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Faith-based health care

"By studying the presence and unique attributes of faith-based care through the lens of health, this Series provides a platform for broader engagement between faith-based groups, medical practitioners, and policy makers."

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Faith-based health-care · July, 2015

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Faith-based delivery of science-based care

Faith is too often perceived as a force that divides. In *The Lancet*, a new Series[1–3] examines the potential of faith-based health care to unite and heal. The Series is led by Ed Mills, from Global Evaluative Sciences in Vancouver, Canada, and supported financially by a grant from Capital for Good, which connects donors with organisations working in health and other development areas. This *Lancet* Series on faith-based health care draws together the insights and experiences of authors from several countries and denominations, academic institutions, and non-governmental organisations (NGOs). Faith-based organisations deliver a substantial volume of health care, and their common visions of stewardship, inclusiveness, dignity, and justice make many such organisations ideally suited as key partners for delivering the post-2015 Sustainable Development Goals.

Religions are about more than good deeds; yet they also inspire behaviours and actions as an expression of faith, which can benefit others. For instance, respect for the diversity of the natural world and preservation of its resources and habitats. Service—particularly care for the sick—is another characteristic. In that care, faith is regularly present, even though it may be silent. Faith is interwoven with local culture and overlaid by personal beliefs and organised religions that can make the disentanglement of individual components a challenge. The purpose of this Series is to examine how faith-based behaviours influence the delivery of health care at an organisational level. A vivid example is the response to the Ebola outbreak, as described in a Comment for this Series by Katherine Marshall and Sally Smith.[4]

In the first Series paper, Jill Olivier and colleagues[1] analyse the characteristics of faith-based care in Africa. A particular strength of faith-inspired organisations is the care they give to populations marginalised by poverty or stigma. Such faith-based care complements government facilities and extends the reach of services beyond traditional populations. Indeed, faith-based organisations account for about 20% of the total number of agencies working to combat HIV/AIDS in Africa.[5] To maximise the contributions of faith-based care, it is essential that such providers are as professional in their organisation and management of human resources, and as evidence-based in practice, as any other health-care provider. The faith moniker does not excuse shortcomings.

Criticism of the influence of dogma on practice can arise from an incomplete appreciation of the doctrinal basis that frames different approaches to health. In the second Series paper, Andrew Tomkins and coauthors,[2] who come from several religious traditions, examine the basis for controversies in faith and health, and separate myths from messages. They provide faith-based explanations for different practices that are valuable to any clinician in a multifaith environment. Appreciation of spiritual, social, and cultural dimensions of health are crucial to care.[6] Better understanding of the reasons for different practices provides opportunities to reframe faith as part of the solution, rather than the problem, in complex consultations.

Jean Duff and Warren Buckingham III[3] conclude the Series with five recommendations to facilitate collaboration between governments and NGOs with faith-based entities, which build on existing strengths to improve health outcomes. Among these is the need for improved measurement of the benefits that faith-based organisations bring to health-care delivery and outcomes.

Faith-based organisations translate beliefs into action through funding, commissioning, researching,

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or providing care. By studying the presence and unique attributes of faith-based care through the lens of health, this Series provides a platform for broader engagement between faith-based groups, medical practitioners, and policy makers. Such engagement, and better recognition and utilisation of faith-inspired behaviours, has the potential to accelerate and improve health and social outcomes.

William Summerskill, Richard Horton
The Lancet, London EC2Y 5AS, UK

1 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.
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The view from above: faith and health

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An estimated 84% of the world's population is religiously affiliated.[1] Faith is a powerful force in the lives of individuals and communities worldwide. At an individual consumer and provider level, faith can influence both health and behaviours that are relevant for medical practice and care. At a community level, faith-related structures and actors engage in health and development activities that intersect with social determinants of health. At the national level, faith-inspired health providers deliver health care in many contexts. Internationally, faith affects and shapes development agendas and responses to poverty and inequity. However, faith factors are not always taken into account in public health discourses. Relevant assessment and actionable policy and operational recommendations to inform worldwide and national public health strategists are absent. This Lancet Series on faith-based health care examines the roles of faith-based organisations in providing and influencing care and recommends how this contribution might be developed to improve health outcomes.

The precise nature and implications of faith roles in health care are poorly understood, especially in low-income countries. Substantially more research seems to be available in English and about Christian faith-based health providers in Anglophone countries in Africa than about other faith-based engagement in other developing country contexts. Faith can encompass wide-ranging beliefs, and often several beliefs intertwine within the same individual.[2] An example of this is the mixed health-seeking modalities commonly found, in which an individual might hold concurrent beliefs in a mainstream religion (eg, Christianity, perhaps with a local contextualised interpretation), traditional cultural practices (eg, a belief in traditional healers or healing forms), and a belief in modern biomedicine, resulting in mixed use of different services and healing modalities.

In different settings (and in diverse languages), faith, religion, or belief are either understood differently, or used interchangeably. Furthermore, no single agreed convention exists for classification of faith-based health-care provision (panel), as is shown in the varied references throughout this Series. Various attempts have been made to classify and record faith-related health assets, actors, and initiatives.[3] Highly visible transnational organisations (eg, Catholic Relief Services and Islamic Relief) exist, but so do the far larger but less visible and more diffuse local faith community networks. Inadequate mapping of faith-based facilities makes it difficult for governments and other potential partners to engage deliberately with faith-based entities.

Examples of local faith communities' participation in health care include coordination of several health and social services and offer of a more holistic approach to care that includes not only a person's physical ailment but also the social and communal context and spiritual

dimensions of wellbeing. One Series paper documents research on the magnitude of care provided through these services and points to rigorous assessments of examples of excellence and cases in which quality is lower.[illegible]

Distinctive characteristics of faith-based health care include access to hard-to-reach populations, priority for poor and marginalised people, mobilisation and support of volunteers, and innovative fee structures and governance approaches. Here too, disadvantages can occur, such as inadequate or unpredictable financing, variable governance, or priorities and strategies that differ from national health systems.

Although few empirical data exist for faith-based health providers in general, at least sufficient knowledge exists about the health providers in sub-Saharan Africa to argue that they are important, when present, to many lower-middle-income country health systems. Some authors argue that, unless specific attributes (such as the provision of compassionate and quality services to poor underserved people and retention of staff in rural areas) are taken into policy account, much might be lost to increasing financial challenges.

The Series paper on controversies[illegible] discusses the influence of religious values on ethics, attitudes, and behaviours related to health and social norms. Some real or perceived religious advocacy (or theological positions) is considered by some health advocates as antithetical to human rights. The resulting debates, often fierce, include aspects of gender, sexual and reproductive health, reproductive rights, family planning (especially contraception), violence against women, and resistance to some vaccinations. Much criticism of the nexus between faith and health centres around little recognition of the political, cultural, legal, and economic considerations that exacerbate gender inequalities in particular, and thereby prevent women; young girls; and lesbian, gay, bisexual, and transgender people from accessing health services.

In terms of worldwide dynamics around international development and health, substantial consequences exist for health and the work of faith-based actors in health delivery.

Contexts of political instability, poor governance, and violence (and weak public or national institutional capacity) inhibit health-service provision. Some of the most challenging instances involve health-care workers (eg, in areas of polio or Guinea worm infection) who find themselves targeted in situations of political tension where religion plays a part. This example underlines the pivotal role of faith actors who advocate for the health practice at issue during such times.

Financing and work-force dynamics are also driven by substantial global health funding by multilateral organisations, such as the GAVI Alliance and the Global Fund to Fight AIDS, Tuberculosis and Malaria, with outcomes including innovation and support for strengthening of community systems, which provides concrete mechanisms to channel funds to civil society groups with a track record in service delivery. In turn, this funding supports demand creation, treatment literacy, adherence, and strengthened service delivery through local community clinics and faith-based providers. Yet funding for faith-based health care still includes uncertainties that detract from patient care and strategic planning, confusion about appropriate national cost recovery and fee payment strategies

Panel: Challenges of naming and definition

What we refer to as faiths consist of highly diverse and disparate communities and groups. Their size and complexity creates substantial terminological and classification difficulties. The term faith community can refer to a single group of regular congregants focused around a meeting place, a religious denomination, or a collective term for people who profess widely varying beliefs and practices but are linked by a common identification as believers. Various attempts have been made to classify faith-related entities, sometimes referred to as faith inspired or, more commonly, faith-based organisations, a task made complex by their sheer variety. At present, no agreed convention for classification exists. The Joint United Nations Programme on HIV/AIDS defines faith-based organisations as faith-influenced non-governmental organisations. The United Nations Population Fund defines faith-based organisations as faith-based or faith-inspired non-governmental organisations, with legal standing, which are working to advocate for or deliver development and humanitarian services whether nationally, regionally, or internationally.

Greenway and Lux include within the category of faith-based organisations, "religious and religion-based organisations and networks; communities belonging to places of religious worship; specialised religious institutions and religious social service agencies, and registered and unregistered nonprofit institutions that have a religious character or mission".[illegible]

(especially those intended to benefit poor and excluded communities); suboptimum coordination; and problems exacerbated by unhealthy competition for resources. Undue reliance on volunteer labour can have negative effects both in terms of exploiting the goodwill of, for example, poor women, or making services less reliable and less professional than would be desirable.

As elaborated in a report by the United Nations Population Fund,[6] September, 2015, is a crucial deadline to launch the new global developmental agenda—the Sustainable Development Goals. Decisions are being made by governments and include negotiations on prioritising issues, as well as specifying targets, means of implementation, and financing. Hence the timeliness of this Lancet Series on faith-based health care.

