Faith-based health care 3

Strengthening of partnerships between the public sector and faith-based groups

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The sharpening focus on global health and the growing recognition of the capacities and scope of faith-based groups for improving community health outcomes suggest an intentional and systematic approach to forging strong, sustained partnerships between public sector agencies and faith-based organisations. Drawing from both development and faith perspectives, this Series paper examines trends that could ground powerful, more sustainable partnerships and identifies new opportunities for collaboration based on respective strengths and existing models. This paper concludes with five areas of recommendations for more effective collaboration to achieve health goals.

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This is the third in a **Series** of three papers about faith-based health care

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Introduction

Converging global health trends, economic realities, and changing development approaches argue for closer partnership between faith and governmental groups in support of the Millennium Development Goals (MDGs) and forthcoming Sustainable Development Goals (SDGs). As the papers in this Series have shown, faith-based groups have provided care, education, and health and social support long before present development agendas were advanced. Faith-based groups predominantly offer capacities well aligned with the MDG and SDG imperatives, despite controversies mentioned in the second Series paper.[1] These capacities include geographical coverage, influence, infrastructure, scale, and sustainability. Faith-based groups contribute to community health (holistically defined to include social, environmental, physical, and spiritual wellbeing) in diverse ways, but especially through health-care provision and through their effect on health-related attitudes and behaviours.

This Series paper suggests that where a good fit exists between community health objectives and the capacities of faith-based groups, committing additional public sector attention and funding to partnerships that engage faith assets can improve health outcomes and save lives.

As the other papers in this Series have noted, faith-based groups have been responding to the health needs of poor people and working in diverse ways with governmental entities for centuries. Legal, cultural, technical, financial, and institutional factors have resulted in the capabilities and assets of faith-based groups being an underused resource for health, but innovative collaborations between faith-based groups and governments are emerging in various forms.

Although faith-based groups are engaged across the range of health promotion and care, we emphasise (and fully describe in a linked case study) how they are contributing to prevention of child and maternal deaths. We conclude with five broad recommendations for improved effective collaboration to achieve health goals.

Four development trends should encourage governments and donors to engage the physical, human resource, and technical capacities (as well as the teaching, service, and advocacy that has been shown to positively affect social norms and health-related behaviours of faith-based groups) in meeting health needs in low-income and middle-income countries. These trends are also complementary to goals prioritised by most faith-based groups in their care for poor, vulnerable, and marginalised people[2] in their core values, which uphold physical and spiritual well being, and their commitment to the dignity of every human being (panel 1).

The first development trend is the possibility to end extreme poverty and achieve a grand convergence on health. Multinational and national investments in health continue to increase and reached an all-time high of US$31·3 billion in 2013.[3] These investments are inspired, in part, by compelling evidence that progress on health is key to achievement of lasting reductions in extreme poverty[4] and that health is crucial to economic growth in developing countries. According to the 2013 *Lancet* Commission on global health 2035: a world converging within a generation, "reductions in mortality account for 11% of recent economic growth in low-income and middle-income countries."[5] The Commission provides an investment framework for this grand convergence on health status across countries of all incomes and envisions rapid and substantial health improvements: "A unique characteristic of our generation is that collectively we have the financial and the ever-improving technical capacity to reduce infectious, child, and maternal mortality rates to low levels universally, by 2035."[5]

For the **2013 *Lancet* Commission on global health 2035** see http://www.thelancet.com/commissions/global-health-2035

Search strategy and selection criteria

We did not do a formal database search, but drew up a reference list based on the suggestions of other investigators and peer reviewers and on their knowledge of the published work in this specialty. We largely selected publications in the past 5 years, but did not exclude commonly referenced and highly regarded older publications between 2005 and 2015. We also searched the reference lists of key articles and selected those we judged relevant.

Key messages

- Focus on global health and multisectoral development approaches favour strong partnerships between the public sector and faith-based groups
- Though public sector and faith-linked entities bring distinctive assets that help achieve health goals, ideological challenges present barriers to collaboration and need careful negotiation on both sides
- Faith-based groups' potent influence on health-related behaviours might contribute substantially to health outcomes (eg, preventable maternal and child mortality) and could be scaled up to national or regional population level
- Models of collaboration between the public sector and faith-based groups exist that could be adapted for sustainable engagement; partnerships with multireligious coordinating bodies such as inter-religious councils show particular promise
- Five areas of activity to strengthen cross-sector partnerships are recommended:
    1. Measure and improve communication of the scope, scale, distinctiveness, and results of faith-based groups' work in health care
    2. Appreciate respective objectives, capacities, differences, and limitations
    3. Increase investments in faith-based groups, and use efficient business style
    4. Exchange and build core competencies in health and faith in both secular and faith-based groups, and inspire innovation and courageous leadership
    5. Refrain from using religious teachings to undermine evidence-informed public health practices; refrain from using secularist ideology to undermine effectiveness of faith-based groups' work in health

Panel 1: Definitions

Faith-based groups

In this Series paper we use the term faith-based groups expansively to include entities that are self-defined by common religiously informed profession (faith) and practice (ethics or worship), their leaders and congregational infrastructures, and faith-linked health-care providers and non-governmental organisations. Although we argue for expanding partnership between faith-based groups and public sector entities, we do not suggest that all faith-based groups would be interested in such a partnership, nor that all would be effective partners. We focus on faith-based groups engaged in delivering and supporting community health, rather than the broader effect of faith-based belief on health.

