Religious coexistence in health-seeking: an ethnographic study in a Pentecostal Hospital, Madina, Accra, Ghana

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General Conclusion

In conclusion, I summarise the most salient findings in light of the thesis's central and sub-questions. I further discuss the importance of hospital ethnography as a tool for understanding religious coexistence and suggest how this concept could be explored through the lens of hospital ethnography in future studies.

As indicated in the introductory chapter, Soares (2016, p. 676), has argued that earlier studies (Sanneh, 2015, 1996; Hock, 2004; Von Sicard, 2007; Kukah, 2007) on religious coexistence have cast the relation in a binary dichotomy of peaceful versus conflictual. Largely coming from the fields of missiology and theology, such studies have focused on coexistence in generic and normative ways, rather than exploring actual practices of coexistence. This is important in order to understand how people live with their differences in an everyday and pragmatic manner (Meyer, 2024, p. 2; Janson et al., 2024, pp. 1-2; Soares, 2016, 2006).

To research actual modalities of coexistence is the prime aim of the Madina project, of which this dissertation is part. I undertook the ethnographic research on which this thesis is based to examine how Muslim clients and patients in pursuit of their health challenges relate to Christian health providers in everyday encounters. Furthermore, health issues and health-seeking produce specific dynamics in bringing people together and reinforcing coexistence, in that many people seeking health for their health challenges in Madina are most often pragmatic rather than dogmatic. Thus, the central question for the study was: How does an ethnographic study of health-seeking by Muslims in a Christian-managed health facility, Pentecost Hospital in Madina, expand/inform and contribute to academic discussions on the practice of everyday religious coexistence within a religiously and ethnically plural urban setting?

The above central question has been segregated into sub-questions, which were addressed in the subsequent chapters. The first sub-question, addressed in Chapter One, was: What is the status of Ghana's healthcare delivery system, and what is the role of religious bodies in health provisioning within a secular constitutional arrangement? In examining the status of the healthcare delivery system in Ghana, I showed that the healthcare delivery system is pluralistic, consisting of public, private, and traditional or indigenous health facilities. I showed that the Ministry of Health is responsible for formulating, regulating, coordinating, and monitoring (the implementation of) health policies. In doing so, I demonstrated that the primary goal of the Ministry of Health (MoH) is to have a healthy population for national development. I showed that while great strides have been made in the health delivery system in Ghana, it is also

challenged with several issues, such as regulatory inadequacies due to insufficient personnel, failing logistics, and funding constraints. The overall consequences of these challenges are a rather heterogeneous system characterised by sub-standard practices in some health facilities. I further indicated that government funding for health in Ghana has declined from 12% to 6% between 2012-2018. This challenge also poses a threat to public health for ordinary Ghanaians. Besides the above challenges, I showed that the state policy document The Health Sector Medium Term Development Plan (HSMTDP 2022-2025) of the MoH outlines challenges such as inequitable distribution of human resources for health, inadequate infrastructure, logistics, equipment, and sub-optimal quality of care at all levels of the health delivery system.

I explained that private participation in the healthcare delivery system is indispensable for the ministry to achieve its goal and minimise its challenges. The private healthcare delivery system is categorised into self-financing, that is, for-profit, not-for-profit, and mission or faith-based facilities. I explained that the Pentecost Hospital operates within the context of health provisioning by faith-based organisations.

I further discussed the Christian Health Association of Ghana as an amalgamated grouping of all Christian health facilities in Ghana. Indeed, the CHAG is the second largest provider of health services and contributes between 30% and 35% of the total health needs of the population of Ghana. I pointed out that the main aim of the formation of the CHAG was to encourage and promote the highest Christian standards in medical care for the citizens of Ghana. I further indicated that the mission of CHAG, as shared by its institutional members, is [88]'to promote the healing ministry of Christ and to be a reliable partner in the health sector in providing the health needs of the people of Ghana in fulfilment of Christ's mandate to heal the sick'. The core values of CHAG and its member institutions are 'having a Christian identity', offering 'an option for the poor and marginalised' and adopting a 'holistic healthcare approach to resolving health challenges'. These are essential pillars in understanding the workings of the CHAG and its member institutions in providing health services to the patrons who patronise their health facilities. The implications for health delivery under such a model are the creation of moments of tension between the patients visiting these facilities and the managers, as I demonstrated from the standpoint of the Pentecost Hospital.

