

Chapter Five

Engaging Religious Health Assets - Conclusions/Recommendations



Bauleni Community Workshop Participants, Lusaka Zambia, 2006

Chapter Five: Engaging Religious Health Assets-Conclusions/Recommendations

We conclude our report, with a set of integrated findings and recommendations for engaging RHAs in the struggle for health and for universal access to HIV/AIDS treatment, care, and prevention. We offer these in three sections: 1) Confirmations, Contradictions, Challenges, 2) Leveraging and Alignment of RHAs, and 3) Respectful Dialogue - A Way Forward.

XVII. Confirmations, Contradictions, Challenges

In April, May, and July 2006, members of ARHAP's interdisciplinary Research Teams met in three plenary workshops to review the study data and to synthesize findings across the multiple dimensions of the study. The teams also sought a "first round" of input and review from several members of the larger ARHAP network of colleagues. Our conclusions and recommendations represent an initial look at the study results; we anticipate opportunities for further integration and synthesis of the findings and vetting/dissemination to wider audiences.

Given the 25-year trajectory of the HIV/AIDS pandemic, our findings rest on a considerable body of research and practice. However, we hope that our focus and approach have yielded new observations and perspectives that will ultimately be of value to those living and working in the struggle against HIV/AIDS. We synthesize our findings in this section, noting those that:

- **Confirm** previous studies, current knowledge and/or conventional wisdom,
- **Contradict** the same,
- **Challenge** us with new insights, challenges, opportunities, and issues for further research.

1. Religion is ubiquitous in Zambia and Lesotho, yet often hidden from Western view. Given this, an engagement with religiously informed healthworlds is vital for the shaping of public health policy in Africa

Study findings support our fundamental hypothesis that religion is ubiquitous in our study sites in Zambia and Lesotho, and we further postulate, in sub-Saharan Africa. In the declared Christian nation of Zambia, previous studies have found that 95% of Zambians identify themselves as affiliated with a major religion, 85% of them with Christian denominations. In Lesotho, Traditional Basotho and Christian traditions have been intertwined in a dynamic and complex interaction over the past 175 years. In our study ordinary Zambians perceived religious entities to be the most significant social institution contributing to community health and wellbeing, while in Lesotho the world of "bophelo" suffuses everyday life.

Yet despite this ubiquity, religion and religious expression in the African context are often hidden from Western view, and, therefore, health leaders, policies, and systems do not take religion fully into account in the global struggle for universal access for HIV/AIDS and other urgent health measures. One of our researchers has noted that "like housework in the economy...which is absolutely foundational to economic life yet almost never shows up in standard economic analyses or scholarly debate...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."⁷²

We are conscious that both Lesotho and Zambia are countries in which Christianity is dominant. We have sought to be attentive to African Traditional Religions and have worked with Traditional Health Practitioners as religious entities. Where it has been possible, we have worked with participants from the Muslim, Hindu and Baha'i faiths. However, we recognize that further research in non-Christian contexts is necessary. While we would anticipate variation in the forms and structures of religion, the wider literature and our experience on the ground would lead us to expect a similar ubiquity and social significance in other contexts.

The combined study approach, employing both Participatory Engagement and GIS mapping, has helped to "make the invisible visible" - the tangible and intangible assets, relationships, networks of trust, religious factors - to a broader range of audiences. We are not suggesting that public health practitioners must themselves be religious or that to engage with these assets they need to be "believers" in one of the multitude of religious expressions found in Africa. What we are suggesting is that if they are to take seriously the on-the-ground key factors that have a significant impact upon people's perceptions of health and wellbeing, then there needs to be a greater willingness to seriously engage with this religiously informed healthworld. It is clear that the concept of health promotion is one that is inherently linked to the notion of healthworld and without a greater appreciation of the assets held by religious entities in Africa, health promotion is likely to be a contested part of the HIV/AIDS continuum.