Public sector

By public sector we refer to bodies charged under rule of law with governance of society at international, national, regional, and local levels. This public (usually secular) sector, concerns public health and health services provision, which is our focus, although we recognise that states are also sometimes faith-based institutions guided by religious law. For the aim of this short Series paper with its unavoidable oversimplification, when we refer to the public sector we are focusing on governmental agencies operating for the benefit of public health.

Health outcomes

We use an inclusive framing of the scope of health outcomes, agreeing with the previous Series paper on faith-based health services provision that faith-based groups engage in a very broad and diverse range of activities that have consequences for health, including operation of health facilities, delivery of community-based health care, care of vulnerable and dying people, and influence on health-related attitudes and behaviours. We offer a case study on maternal and child health as a specific example of this inclusive definition of health roles and outcomes.

The SDGs and targets for the post-2015 development agenda include goals to end extreme poverty by 2030, to attain healthy lives for all, and to reduce inequality within and between countries.[6] As governments and donors prioritise progress on health and increase health-related expenditures,[3] maximum engagement with faith-based groups could be justified on the basis of efficiency alone, but we argue that other benefits of partnership must be considered.

The second development trend relates to the present focus on ending preventable child and maternal deaths. A concerted worldwide effort has led to great progress on reducing child mortality, down from 12·6 million preventable deaths a year in 1990 to 6·3 million per year in 2013,[7] which in turn drives a new priority on positively influencing health-related attitudes and behaviours for lasting change in health-related social and traditional norms. This effort should arguably include a re-emphasis on strengthened systems for community-based, holistic health care and expansion from facilities-based delivery, as well as emphasis on campaigns against specific diseases (eg, malaria and tuberculosis).

A third trend includes activity to strengthen faith understanding (faith literacy) in governments,[8,9] multilateral bodies,[10] and donors to improve their capacities to both respond effectively to the challenges presented by faith-based groups and to capitalise on the opportunities presented by changing development approaches to tap the demand creation, delivery, and advocacy capacities of faith-based groups. The German Federal Ministry for Economic Cooperation and Development (BMZ) has set up a new sector programme entitled Values, Religion, and Development. Its function is to drive forward the implementation of value-based development policy while also ensuring that religion's significance as an important source of values gains greater recognition in development policy and

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international cooperation. The US Government Strategy on Religious Leader and Faith Community Engagement[12] encourages US Government officials to develop and deepen their relationships with religious leaders and faith communities as they complete their foreign policy responsibilities.

Sustained improvements in health will finally be contingent upon increased low-income and middle-income country investment in health and increased public health results from those investments. This investment is encouraging some governments and donors to re-examine their models of development and consider the benefits of scaling up their partnership with civil society and in particular with faith-based groups. Investments in community systems extend the capacity of public systems to hard-to-reach and rural areas and build resilient infrastructures for times of crisis. Faith-based groups have much to offer here.

These trends argue for increased collaboration between faith and public-sector groups and use of new mechanisms for partnership to fully engage the capacities of faith-based groups for the improved health of people and communities. The present international focus on preventable child and maternal deaths draws attention to the potential benefits of engaging faith-based groups more fully (panel 2, appendix).

Long-standing models of partnerships and cofunding between faith-based groups, states, and donors for health include large-scale community interventions (eg, the 10-year Papua New Guinea Community Partnerships Program[15] between the Australian Government and seven Christian denominations and non-governmental organisations); public funding for faith-based hospital and primary care (eg, the national faith-based constituents of groups such as the African Christian Health Association[16] contract through service-level agreements with states and international donors to provide health services in countries such as Zambia,[17] the Democratic Republic of Congo,[18] and Tanzania[19]); and global health campaigns (eg, The United Methodist Church has raised $66 million in cash and pledges for its Imagine No Malaria campaign and contributed more than $18·1 million to the Global Fund for AIDS, Tuberculosis, and Malaria [Henderson G, Global Health Initiative, United Methodist Church, personal communication]).[20]

The report on the consultation on religion and development post-2015 substantiates the capacities of faith-based groups to contribute to international development outcomes and summarises opportunities and challenges for partnership.[21]

Capitalising on this potential must be balanced with awareness that the complexity of the faith sector can present challenges for large-scale engagement by governments, donors, and secular partners. Faith-based groups can help address this barrier by organising themselves across denominational, faith, and geographical boundaries to partner with public agencies. Governments can help by incentivising and supporting such collaborations.

