The RoundTable

Spirituality, Religion and Health

AT THE UNITED NATIONS GENEVA

PANEL REPORT:

"Spirituality, Religion & Social Health"

During the 58th World Health Assembly

at the United Nations in Geneva

May 2005

"HEALTH is only complete for those who see it in a complete physical, mental, social and spiritual light"

Ad-hoc discussions **Dr Halfdan Mahler**
Third Director-General of the World Health Organization (1973-1988)

This booklet and Panel Report provides a brief overview from experts in diverse fields on the religious and spiritual dimension in health. The effects that beliefs and practices can have not only on population health, but also on the health system and health care have been underestimated. The potential benefits and pitfalls of taking into account the religious and spiritual dimension in health is here addressed.

This booklet hopes to serve as a catalyst of future debates and research in the field of religion, spirituality and health for policy makers, health communities and non-governmental organizations working at improving people's health.

The contributions included in this panel report, are built on the basis of scientific evidence and case studies. They underline the value of including religious and spiritual dimensions in research, education, health care and rehabilitation programmes as well as working with the religious organization to address Health for All in a more cohesive and comprehensive way.

This is the third time that a panel on "The Spiritual Dimension in Health" has taken place during the World Health Assembly of the WHO in Geneva. However, it is the first time a panel report is produced with the purpose to launch further discussions and resolutions to take this essential aspect of life and health into consideration. We hope this is only but a first step into this direction…

"This Panel Report represents vast potential for all in society – the patient, the medical care provider as well as key policy makers in the business, civil society and governmental sectors. Therefore, I recommend it be given due regard for implementation into current policy and practices the world over."

Manoj Kurian, MD
World Council of Churches, Head of Health & Healing Section
former chair of the NGO Forum on Health

The RoundTable

Spirituality, Religion and Social Health

AT THE UNITED NATIONS GENEVA

On the occasion of the 58th World Health Assembly in Geneva,

We invite you to join in our debate on what the WHO, governments, NGOs, academic institutions, health agencies and professionals can do and propose in order to:

- identify the link and impact between Spirituality, Religion and Health
- re-launch the proposal to WHO for a definition amendment (see below)
- prepare *a Plan of Action*

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- "***Health is a state of complete physical, mental, social and spiritual well-being and not merely the absence of disease or infirmity."***

Spirituality, Religion and *Social* Health

Thursday, May 19
13:00 - 15:00
United Nations
Geneva, Switzerland

Guest speakers

Dr. Rajinder Pal	Member of the Expert Advisory Panel of WHO
Dr. Astrid Stuckelberger	Geneva University, School of Public Health, Switzerland
Prof. Dr. Fahri Saatcioglu	Oslo University, Department of Molecular Biosciences, Norway
Rev. Robert J. Vitillo	Special Advisor on HIV and AIDS, Caritas Internationalis

Moderator

Werner Peter Luedemann	International Association for Human Values

All human beings are born free and equal in dignity and rights.
They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood (Article 1).
Everyone has the right to freedom of thought, conscience and religion; this right includes freedom to change his religion or belief, and freedom, either alone or in community with others and in public or private, to manifest his religion or belief in teaching, practice, worship and observance (Article 18).

Universal Declaration of Human Rights

adopted and proclaimed at the General Assembly
United Nations, 10th of December 1948

People of different religions and cultures live side by side in almost every part of the world, and most of us have overlapping identities which unite us with very different groups.
We can love what we are, without hating what – and who – we are not.
We can thrive in our own tradition, even as we learn from others, and come to respect their teachings.

Kofi Annan

Secretary-General of the United Nations

Preamble

The RoundTable "Spirituality, Religion and Health" is an international Forum, based on the recognition of the importance of the universal spiritual and religious dimension in *Health for All*.

Purpose

The RoundTable aims at bringing the universal spiritual and religious dimension in health to areas of the United Nations agenda and of international public policy.

The RoundTable acknowledges that the spiritual dimension is common to all faiths, cultures and traditions; the spiritual dimension is universal in nature and can support to transcend boundaries of religion and of nationality.

The participation is open to international institutions, governmental or non-governmental organizations, government officials, UN civil servants, UN missions, and civil society individually or collectively wishing to participate and aspiring to take responsibility to fulfill these goals.

Goals

I. **To share information and knowledge** about the various spiritual and religious traditions in order to enhance consideration and respect. For example by sharing evidence-based knowledge or by bringing more understanding about techniques and practices that religions, cultures and traditions around the world use to improve quality of life and of being (i.e. silence, prayer, contemplation, meditation, breathing techniques, rituals).

II. **To participate in the work of the United Nations** and in international conferences by:

- encouraging a spiritual perspective within the international community and making written contributions for inclusion in United Nations declarations and programmes of action relating to the spiritual and religious dimension in health;
- supporting and exploring the link between spirituality, religion and science, by presenting evidence-based knowledge demonstrating the causal effect of religion/spirituality – health link on the individual, the family, society as well as for the health care system and health policy level;
- promoting the right to lead a spiritual and religious way of life in full respect of the Universal Declaration of Human Rights;
- developing and implementing programmes relating to the spiritual dimension in health;
- publishing a series of documents either from joint events and meetings, or according to projects with partners;
- creating and developing a global network of participants and institutions;

III. **To organize, facilitate public events** in order to initiate dialogue between religious and spiritual dignitaries, speakers from UN agencies, UN missions, NGOs, civil society, private sector, media and others.

Steering Committee of The RoundTable

- Manoj Kurian, PhD, Head of Health Section, World Council of Churches, former chair of the NGO Forum on Health
- Rajinder Pal, PhD, DSC, Member of the Expert Advisory Panel of the WHO
- Astrid Stuckelberger, PhD, University of Geneva, School of Public Health, co-founder of the NGO Committee on Spirituality, Values and Global Concerns at the United Nations in Geneva
- Werner Peter Luedemann, International Association for Human Values, co-founder of the NGO Committee on Spirituality, Values and Global Concerns at the United Nations in Geneva

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Introduction

Werner Peter Luedemann

International Association for Human Values
Co-founder of the NGO Committee on Spirituality, Values and global Concern

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This Panel and the report - directed towards policy makers in the health care sector, including governmental and business communities - provides a brief overview of the substantial potential benefits of implementing what is called by some “Natural Evidence Based Techniques” (NEBT) to provide “complete health” for all layers of society. NEBT shows great promise in this regards, documented by recent scientific research.

The Constitution of the World Health Organization defines health to be a state of complete physical, mental and social well-being. In other words, holistic health -- more than simply the absence of disease or infirmity -- is the birthright of every human being. However the great majority of the world’s population does not enjoy this fundamental right in practice, including the developed countries. The application of modern medicine, despite significant advances and utility, has not given any country, rich or poor, a community that is healthy consistent with the WHO definition of health. NEBT promises to be a fertile resource in this regard, which is yet to be fully explored.

The ideas, described in this booklet, suggest that a new synthesis of modern medicine and NEBT is very timely and very much in line with the economic, scientific, political and social circumstances in all countries, developing as well as developed societies.

This is the third time that a panel on “The Spiritual Dimension in Health” has taken place during the World Health Assembly of the WHO. With escalating medical expenditures and limited resources, it has become increasingly important to explore alternative methods that may provide high quality adjunct medical care for all societies.

Spirituality and Health: WHO historical background

Dr. Rajinder Pal

Member of the Expert Advisory Panel of WHO

Dear Friends,

The RoundTable has met several times and felt the need to have the support of WHO in its endeavour to include spiritual well-being in the preamble of the WHO Constitution.

We were encouraged, as in 1988 under the leadership of Dr Halfdan Mahler, the then Director-General of WHO, the executive Board 101 approved a draft resolution which said:

"Health is a state of complete physical, mental, social and spiritual well-being and not merely the absence of disease and infirmity."

The draft resolution was submitted to the 51st World Health Assembly during May 1998 to revise the wording of the Constitution in its preamble to include "Spiritual Well-being" but it was decided by the World Health Assembly not to consider the proposed amendment.

I was asked by the working group to request the current Director-General, Dr Jong-Wook Lee, to reconsider this proposition and I therefore sent him a letter on 17 October 2004.

The letter was circulated to many departments in WHO and finally I received the following reply, I am presenting only the highlights:

- *"The project proposal was read with interest and we wish the Working Group every success in its realization."*
- *"Should the project get off the ground, the researcher may be interested to be aware, if not already, of a field-test instrument covering quality of life aspects related to spirituality, religiousness and personal beliefs. The relevant weblinks are:*

  http://www.who.int/mental_health/resources/evidence_research/en/

  a. WHOQOL-SRPB Users Manual Scoring and Coding for the WHOQOL SRPB Field-Test Instrument [pdf 216kb]

     http://www.who.int/mental_health/evidence/whoqol_srpb_users_manual_rev_2005.pdf

  b. WHOQOL-SRPB Field-Test Instrument WHOQOL [pdf 92kb]
  "Spirituality, Religiousness and personal Beliefs"

  http://www.who.int/mental_health/media/en/622.pdf

- *"Taking into consideration the urgent need for guidance on a variety of other pressing challenges to human health, it is not expected in the immediate future to establish a committee to consider the spiritual dimension in health."*
- *"We suggest that you might contact the John Templeton Foundation, which we understand is interested in Spirituality and Health, and might therefore be interested in the project.*
- *"We would also be interested in being kept informed of any progress you make in this area."*

In conclusion, I would submit that to pursue further Spirituality and Health, what we need is to:

a) discuss this subject further with interested WHO member States
b) convene a meeting of the member states after contacting them and their willingness
c) raise necessary funds to convene such a meeting.

Personally, I have a strong belief in Faith and Hope. Our genes and DNA may predispose human beings towards religious faiths and some individuals are interested towards meditation and yoga.

The WHO new Commission on Social Determinants of Health should also consider this subject.