Previous sites of intergovernmental negotiations (including various UN Commissions) have unveiled tensions between elements of human rights discourse and rights-based development praxis, on the one hand, and cultural considerations mixed with national sovereignty to establish governments' own priorities, on the other. These considerations are linked to religious concerns and interpretations, many of which relate to health matters.

The fact that some parties to these processes are heavily influenced by certain religious interpretations and concerns is likely to affect progress of these negotiations. With this in mind, an informed appreciation of the highly complex nexus of faith and health-care delivery and engagement becomes a strategic necessity and a tactical advantage.

*Azza Karam, Julie Clague, Katherine Marshall, Jill Olivier, for the Faith and Health Series
United Nations Population Fund, New York 10158, NY, USA (AK); University of Glasgow, Glasgow, UK (JC); Berkley Center for Religion, Peace and World Affairs, Georgetown University, Washington, DC, USA (KM); and University of Cape Town, Cape Town, South Africa (JO)
karam@unfpa.org

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Religion and Ebola: learning from experience

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The largest Ebola epidemic in history, in 2014–15, profoundly disrupted three west African countries that bore its brunt: Guinea, Liberia, and Sierra Leone.[1] Effects include more than 10 000 deaths, more than 26 000 people infected,[1] and high social and economic costs. Religious beliefs and practices shape (positively and negatively) ways of caring for the sick, patterns of stigma, and gender roles. Throughout the crisis, religious institutions have provided services including health, education, and social support.

Despite religions' deep-rooted health and social roles and contributions to resilience and peace-building during lengthy conflicts in the region,[2-4] national governments and international actors were late to appreciate the vital roles of religious actors in addressing Ebola and supporting health systems.

Three lessons stand out: first, strengthening of knowledge of religious demography, institutions, and relationships would facilitate more effective engagement of faith communities; second, public health communities need more systematic and multidisciplinary community engagement approaches; and third, religious dimensions of behaviour change, for example on burials, highlight the value of community expertise and the need to draw on it more purposefully and systematically. These lessons are especially relevant when looking to public health initiatives post 2015.

Knowledge gaps about west Africa's diverse religious communities (table) delayed partnerships, obscured potential ways to mobilise their assets (ie, knowledge, trust, infrastructure, and networks), and complicated

assessment of the impact of interventions. Wide-ranging estimates of different religious communities reflect the complexities arising from overlapping religious affiliations and poor data. Identification of roles of religious actors, robust mapping of their presence and work, and forging of operational, institutionalised links between partners could contribute to fast, organised responses. Many faith-inspired initiatives started quickly and delivered wide-ranging support (eg, Caritas Internationalis and the Methodist Church); these initiatives included (besides health care) training of pastors and mobilisation of volunteers, texting of health messages to congregations, and care for abandoned orphans.[3] However, coordination was restricted and many opportunities were missed. If better equipped for public health challenges than at present, inter-religious structures could more readily coordinate efforts of both local denominations and international groups. Rich knowledge of, and appreciation for, the many roles of religious actors could enhance both health service delivery and public health approaches more generally.

This crisis and long HIV experience show how and why improved interdisciplinary approaches to public health are needed.[4] Complex interrelationships of culture, tradition, stigma, and discrimination affect uptake of health services and health systems' interface with communities. Practical multidisciplinary approaches can achieve results; for example, the World Vision's Channels of Hope programme in Sierra Leone combines scientific information and theology and engages religious leaders (Muslim and Christian).[5] Christian Health Associations active in Liberia and Sierra Leone engaged international volunteers, organised training, and imported medical supplies, but unclear relations with government health systems resulted in inadequate support to faith-run hospitals and clinics.[6] Strategies to strengthen basic health systems and public health approaches will benefit if they take full account of the on-the-ground presence of religious institutions and draw in an integrated way on relevant disciplines (for example, anthropology, religious studies, and social and behavioural sciences).

Health messages, crucial in public health approaches to infectious disease, are more readily accepted if developed with communities through two-way communication and respect for community expertise

	Guinea	Liberia	Sierra Leone
Population	12.2 million	4.3 million	6.1 million
Urban	36%	49%	39%
Muslim	70–85%	12–20%	65–78%
Christian	4–10%	40–85%	15–27%
Ethnoreligious	5–7%	4–40%	2–40%

Table: Religious landscape in Ebola-affected countries[1]

that is concentrated prominently in religious institutions. Ebola's close association with cultural and religious practices makes active community engagement especially important. Change of funeral practices was imperative to reversing the epidemic[7] and religious leaders (modern and traditional, Muslim and Christian) had to be involved. The resulting WHO Safe and Dignified Burial Protocol was vital in halting spread of the disease and laying foundations for community trust.[8–10] In many respects, the protocol was a game changer in the overall trajectory of crisis response. Organisation of home care and guarantee of proper quarantine procedures likewise demand religious communities' involvement.

These lessons apply to the Ebola-affected countries and beyond. They affect preparedness, strengthening of health and community systems, and development of meaningful partnerships, notably looking towards implementation of the post-2015 Sustainable Development Goals. Faith communities, omnipresent in Africa, can be part of the solution if included as full partners, engaging their powerful communications networks and local knowledge. Assessment of how faith resources were, and were not, engaged should be reflected on by the governments concerned and international partners.

*Katherine Marshall, Sally Smith
Berkley Center for Religion, Peace, and World Affairs, Georgetown University, Washington, DC 20007, USA (KM); and Joint United Nations Programme on HIV and AIDS, Geneva, Switzerland (SS)
km393@georgetown.edu

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Faith-based health care 1

Understanding the roles of faith-based health-care providers in Africa: review of the evidence with a focus on magnitude, reach, cost, and satisfaction

Jill Olivier, Clarence Tsimpo, Regina Gemignani, Mari Shojo, Harold Coulombe, Frank Dimmock, Minh Cong Nguyen, Harrison Hines, Edward J Mills, Joseph L Dieleman, Annie Haakenstad, Quentin Wodon

At a time when many countries might not achieve the health targets of the Millennium Development Goals and the post-2015 agenda for sustainable development is being negotiated, the contribution of faith-based health-care providers is potentially crucial. For better partnership to be achieved and for health systems to be strengthened by the alignment of faith-based health providers with national systems and priorities, improved information is needed at all levels. Comparisons of basic factors (such as magnitude, reach to poor people, cost to patients, modes of financing, and satisfaction of patients with the services received) within faith-based health-providers and national systems show some differences. As the first report in the Series on faith-based health care, we review a broad body of published work and introduce some empirical evidence on the role of faith-based health-care providers, with a focus on Christian faith-based health providers in sub-Saharan Africa (on which the most detailed documentation has been gathered). The restricted and diverse evidence reported supports the idea that faith-based health providers continue to play a part in health provision, especially in fragile health systems; and the subsequent reports in this Series review controversies in faith-based health care and recommendations for how public and faith sectors might collaborate more effectively.

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

School of Public Health and Family Medicine, University of Cape Town, Cape Town, South Africa (J Olivier PhD); The World Bank, Washington, DC, USA (C Tsimpo PhD, R Gemignani PhD, M Shojo PhD, H Coulombe PhD, M C Nguyen PhD, Q Wodon PhD); Presbyterian Church USA, World Mission, Louisville, KY, USA (F Dimmock PhD); School of Medicine (H Hines BA), and Stanford Prevention Research Center (E J Mills PhD), Stanford University, Stanford, CA, USA; and Institute for Health Metrics and Evaluation, University of Washington, Seattle, WA, USA (J L Dieleman PhD, A Haakenstad MA)

Introduction

In 2002, World Bank President James Wolfensohn said "half the work in education and health in sub-Saharan Africa is done by the church...but they don't talk to each other, and they don't talk to us."[1] Somehow, faith-based providers of health and education had disappeared off the policy and evidence map. This situation occurred despite the fact that Islamic hospitals and Christian missionary hospitals were some of the first modern health-care providers to be established.[2] In many low-to-middle income countries, even after colonisation ended and despite massive health-systems reconfigurations, faith-based health providers (FBHPs) have maintained a strong presence. However, FBHPs have been neglected by the worlds of research and policy for decades, mainly as a result of a general refocusing on public health provision and also since the historical (and sometimes present) drivers of faith-based health provision have been treated with mistrust, especially in connection with the controversies around health care provided with the underlying intent to proselytise (see Tomkins's and colleagues' review on controversies in this Series).[3] However, in the past decade, bilateral and multilateral donors, the UN agencies, and country governments have pushed towards better understanding of FBHPs.[4,5]

Here, we review the available evidence with a focus on sub-Saharan Africa and Christian FBHPs because little evidence is available for other contexts or other kinds of faith-based groups at present. Even with this focus, robust or systematic evidence is restricted, and substantial confusion and conflicting anecdotes exists in the published work on FBHPs.[6] Reports of the comparative advantages of FBHPs versus other public and secular providers (such as the possible reach, trust and access in communities, quality care, longevity, or service to poor people) are rarely substantiated and are usually balanced by reports of possible comparative weaknesses (such as poor human resource management, absence of financial sustainability, poor record keeping, or preferential service to particular religious groups).[7] The objective of this Series paper is to present what is

Search strategy and selection criteria

We based this Series paper on the assessment of peer reviewed and grey literature that introduces some recognisable evidence to the specialty relating to the importance and unique characteristics of faith-based health providers (FBHPs) in Africa. We searched in Medline, Google Scholar, EBSCO, and World Bank data archives for publications in English and French between Jan 1, 2000, and May 31, 2014, with more than 40 search terms (variations of "faith" and "health") and a geographical focus on Africa and low-income and middle-income country contexts.

