Finding common ground for the common good:
An appeal for innovative collaboration between faith- and non-faith-based organizations

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Abstract

Both faith-based organizations (FBOs) and non-faith-based organizations (NFBOs) make significant contributions to healthcare in low- and middle-income countries, particularly for patients with fewer economic resources. The perception that FBO and NFBO are dissimilar may contribute to there being insufficient interactions between them. But in fact, faith and humanitarianism are intimately and historically connected. As a byproduct, FBO and NFBO share both accomplishments and criticisms, including echoes of imperialism and lack of neutrality. A mutual interest approach could cultivate partnerships between FBO and NFBO, allowing them to pursue the common good of a healthier world without risking assimilation, isolation, or inauthenticity.

Key Words: faith-based organizations, humanitarianism, collaboration, global health

Introduction

Collaborative efforts between faith-based and non-faith-based global health organizations are hindered by an incomplete understanding of their historical origins and current goals. Greater awareness of their similarities in approach could facilitate collaborative partnerships and better health outcomes for people around the world.

Access to healthcare for individuals in low- and middle-income countries (LMIC) is limited. For example, 94% of the population in LMIC lacks access to surgical care, compared with 15% of people in high-income countries.[1] Historically, much of global healthcare was established by faith-based organizations (FBOs).[2] Healthcare delivery in LMIC became a focus for non-governmental organizations, particularly following World War II

in the mid and late 20th century.[3] The rise of formalized academic global health followed shortly after in the 21st century.[4,5]

In 2002, James Wolfensohn, then-president of the World Bank, famously said that "half the work in education and health in sub-Saharan Africa is done by the church… but they don't talk to each other, and they don't talk to us."[6] This statement highlights a perception that persists some twenty years later; although the global health landscape has come to include stakeholders from varied backgrounds, the dearth of interactions between them has not been commensurate with the volume of actors. FBO include any entity whose values are grounded in their faith/belief system and might be understood as distinct from non-faith-based organizations

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(NFBOs) that include non-governmental organizations and academic organizations, in that their values are secular and explicitly not faith-based. Studies of relationships between FBO and NFBO that deliver healthcare services in LMIC suggest that between interest and collaboration, there have been extended periods of estrangement. This is due in part to a perceived contradiction between the core values of FBO and NFBO, as well as a concern that religion, and even spirituality, ought to be relegated to the private sphere, rather than occupying discussions of medical reality.[7,8]

In this analysis, we discuss the important roles that FBO and NFBO play in serving the world's sick and economically disadvantaged, the historical context contributing to the current landscape, and similarities and differences in their approach to global health solutions. By understanding this framework, FBO and NFBO may build more collaborative partnerships and, in so doing, improve the health of people around the world.

The Role of FBO and NFBO in Modern Global Healthcare

At least half of the world's population does not have access to essential health services[9], and in LMIC, out of pocket payments comprise 30–50% of healthcare financing (compared with 14% in HIC).[10] There is a paucity of data exploring how FBO, humanitarian groups, and academic organizations contribute to the remainder of healthcare costs not covered by the government.[8] Where there is data, findings demonstrate wide variability — for example, studies have found that FBO are responsible for anywhere from 2–50% of healthcare delivery in sub-Saharan Africa.[11–13]

One study reviewing family planning and child health services to economically disadvantaged people in Kenya found that 30% of patients received healthcare provided by the state, 23% by the market, 22% by FBO, and 25% by NFBO, meaning that nearly half of the patients had received care from a FBO or NFBO. Though the differences were not statistically significant, they found that NGOs served more of the country's poorest people than the private sector, but fewer of the poorest people than FBO, suggesting that FBO and NFBO are particularly important for the most economically disadvantaged.[14,15]

To some degree, there is regional variation based on the confines within which FBO and NFBO are permitted to participate in healthcare as dictated by local and federal governments. Nonetheless, one can surmise that FBO and NFBO contribute substantially to the healthcare of people in LMIC, and especially to those with fewer resources, making coordinated efforts all the more important.

