THE STATE OF THE EVIDENCE IN RELIGIONS AND DEVELOPMENT

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CHAPTER 2

RELIGIONS, HEALTH, AND DEVELOPMENT

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This chapter describes the varied influences of religions on health and development initiatives, places those influences in historical context, summarizes influential research on this topic over the last two decades, and points to current and emerging issues that are central to understanding religion's current impact on the field. Readers unfamiliar with religions' influence on health and development initiatives can better understand recent research in the field by reflecting on these two concepts:

- **Religious health assets—** This term comes from a series of groundbreaking initiatives in the early 2000s to understand religion's influence on public health programs. A 2005 study funded by the World Health Organization (WHO) as part of these initiatives defined an asset as "range of capabilities, skills, resources, links, associations, organizations, and institutions, already present in a context."[145] A religious health asset is "an asset located in or held by a religious entity that can be leveraged for the purposes of development or public health."[146]
- **Beliefs and behaviors—**Beliefs and behaviors are central to understanding religion's influence on health. People of faith may experience contradictions between the teachings of their faith tradition, their own personal beliefs or actions, their worldviews about the phenomenon of health, and the health impact of their actions. This chapter points to the power dynamics that generate those tensions.

History of health, religions, and development

The historical influences of religion on global health and development practice have been significant. The earliest documented Muslim medical facilities were built in Baghdad in the 9th Century C.E. and over the next 500 years, Muslim hospitals were established across the Middle East, North Africa, Turkey, and Spain.[147] In 1640, Roman Catholic missionaries established the first medical facility on the African continent and the first Protestant Christian missionary arrived in Cape Town in 1795. Into the early 20th century, Christian missionary facilities offered the only clinical medical services anywhere on the continent and by 1910, these facilities were providing medical care to millions of people across Africa.[148] Today, faith-based health facilities are the largest non-governmental provider of health care across sub-Saharan Africa. What remains unknown, however, is the specific scope of their contributions as debates regarding which metrics are most important to consider—numbers of people served, number of beds in inpatient facilities, reach to the poor, etc.—are ongoing.[149]

During the 19th century, Christian medical missionaries from Great Britain established facilities in British colonies across Africa, South and East Asia, Australia, and South America but by the start of the 20th century, American medical missionaries outnumbered their British counterparts and American Christian denominations were supporting over 1,000 health facilities (including 379 hospitals).[150] Direct medical care was not the only focus of such missionary endeavors as 94 colleges, and over 20,000 primary and secondary schools were also established.[151] Throughout the 19th century, the American Tract Society published millions of tracts for distribution around the world. While the majority of the tracts focused on religious instruction, over 40% of the titles addressed topics related to health and hygiene; in 1838 alone, the Society published over 13,000,000 copies of 418 separate titles

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145 African Religious Health Assets Programme, Appreciating Assets: The Contribution of *Religion to Universal Access in Africa* (Cape Town: ARHAP, 2006), 39, http://www.irhap.uct.ac.za/irhap/research/pastprojects/assets.

146 ARHAP, *Appreciating Assets*, 39.

147 Emilie Savage-Smith, "Islamic Culture and the Medical Arts" (Oxford: Oxford University, 1994), 24.

148 Charles M. Good, "Pioneer Medical Missions in Africa," *Social Science and Medicine* 32, no. 1 (1991): 3, https://doi.org/10.1016/0277-9536(91)90120-2.

149 Jill Olivier et. al., "Understanding the Roles of Faith-Based Health-Care Providers in Africa: Review of the Evidence with a Focus on Magnitude, Reach, Cost, and Satisfaction," *The Lancet* 386 (2015): 1765–1775, https://doi.org/10.1016/S0140-6736(15)60251-3.

150 William R. Hutchison, *Errand to the World: American Protestant Thought and Foreign Missions* (Chicago: University of Chicago Press, 1987): 100.

