EMORY | ROLLINS SCHOOL OF PUBLIC HEALTH | Interfaith Health Program
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Title Where to Draw the Line: Crossing the Boundaries of Religion and Public Health

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Background This paper, offered at the session of the Religions, Medicine, and Healing Group during the AAR, raises ethical questions about interdisciplinary work between religion and public health. Dr. Blevins argues that religious health assets may not always be assets for the health of everyone in the community and that the interests and motivations of public health practitioners may compromise the values of religious communities. While he agrees that the important contributions of religious communities to public health must be supported, Dr. Blevins lays out some of the potential challenges to collaboration between religion and public health in this presentation.

In keeping with the theme of this session, *Drawing Boundaries: The Ethics of Negotiating Spiritual and Medical Frameworks*, my paper is an attempt to raise some critical methodological and ethical questions regarding the social and political aspects of power that come into play in the context of religious and public health practice in global contexts. The paper will examine the question not of where or how to draw boundaries, but of where or how to draw the line between boundaries. By that, I am referring to the idea that the critical methodological and ethical issues facing the field of religion and public health are not found by tracing the boundaries of these disciplines; such tracing is, I would argue, largely a question of interdisciplinarity and while this issue is important the tools to engage in interdisciplinary research are being developed and refined. Rather, the critical issues can be identified in attempts to account for which parts of these respective fields—which sources of authority, what kinds of practices, which organizations—should be engaged in our scholarship and applied practice. Accounting for these specific sites within religion and within public health is important methodologically because different sites will have different effects; further, analyzing these effects is important ethically because not all of them will be beneficial for individuals, communities, or societies.

The paper examines these ideas in four sections: the first section traces the recent interest in religion in public health and development practice and argues that much of the recent research

in this area has inadequately accounted for religion's function in the societal context analyzed; the second section turns to an analytics of power developed by the French cultural theorists Michel Foucault and Michel de Certeau to offer a framework to better account for the function both of religion and of public health practice (specifically using Certeau's concept of strategies and tactics); the third section uses this analysis of power to interpret the issues involved in HIV service delivery among faith-based organizations in the east Africa region and in the country of South Africa; finally, the fourth section offers four key methodological and ethical questions for determining where to draw the line between the boundaries of public health practice and religion.

Section I: Religion (re)discovered: on the newfound interest in religion in public health research and practice

I work at the Interfaith Health Program in the Rollins School of Public Health at Emory University. Our program seeks to examine the role of religion as a social force in relation to public health practice. We look at the ways in which religion influences health behaviors and the ways in which religious organizations impact health services and health policies. In 2003, our program worked with colleagues in South Africa to create an international network of religious and public health scholars and practitioners. That network—the African Religious Health Assets Programme (ARHAP)—created a method of mapping religious health assets by adapting principles of community development employed both in the U.S. and other parts of the world (for example, asset based community development out of Northwestern University or participatory rural appraisal out of the Institute for Development Studies). In 2006, ARHAP and IHP received a grant from the World Health Organization to map religious health assets in Zambia and Lesotho.[1] I am not in any way claiming that these projects singlehandedly ushered in a new appreciation for religion among development or public health researchers (in fact, this work is merely one example; it is simply the one with which I am most familiar), but I do believe that they are an example of a newfound appreciation of religion's influence on public health programs, practices, and policies.

As a result of these kinds of projects, religion's relationship to public health practice shifted. No longer was religion seen as merely as one variable among many that the epidemiologist would gather as part of her demographic survey or as a largely private set of beliefs that might influence individual health behaviors but have little societal impact. Religion had arrived among the qualitative social scientists in public health and development practice. It was seen as powerful social force with myriad influences on health and social or economic development from the micro level of the individual to the macro level of the global politics. But while religion had become a subject of study it was understood by most of those involved in that research as a positive force—an asset.

However, naming religion only as an asset obscures its complex effects and leaves us ill-equipped to analyze and describe its function because it predisposes us to overlook the ways in which it functions to thwart public health (and here I mean health itself and not public health programs, which should indeed be thwarted at times). I believe that the newfound appreciation of religion in public health research is a welcome development but that it will fade if we do not develop sufficient methodological rigor to account for the ways that religion obstructs public health as well as the ways it contributes to public health. This question of methodological rigor

[1] For a report on the ARHAP/IHP religious health asset mapping funded through the WHO, see http://www.arhap.uct.ac.za/pub_WHO2006.php

is also an ethical question if one accepts the idea that good health is a good thing; the ethical dimensions of religion's impact on public health arise as soon as one recognizes that human institutions and systems (religion being only one) can either contribute to health or to illness.

