The fields of religion and global health are not often thought of in the same context. Yet with the increasing globalization of our world, interactions with people of different cultures and religious backgrounds are on the rise making our cultural competency, which includes religious traditions, of even greater importance. Dr. Susan Holman, Senior Writer at the Global Health Education and Learning Incubator at Harvard University, has just written a new book entitled: Beholden: Religion, Global Health, and Human Rights, that highlights the benefits of a more robust engagement with religious traditions within the field of global health. In her book, Dr. Holman explores the potential ways in which a better understanding of religious traditions could be useful in combating some of the more pressing global health issues of our times. By learning the language of various religious traditions, those involved in global health would be better able to engage with people on their own terms, fostering a sense of solidarity and utilizing the resources that often already exist within these populations.

In the following interview, Dr. Holman shares her journey of becoming a historian of religion after her experience as a nutritionist and her growing involvement in the field of global health.

As will be shown in her responses, Dr. Holman highlights the vital role that religion can play as we address some of the more pressing global health topics of today. Religion then can help in our engagement with today’s global health issues. By utilizing an interdisciplinary approach which includes religious studies’ experts, we can help combat some of the more challenging health issues of our time and more importantly do it in such a way that acknowledges our unique cultural differences while at the same time highlighting every person’s right to health.

Your background was originally in nutrition. What prompted you to explore religion, particularly the history of religion?

I was always fascinated by connections between culture and religion, but my parents had nudged me toward a more marketable career. For years I wanted to be a veterinarian, but I’m bad at math and faint at the sight of blood – clearly a problem – so eventually I chose to study nutrition. After a dietetic internship and graduate studies at Tufts’ Friedman School of Nutrition Science & Policy, I began to work in maternal-child nutrition with low-income families in Boston and Roxbury. Gradually I came to see how my patients’ food choices were shaped far more by their cultures and beliefs than by any of my professional advice about nutrition science! Somewhat disheartened, I thought my voice might have more meaningful effect if I followed my original interests in the historical studies that were consuming all my free time. So I applied to Harvard Divinity School and stayed connected to the health field part-time as a medical writer and editor. While at HDS, I stumbled across some fourth-century sermons on famine, hunger, and disease that were relatively unknown. These texts eventually became the focus of my doctoral dissertation at Brown. Thanks to the work of Princeton historian Peter Brown and others, there was a trend in religious scholarship to connect poverty in antiquity with modern health issues. So I was blessed with a global community of collegial conversation partners on exactly the issues I was interested in. Since finishing the PhD, I’ve balanced my time between....
these two parallel worlds, with “day jobs” in the health sciences while focusing the rest of my life on scholarship; historical writing, research, and invited academic opportunities to speak, edit, or advise on the history of medicine, maternal-child health, and religious responses to poverty. There’s no obvious job “niche” for connecting these two fields so it’s not been an easy balance; but it’s certainly very fulfilling and worth the effort.

**How did you become interested and involved in public health?**

The problems of global poverty and health disparities matter a lot to me, and my favorite internship rotations at Tufts were community-based public health and writing on what we now call “global health.” I’m a listener and an introvert who enjoys content editing and also happens to have gifts as a writer, so the question was always “Where do I fit?” From 2007 through 2010, I had the privilege of working as a research writer and journal editor at the FXB Center for Health and Human Rights at Harvard School of Public Health. That was profoundly rewarding, in part because I was on a fantastic team with colleagues who shared a commitment to health equity — and sometimes even talked about religion.

**What was your inspiration for writing *Beholden: Religion, Global Health, and Human Rights***?

As a concept, religion does not come up often in public health and human rights — and when it does, it is usually not discussed positively. I knew this tension well from my own journey. Yet in Judaism, Christianity, and Islam, there’s an underlying moral affirmation that everyone ought to have essential food, water, clothing, shelter, and security — much that we think of as economic, social, and cultural (ESC) rights. At HSPH (Harvard School of Public Health) I had been thinking about this massive divide, between ESC rights as they’re discussed in public health and the way that my friends in faith groups — often sensitively and responsibly — were trying to approach poverty and justice from a religious perspective. And I thought to myself, “There needs to be something to help those in both fields actually talk to each other — perhaps a basic primer on human rights that my faith-based friends would actually find relevant.” And then I thought, “Well, I could write that…” I approached my editor with a proposal for a book, and to my amazement about two months later I had a contract. As the project developed, it expanded beyond human rights to include several other themes that also shape these connections in the field: tensions of gift and “charity,” health and solidarity assets, civic duty in health policy, and the nuances of global health in religious pilgrimage.

