of the policy environment in southern Africa concerns the construction of the nation-state itself.(Habermas 2001) For reasons that are rooted in social history, much health policy in the region, especially when it is directed externally in some way or another by outside agencies, assumes a split between state and religion that is much less radical than may be supposed.(Cochrane 2000) The modernist model,

with its heavy inclination to a form of secularism that treats religion as derivative, secondary or private, is at work here.(Casanova 1995)

Both of these reasons—the way in which "religious organizations" are embedded in communities; the policy alternatives that may be identified in researching their social location—taken together with earlier comments on the mobile, even transnational character of what are often assumed to be relatively stable communities (Brettell and Hollifield 2000), drive us to consider new policy frameworks capable of taking into account the realities that shape the actual and potential contribution of religious health assets to healthy people and healthy lives.

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A Comment on Collaboration

ARHAP is a work in progress. Some two years has been spent on preliminary investigations, conceptual clarification and identifying key theoretical starting points. Many people have made inputs into this discussion—colleagues, potential donors, interested agencies, among others—and certain guiding concepts, theories and foci have emerged as a result. And this process has in many respects only just begun.

A Practical and Epistemological Imperative

Perhaps the most important thing to say, then, is that we are persuaded that the complexity of what we are trying to understand is sufficient to tax any single group of investigators, and that only a collaborative approach will be adequate to the task. The four case studies we have planned to begin with – a country study in Lesotho (underway), a local study in the Eastern Cape, South Africa (beginning in March), a regional study in Zambian Copperbelt (in planning), and a network study in Zimbabwe (awaiting funding) – illustrate this commitment. Each is led by a different team of researchers from different research institutions.

Collaboration for us means not just drawing in as wide a range of people from as wide a range of relevant disciplines or practices as possible, but a determined desire to maximize the possibilities of our research in contributing to anyone and everyone who might benefit from it. From the outset, then, we have sought to put in place the rudiments of what we hope will gradually become a powerful network of interested people working in synergy with each other for common purposes in tackling public health crises in Africa.

But collaboration is also important for theoretical reasons. The object of our study – religious health assets – is obscure, difficult to grasp in its fullness, simply because it touches on so many dimensions of human and social life simultaneously. No one discipline or angle of view on this field will offer us a remotely adequate understanding of it, sufficient to guide new ideas, practices and policies that can make a difference. This is the epistemological imperative that makes collaboration essential for ARHAP.

It also makes it clear that ARHAP can only be the beginning of a much larger, and surely much longer, research programme. A further implication of our sense of religious health assets as a bounded field of unknowing has to do with the limits of existing theory. We will learn a great deal about religious health assets only through doing the research, and our theories, however formed by initial ideas and concepts, must ultimately rest on what we discover on the back of the practical realities and imperatives of real people in concrete situations.

PART TWO
Plenary Addresses

Methods and Concepts for Assessing the Health Assets of Religious Gatherings in Africa

Nancy T. Ammerman

Boston University

For more than a decade I have been engaged in the study of congregations in the U.S., observing and interviewing and surveying people in communities across the country and in every sort of religious tradition.[1] They range from tiny to enormous and from declining to thriving, from old and venerable to new and fragile. But what we know about U.S. congregations may only hint at what we need to know about religious gatherings in Africa. So what I will offer in this presentation is a humble and tentative set of suggestions and lessons that may at least stimulate our thinking about how to assess what religious communities bring to the task of fighting HIV/AIDS and otherwise enhancing the health of African people and societies.

U.S. congregations and other religious organizations simply do not have to deal with many of the on-going challenges facing African religious communities. The tragedies of September 11, 2001, offer the closest approximation in our recent history, so I want to begin with a brief look at the sorts of things American congregations and their partners brought to that situation.[2] In the aftermath of that horrific day, thrown into a state of chaos, with enormous immediate and long-term social and economic needs, American religious communities were critical players (for good and ill). How so, provides my starting point.

[1] See, for example, Nancy T. Ammerman, "Grieving Together: September 11 as a Measure of Social Capital in the U.S.," in *September 11: Religious Perspectives on the Causes and Consequences*, ed. Ian Markham and Ibrahim Abu Rabi (London: Oneworld Publications, 2002), Nancy T. Ammerman et al., eds., *Studying Congregations: A New Handbook* (Nashville: Abingdon, 1998), Nancy Tatom Ammerman, *Congregation and Community* (New Brunswick, NJ: Rutgers University Press, 1997), *Pillars of Faith: American Congregations and Their Partners* (Berkeley, Cal.: University of California Press, 2005), and Carl S. Dudley and Nancy T Ammerman, *Congregations in Transition* (San Francisco: Jossey Bass, 2002).

[2] This account draws on "Grieving Together: September 11 as a Measure of Social Capital in the U.S..".

Providing and Organizing Social Service Delivery

The most publicly obvious religious contribution was the fact that congregations provided direct and tangible social services to their members and communities – food, clothing, shelter, counselling, medical assistance, a place to rest, and more. In recent years, a number of studies have attempted to quantify the routine social service contributions of congregations.[3] We now know that it is considerable, but in times of emergency, additional latent capacity can be mobilized, as congregations and religious social service agencies take on the role of trusted organizer and distributor. They are already there – wherever there is – and can be the primary organizing point for response. That is possible, as well, because this pattern of care is lodged in an institutionalized set of cultural expectations.[4] U.S. culture sees helping the needy as a religious virtue and expects religious organizations to be engaged in service activities. So in the aftermath of 9/11, people volunteered at their churches and synagogues and wrote out checks to established religious charities. And sanctuaries from Ground Zero to the Pentagon became sources for material and psychological assistance.

Mobilizing their own resources and the volunteer resources of others, then, congregations themselves provided aid, but they also provided infrastructure for the work of others -- meeting space and transportation, bulletin boards and public address systems, copying machines, internet connections, and paper. A great deal of what congregations do in the community is not done alone. Far more common than programs run by single congregations are patterns of service provision that involve a complex network of organizational partnerships – connections that include everything from informal coalitions among churches to formal programs run with government support to money and volunteers and space provided to religious and secular nonprofit agencies. Across all the congregations we surveyed in our most recent study, there are, on average, six partnerships through which outreach work is done.[5] This is over and above whatever connections a congregation may have through its own denomination and beyond what it may do on its own.

The networks in which congregations participate reach, of course, beyond the immediate neighborhoods in which they are located. Most commonly they are metropolitan and county-wide, linking groups into cross-town relationships. But they also stretch across the nation and around the world, and it was especially these larger networks that sprang into action following September 11. People far from New York and Washington found ways to be connected to people who needed their help. Major international NGOs (and denominations) served as coordinating bodies that expanded to accommodate the enormous influx of donations and volunteers that poured in from around the world. Organizations like this can be in place for the long work of recovery

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[3] See Ram A. Cnaan et al., *The Invisible Caring Hand: American Congregations and the Provision of Welfare* (New York: New York University Press, 2002) and Mark Chaves, *Congregations in America* (Cambridge, Mass.: Harvard University Press, 2004).

[4] Robert Wuthnow describes this institutionalized system of volunteering in *Acts of Compassion: Caring for Others and Helping Ourselves* (Princeton: Princeton University Press, 1991).

[5] Reported in Nancy T. Ammerman, "Connecting Mainline Protestant Congregations with Public Life," in *Quietly Influential: The Public Role of Mainline Protestantism*, ed. Robert Wuthnow and John Evans (Berkeley, Cal.: University of California Press, 2002), Ammerman, *Pillars of Faith: American Congregations and Their Partners*. and Nancy T Ammerman, *Doing Good in American Communities: Congregations and Service Organizations Working Together* [internet] (Hartford Institute for Religion Research, March, 2000 [cited 2001]); available from http://hirr.hartsem.edu/about/about_orw_cong-report.html.

and rebuilding, and their pre-existing infrastructure was critical in the immediate days and weeks of crisis response.[6] The work of facilitating the delivery of social services, then, is the first and most obvious way in which congregations have latent capacities that can respond to meet the needs of a crisis.

Building Community

Congregations could provide these services and connections in part because they had already done the work of building a community among themselves. Congregations routinely gather people together, providing a place of belonging, caring, and comfort for their own members and for strangers who may join them. In fact, congregations themselves recognize this internal community building role as among the most important things they do. They provide "fellowship" activities and try to build a family-like atmosphere for their members. They take seriously the task of creating communal events and spaces where people meet, debate, celebrate, grieve, and know each other on a face-to-face basis.[7]

One result is that people in congregations take care of each other. Congregations are a "first response" social service agency for their own members. They supply food and child care and job assistance and in-home visits to the elderly, sick, and mourning. The congregation is a place of belonging that is bigger than the family itself and into which one does not have to be born, but a place where virtues of common good and public accountability can be learned and practiced in ways that benefit the society as a whole.

After September 11, many in the U.S. seemed to sense exactly this. To be well, they needed to gather, and many chose to gather in communities of faith. Especially in the days immediately after the attacks, wounded and grieving Americans wanted to be with others, to share feelings and stories, to touch and be touched, to declare their citizenship and belonging in some tangible way. When the first weekend after the attack arrived, religious service attendance nationwide jumped by at least 15%, bringing nearly half the U.S. population into its sanctuaries.[8]

Gathering is one of the fundamental "social capital" tasks that congregations do everyday.[9] Their presence is part of the glue that binds people together in such times of crisis. Gathering with others who are recognized as "brothers and sisters" can also, however, lead to dangerous antagonism against those outside the religious family. Since September 11, there have been attacks on mosques and harrassment of individual Muslims, and the "bonding capital" created in the aftermath of the crisis has been used over and over again to mobilize the American people for war. Religious community-building can have a very dark side, in addition to the "health assets" it creates.

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[6] On this latent capacity, see John B. Orr et al., *Politics of the Spirit: Religion and Multiethnicity in Los Angeles* (Los Angeles: University of Southern California, 1994).

[7] Ammerman, *Congregation and Community,* Penny Edgell Becker, *Congregations in Conflict: Cultural Models of Local Religious Life* (Cambridge: Cambridge University Press, 1999), R. Stephen Warner, "Changes in the Civic Role of Religion," in *Diversity and Its Discontents: Cultural Conflict and Common Ground in Contemporary American Society*, ed. Neil J Smelser and Jeffrey C. Alexander (Princeton: Princeton University Press, 1999).

[8] *Gallup Poll Topics: Religion* [internet] (The Gallup Organization, 2001 [cited December 1 2001]); available from http://www.gallup.com/poll/indicators/indreligion.asp.

[9] Social capital and bonding capital are concepts most prominently used recently by Robert D. Putnam, *Bowling Alone: The Collapse and Revival of American Community* (New York: Simon & Schuster, 2000).

Creating Sacred Space

In the face of massive suffering and incomprehensible evil, simply gathering was important, but not enough. Both our laments and our hopes needed a sacred hearing. As much as people know they can turn to congregations for material assistance and as a gathering place, they also know that congregations are primarily spiritual institutions. Indeed, we have found that the vast majority of congregations themselves are very clear that their primary task is a spiritual one – to provide opportunities for their members to worship, to help those members deepen their individual spiritual lives, and to provide religious education for their children.[10]

Nor are these spiritual activities without this-worldly consequences. As Peter Berger pointed out nearly four decades ago, the root of the word "ecstasy" is "ex-stasis" or literally standing out of place.[11] The liminal space (as Victor Turner[12] would have called it) provided by worship can often provide both critical perspective and a sense of possibility that have real effects in how people then engage the world outside. Not all churches are "activist," in the usual sense of that word, but nearly all churches think that the spiritual work they do makes a real difference in this world.[13]

That spiritual work has taken as many forms as there are religious traditions in U.S. society, as leaders reached for words and music and rituals to express and transcend what we had experienced. Around the nation, clergy searched for the words to use that next weekend, with record crowds in their pews. In whatever theological categories they had at hand, clergy played their role in helping citizens make sense of a crisis, giving it enough comprehensibility to allow life to go on.

Beyond their sermons, clergy were also challenged to deal with the myriad ritual complications of life and death. Catholics and Jews faced the liturgical dilemma of how to have funerals in the absence of a body. And leaders of all faiths found themselves offering pastoral care for griefs they might never have faced before and in a volume unprecedented for most.[14] Both the living and the dead needed the blessing of religious leaders and religious traditions that could anchor and comfort them in the midst of chaos.

Religious responses were not just words. In the face of such tragedy, many of the most meaningful moments came through sight and sound. Sometimes it was the elusive but deep comfort of a familiar sanctuary, where memories of weddings and baptisms and generations of participation spoke of transcendent connections. Sometimes it was the silence of a sacred space, even an ancient burial ground, or the inspiration of sacred art, stained glass, or soaring steeples. And sometimes it was the sound of a bell. At noon on Friday the 14th, the U. S. President had declared a Day of Prayer and suggested that church bells be rung. As people paused on that day, in a world still disrupted and too quiet, bells rang out, reminding us that our communities and their religious institutions were still there. Both with ancient and well-recognized symbols and with improvised rituals, religious communities articulated both the mystery of death and a sense of hope and transcendence. Our religious institutions hold in trust for us the space and the ritual knowledge that allows this to happen.

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[10] Ammerman, *Pillars of Faith: American Congregations and Their Partners*.
[11] Peter L. Berger, *The Sacred Canopy* (Garden City, New York: Anchor Doubleday, 1969).
[12] Victor Turner, *The Ritual Process* (Ithaca, New York: Cornell University Press, 1977).
[13] Omar Maurice McRoberts, Streets of Glory: Church and Community in a Black Urban Neighborhood (Chicago: University of Chicago Press, 2003).
[14] Daniel J. Wakin, "Seeking Guideposts to Help in No-Man's Land," New York Times, November 18 2001.

Religious Innovation in the Face of Tragedy

Times of crisis are also likely to be times of religious innovation, and 9/11 was no exception. In a culture already characterized by widespread spiritual questing,[15] this crisis brought questing people together in new ways. Interfaith prayer services, candlelight vigils, and spontaneous public shrines were three of the most common ways that strangers came together to symbolize their griefs and their hopes. The U.S. publicly experimented with ways to honor its enormous religious diversity, attempting to balance acceptance of particularity and need for common ground. Sometimes that was best accomplished in widely-shared ritual gestures, such as lighting candles. People have long been drawn to the wonder of fire's warmth and light, using it to express what they have no words or other rituals to express. Around the world, especially on that Friday "Day of Prayer," candles were placed on porches and sidewalks, sometimes only one, sometimes hundreds. When stars of the entertainment industry broadcast their telethon on September 21, they chose candles as their only stage setting. People who had no other religious connection or tradition drew on this one to mark their participation in something beyond themselves, something somehow eternal.