A History of Medical Missions and Humanitarianism

FBO have participated in healthcare for centuries. Hospitals as structures were created to care for sick strangers (*xenodochia*), pioneered by the early Christian church in the 4th and 5th centuries CE.[16] Early Christians were known for their intentional care of the sick in contrast to the social and political structures that neglected those in need.[17] "Medical missions" in its current form developed between the sixteenth and eighteenth centuries.[18] The use of the Latinized term "missions" dates back to the 16th century and refers to the institutionalized expansion of the faith by Jesuit Christians in the context of the conversion of distant non-Christian territories.[2] Medical care was part of this work; missions historian, David Hardiman, wrote that "from an early stage, missionaries who traveled to Asia and Africa sought to heal those they intended to convert."[18] In the 17th and 18th centuries, medical care became a more significant component of missions as the Enlightenment popularized individual autonomy and human equality, making voluntarism popular among missionaries.[18]

The medical care that missionary physicians provided was not without controversy. Although FBO did not necessarily uphold the systems that maintained colonial power, the link between faith-

based medical missions and imperialism cultivated a sense of mistrust, much of which continues to be expressed about FBO today.[13,18] The exodus of missionaries and their families to overseas destinations, many of which were by then formalized Western colonies, blurred the distinction between imperial migration and voluntary mission. In light of the skepticism engendered by medical missions, humanitarian medical initiatives were developed over the subsequent decades with the explicit purpose of providing care disassociated from evangelism, most notably with the formation of the quintessential medical humanitarian organization, the Red Cross in 1863.

Many religions teach compassion and care for the sick (*zakat* in Islam[19], *tikkun olam* in Judaism[20], and *Vasudhaiva kutumbakam* in Hinduism[21]), and non-Christian religiously affiliated humanitarian organizations have also historically contributed to medical care. For example, formalized Muslim humanitarian medical care was marked by organizations like the Aga Khan foundation (1967) and the Islamic Association of North America (1967).

That said, owing to its long history, some historians view that "it is Christianity and Christian faith-based organizations that has had the most significant influence on contemporary humanitarian action"[22], rendering missions and secular humanitarianism intimately tied and Christian organizations specifically the greatest recipients of skepticism and mistrust. Historian Michael Barnett attributes this intimate connection to the fact that humanitarianism began in the 1800s as Christian reform movements created a language around humanity and human rights, as well as a belief in the "possibility of using social institutions to bring progress to society and perfect the individual."[22] Even today, numerous Western humanitarian organizations have religious origins, and religious images like that of the Good Samaritan.[22] One on hand, Christianity was an integral component of humanitarianism's genesis; on the other, the movement in part developed over and against

explicitly Christian theology and organizational practice.

FBO and NFBO: Proselytization and Political Agendas

One academic group assessing modern FBO summarized the critiques around them as follows: "in liberal democracies, non-faith-based stakeholders are wary of missions organizations due to the lack of accountability, remnants of historical colonialist associations and agendas, proselytizing of vulnerable clients, and discriminatory practices."[23] Another article exploring ethical issues around the activities of FBO expressed concern regarding the proselytizing work of FBO and the challenges proselytization creates for governments and vulnerable populations.[24]

Humanitarianism is defined as that which is "motivated by an altruistic desire to provide life-saving relief; to honor the principles of humanity, neutrality, impartiality, and independence; and to do more good than harm"[22], and these principles were established as core to humanitarianism by the UN General Assembly in 1991.[3] These ideals notwithstanding, humanitarianism has endured critiques similar to those raised about FBO, including concerns about echoes of imperialism and lack of neutrality.

Theorists criticize humanitarianism for participating in the governing of the poor with "rationales [that] bear a striking resemblance to those given to justify European colonialism in the nineteenth century." Revisionist critiques point out that humanitarian organizations are often political actors, lacking neutrality. These criticisms call into question the assumption that the principles of humanity, neutrality, impartiality, and independence always govern humanitarian action in practice.[25]

To proselytize is to "convert or attempt to convert from one religion, belief, or opinion to another."[26] Proselytization is the feature of FBO that most garners skepticism. But faith-based or otherwise, most organizations are attempting to

convince people of a set of opinions. As an example, Médecins Sans Frontières (MSF) is a well-known NFBO that has improved the health of people in conflict and crisis around the world; the organization is self-described as an "international, independent medical humanitarian organization…guided by medical ethics and the principles of impartiality, independence, and neutrality…[whose members] observe neutrality and impartiality in the name of universal medical ethics and the right to humanitarian assistance…[maintaining] complete independence from all political, economic or religious powers."[27] Despite a neutral vision statement, MSF and other similar NFBO have an underlying set of principles which are not value neutral. For example, the idea that "neutrality is not synonymous with silence," means that MSF is selectively vocal about causes they deem worthy. They also permit "extreme cases of mass violations of human rights" to prompt a violation of the principle of neutrality. One such form this has taken includes the issue of immigration, to which the response has been largely grounded in principles of liberal democracy.[28,29] The authors are not implying this is a wrong position to take, only that it is not value neutral. MSF also adheres to "universal" medical ethics, but because ethics are highly culturally contextual, no medical ethic is truly universal, and the one to which they refer is a specifically Western bioethic.[30–32] Although MSF and other NFBO do not attempt to convert those they serve to a particular religion, when they perform good works, they do bring a Western bioethical framework and liberal democratic agenda they believe will assist populations in distress and alleviate suffering. This agenda is often effective at achieving its ends, but it is important to recognize that it is not neutral. The assertion that NFBO are completely impartial is false. For FBO and NFBO to work together, both must honestly consider their own agendas, respond to criticisms, and be willing to concede that there is value in different approaches.