Correspondence : Dr Pal, Tel/Fax +41 22 755 11 52

Religion, Spirituality and Health:
Reflections from an Evidence-based Public Health Perspective

Astrid Stuckelberger, PhD

Public Health Programme, Faculty of Medicine, Geneva University

Science without religion is lame, religion without science is blind. Albert Einstein, Science, Philosophy and Religion (1941)

Those who say religion has nothing to do with politics do not know what religion is. Mohandas K. Gandhi

Addressing the scientific link between religion, spirituality and health has too often been a 'forgotten subject' or avoided for irrational, emotional or 'political' reasons. It is time for the scientific community to integrate religious and spiritual factors, which have guided human behavior over centuries, into health and human sciences. It is time the international community and all of us engage in addressing this theme. It is time to restore and mainstream this dimension into Development and Health and in the agenda of the United Nations as a fundamental right, but more so as a central element of people's values and life.

Religion, spirituality and health have in common the fact that they are of universal concern, are at the center of human life and death and have marked all civilizations throughout humankind history. Despite their common concern engrained in human suffering and human behavior, linking spirituality, religion and health has only been the subject of reliable scientific research very recently. The publication of reliable data and findings has provoked an 'intellectual quake' within the minds of scientists triggering the most passionate debates. Thanks to the advances of research tools and techniques, investigation fields have now demonstrated the effects of the practice of religion and spirituality from the cellular level to the brain functions, from specific to general health improvements. Today, more than ever, religion and spirituality are on the academic table and are questioning the limits of evidence-based medicine.

The aim of this contribution is to draw some emerging findings and issues in the field and share reflections for future developments in science and in policy. We will first be looking at the evolution of definitions and concepts, secondly, reviewing shortly relevant findings and key challenges and finally giving a few recommendations and messages to take away.

HEALTH DEFINITION(S)

The World Health Organisation (WHO) definition of health was endorsed by member states in the Preamble of the WHO Constitution in 1947. WHO provides the only worldwide recognized definition of health, which has never been changed since:

"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"

The WHO definition has not been submitted to revision until a few years ago: at the end of last decade, under the impulse of Dr Halfdan Mahler, WHO Director-general at that time, the executive board submitted a new definition of health including the spiritual dimension of health in the following way *"Health is a state of complete physical, mental, social and spiritual well-being and not merely the absence of disease or infirmity."* This modified WHO health definition was to be presented to the 51st World Assembly of Health in 1998 as it requested a revision of the WHO Constitution. Finally, this proposal slipped away from endorsement and has not yet been brought back on the agenda. [see above article from Dr Rajinder Pal]

Although, the concept and definitions of health rarely include any reference to the belief and metaphysical aspects of the human, it has been challenged by world religions in many ways. For example, while respecting the WHO definition of health, the Roman Catholic Church has re-formulated it by adding the spiritual dimension as well as giving to health a purpose for individual life on earth.

Pope John Paul II gave the following definition of health:

> *"Health is a dynamic tension towards physical, mental, social, and spiritual harmony, and not only the absence of illness, which gives man the ability to fulfill the mission which has been entrusted to him, according to the state of life in which he finds himself."*[1]

Other faiths and religions have found the WHO definition incomplete and proposed a more comprehensive definition. Modifying a definition has implications in the way the constituency will 'treat' and take care of the person (body/mind/spirit) and of his formal and informal network.

The definition of health is also challenged by advances in biotechnology and bio-medical engineering, allowing for the first time in history to modify the 'natural parameters' of the life-health/disease-death spectrum. Many ethical debates are taking place on topics that include gene modifications, end-of-life decisions regarding organ transplant, coma, brain death, or technologically induced life. Not only are the parameters and limits changing the reality of the issue but up to now, there is still no clear position on many of those issues.

This situation reveals on one side the well-founded WHO definition based on the scientific paradigm of the bio-medical model and on the other hand the missing link between the structural-functional approach to health and the 'higher functions' such as consciousness, religiosity and spirituality. In other words, the gap lies between the "must" in evidence-based medicine and the "must" in the value-based requirement in human life.

CAN EVIDENCE-BASED MEDICINE INTEGRATE THE VALUE-BASED APPROACH?

Do religious and spiritual factors have a legitimate role in medicine and public health? Can they be considered as factors in the dominating evidence-based approach to health and policy making?

Let's first have a look at what is required from religion and spirituality to be recognized as integral aspects of the evidence-based approach, of public health and of policy-making.

Since evidence-based medicine (EBM) was first formally described in 1992 (EBM WG, 1992; Jenicek, 1997; Brownson et al., 1999, 2003) some recent definitions have included a value-based approach too: "EBM is the integration of best research evidence with clinical expertise and patient values" (Sackett et al., 2000). EBM is today considered as a "revolution" in health for two main reasons: first, by setting a 'golden standard' based on gathering and synthesizing the most reliable information for the best decisions possible with respect to prevention, diagnosis, prognosis and treatment, secondly by increasingly influencing health policy-making which is defining Evidence-Based Public Health (EBPH) as another standard.

Nevertheless, this systematic and structured approach has been criticized for de-emphasizing the patient's values, perspectives, and choices, as well as failing to account for individual socio-cultural and biological variations (Kohatsu, Robertson and Torner, 2004). Critics also claim that EBM guidelines devalue clinical judgment and fail to include patient preferences and values in the equation leading to clinical management decisions (Sackett et al., 1996). A broader view on health and human development has underlined on one hand the need to encompass a more "value-based medicine" approach and on the other hand to take a broader public health approach.

Kohatsu et al. (2004) proposed to include a stronger community perspective in defining Evidence-Based Public Health (EBPH) as *"the process of integrating science-based interventions with community preferences to improve the health of population"*. Compared to former definitions of EBPH (See table 1 - Jenicek, 1997; Brownson et al, 1999, 2003), Kohatsu takes a more "population-centred" perspective in which the view points of the affected population are at the forefront of decision-making regarding public health interventions (Kohatsu et al., 2004). In this context, the community values and belief system embodied in religion or spirituality should be fully integrated in medicine and public health.

In the same line, Dr Beaglehole, Director of the Evidence and Information for Policy Cluster at WHO, and his colleagues recently suggested a 'short and succinct definition of public health that is both broad in scope and of wide appeal':

> *Public Health is a collective action for sustained population-wide health improvement*
>
> Beaglehole et al. (2004)

Beaglehole et al. recognize the need for collaborating across all sectors affecting health partnering with the populations served to best address their needs, directly or indirectly: "the focus of public

[1] Conference of the International Federations of Catholic Health Care Workers (February 2000), Conference to doctors held at Vatican City by Archbishop Lozano, president of the Pontifical Council for Pastoral Assistance to Health Care Workers.

health has often been on what can be measured easily, such as cholesterol or blood pressure, rather than on the immensely more complex issues of the broader social forces that also affect health, directly or indirectly" (2004:2085). Other WHO experts recognized the imperative to include mental and social aspect of health in early intervention strategies during and after acute emergencies in order to address mental problems such as post-traumatic stress disorders during and after natural disasters, wars, violence and conflicts (van Ommeren, Saxena and Saraceno, 2005).

TABLE 1 - THREE DEFINITIONS OF EVIDENCE-BASED PUBLIC HEALTH (EBPH)

DEFINITION 1 - JENICEK (1997)

EBPH is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of communities and populations in the domain of health protection, disease prevention, health maintenance and improvement (health promotion).

DEFINITION 2 - BROWNSON ET AL. (1999, 2003)

EBPH is the development, implementation, and evaluation of effective programs and policies in public health through application of principles of scientific reasoning, including systematic uses of data and information systems and appropriate use of program planning models.

DEFINITION 3 - KOHATSU (2004)

EBPH is the process of integrating science-based interventions with community preferences to improve the health of populations.

Many authors have underlined the challenge to integrate community values and culture "*The objectivity and rationality which is part of the rhetoric of evidence based medicine tend to obscure the fact that values play an important role in the conclusions from evidence based medicine.*" (Hope, 1995: 260). Bringing evidence on the cause effects between health and community values such engrained their beliefs system, whether it is religious, spiritual or not.

The evidence-based approach would require however that the values a community attributes to the religious and spiritual dimensions of health practices and beliefs be scientifically assessed as potential positive and negative risk factors for health and quality of life. The question is what body of research and evidence do we have today on the link between religion/spirituality and health and what are the future challenges in this area of research?

HOW DOES SCIENTIFIC EVIDENCE BRIDGE SPIRITUALITY, RELIGION AND HEALTH?

For over a century, social scientists have debated whether science and religion are necessarily antagonistic to each other and which models for the future would make sense: religion without science, religion with science, science without religion or science with religion. Scientific debate on the religion/spirituality-health relationship has increased in the last decade. The interest in this topic has polarized researchers in many aspects bringing contradictory results and interpretations but also criticism on methodological biases induced by the sceptics versus the convinced.

People have used religious or spiritual techniques for their own and others' health concerns for thousands of years. Those techniques are many and diverse: prayer, chanting, yoga, meditation, reiki, tai chi, etc. but body rituals such as swaying in prayer, turning sacred objects like rosary bids in the hands and other rituals. Those techniques also represent a spectrum of repetitive, mind-clearing practices eliciting the so-called relaxation response.

Thorough scientific investigation of religious and spiritual practices only appeared quite recently. Their effects on health are supported by a growing body of fundamental and clinical research but also lately by community studies. The fundamental and clinical studies aim at better understanding the underlying mechanisms at work at genetic, molecular, and cellular levels looking at markers and measures in the body and draw upon an array of high-technology tools and techniques, such as brain imaging or the immune system response. At the population-community level, the goals range from improving quality of life, to looking at the impact of these practices and on serious chronic health conditions, to assisting people through the end of life. Findings highlight the positive or negative 'health behaviour pattern' supported by religious and spiritual beliefs. Through their dogmas, religions provide a set of codes of conduct, including a kind of 'health behaviour policy" which hypothetically can benefit or hinder the development of the population health. For example, hand hygiene practice and recommendation in the Orthodox Church have a decisive impact on the health behaviour of populations of Orthodox faith (Vachicouras, 2005). The same can be said with the Jaïn community in India and many others.

