practical matters

The Language that Difference Makes: Translating Religion and Health

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What we have then [in language] is a universal competence denied by its local performances, a universal capacity denied by its fragmented, disseminated, dispersed actualization.

—Paul Ricoeur[1]

ABSTRACT

The attempt to think about "religion and health" together as if they were wholly disjunct concepts falters in many contexts, both because the practices of health seekers often pragmatically assimilate them and because many languages do not, in the first place, treat them as disconnected ideas. That brings into question modernist constructs, particularly in secularist or positivist frames, of the separation of religion and health, and it raises the question of translation—not as a linguistic enterprise, but as a shift between disparate epistemologies. Drawing on studies based on field research in Lesotho, this is the focus of this article, considered via Paul Ricoeur's theory of translation, specifically the double difficulty he discerns of incommensurableness in meaning and of "welcoming" the language of the other. At stake is not simply understanding but the practical

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efficacy—or failure—of particular health interventions to the extent that they seriously take into account the impact of religious worldviews on how health is understood and behavior modeled. Here the concept of the "healthworld" helps to deepen our ability to design appropriate, acceptable, and sustainable health interventions.

Introduction

The ancient myth of the Tower of Babel, for Paul Ricoeur, describes a dilemma at the heart of all human speaking: that our attempts to communicate with each other across linguistic divides often creates confusion or "*bālal*," the Hebrew root word from which the name Babel derives.[2] The reality that the myth reflects is one of diverse, often incommensurable languages. The problem with which it confronts us is that of communicability: we all speak—speech being a criterion of humanity—but we do not really understand the other who speaks differently.[3]

In what follows, we will deal with the problem of communicability, initially by considering a particular task of translation across diverse languages that was occasioned by research carried out in Lesotho, then by extending our view on translation beyond the sphere of language to constructs of the lifeworld, whence arises the aporia at its heart: one must always translate between worlds, but one always does so by violating the lifeworld of the other. This aporia always accompanies any attempt at understanding the encounter with the other, especially the alien other, the stranger, as became clear in the research in Lesotho, which aimed at discerning how religion might play a role in contributing to the strengthening of health systems and to the general well-being of the populace.

But it also lies behind my own attempt here to reflect on that research "from the outside," so to speak, as one reflecting at a meta-theoretical level on the problems encountered in the research. Conducted along participatory lines, the research tools were designed to probe the relationship, in the understanding and experience of ordinary people, between religion and health. They have also been applied in other African countries and in the USA, with similar issues of translation arising despite the wholly different linguistic and social contexts. What I seek to unpack here, therefore, is not the specific problem of translating a language in one context (though Lesotho, for good reasons, provides the case study in this instance), but the general challenge of translation between differing linguistic worlds in any context and the implications for understanding how health interventions might succeed or fail as a result.

Though the specific "disease-focus" of the research in Lesotho was HIV and AIDS, the tools themselves were designed to probe the nature, scope, and scale of religious entities engaged in health promotion, treatment, and care, as part of a general concern to establish whether or not such religious activities—including but going beyond the work of formal health facilities (hospitals, clinics, dispensaries) run, owned, or initiated by religious institutions—could be aligned with national and international public health agencies to improve the health of all. In this respect, the issues raised here are not specific to any particular disease or targeted invention but are of signifi-

cance for health systems and health policy generally.

At stake is the challenge of speaking simultaneously about religion and health when it is not clear that those terms can be taken for granted at all. This is my focus here, arising initially from the research done in Lesotho. The research team, of which I was a part (as advisor and analyst but only marginally in the field), sought to uncover how indigenous Basotho (plural for Sotho persons) understood the relationship between religion and health. However one frames the context, any health system or intervention—any action that involves human beings at a point of their well-being—takes place in situations that are more often than not fraught with issues of translation, not just between particular tongues but between worldviews or epistemic judgments.

Translating the research instruments from English into Sesotho was the first step. Above all, it needed to be understood that our interest lay in the interface between religion and community or population scale health. We needed to find congruent terms to ask about religion and health in native Sesotho—translation in the restricted sense. Precisely here the problem of communicability, the conundrum of Babel, emerged with full force. We were immediately faced not simply with a matter of translation from one language into another but with the incommensurability of the conceptual foundations that lay behind the terms themselves.

The real problem of translation in other words (pardon the pun) is not that of the most adequate equivalents in one language to what is said in another, but of the shifts in perception, or of worldview, occasioned by the attempt to understand at all. Any real understanding across linguistic paradigms is inevitably accompanied by a destabilizing of the familiar, which takes place as a result of moving from the conceptual framework that one knows into another that one does not initially know—perhaps can never know in the same way. This is a problem nicely articulated by Michel Foucault in his introduction to *The Order of Things* where, focusing on a passage from Borges about how "animal" is defined in a certain Chinese encyclopedia, he recounts the impossibility of making sense of its terms for someone schooled in European cultures and languages.[4] A different order of things is at work. The unfamiliar is what must be comprehended, not primarily in lexical terms but in respect of ways of seeing the world.