151 Hutchison, *Errand to the World*, 100.

in 32 different languages across 18 different countries.[152] All of these efforts were carried out with an uncritical acceptance of Western cultural, religious, and intellectual superiority and medical missions provided a religious rationale not only for the development of global health and development institutions but also for colonialism up through the mid 20th century.[153]

By the latter decades of the last century, the secularization of public health and development fields had largely relegated religion to the margins. Most health and development professionals from Western societies minimized the influence of religious beliefs on the health of the people to whom they provided services,[154] overlooked the importance of partnerships with faith-based health and development programs,[155] and assumed religious belief was merely a private matter that should have no bearing on their programs or on governmental policies.[156]

William Foege voiced an exception to this commonly held perspective. Foege served as Director of the US Centers for Disease Control and Prevention (CDC) between 1977 and 1983. In 1992, as Director of The Carter Center in Atlanta, Foege founded the Interfaith Health Program (IHP) to support collaboration between public health and religious leaders. In 2002, IHP convened two conferences that expanded its work to global contexts. The meetings put forth the claim that faith communities possess extensive and powerful assets in support of health, arguing that these "religious health assets" are both tangible and intangible.[157] Tangible assets include health ministries, faith-based health facilities, or nongovernmental organizations founded and supported by faith communities. Intangible assets include trust, longevity, motivation, commitment, and sense of purpose.

These initial conferences were a watershed in raising awareness of religion in the field of global health. They led to the creation of the International Religious Health Assets Programme (IRHAP),[158] an international consortium of religious, health, and development practitioners and researchers, which helped to coordinate a groundbreaking study with funding from the WHO in 2005.[159] Researchers affiliated with IRHAP have subsequently influenced other efforts to build collaborations between health and development leaders and faith leaders and communities in areas such as:

- **health systems** strengthening in which partnerships between local faith communities and health systems have been developed[160] and stronger national networks of faith-based health providers supplement the coverage of Ministries of Health;[161]
- **development** in which faith communities and faith-based organizations provide resources for those in extreme poverty,[162] and fill the gaps where governmental policies have limited access to health services for those living in informal settlements;[163]
- **adolescent sexual health** where religions may not be particularly successful in encouraging abstinence, but they are identified as resources for making healthier choices and creating healthier relationship by young people;[164] and

152 *Twenty-Fourth Annual Report of the American Tract Society* (Boston: Perkins & Marvin, 1838).

153 For a fuller discussion of this history, see John Blevins, *To Save the Empire of the World: Christianity's Role in United States Global Health and Development Policy* (New York: Routledge, 2019), 56-107.

154 Jill Olivier, "Religion at the Intersection of Development and Public Health in Development Contexts," in *Routledge Handbook of Religions and Global Development*, ed. Emma Tomalin (New York: Routledge, 2015), 346-358.

155 For a summary of the decline in such partnerships along with a defense of their importance, see Ellen Idler and Allen Kellehar, "Religion in Public Health-Care Institutions: US and UK Perspectives," *Journal for the Scientific Study of Religion* 56, no. 2 (2017): 234-240, https://doi.org/10.1111/jssr.12349.

156 The Christian theologian Lesslie Newbigin challenged the relegation of religion to the private sphere. See Lesslie Newbigin, *The Gospel in a Pluralist Society* (Grand Rapids: Eerdmans, 1989). For an inter-religious discussion between Christian and Muslim scholars on the privatization of religion that draws on Newbigin, see Centre for Muslim-Christian Studies, "Thinking After Newbigin: Faith Responses to Relativism and Pluralism in a Secular World" (Oxford: Centre for Muslim-Christian Studies, 2017), https://www.cmcsoxford.org.uk/resources/research-briefings.

157 The first meeting entitled the "Global Religious Health Assets Initiative" was held between April 29-30, 2002 at The Carter Center. See http://ihpemory.org/wp-content/uploads/2014/12/Global-Religious-Health-Assets-Initiatives.pdf for the proceedings of the meeting. The second meeting was held between December 1-3 at the World Council of Churches. See http://ihpemory.org/wp-content/uploads/2014/12/African-Religious-Health-Assets-Program.pdf.

158 For more information on the International Religious Health Assets Programme, See http://www.irhap.uct.ac.za.

159 See ARHAP, *Appreciating Assets*.

160 One example of such efforts is the Stakeholder Health Initiative. See https://stakeholderhealth.org/promising-practices-mapping/.

161 Frank Dimmock, Jill Olivier, and Quentin Wodon, "Network development for non-state health providers: African Christian health associations," *Development in Practice* 17, 5 (2017): 580-598, https://doi.org/10.1080/09614524.2017.1330402.

162 Jill Olivier and Quentin Wodon, "Health, Cost, and Reach to the Poor of Faith-Inspired Health Care Providers in Sub-Saharan Africa" (Washington, DC: The World Bank, 2012), https://openknowledge.worldbank.org/handle/10986/13573.