2. Religion, health, and well-being are locally and contextually driven

Our study confirms that religion, health, and well-being are contextually driven, and that local context is most significant. Ordinary Zambians and Basotho perceive their daily struggle for health and well-being and their response to HIV/AIDS in the overall context of a daily struggle for survival - marked by extreme poverty, weak public health capacity, and serious environmental challenges - and most significantly by factors in their local communities. Similarly, their religious belief systems and practices are locally contextually driven. There is a rich variety of religious expression, as evidenced by the diversity of participants and religious entities included here and by the underlying influence of African traditional beliefs and healing practices. For those seeking to engage, religion cannot be viewed as a single, simple cultural "variable" - no "one size fits all."

Our study demonstrates significant and important differences in context at all levels - country to country, region to region, community to community - spanning language, culture, environment, religious interplay, health indicators - all important to the accessibility, affordability, and acceptability of HIV/AIDS treatment, care, and prevention strategies. Our findings reinforce previous recommendations that health policies, interventions, and resource allocation be driven by local strategies and that local assets and agency be appreciated and strengthened. Furthermore, in the dialogue between religion and health this means that just as there is no such thing as "health" other than health for particular people in a particular context, so there is no such thing as "religion" other than a particular religious expression by particular people in a particular context.

Religious landscape and motivations are complex and must be appreciated and understood. Alignment with public policy requires one to deal with these assets in many different ways; effective engagement is not a

⁷² S. de Gruchy, "Like Housework in the Economy, the Hidden Ubiquity of Religion in African Well-Being", Presentation (Atlanta: Religion and Health Connection, Rollins School of Public Health, Emory University, February 21, 2006).

matter of “business as usual.” As one of our researchers put it: “You can’t talk to one bishop and think you’ve dealt with the whole religious community.” Another added, “If you are in Zambia, you must go through the pastor; if you are in Lesotho, you must go through the chief.” These contextual realities have significant implications for mass scaleup of HIV/AIDS and other health interventions and for replicability of research and programmatic approaches and strategies.

Our study sought to engage religious leaders and organizations across the religious spectrum in each country through purposive sampling and extensive engagement and networking at all levels. As we have noted, we were not successful in engaging *all* religious traditions in each instance, though we were able to bring together a range of leaders and ordinary citizens in each setting - some for the first time - who participated fully in the PIRHANA process and often joined together to form local task forces for continued work. We believe that the PIRHANA tool and our overall approach and methods are replicable in a variety of religious settings, with proper adaptation and, most importantly, facilitator training in the understanding and appreciation of religious tenets and “protocols.”

A challenge and opportunity for the future is adaptation to other African contexts, including Islamic environments, and to regions beyond Africa.

3. Religious involvement in health and HIV/AIDS is increasing, and religious entities have expressed a strong local commitment and desire to be more effective in the area of HIV/AIDS

In Zambia and Lesotho, ordinary citizens and religious and health leaders recognize a significant shift in the involvement of religious entities in health and HIV/AIDS, especially over the past 5 years. This finding both confirms and contradicts current perceptions and presents opportunities and challenges for effective engagement.

Our study documents a proliferation of religious entities working in the areas of health and HIV/AIDS over the past decade, with a rapid acceleration since the year 2000; involvement has been prompted by a combination of 1) external and 2) internal driving forces. These include: 1) the worsening pandemic; changing health policies surrounding ARV therapy; advances in HIV/AIDS rapid testing and other new technologies; and a significant increase in donor funding as well as 2) gripping needs at the local level; increased impact and demand on congregations and clergy, especially in the care of families, orphans, and vulnerable children; breaking of silence by many religious leaders around issues of stigma and discrimination; disclosure of HIV/AIDS status by clergy and other religious leaders and encouragement for living positively with HIV/AIDS; increasing linkage of religious leaders worldwide and new uses of mass communication and networking.

The variety, scope and scale of religious entities involved in health and HIV/AIDS is evident from our extensive GIS mapping database and our detailed new schema of organizational categories and types. The religious community spans multiple sectors and levels - from local congregations, traditional healers, and support groups in the remote Lesotho mountains of Thaba Tseka to national health-care providers in Zambia and a broad range of primary to post-tertiary educational systems, mass media, international development agencies, new faith-based NGOs, and various linking, intermediary, and connecting bodies.