As funding for research is the basis of expanding our knowledge in the area, the data collection and number of studies depend largely in government and research policy. For example, since 2000 in the United States, prominent research institutions including the Mind/Body Medical Institute run by Harvard Medical School associate professor Dr Benson as well as the Duke University and the University of Washington have carried numerous studies in the field.

Mind-body medicine[2] is also a research priority of The National Center for Complementary and Alternative Medicine (NCCAM) within the National Institute of Health of United States. Through a large array of research, this Center seeks to discover means for enhancing and accelerating the healing process beyond the effects of conventional medicine; preventing, treating, and slowing the progression of diseases and disorders; reducing the burden of stress-related chronic illnesses; and enhancing people's resilience and coping--all toward improving public health and well-being. As noted by Dr Straus from NCCAM: *"The growing body of physiological evidence about these approaches is helping to shatter a long-held cultural belief in the West that mind and body are separate, Indeed, the potential exists for safe and effective mind-body practices to add to the repertoire of conventional medicine. NCCAM is working to move study in this important field forward.* In recent years, studies found evidence that patients faced with chronic and even terminal illnesses--particularly conditions like heart disease and cancer--can learn and utilize a variety of mind-body practices to achieve symptom relief, a better quality of life, and, in some cases, improvements in health outcomes (NIH, 2005).

Through a *systematic review* of over 1'200 studies on the religion-health relationship Koenig et al. (1999, 2001) have demonstrated that the vast majority of theses studies show a relationship between greater religious involvement and better mental health, better physical health or lower use of health services. Many studies are not perfect because of the difficulty of the topic, but nevertheless only few studies find no relationship and even fewer studies show significant negative relationship between religion and health. It also revealed that when people become physically ill they rely heavily on their sense of meaning and purpose in life. From the data gathered, religious involvement appears to enable the sick, particularly those with serious and disabling medical illness, to cope better and experience psychological growth from their negative health experiences, rather than be defeated or overcome by them (Koenig, Larson and Larson, 2001).

Many other clinical and population studies are available today and cannot be mentioned here. Some authors have countered those findings with a selection of researches demonstrating the 'no effect' line (Sloan et al., 1999). Other studies on a specific aspect of religious practices such as the Cochrane systematic review on intercessory prayer by Ahmed (2000) found little or contradictory results. Other authors have addressed the importance of religion for public health (Chatters, 2000). After analyzing the methodological aspect of Sloan et al. negative review, Koenig et al. (1999, 2001) criticized the highly selective and over-emphasized negative aspects of many highly credible studies published in some of the best epidemiological journals, while minimizing or dismissing their substantial positive findings.

On the other hand the "philosophy" of the scientist can have huge effects on his outlook on the subject. For example, the proponents of "Neurotheology", the study of the neurobiology of religion and spirituality, take a hard line on focusing on biological evidence. From this point of view, the experience of God and religion is biological and in your head; the question is to find in which part of the brain it all happens. This extremist view of the human-body-machine considers the 'state of physical, mental and social well-being' in its most reductive matter which makes it legitimate to doubt about any reference to non tangible factors or even that the brain has any effects on health. "The question of whether our brain wiring creates God or whether God created our brain wiring will most likely remain purely a matter of faith" (Newsweek, 2001).

From a short overview and analyses of the scientific literature, a few more points can be underlined for our discussion:

IMPACT OF RELIGIOUS AND SPIRITUAL HEALTH BEHAVIOUR ON MORTALITY AND LIFE EXPECTANCY

Religion and spiritual groups usually have within their belief system a set of "Behavioral rules or guidelines", some "life commandments" which they live by. Some of those life precepts very clearly shape healthy or unhealthy lifestyles (non-violence, good nutrition, no drinking, etc.), which decreases the risk of morbidity and mortality over time and increases the health capital for higher ages. Thus, the measurement of life expectancy in different faith groups would hypothetically show

[2] *Mnd-body medicine involves the interaction of mind, brain, other body systems, behavior, and, ultimately, health and disease*) http://nccam.nih.gov/news/newsletter/2005_winter/prayer.htm#overview#overview

a difference with non-religious groups. Up to now, only few and 'mismeasured' data of religion in mortality research has been conducted (McCullough et al, 1999). A recent longitudinal study in Israël found that characteristics of one's immediate neighbourhood, namely, community wealth and religious affiliation, have valuable health implications that should be included when assessing mortality risks (Jaffe et al., 2005). Another study revealed that religious attendance is associated with U.S. adult mortality in a graded fashion: People who never attend exhibit 1.87 times the risk of death in the follow-up period compared with people who attend more than once a week. This translates into a seven-year difference in life expectancy at age 20 between those who never attend and those who attend more than once a week. Health selectivity is responsible for a portion of the religious attendance effect: People who do not attend church or religious services are also more likely to be unhealthy and, consequently, to die. However, religious attendance also works through increased social ties and behavioral factors to decrease the risks of death (Hummer et al., 1999).

IMPACT OF RELIGIOUS AND SPIRITUAL PRACTICES ON HEALTH: PRAYER AND MEDITATION

A. PRAYER

Can prayer heal illness? Can science prove any effects of prayer? Studying the cause-effect association between prayer and health parameters has become a complex and controversial area of research from which emerge contradictory findings, interpretations and hypothesis.

The NIH National Center for Complementary and Alternative Medicine (NCCAM) has supported a series of researches demonstrating a) the importance of prayer in the community, b) the motivation for praying, c) the effects of praying on health and coping, d) the community care of health/disease/death related to religious groups. Some of the findings can be shortly mentioned:

- The largest and most comprehensive survey to date on Americans' use of complementary and alternative medicine showed that many Americans are using prayer and other spiritual practices. (see Barnes PM et al., 2004). This survey of more than 31,000 adults found that 36% had used complementary and alternative medicine (CAM), when prayer was not included in the definition of CAM; when prayer was included in the definition of CAM, 62% had used CAM (all figures refer to use in the preceding 12 months). Among the respondents:
  - 45 % had used prayer for health reasons.
  - 43 % had prayed for their own health.
  - Almost 25 % had had others pray for them.
  - Almost 10 % had participated in a prayer group for their health.
- A recent government study found that 45% of adults prayed specifically for health reasons, and suggested that many of them were poor people with limited access to care. Authors conclude that it is a public health imperative to understand if this prayer offers them any benefit.

Catherine Stoney, Program Officer in NCCAM Division noted: "*There is already some preliminary evidence for a connection between prayer and related practices and health outcomes. For example, we've seen some evidence that religious affiliation and religious practices are associated with health and mortality--in other words, with better health and longer life. Such connections may involve immune function, cardiovascular function, and/or other physiological changes."* However, she added, this is by no means proven: *"For some individuals, religious practices are an effective way of coping with stress, and the beneficial health effects may come about by reducing stress. For others, religious practices may not result in reduced stress or be associated with health benefits. It can be challenging to separate out these effects because people have different ideas regarding the meaning of various practices. For this reason, we are particularly interested in understanding the impact of personal, positive meaning on health."*

B. MEDITATION

The advances of medical technology permit different investigations of those techniques: for example neuroscience and biochemistry have developed high-tech tools that can tease out how those benefits work at the micro-cellular level. Increasingly, scientists are focusing on how prayer and meditation may help not only the body but the brain (from lifting depression to relieving pain to fighting flu). While some of the most striking studies have involved monks who were experts at meditation, more and more researches also back up claims that less advanced meditation can bring scientifically demonstrable benefits: "As time goes on, we are understanding this phenomenon in ever more advanced scientific terms" said Dr Benson, president of the Mind/Body Medical institute and a Harvard Medical School associate professor studying body's relaxation response' for nearly 40 years. (IHT, 2005).

In November 2005, the International Herald Tribune reported a series of recent, yet unpublished researches presented at 35th Neuroscience Convention 2005 [3], praising the effects of meditation with an inaugural lecture from the Dalaï Lama. This convention reported striking findings:

- Massachusetts General Hospital researchers scanned the brains of 20 people who meditated regularly. These people had four regions of cortex – the rind of the brain, associated with higher functions like memory and decision making – that were thicker than in 15 subjects who did not meditate. In addition, the researchers found signs that one area of the cortex seemed to have aged less quickly than it did in non meditators. People who reached deeper states of relaxation exhaled more nitric oxide, a gas known to relax the smooth muscles in arteries, and aid blood flow.
- University of Kentucky found that meditation could offset the lethargy of sleep deprivation better than a nap, even for novice meditators.
- Buddhist monks have demonstrated that meditation can give them extraordinary powers of mind according to work by Olivia Carter of Harvard. Test on the powers of concentration of 76 Tibetan monks to whom different images in each eye where shown. The normal brain flip for normal people is of two images every 2.5 seconds, but the monks averaged about 4 seconds per eye and one monk reported focusing on one of the images for 723 seconds. Ultimately, scientists aim to understand not only the powers of the monks but the everyday experiences of an amateur who begins training late in his life: after six weeks of training his high blood pressure fell and he has more energy.

Neuroscience 2005 has innovated and expanded its boundaries by launching a new series of lectures, "Dialogues between Neuroscience and Society," featuring leaders from fields outside of neuroscience whose work relates to subjects of interest to neuroscientists. The evidence-based approach is bounding with more societal values as demonstrated by this event.

Many other researches on the link between health, prayer, meditation and other practices have been conducted[4] (ie for a review see: Pargament et al.1997; Koenig et al., 2001). Many more are done or under way in different countries and do not reach out to the scientific community. Those studies still need to develop irreproachable methodology and sound statistical analysis to be recognized and published.

Religious and spiritual practices have many other potential areas of study still not investigated such as in post-traumatic situations for mental and social care in the community (van Ommeren, Saxena and Saraceno, 2005). Religious and spiritual practices are also engrained in other health behaviours to include in the future such as the hygiene practices of hand or feet washing, and many others (Vachicouras, 2005). Studies would also gain visibility and credibility if they demonstrate how important religious and spiritual factors are for the community and translate the findings into public health and policy frameworks as stressed by Beaglehole et al. (2004).