We also drew from three other more detailed systematic reviews in which some of the authors of this Series paper participated and on interviews and engagement with key researchers with an established record in this area. This report draws on the review and empirical work recorded in a three-volume collection that focuses on the role of FBHPs in Africa. From this work, the analyses of factors such as the satisfaction of patients, extent to which FBHPs reach poor people, and their cost for households were done. Additionally, material was taken from two systematic review projects in progress, one that has been collecting materials (peer reviewed and grey in English and French) relating to religion and HIV/AIDS since 2008, and the other that has been collecting material on religion and public health since 2005. These two databases include material from 1980, to 2014, with the search terms "religion", "public health", and "HIV/AIDS" (each with several variations), and each containing several thousand distinct entries.

Key messages

- Increased attention has been paid to faith-based entities engaged in health from a policy level during the past decade
- Little systematic and similar data is available relating to faith-based, non-profit health providers
- Data from household surveys suggest lower market shares than commonly assumed, but higher levels of satisfaction than in public facilities
- Faith-based health providers play an important part in many countries in Africa, particularly in fragile or weakened health systems
- However, many faith-based health providers show signs of weakness and little ability to adapt to their changed health systems contexts and financial constraints
- Appreciation of health providers' contribution to health care is tempered by lingering controversies tied to faith-based social engagement (which are discussed in more detail in later parts of this Series)
- Broad generalisations about faith-based organisations or the faith sector should be avoided
- More detailed health systems research is necessary (eg, research that unpacks how exactly faith-based health providers contribute (or don't) to universal health coverage at a country level)
- More detailed policy implementation strategies relating to faith-based providers are needed (eg, specific strategies for improved public-private partnership with faith-based providers)

Correspondence to: Dr Jill Olivier, Health Policy and Systems Division, School of Public Health and Family Medicine, University of Cape Town, Observatory, 7925, South Africa jill.olivier@uct.ac.za

more strongly supported by evidence, as a background for other reviews that follow, and include the caveat that more detailed assessments of health systems interactions are preferable and urgently needed. We cover a broad terrain of evidence and introduce empirical analyses done by some of the investigators of this paper. Our Series paper is followed by two more that discuss faith-linked controversies in global health, including sexual and reproductive health, harm reduction, violence against women, and end-of-life care; and five sets of recommendations for how public and faith sectors might collaborate more effectively to achieve health-related goals.

One of the main challenges to any kind of generalisable interpretation of faith-based health care is that the world of faith-based entities implicated in health is diverse and complex. What is frequently termed the faith sector at a policy level includes, among others, faith-based civil society organisations, informal faith-based programmes, initiatives and community-based organisations, larger national and international non-governmental organisations, congregations such as places of worship, religious leaders, faith-based health-care facilities, and denominational and interdenominational health networks such as the Christian Health Associations, which are national umbrella networks of FBHPs. The bulk of evidence on the role of FBHPs in health is predominantly on their role in the response to HIV/AIDS, which places restrictions on those seeking to understand specific health systems functioning or effects. At the turn of the 21st century, no one really knew how many faith-based entities existed or what they were doing towards health and development goals, and despite the launch of several mapping and scoping studies, evidence is still fragmented.

The magnitude of faith-based health services in Africa

The first kind of evidence usually sought at a policy level in relation to FBHPs is their comparative magnitude against other health providers. The magnitude of the diverse faith sector can be counted in several different ways. For example, thousands of faith-based community-based organisations and non-governmental organisations have been reported to contribute to all aspects of HIV/AIDS response (eg, WHO's 2004 World Health Report estimated that faith-based organisations [FBOs] account for about 20% of the agencies working on HIV/AIDS). Basic self-provided estimates of health facilities owned by faith-based groups show a similar scale. For example, The Salvation Army provides health services in 124 countries through 73 hospitals, 56 specialist clinics, 135 health centres, and 64 mobile clinics. In sub-Saharan Africa, the various Christian Health Associations operate and represent thousands of hospitals and clinics. The Adventist Church operates 173 hospitals and sanatoriums, and 236 clinics and dispensaries worldwide. The Catholic Church operates an estimated more than 5300 hospitals worldwide.

At a local level, a few studies directly compare faith-based entities against their equivalent secular entities. One example is the mapping of the Mukuru settlement in Kenya that reported 194 programmes working on HIV/AIDS, of which a third were classified as faith based. Birdsall analysed the South African National AIDS Database that lists registered organisations working in HIV/AIDS and about one in ten of those were self-identified as faith based. More generally, faith-based entities have been identified as being active in all aspects of public health, such as immunisation, antimalaria campaigns, child and maternal health services, and tuberculosis, although the comparative magnitude of this activity is not known.

Local congregations and informal faith-based initiatives and volunteer groups engage in health care in a different way. The Pew Research Centre estimated that in 2012, 84% of the world's population considered itself as religiously affiliated, and the world's main religions share a belief in the importance of caring for the sick (again, noting the controversies around drivers such as proselytisation, which often accompany this belief). Congregations are an important entry point for primary care and support, as are informal and community-based volunteer initiatives. For example, a study of the response of different local faith communities to orphans and vulnerable children in six African countries reported more than 9000 volunteers informally supporting more than 156 000 children within the study cohort. In Zambia and Lesotho, a religious health-asset mapping study done

for WHO reported the expected FBHP facilities and faith-based non-governmental organisations but also reported hundreds of local and mostly informal initiatives in each site mapped.

These examples depict a varied contribution of faith-based entities to health generally, but some clarity on the relative contribution of faith-based biomedical health provision versus other public and private provision exists. In most African countries, Islamic hospitals and Christian missionary facilities were among the first biomedical health-care providers and often established the first health systems. This history is not without controversy in view of the complex connections between FBHPs, proselytisation, and ties to colonial powers. However, in terms of magnitude, at the time of independence from colonial rule, many FBHPs dominated the health systems in terms of number of facilities and magnitude of services. However, since independence, FBHPs have experienced substantial shifts in this role. New national governments took a strong governance role and public systems expanded rapidly amidst a series of health sector reforms. Governance of most FBHPs was transferred from international denominational bodies to local churches, resulting in substantially reduced support from traditional sources and sometimes reduced growth of FBHP services.

Despite these great changes, nowadays (panel) a (problematic) perception exists that anywhere from 30% to 70% of health-care services are provided by faith-based entities of various forms worldwide and in Africa. Although some historical and empirical basis for these statements exists, the origins of such estimates are poorly acknowledged, and these estimates are often overstated.

During the past two decades, many attempts have been made to synthesise such evidence, especially for sub-Saharan Africa and anglophone countries. These assessments of the role of FBHPs are based on partial datasets and usually rely on rough counts of the number of hospital beds held by Christian Health Associations versus the public health system. All of these investigators highlight the limits of such syntheses (table 1). The countries shown in this Series paper tend to have a representative national faith-based health network such as a Christian Health Associations, and the estimates are based on self-reports of the number of facilities or hospital beds networked by the Christian Health Associations versus the public sector. These figures rarely factor in the presence of the private for-profit sector and rarely include other FBHPs that are not in-network (such as the Islamic health providers that are largely invisible). These countries are African states that have a historically higher presence of FBHPs, which is why a Christian Health Association is present (table 1).

On the basis of little evidence, FBHPs are present in many countries in Africa, usually in countries with otherwise weak health systems (table 1). The graphic example of this is the Democratic Republic of the Congo, a fragile state where a consortium of local FBHPs and other partners operate more than half of the national health system.

At a policy level, these poorly substantiated comparative magnitude estimates cause discord and have been detrimental to collaboration. For example, when estimates for this particular set of countries are stretched to represent the whole of Africa, the figures are distorted (because the countries not represented in table 1 tend to have a lower market share), and this tends to result in immediate push-back at policy level. Limitations to comparisons based on number of hospital beds also exist because this might be misleading if levels of use differ between providers and do not take primary care into account. Furthermore, what these market share estimates mask are other nuanced and important characteristic

Panel: Past and often problematic examples of market share estimates for faith-based health care

WHO

"Faith-based organisations... account for around 20% of the total number of agencies working to combat HIV/AIDS."

Christoph Benn (The Global Fund to Fight AIDS, Tuberculosis, and Malaria)

"Faith-based organisations in many African countries provide between 30% and 50% of institutional health care."

Katherine Marshall and Richard Marsh (The World Bank)

"Across Africa, for example, faith-based organisations provide up to 50% of health and education services, especially in poor, remote areas."

PEPFAR

"In certain nations, upwards of 50% of health services are provided through faith-based institutions, making them crucial delivery points for HIV/AIDS information services."

Tearfund

"Faith groups provide on average 40% of the health care in many African countries."

Bandy and colleagues (WHO)

"Faith-based organisations are major health providers in developing countries, providing an average of about 40% of services in sub-Saharan Africa..."

The United Nations Population Fund

"Moreover, there is clearly an important parallel faith-based universe of development, one which provides anywhere between 30–60% of health care and educational services in many developing countries."

The World Bank

"In many African countries, you provide 30–70% of the health services, and in post-conflict countries, the majority of primary education services."

Vitillo (CAFOD)

"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."