Public religious expression also included spontaneous public shrines, an increasingly common ritual gesture. At firehouses and public squares, embassies and the disaster sites themselves, assemblages of flowers, candles, and mementos were the material "vocabulary" of this modern grieving ritual. Begun without official deliberation or fanfare, one bouquet invites another. "The shrines are a metaphoric threshold which represents the end of numbness and the beginning of the ability to take action," writes Sylvia Grider, who has studied such shrines in recent years.[16] We have learned new collective rituals that remind us we are not alone.

These observations about responses to 9/11 provide, then, a tentative set of questions and categories we might use as we think about what religious communities bring to the task of creating healthy communities. I want to suggest that we might think of these gatherings as *collectors* of material, relational, spiritual, and informational assets that have been generated in larger religious institutions and traditions, as well as *creators* of artifacts, bonds, experiences, and stories that come out of their own experience together. In addition, they exist in a dense web of *connections* to people, resources, and power beyond themselves. That is, religious gatherings import elements in from the outside, mix them up in a creative brew of their own, and can potentially send that brew out along all the lines of connection they individually and collectively represent. Our task is to look for the kinds of elements in each of these categories that bear on the ability of that gathering to lead toward (or away from) life.

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[15] Wade Clark Roof, Spiritual Marketplace: Baby Boomers and the Remaking of American Religion (Princeton, New Jersey: Princeton University Press, 1999).

[16] Sylvia Grider, *Preliminary Observations Regarding the Spontaneous Shrines Following the Terrorist Attacks of September 11, 2001* [internet] (New Directions in Folklore, October 5, 2001 [cited November 20 2001]); available from http://www.temple.edu/isllc/newfolk/shrines.html. See also Mark Stevens, *Modern Ruins: How the Spontaneous Outpourings of 'Art' since the Disaster Have Brought a New (Old) Look to the City* (November 12, 2001 issue of New York Magazine) [internet] (Newyorkmetro.com, 11/20/01 [cited November 20 2001]); available from http://www.nymag.com.

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Questions & Responses

— There is a strong correlation between this viewpoint and the "health worlds" (*Bophelo*) framework presented in the previous session. This reveals the importance of the sociological dimension.

— Translating the analogy of congregational responses to 9/11 to the African context is problematic as the situation differs vastly. For example, how would the Rwandan experience be compared with respect to national and international sympathy?

— In some respects, this analogy fails because of the difference in global power.

— While positive developments can be expected from congregations in stable situations, in Africa those gatherings are destabilized all the time. Tracing assets here will be more difficult because they are unstable.

— With mobility and globalization it is increasingly difficult to work with different frameworks – with people, resources etc on the move.

— However, this does highlight that what we are learning about the African experience is important to the rest of the world, where even in the "first world" people are experiencing more vulnerability.

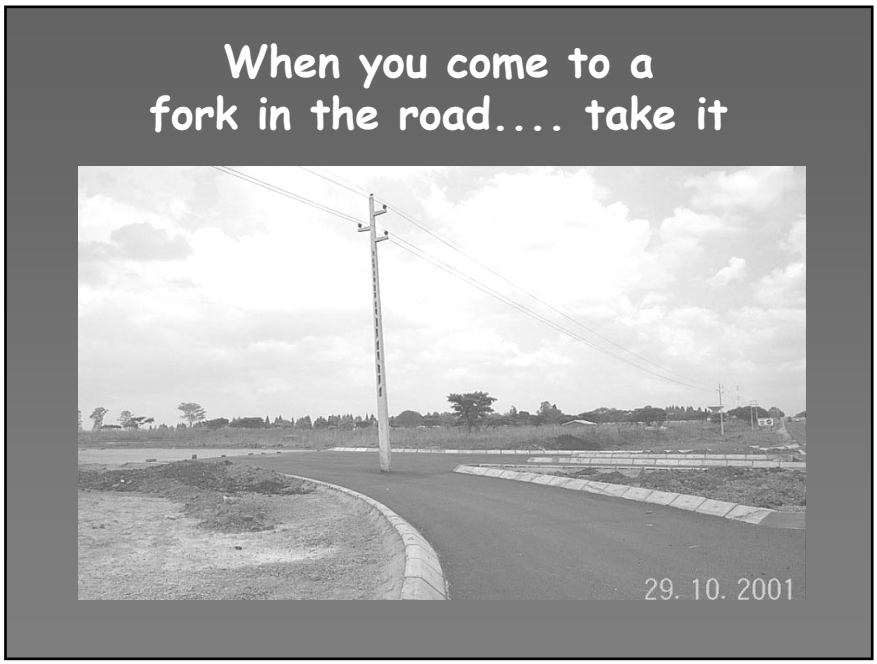
— The difference might also be in the psychology of mass crisis, compared with the tragedy of HIV and AIDS which is ongoing over a long period. If it happened overnight it would be more dramatic and might bind us together more in our common humanity.

When You Come to a Fork in the Road … Take it!

Deborah McFarland

Rollins School of Public Health, Emory University

This (below) is one of my favourite pictures and it comes from Zimbabwe – it's a good metaphor for ARHAP with roads coming in from all sides, an unpaved road ahead and an obstacle strategically placed right in the middle. Thus when you come to a fork in the road, take it!



The original malapropism comes from a great American philosopher (baseball player, actually), Yogi Berra. But there is another interpretation of the quote that until yesterday was unknown to, drawn from Jeremiah 6. Once pointed out to me, I found it said something about…"when you reach a crossroads…do the right thing…". What does this have to do with religious health assets or public health?

Well my trajectory in ARHAP has in some ways been like that picture. I feel that I've come to it down many roads – I understand health assets, public health, health economics…religion…well, I certainly am not a religious scholar, but I have a personal faith…so how did I get into this? I have been involved in ARHAP from its beginning. I met Gary when I needed a visa to Burkina Faso. Gary was the honorary counsel for Burkina Faso for the southern United States.

So I started talking with Gary and started expressing some of my own interests, and eventually asked Gary this very simple question: "Do we know what the evidence base is for religious institutions and organizations - in particular thinking about hospitals, clinics and public health units, in Sub-Saharan Africa…because I'm very interested in those resources. When I look around at the landscape it very often seems that those are the only ones left standing in many places…So what do we know about these things? I don't know…so let's find out. So my preoccupation has been with quadrant 1 of our religious health assets matrix – tangible assets (see Matrix above, page 22).

I take the perspective of a public health economist. If we stand back and ask "what is a public health economist?"… we are implicitly caught up in a contradiction in terms, because for an economist, the unit of analysis is the sovereign individual, and the sovereignty of the individual is paramount, and so we are looking at transactions, demands that consumers make. Economists are interested in individual behaviour and the aggregate sum of those individual behaviours. Public health has as its unit of analysis the population and that population can be communities, countries, the world – but it is a different way of thinking about things. Public health also has within it the notion of public good, and so thinking about and valuing public goods become part of the rubric of public health. To marry those two together is sometimes a very difficult task, as economics folk don't speak public health, and public health folks don't speak economics…and these days it is the economic language that has tended to dominate the globalisation debate and, in my area of interest, the health systems debate. Economics and economic language has become something that many in public health and other disciplines either viscerally react against or we just ignore it. *What I am pleading for is for us to try to bring public health and economics together.*

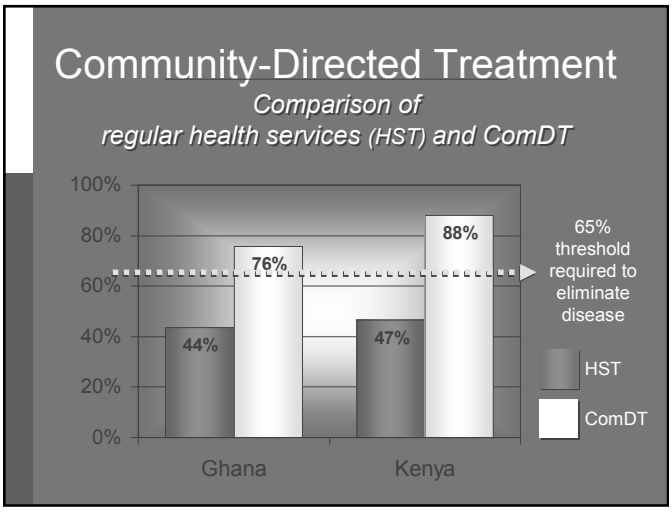
I want to ask the following two questions. I have been pondering these in the context of ARHAP, and I hope they'll provoke some discussion. The two questions are these: Why are all the onchocerciasis river-blindness drug distributors in northern Nigeria men? And what difference does it make? And the second, bigger question: What might an ARHAP'ian approach to health systems strengthening look like?

Religious Values and the Eradication of Onchocerciasis in Nigeria

The first question may seem very strange to you and it certainly requires a bit of background explanation. So let me tell you a bit about river blindness or onchocerciasis. This is a program that is a partnership between a number of organisations - NGOs, Ministries of Health, the World Health Organisation, the World Bank and a number of bilateral donors. There are over 100 projects in some twenty countries in Sub Saharan Africa. The base of the program is what is known as community-directed treatment

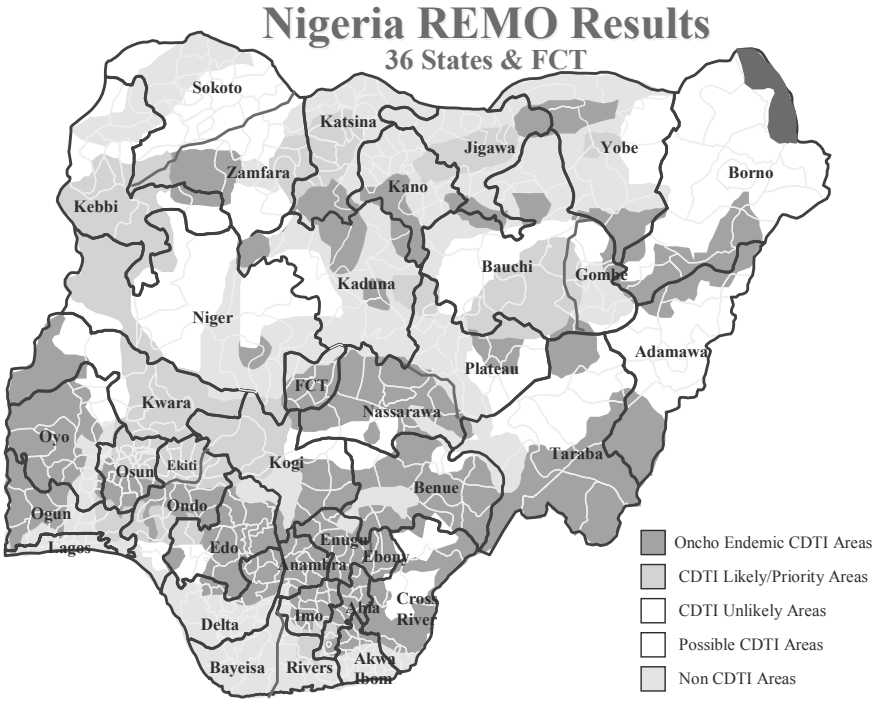
(ComDT), where the community or village is the director – its not just community-based, but community-directed – and the whole thing is based on the distribution of a drug called ivermectin, a drug donated by the pharmaceutical company Merck for as long as it takes to eliminate onchocerciasis as a public health problem in the world. The drug has to be delivered one time a year, one dose, to the eligible population – about 90 million people in Sub-Saharan Africa. It's a drug with absolutely no side effects and a drug that doesn't have a parallel market for any other human disease. The community collects ivermectin from the nearest health facility, the community decides when and how to distribute the ivermectin, the community collectively selects the people who are going to distribute the drug. The drug is distributed by the CDDs – community directed distributors – either everyone comes into the centre of the village, or it is delivered house to house…it's up to the community to decide.

The formal health services are also involved as well as the NGOs in training and monitoring these activities. And so, the sense is, that community distributed treatment (ComDT) has very much empowered local communities. Now in order to eliminate onchocerciasis you have to achieve a threshold of 65% coverage in an endemic population for at least 15-20 years. We do not know the exact endpoint because this is all based on computer models. But in an endemic community in a given area, each year the program must reach 65% threshold to achieve disease elimination.



What you see in the slide is that for the onchocerciasis programs, certainly in Ghana and Kenya, ComDT programs have achieved far beyond 65% and for regular health services they are certainly much lower than that. So ComDT is reaching populations that the health services do not reach and as such the oncho program is being viewed as an opportunity to add on lots of other public health interventions.

In a number of countries in Central, East and Southern Africa, the purpose of the APOC is "to establish in a period 12 to 15 years, effective and sustainable, community-directed treatment of ivermectin throughout the endemic areas within the geographic scope of the program." One of the most endemic countries for onchocerciasis is Nigeria.



Now you can see that oncho is fairly well distributed throughout the country. In each one of the oncho endemic states there is a partnership between the ministry of health, an NGO (that may be a local one or an international one), with some funding from external agents including the World Bank, but that funding is now coming to an end after 8-9 years of consistent funding. Each community and each village is selecting its own distributors and trying to achieve 65% coverage. I am on the WHO technical consultative committee for the Africa program on oncho control, so I spend a lot of my time on this program and in Nigeria. We review these projects at least once a year and in the review the projects report to this technical group on the coverage they've achieved, any problems they've encountered, financial aspects, a whole range of issues.

Each time we get the report from the states in northern Nigeria, we note that the project says they've achieved 65%-75% coverage, they've selected all their distributors, but they are still working to get more female distributors. This is something that APOC has really been pushing, to get more female distributors…so my question to APOC has always been, why do we care? If they are achieving the 65%-70%, if they are selecting their own distributors, if this is embedded in the community, then why are we imposing our notion that says you need female distributors? We get reports from the projects that say we tried but we can't get female distributors because of the religious traditions in the

community, because of purdah, because of a host of other things…it is not in our cultural or religious tradition for women to enter households where men, non-family members, might be … nor is it in our tradition for women to be out doing these kinds of activities. And yet every time the technical review committee meets we say you need to select more women, and every time they come back with the same explanation. And I just keep asking myself, why do we do that? We simply don't seem to understand the cultural or religious norms in this community, we are superimposing on top of that our notions of gender equity, when the whole purpose of the program is to establish a sustainable community directed program.

It seems to me that if I had, in the early days of my technical committee consultative membership, been part of ARHAP, I might have been able to inform that debate in a much more informed way than I have been able to do so far. This has very little to do with economics. For me this is a very simple example of the intersection of religion and public health – and perhaps Western social values that we are trying to impose or trying to include, in a sense of spirit or good will, on a community that has totally different religious tradition, a different approach to the selection of distributors … but indeed is doing a great job. So why, in northern Nigeria are they all men? Because it fits. It aligns with religious traditions and with cultural norms. And what difference does it make if there are no female CDDs? In terms of public health outcomes it makes absolutely no difference.