Panel 2: Faith-based groups' activities and contributions towards ending preventable child and maternal deaths

The global movement to end preventable child and maternal death prioritises interventions in so-called accelerator behaviours, such as early initiation of breastfeeding, malaria prevention, and in removal of impediments to their effective implementation. Many inhibitors of these are behaviours related to culturally and traditionally determined family and community and social norms, and are best addressed through community-based efforts. Faith-based groups have distinctive and constructive parts to play in positively influencing health-related attitudes and behaviours and mobilising communities to save mothers' and children's lives. Some examples (elaborated further in the linked overview appendix) of faith based-groups' contributions to accelerating health related attitudes and behaviors are as follows:

- In Sierra Leone, Muslim and Christian leaders led the UNICEF supported Maklete social mobilisation campaign, which increased immunisation rates in children under one-year old from 6% to 75%.[12]
- In Democratic Republic of Congo, there were substantial increases in net-use by children younger than 5 years from Anglican Church sponsored door-to-door distribution and hang-up of bed nets when compared with public sector fixed distribution points.[13]
- In four provinces in Mozambique, a USAID-funded multi-religious collaboration known as PIRCOM mobilised and trained more than 27 000 faith leaders, reaching nearly 2 million congregants with basic malaria education[14]

See Online for appendix

UN agencies have established international co-ordinating mechanisms and published advisory documents to support partnering, including the UN InterAgency Taskforce on Engaging Faith-Based Organisations in Development,[21] UNFPA's Global Interfaith Network on Population and Development,[22] UNAIDS' framework for faith-based and civil society partnerships on HIV[23] that articulates what the saying do no harm can mean in these sometimes politically charged relationships, and UNICEF's numerous partnerships with faith-based groups for the benefit of children.[24] The World Bank and Vatican are also exploring ways to collaborate to end global poverty (panel 3).

Faith-based groups actively contribute to long-term development and response to health crises. They were active in the response to the Ebola virus disease outbreak in west Africa, coordinating across denominational and faith lines including the convening of Christian aid non-governmental organisations and UN agencies by the World Council of Churches for an escalated response to Ebola;[26] as documented in the Berkley Center mapping,

Panel 3: **World Bank Vatican collaboration**

Meetings between Pope Francis and World Bank Group President Jim Yong Kim raise the possibility of more intentional collaboration between the church and state or secular agencies. According to Kim, "We talked about ways we could work together with faith leaders to make a preferential option for the poor, so they can have greater opportunity and justice in their lives."[25]

faith-based groups have also been key mediators of community education, especially about safe burial, and have provided vital medical services and supplies and psychosocial support.[27]

As additional evidence of faith-based groups who actively seek to partner with national and international development processes, we note the decision made by the Africa Faith Leaders' Summit in Kampala in July, 2014, for inclusion of religious leaders on the post-2015 development agenda[28] and their active role in an international consultation among UN agencies, donors, and faith-based groups on religion and development post 2015.[21]

As noted elsewhere in this Series, funding of faith-based groups for health and development activities comes from a mix of public, private faith-inspired, and secular sources that can be unpredictable. The trend towards increased integration of faith-based groups into national health systems is positive; more efficient mechanisms for this engagement can contribute to more stable service delivery and funding.

Funding sources for faith-based groups' health and development activities vary across the world, but public funding is often leveraged by substantial private support. For example, private funding for the largest US faith-based international development non-governmental organisations exceeded $5 billion in 2013[29] compared with just $777 million in US Government support in the same year. These private funds (supplemented by the earned income base, volunteer labour, and in-kind contributions that accrue to faith-based groups) provide a platform for public investment and might also help protect faith-based groups' autonomy in responding to community health priorities.

Bilateral and multilateral donors have partnered with faith-based groups, but disbursements are by no measure on par with even the most conservative estimates of faith-based share of provision of health services.[30] The Global Fund has disbursed over $1·4 billion to faith-based groups since 2002, and has been encouraging their increased representation in recipients. Although disbursements to faith-based groups in 2010 amounted to $380 million (5% of all disbursements in the then current portfolio),[17] an additional $520 million has been disbursed since then to faith-based principal recipients (17 of whom are new), showing the new emphasis on inclusive partnership.[31] The US President's Emergency Plan for Aids Relief (PEPFAR) prioritised engagement with faith-based groups from the outset and has contributed to greatly expanding the capacities of faith-based groups for HIV and for community health care in general.[32] Although disaggregated data for disbursements of PEPFAR funds to faith-based recipients are not available, country-level studies (eg, in Kenya)[33] suggest that although faith-based groups deliver a substantial proportion of care, they receive disproportionately small levels of PEPFAR funding. The World Bank provides nominal funding through governments to population-level faith networks such as the Nigerian Interfaith Action Association.[34]

Recognising the special capacity of faith leaders to influence governments and others, private philanthropies such as the Bill & Melinda Gates Foundation are supporting efforts to engage this influence constructively on issues including family planning,[35] immunisation (especially polio), and child survival.

In sum, trends in development and public health elaborated on and corroborated in the UN donor faith-based organisation consultation report[21] present new opportunities to partner with faith-based groups for lasting health-related behaviour change and for stronger community structures that support and sustain positive health and development. Each country context presents different opportunities on the basis of development priorities and faith-based groups' capacities, but common cause and common action are possible. challenges for partnership challenges for partnership

Recommendations for full engagement of faith-based groups in achieving health goals

1. Measure and communicate the scope, scale, distinctiveness, and results of faith-based groups' work in health

An agenda for action for improved partnerships between state or secular and faith-based groups should be predicated on mutual respect for autonomy, freedom to establish when partnership is not optimum, and a shared commitment to the dignity and wellbeing of every human being. Faith-based groups should not undermine internationally accepted public health practice (eg, by promoting refusal of immunisations or conflating religiously grounded stances on sexual minorities with public health imperatives for non-discriminatory access to essential services). Although some faith beliefs have negatively shaped health or health-seeking behaviours, public and non-governmental secular actors should not assert that faith is de facto detrimental to health. With those caveats, and building on sustained and sincere efforts to advance partnership, we recommend five areas of focus for common action in the face of changing community health needs and evolving health systems.