163 John Blevins, "Are Faith-Based Organizations Assets or Hindrances for Adolescents Living with HIV? They are Both," *Brown Journal of World Affairs 22*, no. 2 (2016): 25-38.

164 John Blevins, "Tough Negotiations: Religion and Sex in Culture and in Human Lives," in *When Religion and Health Align: Mobilising Religious Health Assets for Transformation*, ed James R. Cochran, Barbara Schmid, and Teresa Cutts (Pietermaritzburg: Cluster Publications 2011), 118-134, http://www.irhap.uct.ac.za/sites/default/files/image_tool/images/244/Book_Ch_When_RH_Align_Ch9.pdf.

- **health and development policy** where changes in bilateral and multilateral funding mechanisms rock the financial stability of faith-based organizations[165] and where such organizations nonetheless retain similar levels of funding relative to civil society organizations.[166]

This generation of researchers, many of them affiliated with IRHAP, published a groundbreaking special issue of *The Lancet* on Faith-Based Health-Care in 2015.[167] *The Lancet* issue provided a benchmark on research in the field to date on topics such as:

- **faith-based health service delivery**, noting the substantial contributions of faith actors but also laying out gaps in the literature and describing programmatic and methodological challenges related to an analysis of health services data;[168]
- **controversies in faith and health care** in an article that surveyed points of tension between religions and health in certain topics such as sexual and reproductive health;[169] and
- **the importance of partnerships** across governmental, faith, and civil society sectors in an article that surveyed trends pointing to the importance of such partnerships and offered recommendations for strengthening them.[170]

Current trends and challenges in health, religions, and development

Religion as all positive or all negative for health and development

All the efforts summarized above have reminded leaders in health and development that religions are a powerful social force; they have also contributed to controversies. One controversy relates to a perceived bias about religion's influences on health and development. Those advocating for religion's contributions had to make their case to a field that had relegated religion to the margins; in doing so, they did not always interrogate the tensions between religion and health and development as rigorously. For example, the 2005 WHO study report mentioned above enthused that "religion is so overwhelmingly significant in the African search for wellbeing, so deeply woven in the rhythms of everyday life, and so deeply entwined in African values, attitudes, perspectives and decision-making frameworks that the inability to understand religion leads to an inability to understand people's lives."[171] In short, the report implied that religion's powerful effects always contribute to better health.

Not everyone was convinced. For example, in 2010 the former global director of the US President's Emergency Plan for AIDS Relief (PEPFAR) argued that while PEPFAR had saved lives, "its positive impact has been limited due to program requirements in the law that are based largely on a conservative religious ideology, rather than a sound, scientifically driven strategy."[172] Unbiased research into religion can be difficult to carry out in the field of health and development when strong and vocal camps articulate all-or-nothing perspectives that religion is either the essential underappreciated partner to health and development initiatives or the singular social force that thwarts the best efforts of those initiatives.

Focus on tangible faith-based health assets has left out intangible factors

A second controversy is seen in the focus among many funders of health and development programs on the tangible contributions of faith partners, limiting our understanding of intangible factors. For example, because faith-based health facilities can be counted and their service quantified in terms of patients seen, their contributions as religious health assets are prioritized. In contrast, qualitative and intangible factors are minimized. However, in the past decade research on intangible factors such as trust[173] has risen in response to pressing health challenges. Sustained efforts to address HIV-related stigma and respond to pandemics have pushed researchers and policymakers to think more broadly about religion.

165 Christoph Benn, John Blevins, and Sandra Thurman, "Reflections on HIV-Related Experiences of Two Global Funding Mechanisms Supporting Religious Health Providers," *The Review of Faith and International Affairs 14*, no. 3 (2016): 110-117, https://www.tandfonline.com/doi/abs/10.1080/15570274.2016.1215815?journalCode=rfia20.

166 Annie Haakenstad et al., "Estimating the Development Assistance for Health Provided to Faith-Based Organizations, 1990-2013," *PLOSOne 10*, no. 6 (2015), doi: 10.1371/journal.pone.0128389.

167 See *The Lancet* series on "Faith-Based Health-Care," *The Lancet* 396, no. 1005 (2015): 1765-1794, https://www.thelancet.com/series/faith-based-health-care.

168 Olivier et al., *Faith-based Health Care Provider*, 1765-1775.

169 Andrew Tomkins et. al., "Controversies in Faith and Health Care," *The Lancet* 396, no. 1005 (2015): 1776-1785, https://doi.org/10.1016/S0140-6736(15)60252-5.