We hypothesized that RHAs have a public impact on health, well beyond health services. Our study demonstrates a wide variety of health and HIV/AIDS-specific activities, blending the independent perspectives of Workshop participants and reports from GIS mapping and field interviews; 84% of religious

organizations with profile data were engaged in HIV/AIDS work, spanning the spectrum of 22 subcategories of Prevention, Care and Support, Treatment, and Linking activities. Of special note were the consistently high participant ratings of the perceived quality and accessibility of religious hospitals, schools, support groups, and linking organizations in these contexts. These ratings seem to reflect a complex understanding of objective quality as well as contextual qualities including dignity, respect, and linguistic and cultural competence.

Our research also identified an extremely strong desire to use these religious health assets in the area of HIV/AIDS., an example of our double meaning of asset appreciation - assets that are appreciated and those that increase in value. It is clear that there is great benefit in undertaking further research and study to appreciate and enhance the potential of these entities and their RHAs and to produce better alignment between religious and public health structures.

4. Religious entities are perceived as contributing to health, well-being, and the struggle against HIV/AIDS in both tangible and intangible ways, and it is this combination that distinguishes them and gives them strength

Our study provides new evidence that the contribution of religion to health and to HIV/AIDS indeed comprises both tangible and intangible factors and that it is the unique interplay that distinguishes the contribution of religious entities and gives them strength. Previous studies that have focused primarily on the tangible contributions of religion to health, such as religious health provision or material support, as well as those that have examined intangible factors such as prayer on *individual* health outcomes have not documented this complex interplay.

In both Zambia and Lesotho we found a set of three *intangible* ways in which religion is perceived to contribute to health and wellbeing. We have identified these as Spiritual Encouragement, Moral Formation and Knowledge Giving. Furthermore, in both Zambia and Lesotho we have found a set of three *tangible* ways in which religion is perceived to contribute to health and wellbeing. We have identified these as Compassionate Care, Material Support and Curative Interventions. In both Zambia and Lesotho “Spiritual Encouragement” is perceived by far to be the strongest contribution of religion to health and wellbeing. This term includes such factors as hope, faith, prayer, and trust and builds resilience and inner strength to deal with the health crisis in which people find themselves. “Compassionate Care” is perceived in both Zambia and Lesotho to be the second most important contribution of religion to health and wellbeing.

When focusing on Religious Entities (REs) we have found that it is their ability to integrate these tangible and intangible factors that gives them “strength”. It is perceived that to make a contribution to health and wellbeing, “spiritual encouragement” needs to find an expression in “Compassionate Care”, but likewise, such caring outside of a “spiritual” framework loses its strength. Thus, in Zambia, church-initiated home-based care groups are seen as the most important REs contributing to health and wellbeing, while in Lesotho it is community-based support groups - with a strong religious flavor - which are significant.

In Lesotho, characterized by the Bophelo healthworld, which understands religion, health and wellbeing in a relational context, we noted a further factor that religion contributes to health and wellbeing, namely, “respectful relationships”. This is both a tangible and intangible factor and a reminder that when the tangible and intangible are working together, religion is at its “strongest”. Furthermore, in Lesotho we noted that once we translate the terms “religion” and “health” into Sesotho, we move out of the categories implicit in English into a more fluid spectrum in which religion is seen to permeate all of life, to build the relationships that are

essential for wellbeing, and to provide a sense of integration and coherence. Thus, for example, we noted that a wide range of “secular” entities in the community are understood by Basotho to have a “religious” nature.

Such findings uncover deep differences in language, vocabulary, concepts and frameworks that sometimes hamper discourse and obscure common ground. The fundamental terms “prevention,” “treatment,” “care and support” as well as “spiritual encouragement, knowledge giving, and moral formation” have very different meanings in religious and public health settings, though they contain, within, many of the same ideas and messages. A key recommendation for the future is the creation of a “shared lexicon” of terms, tools, and methods from both religious and public health disciplines and formal training in “interreligious and public health literacy” for leaders, policy-makers, and practitioners.