	Self-declared NFBHN market share (beds)	Number of NFBHN hospitals	Number of NFBHN health centres	Number of NFBHN training facilities	Selected examples of estimates as used in secondary literature*
Benin	40%	[illegible]	33	28	The private sector (individuals, private for profit entities and faith based entities) is estimated to have provided [illegible] of the outpatient consultations carried out in the country, and faith-based facilities do half of those private visits[illegible]
Botswana	10%	1	6	1	None
Cameroon	40%	20	153	1	The private sector represents 40% of the national supply of care, of which most is held by three faith based organisations[illegible]
Central African Republic	20%	2	52	19	The NFBHN provides more than 25% of the total health care provision in the country[illegible]
Chad	30%	6	194	1	Faith-based care is [illegible] of national health coverage, with [illegible] provided by facilities of the Catholic network[illegible]
Democratic Republic of the Congo	57%	83	500	20	Church related institutions represent 70% of health services;[illegible] faith-based organisations provide around 50% of health services provided and facilities owned[illegible]
Ghana	42%	58	158	33	All faith-based organisations (Christian and Muslim) provide 30% national health services;[illegible] the NFBHN represents [illegible] national health care[illegible]
Kenya	40%	76	808	24	The NFBHN provides 40% national health services[illegible]
Lesotho	40%	8	77	4	The NFBHN represents 40% national health services[illegible]
Liberia	10%	8	57	3	The NFBHN represents about 40% national health sector[illegible]
Malawi	37%	37	161	33	The church provides 40% of health services[illegible]; the NFBHN owns 37% of health services[illegible]
Mali	2%	–	–	–	None
Namibia		8	–		None
Nigeria	40%	143	2747	18	The NFBHN represents 40% national health services[illegible]
Rwanda	40%	–	–		Church affiliated facilities are 40% hospitals and [illegible] primary care[illegible]
Sierra Leone	30%	–	–	–	The NFBHN represents 30% of national health services[illegible]
Sudan	30%	4	–	–	None
Swaziland	–	3	77	1	None
Tanzania	42%	89	551	28	The NFBHN represents [illegible] of the national health service; the NFBHN represents about [illegible] of all health facilities, [illegible] of hospitals, and [illegible] of health services in rural areas[illegible]
Togo	20%	3	38	6	None
Uganda	53%	67	585	19	The NFBHN together own [illegible] beds, [illegible] hospital services, [illegible] hospitals, [illegible] lower-level health facilities, and [illegible] nursing/midwifery schools;[illegible] the Christian NFBHN provide [illegible] national health services; the diocese and parishes provide [illegible] of all private non-profit lower level units and hospitals[illegible]
Zambia	40%	35	155	3	The NFBHN represents 30% of all health services;[illegible] the NFBHN represents [illegible] of rural health-care provision and 30% of total health-care provision[illegible]
Zimbabwe	35%	80	45	11	The NFBHN represents 40% of national health services; Christian hospitals provide 68% of total bed capacity[illegible]

*[illegible]

Table 1: Basic data on estimated national faith-based health networks (NFBHN) market share by country

differences, such as differences in patterns of governance or access. For example, many anecdotes suggest that individuals might walk past cheaper public facilities to access FBHPs,[7] but there are only a few severely outdated analyses of user preference or comparative access to interrogate or verify such anecdotes.[9–11]

In the absence of more up-to-date access-related data, analysis of household surveys can provide a piece of the puzzle about the patterns of choice and use between different components of the health system.[12,13,14] The Marketing International reference and the US Demographic and Health Surveys do not separately identify FBHPs from other private providers, although some efforts have been made to extrapolate the FBHPs out of this large sample (which is inclusive of markets for self-medication, traditional practitioners, and drug peddlers).[15] More precise data are available for a subset of countries where multipurpose household surveys separately identify

FBHPs from other private "secular" providers.[illegible] In the 14 African countries in which this differentiation is possible, analysis reported the pooled average use-based market share of FBHPs was at about 6%. However, this estimate is almost certainly on the low side because some countries where faith-based provision is large, such as the Democratic Republic of the Congo, are missing from the sample. Also, household surveys might underestimate the market share of FBHPs if households do not know whether a provider is public or private, or whether it is faith-based or not, and mistakenly assume that a FBHP is a public provider (common with FBHPs that frequently act more public than private, often receiving public funding and taking on the responsibilities of a district hospital). When looking through this very different lens of understanding health-care use (where the entire representative sample is larger and includes more entities, so the portion held by all parties is automatically smaller), the estimates tend to be much lower. Despite these caveats, engagement with household datasets of this sort is one of the only systematic and comparative data methods available at this time. This approach highlights the massive array of actors to consider in policy discussion about the faith sector engaged in health.

These different ways of viewing the magnitude of faith-based health provision are not really comparable: bed counts cannot be adjusted by broad household-use estimates. However, by consideration of these different kinds of data, some important points emerge for those seeking to understand the importance of FBHPs in Africa.[illegible] First, estimates based on hospital bed counts often do not factor in private secular hospital beds because these are often not known, even to the government. Second, the popular estimates based on comparison of numbers of hospital beds does not adequately measure primary health-care level or community outreach. Third, estimates of market share based on facilities-based care does not account for the role of a wide range of other private providers of care such as shops or markets for self-medication, traditional (religious) practitioners, and drug peddlers. Such considerations are important in view of the high use of such providers in these health systems.[7] Fourth, the present estimates for magnitude of faith-based health care in Africa and the world are based on a select group of countries that have a strong historical footprint of faith-based provision. When estimates are provided for Africa, or the world, these seldom include the countries that have a low prevalence of FBHPs (eg, many Muslim-majority countries or South Africa, where FBHPs were nationalised into the public system), suggesting that regional or worldwide estimates in particular should be treated with caution. Finally, some of the post-conflict countries where FBHPs are known to have a large footprint owing to government failure, such as the Democratic Republic of the Congo, are not yet properly represented.

These factors suggest that overestimation and underestimation are common, so care is warranted when using such figures. The suggested comparative advantage factors that are sometimes said to be characteristic of FBHPs cannot be examined through such estimates. Consider whether the number of facilities owned by a faith group is more or less important than whether they are providing quality health care to poor people in support of goals such as universal health coverage? If even a handful of FBHPs were present, but were managing to provide a particular kind of access to a particular population, this would be important. But such consideration would need a vastly different evidence base than is available at present. We recommend a refocusing away from estimates of comparative magnitude, first towards the establishment of basic comparative and systematic evidence and, second, towards more complex systems analysis.

Financing and other support

Most FBHPs have experienced major changes in their health systems configuration and their financial resourcing in the last decades.[illegible] Around the time of independence, most African FBHPs have had to source new support from local governments and international donors because their traditional funding pools dried up (mainly as a result of the independence movements within local religious bodies).[illegible] FBHPs now commonly finance their services with a combination of government resources, user fees from patients, development assistance from bilateral and multilateral donors, and funding and in-kind contributions from within-country faith groups and local communities.[illegible] Although this diverse landscape undoubtedly affects how FBHPs operate, the services they offer, and who they serve, little comprehensive tracking of these funding streams exists. Information systems are often weak in these contexts (FBHPs are usually reluctant to share financial data) and the highly decentralised nature of FBHP networks makes reliable resource tracking only possible when it is done at the facility level.[illegible] A key source of funding, the user fees received from patients, is totally hidden at an evidential level.

Although some FBHPs are reluctant to align themselves too closely with governments[illegible] most are now becoming more integrated with their national health systems through alignment of priorities, contracts, and service-level agreements.[illegible] In most cases, a closer financial relationship with the government, usually through the Ministry of Health, has resulted in improved public–private awareness, if not always robust partnership. For example, partnership agreements have been forged between the Ministries of Health and several Christian health associations such as those in Chad, Malawi, Uganda, Tanzania, Zambia, Lesotho, Benin, Ghana, Kenya, and Cameroon.[illegible] These agreements usually state the terms of a reciprocal relationship, where

the FBHPs commit to supporting public health sector goals and priorities (in particular, serving poor people in hard-to-reach areas), and in return, the government commits to some kind of financial compensation, often in the form of salary support, and usually negotiated to match bed-based market-share estimates. However, in many of these countries, partnerships are strained, for example when service-level agreements are not fulfilled or finance and human management systems do not work together.

Development assistance for health from abroad can come to FBHPs through national strategies from bilateral and multilateral donors. The Christian Health Associations of Zambia has been a primary recipient of The Global Fund to Fight AIDS, Tuberculosis, and Malaria. Such funding can also flow from international non-governmental organisations to FBHPs. Although no assessment has been made of international funding flows to FBHPs, some efforts are being made to track finances from and to faith-based organisations in general. For example, a basic analysis suggested that at least US$1·53 billion of development assistance for health flowed from faith-based non-governmental organisations receiving funds from the US Government, Bill & Melinda Gates Foundation, or the Global Fund to Fight AIDS, Tuberculosis, and Malaria; however, this figure cannot be verified so it mainly shows that this funding flow exists. Similarly, the assessment of financial flows to FBHPs (as opposed to the broader range of faith-based non-governmental organisations) is restricted and relies on simple analyses.

Donations by other faith groups (local or from abroad) are an important source of support. Anecdotal reports of informal and often unrecorded flows of funds from congregations abroad exists. In 2008, US churches were estimated to have raised $4 billion for overseas ministries, some of which was health focused. Cash and in-kind contributions from local communities and groups are important, and research shows that many Christian FBHPs depend on irregular emergency support from their local governing denomination. Several studies have emphasised that the informal community levels are where substantial religious health assets lie, visible in capacities such as volunteering and small financial and material grants. A study of faith-based HIV/AIDS initiatives in six African countries reported that more than half of the initiatives identified were run without any external support. In countries where Islam is prevalent, Zakat and other direct payments from Islamic communities play a part in the funding of such initiatives (noting the substantial controversies sometimes linked to this kind of support, in particular the possible rise to politicised Islam). In Christian Zambia, a health mapping study reported a local Islamic group paying for the upkeep of a wing of the local government hospital, which shows the various forms health-care support can take.