I pointed out that, unlike the CHAG, there is no unified body for Muslim health providers in the health delivery space in Ghana. I further showed that within the La Nkwantanang-Madina

[88] https://chag.org.gh/vison-mission/

Municipality, the healthcare options available to residents were the Madina Polyclinic (the only public health facility in the municipality), several for-profit health facilities, two faith-based health facilities, and a wide range of traditional health facilities. I indicated that the private-for-profit fees deter many residents from patronising their services. This situation has left many residents to depend on the indigenous and mission facilities for their healthcare needs. My research revealed that the Islamic health facility in the municipality offers limited healthcare services to its clients. It has a general practitioner (GP) and a retired nurse providing services to potential clients. This shortfall in the provision of allopathic services in the municipality has made the Pentecost Hospital the go-to place for residents within the municipality. This situation affirms the position made by the president of the Ghana Catholic Bishops' Conference in 2017 to the effect that health service provisioning by the Christian religious groups in Ghana is recognised as the second largest provider of health services in Ghana, with about 30% to 35 % share of health service output. He indicated that collectively, the Christian health providers have offered health, healing and hope to millions of people, including mothers, children, the aged and the disabled. This status, recognised by the state, makes the CHAG a very powerful organisation in the health delivery space in Ghana.

I showed that even though Ghana is a secular state, religion permeates almost every aspect of the social structure. Quashigah (2015, p. 332) has argued that the tone and preamble of the 1992 Constitution of Ghana make the country a religious-secular nation. Within the above context, I argued that Ghana operates a political and pragmatic secularity, where there is a strong relationship between religion and the state. This is manifest in the performance of state functions where prayers are offered by the Christian leadership, the Muslim leadership, and sometimes by a traditional priest. Since Ghana has a Christian population of about 70%, the relationship between the state and religion is particularly strong with the Christian Churches. The pervasive nature of religion in the body politic of Ghana finds expression in the Constitution, where state organisations are mandated in Article (166; 1a, V, and VI) to have specific representations from both the Christian and Muslim groups in management, but the number of the Christian groups on such boards far out-number that of the Muslim group. Tellingly, and in my view unfortunately, such religious representations do not include traditional and other minority faiths.

I demonstrated that secularity in Ghana is an adaptive concept when it comes to health provisioning. I showed that the state has little or no control over the day-to-day practice of religious organisations providing healthcare services for the citizenry. This allows religious

organisations to push their religious convictions as part of the health services they provide. Focusing on the Pentecost hospital in Madina, I showed that such arrangements often create tension between clients and facility managers. These tensions stem from the understanding or misunderstanding of religious liberties guaranteed in the 1992 Constitution. While the Constitution allows all citizens to believe in and manifest their religious faith, the facility's managers also argue that their actions are premised on the Constitution, and the clients/patients put forth similar arguments. Ultimately, the State, which must act as an arbiter, becomes indifferent or, at best, only engages in public commentary on the issues without developing any concrete, actionable plans to resolve such tensions. It is within the above context that Dickson (2003, cited in Quashigah 2015, p. 1), argues that '…generally speaking, freedom of religion is a reality in Ghana, as it is elsewhere in Africa, and that this has led to unprecedented growth: attempts to restrict the Churches' freedom have usually been restricted.' The State's actions or inactions must be understood within the context of the complementary developmental relationship that exists between it and religious organisations, especially the Christian organisations. As argued by Kudaji and Aboagye Mensah (1991, cited in Quashigah, 2015, p. 1), 'We are clear in our minds that the Church has a valid case to be involved in the affairs of the State in all aspects, including national politics.' Similarly, Yirenkyi (cited in Quashigah, 2015, p. 2) argues that 'the Church as an established institution has the responsibility to serve as the conscience of the society. Thus, secularism in Ghana must be understood to allow, and even encourage, State recognition and accommodation of religion and religious identity.' In practice, however, this does not work out smoothly.