One specific area for potential engagement is in the emerging, global dialogue on “Decent Care” now being catalyzed by WHO leadership as a mediating concept. “Decent Care” could engage the findings of this study around “Compassionate Care”, “Respectful Relationships” and the integration of tangible and intangible factors, and expand practical strategies beyond the individual and the family to communities living with HIV/AIDS. “Decent Care”, if expressed in caring behavior at all levels of social structure from family to nation, would be consistent with the complex understandings of religious health assets found in our study.

5. Certain REs are acknowledged as “Exemplars” in the community, and these demonstrate exceptional programmatic, operational, and associative characteristics

This finding may contradict conventional wisdom that REs lack the skills and capacities found in secular organizations and therefore are more “costly” (in time or material resources) to engage. In addition to the “intangible” religious assets they bring, many “Exemplar” REs also demonstrate a high level of expertise and competence in program management, human resources, financial management, and partnership development on a par with high-performing organizations in the public and private sectors. Their capacity to achieve both efficiencies and innovations that are valued by public health agencies may reflect their capacity to weave together specifically religious assets as well as more commonly recognized skills of resource management.

However, such expertise and competencies are not to be overstated, especially in these times of fragility brought about by HIV/AIDS. The context of the pressures on health systems, especially the exodus of health workers and financing pressures, means that the REs cannot be expected to continue to do the job that they do without substantive support that does not undermine their strengths but gives them strength to go on. Furthermore, this finding should not under any circumstances be read as implying that REs may substitute for state responsibilities and business engagement in the life of the society.

Finally, engagement with REs must not be with an eye to “convert” them to exemplary NGOs and diminish the very intangible dimension that distinguishes their contribution to health. A key opportunity for future research and engagement is deeper examination of the Exemplar REs identified here and of case studies such as the ARHAP Masangane Project, described in Appendix J. The opportunity is not to turn public structures into religious ones or to turn religious structures into public ones, but to gain the benefits of the alignment of their respective strengths for the community. Exemplar REs tend to model this alignment and thus may suggest skills and behaviors that are more generalizable.

6. An Assets-Based Approach to research and implementation of religion and health initiatives and HIV/AIDS scaleup offers the potential for more rapid, sustainable, and effective capacity-building and action

While this finding goes well beyond the design and scope of our study, we think it is important to acknowledge that, at its core, our assets-based approach is part of the growing field of appreciative, participatory, community-centered inquiry and development that seeks the building - and revival - of communities based *not* on what they lack - their “needs” - but on what they already have - their “assets, networks, and agency.” Such an approach may contradict conventional wisdom which often views religion and religious engagement as a “liability” for health and development, just as it tends to view communities as fraught with liabilities. Religion is not the only community asset that tends to be overlooked by external bodies, but it is a fundamental one. By appreciating religious assets, we may learn to appreciate the other assets held by local communities.

We are not naïve about the role of religion, especially in the struggle against HIV/AIDS and especially in Lesotho and Zambia, nor are we naïve about the danger of romanticizing local experience and knowledge. Rather, we have a keen appreciation for the social realities on the ground and hence recognize the imperative to balance the positive with a clear grasp of the limits and potential negative impact of religious traditions, practices, and influences on the lives of individuals, families, and communities and on global discourse and decision-making regarding HIV/AIDS. A further challenge and opportunity is to more accurately measure the value and impact of an assets-based strategy over time and to determine the societal and economic benefits that might accrue from strengthening and aligning RHAs with public health assets, especially in the most vulnerable communities. Our PIRHANA workshops have already spawned a number of local interfaith and interdisciplinary task forces formed as a result of this study to carry forward the local action plans generated by the participants. These offer a starting point for the next level of engagement.

Building on these findings, we now turn more specifically to the issues of Leveraging RHAs and effective strategies for such alignment with public health systems.

XVIII. Leveraging RHAs and Alignment with Public Health Systems

Describing and locating RHAs and their activities, networks and agency using the tools provided by the PIRHANA and GIS techniques in Zambia and Lesotho is important. This enables us to appreciate these assets and their contribution. We need also, however, to shift the focus to how these assets can appreciate and grow stronger. Thus, asking how these assets may be leveraged for greater alignment with public health systems and greater health outcomes relevant to scaling up a response to HIV and AIDS is the next, vital step. What will allow for such leverage, and what do we mean by leverage and alignment?