Measurement of the contributions of all sectors is urgently needed to improve public health, and in particular, the proportion of health-care delivery provided by

faith-based groups. Olivier and colleagues' paper[36] in this Series highlighted the serious limitations to data on the attributes and effect of faith-based groups in health. A new comprehensive review of evidence[37] on population-level behaviour change to enhance child survival and development in low-income and middle-income countries corroborates the important contributions of social and behaviour change to achievement of health outcomes and provides a framework for consideration of scaling up from single to holistic interventions, and from individual to community level outreach. In view of the absence of data on faith-based stakeholders, this Series paper also reinforces how little information is available about faith-based groups as actors in community engagement for health outcomes. The next generation of the WHO Health Management Information System should respond to recommendations of their 2010 consultation[38] with international faith-based groups; improved data on faith-based groups' activities is in the interest of health planners and policy makers. Faith-based groups who wish to partner with secular entities should commit to full participation in these data collection systems on a continuous basis.

Crucial questions bearing on successful partnerships should be collaboratively researched by policy makers, practitioners, faith-based groups, and academia. These include faith-asset mapping; distinctive, positive, and detrimental faith influences on health-related behaviour change; quality of care; sustainability and funding of faith-based groups' activity for health; and barriers to effectiveness and efficiency. Funding for such research should be prioritised by public and private donors and by faith-based groups themselves. Examples of such cross-sector applied research collaborations include the Joint Learning Initiative on Faith and Local Communities,[39] the International Religious Health Assets Program,[40] and the Berkley Center for Religion, Peace, and World Affairs.[41] Improved synthesis and communication of the available evidence generated by academia and praxis around the world will be useful for policy makers and practitioners. More comprehensive data on the effect of faith-based groups on changing key attitudes and behaviours can inform cost–benefit analysis for potential investment in faith-based groups.

2. Appreciate each other's objectives, capacities, differences, and limitations

Effective partnerships are grounded in common understanding of each party's value commitments, resources, differences, limitations, and needs. Both faith and secular entities can do much more in consultation with each other to develop these understandings and build trust (panel 4).

Although access to public funding should not be harder or easier for faith-based applicants than for other organisations, existing principles and recommendations for relations between governments and faith-based groups,[8,42,43] including promotion of transparency and mutual respect, should be actively adapted to local circumstances. Established standards[44,45] for non-discrimination based on religion and strictly separating proselytising and other inherently religious activities from health care, relief, and development services, should be strictly observed in any expansion of publicly funded faith-based delivery.

To help their work across sectors and in religiously pluralistic societies, theologians from several world faith traditions have worked substantially to explore the intersections of faith, health, and rights. Faith-based groups and theologians would do well to further develop and communicate theological framings for the relation between faith values and health service, or so-called mission and ministry. An example from the evangelical Christian world is the conceptual framing of integral mission developed as a guide for religiously grounded development practice by Micah Challenge.[46] Paralleling the growth in faith-based Muslim relief and development of non-governmental organisations is a clarification of the grounding from Quranic texts and hadiths for humanitarian aid,[47] which specifically includes meeting the needs of non-Muslims.

Faith-based groups and those considering partnering with them should assess the effect of beliefs and customs on factors affecting health for women and girls (and indeed for other vulnerable or socially excluded populations) in determining the scope or limitations of proposed partnerships.

Interested faith-based groups should actively inform prospective public partners about their capacities and articulate specific contributions they could make to the achievement of public health goals. States should assess and strengthen the effectiveness of present efforts to educate public servants about faith-based groups working in health care and development, and consider innovative mechanisms and quantified targets for outreach to faith-based groups when bringing wider civil society to the planning and funding table.

Multilateral health organisations such as Global Alliance for Vaccine and Immunization, the Global Fund, and WHO could, in close consultation with faith-based groups, commission country-specific studies of how the capacities and resources of faith-based groups might support specific health priorities and address key delivery

***Panel 4:* Faith-based groups and the Millennium Development Goals**

"A mission with the breadth and consequence of the health Millennium Development Goals would simply be unachievable without the engagement of the faith community. I have been so impressed by the many faith leaders who have supported health-related attitude and behaviour change, whose effect has been the saving or improvement of millions of lives."—Ray Chambers, the UN Secretary General's Special Envoy for Financing the Health MDGs and for Malaria.

challenges. The Global Fund, for example, supported a consultation with faith-based groups organised by Caritas Internationalis and UNAIDS to develop a roadmap for faith-based organisations to expand access to HIV treatment.[48] These consultations could also frame a range of different partnership models, explore how best to reach populations in greatest need, and describe conditions and resources needed to enhance collaboration.