Section II: Employing strategies and tactics in the context of productive power

Having raised a methodological and ethical critique, in this section I want to identify some theoretical perspectives that provide ways to address these critiques. In doing so, I turn to the work of Michel Foucault and Michel de Certeau. Specifically, I am employing Foucault's analysis of social power and Certeau's related concept of strategies and tactics that are responses to the social power Foucault describes.

Although Foucault was clearly engaged in a critique of cultural power throughout his career, his conceptualization of power did not begin to crystallize until the publication of *Discipline and Punish* in 1975 and was further developed in the first three volumes of *The History of Sexuality* between 1980 and 1983. Foucault was turning his attention to this question of power in relation to sexuality and Christianity at the time of his death in 1984 and a number of shorter essays and public lectures in the early 1980s reveal additional dimensions to his analysis of power.

Foucault's unique contribution to our present-day understanding of power consisted in completely overturning the conceptual framework by which it was understood. For Foucault, repressive power existed and it should be resisted through individual and collective efforts. We should, in short, speak out against the tyrant. However, the more interesting (and interesting because it was pernicious) effect of power lay not in what it disallowed or repressed but in what it made possible or produced. For Foucault, this dimension of power was much more dangerous because it was pervasive, seductive, and diffuse. In its pervasiveness, productive power touches us all; it puts into place and flows through the mechanisms we use to understand the world around us. Through its seductions, productive power incites us to agree to its benefits if we will only allow ourselves to be shaped through the cultural systems through which it flows. Finally, productive power resides not as a concentrated force at the feet of the sovereign ruler who exercises it with unilateral control; rather, productive power is diffuse, penetrating various sectors of society, exerting its influence across governmental, corporate, cultural, religious, and academic institutions.

As he developed his conceptual analysis of power, Foucault argued that the danger of productive lay in its variability. Not all productive power was bad; it catalyzed large scale social institutional forces in the service of producing certain effects. Rather, those effects were variable: they ranged from restrictive norms related our sexual lives to economic processes that enabled the growth of neo-liberal society to clinical and social interventions to encourage better health. Indeed, not all of those effects were bad—but they were dangerous, as Foucault himself acknowledged in a famous quote: "My point is not that everything is bad, but that everything is dangerous, which is not exactly the same as bad. If everything is dangerous, then we always have something to do. So my position leads not to apathy but to a hyper– and pessimistic activism."[2]

The ethical question for Foucault consisted in understanding where productive power ensnared you and determining what you should do about it. To do so, Foucault argued that we must acknowledge the ways in which productive power bestows benefits to us as individuals and to acknowledge that we enjoy those benefits only because someone else has paid some cost in

[2] *Essential Works of Foucault 1954-1984*, ed. Paul Rabinow, Volume I: Ethics: Subjectivity and Truth, *On the Genealogy of Ethics* (New York: New Press, 1997), 256.

the equations of power within the social sphere. Our response was to use our limited agency to affect the kind of self we would be—to assess the specific forces of power that shape us and to determine how to resist or manipulate or re-channel those forces in services of different kinds of selves. Foucault called this practice a "care of the self," an ethic of aesthetics marked by our efforts to fashion our selves with some intention in relation to the myriad social forces impacting us.

Foucault died before he was able to fully develop these ideas[3]; others, however, have done so.[4] One prominent example of such efforts to carry Foucault's ideas forward can be found in the work of his contemporary, Michel de Certeau. In his book, *The Practice of Everyday Life*[5], Certeau describes the daily activities of people in cities and the ways in which their lives intersect with social forces and social power. Directly drawing on Foucault's concept of power, Certeau develops a notion of strategies and tactics. Strategies consist of an exercise of power emanating from the various recognized institutions of society; strategies, then, are examples of productive power put to use to further existing power structures. Certeau is mindful of Foucault's point that the benefits of productive power's strategies are given to those who already possess some level of power only because others without access to power pay a price. He explores this claim to narrate the lives of those who pay such a price—those who are marginalized or who fail to meet the norm—in *The Practice of Everyday Life.* The kinds of power employed by those with little or no access to strategic power is tactical.