Public Health and Health Systems

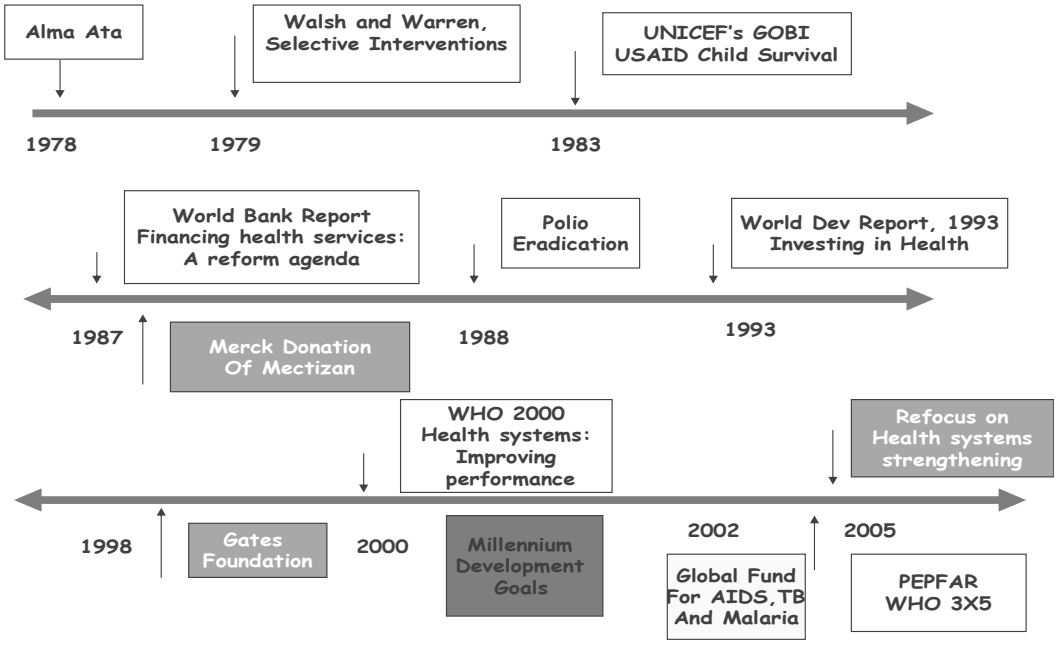
Now to the second question, and there is no link between these two, other than I spend my life in these worlds – one the economics of elimination and eradication programs of which onchocerciasis is a perfect example, and on the other side, the issue of health systems and trying to understand health systems and strengthening health systems. The question is, if we look at health systems from an ARHAP perspective, through an ARHAP lens, what would the health systems look like? How would we begin to work or do research, how would our interaction with health and the health systems debate differ because we are part of ARHAP?

Health systems, to my mind are a reflection of the social, political and economic structures and values of a country. I don't think there is any debate about this. You look at any country…the United States health system is a particularly individualistic one, predicated upon the economic notion of the sovereignty of the individual. "Health systems are a vital element of the social fabric in a country, not just delivery mechanisms for health care interventions".[1] If health systems are not just delivery mechanisms and if they are a reflection of the political, social and economic structures in a country, that puts health systems within ARHAP's purview. I would say that ARHAP must engage with health systems proactively – shaping policy, helping to shape policy, not just being the implementers of policy that someone else has shaped, but we must reflect in the health policy debate the things that we have been talking about in the last few days.

Public health and health systems have sometimes waged a very uneven battle. And health systems, which have traditionally been focussed more on medical interventions have come out paramount, and public health has suffered

By way of background on health systems and global health, let me use this timeline as a short cut to describe what I think are some of the key ideas we need to understand.

[1] Gilson L. Editorial: building trust and value in health systems in low-and middle-income countries. Social Science & Medicine 61(2005): 1381-1384.



I'll start in 1978 with the Alma Ata declaration of primary health care. Over the course of the last almost 20 years we have seen the shift from Alma Ata, which is very much a primary health care focus, a community focus, a prevention focus, to what over the years have become to be known as selective interventions. Comprehensive primary health care, we can't do it, so we are going to select those interventions that we know work, and we are going to focus on those. And so, in the mid 80's it was growth monitoring, oral rehydration, breast feeding, malaria control, immunizations…a whole variety of selective interventions that all develop their own vertical programs…all of which develop their own silos in ministries of health and among political constituencies at a global and national level. We had evidence that suggested that these child survival interventions make a difference, in terms of kids lives, you do 'em right, you get 'em right and kids live.

The World Bank entered this debate in the late 1980s. The World Bank produced this report called "Financing health services: A reform agenda" and the nature of that reform agenda was the one that many of you have talked about, it is the one that speaks of the privatisation of health services, the development of insurance models, the development of markets for health care – and, it was a reflection of who dominates the World Bank thinking - the economists do.

The other seminal report came out of the World Bank in 1993, called "Investing in Health". The World Bank puts out a new report every year focussing on a particular sector or area of interest – and this was the first report that focussed on health. The question that the World Bank asked was, is it worth investing in health? Now, just from the title you can tell that this is a very bank way of looking at the world. Investing in health! And when a bank invests in health, it expects a return on that investment. So a large part of investing in health is measuring how we are going to get a return on that investment.

The private sector has become involved in health systems. The Gates foundation in the late 80's became the eight-hundred pound gorilla in the public health donor community because it has more money allocated to global health than the WHO and World Bank combined. And so the Gates Foundation has become a private entity that is

influencing the course of the debate about health, health care and health systems in ways that reflect a particular way of looking at the world…and that is a very technocratic, instrumental way of looking at the world. Many of the people who are the advisors to the Gates foundation were the leaders of the small pox eradication effort. And these folks are having enormous influence on the public health agenda. It's a technical fix which fits with Gates. I do not in any way decry or despise Gates or those who led smallpox eradication, it has brought enormous new funding into global health. If ARHAP is working in this arena, though, and is going to influence these global agendas, we have to understand who the players are.

WHO produced another report on health systems in 2000. This was the first time that the WHO engaged in the health systems debate. WHO is organised as a disease control entity; it is not organised in terms of health systems. The 2000 report ranked 191 health systems around the world on a selective set of criteria. In the performance of health systems, number 1 was France, number 191 Sierra Leone. The US was 37, and SA was about 70. This whole report threw a cat amongst the pigeons and everyone got upset about how the measures were done, and what they meant; what does it mean that Sierra Leone is ranked below France. Does Sierra Leone have to spend as much money as France, is that ever going to happen? So the health systems performance measures have taken on a life of their own and there is a whole industry of critiquing the report … academics love that.

At the same time, the Millennium Development Goals (MDG) came out. The first two goals relate to poverty and health respectively. Then in 2003 we had the introduction of the Global Fund and PEPFAR and WHO's 3x5…all of which have begun to focus us again on health systems.

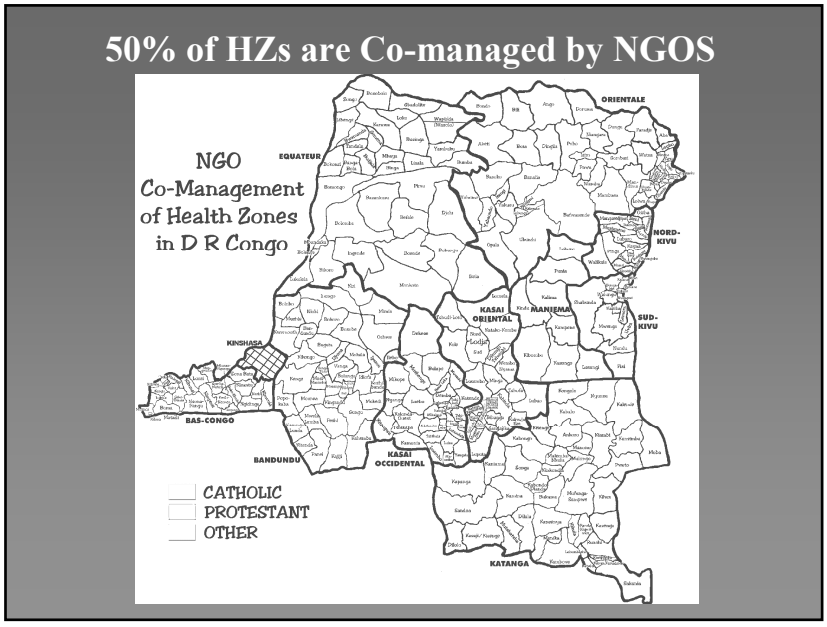
There is an emerging consensus, that, in order to achieve improved health outcomes around the world strong health systems are needed. Now that may seem very self evident, but it is surprising that the health debate throughout the whole period I have described here was really focussed on selective vertical interventions. But as more of these globally driven agendas (PEPFAR, GAVI, MDGs, oncho) roll out, they all rest on health systems that are very weak. Finally people are focussing on health systems, saying the time has come not just to focus on selective vertical intervention strategies, but rather to strengthen health care systems. To achieve the millennium development goals we have to make sure that the notion of health financing and health equity are front and center.

The huge issues of how to bridge the gap of human resources for health, and to achieve this coverage with these health interventions that we know work are based and fundamentally depend on the health system. Even oncho has this interaction with the health system even though it is community-directed. Parenthetically, my sense is that with something like oncho, where you have community distributors that have performed well in a single intervention or task, the impetus is to start adding on interventions…for example impregnated bed nets for malaria, Vitamin A. Then we say to the communities, it is your responsibility to sustain these things. Are we are placing the burden of sustainability on these very poor communities without giving the support in health systems that is necessary? That is where many of us are engaged…in trying to think about very specific, proactive ways to strengthen health systems, health systems financing, infrastructure, the health systems workforce, the health systems priority set.

An ARHAP Perspective on Health Systems

The health systems that most of us are familiar with fit in quadrant 1 of the ARHAP theory matrix. Let us look at an example from the DR Congo, which is divided into

numerous health zones. Each health zone has a designated district hospital which then has a series of primary health care centres and small health units that revolve around it. Some of these district hospitals are public, some are private, and 50% are co-managed by NGOs, some of which are religious, some are not. Certainly in the DRC the influence of religious institutions or organisations on the official health care system is huge. How well do these systems perform? What do we know about the evidence base for the efficiency, effectiveness, cost, mission, target populations, etc? The documented evidence is pretty weak.



An organization called Interchurch Medical Assistance (IMA) that started out as a commodities distribution system of drugs and supplies, and moved into the administration and development of healthcare models. IMA is working in some of the most difficult areas of the DRC, as well as some of the most populated areas of the DRC … and it is linked with the Protestant Church of Congo. It is a network of 61 protestant communities with 80 hospitals and 600 health centres, and the co-manager of 50 health zones. That's a significant proportion of the health system, such as it is, in the DRC. And yet we know more about these members than we know of any of the other hospitals in DRC…and for that reason, the model of the IMA provides us with a really good ongoing case study of quadrant 1. This is an example of a group that we want to work with to introduce some ARHAP concepts.

But we've said that ARHAP is more than Quadrant 1, and we've said that health systems are part of the vital social fabric of a country, and not just a delivery mechanism. So how do we get 'ARHAP'ian' thinking and evidence into the health systems debate? I remember one of those first meetings we had in Cape Town where we had a big debate about this word "evidence", and there was reaction against the notion of "evidence"; a reaction that may have come from a misunderstanding that the only things taken as evidence are those that can be counted, that measure the norms that economists and development folks put on healthcare systems. I don't think that has to be the case. I think we have to be wary of measuring only the readily measurable. But I do think that we have a window of opportunity in terms of health systems to provide a new kind of evidence. This is for all the reasons I have suggested. Finally, policy makers are paying attention to health systems, as a focal point for understanding differences in the health of

populations. Disease control programs are doing so, the big agencies are doing so, the private funders, the big ones and little ones are doing so…and I think that we in ARHAP need to do so as well.

There is an increasing frustration for many in the South at the dominance of Northern models of health systems. Anyone who lives in the U.S. knows that when you have some of the worst health indices in the richest country in the world, two miles from the front door of the White House – that this is not necessarily a model that we want to export to the world. The growing frustration of many from the South about the wholesale appropriation of U.S. and European models of healthcare is palpable. In most parts of Africa – unlike in the U.S. – there is a belief that the government has got to be involved in health care.

We must incorporate local values into methods and approaches and develop new models that fit the context. It is not to say that economics is not economics is not economics; it is. There are principles and theories that are not context specific. But we want to break the hegemony of the economists. It is the economists' model that is dominating the health care debate.

So how does ARHAP influence the health systems debate. An easy way for us to think about it is the model of the 4 E's:

Engage	Evidence	Expertise	Evangelise

I would say that ARHAP's agenda is to *Engage*; to engage the policy makers from within the policy arena. And to do that through *Evidence*; evidence that is both critical as well as positive and that contributes in a way that policy makers understand. We must understand the language of health systems and this debate.

We also have an opportunity to introduce *Expertise*; to introduce people who have this expertise into the policy arenas. We have people who are engaged with this at a global level, but we also have people we need to seed in countries around the world. And then if I can use this word "*Evangelise*": it is advocacy. That is one of our big roles.

Then add these to my three E's – the discipline of *Economics*, *Epidemiology*, which is the basis of public health, and *Ethics* – I think if you put those together you can begin to shape an ARHAPian health system.

Questions & Responses

ARHAP ENGAGING WITH PUBLIC POLICY

- How do you "reform" the hegemony of the economists?
- And beware of the hegemony of the North, that keeps talking about Africa without involving local voices, cf. the WHO 3x5.
- ARHAP should more consciously utilize its data (e.g. through ATLAS) to develop quantitative measures out of the existing qualitative evidence.
- The issue of an index for (country-wide) comparison was discussed. While some of the current "ranking" systems were inherently flawed, they are nevertheless

useful. That is, despite the hot debate on the indicators, the reports were accepted anyway. Such a religious-public health index would be essential to ARHAP's research and interaction at the public health (policy) level.

— Much of this theory has already been established in the ARHAP model, and now needs to be pulled together.

— The Catholic healthcare system in post-apartheid SA is being reinvented from the bottom up – not from health professionals or government. Some of these new home-grown models of health care are working, despite having little skills or capital, but they are working – and as they are given injections of agency and funds they improve. Commitment and dedication can be seen as both driving forces and outcomes that can be measured in healthcare terms.

— It is important for ARHAP to consider the nature of the relationships between such bottom-up organisations and primary healthcare systems. We need to look at issues such as staff burnout, process of care, morale and appreciation of staff.

— It is important to be able to write a 2-page policy paper, as no policy maker will read more than 2 pages. We need to distil ARHAP, in order to make it compelling to health policy-makers.