Respectful consultation and attentive listening are essential to building trust, common understanding, and collaboration, and can have profound effects. The consultation convened by the International Interfaith Peace Corps on immunisation held in Senegal with Muslim scholars from across the African continent[49] established that faith leaders' sceptical attitudes to immunisation were rooted more in health-related concerns than religious belief. Leaders were receptive to discussion of those concerns and to receiving new health information. They subsequently produced a declaration supporting vaccines and incorporated specific religious and health justifications. Similarly, 70 representatives of governments, faith-based groups, and women with HIV met in February, 2013, to strengthen joint efforts to make sure that no child is born with HIV.[50]

Although perhaps no area of discussion between faith and public groups is more contentious than sexual and reproductive rights, by building on a legacy of partnership and affirming areas of agreement and common objective, faith leaders and scholars representing Baha'i, Buddhist, Christian, Hindu, Jewish, and Muslim faiths joined with UNAIDS and UNFPA to develop consensus on a landmark Declaration and Call to Action on sexual and reproductive health (panel 5).[51] Taken together, these steps can improve appreciation of health benefits achievable through closer partnership, affirm areas of agreement and common objective, acknowledge areas of difference in either policy or approach to be accommodated, and suggest procedures for navigating contested areas.

3. Increase investments in faith-based groups and use efficient business models

If the contributions of the faith sector for community-based health care laid out in this Series paper are to be fully realised, states and faith-based groups need new ways to partner and to invest in sustainable capacity development and service delivery.

Governments and donors should invite full representation of faith-based groups in planning and funding processes and promote partnerships that prioritise easier access, respect autonomy while insisting on accepted public health practice, promote quality care and standardised reporting of outcomes, and reduce transaction costs. The Global Fund provides a leading example by encouraging faith community caucusing as a mechanism for faith-based groups to speak with one voice and to more effectively align with national health planning processes.[31] Faith-based groups should in turn be prepared to respond to such invitations, and be accountable for outcomes and for funds received. Improved knowledge on both sides of working models, respective competencies, and methods of collaboration can support this.

Faith communities can make it easier for public and private partners to do business with them and to do so on a large scale. Organisation or strengthening of religious coordinating mechanisms such as inter-religious councils, interfaith action associations,[52] or faith caucuses representing most religious assets in a district or country might help while also obviating co-option of these groups by states as cut-rate health care utilities.

Religious coordinating mechanisms models range from ad hoc coalitions to separately incorporated agencies able to source and disburse public funding. The African Council of Religious Leaders includes many national inter-religious councils and coordinating mechanisms.[53] Programa Inter-Religiosa Contra a Malária[54,55] is a locally incorporated non-governmental organisation guided by a board of Muslim, Christian, Hindu, and Baha'i faith leaders with funding from USAID through which the Mozambican Government engages faith communities nationwide in campaigns against malaria. States and donors might expand use of such mechanisms by favouring multidenominational and, where demographically appropriate, multifaith partnerships.

Innovative funding mechanisms are essential if governments are to establish sustainable partnerships with faith-based groups and to reward attitude-related and health-related behaviour changes and sustained delivery of community-based care. New approaches with performance-based contracting designed for faith-based groups, as in the case of the World Bank's funding of the Nigerian Interfaith Action Association, should be studied and adapted.

Agreements between states and faith-based groups should specify criteria for effective partnership, including fit with mission and capacity, standards for organisational stability and transparency, track record in health care, communications capabilities to reach members, and sustainable core funding and accountability mechanisms.

Panel 5: A call to action: faith for sexual and reproductive health and rights

"Not in our name should any mother die while giving birth. Not in our name should any girl, boy, woman or man be abused, violated, or killed. Not in our name should a girl child be deprived of her education, be married, be harmed or abused. Not in our name should anyone be denied access to basic health care, nor should a child or adolescent be denied knowledge of and care for his/her body. Not in our name should any young person be denied their full human rights."[51]

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4. Build core competencies in health and faith in both secular and faith-based groups to inspire innovation and courageous leadership

As Tomkins and colleagues' Series paper[1] on controversies documents, religious influence in health predates modern medicine and spans the continuum from life-threatening to powerfully positive and life-affirming. The ability of religious leaders to inspire effective movements for social change is attested to by the Jubilee 2000 campaign for the cancellation of third world debt, Make Poverty History campaign to end extreme poverty, and We Will Speak Out campaign against gender-based violence.

Religious leaders can speak forcefully to one another, across traditions, and to governments and civil society about the direct links between improved health and the core values of compassion, justice, and giving priority to the poorest and most needy people.

Faith-based groups working together can amplify their advocacy for equitable delivery of primary health care, holding governments accountable for delivery of quality health care to all. Local communities and consumers of faith-based health services can insist on equitable, quality, and stigma-free service delivery. Governments and donors can and should hold faith-based groups accountable for quality standards.

Many denominational and faith networks in developing countries are working to build capacity of grassroots faith communities to meet local health needs. These networks are also committed to collaboration and learning from each other. Faith-based groups as diverse as Islamic Relief, Salvation Army, Anglican Alliance, Tearfund, Catholic Agency For Overseas Development, Samaritan's Purse, and Adventist Relief and Development Agency are collaborating on best practice relating to their continuing work of building the capacity of local faith-based groups for the health and wellbeing of their communities and have jointly refined a theoretical framework for faith-based social and community mobilisation.[56] Channels of Hope, for example, has mobilised more than 390 000 local faith leaders for health and development.[57] With more support from governments, donors, and international faith networks, this movement to equip and mobilise local faith leaders and communities could rapidly scale up to reach millions of people with critical health issues.