Tactical power is transient, improvisatory. It does not reside in institutions and it does not set down roots. Tactics to circumvent or subvert strategic power are employed "on the run," in response to the well-organized and institutionally supported strategies of social power. As such, they do not last long; they do not take up a home in an institution. If tactical power is subsumed under an institution, most commonly this turns the tactic into a strategy; the power exercised by those on the margins is recalculated in support of those in power. Tying Foucault's notion of ethics as a process of self-creation by employing alternative expressions of power to Certeau's concepts of tactics, the tactical becomes an ethical practice to the extent that it resists mechanisms of strategic power and appropriates that power for a different purpose. This idea becomes a foundation from which we can now begin to think about where we draw the line in relation to religion and public health.

Section III: Strategies, tactics, and the ethics of power in religion and public health

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[3] This notion of ethics comprised much of Foucault's scholarly work in the last years of his life. Volumes II and III of his multi-volume *The History of Sexuality* dealt with these questions and the largely-completed but unpublished fourth volume examined them specifically in relation to Christianity. See Michel Foucault, *The History of Sexuality, Volume II: The Use of Pleasure* (New York: Vintage, 1990) for Foucault's survey of Greek ethical perspectives and practices on sexuality. See Michel Foucault, *The History of Sexuality, Volume III: Care of the Self* (New York: Vintage, 1988) for Foucault's perspective on Roman culture.

[4] In addition to Michel de Certeau, whose work is summarized in this paper, see Judith Butler, *Giving an Account of Oneself* (New York: Fordham University Press, 2005).

[5] Michel de Certeau, *The Practice of Everyday Life* (University of California Press: Berkeley, 1988 edition).

Religion and public health are both cultural sites through which productive power flows. As such, both fields are populated with strategic mechanisms of power. At the same time, however, the two fields are also sites through which resistance to productive power can be marshaled. As such, both fields are also sites from which tactical responses to strategic power can be formed. If the tactical is key for understanding ethical practices of resistance to the normalizing mechanisms of productive power, then assessing the strategic or tactical nature of specific practices in each field is important. As it stands now, however, we have not developed any means for such an assessment. Public health practice is blindsided by what it names as unintended effects of its myriad interventions into societies and populations because it has developed few ways to critically account for its own cultural location—its norms, priorities, values, and biases. Having finally gotten colleagues in public health to pay attention to them, theologians, religious studies scholars, and religious leaders have proudly named religion as a community health asset but fail to adequately account for the ways it compromises health for some.

The limitations of either field to adequately account for the play of strategic power in ways that trample tactical power can be seen in numerous examples; I will demonstrate these limitations in the context of two consultations with religious leaders in the east Africa region and the country of South Africa to better understand the contributions of the faith-based sector to sustainable HIV services. The consultations were carried out with funds allocated from the U.S. government's President's Emergency Plan for AIDS Relief (PEPFAR).

In May of 2012, the Interfaith Health Program worked with PEPFAR staff from Washington, DC and Nairobi to convene a consultation of 96 religious leaders from Kenya, Tanzania, Rwanda, and Uganda to discuss the role of faith-based organizations in sustainable HIV programs at the country level.[6] In September and December of 2012, our program conducted small key informant interviews with religious leaders in South Africa to gather their perspectives on the same topics.

Both of these activities took place because of large scale programmatic and policy changes within PEPFAR. PEPFAR faced Congressional reauthorization in 2013; by 2012 it had become clear that the program would not grow any further and that it would, in fact, begin to scale back in light of economic sluggishness in the United States and political fighting in Congress about the federal budget. PEPFAR directors had already instructed the various PEPFAR Country Offices to begin to move toward a model of local country leadership in which all primary grantees for PEPFAR-funded services would be indigenous organizations within each specific country and the coordinating entities responsible for developing national strategic plans (e.g., the Ministry of Health, donor governments, and various civil society representatives) would take the lead in developing long-range plans for transition to in-country financing of HIV programs.