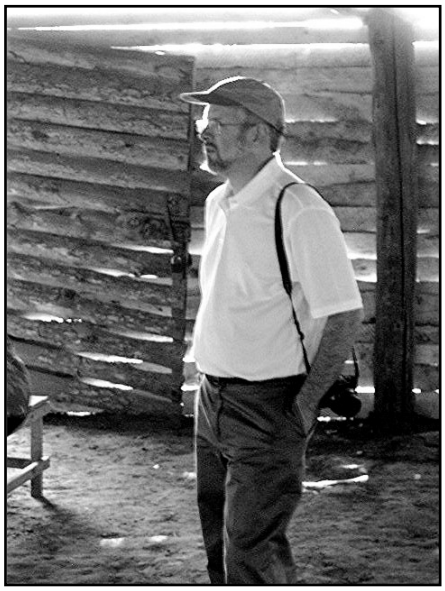
— In considering the connections between health systems and food, the environment is often lacking. What religions contribute to some systems is a holistic way of looking at things. This (environment) is an aspect often missing from ARHAP.

The Apartheid Museum

Listening for an African Heartbeat

Gary Gunderson

Interfaith Health Program, Emory University



Some of us pale Africans began the week at the Apartheid Museum (picture on opposite page), one more South African miracle to add to the long list. Near the beginning of the journey through the museum there is a tiny sign, no more than an inch high, down low on the brick wall, that simply says, "We all share the same African ancestor." And next to it is a very large picture of one particular skull known affectionately, and surely inaccurately, as Mrs. Ples (*Australopithecus Africanus*). We think she walked near here about 2.8 to 2.6 million years ago. I like to think that she was guiding her small band across the grass a bit like Barbara does with us.

Among other things the sign is a good example of how we can be very, very right even when we are certainly very, very wrong. That is not our mother, maybe not even within a quarter million years of her. But we have one. One. One. One.

I speak today on the authority of our mother. I was asked to play a humble role in this colloquium—to *listen*, and I have done so. I listen with my fingers, so you've noticed me typing pretty much constantly, straining to capture the flow and nuance of the bursts of amazing language, typologies and narratives that are distilled from what have been many, many days of laborious, exhaustive, systematic field work. Listening; in a way that's all ARHAP is—a listening project straining to hear the birdsong amid the jets, the heartbeat of life amid the cries of cruel and vastly premature death. There are skulls in the room with us so vividly that we have not needed to name them. They are not two million, but perhaps only a month or two buried. But we are here because they urge us, like Mrs. Ples I think, not to miss the point, which is life. That's what we are trying to help each other pay attention to in ARHAP, the African heartbeat of life.

In a sometimes awkward way, inventing new words and bending old ones at every step, we have tried to help each other listen for the heart. We suspect—hypothesize, as Alan would want us to do—that the place to listen is as close as we can get to the vital confluence of health and faith. And we are quite certain that we must attend with

diligence to the way in which this confluence is a place of emergent life—a living asset. We expect to be surprised, but we are very systematic about putting our ear to the heart where surprise is most likely to happen. Our awkward language of "religious health assets" keeps us focused, so that we will be paying attention when the surprise happens.

I have listened to the shared fruits of this listening project that is ARHAP and I want to tell you what I have heard. It would not be ARHAP if I did not bend, steal, invent and rearrange some words. I am not foolish enough to try to simply play back snippets of the numerous crafted presentations, all of which were themselves snippets of work in progress. Like the paleontologists, I want to try to get it right by getting it wrong, in this case to try to play back to you the connecting logic I have heard beating here. I am surely wrong in all the particulars, but right, I think, that I have heard life. I don't want us to miss the point of our increasingly shared life.

Leading Causes of Life

You heard, but may not have *really* heard, both Jim and Frank use the phrase "leading causes of life." Like much of our jargon, it signals that there is a stream of thinking flowing. This one has popped up like a surprising spring in a dry land about a year a half ago and captured my imagination almost as soon as I heard it echo in my head, or, perhaps, heart. A bit like Jim's work on migration, Paul's on healthworlds, Steve's on appreciation, or Deb's on the E-cubed conundrum, the leading causes of life flows both in and out of AHRAP like a coastal river in the wetland boundary zone.

Let me use this LCL (Leading Causes of Life) framework as a way of amplifying what I have heard this week so that you can hear it, too, and see if it does sound like our heart. The point that we must not miss—that we must help each other not miss—is that the assets are alive.

The simple idea that there are leading causes of life is an act of appreciative recoil from the power of death. Death has so dominated our professional imagination that we have developed exquisitely sophisticated ways of mapping how we die and the phenomena that kill us. We can actually rank the various pathological causes in fine detail, a remarkable intellectual enterprise so common now that we hardly marvel at it. It helps us fight back and has helped us a very great deal, as anyone who appreciates the power of systematically implemented public health policy and strategies. I am grateful for Deb's presentation of Oncho control as an ideal example of this noble work. Part of their power, these leading causes of death, is that ranking brings order to the swarm of possible bad things and that ranking focuses the mind on what to do first, second, third, fourth, fifth.

Compared to life, of course, death is simple. Something breaks, something stops working, some process wears down. It is simple, really. It only seems complex because *that which is broken* is highly complex, adaptive, filled with surprise and mobility.

Life is more complicated than death, which is why ARHAP—listening for the heartbeat of the assets—is far more complex than a needs assessment, an inventory of problems. If I ask you right now to go outside and find something dead, you could be back in five minutes with a most interesting assortment. On the walk back in, you could probably make a pretty good guess at why that once-alive thing is now dead. It's not that hard. But if I asked you to go outside and find something alive and bring it back, we might not all *make it* back. Half the stuff is moving, for one thing; and the rest might bite, or play with us or hide, or even try to look dead to confuse us. And some of us would surely find the life outside more interesting, vital, life-giving than what we're doing inside, so we'd stay and join it.

Even such a brilliantly cruel virus as HIV is dumb simple compared to the complex life it destroys.

The point that we must never miss, is that we are listening for life, which is profoundly different than listening for death. Breaking is simple; that which is broken is complex to the point of holiness. This is the real reason for the all the awkward ethical guidelines for our research—we are listening to a vital, holy heartbeat and must not disrupt it in our clumsy attempts to get it right.

Over the past year or so, a number of us now have come to settle on five basic causes of life and I am going to use that framework to play back what I have heard. And then we'll use those causal categories as a way of breaking apart to listen more intensely together and then re-gather a bit later to see if we have helped each other hear clearly. I'm sure I'm wrong about all five and certainly the number itself. But the framework is holding up pretty well so far enough that we're using it for a book that might exist when we gather again next year. But it looks to be a busy year, so let me not wait to share it as it is.

For the health sciences, it is quite a fundamental statement to say that something causes something else. That's what most of our evidence gathering is all about, to give us confidence. It is something of a religious claim, of course, which is why bio-medical western science comes in for a lot of sideways pejorative reference in gatherings as ARHAP. It claims to have identified what is really happening and the rest of us say, no, that's not quite it, not enough. But it can take a bit of bashing without apparent damage to its positive self-image, so I'm not too worried.

Connection

My hypothesis is that ARHAP is alive because (be-cause, cause being that...) we are seeking connection, we are seeking meaning and coherence, we are seeking agency, we are drawn to the possibility of both blessing and receiving blessing. And of course, as Frank pointed out, because our hopes give us life. I think this is true of human social life at every level of lifeworlds. The only way to study life is to be alive. Indeed, what I have heard most clearly is evidence that the process of trying to attend to life in those assets we find at the confluence of faith and health makes *us* more alive. We are becoming more alive the more we try to study the life of these assets. This is the experience that pervades our gatherings and why so many of us find ways to get here, stay here and come back.

Life is social; it is a causal hypothesis to say that I am because we are. I am, the cause being, that we are. We live only because we connect in squishy, warm, vital ways. Every virus, not just AIDS, exploits this connectional strategy, of course. But we have got to connect. And what I hear in ARHAP is the life process of moving toward more and more complex, dense, layered interconnection. Everywhere we look, we see more connections. the closer we look at what would seem like simple projects—Masangane, for example—the more we find that they are an infinite web of connections that are its life, that evokes, supports and sustains life. Someday, of course, like every thing human, it will die probably because it will lose that supple capacity to weave. But another life will emerge in the same vital logic. Steve was noting this vital characteristic of religious health assets—they are fragile and unstable and personal. But they emerge and thrive in most amazing way. The more we understand this vital logic, the less we will fear the apparent fragility. We will trust their way of coming to life, staying alive over a healthy lifespan and laying down their life, too. We will be able to train leaders without that fear, even to the point where we might speak of *life* competencies that could be expected of vital leaders nurturing the life of the social organizations that spring from faith. This may

be the most vital contribution that emerges from ARHAP's studies—not just where stuff is, but why these living assets are there, and how they might be nurtured. This may be the vital role of our seminary partners, who are beginning to join us in significant ways.

Faith-forming things are surprises that can be anticipated. Nancy pointed us toward the vital way that faith-forming things network. Just as they are not able to be plotted by only three points (triangulation) and seem to need multi-angles, so too they connect in ways that defeat our simple languages of negotiated institutional agreements. I have heard more attempts to describe this complex connecting phenomenon than we have language adequate to the task. And it is true of ARHAP as a living phenomenon, too. We are too connected to even figure out how to write it down. And we get more connected to more kinds of relationships than we can categorize or list. We are university faculty, friends, physicians, students, health seekers, God-seekers, forced migrants from lost worlds, daughters and executives, leaders of Churches, Mosques, denominational and world agencies. Many of us are several of these all at the same time, with all hands on deck, in what Liz named a muddle. Muddles are actually highly efficient ways to deal with complex, emergent phenomenon, so we should not apologize for the complex intelligence working here.

Living connections create trust, which turns out to be far more efficient, if fragile, than negotiation. This is why Masangane can get someone on treatment in three days when the government's best efforts take three months.

The greatest gain in the systems efficiencies that agencies seek in faith partnerships lie in the predictable mysteries of how faith groups connect. That's why we need a participatory aspect even in our mapping. You can't map the connections to which you want to connect without connecting to those who are connected to them. It always seem to be more than we really need to know.

The more we pay attention to connection and allow our own complex connections to work, the more we will understand about these living assets and the more alive we will be.

Coherence

The second cause of life is coherence, meaning-seeking. This is, perhaps, ARHAP's most obvious heartbeat, our lively (far beyond the point of annoyance) attraction to new words and our profound disrespect for the existing usage of any word by someone else. A bit like Mrs. Ples who surely felt human partly because she could recognize that a stick could be a tool useful for some purpose other than that intended by the tree, we move toward meaning with a voracious appetite for words, theory, typology, and tools of meaning-making, meaning-testing, meaning-re-making. This is serious play in exactly the way that life is serious, that sex is serious. It is vital. As we listen to *Bophelo* we find it illuminates our life, a little bit as it does for the BaSotho.

We need a glossary, I think, not because we need to strip off the surprising and inconvenient awkwardness of some of words, but so that we don't forget them. Some will work and remain vital for us while others will only serve to mark our pathway. But it is probably time for us to start our ARHAP glossary. As in Biblical tongues, we may need to be sure that some of us are present to interpret to others some of the more inspired and raw inventions. But it would help to note those that recur and seem to be capable of holding meaning long enough to carry it across boundaries.

I remember that the very first, original idea of ARHAP was to build on academic work that would need to be done anyway in order to do what academics do: write theses and articles and books. We've seen the very powerful fruit of the very first seven or eight

theses that have emerged under ARHAPian influence. They are helping us greatly. We need the other 93 that will emerge over the next four or five years. That coherence itself will be a kind of life.

It is interesting to imagine what a literature review will look like in five years as we've not only produced a lot of great theses and articles, but invited into our categories of thought many others. What would a *Bophelo*-influenced healthworld literature review look like? Not what we've got today; probably more lively and interesting.

Agency

Life is notable in that it *works*. Meaning, or faith, that does not work, is dead. That is so obvious to religious people that we have to be rigorous in not letting that be *all* that we know. Humans that are connected in webs of meaning work. They can make choices, including the choice to move, act systematically, with purpose, *to do*. ARHAP works, sort of. I can say that making connections, recognizing and mapping connections is work that expresses agency and causes life. I can say that making up new words that might better hold meaning is work. But my wife tolerates this poorly on days she has spent on the hospital wards working with every technical tools she knows to pull someone back from the edge of death.

As ARHAP focuses on understanding the agency of religious health assets, we may find its own agency, too. But maybe we are not connected enough to those doing *other* kinds of work, expressing other kinds of agency. This is the life-giving potential of the WHO collaboration, because they are *way* serious about work, really, really urgent work that really matters. I suspect we will find ourselves even more alive as we discover that *our* agency, our meaning-making connections are vital to *their* agency. The money helps, but we've been quite lively without it for years. It is the *work* in which we will find our life.

This is true for me personally and is why, I think, I am drawn to take on my enhanced role in Memphis with the Methodist healthcare system there. I am not leaving IHP, but it feels like life to be in closer relationship to institutions struggling to express agency in more concrete ways.

Deb challenges us quite directly to express agency, to seize the opportunity at the point of engaging the current need for the basic reform — I would say the re-imagination — of the systems that can create the conditions in which health could flourish. She notes the current frustration of many in the South with the dominance of Northern systems models. She notes that many are beginning to understand that we must incorporate local values into health system methods and approaches and develop new models that fit the context. She says we might aim to break the hegemony of economists.

Agency would mean her 4 E's: Engage, Evidence, Expertise, Evangelize (advocate). This feels like life to me, and doing it will feel even more lively. We need to organize ourselves for *doing* this.

Blessing

The fourth cause of life is blessing which, like the third is directly influenced by what I've learned through ARHAP. It speaks to the way in which we find life in being worthy heirs of those that have come before us. And because of those whom we hope will follow. This is easier to see in more mature societies than mine, where we are so focused on the present.

But as ARHAP looks carefully at those practices which engage the orphans and note the ways in which people pass on powerful memories, we will also become more alive to the life that is happening within our own web of relationships. I loved watching Jill (a young scholar) and Alan (a venerable expert) interacting yesterday, the sense of being part of a living multi-generational tradition of learning, giving both a lively bounce to their presence. It gives me life to see the first of the 100 theses emerge, knowing they will go far beyond me, just as it gives me life to be in Alan's presence and sense of the power of doing honorable work as he has in one place for 41 years. I think it will give us life to be even more focused on how we are systematically building the way for more students to participate while we also reach out to some of our elders.

Hope

Finally, as Frank noted, Life follows hope. Hope is like a memory of the future that pulls us forward. At earlier points in the emergence of ARHAP it has been common to ask each other, "what are you hoping for?" Sometimes this comes out as questions about what difference it will make, but I think the heartbeat is driven when we are able to visualize a vivid, vital image of a possible future that compels us to act. It gave me life yesterday to hear Deb's sketch of what might be possible to hope for. Alan's description of how rapidly communities change perception as the reality of access to treatment appears is a sign of how hope is shifted by new agency. As that becomes real, we can hope in quite different ways. Faith without works is dead; hope without agency is, too. The horizon shifts. So it is no small thing to ask continually, are we hoping enough, for what is really possible, *now*.

We will live because we hope, at least if those hopes reflect our connections, coherence, agency and place in a stream of blessing.