Importantly, the sacred texts of every tradition abound with teachings that promote good health. Faith leaders should be supported to convey these health-affirming messages rather than those perpetuating harmful gender or cultural norms (many of which, like child marriage, are not integral to religious belief but are cultural or social norms that have become embedded in religious traditions). Faith-based groups' delivery of accurate health messaging can be improved through access to evidence-based behaviour-change communication materials developed consultatively and easily adapted for use in diverse faith settings. Strong examples of educational guidelines developed by and tailored to faith-based groups already exist (eg, sermon guides, community dialogue scripts, faith-specific health training guidelines, etc).[58] Increased availability of these and other materials linked to global health priorities would be invaluable, as well as the development with faith-based groups of evidence-based materials to fill identified gaps.

5. Do not use religious teaching to undermine evidence-informed public health practice or use secularist ideology to undermine faith-based groups' work in health

Tomkins and colleagues' paper[1] in this Series on controversies and other sources document instances where religious belief conflicts with public health values. When this conflict is the case, faith leaders might productively consider the medical professional's commitment to primum non nocere (first, do no harm) affirmed in the Hippocratic Oath. This same principle is upheld in the tenets of all major faiths and cannot be a coincidence.

Although affirming that faith-based groups have the right to define what they believe for their adherents, we hope that this paper and Series will help to build a consensus for respect of the rights of non-members and honest acknowledgment that some beliefs contribute to harmful health conditions.

Not all faith-based groups will choose to collaborate with public bodies in achieving health goals. Nor will all faith-based groups be desirable partners for public bodies. But states, in particular pluralistic nation states, should not, as a matter of practice, systematically exclude faith-based groups as partners in improving health. Acceptable terms of reference for both states and faith-based groups should be clarified and negotiated as a basis for effective collaboration to achieve health goals.

The golden rule common to almost all world religions—that one should treat others as one wishes to be treated—provides a solid foundation on which to build the structures for improved linkage between the public sector and faith-based groups. The universality of this saying can also be an effective starting point for overcoming resistance to partnering.

Fulfilling the promise of universal health care, especially for poor and marginalised groups, can best be achieved by engaging all potential contributors. We hope this paper invites closer collaboration between two critical actors: the public sector and faith-based groups.

Contributors

JFD and WWB contributed to the design and substance of this Series paper and collaborated on the final manuscript.

Decalration of interests

We declare no competing interests.