Reach to poor people and cost for households

A preferential option for poor and vulnerable people is often a central stated tenet of the major faiths and also a worldwide priority of universal health care and public health. Many FBHPs were established with the stated intention to serve poor people in hard-to-reach locations, although this intent is at times controversially linked to other missionary drivers such as proselytism. Whatever the intent, some evidence substantiates the resulting presence of FBHPs in remote rural areas in Africa. More than 20 years ago in a World Bank analysis, De Jong noted that mission-based health facilities were located in poor, remote areas, either because of a commitment to serve the underprivileged or because they were filling a gap in areas not already met by government services. Similar statements have been made at a high level, especially in relation to sub-Saharan Africa, including in policy dialogue on Burundi, Ghana, Kenya, Malawi, Senegal, Tanzania, Zambia, and Zimbabwe. However, whether FBHPs can prioritise provision to the rural poor in the face of their present financial and systems constraints is a growing question.

Household surveys from the 14 African countries mentioned in this Series paper can be used as a basic first assessment of the extent to which FBHPs manage to reach poor people. In table 2, each row shows the share of the services provided by a specific type of provider that is used by households in five quintiles of wellbeing, from the poorest to the richest. None of the three types of providers (whether public, faith based, or private secular) serve poor people more than wealthier groups in absolute terms. However, although the household's use of facilities-based health care by wealth quintile shows private secular providers are the least pro poor, FBHPs seem to serve poor people slightly more than public providers (with 17% of patients in the poorest quintile).

These results are affirming for modern-day FBHPs, especially when one considers the resource constraints they now face. However, policy-level dialogue that

	Welfare quintiles					All quintiles
	Quintile 1 (poorest)	Quintile 2	Quintile 3	Quintile 4	Quintile 5 (richest)	
Public	14.5	17.8	[illegible]	[illegible]	26.8	100.0
Faith-based	17.3	17.8	19.4	16.9	22.1	100.0
Private secular	14.1	19.3	19.2	21.3	[illegible]	100.0
Total	14.5	18.8	[illegible]	21.5	27.1	100.0

Estimate from national household surveys adapted from [illegible] and colleagues. [illegible] based on the household survey question "where do you go for care when sick or injured?" The term private secular is acknowledged to be problematic; however, [illegible]. The analysis is based on [illegible] nationally representative household surveys for 14 countries: Burundi, Cameroon, Chad, Ghana (two surveys), Kenya, Malawi, Mali, Niger, Nigeria, Republic of Congo, Senegal, Sierra Leone, Swaziland, and Zambia. The questionnaires of these surveys are sufficiently detailed to identify separately public, private secular, and faith-inspired health-care providers.

Table 2: Use of facilities-based health care by wealth quintile, average for 14 African countries (%)

suggests FBHPs serve only poor people is being challenged. FBHPs often find themselves in a changed health system, with public sectors increasingly oriented towards serving poor people and developing public primary care in remote areas. Also, although many FBHPs might have been historically located in remote and poor areas, profound changes have occurred in the geography of poverty in many countries.[8] Faith-based clinics and hospitals that were established in rural areas find themselves surrounded by urban (sometimes wealthier) communities as a result of the combined effects of migration and population growth and because mission settlements often transformed into commercial community hubs.

Another key consideration is cost recovery (sometimes described as Robin Hood payment mechanisms). Many FBHPs need to recover a large share of their costs through user fees and, as such, could become (on average) more expensive for households than public facilities, which might be a barrier for very poor people (note, however, that FBHPs often have sliding-scale cost recovery mechanisms). We looked at the cost ratio for households for each type of provider (based on the same data and analysis as table 2), and on average FBHPs were more expensive for households than public facilities (table 3).[4] These figures can in part be explained by the fact that FBHPs usually do not benefit from the same level of subsidisation from the state. They are also shown here to be more expensive than the category of private secular providers, but this might be expected in such surveys as this category also includes traditional healers, peddlers, chemical stores, and other low cost health-care providers to which poor people might turn to. This heterogeneity in the private secular sector explains why the average cost of care in that sector is low and also why the sector's use in very poor people is substantial.

These broad comparisons of use and costs for households are across all types of facilities within one of the three sectors (public, faith based, and private secular) and across all types of consultations.[5] The fact that different providers have different services explains part of the differences in cost. Although faith groups were involved with conceptualising primary health care in the 1970s, in practice they tend to be heavily hospital centric, which makes FBHP systems (and services) more expensive.[7] The comparative cost ratio of FBHPs is lower for the bottom three quintiles than for other groups (table 3). This result might support the argument made by FBHPs that they are making efforts to keep their costs affordable for poor people through cost-recovery strategies.[4,5] But this claim is only lightly shown, and again, the lesson is that more robust evidence is needed in relation to the routine systems functioning of FBHPs, which might include activities to keep costs low and services accessible to poor people in resource-constrained environments. We also advise steering away from the broad question of whether all FBHPs in the world have a preferential option for poor people or not, as this is largely futile in the face of local differences.

	Welfare quintiles					All quintiles
	Quintile 1 (poorest)	Quintile 2	Quintile 3	Quintile 4	Quintile 5 (richest)	
Public	1.11	0.77	0.94	0.86	0.96	0.85
Faith-based	1.04	0.95	0.55	2.03	1.52	1.71
Private secular	0.76	1.14	1.13	1.12	1.03	1.08

Estimates from national household surveys adapted from [illegible] and Wodon.[4] The analysis is based on a subset of the surveys mentioned in table 1 for Burundi, Cameroon, Ghana, Nigeria, Malawi, Sierra Leone, Swaziland, and Zambia. The analysis provides estimates of the cost ratio for households for each type of provider compared with the average cost of consultation across all cost providers, so a ratio greater than 1 implies that costs are higher than average.

Table 3: Average cost ratio for households of health-care providers by household wealth quintile for eight African countries (%)

Quality of services

Understanding of the characteristic nature and quality of services provided by FBHPs is crucial, eclipsing magnitude as a policy issue, since even small pockets of quality provision to poor people in areas where other services do not reach would be a more important concern than whether they compete in size or number of beds with the public sector across the whole system. In the absence of other systematic data, quality can be proxied in a rudimentary way by rates of patient satisfaction. Although satisfaction is only a partial measure of quality (and not as robust as other measures such as clinical outcomes, which are not available), it is important because it affects access and the demand for care in households. A systematic review of published work on comparative satisfaction with faith-based versus other health-care providers in Africa noted that most of the available empirical evidence showed FBHPs enjoying higher satisfaction rates from their clients than other health providers (particularly other public facilities), although this evidence was varied and usually qualitative.[6]

Household survey data can again provide some clues, with data from six countries where FBHPs enjoy higher satisfaction rates than both public and private secular facilities (table 4). These data support the anecdotal evidence of perceived higher quality of care that can be found in FBHPs.

What drives the higher satisfaction rates with FBHPs? Most studies show that it might not directly be religion that makes the difference. Although FBHPs have in the past been accused of religious favouritism (only serving clients of the same religion), this is not apparent in present studies, suggesting that direct proselytism is restricted (or at least has been constrained by integration with the public system), and access is not commonly denied based on religious terms.[6] Few indications suggest that patients are choosing FBHPs by their own religious affiliation. But the secondary effects of religion

	Welfare quintiles					All quintiles
	Quintile 1 (poorest)	Quintile 2	Quintile 3	Quintile 4	Quintile 5 (richest)	
Public	65·6	67·4	64·0	70·5	57·4	59·5
Faith-based	73·8	84·3	77·9	80·6	64·0	78·6
Private secular	75·2	75·4	75·1	72·2	76·0	74·9
Total	70·5	70·9	68·4	69·3	72·6	70·1

Estimates from national household surveys adapted from Wodon and colleagues. The analysis is based on a subset of the surveys mentioned in table 2 (for Burundi, Ghana, Mali, Niger, Republic of Congo, and Senegal).

Table 4: Average satisfaction rates with health-care services across wealth quintiles in six African countries (%)

and in particular a religious organisational culture in these FBHPs does seem to have an effect. For example, in Burkina Faso, the reasons that led patients to choose FBHPs are not immediately related to religion itself, but seem to be driven by lower out-of-pocket costs for households and then by perceptions of a higher quality of service than public health providers. In Ghana, perceptions of high quality are by far the most dominant factor for patients and also for health workers' choice of employer. In many of the available studies, the quality of the services provided is perceived as high because of a particular attention paid to the dignity of patients, sometimes articulated as more compassionate care than received elsewhere, such as in other public health facilities. Again, this comparison of quality care is poorly substantiated, as are its drivers or causes. One study in Uganda did find that FBHPs have a higher performance than that of staff in other public facilities, attributed mainly to their intrinsic motivation, with staff driven to work for longer hours and sometimes for less pay by the faith-based organisational ethos. Several other hypotheses have been suggested, such as different governance structures, community ownership, intrinsic values and organisational cultures promoted among the health workers, or low patient–health worker ratios enabling more time to be spent per consultation. However, the connection between faith-based values and health systems performance needs substantially more attention to be able to inform policy-level action.

Conclusion

This Series paper has deliberately focused on the growing evidence of the nature of health care provided by faith-based health providers in Africa. The comparative weaknesses and potential negative effects associated with some FBHPs should be known. For example, contrasting with the above emerging evidence, published work commonly states that FBHPs can be of poorer quality than their public counterparts in some locations and that they sometimes have weak governance (such as financial and human resource management) as a result of managers being hired because they are a said to be good Christians rather than skilled health-service managers. Additionally, although religion is described mainly as a positive value, when theology mixes with health-service policy, negative health effects have been noted, most strongly documented in relation to sexual and reproductive health. However, the slowly emerging evidence on FBHPs suggests that they are not simply a health systems relic of a bygone missionary era, but still have relevance and a part to play (especially in fragile health systems), even if we still know little about exactly how they function.