Mutual Interest: Pursuing the Common Good

FBO and NFBO have both succeeded and failed in their attempts to live up to their religious and humanitarian ideals, respectively. Whenever any organization provides good works, they bring their own agenda, and the attempt to operate under the premise of neutrality will not bring organizations in separate spheres into collaborative relationships. True plurality requires each party to come to the table authentically and honestly.

In recent years, there has been a shift within large, multinational NFBO to acknowledge the importance of FBO in providing healthcare services. FBO have advantages in certain communities, having been present for decades to centuries and having access to funding and a volunteer workforce.[7,8] There have been successful examples of the so-called "common ground" framework of bringing FBO and NFBO into collaborative relationship, where common ground can be understood as "shared values, shared goals, and shared language."[33] The African Religious Health Assets Programme (ARHAP)is an international collaborative of theologians, physicians, sociologists, and anthropologists seeking to improve public health and inform health policy in Africa, with an understanding of the important role of religion in health. In her discussion of this organization, Jill Olivier suggests the three factors required for successful interdisciplinary work are compatible personalities, common interests, and common vocabulary.[33] Olivier acknowledges that although developing relationships requires time and commitment from both parties, even with differing ideologies, common ground can be achieved by identifying the commonalities underlying those perspectives, such as "social justice."

The pursuit of universal healthcare by the WHO in conjunction with FBO was another success in which both parties were willing to come to a shared vision, much like the common ground approach Olivier describes. The development of this

shared vision and language required that FBO be willing to operate within a context that "may be criticized as a neoliberal instrumentalization of religion" and see themselves as mediators between religious communities and secular institutions rather than as polarizing forces with political theologies that hinder or reverse cooperation.[8] When the United Nations (UN) developed the Sustainable Development Goals in the early 2000s, there was "little attempt to engage faith actors as a distinct stakeholder group;" FBO who were included had close connections to the UN such that they "were already at the table" and participated primarily as civil society actors whose "religious identity did not make an obvious difference."[34]

When organizations with diverging agendas attempt to arrive at a forced shared vision, ideas like social justice or human rights become "decoupled from the practices and habits that sustain it," reducing them to "hollow constructs, a blank sheet upon which to project a variety of perceptions."[35] Each organization bears ideas too valuable – faith, freedom, fairness, compassion — to be compromised simply for the sake of a pretense of shared vision. Thus, even if a common ground approach has been successful in the above cases, the integration of FBO and NFBO on a grander scale will likely require deeper insight into their historical underpinnings and present ideologies, not to fundamentally change the principles for which they stand or to arrive at a pretense of common ground, but to permit organizational and ideological authenticity such that they can collaboratively pursue the common good.

Salvation Army International Health Service Coordinator, Dean Pallant, asserts a "mutual interest" framework where people from diverse backgrounds are able to pursue the common good in ways that do not pose the risks of assimilation, isolation, or inauthenticity.[36] One such example is a partnership that developed between MSF and Samaritan's Purse, a well-known FBO, during the Ebola epidemic in West Africa in 2014. The two organizations used their respective skill sets and expertise to pursue the common good in a way that held true to their values. This is an excellent example of mutual interest, although interestingly, the author refers to their partnership as "unlikely," suggesting that these types of collaborations are an exception rather than the rule.[37] Similarly, the relationship the UN is now developing with FBO in pursuit of the Sustainable Development Goals (SDGs) provides another practical illustration of a mutual interest framework like the one Pallant describes. The UN's proposed policies incorporate faith actors as both development partners and explicitly religious voices, inviting faith actors to provide insight on perceived tensions between SDGs and religious values. This approach includes faith actors on their terms, rather than instrumentalizing them for a priori goals, and encourages members of NFBO and governments to expand their religious literacy and understand the role of faith in the context they occupy.[34]

The mutual interest approach to the common good will require grit and "a significant degree of humility and dwelling in places of tension."[36] The tension that currently exists between FBO and NFBO is one of separation and has posed a challenge to the formation of productive partnerships. By contrast, the tension Pallant alludes to encourages relational authenticity, inviting all parties to come as they are with their offerings to a world in great need of health, healing, and wholeness.

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