For the countries represented in the east Africa consultation, the faith-based sector was a key provider of medical services (delivering approximately 40% of the medical care in the region). The situation in South Africa was different because South Africa's government had nationalized many of the older faith-based health facilities established earlier in the twentieth century when the religious traditions that had founded and run those facilities joined in the opposition movement against Apartheid in the 1970s and 1980s. By the early 2000s, South

[6] A copy of the consultation report can be found at http://www.interfaithhealth.emory.edu/documents/fboreport2012.pdf

Africa was in dire straits as HIV prevalence ballooned and the Mbeki Administration placed tight restrictions on governmental funding of HIV services because of Mbeki's belief that AIDS was a clinical manifestation of something other than HIV. Even though faith-based clinical networks were not well established in the country, the faith-based sector mobilized to create new networks and received funding to provide services under PEPFAR beginning as early as 2003.

PEPFAR officials decided to begin the transition process to country leadership in South Africa. This had begun by the time the first interviews were conducted in the fall of 2012 and it was not going well. The national Department of Health lacked the infrastructure to deliver comprehensive HIV prevention, treatment, and support services because it had been prohibited from carrying out such programs under Mbeki and President Zuma's Administration had only been in power since 2009. In addition, coalitions of religious leaders were openly critical of the Zuma Administration for corruption and for favoring the wealthy at the expense of poor South Africans. By the time of the second round of interviews in December, those leaders were running full page ads in the country's major newspapers excoriating the President and his administration for their policies as the African National Congress (ANC), the ruling political party in South Africa, was holding its national assembly.

The transition process in the east Africa region will roll out over the next 2-3 years and in-country organizations are already preparing for the changes. In both contexts, the meetings with religious leaders were designed to try mobilize the capacities of the faith-based sector in support of this transition to local country leadership in providing ongoing services to people with HIV/AIDS.

The two consultations are examples of the complex interplay between strategic and tactical power. They were explicitly suffused with political power—both of the respective national governments of the five countries represented and of the United States government in its role as the funder of PEPFAR programs. Each of those governments had their own interests, which were also situated with internal political negotiations inside of the respective countries. The religious leaders represented were the formal heads of various faith-based organizations; they were individuals who had derived authority through alignment with the strategic power of their respective religious traditions. The public health leaders represented were the programmatic and administrative leaders of spectrum of governmental and nongovernmental initiatives; they were individuals who had derived authority through adherence to established administrative protocols, evidence-based practices, and accepted public health research and policy. The academic researchers represented were named experts in their particular fields of study, having derived authority on the basis of meeting certain benchmarks in a variety of academic disciplines. The consultation participants, then, benefited from strong connections to strategic forms of power within their respective fields.

To varying degrees, participants also sought to work in partnership with those exercising tactical power. One staff member of a Muslim program working with injection drug users sought consultation in private on how to provide good care to the male couples who came to the organization. A Roman Catholic nun spoke about the importance of religious leaders holding government accountable in the interest of solidarity with the poor. Program participants developed two formal recommendations that echoed these commitments: 1) "FBOs that actively use religion to promote stigma and shame [in relation to HIV] should be held accountable by FBOs endeavoring to offer strong HIV prevention, treatment, and support service; and 2) Marginalized, stigmatized, and most-at-risk populations [men who have sex with men, commercial sex workers, and injection drug users] should be included in program design,

implementation, and program monitoring."[7] But how do we hold strategic power accountable when it seeks to silence tactical power? How do religious leaders hold their governments accountable, staff members in local community-based organizations hold their supervisors accountable, and religious organizations hold other religious organizations accountable?

The consultations demonstrated the important contributions of FBOs but they also demonstrated the challenges in attempts to draw the line in determining the misuse of strategic power. A clinical care program offers comprehensive treatment services in Nairobi but it is affiliated with a religious community that stigmatizes men who have sex with men. Is it an asset to be strengthened or "an FBO that actively uses religion to promote stigma and shame?" A government department supports innovative and effective services to commercial sex workers in the Western Cape but resists building new facilities in Limpopo because the predominant ethnic group in the province has been critical of the President. Is it employing innovative models to reach hard-to-reach populations or is it using policy as a means to punish a population? The reality, of course, is that they are both. There are countless examples of organizations and individuals marked by a bewildering mixture of the strategic and tactical.