170 Jean Duff and Warren W. Buckingham, "Strengthening of partnerships between the public sector and faith-based groups," *The Lancet* 396, no. 1005 (2015): 1786-1794, https://doi.org/10.1016/S0140-6736(15)60250-1.

171 ARHAP, *Appreciating Assets*, 1.

172 Scott Evertz, "How Ideology Trumped Science: Why PEPFAR Has Failed To Meet Its Potential" (Washington, DC: Center for American Progress, 2010), 12.

173 Lise Rosenda Østergaard, "Trust matters: A narrative literature review of the role of trust in health care systems in sub-Saharan Africa," *Global Public Health* 10, 9 (2015): 1046-1059.

Progress in the global HIV response has not been equal for all communities, due in large part to stigmatizing attitudes toward key populations. While religious messages have been tied to HIV-related stigma, efforts to challenge such attitudes can be more effective when they are carried out by faith communities and religious leaders.[174] The 2015 Ebola outbreak in Western Africa and the global COVID-19 pandemic have both demonstrated the distinctive ways in which religion can draw on deep reservoirs of trust. The initial public health Ebola response, calling for religious burial practices to be suspended without any input of religious leaders, was ineffective but when collaboration led to modified practices that allowed for safe burial while maintaining spiritual significance, infection rates dropped dramatically.[175] We have seen similar ways in which the authority of religious leaders has affected vaccine acceptance or hesitance during the COVID pandemic.[176]

Emerging areas of interest and questions for future research

Moving into the future, a new generation is pushing the field into new areas of inquiry. Efforts to identify, amplify, and align religious health assets continue, with an effort to understand whether those assets in fact offer distinctive advantages: do they provide essential services in areas with weak health infrastructure? Do they reach the poorest and most vulnerable members of society? Does the care provided result in improved health outcomes?[177] At the same time, there is a growing movement to consider religion's influences in other ways. Scholarship into the frameworks that people employ to make sense of life helps us to understand the relationship between beliefs and behaviors, quickly opening lines of inquiry in religion and health.[178]

Examples of such scholarship include: negotiations in the health behaviors of people of faith when daily actions are in tension with teachings and moral principles championed by their faith tradition;[179] the alignments and tensions between religious and scientific frameworks for making sense of health;[180] the similarities and differences in teachings across various religious traditions that inform health beliefs and behaviors;[181] and the differences between the cultural frameworks that inform the grounding assumptions of the health and development field and those frameworks that inform very different assumptions in the societies in which health and development programs are carried out.[182]

Each of these topics is conceptual but when we use such concepts to reflect on real-world practice, pressing ethical questions about power arise. Who has the authority to articulate "right" and "wrong" ways of believing or behaving? How do we guard against uncritically interpreting religious and cultural systems through our own frameworks? How can we interrogate the grounding assumptions not only of religious traditions but also of the tradition of scientific inquiry grounded in evidence-based practice that is the foundation of health and development research?

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174 The various anti-stigma efforts of the International Religious Network of Religious Leaders Living With or Affected by HIV/AIDS (INERELA+) are an outstanding example. See https://inerela.org. For a summary of faith-based anti-stigma efforts, see John Blevins and Sally Smith, "A Common Vision: Faith-Based Partnerships to Sustain Progress Against HIV," Report (Atlanta: Interfaith Health Program and Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS), 2019), https://ihpemory.org/wp-content/uploads/2019/09/A-Common-Vision-Report_FINAL_2019.pdf.

175 Katherine Marshall and Sally Smith, "Ebola and Religion: Learning from Experience," *The Lancet* 386, no. 1005 (October 31, 2015): e24-5, https://doi.org/10.1016/S0140-6736(15)61082-0. John Blevins, Mohamed Jalloh, David Robinson, "Faith and Global Health Practice in Ebola and HIV Emergencies," *American Journal of Public Health* 109, no. 3 (March 2019): 379-384, https://doi.org/10.2105/AJPH.2018.304870.

176 See Megan A. Milligan, et al., "COVID-19 Vaccine Acceptance: Influential Roles of Political Party and Religiosity," *Psychology, Health, and Medicine* 2021, DOI: 10.1080/13548506.2021.1969026. See also: Ellen Idler, John A. Bernau, and Dimitrios Zaras, "Narratives and Counter-Narratives in Religious Responses to COVID-19: A computational text analysis," *PLOS One* 17,2 (2022), https://doi.org/10.1371/journal.pone.0262905

177 Jill Olivier, director of ARHAP and a global leader in the field of religion and public health, is asking such questions in relation to faith-based health systems. See Olivier and Wodon, *Faith-Inspired Health Care*, 2012; *The Lancet* special issue.