The second sub-question, addressed in Chapter Two, was: how do Muslim health workers negotiate the hospital setting, which is highly Christianised? In discussing the modes and strategies employed by Muslim health workers in negotiating the hospital setting, I first addressed the reasons for establishing the Pentecost Hospital. Among other things, the study found that not only did the need to provide healthcare for the residents in La-Nkwantanang Madina influence the setting up of the health facility, but also that the municipality was a place for local medical missions, as the chaplain of the facility alluded to. In his words, '… the Church is bent on promoting kingdom values and principles… we believe Jesus Christ is the son of God and the saviour of the whole world, …we want people to come to this saving knowledge, …the hospital is one of the institutions of the Church which we want to use to witness to people.' This agenda is captured in the hospital's mission, vision, and core values. The above position has been the long-standing praxis of mission facilities pre-dating the

country's independence. Schmid (2013, p. 61), argues that in the case of Agogo Hospital (the first missionary hospital in the Gold Coast), that besides healing, the hospital was intended 'to be a place where people would come to be healed and, at the same time, to hear the word of God, a space where the soul was cared for as much the body.' I further demonstrated that for the facility to prosecute this agenda, the management has provided some 'permanent essentials' architecturally and materially for its Muslim clients. The permanent essentials are the provision of ablution cans (*buta*) and the construction of an Islamic-friendly urinal for the Muslim clients and patients who form the majority of the patrons of the facility. This deliberate act points to how religious coexistence is practised at the micro-level. That is to say, the Christian facility managers are intentional in their actions when dealing with their Muslim clients/patients in the provision of health services.

Another critical strategy of coexistence by the facility managers towards their Muslim clients and patients was the practice of humanitarian healthcare delivery. This strategy, employed by Pentecost Hospital as a modality of religious coexistence, involved the payment of debts of patients who had accessed and utilised one or more services of the facility but were unable to settle their indebtedness. Management employed this approach to strengthen its presence in the community and in the eyes of the Muslim leadership. This deliberate action by the facility managers as an act of helping and caring for their patients, especially the Muslim patients, explains how religious coexistence is done in the day-to-day management of the hospital space. What is obvious in this practice is the 'deliberateness' attached to the practice, which explains the complexities involved in Christian-Muslim interactions. The practice of humanitarian health is so critical to the facility managers that they rally well-to-do church members to support this cause. This practice aligns with what Iddrissu Adam Shaibu (2021, pp. 30-36), calls the 'Nehemiah Fundraising Strategy', which is a shift from the conventional way of raising funds for church projects. The Nehemiah fundraising strategy includes but is not limited to raising funds through an appeal to a major donor (Shaibu op. cit.). This is the strategy that the hospital used to give oxygen to the humanitarian healthcare delivery strategy as a modality of coexistence.

Also, I pointed out how religious coexistence is lived practically within the facility when facility managers sometimes try to maintain a strong Pentecostal identity by projecting their values. This act of projecting church values in the health facility is sometimes met with resistance from members of staff, who may either be Muslim or non-Pentecostal in their religious orientation, as indicated by the chaplain when he wanted to introduce staff devotion.