CONCLUDING REFLECTIONS AND RECOMMENDATIONS

Evidence-based medicine and evidence-based public health (EBPH) will reproduce an intervention only if the intended outcome is achieved within a community (reduced mortality, improved quality of life, decreased risk factor prevalence or increased adoption of a healthy lifestyle).

From the above overview, it appears clearly that today all components are present for endorsing the proposal to modify the WHO definition of health mentioned at the beginning of this paper :

- To acknowledge that religious and spiritual practices fit the definition of public health given by Beaglehole et al., 2004: they are part of "a collective action for sustaining population health improvement" as well as Kohatsu's definition (2004) reflecting those practices are a community preference chosen by many for their own mental, physical, social and spiritual health.

- To recognize religious and spiritual practices as inherent to individual and collective health behavior and to include them as health determinants;

- Because prayer and other religious and spiritual practices in different parts of the world are so common a response to illness, researchers and health experts have a responsibility to investigate it.

Recommendations for addressing the theme of religion, spirituality and health can be drawn from the above analysis.

[3] http://web.sfn.org/am2005/

[4] See http://www.cognitiveliberty.org/neuro/Dalai_lama_brain.html

- *Conflict of interests* need to be clarified and a neutral objective line taken among scientists. Hope (1995) demonstrated that the questions addressed and the conclusions from systematic reviews are affected by the reviewer's own values. Objectivity criteria and ethical framework must be put in place to safeguard a neutral attitude at both ends of 'scientific extremism' (ultra-convinced vs ultra-skeptic). If evidence-based medicine can benefit from ethical critique so too can ethics benefit from the values of evidence-based medicine (Hope, 1995).
- *Doctor-patient relationship*: need to be revisited as many people find comfort in the face of illness and life crisis in religious or spiritual activities. While no ethical objection could be made when doctor and patients discuss medical issues in the context of a shared faith tradition, guidelines for appropriate ethical behavior and attitude in the face of different faiths are needed to respect each person's belief system.
- *Right to religious and spiritual care during hospital stay, terminal illness and end of life care*: should be respected as a human right (see Universal declaration of human rights, article 18 – beginning of this booklet). The health team has the duty to address the deepest health needs of a person to ensure quality of care and of life. The respect of the religious practices surrounding death is too often ignored and health care teams are helpless in front of certain rituals – a new area of expertise needs to be developed. If end-of-life care and dying/death rituals are not respected and done within the religious/spiritual values of the individual and the community, the scars left can carry on for generations to come (Stuckelberger, 2002). Therefore, Human Rights for older persons must be seriously addressed on the UN agenda – only very few specific comments and rights have been endorsed within the Human rights commission (Stuckelberger, 1999, 2005).
- *Limits of End-of-Life*: Advances in medical technology has lead to question the limits of life and death. Religion is claiming for ethical limits and respect of natural death. Technologically induced respiration, coma, etc. have lead the medical teams to maintain a human being artificially alive. Religious and spiritual leaders contest the limits of this practice in defining death as not only organic, but functional and addressing the lack of consciousness. For example, under established Jewish legal codes, it's forbidden to do anything to hasten death. But other teachings say it's permissible to remove an "impediment" standing in the way of the natural end of life, such as a feeding tube or respirator. Since the Harvard Committees bold and highly successful attempt to redefine death in 1968 (Harvard Ad Hoc committee, 1968), multiple controversies have arisen but no clear definition has yet been recognized. Most European nations, Canada, Australia, and Central and South American nations define death either as the loss of all independent lung and heart function or the permanent and irreversible loss of all brain function
- *Medical teaching curriculum* in the field of religion/spirituality is increasing in United States and in the world. The relevance of this subject is acknowledged through the fact that over 60 to 126 medical schools in the United States have initiated courses on religion/spirituality, and more are planning to do so (Koenig, 1999). Training scientists and researchers into adopting a neutral ethical attitude in the construction of research as well as in conducting it and interpreting its results.
- *Methodological Recommendations :*
    - *Mortality and Life Expectancy*: given the recently observed links between religion and longevity, we recommend that mortality and life expectancy researchers include more adequate measurements of religion in future studies.
    - *Adequate questionnaires and instruments*: instruments still need to be methodologically further refined. The WHO questionnaire on Quality of Life developed by Dr Saxena is a first step into offering an reliable and tested instrument to be applied in different settings (WHOQOL SRPB Group, in press). WHO field-test instrument covering quality of life aspects related to spirituality, religiousness and personal beliefs can be found and used from the following weblinks :

      http://www.who.int/mental_health/resources/evidence_research/en/

      a. WHOQOL-SRPB Users Manual Scoring and Coding for the WHOQOL SRPB Field-Test Instrument [pdf 216kb]

      b. WHOQOL-SRPB Field-Test Instrument WHOQOL [pdf 92kb] "*Spirituality, Religiousness and personal Beliefs"*

      The questionnaires developed should be mainstreamed in all researches involving population health, life style, behavioral changes and will allow to grow the body of research and increase the the understanding of those key cross-cultural factors related to health, quality of life and end-of-life issues (Saxena, O'Connell and Underwood, 2002). Too often overlooked, spiritual and religious factors in ageing and in collective memory building marks healthy and unhealthy behaviour patterns from generations to generations (Stuckelberger, 2002, in press).

      Specific quantitative faith-related questions should be mainstreamed in questionnaires, for example: Socio-demographic factors (i.e. what religion or spiritual movement are you affiliated to? What religion have you been educated in?), Behavioral (i.e. what religious practice? Frequency? Place? Collective vs individual?), Health appraisal (i.e. subjectively do you feel better after meditating, after praying, etc.), coping and health beliefs (Stuckelberger, 2000).
    - *Defining and classifying parameters in the different religious and spiritual practice:*

New factors need to be further developed and conceptualized which are core values of the community or of specific cultures: love[5], forgiveness, justice, healing, recognition, reconciliation, death concept, natural elements, etc.

Definition and criteria development for each religious or spiritual practice: for example, prayers vary in their purpose and content: some give praise, others petition for strength, many ask only that God's will be done. This demonstrates that behind practice measurement (frequency, duration, place of worship) other aspects will have to be better defined regarding deeper psychological components such as intention, intensity of conviction, beliefs. On the other hand, no one knows what constitutes a "dose" and the "concentration of this dose": some studies have tested a few prayers a day by individual healers, while others have had entire congregations pray together. Furthermore, different religions and spiritual groups can be subject to research and should be distinguished and compared: while some studies have involved evangelical Christians, Mormons or Muslims others have engaged rabbis, Buddhist, Hindus and new Age healers, or some combinations. Classification of parameters according to religions and their practices is indispensable for testing.

- *Background concepts are lacking:*

  Laying the hypothesis supposes a conceptual framework: the explanatory mechanisms underlying the cause-effect link between prayer and health which is not yet clear among researchers. Some are "neurotheologist" for whom it is all in the biology of the brain a type of "cellular auto-activation", some think prayers' effects – if they exist – have more to do with, "subtle energies", "mind to mind communication" or "extra dimensions of space-time", some suggest that prayer plays the role of a placebo for believers who know they are being prayed for. While some scientists are thrilled to demonstrate their own belief and faiths or prove the non-existence of effects, some other authors are outraged by the fact that scientists want to touch Religion which 'cheapens religion, and promotes an infantile theology that God is out there ready to miraculously defy the laws of nature in answer to a prayer'[6].

- *Funding*: Anyone wanting to proceed to a thorough scientific review of the subject will automatically be faced with the fact that the majority of 'peer-reviewed journals' and acknowledged scientific articles are Anglo-Saxon. Governments financing research on the religious and spiritual dimension in health must sometimes face the resistance of scientists. For example, in the United States intercessory prayer research began in the mid-1990's. Critics express outrage that the US federal government has financed $2.3 million over the last four years for prayer research and to spend taxpayer money to study something they say has nothing to do with science (New York Times, 2004).The westernized development of science has naturally created a selection of researchers and subject areas. Therefore the data presented address the effect of a specific region with specific religious or spiritual practice. More will have to be done in the future to encourage and encompass the different religious and spiritual practices in research on health.

Even though the literature indicates that religion is generally associated with health behaviors, health status, and longevity, further research on the specifics of this relationship is needed. On the other hand grassroots faith-based organisations are contributing substantively to the health of populations and are beginning to be recognized by the United Nations agencies and specialized programmes such as the recent UNFPA report "Culture Matters" (2004).

More can be done to improve coherence by strengthening the evidence linking health and development with religion and spirituality, in its positive and negative aspects. It will improve all aspects of health, quality of life, life expectancy and poverty reduction. Without health, a country cannot grow … Real impact cannot be achieved without a renewed effort by national governments - our governing bodies – to face the issues I have raised today: tackling health and other policy inconsistencies, getting research and religion right, and bringing together religion, spirituality, development and health in new and productive ways.

A lot of work lies on the table to bring more understanding and respect within the scientific mind and likewise more science and objectivity within the religious and spiritual reality in order to build a sustained and coherent public health policy prioritizing community needs for a higher dimension and meaning to health and human life.

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5 See for example text on Love and just behaviour, Pope Benedict XVI first Encyclical (25.1.2006) http://www.vatican.va/holy_father/benedict_xvi/encyclicals/documents/hf_ben-xvi_enc_20051225_deus-caritas-est_en.html

6 Rev. Raymond J. Lawrence Jr, director of pastoral care at New York Presbyterian Hospital, Columbia University Medical Center quoted in Carey Benedict "Can prayers heal? Critics say studies go past science's reach" New York Times, 10 October 2004.

References

Bainbridge WS (2004) , Religion and Science Futures, Vol 36 (9)

Barnes PM, Powell-Griner E, McFann K, Nahin RL. Complementary and alternative medicine use among adults: United States, 2002. CDC Advance Data Report #343. 2004. Accessed at nccam.nih.gov/news/report.pdf on January 17, 2005.

Beaglehole R., Bonita R., Horton R., Adams O. and McKee M. (2004). Public health in the new era: improving health through collective action, The Lancet, Vol. 363: 2084-2086.