At the first level, assets for health held by religious entities remain at rest until they are acted upon, that is, until an agent does something with them. ARHAP’s work shows that such agency is widely present, often where other agents, including the state, are not. This is an important finding in itself. It suggests that religious entities have a strategic advantage in many contexts for health promotion and care, hence, some power to accomplish better health outcomes for the populace. This is one understanding of leverage, leverage that may best be exercised through the agency of boundary leaders, as described below.⁷³

The ARHAP work also shows, with some exceptions, that this first level of leverage by religious entities occurs in many contexts with weak, or no, alignment with public health systems. Moreover, the potential of

⁷³ See G. Gunderson, *Boundary Leaders: Leadership Skills for People of Faith*, (Minneapolis: Augsburg Fortress, 2004).

health assets held by religious entities could be realized to a significantly greater degree were there better ways of aligning public resources and programs with them. Most REs and their leaders were knowledgeable about public and secular health structures, but the public structures were often not conscious of the significance of these relationships. Leaders of REs often displayed the agency needed to gain access to some of the benefits of relationship with public systems, but the public systems often failed to appreciate the potential gains to be had from a systematic alignment of their respective strengths. Thus, both leaders - public and religious - fail to gain the leverage that could be found in systematic alignment. This alignment requires leadership agents with skills that allow them to appreciate and negotiate with systems beyond their traditional boundaries of control. We call this type of agency, boundary leadership. Like other aspects of RHAs, it is already present in the social systems at every level, but often unappreciated, even by those who may have the skills. A number of the “Exemplar” RHAs noted in this study exhibited this kind of leadership.

At a second level, leverage has to do with how one strategically enhances the contribution of RHAs in three directions: 1) helping religious entities realize their potential more effectively; 2) encouraging the replication of “promising practices” among religious entities; and, 3) promoting meaningful ties between such religious entities and public health services in strengthening health systems. The work of ARHAP shows, with adequate sensitivity to the nature of RHAs and religious entities in particular and to the way in which religious discourses function to motivate and mobilize people, that such leverage is possible. The Zambia Interfaith Networking Group on HIV/AIDS (ZINGO) represents one example of a body that is both an outcome of such leverage and a mechanism for further leverage. At the same time, not all conditions are equally favourable to the leveraging of health assets. This will depend, among other things, on at least two factors: 1) the type of regime that governs the nation-state within which the work is done; and 2) the extent to which mediating agents are part of the equation.

RHAs are more likely to bypass state institutions “where government capacity is weak, particularly in some of the poorest sub-Saharan African societies, where local government has almost disintegrated under structural adjustment.”⁷⁴ At the same time, they cannot replace the state, nor should they, in the sense of substituting for its responsibilities. Many NGOs often lack broader structures of accountability, and they tend to have short lives, both of which affect credibility and sustainability. In this respect, the more enduring character of RHAs, *if* they are rooted in enduring traditions to which local people are also committed and linked to translocal parent or partner organizations and institutions, is an important asset. Mediation is an empowering action to the extent that it helps create, manage and sustain important links to donors, partners and government agencies where these are necessary for the life and work of the local agent. In terms of social capital theory, mediation in this sense is the work of networking connected bodies and simultaneously bridging social holes between otherwise disconnected bodies⁷⁵ - of establishing, strengthening and extending ties that carry knowledge, resources and finance relevant to the local agent - for comparative advantage.

One finding from ARHAP’s work, both in the WHO study and its recently completed Masangane Case Study (Appendix J), is that mediation together with the role of mediating agents or boundary leaders, is crucial to sustainable activities for many religious entities working in health. Further, many religious entities “naturally” enter into mediating relationships through their denominational, confessional or international religious partners, who frequently offer support of all kinds and access to resources. Where strong mediating agents are present, the entity tends to be strong and able to expand its activities sustainably; where they are

⁷⁴ W. Campbell, *The Potential for Donor Mediation in NGO-State Relations: An Ethiopian Case Study*, (Brighton: Institute of Development Studies, 1996), 9.