The main conclusion is that more and improved data are needed to provide support at management and policy levels on every aspect relating to how FBHPs routinely function within their health systems. We need to move away from broad generalisations of the magnitude and character of FBOs and instead find out how different kinds of FBHPs operate within different contexts and systems. Rather than relying on basic proxies, we need to understand in a more complex manner, the interactions of management practice, organisational culture, pharmaceutical supply, cost recovery, and human resource management, and how these affect (clinical) quality, satisfaction, and use, and then how this affects access, reach to poor people, and broader goals such as universal health care.

For the presence of FBHPs to be invisible in some contexts is no longer acceptable, in particular fragile and post-conflict states where their role seems to be potentially important. Non-Christian providers, non-mainstream religious groups, and non-anglophone contexts are worryingly absent from the present analyses (particularly as there seems to be a substantial growth in Muslim health-care provision in some regions of Africa). Furthermore, increased information gaps are found in regions such as South and Central America, Asia Pacific, and eastern Europe.

This missing information is urgently needed if FBHPs are to align with their national governments in a way that strengthens the systems.

Contributors
JO and QW jointly conceptualised, wrote, and edited this Series paper as well as the group of studies on which this paper is based (a World Bank programme) to which CT, BO, MS, HC, FD, and MCN contributed substantive content. EDK, JJD, and AH contributed to the review of this paper and HH to the organisation of the work. All authors reviewed and approved the final version.

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The authors declare no competing interests.

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Faith-based health care 2

Controversies in faith and health care

Andrew Tomkins, Jean Duff, Atallah Fitzgibbon, Azza Karam, Edward J Mills, Keith Munnings, Sally Smith, Shreelata Rao Seshadri, Avraham Steinberg, Robert Vitillo, Philemon Yugi

Differences in religious faith-based viewpoints (controversies) on the sanctity of human life, acceptable behaviour, health-care technologies and health-care services contribute to the widespread variations in health care worldwide. Faith-linked controversies include family planning, child protection (especially child marriage, female genital mutilation, and immunisation), stigma and harm reduction, violence against women, sexual and reproductive health and HIV, gender, end-of-life issues, and faith activities including prayer. Buddhism, Christianity, Hinduism, Islam, Judaism, and traditional beliefs have similarities and differences in their viewpoints. Improved understanding by health-care providers of the heterogeneity of viewpoints, both within and between faiths, and their effect on health care is important for clinical medicine, public-health programmes, and health-care policy. Increased appreciation in faith leaders of the effect of their teachings on health care is also crucial. This Series paper outlines some faith-related controversies, describes how they influence health-care provision and uptake, and identifies opportunities for research and increased interaction between faith leaders and health-care providers to improve health care.

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Institute for Global Health, Institute of Child Health, UCL, London, UK (Prof A Tomkins FMedSci); Partnership for Faith and Development, USA (J Duff MPH); Islamic Relief Worldwide, Birmingham, UK (A Fitzgibbon); UNFPA, New York, NY, USA (A Karam PhD); University of Ottawa, Ottawa, ON, Canada (Prof E Mills PhD); Buddhist Healthcare Chaplaincy Group, London, UK (K Munnings BSc); UNAIDS, Geneva, Switzerland (S Smith MSc); Azim Premji University, Bangalore, India (Prof S Rao Seshadri PhD); Hebrew University-Hadassah Medical School, Jerusalem, Israel (Prof A Steinberg MD); Caritas Internationalis, Geneva, Switzerland (R Vitillo MSW); and Daystar University, Nairobi, Kenya (P Yugi PhD)

Correspondence to: Prof Andrew Tomkins, Institute for Global Health, Institute of Child Health, UCL, London WC1N 1EH a.tomkins@ucl.ac.uk

Introduction and ethics

More than 80% of the world's population reported having a religious faith, but attribution of individual health-related viewpoints to this faith is very difficult because of variations in acceptance of the authority and interpretation of sacred texts and viewpoints that might be substantially modified by culture, education, economics, politics, and laws. We describe a series of common religious faith-related controversies in health care, reviewing some teachings within the different faiths. We also examine ways in which faith-inspired groups are advocates for, and provide, health-care services, and we make a plea for improved analysis and documentation of faith and health-care interactions to provide improved health-care services, especially for marginalised populations.

Codes of medical ethics can be considered on four levels: motivation; the source of reference and method of analysis; the ethical principle, theory, or value; and the consequences. Secular ethics is based on humanist values whereas faith-based ethics is based on sacred texts and teachings that are interpreted by faith-grounded experts.

The humanist approach has four fundamental principles: autonomy (recognition that every person has intrinsic value and dignity, often viewing autonomy as the most important ethical principle), non-maleficence (do no harm), beneficence (the moral obligation to help others in need), and distributive justice (which requires that rights and assets should be distributed in an equitable and appropriate manner within society). Faith-based ethics and secular bioethics share many principles, but differ in several ways. Faith-based ethics give varying weight to each of the previous four ethical principles. A high value on the sanctity attributed to human life might conflict with expectations of rights and emphasises the need for mutually shared values and solidarity, which might lessen the overriding importance of autonomy. Ethical issues are also important, though less frequently discussed, in public-health medicine and health-care policy.

Search strategy and selection criteria

We searched PubMed, PsycINFO, and CINAHL for articles published in English between Jan 1, 1975, and Dec 31, 2014 with the search terms "faith", "religion", "ethics", "controversies", and "health care". We also searched websites of faith-based and secular organisations with expertise and experience in religious faith and health care.

Faith-linked controversies

Family planning

Different viewpoints exist on when human life begins. Buddhists, Catholics, and Hindus teach that human life starts at the moment of conception. Protestants vary; some believe that human life starts at conception whereas others believe it starts at implantation or even later. Islam teaches that human life begins after 4 months of pregnancy, with the infusion of the spirit into the fetus. Judaism teaches that human life is progressively acquired, starting 40 days after conception.

Many Buddhists oppose contraceptive methods that prevent implantation, including intrauterine devices and the emergency contraceptive pill. Catholics teach that couples should use natural family planning by restricting sexual intercourse to infertile periods in the woman's menstrual cycle. Protestants accept oral or injectable contraceptives and condoms, but vary on their acceptance of intrauterine devices and the emergency contraceptive pill. Hinduism has no injunctions against contraception. Muslim opinion on contraception varies, a minority arguing that it is categorically prohibited, whereas the main opinion allows contraception, permitting oral

and injectable contraceptives and condoms.[illegible] Judaism accepts oral contraceptives and intrauterine devices as the preferred contraceptive methods when contraception is sanctioned by Jewish law, followed by diaphragm and rhythm methods; condoms are forbidden.[illegible] Acceptance of family planning can be strongly supported or discouraged by the teaching and personal influence of faith leaders.[illegible]

Faith-based family planning services usually operate within national government frameworks, but there is little assessment of how much delivery of information, services, and supplies is influenced by a faith perspective. In particular, disappointingly little assessment has been done of the content, coverage, and effect of faith-based family planning services for populations in sub-Saharan Africa.

Abortion and artificial reproductive technology

All major religious faiths oppose abortion for sex selection. Faith-based viewpoints vary on abortion for preservation of maternal life in severe illness, which is unacceptable to the Catholic Church. Faith groups also vary in their viewpoints on abortion for pregnancies that might contribute to psychological ill health.

Modern technologies can increasingly diagnose and treat fetal abnormalities in utero, but some clinicians might recommend abortion. Catholics teach that prenatal diagnosis is acceptable to enable procedures that treat the human fetus, but abortion is not acceptable.[illegible] Many Buddhists reject abortion for fetal abnormalities, maintaining that meaningful life is possible, even for children with severe disability.[illegible] Protestants vary: some support early detection of, and abortion for, abnormalities that lead to disability, such as Down's syndrome, but others do not.[illegible] Hindus also vary, making their decision according to what is thought to be least harmful to the mother, the fetus, and society.[illegible] Some Islamic scholars permit abortion for conditions such as thalassaemia; decisions over abortion for serious fetal abnormalities can be informed by the belief that ensoulment occurs 120 days after conception.[illegible] In Judaism, many rabbis accept abortion before 40 days of gestation for serious fetal abnormalities, and after that abortion is only permissible if fetal malformation is incompatible with life. Preservation of maternal life is highly regarded in Judaism when managing life-threatening conditions in pregnancy. There are few data for the influence of faith-based viewpoints of patients on their decision to abort for fetal abnormality or the provision of abortion services for fetal abnormalities by faith-inspired health-care providers.

Modern artificial reproductive technologies are increasingly available to previously infertile couples. Faith leaders in Buddhism, Protestant churches (variably), Hinduism, Islam, and Judaism support in-vitro fertilisation and artificial insemination by a woman's husband,[illegible] but generally oppose artificial insemination by a donor.

Key messages

- More than 80% of the world's population report having a religious faith
- Faith-linked controversies in health care are often closely linked with culture, social factors and politics; precise attribution is difficult
- Child protection practices—child marriage, female genital mutilation and immunisation—vary between and within faith groups
- Faith groups differ in their support for health care practices including family planning, sexual and reproductive health, HIV care and harm reduction
- Notwithstanding some differences, there is increasing documentation of different faith groups working together to achieve considerable improvements in health care
- Policy-makers and Faith Leaders strongly influence the provision and uptake of health care but largely work independently of each other, often lacking knowledge and appreciation
- Robust research is urgently needed on the interface between faith and health care in order to improve provision and uptake of health-care, especially for marginalised populations.