The unfamiliar is thus what confronted us in our research in Lesotho (this is true even for the native Sesotho-speaking researcher who, schooled in English, had not thought about the "religion/health" conjunction before, had not comprehended its instability in relation to his own home language). Three sentinel sites were chosen: the capital city of Maseru, the outlying town of Morija, and the mountainous rural district of Thaba Tseka. We had made certain assumptions: that virtually everyone spoke Sesotho (a fair assumption); that traditional religious views would remain present, especially in more rural areas, despite a century of Christianization; that religion and health were terms reflecting discrete aspects of life; but that there was some understanding of the link between religion and health to enable us to research their commensurate relationship.

But quickly our ground had to be shifted. In attempting to ask, as we did, about the interaction between religion and health in the life of a Mosotho person (singular form), we promptly became

conscious, no matter the location, of paradigmatic constructs of knowledge at work in our own thinking that dominate the ideas of religion and health in the social and health sciences. We had run into trouble. Despite the fact that both the main field researchers (one white, one black) were raised in Lesotho and fluent in Sesotho (one of them deeply rooted in Sotho traditions), our assumed constructs of "religion" and "health," honed in the modern academy, which separates the terms and treats them as distinct realities, turned out to be less than helpful. We took that separation for granted, but there was no way of articulating any such distinction in Sesotho. As we were specifically concerned to understand the lifeworld and worldviews of Basotho people, recourse to English was ruled out a priori. We had to confront the aporia.

One could argue that we should have known better, but we did not. And this was clearly less a reflection of any lack of training or reading (on the contrary) and more a consequence of insufficiently reflected epistemic constructs. In the academy, health and religion are discrete fields with differing core conceptual tools and methodologies, so much so that in many contexts they are actually invisible to each other, notwithstanding the available insights from anthropologists and others that would destabilize such assumptions.

This issue forced us to rethink our entire research process, as we shall see. The narrower focus of our research was on the interaction between health providers and health seekers. From the side of health providers, health interventions are generally understood to be in the best interests of the health seeker. Here there is little interest in "translation" except to understand for diagnostic purposes what a person is saying or to explain a treatment protocol. Most health interventions are thus aimed, by "experts," at the other, who is expected to receive them in the form and for the purposes intended. This is not simply a pragmatic issue, as many health practitioners appear to believe when they assume that all that is needed is properly to train a health seeker to follow instructions, or when they complain that the failure to follow a protocol is a simple lack of education or ignorance of science. Sometimes this may indeed be the case, but (probably far more than is realized) what is at stake is in fact an ideational issue.

In short, how the intervention is *perceived* by the other is as crucial to its outcome as any *intention* on the part of the provider. Translation here confronts reception. As we shall see, reception invokes another kind of act of translation, one internal to the linguistic community of the recipient. The relationship between translation and reception across differing linguistic (epistemological) paradigms thus frames a series of reflections that rest on the extended field work that has been conducted to determine how best to leverage, to build upon, the work of religious entities in health in the face of collapsing or collapsed public health systems in Africa. The paper ends with a brief discussion about how changing one's language shifts one's view of reality, with implications for practice, using the concept of a healthworld.

The Language that Difference Makes: On Translation

Our analysis commences with the act of translating our concern about religion and health in Lesotho. The specific locations of our three research sites made little difference to the fundamental aporia we encountered as soon as the question of the relation between religion and health was posed in Sesotho rather than in English. As noted earlier, we wanted to discover if and how religion or religious entities are contributing to the health and well-being of the populace and in what way they are aligned with the formal public health system, if at all. This was part of work commissioned by the World Health Organization and done by the African Religious Health Assets Programme (ARHAP),[5] an international research collaborative established in 2003 on the interface between religion and public health.

ARHAP's premise is that religion, whether institutionally or communally grounded,[6] plays a significant role in how people respond to health interventions, and its assumption is that, more often than not, formal health systems tasked with providing health services are largely ignorant of how to deal with this dimension. The ignorance stems not from a lack of awareness among officials and professional health workers about religion or about its significance for many of their clients or patients. It stems, rather, from an entrenched framing of their specialized fields of activity in terms of a thoroughly secularized clinical and biomedical paradigm.