⁷⁵ R.S. Burt, "Social Holes Versus Network Closure as Social Capital", in *Social Capital: Theory and Research*, edited by N. Lin, K. Cook and R.S. Burt, (New York: Aldine de Gruyter, 2001), 31-56.

absent, sustainability is much less likely. Mediation, therefore, is a crucial aspect of leverage, if one wants to scale up and sustain the work of religious entities in health.

In our research we identified a number of important network hubs that acted as mediating agencies. In Zambia participants pointed to organisations like CHAZ, ZINGO, and denominational structures such as the UCZ and Catholic Church as providing such mediation. In Lesotho, entities such as CHAL, World Vision and Scott Hospital played such a role. At the same time, we noted that in Lesotho there is little role played by non-religious entities in aligning the assets of REs apart from the formal CHAL-Ministry of Health connection. In Zambia, however, we noted how non-religious organisations play an important mediating role. In Zambia the District AIDS Task Forces included many REs and provided a clear example of how RHAs could be leveraged into alignment with public health systems.

The organization CHEP (The Copperbelt Health Education Project) is a good example of a secular mediating agency that is assisting FBOs and CBOs in exemplary fashion.⁷⁶ With respect to mediation, CHEP operates on the assumptions that CBOs do not have, and never will have, all the capacities necessary for sustainable health interventions, that it can play the role both of strengthening their own capacity on the ground through long-term accompaniment, that it can offer access to the funds and other partnering resources of national and international agents (such as donors), that it can act as brokers - in effect, in situ auditors and comptrollers - of funds, and that in this way it mediates sustainable engagements between local agents engaged in health work and translocal agencies interested in supporting such work. In our view, a replication of a model of mediation such as this is vital to scaling up the potential contribution of locally rooted and effective RHAs or religious entities in general in a sustainable manner. It is the institutionalization of the best of social capital bridging possibilities.

XIX. Respectful Dialogue - A Way Forward

Our broader work in ARHAP and the findings of this particular research project have reinforced our belief that religious leaders and public health practitioners have a responsibility to engage in respectful dialogue. The commitments of the best of religious imagination and of public health policy are to a world in which health and wellbeing are the experience of all, particularly those living on the margins of society, and today this means those infected and affected by HIV/AIDS. This dialogue is therefore essential, not for the sake of polite conversation, but for the sake of decency, universal access and the development of communities.

It is clear that there have been tensions around religion and public health, especially when it comes to HIV/AIDS and matters to do with sexuality, condoms and stigma. The findings of this research suggest that this tension is part of the past, and that the sheer human impact of the pandemic is drawing religious entities into new and significant contributions to health and wellbeing. Indeed, our confidence in respectful dialogue is strong given that in Zambia and Lesotho we have uncovered a large and diverse range of religious people and organizations who are doing significant work, and who are committed to partnering with health practitioners in the struggle for health and wellbeing.

What is clear, however, is that this dialogue needs to be undertaken in a way that is respectful of all partners, and this does mean dealing with the suspicions on both sides. Given the way in which religion and health are intertwined in Africa, public health practitioners need to ask: “How can we expect to understand and help people if we miss the very thing that *they* consider to be the most important thing in their lives even if it may not be so in our own?” At the same time, religious leaders need to ask: “How can we expect to make a real

⁷⁶ See <www.chep.org.zm>

difference in the health and wellbeing of our communities, if we do not draw on the wisdom and experience of those dedicated to and trained in these fields?” A mutual appreciation of the assets held by both the religious and public health sectors is necessary.