The Tasks

Each of us around the web that is ARHAP finds one or another of these causes more seminal and evocative. But it seems to be the way the causes work, that if you have any of them, it will create the space for another, and eventually for the whole ensemble. I have heard at least four causes of life addressed this week and the fifth lurks there too.

But this is what *I* have heard which may not yet be what *we* have heard.

If this makes any sense, I'd like to ask you to choose one of the five causes as a place to work, to refine, amplify, correct and sharpen that cause of ARHAP's life. Or, perhaps better for you, the life of the system which we love whether your part in it is the health or the faith dimension. Move that which seem to be most alive to you, what which gives you life, which draws you into life.

Connection: Your task is to appreciate and map the connections that currently define ARHAP and to give us a sense of the way further into the rich and vital connectedness that looks like life to us. To whom are we connected and we don't see it, yet.? To whom should we connect, that we have missed? How can we deepen and accelerate the connections among us already involved?

Coherence: In what way is our meaning seeking lively and vital? I've suggested a glossary to help us begin to map the emergence of a lively and vital language of meaning seeking, meaning making, meaning holding, meaning passing. Have we gone beyond words toward a grammar, a language equal to the rich life which draws us? Is our language helping us shrink the perimeter of our unknowing? Is this helping us talk to anyone else, or just each other? It may be that part of this task is the next phase of the

literature review, the more radical design of the pathways into the emerging literature that really do reflect our emerging conceptual frameworks.

Agency: We need a group to explore where is our agency trying to be expressed? I think a group needs to pick up Deb's challenge and imagine how our agency could be expressed in the most concrete, tangible pathway, whether that means next year's colloquium or some other policy forum.

Blessing: I am most eager to see us attend systematically to the astonishing flow of blessing which we see happing across the generations. Concretely, this means paying careful attention to where the other 93 thesis writers are, and the 100 article writers are. And more specifically, how we can be even better at finding them and supporting them in their crucial work. Perhaps the lit review belongs here. At the very least, we could make more visible the pathways toward great theses and meaningful work. Maybe a specialized website that could be done by the students even in advance of our more ponderous efforts at a communications infrastructure.

Finally, I think we need a group to sketch our *hope* more clearly so that we can see it well enough to move toward it. This is not time for timid thinking, but we will be timid by default if we do not name what we now can see. We need a group to draw, or describe the hopeful pathway of the next five, six, seven or 10 years.

You see that while I am talking about life in highly symbolic language, I am doing so as way of locating and keeping coherent some vital work that I've heard being discussed in the last few days. Don't miss the point. We're alive and about life. Don't miss the point.

PART THREE
Case Study Contributions (General)

*Part Three contains **summary reports** on presentations of case studies or research not directly initiated by ARHAP. This includes dissertation research and research done in other projects of relevance to ARHAP's concerns.*

"Capturing the Stories – Creating their Healthworld": Current Findings of Decision-making Processes of Health-Providers and Supporters in Three Faith-based Organisations in Lesotho

Evelyn H. C. Vera

University of KwaZulu-Natal

This paper is an extract from the research project "The Role of Faith in Decision Making for Health Providers: A case study of three faith-based organisations in Lesotho". It presents findings to date from oral interviews conducted with the Health-Care Providers from three Faith-Based Organisations (FBOs)[1]. Interviewees were either Health-Care Providers or Health-Care Supporters; depending on whether their role was primarily to provide health services or support providers of health-care services.

The research aims at gaining insight into the role that faith plays in the decision-making processes of these key informants by listening to their stories as they reconstruct their realities. Through this we probe whether in their experiences and choices as agents of health, their faith orientation increases or hampers their capacity to seek or provide health services.

Research Findings

Traditional chiefs and headmen have been crucial in piloting health-care projects in the mountains. The only requirement for non-salaried local volunteers in these projects was willingness to serve their fellow villagers, whilst missionary volunteers were expected to have particular skills and commitment to the Christian Faith. Perceptions of their Christian vocation differed among the informants as cultures and traditions have influenced values and ethics. At times these differences among volunteers and workers challenge managerial strategies, taking up much energy and time.

Most of the nurses interviewed felt they would have wanted to pursue their studies further but had no access to such possibilities in their remote locations. The general

[1] Mission Aviation Fellowship: an auxiliary health-care organisation that transports the Lesotho Flying Doctors to the Health-Care Centres in the mountains; Beautiful Gates: a child welfare institution that takes care of abandoned HIV/AIDS orphans in Maseru; and World Vision: an international relief organisation that supplies relief aid and runs programmes targeting vulnerable children and women in Lesotho.

feeling was that education or access to information was instrumental in furthering oneself in life. The general approach to health provision reflected this bias, viewing the professional as the one who has the knowledge and the patient as ignorant and in need of help. There was some acknowledgement, however, of the mystery of the survival strategies of mountain villagers, suggesting some appreciation of the livelihood strategies that professionals are ignorant of.

Most of the health-care providers displayed knowledge of the western medical approaches and defined health in professional, bio-medical terms. But when they spoke of health in relation to their own family, emotional, spiritual and psychological aspects of health were included. Health-care trainers and supporters seem to have a wider view of health.

The prevalence of HIV/AIDS seems to have affected people's perception of community targeted health-care programmes as it dominates most training curricula within the FBOs. Orphans, widows, and other vulnerable communities seem to be viewed from the HIV/AIDS worldview.

In all the researched communities served by the organisations involved, there seems to be a dilemma in that the aid, intended to alleviate health problems, has created problems of its own. Relief supplies by World Vision, for instance, have caused accusations of favouritism and misunderstanding among the mountain people. There are even rumours that some mothers deliberately starve their babies so that they become eligible for food aid.

The research findings raised some theoretical issues: The subjectivity of the researcher's religious interpretation, relative to that of the informants needs to be handled with sensitivity. Capacity assets seem to transcend the ARHAP matrix and so could pose a problem in analysis. The tools have to either be more flexible to suit a holistic approach or the methodologies need to be more specific and standard. This poses the further question whether either could produce the required data to impact on policy formulation?

Resilience in Malawian Children Affected by AIDS

Frank Dimmock

Malawi Health Coordination Office

Abstract

This presentation draws on personal experience with young children (aged 8-13) affected by HIV and AIDS who show varying degrees of coping with adversity. It is evident that such children cope well when given the appropriate and adequate care and love. The presentation presents the hypothesis that Malawian children who demonstrate resilience are "hope-full". It considers the measurement of resiliency and its relationship to individual, family and community factors that are related with RHAs, particularly the spiritual and psychological factors which enhance resiliency among children.

Questions & Responses

— What is the children's understanding of being infected and how is this assessed?

— To what extent can resilience be measured? In various age groups, especially younger children? And vulnerability? This has to be done keeping in mind that we are all made resilient?

— Are there issues of fatalism? In relation to hope, what is the child hoping for?

— For sample selection the time factor has to be considered: how long ago were the children affected? Are they newly vulnerable?

Faith Based Responses to HIV/AIDS: From Policy to Action

Liz Thomas

Centre for Health Policy, Wits / Medical Research Council

Background to the Study

HIV/AIDS has become a health issue impacting on every facet of society. South Africa's national policy in response to HIV/AIDS has incorporated partnerships with faith-based organisations as a key principle. Further, international funders have also targeted faith-based organisations as agencies to implement specific strategies.

The case study assessed the response of faith-based organisations in the Eastern Cape Province. This province has major difficulties in delivery of Government services – especially in health care – due to lack of resources, skills, access and infrastructure. Its HIV prevalence is slightly lower than the national average (29.5%); with poverty, unemployment and lack of development acting as main drivers of HIV/AIDS.

Findings

The study found varying responses across Christian denominations, largely defined in terms of the various denominational policies, with ad hoc responses in smaller church groupings not linked to national bodies. There was a lack of cross-denomination vision, commitment and co-ordination at all levels and little collaboration with each other and with local AIDS Councils. Generally urban areas were better off in terms of projects than rural communities.

Major funding was sourced by bigger denominations, with smaller churches depending on ad hoc funding from business, grants, local government or partnerships with overseas congregations. Often individuals in these groups played an important role as bridges to financial support, encouragement, exchange visits and capacity development. The local FBO response was constrained by lack of fundraising, financial management, development and project skills and the need to register as a public benefit organization. Links between local and skilled/resourced congregations elsewhere could increase the role of FBOs, as would ongoing capacity development linked to HIV/AIDS project outcomes.

Churches are in a powerful position to 'break the silence' and address the stigma surrounding HIV and AIDS. Denominations have varying views of their role in this. Some churches – mainly those affiliated to the Evangelical Alliance – see AIDS as peripheral to their calling; while some Pentecostal churches regard AIDS as a result of sin. Such damaging responses are not surprising in a context where many pastors lack a theological (and basic medical) understanding of HIV/AIDS.

Only a small number of ARV treatment projects are offered by FBOs. The national PEPFAR-funded ARV programme of the Catholic Church only serves a small portion of the Eastern Cape. The Moravian Masangane ARV programme highlights the possibility of using FBOs as a first step into ARV treatment for those too ill to get into public ARV programmes.

The national Government policy enables involvement of civil society in its HIV response, yet many churches lack the necessary commitment to this task. Reasons for this are the lack of leadership in churches; stigma; a top down approach restricting innovation in local churches; lack of co-ordination; lack of involvement with local AIDS Councils; limited funding or funding lacking sustainability; land the lack of skills, management and resources.

Key Questions Emerging from the Study

- To what extent is the choice of treatment options made by patients affected by their churches' attitude to healing and to HIV/AIDS?
- Do Churches support, care and encourage those on ARVS?
- What is the role of the church in encouraging testing, given that knowing their HIV status is key to behaviour choices people make?
- How can religious leaders be encouraged to be proactive and mobilise their communities to develop care responses, promote testing and address stigma?
- How to get FBOs to work together?
- How to build capacity in local communities to access and manage resources in order to respond to HIV/AIDS?

Abstract

HIV/AIDS has become a health issue impacting on every facet of society. The national SA policy response to HIV/AIDS has incorporated partnerships with faith-based organisations as a key principle. Further, international funders have also targeted faith-based organisations as agencies to implement specific strategies.

While Christian faith communities are not unaffected, the nature of their awareness of the impact and their response differs widely across denominations and between communities. The case study presents an overview of the national SA HIV/AIDS policy and the funders' approach to directing the role and activities of faith based organisations. The policy of the major denominations and their responses are discussed with a view to identifying the various factors that have influenced the development of their responses.

The case study assesses the response of faith-based organisations in the Eastern Cape Province and identifies the factors that seem to have influenced the variety of responses at a provincial and local level. An approach for local level responses by faith-based organisations is presented as a way that faith based organisations can contribute to achieve integrated sustainable local level development.

Transforming Communities Through Promoting MA/PGD in Pastoral Care & HIV/AIDS Programme: Esther's Base Group

Dr. Peter Okaalet

MAP International

St Paul's United Theological College offers a MA/PGD (post-graduate diploma) in Pastoral Care and HIV/AIDS. It aims to transform communities by equipping practitioners working in the field of HIV/AIDS interventions to become critically reflective, theologically informed, professionally grounded in carrying out research and skilled in relating faith and HIV/AIDS. The first 2 years lead to a Post Graduate Diploma, a further dissertation to the MA, both from the University of Wales.

The Base Groups

Students are expected to create and work with a base group of at least 20 members drawn from the community where they reside and work. This equips them to become theologically informed researchers, while at the same time enabling the base group members to play a significant role in raising community awareness of HIV/AIDS. Students meet with their Base Group members once a month. Through the multiplier effect of these groups the 50 current students create 1,250 change agents within the respective communities.

Sustaining the base group students have to deal with a number of challenges. Most of the group members are unemployed and expect to be paid for their involvement. Some of them are living with AIDS and at times feel stigmatized by comments. Other challenges include creating and sustaining rapport, different educational backgrounds, taboos around sexuality, lack of caring skills, limited theological depth among clergy and laity, limited resources, caregiver burnout and lack of networking with government and NGOs.

The general objective of the Base Group is to promote collaboration at the community level – involving change agents drawn from the religious, civil, government and other sectors – to enhance awareness of HIV/AIDS among faith-based communities and strengthen their responses to it. This includes consolidation and dissemination of knowledge on HIV/AIDS, developing life skills of PLWH and their families, promotion of income generating activities, prevention of HIV infection by equipping children and adolescents with relevant knowledge, skills and attitudes, and to provide equal opportunities for orphans. Activities include peer education in schools and churches, awareness campaigns, seminars and retreats for pastors and church workers, workshops on home based care, home visits.

One of these, Esther's Base Group, includes different professionals such as teachers, medical doctors, nurses, pastors, psychologists, social workers, community development workers, VCT Counsellors, army man, peer educators, translators, surveyors, public health officers, a chief. Other members are farmers, businessmen/women, housewives, *Matatu* touts, casual labourers or students. They come from many different denominations and a wide range of ages. This group has lead to the formation of the

NASARU OLOSHO Community Based Organization. This group models how to translate theory (MA Level Work) into practice (CBO).

Some Key Lessons

- Training requires more than dissemination of information
- The 'Messenger' is as important as the 'Message'
- Integration of monitoring and evaluation
- Importance of networking and partnerships
- Church leadership motivated and mobilized with understanding of biblical mandate; their involvement is needed to succeed with church-related projects
- Holistic approaches ensure effectiveness
- Prayer makes a difference

Questions & Responses

— Individuals like Esther, who contribute to the community's wellbeing in terms of health, can be a religious asset as well and should be included when mapping RHAs.

— A further challenge is to create a communal space for these individuals to develop into community assets.

— Is the membership of Esther's group - people who already have a range of skills – typical? And if so, is it appropriate for the kind of help and empowerment the group provides?

Caring Hands, Caring Communities: The Role of Faith Communities as Care-Givers in the Face of Poverty and HIV/AIDS in Zimbabwe

Sophia Chirongoma

University of KwaZulu-Natal

This study offers an exploratory analysis of several faith communities that are actively involved in facilitating health care in Zimbabwe to supplement the crumbling public health system. Once regarded as the emerging star of post-colonial Africa, Zimbabwe is now teetering on the brink of economic and political collapse. The public health institutions which are used by the majority of the population are poorly equipped, short-staffed and over-crowded as a result of the Economic Structural Adjustment Programme. Few people can afford the user fees and the public institutions lack medication and qualified personnel. This has caused a near collapse of the public health institutions.

The HIV/AIDS pandemic has added to the crisis and the health institutions are unable to cope with the demand for services. Approximately 34% of the adult population are infected with HIV at a time when the macro-economic environment has reduced the social safety nets provided by the public sector. Consequently, rural communities are left with the responsibility of caring for the sick and the dying and the increasing number of orphans whose parents die from HIV/AIDS.