Child marriage

The UN Convention on the Rights of the Child (1990) defines a child as anyone younger than 18 years, and yet a third of the world's girls are married before the age of 18 years and one in nine are married before age 15 years. The adverse effects of pregnancy in children are substantial.[illegible] Historically, many faith groups have supported existing customs around child marriage, citing the benefits in terms of chastity and fidelity. However, since the early 20th century, many faith groups have encouraged changes in law and conformity to state laws on age of marriage. Catholic, Protestant, Hindu (including the Arya Samaj and the Brahmo Samaj), and Jewish groups have raised the acceptable minimum age for marriage to 18 years. Buddhists do not promote particular viewpoints on optimum age for marriage. For some Islamic leaders, acceptable marriageable age is when a girl has reached sexual maturity; other Islamic leaders teach that marriage is allowed between 15 and 18 years of age.

Although traditions tend to prevail over religious teachings, many religious leaders work with communities to increase parental and community awareness about the need to stop child marriage.[illegible] In Niger (PLAN International)[illegible] and Yemen (Pathfinders and others; panel 3),[illegible] programmes include messages about the ideal age for marriage within Friday prayers. Faith-based organisations, such as Tear fund, support church partners in many African countries with their programmes on Guardians of our children's health.[illegible]

Panel 1: Benefits for child protection by interaction with religious leaders

A project in Yemen underscores the importance of engagement with and education of religious leaders in campaigns to prevent child marriage

After a pilot intervention in Amran, where 57 planned girl child marriages were prevented, the project was scaled up to five governorates. The Ministry of Religious Affairs asked all religious leaders to disseminate messages on the health and social consequences of child marriage in their Friday sermons. Religious leaders reached 429 147 individuals by the end of April, 2009, in the five governorates.

The end of project review concluded that religious leaders provide a critically important role for health education at the community level by helping the health education volunteers in the specialty as well as engaging in broader advocacy efforts in reproductive and child health. They lend credibility to the effort and help reduce cultural sensitivity and increase acceptability of interventions.

Tostan (meaning breakthrough in the west African language of Wolof) is an international non-governmental organisation based in Senegal, west Africa dedicated to putting African communities in charge of their own futures

Although not the sole focus of their work, female genital mutilation (FGM) has become the rallying point for social change in many of the communities. Tostan works through its human rights-based community empowerment programme to help community members to draw their own conclusions about FGM and lead their own movements for change. So far, more than [illegible] communities in eight African countries have, in [illegible] ceremonies, publicly declared their decision to end FGM and child and forced marriage. External assessments have shown the public declarations for abandonment are not yet 100% effective, but are necessary for building the critical mass that does eventually lead to FGM becoming a thing of the past.

"Engagement of local religious leaders is a key priority of the community empowerment programme" said Mohammed Cherif Diop (personal communication), Tostan's Islamic rights specialist and head of child protection, who is working to build a critical mass of faith leaders who show that they support the rights of women.

Female genital mutilation

Female genital mutilation (FGM) is also known as female genital cutting and female circumcision. FGM is defined by WHO as "all procedures that involve partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons". The effects are often devastating. An estimated 101 million girls in Africa have been cut when they were less than 10 years old. Some local religious leaders and medical personnel might uphold the practice.

Christianity and Judaism oppose FGM; however, FGM occurs in some Christian communities in Burkina Faso, Egypt, Ethiopia, and Kenya, who justify it as a traditional, centuries-old practice that maintains a girl's purity by restricting or controlling her sexuality. Indeed, FGM had been widely practised before the introduction of Christianity and Islam, which emphasises the need to distinguish between cultural and faith drivers for attitudes and practice in health care. Islamic scholars differ in opinion; some scholars refer to a jurisprudential principle that there should be no harm to the body and others quote a contested hadith (sayings of the Prophet Mohammed) that allegedly advocated for a lighter type of cutting, thus giving rise to a sunnah (a commendable but not an obligatory practice). However, some Islamic scholars do not accept the authenticity of either the hadith or the practice. FGM is not practised in countries with large Buddhist or Hindu populations and it is not supported by either religion.

Several programmes show that elimination of FGM can be achieved rapidly if communities, supported by religious leaders, decide to abandon the practice. Sheikh Ali Gomaa, formerly the Grand Mufti of Egypt and then Sheikh Al-Azhar, issued a fatwa (religious edict) on female circumcision noting that "since medical specialists have come to the consensus that even the least invasive of the circumcision procedures causes harm, FGM is forbidden and should be criminalised". The Shia Grand Ayatullah of Lebanon, Sayed Muhammad Hussein Fadhullah, also issued a fatwa forbidding FGM. FGM is now illegal in 24 African countries and in 12 industrialised countries with migrant populations from FGM-practising countries.

Immunisation

All major religions support immunisation of children. However, a few Christian and Jewish groups object to vaccines derived using cell lines from aborted fetuses; some groups also claim that immunisation shows a distrust in God. Some faith leaders have disseminated misinformation, for example that some vaccines contravene halal dietary standards or contain contraceptives or sterilisation drugs. Other faith leaders have political and sectarian reasons for forbidding communities to immunise their children. Despite pronouncements on the safety of oral polio vaccine by Nigerian Islamic leaders, oral polio vaccine immunisation is still opposed in some communities. Several factors contribute to the breakdown of confidence in immunisation, including putative covert military operations in collaboration with health workers within these communities. Some religious schools have not supported human papillomavirus (HPV) vaccine immunisation on the moral basis that vaccination of schoolchildren against HPV could lead to conclusions that sexual abstinence before marriage and fidelity thereafter are not necessary.

Although manipulation of some faith leaders for political ends is a serious issue, many examples of faith-based support for immunisation exist, as reviewed by the Joint

Panel 2: UNICEF 2013[illegible]

"Almost 5000 schools and madrassas promote polio eradication on a monthly basis in Karachi, Pakistan." As a teacher at a madrassa in one of Karachi's poorest areas, Qari Aqeel educates children in the fundamentals of Islam and the Holy Quran. He also tells students, from his own painful experience, what it is like to live with polio. As a devout Muslim, Aqeel takes his role as guardian of the children under his care very seriously. Clear guidelines are given, in an Islamic hadith, about the personal responsibility of every Muslim to care for others, "All of you are guardians, and all of you will be asked about the wellbeing of those who you are responsible for". Aqeel talks to parents and children about the importance of vaccination from an Islamic perspective and tries to personally ensure that every child at the madrassa is vaccinated against polio. Pakistan's Government, with technical and logistic support from UNICEF, has begun to shift its polio communication approach to highlight the risks of the disease and emphasised vaccination as an Islamic responsibility.

As part of this initiative, Aqeel has stepped further into his role as a guardian. In a video shown on Pakistani television, which aims to reach 21 million Pakistani households, Aqeel takes the spotlight away from the politics and misunderstandings that can muddy the dialogue about polio vaccination.

Learning Initiative on faith and local communities (JLIFLC).[illegible] Additionally, some Catholic groups in the USA support HPV immunisation for schoolgirls and oral polio vaccine is supported by Islamic groups in Pakistan[illegible] and Nigeria. Fatwas by Islamic scholars about the benefits of immunisation and collaboration between imams and UNICEF have helped immunisation in thousands of Koranic schools in Pakistan (panel 2). Many faith communities now promote and deliver immunisation in countries where it had previously been opposed.

Stigma and sexuality

Many faith communities have responded to HIV,[illegible] taking major steps to reduce stigma and discrimination and provide widespread health care and support; unfortunately, other communities have not. Stigmatising attitudes and behaviours towards people with HIV, or thought to have HIV, result from a range of cultural attitudes, traditional practices, laws, and interpretations of religious beliefs; these views are serious obstacles to the HIV response.[illegible] Many people experience stigma after declaring their HIV status. However, the International Network of Religious Leaders living with or personally affected by HIV or AIDS (INERELA) website describes how religious leaders living with HIV in Africa and Asia now live and work with integrity and respect.[illegible] The World Vision Channels of Hope methods,[illegible] the INERELA+SAVE toolkit,[illegible] and Tearfund training materials[illegible] build on the positive aspects of faith teachings, which include HIV, human rights, sexuality, and gender.

Panel 3: Roadmap for faith-based organisations to expand access to HIV treatment[illegible]

Faith-based organisation (FBO) partners came together with international organisations, donors, governments, and UN representatives to increase and scale up FBO work in providing HIV treatment.[illegible] While meeting participants were travelling to the consultation, a law was signed in Uganda to criminalise homosexuality (in which men have sex with men).

A participant from Uganda described how on returning home, his first task would be to discuss with his staff how to protect health-care service provision to homosexual men in Uganda and how to protect patients and staff in the context of the new law. For him, his staff, and clients, the new law has a very immediate effect on health-care delivery. He was very clear that as a doctor in a faith-based health-care facility, his priority is to protect non-judgmental service provision and the safety of his patients and staff.

Subsequent to the meeting, another participant, Cardinal Peter Turkson (President of the Vatican's Pontifical Council for Justice and Peace), was asked questions about the homosexuality law in Uganda by the media. He made strong statements about the importance of not treating homosexual people as criminals and, at the same time, urged caution on the part of the international community in terms of withdrawing financial aid in response to the law. Some civil society groups also cautioned against aid cuts, arguing that this can negatively affect health-service provision. These kinds of statements are very influential in this highly charged environment.

Outcomes from this meeting build on recommended roles and responsibilities of faith-based organisations and international partners as articulated in the UNAIDS Strategic Framework for Partnership with FBOs. Adherence to such principles of mutual respect and the provision of non-judgmental, evidence-informed health care by both FBO and secular partners is essential.

The Indian Interfaith Coalition on AIDS engages with religious leaders as mediators of hope in their respective communities, creating a stigma-free and discrimination-free response. The group has been influential in motivating the Hindu community response and encourages other major Indian faiths (Islam and Christianity) to work through their faith leaders to mobilise an effective response around HIV/AIDS.