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References

1 Tomkins A, Duff J, Fitzgibbon A, et al. Controversies in faith and health care. *Lancet* 2015; published online July 7. http://dx.doi.org/10.1016/S0140-6736(15)60252-5.
2 Olivier J, Paterson GM. Religion and medicine in the context of HIV and AIDS: a landscaping review. In: Haddad B, ed. Religion, HIV and AIDS: charting the Terrain. Durban: University of Kwazulu Natal, 2011.
3 Institute for Health Metrics and Evaluation. Financing global health 2013: transition in an age of austerity. Seattle, WA: IHME University of Washington, 2014. https://www.healthdata.org/sites/default/files/files/policy_report/2014/FGH2013/IHME_FGH2013_Full_Report.pdf (accessed Sept 9, 2014).
4 WHO. Social determinants of health. http://www.who.int/social_determinants/en/ (accessed Sept 9, 2014).
5 Jamison DT, Summers LH, Alleyne G, et al. Global Health 2035: a world converging within a generation. *Lancet* 2013; **382:** 1898–1955.
6 UN Sustainable development Knowledge Platform. Twelfth session of the Open Working Group on sustainable development goals. http://sustainabledevelopment.un.org/owg12.html (accessed Sept 9, 2014).
7 UNICEF. Committing to child survival: a promise renewed progress report 2013. http://www.unicef.org/publications/files/APR_Progress_Report_2013_9_Sept_2013.pdf (accessed Sept 9, 2014).
8 Department for International Development. Faith partnership principles: working effectively with faith groups to fight global poverty. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/67352/faith-partnership-principles.pdf (accessed Sept 9, 2014).
9 Sector Programme Values, Religion and Development. Recognising and harnessing the potential of religion. Factsheet Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH on behalf of German Federal Ministry for Economic Development and Cooperation and Die Rolle von Religion in der deutschen Entwicklungspolitik. March 2015. http://www.bmz.de/de/mediathek/publikationen/reihen/infobroschueren_flyer/flyer/Flyer_Religionen.pdf (accessed May 25, 2015).
10 World Bank Group. Towards more active and effective engagement with faith communities and organizations. http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/CSO/0,,contentMDK:23562608~pagePK:220503~piPK:220476~theSitePK:228717,00.html (accessed Sept 10, 2014).
11 USAID. US strategy on religious leader and faith community engagement. http://www.usaid.gov/faith-based-and-community-initiatives/us-strategy (accessed Sept 9, 2014).
12 UNICEF. Building trust in immunization. Partnering with Religious Leaders and Groups. http://www.unicef.org/ceecis/building_trust_immunization.pdf (accessed Sept 9, 2014).
13 Anglican Church of the Province of Congo. Pilot study of long lasting insecticide-treated nets distribution with door to door strategy combined with hangup method in the Netsforlife supported health zones in the Democratic Republic of Congo. Nets for Life, November 2012.
14 LaTondrese C. "Religious Leaders "Noisy About Malaria" in Mozambique." USAID's Center for Faith Based and Community Initiatives. April 25, 2013. Accessed September 9, 2014. http://blog.usaid.gov/2013/04/religious-leaders-noisy-about-malaria-in-mozambique/ (accessed Sept 9, 2014).
15 Clarke M. Innovative delivery mechanisms for increased aid budgets: lessons from a new Australian aid partnership. Working Paper number 2011/73, United Nations University, November 2011. http://webcache.googleusercontent.com/search?q=cache:Wu6VQMMGKqEJ:www.wider.unu.edu/publications/working-papers/2011/en_GB/wp2011-073/_files/86646470763544601/default/wp2011-073.pdf+&cd=1&hl=en&ct=clnk&gl=uk (accessed Sept 9, 2014).
16 African Christian Health Associations Platform. http://www.africachap.org (accessed Sept 9, 2014).
17 The Global Fund. 2010 Update: report of the involvement of faith-based organizations in the Global Fund. February 2011. http://www.nrasd.org.za/wp-content/uploads/CivilSociety_InvolvemenOfFaithBasedOrganizationsInTheGlobalFund_Report_en-6.pdf (accessed Sept 9, 2014).
18 The SANRU Rural Health Program. http://sanru.info (accessed Sept 9, 2014).
19 Christian Social Services Commission. http://www.cssc.or.tz/history (accessed Sept 9, 2014).
20 United Methodist News Service. http://www.umc.org/news-and-media/united-methodist-church-contributes-9.6-million-to-global-fund (accessed May 25, 2015).
21 Karam A. Religion and development post 2015: report of a consultation between donor organizations, UN development agencies and faith based organizations. http://jliflc.com/resources/religion-development-post-2015-outcomes-consultation-donors-un-faith-based-organizations/ (accessed Sept 9, 2014).
22 United Nations Population Fund. Building bridges among faith-based organizations and secular development practitioners. http://www.unfpa.org/culture/fbo.html (accessed Sept 9, 2014).
23 Joint United Nations Programme on HIV/AIDS. Partnership with faith based organizations: UNAIDS strategic framework. Geneva: UNAIDS, December 2009. http://www.unaids.org/sites/default/files/media_asset/20100326_jc1786_partnership_fbo_en_0.pdf (accessed Sept 9, 2014).
24 United Nations Children's Fund. Partnering with Religious Communities for Children. http://www.unicef.org/about/partnerships/files/Partnering_with_Religious_Communities_for_Children_(UNICEF).pdf (accessed Sept 9, 2014).
25 World Bank Group. World Bank Group President Kim and Pope Francis Meet to Discuss Mutual Efforts to End Poverty. http://www.worldbank.org/en/news/press-release/2013/10/28/world-bank-group-president-kim-pope-francis-efforts-end-poverty (accessed May 25, 2015)
26 World Council of Churches. Churches and agencies formulate response to Ebola outbreak. Oct 1, 2014. http://www.oikoumene.org/en/press-centre/news/churches-and-agencies-formulate-responses-to-ebola-outbreak (access Oct 5, 2014).
27 Berkley Center for Religion Peace and World Affairs Response to ebola: mapping religious networks and FIOs. February 2015. http://repository.berkleycenter.georgetown.edu/141008BCWFDDResponseEbolaMappingReligiousNetworksFIOs.pdf (accessed May 25, 2015).
28 Africa Faith Leaders' Summit. Position paper: beyond the post 2015 development agenda. African Interfaith Initiative on the post 2015 development agenda. http://www.beyond2015.org/sites/default/files/Faith%20Leaders%20Position%20on%20SDGs%20July%202014%20Final.pdf (accessed Sept 9, 2014)
29 Duff J. Sources of revenue for US faith-based NGOs, FY 2011-13. http://www.partnershipforfaithanddevelopment.org/wp-content/uploads/2013/08/Total-vs-Govt-Revenue-Final-.pdf (accessed Jan 22, 2015).
30 Haakenstad A, Johnson E, Graves C, Olivier J. Duff J, Dieleman JL. Estimating the development assistance for health provided to faith-based organizations, 1990. *PLoS One* 2015 (in press).
31 Friends of the Global Fight Against AIDS, Tuberculosis and Malaria. A critical partnership: the life-saving collaboration between the global fund and faith-based organizations. http://theglobalfight.org/wp-content/uploads/FBO_FINAL_121514.pdf (accessed Sept 9, 2014).
32 US President's Emergency Plan for AIDS Relief. A firm foundation: the PEPFAR consultation on the role of FBOs in sustaining community and country leadership in response to HIV/AIDS. http://www.pepfar.gov/documents/organization/195614.pdf (accessed Sept 10, 2014).
33 Blevins J, Griswold E. Essential participants: the scope and contributions of faith-based health systems to HIV prevention, treatment and support in Kenya. http://ihpemory.org/wp-content/uploads/2014/08/Essential-Partners-Kenya-Country-Report-Final.pdf (accessed Sept 24, 2014).
34 Nigerian Interfaith Action Association. Nifaaonline.org (accessed Sept 9, 2014).
35 Hope through healing hands. The faith-based coalition for healthy mothers and children worldwide. www.hopethroughhealinghands.org/faith-based-coalition (accessed Sept 9, 2014).
36 Olivier J, Tsimpo C, Gemignani R, et al. Understanding the roles of faith-based health-care providers in Africa: review of the evidence with a focus on magnitude, reach, cost, and satisfaction. *Lancet* 2015; published online July 7. http://dx.doi.org/10.1016/S0140-6736(15)60251-3.