Within this context of crumbling public health institutions the faith communities are playing a significant role in providing social services and health care to rural communities. Faith communities are present in almost every community and reach out to every sector of the community, however poor and under-resourced. Despite many divisions, Christians in Zimbabwe have achieved at least a measure of practical cooperation in the field of healthcare, education and social services. Pilot programmes through mission hospitals and international NGOs at rural districts have proved the possibility that HIV prevention, treatment and care can be integrated into the lowest levels of the health system.

The Zimbabwe Association of Church Related Hospitals (ZACH) provides 45% of all hospital beds in Zimbabwe and 68% of all rural hospital beds. ZACH also provides other activities such as development of AIDS education, family planning and reproductive health, strengthening health information, home based care and clinical reproductive health services and research. The Catholic Relief Services (CRS) takes an integrated approach to programming by supporting initiatives in justice and peace, food security and economic strengthening centred around the impact of HIV/AIDS on communities. The provision of food to those affected by droughts and the formation of income-generating projects demonstrate faith-based organizations' commitment to holistic care.

Some faith communities focus specifically on vulnerable groups like women and children. Various interventions have also been put in place to care for orphans, providing payment of their school fees and other social needs such as drop-in centres. The formation of AIDS committees and the establishment of community volunteers who visit and care for the sick has lessened the burden of the disease and acts as support network for the infected and the affected. These religious health assets play an important role in sustaining hope in communities.

This study demonstrates religion as a driving force in the activities which attend to the communities' health and social needs. Clearly Christians take seriously their challenge to be a *catholic*, *prophetic* and *apostolic* community, maintaining solidarity with those who are suffering and experience fear of rejection, poverty and death. Yet many challenges remain for faith communities in Zimbabwe: The emphasis on moral issues at the expense of practical solutions is detrimental in attempts to promote behavioural changes that can prevent HIV infection. Male dominated church hierarchies result in a silence on gender issues that contribute to the spread of HIV/AIDS. Division among the churches limits the impact of advocacy efforts against a system – both nationally and globally – that exposes poor people to so much suffering and deprivation.

Questions & Responses

— Why do people in Zimbabwe prefer to go to church run hospitals and not government hospitals even when the former are more expensive than government hospitals? Health seekers feel that they receive more attention and love from staff in church run hospitals and believe that prayers offered there on their behalf speed up their healing.

— User fees have hindered poor people from visiting government hospitals and even some church run hospitals. This has increased the death rate in Zimbabwe. Yet when the government had been providing free medical services and medicines, facilities were not taken good care of and people handled medicines carelessly, knowing they would be freely replaced. Now that people are paying

for medicines they are taking good care of it and the facilities because they have a sense of ownership. Fees for traditional healers are very high but people go to them nonetheless because it fits well with their world-view and belief system.

— There is lack of accountability in Zimbabwe with regard to tax payers' money and donor funding. This, combined with the lack of democracy, has led to a number of donors choosing to work with NGOs rather than the government. As a result government hospitals have run out of essential medicines and equipment.

— What helps people cope with the problems relating to poverty and bad governance in Zimbabwe? Poverty alleviation programmes of some NGOs and CBOs; as well as church HIV/AIDS services, e.g. voluntary counseling and testing.

— Question: What are some of the fundraising activities is the church involved in, in Zimbabwe? The church does a lot of writing funding proposals, making of peanut butter which is currently a booming business, gardening etc. The church has also been involved in protest marches, praying for the nation and the Catholic Church has been instrumental in fighting the HIV/AIDS stigma.

— What are the key religious assets in Zimbabwean communities? The religious leaders, church hospital buildings, Christian doctors and nurses, church buildings etc.

— Question: What one thing is the government doing that is good? Land distribution – Some people are very happy that there has been land distribution in Zimbabwe, though there has been a lot of corruption in this process.

Positive Faith in Action against AIDS Related Stigma and Discrimination

Rev Christo Greyling & Rev Japé Heath

Vice Chairperson & Regional coordinator: ANERELA+

Twenty five years after the discovery of the HI virus, people continue to die, despite the advances made in modern medicine and the myriad of interventions at all levels. At the root for this lie six words: Stigma, Shame, Denial, Discrimination, Inaction and Mis-action. During the 15th International AIDS Conference in Bangkok in July 2004, religious leaders concluded that they were part of the problem by practicing "the love of law" rather than "the law of love" in their response to the HIV and AIDS pandemic. These leaders have the potential to use their positions to impact positively on the pandemic. On the other hand, religious leaders affected by HIV and AIDS suffer additional stigma because they are looked to as "Bastions of Perfect Religious Living".

The Africa Network of Religious Leaders Living with or Affected by HIV and AIDS (ANERELA+) is a regional network of religious leaders who are living with and affected by HIV and AIDS. ANERELA+ was launched in October 2003 in Kampala, Uganda. Its membership consists of African religious leaders from all faiths and denominational identities, who are either living with HIV and AIDS as a result of proven HIV infection, or are personally affected by HIV and AIDS through nursing or

having lost a child, spouse or parent to HIV/AIDS.

ANERELA+ exists in order to:

- Provide a platform whereby the impact of HIV and AIDS is overcome in Africa through the testimony and work of religious leaders living with and personally affected by HIV and AIDS.
- Ensure that these leaders are empowered to break the silence and live openly and positively; end self-stigma, denial and shame; be forces of change and action in their congregations and communities.

Members become living examples that HIV is something you can *live* with and role models of living positively, openly and healthily. They use their empowered status to reach out to their immediate religious congregations, surrounding communities and the civil society at large in breaking the silence surrounding the HIV epidemic, ending stigma and discrimination, and advocate for enhanced prevention, care, support and treatment. National networks work to secure and sustain awareness and share publicity information and communication.

One of ANERELA+'s means of working towards its aims is by providing accurate comprehensive information on HIV and AIDS, instead of mere moral messages. Hence their slogan to *Move from "ABC" to "SAVED"* by promoting **S**afe(r) practices; **A**ccess to treatment; **V**oluntary testing; **E**mpowerment and **D**isease prevention & control. In teaching about stigma they point to contributing factors such as associating HIV infection with immorality, associating sickness with punishment, confusing risky behaviour with risky environment, confusing refusal with failure, mixing individual responsibility with collective responsibility. Achieving the aim of people taking responsibility for their own sexual health is only possible if they have accurate information; are equipped with adequate skills for self protection - How to abstain, How to stay faithful, How to use condoms; and if they have access to affordable services within a supportive environment.

Successes ANERELA+ has achieved include raising funds for the network, membership growth and an increasing demand to provide speakers. Limitations are still experienced with developing its capacity on the ground, experiencing delays between building capacity and demands for speakers/trainers, continued presence of stigma that makes it difficult for members to disclose their status and providing for the health needs of its members.

A Quantitative Evaluation of the Impact of Religious Leaders in the Promotion of Couples Voluntary Counseling and Testing in Lusaka, Zambia

Helen Ji

Zambia-Emory HIV Research Project (ZEHRP), Lusaka; a project of Emory University

Background to the Study

More than 60% of new HIV infections in Africa are acquired from a spouse or cohabiting partner; yet fewer than 1% of African couples utilize Couples' Voluntary HIV Counseling & Testing (CVCT) services. 30% of all couples getting tested are

discordant (one partner positive, the other negative).

Approach for the Study

The study used Influence Network Agents (INAs) – referred by Influence Network Leaders (INLs) from the health, private, NGO/CBO, religious sectors – to invite couples for CVCT. Religious Leaders were specifically targeted in this study – 268 of the total 511 INAs were from the religious sector – to test the hypothesis that religious leaders are effective in inviting couples for CVCT and because 80% of Zambians are Christian.

Results

Some of the findings of the study showed that:

- Out of 3143 couples who sought testing, only 100 (3%) reported having heard about CVCT from a religious official.
- INAs were more likely than INLs to report having been tested for HIV either alone (35% vs. 11%) or with their spouse (30% vs. 8%), with similar proportions in religious INAs and other INAs.
- Only 11% of public endorsement of invitations were delivered by religious leaders.
- 7% (4590) of invitations were delivered by an INA to a person or couple they described as fellow church members; 4% (2403) of invitations were delivered at a church or mosque.

Conclusion and Implications

Even though churches are places where couples are found together, systematic efforts to use church networks to promote couples' VCT have not been very successful. The following implications emerged from the study:

- AIDS still carries stigma in Zambia. AIDS within a marriage may carry an additional burden of shame.
- The message of Zambian churches regarding CVCT needs to be clarified. Churches have for a long time promoted premarital abstinence and fidelity within marriage. Hearing about couples' testing in church may arouse a paradoxical negative response and denial that HIV risk may be present.
- Fear is a barrier. General messages about the importance of being tested as a couple may not be powerful enough to overcome the fears husbands and wives may have about disclosure.
- The low number of senior INLs who had themselves been tested with their spouse confirms that they are not leading by example.

Strengthened partnerships between CVCT providers and faith-based research organizations could be beneficial in the fight against HIV/AIDS. More research needs to be conducted on religious dynamics in Zambia and its effects on public perception of couples' VCT.

Questions & Responses

— A similar study to this one was done in Kigali with higher results (In Kigali the Catholic Church dominates; while in Lusaka there are many Zionist churches.) A comparative study might yield interesting results regarding how well different kinds of religious structures deal with higher-level information.

— INAs differ in different societal groups, but also between religious groups. Each group has to be addressed in language that is appropriate to them. The use of "wrong language" in the study could be a key factor in its findings.

— Zambia has been declared a Christian nation. Now so-called "religious leaders" are appearing all over as is expedient; they only need two "members" to qualify as a religious leader.

— The system of providing services has changed dramatically over the last few months because of people (staff?) being drawn to PEPFAR programmes.

— Problems of implementing VCT are huge. The role of the church could be to encourage "first steps" towards this.

— There are fears around testing; drawing of blood is connected with "Satanist" practice.

— This project could be an opportunity for ARHAP to link with NIH research in this area.

An Exploration of Actions Taken by South-African Faith-Based Organizations to Address HIV/AIDS Stigma and Discrimination

Mpoe Johannah Keikelame

University of Cape Town

This presentation is based on a study by C Murphy; K Ringheim, S Woldehanna et al. of the Global Health Council, funded by the Catholic Medical Mission Board.

Faith-based organizations (FBOs) in South Africa have been playing an important role in addressing the HIV/AIDS pandemic. However, their preventative actions have been hampered by deep-rooted societal constraints and lack of a holistic understanding of the problem, which accounts for AIDS related stigmatization and discrimination.

The aim of the study was to obtain knowledge and understanding of the actions taken by FBOs to address stigma and discrimination, with the objective of providing information to guide policy and development of appropriate integrated interventions. An exploratory study was conducted in partnership with the Global Health Council, USA, between September 2003 and June 2004. Twelve key informants representing FBOs participating in HIV/AIDS activities in four provinces were interviewed.

The study revealed that most FBOs were taking actions to dissuade HIV/AIDS stigma and discrimination through education and positive messages. However, stigma and discrimination resulted due to a lack of skills, and the misconceptions FBOs held about HIV/AIDS, e.g. seeing it as immoral or sinful. FBOs need to address the way they deal with issues such as confidentiality, encouraging openness, increasing participation of people with AIDS, promoting testing and addressing cultural or societal factors to enable

them to render programs that are appropriate, effective and empowering.

The study concluded that FBOS need to do more to address stigma and discrimination among people infected with HIV. This can be promoted through a "bottom-up" inclusive participatory approach to gain a contextual understanding of the problem and the development of appropriate culture-sensitive interventions.

ARHAP Literature Review: Presentation of a Work in Progress

Jill Olivier & Lauren Graham

Cape Town & Witwatersrand Universities

This work-in-progress presentation introduced the ARHAP literature review, which was initiated not only to assess relevant material in the fields of interest to ARHAP, but also to further define that field itself. ARHAP has developed into a multiplex entity, with a wide field of interest. Furthermore, the fields with which it is concerned (such as public health or HIV/AIDS and society) are themselves expansive. Therefore, for practical reasons, it was deemed necessary to draw some boundaries around the declared fields of interest: namely, to focus on the intersection of religion, public health and society, and to create a "living document" that would develop as those interested in ARHAP engage with it. This initial version of the ARHAP literature review would focus on material from the last ten years, with a specific focus on sub-Saharan Africa – although valuable material falling outside these criteria would be considered.

The following are the categories in which the collected material is being arranged, which will include a sampling of the material that would fall in these sections, as well as give preliminary observations on the "gaps" in the literature:

1) Introduction and Overview

2) Cursory Review of Established Fields

The first content section points to reviews of the extensive literature dealing with the impact of spirituality and personal faith on the well-being of individuals. It is an established field of "religion and health" research, but falls outside ARHAP's domain.

3) Religion and Public Health

This section looks at the way in which public health has challenged the biomedical model of health and created a space for a far more holistic approach to health and a far broader definition of it. This is a key area for ARHAP as it intends to make policy interventions in public health. It is therefore critical to understand the current dominant thinking within this field. Themes included in this section are Public Health and Quality of Life; Social Determinants of Health; Health Behaviour; Political Economy; Health Systems; and Health Policy.

Preliminary Review: It is clear that within the field of public health there is very little recognition of the role that religion plays in determining health. However, within the

category of health behaviour, there is an increasing amount of literature that points to the role of religion in health and healing. This is an important area for ARHAP to engage.

4) HIV/AIDS as Illustration of the Intersection of Religion, Health and Society

This section contains overarching debates that are important illustrations of research areas and concerns at the intersection of religion, health and society. It covers Stigma; Religion, Sexuality and Gender; Blending African Religion, Health and Culture; and Calls for Change.

Preliminary Review: While there is an increasing amount of material being published on religion-health-HIV/AIDS, there is still a great deal that ARHAP can do. For example, while there is a common realization that religion is an important factor in issues such as stigma and sexuality, there is little nuanced research that would aid FBOs in effecting behaviour change or in understanding the complexities of health decisions being made at the intersection of conflicting paradigms of religion, culture and biomedicine – specifically in the African context.

5) Intentional Religious Interventions and Approaches

Literature on direct or intentional health interventions are the concern of this section. It moves from material on more tangible or visible interventions such as those run by faith-based organizations or churches, to the less tangible and under-researched areas such as spiritual mechanisms relevant to community/congregational health in Africa. This section deals with Faith-based Organizations; On Death and Dying; Orphans and Vulnerable Children; Behaviour Change; Home-based Care (Parish Nursing); Congregational Support and Spiritual Mechanisms to Health.

Preliminary Review: Again, while attention is increasingly being paid to the "religious response" to HIV/AIDS and other health interventions, there is a lack in nuanced synthesis, assessment or evaluation. The material, in general, is widely dispersed and frequently of the "grey" variety, rather than academic, peer reviewed literature. There is a clear gap here for ARHAP contributions.

Questions & Responses

— Some gaps were pointed out in the literature review for ARHAP. Literature on eschatology and on missions and the missionaries' medical and spiritual influence in Africa could be considered for inclusion.