Enough has been written to question the over-determined rationality of this paradigm, from at least three starting points: the Cartesian split between the subject and object (privileging the objective, as in the emphasis on biology, germ theory, and medical technology over and above the human and relational dimensions of health, but also in all too often separating the two in practice, something old-style general practitioners serving particular families and communities would have found strange); a bondage to a nominalist ontology that suggests a direct correspondence between the scientific terms one uses and the reality one observes (which tends to shut out alternative explanations of and responses to a particular health event); and, an increasingly powerful materialist and instrumental approach to the world (driven by the powerful lure of natural science and the intrusion of the market into all corners of its activity).

To be sure, the methods, capacities and products associated with the biomedical paradigm are undoubtedly powerful and vitally necessary at one level—we do want antibiotics or flu vaccinations able to save lives, for example—and they govern much of what is taken to be best practice in public health. Still, after some hundred years of public health practice, it is clear that this paradigm cannot deliver more than a partial result as public health practitioners collectively—despite huge scientific advances and more available resources than at any time in human history—see the grand hopes of the early twentieth century failing.[7]

Simply put, diseases and illnesses correlate not only with the fine points of anatomy, biochemistry, neurology, and the like, but also with other factors that cannot be controlled in a laboratory or measured by metrics. These mostly have to do with the way humans construct their sense of self and society, with how they organize themselves politically and economically, with what they take to be knowledge adequate to their complex realities, and with that sense of transcendence that may

variously be described in terms such as imaginative possibility, spirit, religion, or faith.[8]

Professionals and practitioners concerned with health are naturally not unaware of these matters, and they try to address them as far as possible within the limits of the paradigm they still accept as fundamental (a science of health). The early emphasis on primary health care (PHC) by the World Health Organization (WHO), its growing current interest in the social determinants of disease[9] and a revitalization of PHC,[10] the increasing number of medical practitioners willing to consider or advise their patients on complementary or alternative forms of healing practice—all are indicators of both the limits of the dominant scientific paradigm in health and the search for a more holistic paradigm. This is encouraging.

Within this context, powerfully provoked by the myriad complexities of the HIV pandemic and its link to human sexual and relational norms, values, and behavior, public health bodies have increasingly wondered about the role in health of religion and its practitioners. They see there, at worst, a phenomenon that needs to be critically confronted (e.g. with respect to stigmatization) and, at best, a possible resource that might be leveraged to strengthen health systems. The negative dimensions of religion are notorious among those committed to the rationality of science, including health workers. They dominate public health mentalities globally. But a growing interest in the positive dimensions of religion has become evident in the last five to ten years, or at least in religiously based institutions that might shore up the growing gaps in state provision, as public health agencies and governments have reached out wherever they can for help in dealing with the HIV pandemic in particular.

Nevertheless, understandings of what this means for health interventions remain largely superficial and unexplored. This is the territory of the African Religious Health Assets Programme. Its starting point, as the name suggests, is to probe for what might be seen as an "asset for health." Following an asset based community development approach,[11] ARHAP developed a set of tools to explore the interface between religion and health for the WHO, with its pilot work being done in Lesotho.[12] The core tools adopted not only an asset-based approach but also the methods of appreciative inquiry,[13] participatory rural appraisal,[14] and participatory geographic information systems field mapping.[15]

Knowledge of these tools is not necessary for our purposes here. What is important lies in the congruent research ideology that undergirds these approaches and methods, namely, a systematic commitment to uncovering, as far as possible, the wisdom and knowledge held by local people in their own terms according to their own frameworks of reference. As anthropologists know all too well, such aims are not easy to realize and they are easily subverted, for example, by "arts of resistance"[16] exercised, in what Long and Long have called "battle fields of knowledge,"[17] by research subjects to protect themselves and their lifeworlds from possible or actual threat and invasion. But they are also subverted by translation.

The two leaders of the ARHAP research team in Lesotho, both fluent Sesotho speakers, set out with their team members to probe the interface between religion and health as understood by the

Basotho. And that is when the first and most fundamental problem arose. Already uncertain of the task, they began to interview some key informants—religious and otherwise—on equivalent terms that would enable them to translate these two ideas, religion and health, into Sesotho. It proved impossible. The reason for this incommensurability or, better, incommunicability was straightforward. The only word in Sesotho that makes sense in this context is *bophelo*, but with a twist. It would have to be understood to include both health and religion, inseparably.

The scientific inclination to disaggregate terms for greater analytical precision clearly has its advantages, yet what it gains on the swings it loses on the roundabouts. Disaggregation must, at some point, return to integration if the complexity of reality is not to be missed. If one wants to remove a malignant tumor, then tight, narrowly defined precision is vital. But if one wants to see a person's overall sustainable health improve, then dynamic complexity has to be embraced. This is what the idea of *bophelo* conveys (we will come back to this). There is no Cartesian split between religion and health in the understanding of the Basotho—the terms are in effect interchangeable or, better, indivisible—and the language itself carries this sensibility. That this is so was a major challenge to our research enterprise, which sought to understand the relationship between what we initially presumed to be two epistemic realities that turned out to be one. Our epistemic frame was the problem, rather than the limits of the language of the Basotho.