37 Fox E, Obregón R. Population-level behavior change to enhance child survival and development in low- and middle-income countries: a review of the evidence. *J Health Commun* 2014; **19** (suppl 1): 3–9.

38 WHO Programme on Partnerships and UN Reform. WHO—CIFA consultation NGO mapping standards describing religious health assets. 2009 (accessed Sept 9, 2014).

39 Joint Learning Initiative on Faith and Local Communities. www.jliflc.com. (accessed Sept 9, 2014).

40 International Religious Health Assets Program. http://www.IRHAP.uct.ac.za/research.php (accessed Oct 4, 2014).

41 Berkley Center for Religion Peace and World Affairs http://berkleycenter.georgetown.edu/about (accessed May 25, 2015).

42 Nelson J. The operation of NGOs in a world of corporate and other codes of conduct. 2007. http://www.hks.harvard.edu/m-rcbg/CSRI/publications/workingpaper_34_nelson.pdf (accessed Sept 10, 2014).

43 Center for Interfaith Action on Global Poverty. Many faiths, common action: increasing the impact of the faith sector on health and development: a strategic framework for action. http://www.partnershipforfaithanddevelopment.org/wp-content/uploads/2013/09/Many-Faiths-Common-Action-Report1.pdf (accessed Jan 24, 2015).

44 InterAction. InterAction PVO Standards. http://www.interaction.org/document/interaction-pvo-standards (accessed Sept 9, 2014).

45 Obama B. Executive order—fundamental principles and policymaking criteria for partnerships with faith-based and other neighborhood organizations. http://www.whitehouse.gov/the-press-office/2010/11/17/executive-order-fundamental-principles-and-policymaking-criteria-partner (accessed Sept 9, 2014).

46 Micah Network. Micah declaration on integral mission." http://www.micahnetwork.org/integral-mission (accessed Sept 9, 2014).

47 Krafess J. The influence of the Muslim religion in humanitarian aid. *Int Rev Red Cross.* 2005; **87:** 327–42.

48 UNAIDS-Caritas. Joint consultation with Catholic Church—related and other FBOs on expansion of antiretroviral treatment Rome. . http://jliflc.com/wp-content/uploads/2014/10/Report-brief-as-of-12may2014.pdf (accessed Oct 5, 2014).

49 International Interfaith Peace Corps. Vaccinations and religion: issues, challenges and prospects. Conference report 2014. http://www.iipcnet.org/Resources/VACCINATIONS%20AND%20RELIGION%20Final%20Conference%20Report-%20English.pdf (accessed Sept 9, 2014).

50 The African Christian Health Associations Platform, Caritas Internationalis, Churches Health Association of Zambia, Ecumenical Advocacy Alliance, UNAIDS. Consultation Report: scaling up engagement of faith-based organizations in the implementation of the global plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive. http://www.e-alliance.ch/en/s/hivaids/prevention/prevention-of-mother-to-child-transmission-pmtct/ (accessed Oct 5, 2014).

51 UNFPA, UNAIDS. A call to action: faith for sexual and reproductive health and reproductive rights. http://www.unfpa.org/sites/default/files/resource-pdf/Faith%20leaders%27%20call%20to%20action.pdf (accessed Sept 9, 2014).

52 Hipple A, Duff J. Leveraging congregational infrastructures for maximum impact on disease and poverty in religion and the United Nations. *Cross Curr* 2010; **60:** 368–82.

53 African Council of Religious Leaders—religions for peace. http://www.acrl-rfp.org/index.php?option=com_content&view=article&id=18&Itemid=2#truly (accessed Sept 9, 2014)

54 Programa Inter-Religiosa Contra a Malaria. www.pircom.org. (accessed Sept 9, 2014).

55 Duff J. Together against malaria: faith-led community mobilization in Mozambique. In: Marshall K, Van Saanen M, eds. Development and faith: where mind, heart, and soul work together. Washington, DC: The World Bank. 2007: 67–75.

56 Joint Learning Initiative on Faith and Local Communities. A theory of change for faith group and community mobilization. http://capacity-building.jliflc.com/resources/theory-change-faith-group-community-mobilization/ (accessed Sept 11, 2014).

57 World Vision Inc. Channels of Hope: igniting a movement to transform communities. http://www.wvi.org/health/publication/channels-hope (accessed Sept 9, 2014).

58 Chand S, Erb K. Christian sermon guide to save the lives of mothers and newborns: a toolkit for religious leaders. http://www.accesstohealth.org/toolres/pdfs/christiansermonguide.pdf (accessed Sept 9, 2014).