— Also lacking in the literature review is the area of treatment. We need literature that would help us understand how African spirituality and ATR impact on people's choices for treatment.

— We need to look for articles that are balanced and dealing with different fields like theology, sociology etc.

— There is need for a filtering mechanism to evaluate the literature we are coming up with to see what is essentially part of our ARHAP literature collection.

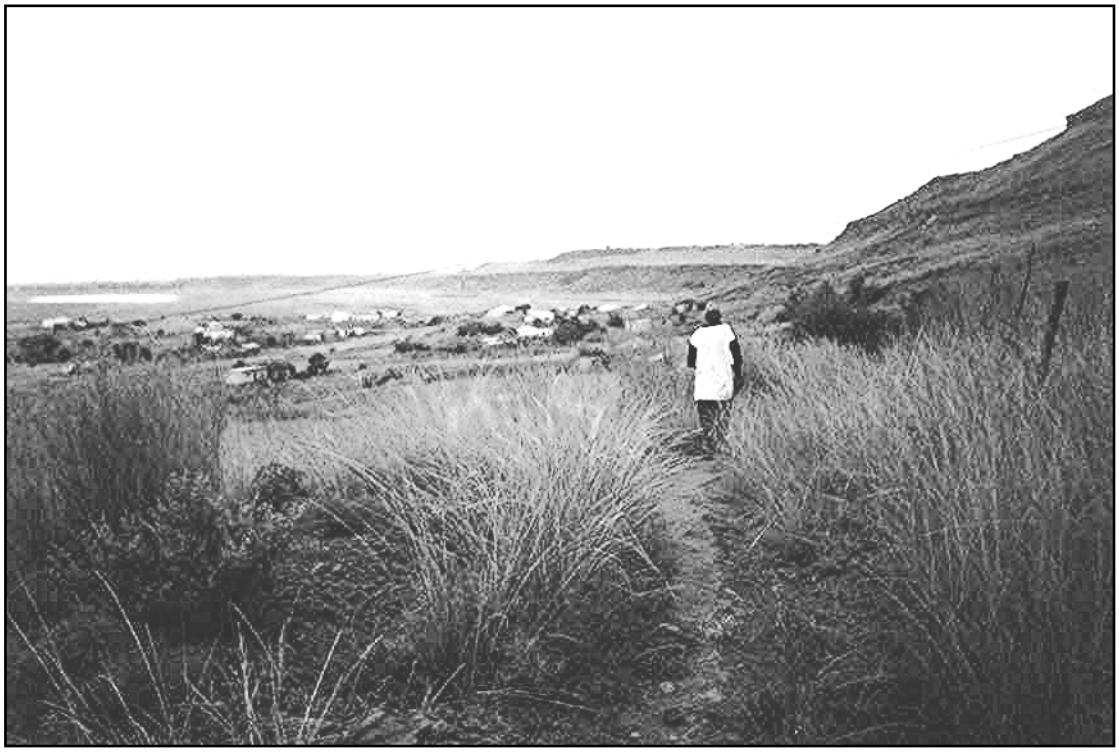
PART FOUR
Case Study Contributions (ARHAP)

*The following **case study summaries** capture research initiated by ARHAP in three different countries. In each case, this is work-in-progress. What is reported here concerns only some of the most important features of this research.*

ARHAP Case Study #1: Masangane

Liz Thomas, Barbara Schmid, Malibongwe Gwele, Jim Cochrane

Centre for Health Policy & UCT



Background to the Case Study

The overall aim of this study is to understand the role of the religious health assets of the Masangane AIDS programme for public health, as a model for a replicable response to HIV/AIDS.

Masangane, Xhosa for "embrace one another" started as a response to the needs of AIDS orphans under the auspices of the Moravian Church in the Eastern Cape. More recently Masangane started with the provision of ARVs to people with AIDS at three sites. It is a cutting edge model, developed with support from Medicins sans Frontiers

and the Treatment Action Campaign in parallel to the gradual ARV roll out of the state.

Field work for this case study, done during March and June – August 2005, consisted of more than 20 key informant interviews of various stakeholders: Masangane staff and management; church leaders; health seekers; donors and health providers. Health seekers also answered 77 questionnaires and were involved in two focus groups. This presentation offers a first look at the collected research data and some initial analysis.

Strengths and Weaknesses

Interviews with key informants from multiple stakeholder groups yielded insights into perceived strengths and weaknesses of the programme. The way in which Masangane operates is regarded as a definite strength: that it is able to provide ARVs in rural areas, get very ill patients onto treatment very fast, and maintain high levels of compliance. This is possible as a result of running effective support groups and offering good follow-up and monitoring of clients by volunteers and treatment assistants, as well as wide range of related activities offered by Masangane.

Weaknesses of the programme – mostly reported by church leaders and donors – include the reliance on volunteers rather than paid staff; management procedures and decision taking; and a charity mindset. Many respondents pointed out that limited funds hampered the work. It is evident that a few key players in the programme have taken on a huge role, yet dependence on them as well as tensions between some of them are potentially damaging.

Impact of Masangane ARV Treatment

Masangane has impacted most dramatically on its clients to "save peoples lives who would prepare for death", giving them and their families new courage and hope. At community level the Lazarus effect in individual lives is a powerful demonstration that ARVs work. This is crucial to efforts of the programme to raise awareness about HIV and AIDS and de-stigmatise the infection. Even churches are opening up to the reality of AIDS in their midst, they are talking about sex and are becoming more accepting towards those affected by HIV.

There health system, too, has also been impacted by Masangane demonstrating that ARVs can be provided quickly and safely. Numerically the impact is small due to the small scale of Masangane (less than 100 persons are on treatment), yet it shows what can be done by a few committed people vs. onerous state process

Value Added (or Negative Role) of Faith in Masangane

Teasing out what value is added to this programme by the fact that it is faith-based was a crucial aspect for this ARHAP case study. A number of dimensions to this emerged from the key informant interviews.

Being part of an established church denomination gives the programme easy access to communities and in that to potential clients as well as motivated, committed volunteers, although membership of the Moravian church is not conditional for either. The programme has been able to 'borrow' credibility from the church and its long-established relationships. A specific Moravian ritual, the daily readings from the 'textbook', is used to promote adherence to the ARV regimen and to link it clearly to the faith. Christian norms and values are recognised as motivation for Masangane and many of its workers, in its inclusivity of all who need its services; yet some clients resent having such norms

imposed on them. Offering spiritual support alongside empowering information about HIV is regarded as valuable.

Effect of Plural Healthworlds on Health Seeking Behaviours

The context of the Masangane is shaped by a plurality of healthworlds: Western medicine, traditional healing and faith healing exist alongside each other. Clients draw on any of these as well as prayer, their churches, the support groups and traditional rituals for survival and health. Often these healthworlds are mixed, either sequentially or simultaneously; ARVs may be used with traditional healing methods or rejected in favour of an alternative depending on what is the perceived as cause for the illness.

This is a complex phenomenon, with much mutual suspicion often resulting in secretive behaviour. Health seekers use traditional healing or faith healing for curing specific illnesses. While many who identify themselves as Christians do not use faith healing, all who call on traditional healers also follow cultural rituals.

While some traditional healers and faith healers seem comfortable with their clients using alternative approaches, those from the Western paradigm – including Masangane staff – discourage clients from compromising their ARV regimen by using other treatments.

Concluding Questions

We end with questions that the research has raised. How sustainable is Masangane and its costly provision of ARVs, especially now that they are increasingly becoming available free of charge in public facilities? Why is that a mostly positive view on churches and their role has emerged? IS this the whole picture? And if not, how do we get at the other side?

Work on Masangane *as an ARHAP case study* has also raised questions regarding ARHAP: How can tools be shared between different case studies and projects within ARHAP? AND how does this or any specific case study link to ARHAP, its objectives and to the ARHAP lit review and other relevant literature?

Questions and Responses

THE ARHAP STUDY

- There was some concern at the way ARHAP was generating new terminology (and new tools), for example, "multi-angulate". The use of the term "healthworlds" in this presentation with its notions of individuals using a framework of multiple healthworlds is inconsistent with its intended use. (See the Lesotho Case study for details.)
- The research should consider including a greater longitudinal perspective, i.e. trying to get more than a snapshot, but also trends and shifts. Implementing this is difficult because of the way everything shifts even while the research is being done, and due to the current budget constraints of the research.
- Quantitative comparative data would be helpful, e.g. drop out and adherence rates.
- There is a need for more data relative to current (public health) research. For example, cost analyses or comparative estimations - the sources of the ARVS and

the costs, the difference between generic and branded drugs, the connection with nutrition, and the income of local people.

— Who has ownership of the research?

— There is need for a deeper study on traditional healing, specifically the relationship between ARV and traditional healing and co-use of the two. What synergies are there between traditional healers, traditional foods and generic drugs? Current research on this interface considers continuum and disjuncture, bridges between healthworlds.

— Is the case study impacting on the Moravian church and its attitude to traditional healers?

— "When treatment comes, prevention is forgotten." Does the Masangane model promote treatment at the expense of prevention? How does this fits in with the Moravian teachings?

— Why is there no mention of counselling and testing? It is still a very important aspect of AIDS work.

— Poverty and lack of sufficient food, as factor in the AIDS pandemic is missing in the study.

— Training is an important factor to study: What training is offered? Who learns from whom?

STIGMA

— A critical question to consider is the manifestation of stigma in relation to the introduction of ARVs. Does stigma lessen with the introduction of ARVs, and what is the role of the church in this?

— It was noted that there is an amazing link between ARVs and self-stigma, as well as the visible effects of the "Lazarus effect".

UNIQUE ASPECTS OF RHAs

— What is the value the FBO (or RHA) adds to health that is different from the state's? E.g. Masangane gets people on ARVs quicker than the state and treatment adherence is high.

— Could they be swallowing more than ARVs or good nutrition? Could they be swallowing "spiritual food" as well?

— Considering the tensions between strengths and weaknesses, between funds, volunteerism (issues which the state is trying to get away from), it may well be that RHAs are just fragile by nature, and hence unsustainable?

— The project should consider sustainability and transfer of skills.

— Sustainability will ultimately be found in relationship with the government. So, what is the value of FBOs? What is different to other good W Cape projects? I.e. the Lazarus effect is happening all over. Is there a difference in dropout, adherence, drug resistance, or return after dropout?

ARHAP Case Study #2: Lesotho

Paul Germond, Lauren Graham, Sepetla Molapo

Witwatersrand University

In April 2004 a team of researchers set up camp in Lesotho to begin work on the first ARHAP case study, looking at how health and religion intersect in Lesotho. We present here some aspects of this study.

The Use of Language [1]

Very early in this project the research team encountered the knotty problem of translation. We discovered that our use of the words "health" and "religion" did not make sense to our Sesotho interviewees. For the majority of them the Cartesian distinctions between religion and health, between body and spirit, did not reflect Basotho conceptions and practices of health and healing. In this light, the Lesotho team made the strategic decision to abandon the words "health" and "religion" in the interview stage of our research at least and substituted them with the Sesotho word *bophelo* (life or health).[2]

[1] Paul Germond (2005), "Of Healthworlds and Health Agency: Recasting Conceptions of Health in an African World". Draft paper.

[2] For a detailed discussion of bophelo see Paul Germond, (2004), "Bophelo: Towards a Working Definition - finding alternatives to the words 'religion' and 'health'" Unpublished working paper, University of the Witwatersrand: ARHAP Lesotho Study

Bophelo at its most basic means biological life; at its most developed it conveys a sense of a fully healthy society. Bophelo is conceived of as existing in five overlapping and intersecting social-spacial nodes. In human terms bophelo begins with *motho*, the individual. Then it is found in *lelapa* – the family or homestead. Agglomerations of *malapa* give rise to the village, or *motse*, the collection of which, in turn, constitutes *naha*, the nation. The fifth node is that of *bodimo*, the realm of the ancestors. The lack of bophelo in any one of these areas means that bophelo of the whole is compromised.

The term "Healthworld" is an attempt to find an English word that captures the complex manner in which the Sotho people construct their understandings of health and illness in local contexts, and how these play themselves out in terms of multiple health seeking behaviours.

Three propositions undergird the notion of healthworld:

- Health seeking behaviour rests on a bounded but dynamic field of knowledge. This knowledge is part tacit, implicit and unconscious; part reflexive, explicit and intentional.
- This, in the African context, explodes the Cartesian distinction between religion and health (and other binaries)
- This manifests itself in new ways of understanding the body.

In Search of Bophelo: The Traditional Sesotho Healthworld

Two essential features of the traditional Sesotho healthworld are that bophelo is fundamentally relational – it cannot be reduced to the health of the individual, let alone the individual's biological health. It is constituted by a complex of social relationships which are, themselves, the source of bophelo; and bophelo is fundamentally based on trust.

A conceptualization of the body in the Sesotho Healthworld includes three dimensions: the interior body, the exterior body; and the social body. Western biomedical science is based on the assumption that the rational person will, in every situation, always make an informed decision to prioritize biological life. The life of the exterior body is privileged over both the life of the interior body and the life of the social body. In search of bophelo this is not necessarily the case. An individual may prioritize the health of the social body or the health of the interior body over the health of the exterior body.

Any health strategy – targeting fields from AIDS prevention to mental health – must understand the relation of the three bodies, and their relative significance for behavior choices. Considering illness and the body we need to ask: Which body is it in this case that determines behaviour? And which body is it that is in crisis? Empowered FBOs are ideally positioned to address the relation of the three bodies and effect substantive change in health behaviour.

Studying the Sesotho Healthworld opens up space for dialogue as well as intelligent and sympathetic critique of different healthworlds. As one situates oneself in the social space of different health perspectives, it allows for perception of what can and cannot be perceived from each point of view. This view also illuminates health agency, as it makes it possible to understand health agents in the context of their indigenous rationalities.

Health Providers

Lesotho society includes a complex of "indigenous" healthcare provision as well as "western" healthcare provision. Categories include *Ngaka chitja* (herbalist); *Ngaka ea*

litaola (diviner); *Mapostola* (a Basotho form of Zionism in which *mapostola* establish communities of bophelo practice); *Moprofeta* (another form of Basotho Zionism, generally located in an already existing religious community); Pentecostal faith healers; religious leaders and health providers from Pentecostal, Roman Catholic or Protestant denominations; secular Western healthcare providers. One research project studies the different traditional Sesotho health providers in detail.

Another project of this study took as its sample healthcare providers in a religious hospital in Lesotho. It sought to identify how they understand health and its maintenance, illness and its causes and the best ways to go about providing care to those that are in need of it.

This provided an interesting area of intersection. The nurses are trained biomedically, yet practice their profession in a workplace that is run by and influenced by the Lesotho Evangelical Church. Finally, all the providers are Basotho and as such are at some level, influenced by their traditional cultural understandings of health. It becomes evident therefore that people somehow manage to hold together competing and conflicting definitions of health in what we have termed a particular *healthworld*. This project considers the *healthworlds* of these providers and makes some contributions to how we can better understand the term *healthworld*. It also suggests that current explanations of how people use competing health discourses are inadequate.