Benedict Carey (10 October 2004). Can prayers heal? Critics say studies go past science's reach, The New York Times: New York. www.nytimes.com

Brownson RC, Baker EA, Leet TI, Gillespie KN (2003). Evidence-based public health. New York: Oxford University Press.

Brownson RC, Gurney JG, Land GH. (1999). Evidence-based decision making to public health, Journal of Public Health Manag. Practice, 6:86-97.

Chatters L. M. (2000). Religion and health: public health research and practice, Annual Review of Public Health, 21:335-67.

Comments by Shields Wright Karen (2004). The Association for Catholic Chiropractors, USA has adopted the definition of health of Pope John Paul II.

Committee on Assuring the health of the Public in the 21st Century. (2002). The future of the public's health in the 21st century. Washington DC: National Academy Press.

Herald Tribune International (24 November 2005). Techniques to manage the mind: New looks at the types, and effects, of meditation, Health and Science, p. 12. New York

Hope T. (1995). Evidence based medicine and ethics (Editorial), Journal of medical ethics, 21: 259-260. http://www.mbmi.org/about/articles/press/healing_prayers.pdf

Hummer RA, Rogers RG, Nam CB, Ellison CG. (1999). Religious involvement and U.S. adult mortality. Demography, 36(2): 273-85.

Jaffe DH., Eisenbach Z., Neumark Y.D. and Manor O. (2005). Does living in a religiously affiliated neighbourhood lower mortality? Annals of Epidemiology, Vol. 15 (10): 804-810.

Koenig HG, Larson DB and Larson SS (2001). Religion and coping with serious medical illness, The Annals of Pharmacotherapy, Vol. 35(3): 352-359.

Kohatsu ND, Robinson JG. and Torner JC. (2004). Evidence-based public health: an evolving concept, American Journal of Preventive Medicine, 27(5): 417-421.

McClain CS, Rosenfeld B, Breitbart W. Effect of spiritual well-being on end-of-life despair in terminally-ill cancer patients. Lancet. 2003;361(9369):1603-1607.

McCullough ME , Larson DB, Koenig HG , Lerner R (1999). The mismeasurement of religion in mortality research, Vol. 4(2): 183 – 194.

National Center for Complementary and Alternative Medicine. Mind-Body Medicine: An Overview. National Center for Complementary and Alternative Medicine Web site. Accessed at nccam.nih.gov/health/backgrounds/mindbody.htm on December 2, 2004.

National Institute of Health (2005). Prayer and Spirituality in Health: Ancient Practices, Modern Science, CAM at the NIH, Vol. 12(1) *http://nccam.nih.gov/news/newsletter/2005_winter/prayer.htm#overview#overview*

New York Times (10 October 2004) Can Prayers Heal? Critics Say Studies Go Past Science's Reach? by Benedict CAREY

Newsweek (10 November 2003). God & Health: Is Religion Good Medicine? Why Science Is Starting to Believe. Claudia Kalb, "Faith and Healing."

Newsweek (7 May 2001). Religion and the Brain by Sharon Begley.

Pargament K.I. (1997). The psychology of religion and coping: theory, research, practice. The Guilford Press: New York.

Roberts L., Ahmed I. and Hall S. (2000). Intercessory prayer for the alleviation of ill health. The Cochrane Database of Systematic Reviews, Issue 2. Art. No.: CD000368. DOI: 10.1002/14651858. CD000368.

Sackett DL, Rosenberg MC, Gray JAM, Jaynes RB, Richardson WS. (1996). Evidence-based medicine: what it is and what it isn't. BMJ, 312: 71-72.

Sackett DL, Straus SE, Richardson WS, Rosenberg W, Haynes RB (2000). Evidence-based medicine: how to practice and teach EBM. New York: Churchill Livingstone.

Saxena S., O'Connell, K. and Underwood L. (2002). Cross-cultural aspects of quality of life assessment at the end of life, The Gerontologist, 42: 81-85.

Stuckelberger A. (2000). Vieillissement et santé subjective: Déterminants et mécanismes différentiels hommes femmes à partir d'une étude transversale de la population genevoise. Rapport de thèse de doctorat no 286, Université de Genève, Faculté de Psychologie : Genève.

Stuckelberger A. (2002). Population Ageing & World Peace. Empowering Future Generations. Older Persons Role and Responsibility. Journal of Psycho-Social Intervention, Special Issue for the United Nations World Assembly on Ageing in Madrid (pp. 29-75). Madrid, Spain.

Stuckelberger Astrid (2005). Statement on Ageing and the Rights of Older Persons. 61st Session of the Commission on Human Rights, United nations, Geneva, 13 April 2005 – supported by 20 NGOs.

Statement on the web: http://www.ngocongo.org/ngosubs/CtteeAgeingStatement_HRC05_item14d.pdf

UNFPA (2004). Culture Matters, Working with communities and faith based organizations: case studies from country programmes. United Nations Population Fund, New York.

Vachicouras G. (2005). Hand Hygiene in Health Care Settings: an Orthodox Christian Perspective. Institute of Postgraduate Studies in Orthodox Theology, Chambésy, Geneva (unpublished Paper)

Van Ommeren M., Saxena Sh. And Saraceno B. (2005). Mental and social health during and after acute emergencies: emerging consensus? Bulletin of the World Health Organization, 83(1).

WHOQOL SRPB Group (in press). A cross-cultural study of spirituality, religion, and personal beliefs as components of quality of life, Social Science and Medicine.

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Spirituality and Health
the Example of Yogic Science of Breath

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"Health is a state of complete physical, mental and social well being
and not merely an absence of disease or infirmity."
World Health Organization

"The biggest mistake physicians make is attempting to cure the body without curing the mind.
The mind and the body are one."
Hippocrates, the father of modern medicine's Hippocratic Oath, ca 400 BC.

"There are two classes of diseases—bodily and mental. Each arises from the other, and neither can exist without the other.
Thus mental disorders arise from physical ones, and likewise physical disorders arise from mental ones."
Ancient Indian Epic Mahabarata

Introduction

It is a pleasure to be involved in this very timely discussion. As noted above, the description of health by the World Health Organization is very comprehensive, one that aims to include all layers of the individual. The influence of these different aspects of one's being giving rise to health or disease has been recognized for millennia. However, this recognition, and UN's very description of health, has not yet found its place firmly in our health systems today. I believe that in addition to the solid personal experience over millennia by different cultures, there is now enough scientific evidence which document the interplay of 'body and mind' and the role spiritual/religious practices play in this interaction. I therefore sincerely hope that this roundtable discussion will be the beginning of an exploration of this field for direct application in healthcare systems by policy makers around the world.

The main thesis of my presentation today is that physiology, mind/emotions, social support structure, spirituality/religious experience are intimately linked. The convergence of these states is stress and its relief. Spirituality or religious experience is very effective in fighting stress and thereby directly affecting the health of the individual and therefore health of the society. I will use the Yogic Science of Breath as an example to provide detailed support for this discussion.

Psychoneuroimmunology

The close connection between mind and body has been recognized since ancient times and has influenced the traditional healing arts from cultures around the world for millennia. Modern scientific recognition of this relationship began in the early 1900s, with broad investigations of psychosomatic phenomena beginning in the 1940s. In the last few decades, this line of research has greatly intensified. The importance of bi-directional interactions between the nervous, endocrine, and immune systems, and the relevance of this crosstalk to disease states, has been recognized and documented more widely than ever before. This has given birth to a new scientific field called Psychoneuroimmunology (PNI) (for reviews, see Ader, 1996; Kiecolt-Glaser et al., 2002). PNI is based on ancient principles that explore how both positive and negative thoughts, perceptions and emotions can affect bodily responses, specifically with regard to the onset and progression of disease states.

A rapidly growing body of research now robustly links psychological and behavioral factors to physiological parameters and to the incidence and biology of a broad spectrum of diseases, ranging from cancer to coronary heart disease, to asthma and HIV-1 infection (e.g. Levy et al., 1987; Redd et al., 1991; Andersen et al., 1994; Kiecolt-Glaser et al., 2002; Antoni, 2003). Evidence exists which links psychological factors to the incidence and progression of cancer (Kiecolt-Glaser and Glaser, 1999; Lewis et al., 2002; Thomas et al., 2002). For example, a number of studies document an association between life stress and higher incidence of cancer in the lung, breast and colon (Horne and Picard, 1979; Courtney et al., 1996). Similarly, numerous studies have shown that there is a significant increase in risk of cardiovascular disease and mortality in response to increased stress (e.g. Schekelle et al., 1983; Anda et al., 1993).

Yet, the very diagnosis and treatment of life threatening conditions often induces acute and chronic stress that can further exacerbate disease progression (e.g. Van der Pompe et al., 1996;

Ben-Eliyahu, 2003). Newly diagnosed cancer patients are often flooded with overwhelming emotions (i.e. fear, depression, anxiety, and anger) and uncontrollable stressors (i.e. increased medical costs, financial hardship, social stigmatization, deterioration of health) which may reduce cellular immune functions (Herbert and Cohen, 1993). Fortunately, current research has also shown that this effect can be mitigated, and that psychological and immunological functioning can be enhanced through certain cognitive behavioral stress management programs (CBSM). The mental and physical health benefits of such interventions may be mediated by specific endocrine and/or immune system changes (Kiecolt-Glaser and Glaser, 1992; Fawzy et al., 1993; Andersen et al., 1994).

Exemplified by this brief review, stress has an important role in the etiology of most diseases. Yet, if one looks at the website of the World Health Organization where all health related topics are listed, stress is not to be found! (www.who.int/topics/en/). This is a reflection of the general medical practice and health systems around the world where the role of stress and its relief is not duly considered for promotion of health and alleviation of disease.

How to relieve stress?

There are many different ways by which stress can be handled—time management, diet, exercise, massage therapy, yoga, meditation, religious practices…I would like to suggest that the most effective way to relieve stress is through spiritual and religious practices. I will give some examples to support this view.