In this regard, the study found that female Muslim members of staff are sometimes confronted with the pressure to choose between their faith and management decisions that challenge their convictions. It was in line with one such decision that the use of the *hijab* by Muslim health workers became the subject of contention within the facility. While management forbade the use of the *hijab* by female Muslim health workers during working hours, the decision led to agitations among the Muslim female workers, which almost led to the resignation of a Muslim female worker. When push came to shove, management was forced by the resistance and the decision to resign to compromise such hard-line stands. This situation points to the fluid nature of doing coexistence. Flowing from the above, it is evident that in doing coexistence within the hospital, management cannot always have its way. There was a need to make concessions by both parties, that is, management and Muslim workers, to bring about a workable coexistence. The above situation points to the practical nature of how coexistence is done. Similarly, a female Muslim worker deliberately opted for night duties to stay away from the constant scrutinising eyes of the management as her particular modality of coexistence. This female Muslim also always wore the bonnet of the ward scraps to maintain her religious convictions regarding veiling. This also points to the fact that religious coexistence requires deploying different strategies at different times and situations, and involves the need to compromise in hegemonic contexts.

I also discussed the facility's staffing policies and showed that certain critical positions were reserved for 'church people' so that the facility could maintain its Christian identity and core values. So, while the facility managers, by purposeful actions such as the provision of certain permanent essentials, allow for the accommodation of the Muslim clients/patients, at the same time, they have also purposefully put in place some restrictions on certain positions regarding staffing to keep their Pentecostal identity and values intact. This is very instructive in understanding how coexistence is practised in the hospital, such as switching between flexibility and rigidity.

Thus, religious coexistence extends beyond the binary assumptions of conflict or peace, often espoused by scholars of theology and missiology, which are analysed in normative forms (Wandusim, 2015, p. 166; Soares, 2016, p. 676). The hospital experience has revealed that different strategies are required under different situations in the practice of coexistence. It also points to the complexity of the practice of coexistence within a health facility run by a Christian denomination that caters mainly for the health needs of Muslim-majority clients. Such complexities can only be unearthed through an ethnographic approach that explores the

pragmatism in which all actors engage, and the problems that may ensue for Muslim patients. The latter are often faced with emotional and psychological difficulties in trying to balance their religious identity in such a hegemonic Christian environment.

In Chapter Three, I examined the reasons behind the institutionalisation of Morning Devotion as part of the biomedical health services provided by the facility. It was to answer the sub-question: what is the rationale behind the institutionalisation of Morning Devotion-church service as part of the medical services provided to clients/patients?

The introduction and institutionalisation of the Morning Devotion as part of the services rendered by the hospital falls within a grand agenda by the facility managers to present Jesus as the healer and saviour to clients and patients who visit the facility. I demonstrated that the hospital employs soft power or subtle manipulation to cajole or persuade clients to participate in the devotion to fulfil its grand agenda.

Contrastingly, some Muslim patients opposed the Morning Devotion and avoided attendance, drawing sharp lines between their religious convictions and what happens at the Morning Devotion grounds. It became clear that the opposition to the Morning Devotion was primarily targeted to the emphasis placed on Jesus as the son of God and Saviour.

Despite the opposition of some Muslim patients to the Morning Devotion, the study found that the Morning Devotion also has become a 'common ground' where both Christians and Muslims meet to battle the unseen forces of nature, evil spirits, and other malevolent agents which have the desire to interfere with their pregnancies and their unborn babies. The study further showed that the Morning Devotion gained acceptance among some Muslim clients and patients because of the diversity of the messages preached at the devotion. I found out that initially, the content of the messages preached at the devotion was mainly intended to proselytise. However, the messages were tweaked to include moral lessons for everyday life concerning pregnancy, which attracted some Muslim clients. What is instructive is that the hospital setting in which Muslim clients and patients seek healthcare is characterised by Pentecostal hegemony, where compromise from both sides is uneven. The facility managers act intentionally to accommodate their Muslim patrons. Since the facility is run by the church, they compromise a bit to accommodate the Muslim clients and patients, whereas the degree of compromise demanded from the Muslims is much higher. An important contribution of this chapter to the discourse on coexistence in everyday practice is how the practitioners of the two Abrahamic faiths sometimes come together to fight what they perceive as a common threat, such as the

attendance of the Morning Devotion. This act by these religious expectant mothers points to the fact that in doing religious coexistence, the two major religious groups may come together or unite.