Questions & Responses

RESEARCH METHODS

- A number of questions and responses considered the background to the project and the research methodology, such as the ethics clearance process.
- In the interview process between the researcher and the nurses, attention must be paid to issues like racial differences, language barriers and location. In response it was noted that these factors could have played a part in the kind of answers people gave, but that the interview process was managed as well as possible given the circumstances – for example, interviews were conducted in homes and staffroom rather than the boardroom.
- Further investigation of the longitudinal (historical) aspects of Scott hospital could add depth to the research on the perceptions of health providers.
- Traditional healers and pastors were not being referred to as professionals during the presentation. It was clarified that traditional healers and pastors are definitely considered to be professionals.
- What is the feasibility of doing an inclusive study of the country? So far it seems that aspects like healing in Pentecostal churches is excluded.
- Rites of passage might be investigated as both a healing model and a religious experience. Furthermore, rituals performed during rites of passage (especially those at birth or death) are key to bophelo and therefore vital for the research.
- ARHAP researchers need to constantly remind themselves of the "so what" question. Deep descriptive work is wonderful, but there is also a great demand for the research results to be translatable and useful to current/existing public health frameworks.

ALTERNATE HEALTH PARADIGMS

— What does the research reveal in relation to Primary Healthcare (PHC) – i.e. what do the nurses at Scott Hospital understand PHC to be? What are the alternatives to PHC in the area?

— Nurses may refer patients to alternate forms of health care (e.g. traditional healers) in secret, as to do so openly would be against Scott hospital's Christian ethos.

— It is collaboration of the hospital with *dingaka* that is difficult and this has implications for the health status.

— Health providers do not confine themselves to the physical body but also work to understand the contribution of the patient's social, spiritual and physiological wellbeing.

— Religion, not only culture, impacts on family medicine. The study is however more concerned with public policy for health provision than individual doctors.

— Apostolic churches (maprofeta) do not differ from e.g. the Catholic Church, except regarding their healing practice. They do not fit under traditional healing.

ARHAP THEORETICAL FRAMEWORK

— There is an urgent need for a cohesive (common) understanding of the ARHAP theory matrix as individuals were using it differently, and some student researchers were struggling to clearly fit their research into the "quadrants" as they are currently defined. Furthermore, pegging research into a single quadrant might have a constraining effect. It is possible that the matrix is more useful as a conceptual tool than in relation to on the ground analysis.

— There is a need in future to have different professions represented among us as we discuss health and wellbeing. Traditional healers, for instance, should be part of future colloquiums.

ARHAP Case Study #3:
Zambia - Pilot Research Project on the Copperbelt

Steve de Gruchy

University of KwaZulu-Natal

Background to the Study

The current state of health – and of religious health assets – in the Copperbelt has to be understood against the conditions that shaped them. This includes the historical development from the pre-colonial period through the nationalisation programme affecting particularly the mines; the economic collapse of the region due to regional conflicts, global politics and local trends. The health situation is characterised by the collapse of national health provision, the impact of user fees, damage to the environment through industry as well as malaria, TB and HIV/AIDS epidemics.

Zambia had a predominantly Christian mission history, and more recently an explosion of Evangelical and Pentecostal activity. It is officially a 'Christian state', with Islam and ATR in a less prominent role. There is a wealth of religious agencies providing health-related services: Churches Health Association of Zambia (CHAZ), Mindolo Ecumenical Foundation (MEF), Copperbelt Health Education Programme (CHEP), Traditional Healers and Practitioners Association of Zambia (THAPAZ), Independent Churches & Other Ministries Zambia (ICOZ), Hindu Association, Bahai Faith, Islamic Association, Chinese Health Providers alongside numerous church bodies and international NGOs.

Pilot Research Project

This project is closely aligned to the ARHAP Theory Matrix, aiming to use it, unpack it and evaluate it. Seven key research foci will be addressed by different researchers, of which the first four focus on specific *assets* and the other three on the *agency* of various players. All of these ought to be wrapped up by February 2006.

1: Faith Communities & Religious Assets that are Tangible and Indirect (Quadrant 2)

In this project comprising her MTh thesis Mary Mwiche will explore to what extent the local churches of Ndola recognise and make use of the assets that promote well

being. In 25 structured interviews and focus group discussions with ministers from a cross section of churches in Ndola she will investigate the ways in which local churches contribute to the wellbeing of people, other than when they are specifically engaged in 'health activities'.

2: Faith Communities & Religious Assets that are Intangible and Direct (Quadrant 3)

Maybin Kabwe's MTh thesis is directed at finding what contribution local churches have made toward direct health outcomes on the Copperbelt Province; with a secondary research question considering the implications of her case studies on the ARHAP theoretical framework. This will be examined through five case studies ranging from faith healing services to a private Christian clinic. The qualitative approach includes archival research and interviews with key informants, both health seekers and health providers from each agency.

3. Religious Health Seekers & Direct Religious Assets (Quadrants 1&3)

Sinatra Matimelo will conduct preliminary work for his PhD focusing on the impact of religion on issues of motivation and resilience amongst health seekers in Ndola in order to learn more about the way that personal religious conviction might be understood as a RHA. He will administer open-ended questionnaires to a random sample of 100 individuals in Ndola.

4. Analysing Quadrant 4: Intangible and Indirect RHAs

In this study Steve de Gruchy will examine the continuities and discontinuities between the matrix and the research findings of the previous three projects in order to contribute to the next generation of ARHAP theory, and to engage with the key policy leaders on the basis of the findings.

5. Alignment of ARHAP Matrix with Policy Leaders

For his MTh thesis Roy Aloysius Hamalyang'ombe will study the correlation between the ARHAP understanding of the relationship between religion and health, and the perceptions of 13 influential leaders in Zambian society who have responsibility in the area of health and/or religion. He will identify ways in which they see religion to be connected and linked to health and how this link contributes to the lives of people in Zambia. The outcomes of the research should uncover the impact of Zambia being a 'Christian Nation' on health policy; impact on networking and relationships between the agencies; and identify those perceptions that need to be integrated into future ARHAP work on health policy.

6. The Health Agency of Forced Migrants (Lusaka based)

Francois Murukezi's PhD proposal investigates the struggle for health, healing and livelihood strategies of forced-migrants in Lusaka with a view to understanding how RHAs such as Peace Centre activities and Religious ministries impact on the way people in exile rebuild their lives. The study will consider issues like the theological significance of exile and *Shalom* in a time of diaspora and point to implications for churches and for public health policy makers.

7. Social History of Religion and Health

Chabu Kangale's PhD proposal develops a longitudinal perspective of health and religious impacts on this on the Copperbelt. It will follow changes from pre-colonial

times through Kaunda's policy of nationalisation, the time of structural adjustment programmes and Chiluba's privatisation policy to the emergence of faith-healing movements.

Learning About RHAs: Participatory Learning and Appreciation

The second major thrust of the Zambia case study is a qualitative participatory mapping process alongside the quantitative survey of RHAs sought by WHO. The qualitative work will help shape the kind of quantitative data to be gathered as well as help validate and interpret the data that is assessed. The process will further enhance our theoretical understanding of RHAs and affirm and appreciate the work being done on the ground through its non-extractive and respectful approach.

In each identified province two workshops will be conducted. The first draws in 25 key leaders working in RHAs and policy leaders to validate and expand the quantitative data that has been provided It will include participatory mapping of RHAs, ranking them and unpacking the linkages that occur within and between RHAs and other health facilities. A second workshop will fill in the gaps by convening 'ordinary people' at local community level in a similar process.

Questions & Responses

THE INTERDISCIPLINARY ARHAP MODEL AND ITS LANGUAGE

- How does ARHAP methodologically incorporate the various research needs and results? If each researcher is using a different methodology, how is it possible to pull all the quadrants together?
- Work elsewhere has shown that the Matrix is flawed; it is useful as a conceptual tool but not in on the ground analysis. Researchers need not attempt to peg research in a single quadrant.
- We work in a hermeneutic circle, and someone has to take a first step using the framework, acknowledging that the research might blow it out the water. We have already taken "assets" from accounting and made it our own concept.
- Is it possible to do longitudinal studies (i.e. if the baseline data is always changing)?
- There is already a substantial amount of baseline data available on Zambia that could be pulled in to the ARHAP study.
- While the ARHAP theoretical model had come a long way in a short time, it may well be the time to revisit it and develop it further. For example, to select direct questions or tools for different aspects which are most important to RHAs. What questions are to be asked of which respondents? Which criteria do we use for evaluating the efficacy of RHAs?
- While all typologies are flawed, what is important is that the language becomes more persuasive and the models become more useful.
- By the end of 2006 ARHAP should have formed a common understanding or language of what we mean by RHAs, a way to convey our shared understanding to people who are not religious.
- Furthermore, it was noted that the public health voice needs to be stronger – for ARHAP to be made accessible to public health professionals.
- There is a need for the research results to be able to dialogue with existing paradigms and frameworks – to find a language that frames the questions in a way that all can engage. For example, it was asked to what extent does a person's faith impact in realising the basic needs and challenges of the Ottawa health charter? And can this be answered in a language that public health practitioners can utilize?

PART FIVE
Final Session, Participant Details

Final session

Evaluation

The evaluation began by reflecting on four categories: surprise, irritation, blessing and inspiration. The resulting discussion crossed these boundaries. Some comments were:

- A sense of surprise and blessing by the level of involvement, especially of students.
- There was some irritation at the room acoustics; and it was felt that there was not enough time allocated to discussion.
- Many people felt blessed by the show of unity and diversity.
- It is inspiring that ARHAP has come so far in such a short time, and that there is now a sense of ARHAP becoming concrete and influential.

Connection

How can ARHAP connect itself with other organizations and individuals who are seeking to achieve similar objectives? Who do we know on the ground? How could we connect systematically?

- ARHAP needs to connect with Government departments throughout Africa, to gain information, disseminate our research and establish connections.
- Need to further connect more fully with the missing voices at the colloquium, e.g. with those fully engaged in ATR, the Islamic community, and other religions.
- Need to connect with more religious bodies in Africa, to both involve them in our research programs and access their information.
- Need to connect properly with disciplines not represented, e.g. psychologists, immunologists, experts in food security or environmentalists.
- Need to connect with the people on the ground – with the research participants and community.
- Need to connect more fully with policy makers - from the beginning of each research project – also to advocate for change in policy matters.
- Need to utilise our current connections to their full, trace existing connections.
- While it was clear that ARHAP was working well to connect students with academic staff and other professionals, this connection needed to be continued, and connect students together with each other (e.g. between USA and Africa).

Coherence

What is the role of coherence in developing research tools, shared language and discourse?

- Throughout the colloquium there was a clear message that ARHAP must begin to create a bounded language – that is, despite our resistance to being tied down, it is necessary to start naming things, clarifying and creating an ARHAP "glossary". This is both a burden and an opportunity; by writing you lose something, but you gain as well.

— Being more "cohered" must not mean losing what ARHAP is.
— We need to link ARHAP more clearly with existing bodies of research and knowledge; to not "reinvent the wheel" unless it really brings new aspects to the research.
— We need to be more cohesive about pulling together the scattered pieces of research that have already been done.
— We need to examine the leading causes of life in terms of measurable indicators.

Bless or Blessing

How are we blessed?

— Being affiliated with ARHAP can be a personal blessing in that it is inspiring, it opens people up to new ideas, is a space to share ideas, and has an integrating as well as emotional element to it.
— ARHAP is theology made practical. These are very practical issues where theology meets health. We have much to offer and need to disseminate it more freely.
— We need to carry what we have out to a broader group of people, take it into the "world." It will be a blessing. We need to collect and disseminate what we have, establish a data base, a presence in a university library, and get up and running on a web site. This would also help students know where to fit in.

Agency/Doing

What should we being doing differently? What should the colloquium look like next year?

— There was some concern as to the ambiguous nature of ARHAP – is it a group of researchers engaged in intellectual gymnastics, or is it an activist organisation? Who "owns" the research produced under the ARHAP framework?
— Some participants and students could not clearly see where they fit into the programme. Is ARHAP an "organisation", a "think tank", or an "advocacy group"? ARHAP needs a more "organisational" structure?
— The work of ARHAP must be policy relevant and have an activist orientation. We must always focus on the "so what" question.
— The 100 theses topics mooted early on must be considered.
— ARHAP is in many ways ambiguous and is yet to make an impact on the ground. We have responsibilities to certain people to have tangible outputs.
— There is a need for everyone to go about consciously making ARHAP more visible in different countries.
— We are a religious health asset by supporting and empowering other religious health assets.

Hope

— Hope was a category that incorporated all the above: we hope to link with other institutions, African scholars, to rediscover connections that make life work, to promote RHAs so that they are recognised as a genuine research agenda and influential at a policy level.
— Develop hope as a curriculum theme, e.g. speak about HIV in terms of Hope.
— Strive for alignment with FBOs to give them credit.
— Hope is also found in secular NGOs and there is much to learn from them.

List of Participants

Prof Nancy Ammerman	Boston University, USA
Dr Jack Ammerman	Boston University, USA
Ms Mary Baich	Vesper Society, San Francisco, USA
Dr Graham Bresick	University of Cape Town, SA
Ms Shirley Butcher	University of Cape Town, SA
Ms Sophia Chirongoma	University of KwaZulu-Natal, SA / Zimbabwe
Prof Jim Cochrane	University of Cape Town, SA
Prof Steve de Gruchy	University of KwaZulu-Natal, SA
Mr Frank Dimmock	Malawi Health Coordination Office
Mr Paul Germond	Witwatersrand University, SA
Mr Ishmael Gqamane	Positive Muslims, Cape Town, SA
Ms Lauren Graham	Witwatersrand University, SA
Rev Christo Greyling	World Vision, Johannesburg, SA
Prof Paul Gundani	University of SA, Pretoria, SA
Dr Gary Gunderson	Interfaith Health Program, Atlanta / Memphis, USA
Mr Malibongwe Gwele	University of Cape Town, SA
Prof Alan Haworth	Lusaka, ZAMBIA
Rev Japé Heath	ANERELA+, Johannesburg, SA
Mr Rick Herman	Wheatridge Ministries, Itasca, USA
Dr Beate Jakob	DIFAEM, Tübingen, Germany
Dr Kipton Jensen	University of Botswana
Ms Helen Ji	Zambia-Emory HIV Research Project, Lusaka
Ms Debbie Jones	Interfaith Health Program, Atlanta, USA
Ms Johannah Keikelame	University of Cape Town, SA
Dr Duane Larson	Wartburg Theological Seminary, Dubuque, USA
Prof Tinyiko Maluleke	University of SA, Pretoria, SA
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