Section IV: Four questions that (may) help us draw the line to understand the ethical implications of religion and public health practice

The challenge in front of us in the field of religion and public health consists of determining where we draw the line in our research and in our practice in light of the "bothness" of our work. We must assess the functional effects of our strategic institutions—religious, academic, clinical, and community institutions—and ask how they relate to the tactical. Doing so is hard. I propose four questions as a starting point for such an assessment. These questions are tentative—this is by no means a fully-formed framework—but they offer a starting point.

I. What is the balance of the strategic and the tactical in our own context? In the context of our programmatic partners?

None of us is located in a purely tactical space in our social relationships. Even the most marginalized social groups are comprised of individuals who have access to varying degrees of strategic power. Similarly, no social institutions exist to further merely strategic or merely tactical ends; rather these operations flow through the institutions to varying degrees depending on the specific actions and intentions of the individuals within those institutions. It is important for us to assess our own mix of the strategic and the tactical but quite often we fail to do so. We assume solidarity with those who are marginalized or poor, for example, but fail to acknowledge the ways in which we are implicated in strategies in our own lives. Failure to do this keeps us from acknowledging the ways in which we benefit from the strategic and this lets us off the hook of grappling with Foucault's ethical call. Assessing the mixture of the strategic and the tactical does not stop with our own context. What is that mixture with our programmatic partners? How do our partners relate to strategic power? Are they attempting to consolidate more power or are they aware of the dangers of such power? How do they relate to tactical power? Do they encourage it and strive to support it or do they fear it and seek to quash it?

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[7] U.S President's Emergency Plan for AIDS Relief, *A Firm Foundation: The PEPFAR Consultation on the Role of Faith-based Organizations in Sustaining Community and Country Leadership in the Response to HIV/AIDS* (Washington, DC: U.S. Department of State, 2012, pp. 44-45).

II. What have the effects of our strategic engagement with the tactical been in the past? What do we intend those effects to be?

How have we related to tactics from the strategic place of productive power in the past? Have we encouraged them? Ignored them? Have we committed ourselves to working in partnership with those who work tactically? What has been the result in the past? Have we helped further their tactical ends or have we built partnerships with them in order to domesticate their tactical power in service of the strategic? In our current efforts, what are we seeking to accomplish? Are those objectives in the realm of the strategic or the tactical? I assume that there are two kinds of ways that the tactical and the strategic are employed. In the first the tactical remains invisible to the strategic; the two never actually relate. In the second, the strategic takes note of the tactical. I can only envision four possible outcomes:

1. The strategic can quash the tactical.
2. The strategic can be aware of but ignore the tactical.
3. The strategic can domesticate the tactical, de-toothing it of its power without the strategic actually changing in any way.
4. The strategic can build alliances with the tactical, transforming the tactical into the strategic in ways that the strategic itself shifts.

Any time the strategic and the tactical relate to one another in any sustained manner, the tactical does not remain as the tactical. For those of us with access to strategic power, the question we must assess is which of these four outcomes our efforts are encouraging. The third and fourth questions help us in that assessment.

III. How can we employ our strategic power ethically?

What kinds of institutions are we committed to? What are the strategic dimensions of those institutions? How do those institutions relate to the tactical? If those institutions' priorities are in tension with our own commitments in relation to the tactical, how do we address this in our practices? If we bring strategic power into our encounter with the tactical, what are our obligations in that encounter? If we continue to relate to the tactical it will not continue in the same way; it will take on some dimensions of our strategic power? Are we clear with those employing tactics that this is the outcome?

IV. Are we willing to be changed by an encounter with the tactical?

Are we willing to let go of strategic power as we relate to the tactical? Are we willing to let go of our own perceptions, our own priorities, in order to live in line with Foucault's description of ethics? How far are we willing to go? How much power are we willing to lose?

The study of religion and public health has emerged in recent years as a new interdisciplinary field. The question of the boundaries between the two is an important methodological question of interdisciplinarity. However, I believe that other questions regarding the ethical implications of ways power traverses this field are far more pressing. This paper represents a first attempt at a framework to draw a line that traces these negotiations of power in relation to religion and public health. This framework is tentative and unfinished. As such, I welcome comments, suggestions, and critiques to hone subsequent attempts in the future. Nonetheless, I believe that such a framework is important to those who spend time in the intersections of religion and health. We have spent a long time developing methods to encourage

the interdisciplinary study of this intersection; now we need some methods to identify the ethical implications of practices that are taking place within it.