178 In fact, researchers affiliated with IRHAP contributed an important concept to help us understand the relationships between beliefs and behaviors and how both help us think about religion and health. See Paul Germond and Jim Cochrane, "Healthworld: Conceptualizing Landscapes of Health and Healing," *Sociology* 44, no. 2 (2010): 307-324, https://doi.org/10.1177/0038038509357202. This chapter makes the case for further scholarship to broaden our conceptualizations beyond healthworlds alone.

179 See Blevins, *Tough Negotiations*. See also Gayle Brewer, et al., "The Influence of Religious Coping and Religious Social Support on Health Behaviour, Health Status, and Health Attitudes in a British Christian Sample," *Journal of Religion and Health* 54 (2014): 2225-2234, doi: 10.1007/s10943-014-9966-4.

180 See Germond and Cochrane, *Healthworld*. See also: Bruno LaTour, "'Thou Shalt Not Freeze Frame', or How Not to Misunderstand the Science and Religion Debate," in *Science, Religion, and the Human Experience*, ed. James D. Proctor (New York: Oxford, 2006): 27-48.

181 See Ellen L. Idler, ed., *Religion as a Social Determinant of Public Health* (New York: Oxford), 38-111.

182 Paul Farmer, "Health, Healing, and Social Justice: Insights from Liberation Theology," in *In the Company of the Poor: Conversations with Dr. Paul Farmer and Fr. Gustavo Gutierrez*, ed Michael Griffin and Jennie Weiss Block (Maryknoll: Orbis Books, 2013). See also Jarrett Zigon, "Morality and HIV/AIDS: A Comparison of Russian Orthodox and Secular NGO Approaches," *Religion, State and Society* 37, no. 3 (2009): 311-325, https://doi.org/10.1080/09637490903056591.

These critical questions unsettle some of the earlier work described above. For example, Christian researchers and practitioners have examined "religious health assets." Yet, we must ask: How do their own backgrounds bias what is seen or overlooked when considering what are tangible health assets? Do we pay particular attention to faith-based health facilities across sub-Saharan Africa, for example, because these health systems are largely Christian and reflect a Western emphasis on clinical medicine? If we considered the religious health assets supporting the practices of zakat among Muslims worldwide, what organizational structures would we see and privilege? Similarly, white men from the US, Europe, and South Africa led much of this earlier research. How did their personal and collective experiences—experiences influenced by race, nationality, and gender—affect the ways in which they framed this research? Would women from East Asia, Central America, or East Africa have described those assets in the same way and would they assume that religion is always aligned with wellbeing, or would they remind us that it can also be used to provide a divinely ordained justification for sexual and gender-based violence?

Questions of power also have political implications, of course. For example, how do we account for the political dynamics involved in an appeal by HIV advocates (most often from Western societies) appealing to human rights in calling for African nations to abolish laws that target LGBTIQ+ people, people who inject drugs, or sex workers? Further, how do we understand resistance to such appeals from religious authorities within those nations who frame their objection in religious perspectives and in a refusal to continue the colonialist imposition of Western cultural norms to dictate the moral standards of their communities?[183]

These are some of the complex questions facing us as we seek to understand religion's varied influences on health and development in the 21st century. Efforts to understand those influences must attend to cultural, political, and religious power, not only in the nations where programs are implemented but also in those nations that fund them. 40 years ago, researchers, health and development practitioners and policy makers rarely considered religion in relation to health and development practice; a generation ago, the concept of "religious health assets" put religion back on the map. Today and for the foreseeable future, efforts to understand religion's influences on health and development must not only focus on those assets but also address to complex questions about the power dynamics involved.

183 Joseph Massad, "Re-Orienting Desire: The Gay International and the Arab World," *Public Culture* 14, no. 2 (2002): 361-385, https://doi.org/10.1215/08992363-14-2-361. See also: Lydia Boyd, "The Problem with Freedom: Homosexuality and Human Rights in Uganda," *Anthropological Quarterly* 83, no. 3 (2003): 697-724, doi:10.1353/anq.2013.0034.

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