In a study on rosary prayer (Christian tradition) and chanting of yoga mantras it was found that these practices had very beneficial effects on cardiovascular rhythms—heart rate variability and baroreflex sensitivity were enhanced which are predictors of heart disease when reduced (Bernardi et al., 2001). It was found that recitation of the rosary of yoga mantra chanting slowed respiration down to almost exactly 6/min and this was correlated to the effect observed. Thus, these religious/spiritual practices may be viewed as a distinct health practice!

In a randomized, controlled trial, in patients with osteoarthritis, pain, tenderness, and finger range of motion were shown to improve after 8 weeks of yoga training (Garfinkel et al., 1994, 1998). Furthermore, significant decrease in pain intensity in patients with carpal tunnel syndrome was observed.

Another interesting study determined hospitalization and doctor visits in 2000 people before and after they learned a meditation practice (Orme-Johnson, 1987). It was found that after learning meditation, both doctor visits and hospitalization were markedly decreased; for example, there was 87% less cardiovascular disease and 73% less nose, throat and lung problems. There was obviously a tremendous benefit for society on all levels.

The Yogic Science of Breath

I would now like to focus on the Yogic Science of Breath to provide further, more detailed evidence for the role that spiritual practices can play for health promotion. Yogic breathing practices have been used as a tool for health promotion for millennia. The leading exponent of Yogic Science of Breath in the world today, Sri Sri Ravi Shankar, states: ’Breath and mind are linked like body and mind. Breath sorts out the imbalances in the mind and body. It’s the secret of life we have forgotten.’’

The central stress management breathing practice that is taught by the Art of Living Foundation founded by Sri Sri Ravi Shankar, is known as Sudarshan Kriya (SK). SK is a unique rhythmical breathing practice traditionally understood to dissolve emotional distress and create the subjective experience of rest and well-being. It is taught during a course that lasts 4-6 days after which participants receive a 20-30 minute daily program to continue independently at home. This course and the home practice regimen have been reported to lead to significant improvements in emotional and physical well-being in individuals regardless of age, sex, religion, and socioeconomic status, educational or cultural background. Some of the research studies on SK and related practices (SK&P) are briefly reviewed below.

SK&P and psychosocial distress

As reviewed above, there is good evidence that emotional/psychological distress can be a significant factor in the genesis of disease. Several studies on SK&P have shown it to be very effective in the management of psychological disorders. For example, in an open, three-month clinical trial of dysthymic (chronic, mild depression) and moderately depressed patients, SK&P was used as the sole treatment. It produced significant antidepressant effects and a remission rate of 68% within four weeks (Janakiramaiah et al., 1998). Several studies have demonstrated that SK&P has important antidepressant effects (Murty et al, 1998: Janakiramaiah et al., 2000). In one study, drug-free depressed patients received SK&P as the sole treatment and were assessed clinically at pretreatment, or 1 month and 3 months after treatment (Murty et al., 1998). SK&P was found to be

uniformly effective against depression, regardless of the severity of biological function as indicated by P300 ERP EEG recordings. Concurrent with remission (as measured by the Beck Depression Inventory, Hamilton Self Rating Scale for Depression and Psychiatric Evaluation) was normalization of P-300 ERP, a measure of expected response to treatment. In the second study, a prospective, randomized, controlled trial on melancholic depressive patients, the antidepressive activity of SK&P was compared with those of a common drug, Imipramine, or electroconvulsive therapy (ECT) (Janakiramaiah et al, 2000). SK&P intervention resulted in a 67% remission rate at four weeks which was comparable to Imipramine, and almost as effective as ECT. This suggests that SK&P is a potential non-invasive treatment alternative to drugs and ECT in melancholia.

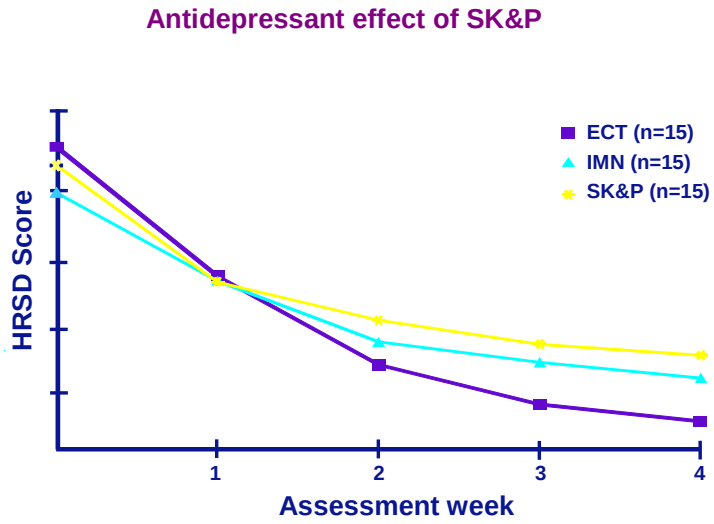

Figure 1. The antidepressive activity of SK&P compared with those of a common drug, Imipramine, or electroconvulsive therapy (ECT) (Janakiramaiah et al, 2000).

SK&P and Immune Changes

Numerous studies have shown that psychological stress can affect many aspects of immune function (e.g. Glaser et al., 1987; 1992; Malarkey et al., 1995). Given the efficacy of SK&P in relieving psychological stress, noted above, possible immune system changes were assessed in individuals who practice this program. In one study, total levels of T lymphocytes and its T-helper subset (involved in B lymphocyte activation and amplification of the immune response) along with NK cells were compared among normal controls, cancer patients in remission and SK&P teachers (Das et al., 2002). Whereas there was no significant difference in the T cell populations between the control and SK&P groups, both of which displayed higher T cell counts than the cancer patients, SK&P teachers displayed significantly higher circulating NK cells compared with both the control group and the cancer patients. In another study, the NK cell levels were determined in 16 cancer patients in remission before and after they learned the SK&P (Devinder et al., 2002). Data suggest that there is a significant increase in NK cell number with SK&P practice. These studies indicate beneficial changes in the immune system in SK&P practitioners.

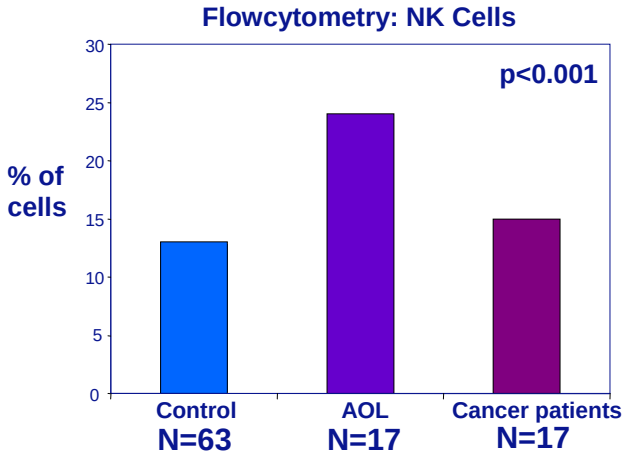

Figure 2. Improvement in the NK cell count in people who practice SK&P (AOL) compared with either control subjects or cancer patients (Devinder et al., 2002).

SK&P and Oxidative Stress

Oxidative stress may contribute to the pathophysiology of many different diseases including cancer (Cooke et al., 2003). Since previous studies have suggested a link between psychosocial and oxidative stress (e.g. Adachi et al., 1993; Scarpellini et al., 1994) and given the effectiveness of SK&P against psychosocial stress as reviewed above, a study

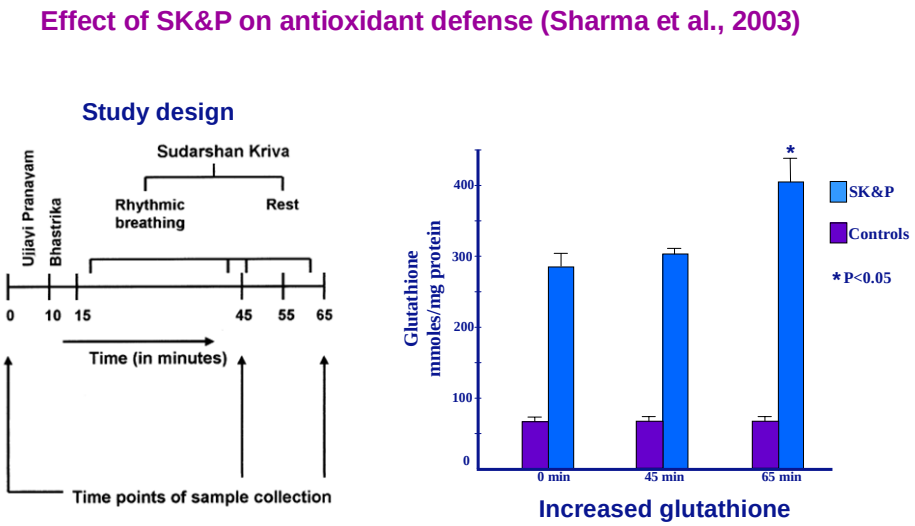

Figure 2. Significant increases were observed in the antioxidant defense mechanisms in people practicing SK&P compared with control subjects. Blood was drawn at the indicated time points and then assayed for the levels of glutathione, a major defense enzyme against oxidative damage (Sharma et al., 2003).

was conducted to assess the possible effect of SK&P on various physiological parameters of oxidative stress (Sharma et al., 2003). Significantly lower levels of blood lactate were found in practitioners of SK&P compared with the control group. Conversely, the levels of superoxide dismutase (SOD), catalase, and glutathione, three major defenses against oxidative stress were all found to be significantly higher in SK&P practitioners compared with the control group. These data suggest that people who practice SK&P have an improved antioxidant status and a better defense against oxidative stress.