Appreciating Assets: Recommendations

In concluding this report, *Appreciating Assets*, we offer the following set of recommendations for all audiences interested in this work in a spirit of respectful dialogue:

1. Develop religious and public health literacy

Given the need for dialogue, it is crucial that as a first step religious leaders in Africa gain a basic level of public health “literacy”, and that public health practitioners gain a basic level of religious “literacy”. To this end we recommend that key agencies such as the World Health Organization:

- Invest in the development of formal courses and experiences to build religious/interreligious and public health literacy for the full range of leaders, policy makers, scholars, and practitioners working in the fields of religion, public health, and HIV/AIDS, and especially for those working at the intersection of all three.
- Develop and make available a “shared lexicon” and “knowledge base” of terms, tools, methods, and results drawn from interreligious and public health disciplines, beginning with the definitions and schemas presented in this report.
- Provide joint training and orientation for religious and public health workers already in the field and for those to be newly deployed.

2. Engender respectful engagement

Our findings make clear that “religion” is perceived by ordinary people to be extremely significant in the struggle for health and wellbeing in African communities. At the same time this “religion” only exists as specific religious commitments and practices in specific contexts. To take forward respectful dialogue means to engender respectful engagement. To do this we recommend that key actors in public health and religion:

- Build on local wisdom, context, and commitment and develop more formal ties to the individuals and organizations, such as those participating in this study and similar groups found in other nations and social contexts. The expansion of the PIRHANA tool to include local community engagement in community health issues from a religious perspective has great promise, given the positive impact experienced by those who participated in this field investigation.
- Develop a new approach to engage with religious and health leaders, academics, policy- and decision-makers, potentially based on an “Executive Sessions” model (see Hauser Center <http://www.ksghauser.harvard.edu/>) that allows for long-term engagement and collaborative policy development.

3. Align religious and health systems, beginning with tangible assets

Our research has found a great deal of public health activity being undertaken by Religious Entities that is not always effectively aligned with public health systems. To strengthen this alignment we recommend that key religion and public health actors:

- Use Health Mapping in strategic ways to recognize the assets on the ground and their potential connections.
- Strengthen local community “Support Groups” working in the field of health and wellbeing, and link them to public health structures, including neighboring hospitals, clinics, dispensaries, and laboratories.
- Support the replication of “Network Hubs” to leverage existing RHAs and develop and nurture additional ones.
- Further link to the Exemplar REs such as those identified in this study to understand “promising practices” and implications for adaptation to other settings.

4. Conduct further collaborative research

The interdisciplinary nature of this research project and the nature of the findings suggest that the alignment of religious health assets and public health systems in Africa requires ongoing research and reflection. In particular, this calls for further research to:

- Extend Participatory Religious Health Assets Mapping to other African countries and other regions of the world and in particular in settings where Christianity is not the dominant religious tradition.
- Explore the link between “Compassionate Care”, “Respectful Relationships” and “Decent Care” and their extension to the Community level
- Further study the Exemplar Religious Entities and Existing Case Studies to determine “Promising Practices” and Effective Strategies for Alignment
- Explore specific areas in which exemplar REs are vulnerable in the context of health systems that are fragile, and develop specific strategies to obviate the vulnerabilities so that the REs maximize their potential and are not undermined by demands and expectations that far exceed their capacity to act and to do.
- Engage in further study of what have been identified as “intangible” religious health assets and how public structures can relate to them in a respectful way.
- Explore further the “healthworlds” found in Africa and the impact that religio-cultural frameworks have upon the way in which people conceive of health and wellbeing and undertake health-seeking agency.

In drawing this research project and report to a close we emphasize yet again the importance of respectful dialogue. In conclusion, our aim has not been to force a single perspective or overly simplistic view on the deeply textured study results but rather to present the full complexity of issues and findings, with a desire to build greater understanding, communication, and engagement.

The research theory guiding this project emphasizes the importance of appreciating local wisdom, practice, and perceptions. We believe that the depth of the findings and the goodwill generated by this process more than justifies this approach. Furthermore, the methods have drawn from participatory research that seeks always to integrate research with action. The proof of the effectiveness of the research process and findings will be in transformed practice. In Lesotho and Zambia and throughout southern Africa, the methods have drawn from participatory research that seeks always to integrate research with action, and the impact of this project and report needs to be found at the level of transformed practice. In our context in which the HIV/AIDS pandemic is a major human tragedy. It is incumbent upon religious and public health leaders to undertake respectful dialogue and mutual engagement to make a difference.