The fourth sub-question was: How do Muslim women negotiate access to obstetric and gynaecological services with male service providers? The study found that one of the major ways Muslim women negotiate access to maternal health services (obstetrics and gynaecology) in the presence of male health providers was the invocation of the Islamic principle of necessity (*darura*) to allow for the forbidden to happen. The principle allows for negotiation of what would have been otherwise prohibited, that is, women allowing men other than their husbands to see their nakedness, becomes allowed in emergencies, where they are attended to by male health providers. The study found out that even though the principle was invoked by expectant Muslim women in moments of emergency, some did that with a lot of psychological and emotional difficulty. The lesson from such experiences of the Muslim women is that coexistence does not only happen between religious adherents, that is, between Christians and Muslims, but sometimes within one's self. That is to say, people are forced to live with experiences that are emotionally tense, morally conflicting and psychologically traumatising. The above point is the lived experiences of the Muslim women who come in contact with male health providers in their quest to access maternal health services at the Pentecost Hospital. These encounters by Muslim women are sometimes characterised by moments of tension between them and the male health providers. The game changer in managing all these conflicting moments among my female Muslim interlocutors was invoking the principle of *darura* (the principle of necessity). While it was the case that in the conduct of the Morning Devotion at the facility, some Muslim clients could exempt themselves from participation, the story was different when it came to accessing obstetric and gynaecological services. In the latter, the life of the mother as well as that of the unborn baby was at stake, hence the approach of the Muslim clients was different: they did not resort to strict religious conviction adherence, but rather the focus was on the survival of the mother and her unborn child. Thus, the need to employ pragmatism was at the core rather than strict religious adherence. This points to the fact that in day-to-day encounters between Christians and Muslims in the hospital concerning obstetrics and gynaecology, the practice of coexistence is characterised by compromises: the invocation of darura or the principle of necessity by the Muslim women to allow for the forbidden is a compromised position. Thus, coexistence at the micro-level is not about striving

for peace amid misunderstanding, which may lead to conflicts, but rather about survival, which involves pragmatism and compromise.

The final sub-question was: What motivates the actions of both Christian and Muslim guardians or parents to utilise infant circumcision services by their religious other? This question was addressed in Chapter Five.

I showed that the utilisation of infant circumcision services served as a bridge which brought both Christian and Muslim guardians or parents together. The quality of the service delivered was preferred over religious strictures. Adherents of both Abrahamic faiths patronised and used the services of the other to achieve the ultimate goal of quality service. Importantly, the study found that the position of the circumciser has shifted from its traditional orientation as an occupation for male Muslims to a current place where Christians have also taken the practice as a profession. More interestingly, the study found that infant circumcision is no longer a male-dominated profession, but also a career path for females: both Christian and Muslim females. Thus, the Wanzam Association comprises both male Muslims and Christians, as well as female Muslims and Christians, and is governed by the same rules and ethics. This also offers a different dimension of appreciating religious coexistence. The practice of infant circumcision has brought both Muslim and Christian practitioners together, something that so far had not been explored in the study of religious coexistence in previous studies.

Another interesting observation from the practice of infant male circumcision was the fact that while some medical matters, such as obstetric and gynaecological issues, created tensions and concerns across the Christian-Muslim divide, others – such as infant male circumcision – did not. Again, devotional strategies were present in some medical contexts, such as relating to pregnancy and childbirth. In contrast, in others, they seem absent, such as in the case of infant male circumcision. Equally, it is also instructive to note that when it came to 'female' matters, sensitivities played out more sharply than in an issue such as infant male circumcision.

Finally, the central question of this study was: How can an ethnographic study of health-seeking by Muslims in a Christian-managed health facility, Pentecost Hospital in Madina, inform and contribute to academic discussions on the practice of religious coexistence within a religiously and ethnically plural urban setting?