Perhaps this is not so surprising when one considers that the concept of religion, like many words taken for granted in the social sciences that derive from Western thought, is also a relatively recent construction and a specifically Latin one (commonly understood to be from *religere*, "to bind (together)"), part of a process of colonization via language that Derrida felt needed to be named as "globalatinization (*mondialatinisation*)."[18] Its utility was for a long time so narrowly defined that European settlers in Africa could initially readily declare that Africans have no religion because nothing they took to define religion could be discerned. Later, when it proved necessary for building some social cohesion, after conquest had extended sufficiently to secure the existence of settler communities, Africans were discerned to have religion after all, but a primitive form that needed guidance, education, and, above all, supervision and control.[19] The same considerations probably hold for how conceptions of health have changed over time according to the dominant epistemé.A little reflection on the problem described above of translating religion and health into Sesotho, as separate categories one wants to correlate, brings us to another dimension of the problem. It is in fact a predicament. Let us begin with Sesotho rather than English. Let us assume back translation, a standard technique for controlling questionnaires, interview materials, and the like. We would have to do violence to the concept of *bophelo* were we subsequently to split it into the two notions of religion and health. Our basic research framework comes into question thereby. Why did we split these two terms in the first place? At one level, the answer is obvious: we did so because they are standard, if fuzzy, social scientific ideas, given expression in separate institutional identities under the conditions of the modern nation-state.[20]

But at another level, the attempt to translate *bophelo* faces us with the uncomfortable realiza-

tion that our paradigmatic constructions of knowledge that we usually take for granted as fixed, stable, and ordered might be anything but. We are here in territory analogous to Foucault's wonderful description of the conundrum posed to its reader of the meaning of the entry on "animals" in a Chinese encyclopedia, in which several senses of the idea make no sense to a Westerner, leaving Foucault to conclude that a different and, in part, incommensurable order of things is at work here.[21] In the case of the Basotho understanding of *bophelo*, the dualism represented by the phrase "religion and health" is unthinkable, in the strict sense of "being unable to think that."

What if we were to take the same view in relation to interventions intended to enhance peoples' health where, rather than biomedicine, statistics, or the instrumental needs of social systemic imperatives (the bureaucratic constraints and methodologies of a health ministry, for example), *bophelo* is the basis for what people actually do with these interventions?

The Power of Intervention: On Reception

The focus now shifts, of course, to reception. Let us begin our discussion of reception by considering again the meaning of *bophelo*. I depend here upon the work of the two team leaders in Lesotho already mentioned, both of whom are fluent in Sesotho (noting that they too, like me in my dependence upon them, are engaged in an act of translation they know to be disruptive but, equally, necessary—the ambiguity is irrevocable, with the alternative being only a refusal to understand the other at all).[22]

To understand the sense in which the term *bophelo* unites what we would otherwise try to distinguish in the opposition between religion and health, it is necessary to unpack the range of meanings it encompasses. Let us do this by thinking about the health of a person, specifically from a Basotho (plural for Sotho persons) perspective. Here the person is an individual, with a definable, identifiable, and socially categorized body. Body, mind, and spirit, however, once again do not sit under the Cartesian split but are inseparable. As far as health is concerned, therefore, to treat one aspect of the person without treating the other is generally regarded as rather impotent, an unconvincing strategy.

To be sure, Basotho understand that specific medications will treat particular complaints, and there is a deep and long tradition of medicine among the Basotho. But that does not mean the complaint has no other roots that might also require treatment, roots that are not susceptible to medicinal intervention because other factors—relational factors or different views of causality, for example—are at work. Multiple factors thereby become part of diagnosis and treatment, so that any particular person might, and is likely to, respond to a condition in a complex rather than a straightforward way, pragmatically adjusting their response according to an astute (rather than "ignorant") capacity to make distinctions about their condition, its etiology, and its resolution. In this respect, health seekers typically, rather than abnormally, live in and work with parallel or variously interrelated health systems, including Western biomedical, faith healing, traditional or

indigenous, and so on.[23] A similar pattern was found in the Eastern Cape of South Africa in work done by ARHAP to study the character and distinguishing marks of a faith based, integrated, and comprehensive response to HIV and AIDS.[24] There is every reason to believe that the same kind of practice holds in Lesotho.[25]