SK&P and stress hormone cortisol

There are also indications that SK&P results in changes in the blood chemistry of critical hormones. For example, two studies assessed possible effect of SK&P on serum cortisol levels, a hormone that is regulated through the HPA axis, as reviewed above, and is closely associated with the stress response (McEwen, 1998). The first study compared steady state levels of cortisol in 21 individuals 35-50 years of age. Regular SK&P practitioners were compared with beginners, and measurements were made in beginners during SK&P compared with listening to classical music. SK&P practitioners had significantly lower blood cortisol levels at baseline indicating that they are less stressed compared to beginners. There was a further fall in serum cortisol levels during SK suggesting that SK&P is the cause of this decline. Among beginners, the fall in cortisol levels was greater during SK compared with when they were just listening to classical music, suggesting that SK&P is more deeply relaxing than listening to music.

Other research findings on SK&P

Various additional studies indicate that SK&P results in improved physical and psychological health. To study the long-term effects of SK&P on brain function, EEG changes were recorded in 19 SK&P practitioners outside of the practice of SK&P, and compared with controls (doctors and researchers who did not practice SK&P, yoga, or meditation). All subjects were sitting comfortably throughout the session (Bhatia et al., 2003). There was no significant difference between the two

groups in EEG alpha or theta wave activity. However, a significant increase in beta activity, was observed in SK&P practitioners in the left frontal, occipital, and midline regions of the brain compared with controls ($p<0.05$). These results are interpreted by neurologists as indicative of heightened awareness/mental focus.

To examine brain function during SK&P, EEG was studied in 5 female practitioners with similar age, socioeconomic and educational background. There was an increase in EEG alpha activity with interspersed persistence of beta activity. This indicates a state of relaxation co-existing with heightened alertness during SK&P.

One of the major diseases that are affected by psychosocial stress is coronary heart disease (CHD). The basic pathology in CHD is deposition of LDL cholesterol, fat, and other substances to the arterial walls which slows or blocks the flow of blood. A study was conducted to assess the lipid profile of individuals before they learned SK&P, as well as after 7 and 45 days of regular practice. A significant drop in total cholesterol and LDL (harmful) cholesterol and an increase in HDL (beneficial) cholesterol were observed (Geetha et al., 2002). These findings suggest that SK&P improves the blood lipid profile and may therefore be an effective tool in preventing CHD and hypertension.

In an ongoing study, gene expression profiles in peripheral blood lymphocytes were determined and compared before and after the practice of SK&P, or in a control group before and after they listened to classical music with their eyes closed (Saatcioglu et al., 2005). Interestingly, there were unique gene expression clusters in people who practiced SK&P, compared with the control group, suggesting that SK&P affects the physiology at a very fundamental level, the level of gene expression. It is necessary to expand this pilot study and would be interesting to analyze the individual genes that are differentially regulated between the two groups which may give clues to the molecular mechanisms through which SK&P functions.

Conclusion

The constant communication between the nervous, endocrine and immune systems and the' relevance of this crosstalk to disease states through regulating the impact of stress on the physiology is now well documented. The time is ripe to responsibly integrate psychosocial and physiological interventions which are provided by the spiritual/religious practices into current medical protocols, both for prevention of illness and for the treatment of individuals who suffer from serious diseases. Furthermore, I believe that these practices should be included as an integral part of government health policy. Various practices may be considered in this regard with benefits documented by scientific research. SK&P provide a robust and easily implemented strategy that may fill this need and that supports existing protocols and appears to be beneficial from a physiological, psychological, financial and humanitarian perspective. In addition to the policy issues, in the future, larger, better controlled scientific studies on the psychosocial interventions derived from spiritual practices need to be conducted for validating and extending the current findings.

References

Ader R. Historical perspectives on psychoneuroimmunology. In: Friedman H KT, Firedman AL, editor. Psychoneuroimmunology, stress, and infection. Boca Raton: CRC Press; 1996. p. 1-24.

Aggarwal D, Bhatnagar, S., Dash, C., Leekha, S., Guha, S., Bhardwaj, N., Goswami, R., Gupta, N., Kochupillai, V. A comparison of Serum Cortisol Levels Before and After Pranayam and Sudarshan Kriya. Presentation at the All India Institute of Medical Sciences (AIIMS) Conference, New Delhi, India, 2002.

Andersen BL, Kiecolt-Glaser JK, Glaser R. A biobehavioral model of cancer stress and disease course. Am Psychol 1994;49(5):389-404.

Antoni MH. Psychoneuroendocrinology and psychoneuroimmunology of cancer: Plausible mechanisms worth pursuing? Brain Behav Immun 2003;17 Suppl 1:S84-91.

Ben-Eliyahu S. The promotion of tumor metastasis by surgery and stress: immunological basis and implications for psychoneuroimmunology. Brain Behav Immun 2003;17 Suppl 1:S27-36.

Bernardi L, Sleight P, Bandinelli G, Cencetti S, Fattorini L, Wdowczyc-Szulc J, Lagi A. Effect of rosary prayer and yoga mantras on autonomic cardiovascular rhythms: comparative study. BMJ. 2001 Dec 22-29;323(7327):1446-9.

Cooke MS, Evans MD, Dizdaroglu M, Lunec J. Oxidative DNA damage: mechanisms, mutation, and disease. Faseb J 2003;17(10):1195-214.

Courtney JG, Longnecker MP, Peters RK. Psychosocial aspects of work and the risk of colon cancer. Epidemiology 1996;7(2):175-81.

Das SN, Kochupillai, V., Singh, D., Aggarwal, D., Bhardwaj, N. Flowcytometric Study of T-Cell Subset and Natural Killer Cells in Peripheral Blood of Art of Living Teachers, Normal Subjects and Cancer Patients. . Presentation at the All India Institute of Medical Sciences (AIIMS) Conference, New Delhi, India. April 2002 2002.

Devinder SS, Das, S.N., Saurabh,V., Aggarwal, D., Bhardwaj, N.K., Kochupillai,V. Devinder, S.S., Das, S.N., Saurabh,V., Aggarwal, D., Bhardwaj, N.K., Kochupillai,V. Immunological Study of Cancer Patients Before and After Sudarshan Kriya and Pranayam.(2002). Presentation at the All India Institute of Medical Sciences (AIIMS) Conference, New Delhi, India. April 2002.

Fawzy FI, Fawzy NW, Hyun CS, Elashoff R, Guthrie D, Fahey JL, et al. Malignant melanoma. Effects of an early structured psychiatric intervention, coping, and affective state on recurrence and survival 6 years later. Arch Gen Psychiatry 1993;50(9):681-9.

Garfinkel MS, Schumacher HR Jr, Husain A, Levy M, Reshetar RA. Evaluation of a yoga based regimen for treatment of osteoarthritis of the hands. J Rheumatol. 1994 Dec;21(12):2341-3.

Garfinkel MS, Singhal A, Katz WA, Allan DA, Reshetar R, Schumacher HR Jr. Yoga-based intervention for carpal tunnel syndrome: a randomized trial. JAMA. 1998 Nov 11;280(18):1601-3.

Geetha H. Effect of Sudarshan Kriya Practice on Lipid Profile and Lipid Peroxidation in Normal Individuals. Presentation at the All India Institute of Medical Sciences (AIIMS) Conference, April 2002, New Delhi, India 2002.

Glaser R, Rice J, Sheridan J, Fertel R, Stout J, Speicher C, et al. Stress-related immune suppression: health implications. Brain Behav Immun 1987;1(1):7-20.

Herbert TB, Cohen S. Stress and immunity in humans: a meta-analytic review. Psychosom Med 1993;55(4):364-79.

Horne RL, Picard RS, Carrier Foundation BMNJ. Psychosocial risk factors for lung cancer. Psychosom Med 1979;41(7):503-14.

Janakiramaiah N, Gangadhar BN, Naga Venkatesha Murthy PJ, Harish MG, Subbakrishna DK, Vedamurthachar A. Antidepressant efficacy of Sudarshan Kriya Yoga (SKY) in melancholia: a randomized comparison with electroconvulsive therapy (ECT) and imipramine. J Affect Disord 2000;57(1-3):255-9.

Kiecolt-Glaser JK, Glaser R. Psychoneuroimmunology: can psychological interventions modulate immunity? J Consult Clin Psychol 1992;60(4):569-75.

Kiecolt-Glaser JK, Glaser R. Psychoneuroimmunology and cancer: fact or fiction? Eur J Cancer 1999;35(11):1603-7.

Kiecolt-Glaser JK, McGuire L, Robles TF, Glaser R. Psychoneuroimmunology and psychosomatic medicine: back to the future. Psychosom Med 2002;64(1):15-28.

Levy S, Herberman R, Lippman M, d'Angelo T. Correlation of stress factors with sustained depression of natural killer cell activity and predicted prognosis in patients with breast cancer. J Clin Oncol 1987;5(3):348-53.

Lewis CE, Barraclough OBR, J. Psychoimmunology of cancer. In: Lewis CE OBR, Barraclough, J, editor. Oxford: Oxford University Press; 2002.

McEwen BS. Protective and damaging effects of stress mediators. N Engl J Med 1998; 338(3):171-9.

Naga Venkatesha Murthy PJ, Janakiramaiah N, Gangadhar BN, Subbakrishna DK. P300 amplitude and antidepressant response to Sudarshan Kriya Yoga (SKY). J Affect Disord 1998;50(1):45-8.

Orme-Johnson. Medical care utilization and the transcendental meditation program Psychosom Med 1987 Nov-Dec;49(6):637

Redd WH, Silberfarb PM, Andersen BL, Andrykowski MA, Bovbjerg DH, Burish TG, et al. Physiologic and psychobehavioral research in oncology. Cancer 1991;67(3 Suppl):813-22.

Scarpellini F, Sbracia M, Scarpellini L. Psychological stress and lipoperoxidation in miscarriage. Ann N Y Acad Sci 1994;709:210-3.

Sharma H, Sen S, Singh A, Bhardwaj NK, Kochupillai V, Singh N. Sudarshan Kriya practitioners exhibit better antioxidant status and lower blood lactate levels. Biol Psychol 2003;63(3):281-91.

Thomas BC, Pandey M, Ramdas K, Nair MK. Psychological distress in cancer patients: hypothesis of a distress model. Eur J Cancer Prev 2002;11(2):179-85.