**What are some of the boundaries that you have encountered when proposing the utility of certain religious themes such as philanthropy, moral obligation, etc, into the realm of public health particularly in the pursuit of health and equity? Where do you think the hesitancy lies when experiencing the pushback from suggestions such as these?**

Those of us in the academy in public health may have a kneejerk reaction when we hear ‘faith’ or ‘religion,’ thinking, “Oh God, another fanatic preaching Western colonialism and conversion, swooping in and out to try and ‘fix’ things without the humility to stop, listen, and learn.” It’s a very common image of religion, as something that stands in the way of effective health, economic, and justice systems. Yet at the same time, I find that most people who care about public health — whether they are religious or not — share a deep sense of moral obligation, and
value philanthropy when it’s done in a way that promotes human rights, dignity, and respect for human agency. Many of us have experienced what calls itself charity and religion as dehumanizing, abusive, and patronizing. Religions do not have a monopoly on the human capacity for goodness and kindness. I personally try to avoid even using the words ‘charity’ or ‘philanthropy’ because they are so cloaked in these stereotypes. Yes, both are positive religious values in Christianity, Judaism, and Islam, but so are social justice, human rights, dignity, honesty, some measure of material divestment, and respect for the other. It’s easy to forget that the anthropological concept of the gift is not about handouts; it’s about exchange; it’s about living in a human intersection. It’s about being vulnerable. The chapter in Beholden on human rights focuses explicitly on the need for faith-based communities to use more human rights and justice discourse in the way they talk about health, in part as a way to try and change these stereotyped boundaries.

**Is the incorporation of religion and or spirituality into the public health discourse possible in a pluralistic society such as the United States let alone the world at large?**

Such discourse takes place all the time— even at Harvard! For example, at a “Global Health Summit” hosted in late 2013 by Brigham and Women’s Hospital, Harvard Medical School, and Harvard School of Public Health, the webcast panel on “Mobilizing for Global Health: Stories from the Field” included a lively conversation between HSPH Dean Julio Frenk, a surgeon Dr. Robert Riviello, two philanthropists (J. Christopher Flowers and Daniel Ponton), and Dr. Dyann Wirth, an infectious disease specialist who leads the Harvard Malaria Initiative. In the midst of this intensely scientific forum, three of the panelists (including Dean Frenk) made related remarks about the positive role religion has played in their own dedication to health care and health equity. Religion was not the focus, but it was part of the conversation. As another example, I was part of the cross-university project, “Mapping the Kumbh Mela,” cosponsored in 2012-2013 by the South Asia Institute and the Harvard Global Health Institute. That project deliberately brought together faculty and students from the health sciences, the study of religion, architectural design, and business to consider how a Hindu bathing festival might contain lessons for our individual disciplines as well as the connections between them. In addition, the U.S. health care system has been working together with faith-based organizations in a number of ways for years; Professor Fr. Bryan Hehir at the Harvard Kennedy School of Government has explored many of these connections in detail. Yes, there are tensions, and often well-founded distrust about motives and hidden agendas, especially related to gender, sexuality, and reproductive health. But conversation is definitely possible — and happening.

**In countries where the ideas of health and/or religion are so closely intertwined and in some cases inseparable, how is it possible to engage them in the global health discourse, particularly when most “westernized” countries have a clear separation between the two?**

Researchers in the African Religious Health Assets Programme (ARHAP), which I describe in Beholden chapter 5, encountered exactly the issue you mention during their survey in Lesotho. They were trying to map resources that local villagers connected with faith and at first tried to distinguish them from other resources that people connected with health. But nobody understood their question, since the only relevant local word, *bophelo*, encompasses both. So rather than force a Western idea or give up their research, the team decided to learn from this local perspective. They drew on the Sesotho concept to craft a new approach, one they call “healthworld,” a coherent theory of the complex reality of health behavior and practice. Our more general concept of social determinants of health, particularly cultural determinants, the role of stress, mental health, belongingness, etc., is another way I find it helpful to envision the
overlapping connections between these ideas. A key part of global health discourse is listening to the “other,” whether it’s the person across the table or someone from a culture that sees the world quite differently than you do. Often folk healers are not at all opposed to incorporating aspects of Western medicine into their broad view of how spirit and body connect. In theology or clinical field studies, ideological distinctions may really matter to both of you, but much of the time in health activities that engage Western medicine and public health across cultures the question is not “can you agree?” but “how might you work together?”