However, the idea of *bophelo* is not exhausted by a holistic delineation of the person. There is in Basotho thought no atomic individual by which personhood may be defined, no separate anatomy or mind that is well on its own. Relationality is decisively implicated in what it means to be a person, to be healthy. This claim is not limited to the Basotho, of course: Paul Ricoeur makes much the same assertion in his definitive work on the self, where he distinguishes between *idem*-identity (sameness of identity through time, as in Descartes' *cogito*, a "pointlike," abstract identity) and *ipse*-identity (difference of identity over time, with the other as constitutive of identity).[26] *Idem*-identity is important to scientific method and its aim to establish objective judgments free of the particularities of the subject. Only *ipse*-identity has historical, ethical significance for an understanding of the person as subject. It does not take a leap in intuition to recognize that health interventions understood only through science, that is, objectively and without reference to the subject, have limited application and fail beyond that application.

Hence, for example, were one to see the temporary solution to HIV as lying in providing anti-retrovirals until a vaccine is found, one would miss entirely the subject's response to the illness in the context of her lifeworld. It would fail to address the relational context of the subject, and hence, it would be a recipe for failure. Its failure lies at the point of reception. That HIV infected persons sometimes refuse ART (anti-retroviral treatment) despite being very well informed about the virus medically and scientifically, that they resort to taking other potions or forms of treatment when on ART even when this might cause complications, that they share ARV tablets with others who are ill and have none in disregard of treatment protocols, that they are uncertain about the nature of HIV and its origins in the face of suspicions about political and economic interests that enter into health and health interventions—all of these ways of thinking and behaving are indications of the importance of understanding reception.

Lest one imagine that such concerns are particular to HIV, with its intimate connection to the most intimate sphere of human life, much the same can be demonstrated in relation to public health challenges around diabetes, violence and trauma, heart disease and cancer, to name a few. We are in each case dealing not simply with the meaning of a particular affliction but with how one understands health and healing *per se*, with what we can call "blocks of meaning" that shape any particular experience or perception of affliction. This is Ricoeur's term to designate what he calls those "heterogeneous linguistic conglomerations" that serve to hold and protect the identity of particular historical communities in the face of diversity and plurality, "organic wholes" that spread beyond the organizing center of meaning to adhere to heart, mind, and will.[27] To "translate" a health intervention defined within one paradigm (ART in biomedical science, let us say) into another paradigm that governs the reception of this intervention (*bophelo* in a Basotho worldview,

for example)—in this sense, to speak across the boundaries of two distinct languages—is to move from one block of meaning to another, to leave one metaphorical universe for another and thus to face what lies "beneath our abstractions like a kind of silent hermeneutics."[28]

Translation is thus not a simple task of finding equivalent words. It is more fraught than that, with a basic challenge: it means welcoming the language of the other into one's own discourse, and hence, it means serving two masters at the same time. As Ricoeur puts it, it means making room within my own discourse "for another way of formulating problems" just as it means, simultaneously, "reformulating in another way the very terms of age-old conflicts."[29] Reception and translation go hand in hand. But let us remind ourselves of the "blocks of meaning" entailed in this activity: They are not equivalent. There is no translation without retranslation, no fidelity to the original without some betrayal of it.

The attempt to arrive at a perfect translation from one realm of discourse to another is compromised at the outset, in principle and not just in practice. This gives rise to what Ricoeur calls "the work of mourning" that accompanies a loss both in the host language (biomedical science, say) and in the target language (*bophelo*, once more), which makes acceptable the idea of equivalence without identity between two discourses, two blocks of meaning, and gives us "the formula for justice in the field of translation."[30] The gain that balances this loss is communicability, some commensurate understanding between parties on either side of this dialogical relationship. In relation to health interventions, this kind of discursive practice applied to the relationship between the health provider and the health seeker may lead us to expect not only greater understanding on the part of the recipient of the intervention but a more positive and sustainable health outcome.

The Difference that Language Makes: Healthworlds

Language makes a practical difference, therefore. The metaphors we use, because they predicate the tensive opening up of the given to new, non-trivial insights into reality,[31] impact on how we see and do things. And framing metaphors work differently across linguistic divides as well as across discursive fields. In the work that ARHAP has done in trying to understand the interface between religion and health, this realization has spawned a fair bit of thinking about what we might call its host discourses—the languages of the social and health sciences, spoken and written largely in English. But what is at stake here is not a particular tongue; it is a particular view on reality conveyed by the languages of the social and health sciences as they have come to dominate most of the academy and of professional practice worldwide, not least in public health circles.