Van der Pompe G, Antoni M, Visser A, Garssen B. Adjustment to breast cancer: the psychobiological effects of psychosocial interventions. Patient Educ Couns 1996;28(2):209-19.

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Role of Faith in the Global Response to HIV and AIDS

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I consider it a great honour to have been invited to join you in this panel discussion. While the overall topic for the panel is a broad-ranging and comprehensive one, I will restrict my remarks to a field in which my efforts, both as a Roman Catholic priest and as a professionally-trained social worker, are concentrated almost exclusively at the present time, that of the faith-based response to the global pandemic of HIV and AIDS. Why such an apparently "narrow" focus to my work? I doubt that it is necessary to remind this knowledgeable audience that there is hardly any aspect of practice and policy-setting within the pursuit of health care science that is not affected by the pandemic of HIV and AIDS. In fact, in many parts of the world, one cannot find an individual whose life has not been deeply affected by the presence of this virus in his or her own body or in that of a loved one, family member, or neighbour. In view of the staggering numbers of persons presently living with HIV (estimated at 39.4 million at the end of 2004), the unrelenting number of new infections (some 5 million annually in recent years), and the number of people who have died, often at an early age, as a result of AIDS-related illnesses (more than 3 million in 2004 alone)7, this pandemic demands a concerted effort by all those who subscribe to the laudable but still-unattained goal of "Health for All". In his report to the 59th United Nations General Assembly on the "Progress made in the implementation of the Declaration of Commitment on HIV/AIDS," Secretary General Kofi Annan urgently makes the following observation:

> *The most damaging aspect of the epidemic may be its tendency to sever the generational ties on which societies depend for the transmission of values, cultural norms and practical know-how. By targeting the young, working-age adults, AIDS unleashes a chain of events that threatens to cause entire societies to unravel. In short, AIDS is an exceptional problem which demands an exceptional response.* [8]

In recent years, the global response to HIV and AIDS has been transformed from one that focused almost exclusively on clinical care and management of opportunistic infections and other life-threatening illnesses related to the "clever" destruction of the immune systems in those individuals whose bodies had been "invaded" by the Human Immuno-Deficiency Virus to a multi-sectoral approach that engages all sectors of both governments and society-at-large. In fact, in the report which I just mentioned, the U.N. Secretary General acknowledged in a hopeful manner:

> *Since 2001, there has been a dramatic change in global action to combat AIDS. Political commitment to fight against AIDS, sorely lacking in the early stages of the epidemic, has markedly increased at the national, regional, and global levels.* [9]

Despite this broadened perspective on the necessary elements to be included in the global response to the pandemic, it is my impression that the role of faith and of faith-based organisations often, at best, is ignored and, at worst, is misrepresented or even "demonized" as being responsible for much of the negative impact of this disease. For example, in a draft report on HIV prevention to be reviewed in June 2005 by the UNAIDS Programme Control Board, mention is made of "religious barriers" as one of several "obstacles to the scaling up of HIV prevention", yet no recognition is given to the crucial role of faith-based organisations in promoting responsible sexual behaviour as an effective and valid way to prevent the widespread transmission of HIV.

This observation brings me to the major question to be addressed in my presentation: How does Faith and Religion enter into the global response to HIV and AIDS? Perhaps the most obvious way is through the call issued, from the deep roots of most major faith traditions, for their believers to address the needs of their neighbours who are most vulnerable. The Jewish call to mend the very fabric of our broken world and the Christian call to respond to the needs of the hungry, thirsty, sick, and imprisoned as they would to the needs of Jesus Himself are two excellent examples of the motivational force of religion in the struggle against HIV and AIDS. In his Foreword to the recently-

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[7] *AIDS Epidemic Update – December 2004, UNAIDS, Geneva, UNAIDS/04.45E, 2004.*

[8] *"Progress made in the implementation of the Declaration of Commitment on HIV/AIDS," Report of the Secretary-General, United Nations General Assembly, 59th Session, Agenda item 43, A/59/765, 4 April 2005, p. 5.*

[9] *Ibid., p. 3.*

published report entitled, *Faith in Action: Examining the Role of Faith-based Organizations in Addressing HIV/AIDS,* which was prepared by the Catholic Medical Mission Board and the Global Health Council, Archbishop Desmond M. Tutu writes:

> *There is an expression we use in South Africa called Ubuntu, loosely translated as "a universal bond of sharing that connects all humanity." Ubuntu stresses that we belong together; our destinies are bound in one another's … You are my sisters and my brothers, whether you consider yourself a Buddhist, Christian, Hindu, Jew, Muslim or agnostic, and we must treat each other as such. We must respect each other, as each one of us is a precious individual. We must stand shoulder to shoulder, heart to heart in the fight against HIV/AIDS.*[10]

Such strongly-held values have inspired faith-based organisations to provide some 50% of health care services in many developing countries. The Vatican's Pontifical Council on Health Care estimates, in fact, that at least 25% of all HIV/AIDS-related services are sponsored by the Catholic Church, and the Catholic AIDS Funding Network group of emergency relief, development, health and social service, and mission organisations, for which I am privileged to serve as chairperson, has calculated that faith-based organizations within the Catholic tradition either support or directly sponsor HIV/AIDS services in some 102 countries of the world.

The second and perhaps most unique and important area of the faith-based response to HIV and AIDS is that of spiritual accompaniment and pastoral care. In reporting the findings of their multi-country, key informant survey, the Catholic Medical Mission Board and Global Health Council state the following:

> *Nearly all interviewees feel that spiritual and social support is a key component of FBOs' work. The provision of hope, compassion, and acceptance is considered by most as a first level of care that must be offered and underlies all other services.*

One key informant in this survey stated quite emphatically:

> *[If] you are to take a holistic approach to any issue that people are wrestling with, you can't leave the spiritual dimension out. We can respond to needs but if the spiritual need is not met, and if one's wrestling with the nature of God – I think there are a number of things that government cannot respond to, that churches need to deal with.*[11]

Speaking from personal experience, Mr. Peter Randall eloquently described the urgent need of people living with HIV/AIDS to confront the aspects of human life that reach far deeper than the immediate and the physical realms:

> *One of the greatest problems encountered by people with AIDS is to find the meaning of their experiences … During their search, what is needed is a place in which these persons do not have to be faced constantly with the feelings and attitudes of despair … while they take into account the fact that their bodies continue to lose control and that they no longer are able to nourish themselves. They will try to arrive at the stage in which the mind separates from the body, given the fact that the body is less and less able to take care of itself.*[12]

With your permission, I would like to add my own personal testimony in this regard. One of the most moving experiences in my life occurred when I accompanied Sr. Ursula Sharpe and her Mobile Home Care Team from Kitovu Hospital in Masaka, Uganda, to a rural village in the neighbouring Rakai District. After struggling to pass through much dust, roads in great disrepair, and the thick vegetation of banana plants, we stopped at the home of an old Muslim merchant. He offered us places of honour in his humble house. We exchanged pleasant greetings and asked about his family which consisted of several wives and children. Then he asked Sr. Ursula to examine and treat the purulent sores on his buttocks and to pray with him. During this curiously sacred moment, I experienced a great advance in my understanding of the mission of the Church and of human nature. At that moment, there was no more difference between the white Christian woman and the black Muslim man. In that hot and dirty house, we found our true and common identity – the identity of sons and daughters of the one Creator, sons and daughters who feel a deep relationship and a call to give praise to the merciful God who offers sufficient love to all God's children.

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[10] *Faith in Action: Examining the Role of Faith-Based Organizations in Addressing HIV/AIDS: A Multi-Country, Key Informant Survey.* Published by the Global Health Council and Catholic Medical Mission Board, 2005, p. 3.

[11] *Ibid., pp. 33f.*

[12] *As quoted in William Kirkpatrick, AIDS: Sharing the Pain, London: Darton, Longman, and Todd, 1988.*

Limitation in time will force me to restrict my presentation to one final aspect of the role of faith in the global response to HIV and AIDS – that of defending and promoting respect for the human rights of all who are affected by the pandemic. I have no intention of defending the small but vocal minority of religious leaders who have furthered the stigmatization of people living with HIV by claiming that the disease is God's punishment on those whose lifestyles do not conform to religious teaching and values. I believe that these people of so-called faith are seriously mistaken in their understanding of God and of God's inter-action with the human family. I daresay that significant numbers of religious leaders not only defend the rights of people living with HIV but also counteract the fear and prejudice toward the disease which is found among the general public. Less than one month after his election as the leader of the Catholic Church, Pope Benedict XVI, focused on human rights as a priority concern by saying to the Diplomatic Corps accredited to the Holy See:

> *… the Church does not cease to proclaim and defend fundamental human rights, unfortunately still violated in different parts of the world, and works so that the rights of every human person will be recognized [- rights] to life, food, a roof, work, health care, protection of the family, the promotion of social development, and respect of the dignity of man and woman, created in the image of God.*[13]

Moreover, especially through his own personal witness and example of visiting with and listening to those affected by this pandemic, the late Pope John Paul II discouraged any type of HIV-related stigmatizing or discrimination.

Spirituality and religion can and should exert much positive influence and action on the overall situation of social health in the world. In the case of HIV and AIDS, faith-based principles and values have motivated effective services, have assisted those affected to discover the God-given meaning and values of their lives despite the trauma and suffering wrought by the disease, and have insisted on respect for the human rights of such persons. In my opinion, the Catholic bishops of the United States offered a true "litmus test" to the effectiveness of the faith response to HIV and AIDS when they said:

> *Our response to the needs of persons with AIDS will be judged to be truly effective when we discover God in them and when they, through their encounter with us, are able to say, "In my pain, fear, and alienation, I have felt by your presence, a God of strength, love, and solidarity.*[14]

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[13] *Benedict XVI's Address to Diplomatic Corps, "Overcome Temptation of Clash of Civilizations", VATICAN CITY, MAY 12, 2005 (Zenit.org).*

[14] *United States Catholic Conference Administrative Board, The Many Faces of AIDS: A Gospel Response, in Origins, XVII, 28 (December 24, 1987), p. 136.*

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