**Why is an interdisciplinary approach to global health so important?**

Health is more than cellular and clinical medicine. Global health is about the health of everyone, in all populations, everywhere. Health risks cross borders, and addressing those risks requires creativity at all levels: in global governance; health policy; innovative technology; diplomacy and reconciliation where conflict has destabilized agriculture, business, economics, and destroyed infrastructures. This has been a huge emphasis of the faculty I’ve worked with since 2011, at the Harvard Global Health Institute and now at the Global Health Education and Learning Incubator. We know music and the arts have an effect on healing. We need history to understand and learn from disease responses, health policies, successes, and disasters in the past. We need improved education since we know – in part thanks to the work of Professor Robert LeVine and colleagues at the Harvard School of Education – that girls’ literacy even in very poor settings can have a positive effect on the health of the next generation. Education impacts employment which impacts income which impacts resource access which impacts health options. And it’s not enough to draw discrete lessons from across disciplines; a health approach needs to also be interdisciplinary since opportunities and successes depend on the cooperation and synergies between people, multiple skills, and social factors.

**Why is religion in particular such an important component in this type of approach?**

Whether we like religions or not, they are – and will remain – part of the fabric of social welfare activities, humanitarian aid, and other responses to need and poverty. Many healthcare services around the world are rooted in faith-based organizations, and health-related services that address poverty and disparities commonly depend on persons who live out a commitment to a service ethic, often based in a religious perspective. Medical “missions,” schools, and food-based aid often depend on funding that comes out of a religious sense of obligatory giving such as, for example, the Christian “tithe,” the Sanskrit concept of dāna (cultivating generosity), or “zakat” (almsgiving), one of the five pillars of Islam. Religion can also profoundly influence social determinants of health (including education as well as stigma and discrimination); attitudes toward gender and suffering; health policies; ethics and law; and how we understand wellness and contagion. Religion is rarely a neutral force, and we all know how sometimes its effect can be toxic. But it can also include opportunities to advance global health.

**What do you see are some of the benefits of including religion?**

Because religious influences can hurt as well as heal, destroy and control as well as liberate, it’s difficult to do empirical studies that measure reproducible benefits. And religion is not like a magical cooking ingredient that you titrate, add, and stir. Religious viewpoints and practices are rooted in personal perspectives and community relationships that are often complex and even invisible. That said, I think there are a couple of things we can say about why it’s good to recognize religion as part of the social framework in a context of Western medicine and public health:
First, naming something that is already there (see question 8) validates discussion about it. Such discourse is a vital step in understanding differences. Such naming includes self-reflection. I talk in *Beholden* (and especially in an earlier book, *God Knows There’s Need*) about the importance and value of taking time to be transparently honest with ourselves about our own issues of need. How we want to respond to others is shaped by our personal stories, opinions, our neediness as well as our implicit biases. If we belong to a faith community, perhaps seeing it as healing in our own lives, we will want to listen and practice an integrated mindfulness to ensure that our views don’t harm others. I am convinced that the academy – schools of public health, medicine, religion, and community or government service, as well as informal student groups within such settings – is precisely where such discourse can most fruitfully be nurtured in ways that avoid sectarianism and help to train the next generation of global health leaders.

Second, narratives of community health/religion partnerships can help us avoid repeating disasters from the past, and encourage us before (and when) we teeter on the brink of burnout. The World Bank, for example, recently sponsored a panel of religious leaders who talked about *“The power of faith to help end extreme poverty.”* The entire November 2014 issue of *Forced Migration Review* looked at faith-based responses to global displacement, including tensions and health factors. The ARHAP researchers continue to foster both academic and community partnerships in several countries. Some hospitals in the U.S. (*Memphis is one example*) draw on local religious leaders and their faith communities to help fill the tragic American health care social service gap between hospital discharge and people’s ability to live at home independently. These and other examples offer not just news and research: they offer real-life stories of what does and does not work. As a theme within such narratives, religion can have a positive place in storytelling to empower global health.