Hospital ethnography as a method of enquiry has been used by anthropologists to study various phenomena at the hospital (Van der Geest & Sarkodie, 1998; Krause, 2006; Zaman, 2005; Böhmig, 2010; Dapaah, 2012). However, so far hospital ethnography has not been used to

gauge coexistence between Christians and Muslims. This study employed ethnography as a method of enquiry to explore how religious coexistence, that is, how Muslim clients/patients navigate access to healthcare services provided by a Christian health facility. The study also examined how Muslim health workers navigated the hospital environment, which was dominated by Pentecostal convictions and practices. The hospital setting served as a microcosm of the larger Ghanaian society, which is predominantly Christian, and the modes employed by minority religious groups like Muslims in living with the Christian majority were those of pragmatism and compromise. Similarly, the Christian managers of the hospital demonstrated how circumstances sometimes force majority groups to tone down their hard-line stance to accommodate minority groups. There was also the demonstration of intentionality on the part of the facility managers in the provision of the permanent essentials to accommodate the Muslim patients.

Another important insight offered by this study is that, through the lens of hospital ethnography, religious coexistence appears as a layered encounter. As indicated, the layered coexistence is dependent on the duration of the encounter between Christians and Muslims. It was within the above context that I argued that the hospital offers both transient and semi-permanent forms of coexistence. For Muslim clients and patients, coexistence often occurs during the duration of accessing healthcare within the facility, which is transient. By contrast, for the Muslim health workers, coexistence could best be described as semi-permanent as long as their employments are maintained with the facility.

All in all, this study has shed light on how religious coexistence is practised at the grassroots level. It is often characterised by negotiations, compromises, hard-line stances, and uniting for the general good of all actors involved.

The study has also shown that the hospital offers a special setting for understanding Christian-Muslim coexistence at the micro-level. The hospital with a Christian hegemony is prepared to accommodate all patients, especially Muslims. At the same time, the facility managers seize the opportunity to evangelise to these clients/patients, hoping to make converts out of some. What is striking is that the health needs of the generality of the Ghanaian populace cannot be met by the central government in terms of the provision of health facilities and services. This gap has occasioned the provision of health infrastructure and services by private entities. The Christian health organisations have seized the opportunity to be important players in this space, providing about 35% of the health infrastructure and services to the Ghanaian population in

areas deemed hard to reach by the state health provider. The absence of these private health providers may lead to the collapse of the health system in the country. Thus for Muslim patients to access health services in these Christian health facilities, especially, the Pentecost Hospital they must adopt pragmatism, that is, *darura* and compromise as the modes for negotiating the hospital space out of necessity. It is this pragmatic approach by the Muslim clients/patients that show the intricacies of the religion-secular arrangement in Ghana.

Directions for future studies

This study was conducted at Madina, particularly, the Zongo community, which has a high number of Muslim inhabitants and whose health needs are mainly supplied by a Christian-based health facility. This Christian facility also has a grand agenda of using the hospital as a place to propagate its convictions. The pursuit of this agenda by the health facility sometimes leads to a clash of convictions between the providers and takers of the health services.

Thankfully, there is a well-resourced Islamic Hospital at New-Town, a suburb of Accra, which also has a high Muslim population. I therefore suggest a study to be done in this Muslim hospital to gauge the extent to which the facility also deploys its convictions and practices on its clients and patients, as manifested in the Pentecost Hospital. I further suggest a comparative study that will focus on another secular African country with a higher Muslim population, like Senegal, which has a 95% Muslim population but has a Christian president to gauge the religion-secular dynamics in health provisioning. Finally, I suggest a comparative study between religious health institutions in Africa and those of Europe to measure the extent to which religious convictions are deployed as part of the health services provided to clients/patients as practised in the Pentecost Hospital. Such studies will further contribute to the unpacking of academic discussions on religious coexistence from diverse health provisioning perspectives, using ethnography as a method of enquiry.

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