In Ricoeur's analysis of translation, the key point is recognizing, in our host language, the inhospitableness of our attitude toward the language of the other. If we do not simply reject it, we colonize it, so to speak, and think we have a translation. But proper translation means to take the language of the other into our own language in order to "do justice to a foreign intelligence, to install the just distance from one linguistic whole to another."[32] The tension between welcoming

the other and colonizing or doing violence to the other never disappears—it *is* the aporia at the heart of translation that we do better to understand and take into account than ignore or deny. Only in this way can we lessen or compensate for the violence we do in translation (in anticipation of mutuality that, even if it remains ultimately an ideal, nevertheless has penultimate significance for how we live and act). So the question about religion and health in Sesotho would now be turned around against our own metaphorical distinctions, and it would require us to understand how to incorporate the difference that *bophelo* represents into our constructions of religion and health.

We might remember that *bophelo* signifies a holistic and relational notion of the person, and thus we begin to unpack additional dimensions of relationality. This step is decisive, for it takes us to a complex of relationships that are understood in the Basotho worldview to be essential to any conception of health and well-being, within which the sacred or the spiritual (*borapedi*) is present as a transversal accompaniment to every element of this complexity. Again following Germond and Molapo,[33] the notion of *bophelo* incorporates several spheres of overlapping and intersecting socio-spatial configurations.

At its most elementary, it is biological life. But for the human person (*motho*) it also includes the family or homestead (*lelapa*), a conglomeration of homesteads or the village (*motse*), the nation (*naha*), ancestors (*badimo*), and the earth itself (*lefatse*). As a key social imaginary, or framing metaphor, of the Basotho, it reflects an economy of life. If any one element becomes diseased, then every other element suffers a loss in well-being as well. To treat a person's illness is thus incomprehensible without simultaneously considering other dimensions of this illness in the economy of the whole, any element of which may be implicated in its genesis and its resolution.

Here is a "block of meaning" that, if ignored, will defeat standard public health interventions, at least until the language that is there within the conceptualizations of primary health care, social determinants of health, and the like become more central and better thought through in terms of the notions of translation and reception we have been probing. How would one then conceive of *bophelo* within that framework? Is there an equivalent, if not identical, concept in English, say? Some thought has been given to this in the work that ARHAP has done. It requires an invention.[34]

Germond and Cochrane have proposed the idea of a "healthworld" as an appropriate and theoretically pregnant equivalent of the "block of meaning" encapsulated by the Sesotho idea of *bophelo* (which has equivalents in many other African languages).[35] Here I give no further defense of the idea of the healthworld, other than to say that it mirrors the notion of the lifeworld defined by Jürgen Habermas as that culturally transmitted, linguistically organized, and taken-for-granted stock of knowledge out of which one cannot step, normally functioning in the background and supplying unproblematic convictions that frame an horizon of action.[36] The tacit knowledge it represents becomes conscious in relation to particular situations of action governed by "contexts of relevance" when what was tacit or in the background now moves into the foreground. This is not a static process because, to the extent that something new is experienced or learned in the process, one's existing way of understanding the world is expanded, affirmed, or corrected. But

the background pattern of knowledge is not simply set aside either, and it will and does constrain behavior and action.

What then makes for the specificity of the healthworld? To see it merely as a particular domain of lifeworld alongside, say, sport, aesthetics, or religion would make of the concept of the healthworld something fairly trivial, simply a subset of the lifeworld among multifarious other pertinent subsets, relevant only to a limited context of action (Habermas calls these "segments" of the lifeworld). It would, moreover, not then really be an adequate translation of *bophelo* (remembering Ricoeur's warning that translation always involves both fidelity to and a kind of betrayal of the original).

The unique idea of a healthworld is that it represents a fundamental orientation within the totality of the lifeworld, namely, an orientation towards a fullness of being, that is, towards well-being, or a lifeworld without dysfunction (for lifeworlds naturally and normally are not thus teleologically oriented, incorporating as they do both an ontology of being and a pathology of being). The healthworld is thus not simply a segment of a lifeworld of relevance to a particular action situation but an anthropologically rooted dimension of the lifeworld that thoroughly traverses it. The healthworld in this respect represents and reflects a specific kind of horizon of action, a way of knowing the world that, aware of ambiguity, is intrinsically and holistically "redemptive," that is, oriented towards comprehensive well-being.

From this point, it is not hard to recognize in the notion of the lifeworld the full complexity of *bophelo* in the way it intrinsically links the person to that person's social and natural environment through inherited and socialized forms of knowledge linked to the full range of relevant action contexts that confront a human being in life. What is more, the teleological orientation towards comprehensive well-being also links the notion of the healthworld to the most fundamental features of those dimensions of human experience we label religion and health, though without any implied dualism.

What is lost in the process of this translation are the specific cultural characteristics of *bophelo*, which in itself signifies not an abstract, eternal, and unchanging reality but one conditioned by time and space, by history and geography. What is gained in the process of this translation is a generalizable view on the meaning of religion and health read together, applicable to other times and spaces, histories and geographies. The full weight of the initial conundrum posed by the attempt to translate the somewhat artificially separated categories of religion and health now appears: in the context of public health and health interventions generally, its resolution suggests that the "translation" of such interventions into frameworks of meaning other than one governed by the paradigm of Cartesian science and the excision of the subject requires much greater attention to the question of reception; hence to the reality of the subject for whom the intervention is intended; hence to their healthworld and its theoretical incorporation into health practice and the ordering of health systems.

Put differently, now by way of reverse translation back into the dominant paradigm of public

health, it means recognizing the sense in which this paradigm in itself constructs a particular view of the healthworld, reductionistically, through the search for objective foundations for the practice of health that transcend particular subjectivities and, hence, transcend the subject *per se*. While some confidence in the language of science is both necessary and a boon, too strong a confidence in it has negative consequences, arising whenever a presupposition is at work (as it often is) that there is "a complete homology between the sign and the thing . . . [and] more broadly . . . between language and the world, which would be a tautology."[37] The knowledge construct this represents, the way in which it expresses a particular epistemé, and the massive resources that flow into it, exercise power over the other, carrying the danger that translation as mere homology does violence to the other and her healthworld.

This danger is averted only by opening up one's own language, making it hospitable to the language of the other. To recall Ricoeur once more, "to translate is to retranslate," if one is to welcome the other and her discourse or, better, her discursive world, into one's own—if one is to concern oneself with justice, esteeming the other and treating the other as an end and not merely as a means.[38]

The practical point behind such an orientation or perspective is simply this: it should make for better and more sustainable health interventions at the same time as it recognizes, and hence encourages, the agency of the other in their own health, in itself a mark of well-being that is already one of the goals of public health.

Endnotes

1 Paul Ricoeur, *Reflections on the Just*, trans. David Pellauer (Chicago: University of Chicago Press, 2007), 107.

2 Ibid.

3 The phenomenon of glossolalia ("speaking in tongues") inaugurated at the original Pentecost may be seen as a utopian counter-narrative to the confusion of Babel.

4 Michel Foucault, *The Order of Things: An Archaeology of the Human Sciences* (New York: Random House, 1973), xv-xvi.

5African Religious Health Assets Programme, "Appreciating Assets: The Contribution of Religion to Universal Access in Africa," (Cape Town: ARHAP, Report for the World Health Organization, 2006).

6 An important analysis in the African context of the difference between institutionalized forms of religion (a denomination, for example) and communal forms (as much African traditional religion appears) is to be found in William Johnson Everett, "Religion in Democratic Transition," *Journal of Theology for Southern Africa* 104 (1999): 64-68.

7 Laurie Garrett, *Betrayal of Trust: The Collapse of Global Public Health* (New York: Hyperion, 2000); Jim Yong Kim et al., eds., *Dying for Growth: Global Inequality and the Health of the Poor* (Monroe, ME: Common Courage Press, 2000).

8 Philosophically, transcendence here may be described as the quality, specific to sentient beings, that enables humans to transcend the actual by envisaging, and bringing into being, a new possibility, thus transforming (and not simply conforming to) the world. See Douglas R. McGaughey, *Religion before Dogma: Groundwork in Practical Theology* (New York; London: T & T Clark, 2006).

9 CSDH, "Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health," (Geneva: World Health Organization, Commission on Social Determinants of Health, 2008); S. Leonard Syme, "Historical Perspective: The Social Determinants of Disease—Some Roots of the Movement," *Epidemiologic Perspectives & Innovations* 2, no. 2 (2005).

10 World Health Organization, *The World Health Report 2008: Primary Health Care—Now More Than Ever* (Geneva: World Health Organization, 2008).

11 John P. Kretzmann and John L. McKnight, *Assets-Based Strategies for Faith Communities* (Asset-Based Community Development Institute of Northwestern University, 2002); John P. Kretzmann and John L. McKnight, *Building Communities from the inside Out: A Path toward Finding and Mobilizing a Community's Assets* (Chicago: ACTA Publications, 1993).

12 African Religious Health Assets Programme, "Appreciating Assets."

13 Charles Elliot, *Locating the Energy for Change: An Introduction to Appreciative Inquiry* (Winnipeg: International Institute for Sustainable Development, 1999). Appreciative Inquiry (AI) requires "a shift away from the problem-oriented methods toward processes that build on community achievements, existing strengths and local skills . . . identifying and reinforcing the adaptive strategies that local people often develop to maintain their livelihoods in adverse circumstances. . . . The appreciative approach involves collaborative inquiry, based on interviews and affirmative questioning, to collect and celebrate the good news stories of a community—those stories that enhance cultural identity, spirit, and vision." (The International Institute for Sustainable Development, http://www.iisd.org/ai/).

14 Robert Chambers, "Rural Appraisal: Rapid, Relaxed and Participatory," (Brighton: Institute of Development Studies, University of Sussex, 1992). Chambers argues, following Paulo Freire, that poor, exploited, or marginalized people can and should be enabled to analyze their own reality through a wide range of participatory techniques, placing a strong emphasis on oral communication rather than written expertise, with new ones being invented all the time that decentralize authority and empower people at the local level.

15 Christine E. Dunn, "Participatory GIS—a People's GIS?" *Progress in Human Geography* 31, no. 5 (2007): 616-37.

16 James C. Scott, *Domination and the Arts of Resistance: Hidden Transcripts* (New Haven: Yale University Press, 1991). PGIS is an approach to mapping that combines Participatory Learning and Action (PLA) methods with Geographic Information Technologies and Systems (GIT&S), and seeks to place "control of access and use of culturally sensitive spatial information in the hands of those who generated them, [to] protect traditional knowledge and wisdom from external exploitation" (see http://www.ppgis.net/pgis.htm)

17 Norman Long and Ann Long, eds., *Battlefields of Knowledge: The Interlocking of Theory and Practice*

in Social Research and Development (London: Routledge, 1992).

18 Jacques Derrida, "Faith and Knowledge: The Two Sources of 'Religion' at the Limits of Reason Alone," in *Religion*, Cultural Memory in the Present, eds. Jacques Derrida and Gianni Vattimo (Cambridge, UK: Polity Press, 1998).

19 David Chidester, *Savage Systems: Colonialism and Comparative Religion in Southern Africa* (London: University of Virginia, 1996).

20 The predilection towards, indeed necessity of, controlled, ordered and subdivided frameworks for the organization of modern societies is eloquently analyzed in relation to its limits by James C. Scott, *Seeing Like a State: How Certain Schemes to Improve the Human Condition Have Failed* (New Haven: Yale University Press, 1998).

21 Foucault, *The Order of Things*.

22 Paul Germond and Sepetla Molapo, "In Search of *Bophelo* in a Time of AIDS: Seeking a Coherence of Economies of Health and Economies of Salvation," *Journal of Theology for Southern Africa* 126 (2006): 27-47.

23 Malibongwe Gwele, "Medical Pluralism in Khayamandi, Stellenbosch" (Masters diss., University of Cape Town, 2005); Sandy Lazarus, "An Exploration of How Native American Worldviews, Including Healing Approaches, Can Contribute to and Transform Support Services in Education," (Cape Town: University of the Western Cape, for the South African National Research Foundation: Indigenous Knowledge Systems, 2004); C. Leslie, "Medical Pluralism in World Perspective," *Social Science and Medicine* 14B, no. 4 (1980): 191-5.

24 Liz Thomas et al., "'Let Us Embrace': Role and Significance of an Integrated Faith-Based Initiative for HIV and Aids: Masangane Case Study," (Cape Town: African Religious Health Assets Programme, University of Cape Town, 2006), 50ff.

25 African Religious Health Assets Programme, "Appreciating Assets," 116ff.

26 Paul Ricoeur, *Oneself as Another* (Chicago: University of Chicago Press, 1992).

27 Ricoeur, *Reflections on the Just*, 29-30.

28 Ibid., 29.

29 Ibid., 30.

30 Ibid., 31.

31 Paul Ricoeur, *The Rule of Metaphor: Multi-Disciplinary Studies of the Creation of Meaning in Language*, trans. Robert Czerny, Kathleen McLaughlin, and John Costello (Toronto: University of Toronto Press, 1977).

32 Ricoeur, *Reflections on the Just*, 31.

33 Germond and Molapo, "In Search of *Bophelo*."

34 Changing language to shift practices has to do with attempting to move out of a paradigm in crisis to another that may enable us to deal better with the crisis; ARHAP thus regularly invents language to describe and analyze the interface of religion and public health, including for example the notion of "religious health assets" already noted, a move from discourses about the burden of disease and the leading cause of death to the "leading causes of life," from disciplinary and institutional limits to leadership to "boundary leadership," from patient throughput and average days per patient per bed to "journeys of health," as well as the concept discussed here, "healthworld."

35 Paul Germond and James R. Cochrane, "Healthworlds: Conceptualizing Landscapes of Health and Healing," *Sociology* 44, no. 2 (2010): 307-24.

36 Jürgen Habermas, *Lifeworld and System: A Critique of Functionalist Reason*, trans. Thomas McCarthy, vol. 2, The Theory of Communicative Action (Boston: Beacon Press, 1987), 124.

37 Ricoeur, *Reflections on the Just*, 111.

38 Ibid., 30.