One area of controversy is homosexuality. Although Hinduism accepts homosexuality and Buddhist viewpoints vary on its acceptance, traditional interpretations of Christian, Islamic, and Jewish scriptures state that sexual activity should be restricted to between one man and one woman within the context of marriage, and homosexual acts are not accepted.[illegible] This contrasts with the lived experience of people who

Panel 4: Gender-based violence

Although often prevalent in conflict and humanitarian contexts, sexual violence is common within communities worldwide, but as an issue that is largely hidden. Women, girls, men, and boys are all at risk of sexual violence. Today, many women (in some countries, as many as one in three) are beaten, coerced into sex, or otherwise abused in their lifetimes. Worldwide, one in five women will become a victim of rape or attempted rape in her lifetime. Gender-based violence increases the risk of HIV infection and contributes to malnutrition in women and their children.

In May, 2014, the UK Government hosted the Ending Sexual Violence in Conflict Meeting in London, UK, in which the role of faith leaders as a first port of call for many survivors of sexual violence was prominent.

We will speak out (WWSO)

WWSO is a worldwide coalition of Christian-based non-governmental organisations, churches, and organisations supported by an alliance of technical partners and individuals who together commit themselves to see the end of sexual violence across communities around the world. The WWSO coalition is dedicated to empowering women and girls, transforming relationships between women and men, and ensuring that the voices of survivors of sexual violence—women, girls, men, and boys—are central to their work.

are lesbian, gay, bisexual, or transgender (LGBT) for whom this is not a lifestyle choice but an expression of their identity. UNAIDS reports that 63 countries criminalise some aspect of HIV (including non-disclosure, exposure, or transmission) and 78 countries criminalise consensual same-sex sexual behaviour. UNAIDS clearly states that the criminalisation of HIV transmission and homosexuality has a negative effect on HIV and health-care provision; ending punitive laws will support access to life-saving HIV services.

Some Christian leaders challenge traditional interpretations of scriptures, and some churches now offer blessings on, or perform, same-sex marriage. Although some religious leaders support criminalisation of same-sex behaviour, prominent Buddhist, Christian (Anglican and Catholic), and Muslim leaders strongly condemn stigma, discrimination, and violence towards people who are LGBT. Jewish law also teaches that all people should receive medical care and empathy, regardless of their lifestyle, although same-sex relationships are strictly prohibited.

The interventions by faith-inspired individuals, including politicians, in persuading the former US President George W Bush and a sceptical US Congress to launch PEPFAR (the President's Emergency Program for AIDS Relief) in 2003 have been described, including the emphasis on abstinence-only methods for prevention of HIV and non-use of US funds for abortion-related activities. Much of PEPFAR funding was channelled through faith-based health-care providers in Africa, building on long-standing medical missionary work. Some argue that US faith groups have contributed to criminalisation of homosexuality in Africa. However, attribution of development of laws to single influences of faith, political leadership, or culture is not easy and can be unhelpful. The more nuanced complexity is shown by an example in Uganda (panel 5).

Harm reduction and HIV

Harm reduction interventions to prevent HIV transmission include opiate substitution therapy, needle exchange for people who inject drugs, condom use, male circumcision, postexposure prophylaxis, postoccupational exposure to HIV in health settings and rape, pre-exposure prophylaxis, and the use of treatment for the prevention of HIV transmission. Objections to harm reduction interventions include collusion with continuing unhealthy behaviour, thereby diverting attention from the primary need for behavioural change. However, there is much support for harm reduction from sacred texts, and many faith-inspired organisations, including Buddhist, Christian, Hindu, and Islamic, provide a wide range of harm reduction services in their HIV response, such as clean needles and condoms. Needle exchange is supported in predominantly Islamic Malaysia. Hindu groups support HIV prevention in India and many Christian groups provide male circumcision in HIV-affected communities. Buddhist groups support harm reduction HIV services in Cambodia, China, Laos, Thailand, and Vietnam, including mindfulness as a supportive component for seeking to achieve behavioural change among those with addiction to intravenous drugs. The Indian Interfaith Coalition on AIDS (IICA), involving faith leaders and health professionals from Hindu, Christian, and Islamic faiths, speak out against criminalisation of homosexuality and support provision of health-care services to vulnerable populations.

Violence against women

WHO defines violence against women as any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or in private life. Violence against women contributes to many fatalities and serious consequences for women and their children, both physical and psychological, and is prevalent in many countries.

Buddhism, Christianity, and Judaism oppose violence against women. Indeed, Catholic bishops in the USA, Uganda, and Ethiopia, among others, draw attention to the need for pastoral care. The Archbishop of Canterbury highlights the work of the Anglican Church in Democratic Republic of the Congo and elsewhere. Within Hinduism, some traditional texts specify that women should be honoured but not encouraged to think

for themselves. Coupled with karma theory that accepts suffering (including domestic violence) as payment for sins committed in a previous life, a strong tendency to accept violence against women or view it with complacency exists; however, international protest against rape has occurred, and the Prime Minister of India, a Hindu, has publicly named rape as a national shame. Islamic teachers vary: there is a word—idrabuhunna—within a Quranic verse that has been interpreted by some to justify the beating of wives, but many Islamic scholars do not accept any interpretations justifying violence.

Imams Against Domestic Abuse works with religious leaders and communities to make them more aware and active against all forms of violence against women, using the authority of the Quran and the Sunnah to protect them. Saudi Arabia has made violence against women illegal. We Will Speak Out (WWSO; panel 4) is a worldwide coalition of Christian-based non-governmental organisations, churches, and organisations working in advocacy against violence against women.

For the WWSO see www.wewillspeakout.org

Gender

According to WHO, sex refers to the biological and physiological characteristics that define men and women, whereas gender refers to the socially constructed roles, behaviours, activities, and attributes that a particular society deems appropriate for men and women. The term gender, however, is not without controversy in some faith communities and within various cultures. According to some health experts and human rights advocates, absence of specific terminology can lead to reinforcement of harmful patterns of behaviour or to turning a blind eye to inequalities, particularly those experienced by women in the provision and access of health-care services; however, many faith leaders oppose such deprecating and damaging viewpoints about women (panel 5).

Panel 5: Quote from Archbishop Desmond Tutu at the Women, Faith, and Development Alliance Breakthrough Summit at Washington National Cathedral, April, 2008

"Despite its global leadership on human rights and humanitarian aid, the faith community has failed to champion gender justice and the cause of women and girls. Religion has too often been used as a tool to oppress women, and we must bear responsibility for contributing to the unjust burden borne by women. Too often we have not named, and condemned roundly, culturally and traditionally rooted discriminatory practices like child marriage, genital mutilation and violence against women and children."

"We need courageous faith leadership rooted in our common understanding of the dignity and value of each human person. We must come together as people of faith and stand up for women and girls by addressing these issues from every pulpit and platform in synagogues, mosques, churches and other places of worship. The interfaith community must join with leaders in other sectors to press for more resources so that women and girls can change their own lives and those of their families and communities."

Faith activities

All religions believe that God or a superior force can intervene for the prevention and treatment of illness as a response to personal prayer, meditation, reading of sacred texts, or healing services. Such faith activities are often done in the hope that they will incrementally boost medical treatment and bring personal peace and healing. Although prayer offered by hospital chaplains and faith leaders is widely provided, strict guidelines exist, with disciplinary procedures in some countries, for doctors and nurses who offer prayer. Safeguarding of patients is important so that they are not pressurised by zealous proselytising individuals. Spiritual aspects of health care are therefore often excluded. In other countries, however, prayer for patients by staff is widely offered and evidently welcomed. Unfortunately, few data exist for the types of faith activities that patients would appreciate in different cultures. Concerns that humanitarian activities should not be offered to promote a particular religious standpoint is enshrined in the SPHERE guidelines, but many people affected by disasters live in countries where religion is practised widely and on a daily basis. Data are inadequate for the type of faith activities that such populations might value in times of illness or crisis, alongside humanitarian relief and psychosocial counselling. Judaism advocates combination of prayers and effective medical treatment.

Some (eg, specific Pentecostal African) groups emphasise dependence on prayer, which is promoted in congregations and TV channels, with advice not to take medical treatment. The popularity of healing missions, especially for those with disability and long-term illness, is well documented; however, the long-term effect of these missions on physical and mental health is not. Combinations of prayer within major faith systems and traditional belief systems, including sacrifices, appeasement ceremonies, and talismans, are common, but their effectiveness is unknown.

Buddhism emphasises the importance of seeking peace and freedom from pain, even in the presence of disease. Traditional healing ceremonies, together with informal counselling and HIV prevention messages, are offered by Buddhist groups throughout southeast Asia. Cooperation between the Yunnan AIDS bureau and the Sipsongpanna Buddhist Association provides community care and support in China. Traditional healing customs, such as Ayurveda in Hinduism, are widely practised and include consultation with local healers, retributive prayers, and meditation before going to practitioners of scientific medical care. Belief in a spiritual cause for illness and the need for casting out of evil spirits for

treatment of illness, especially mental illness and epilepsy, occurs in many countries, including some in Europe. The scale of such practices and the extent to which they contribute to improvement in health status or delay in accessing effective health care is largely unknown. National religious councils and faith-based health associations are reportedly increasingly active in educating and working with local traditional healers to improve access to effective health care, but there are few robust descriptions of such partnerships, their activities, or their effect.

End-of-life issues

Different faith-based viewpoints about end-of-life issues have been reviewed previously in *The Lancet*. Much advocacy by secular groups exists towards changing existing laws that prosecute health professionals for being involved with the killing or assisted suicide of patients, as evidenced by the law changes in Belgium, which now allow euthanasia and assisted suicide in children. Many faith-based groups strongly oppose killing of patients or assisting with their suicide; they are vigorously supported by palliative care health professionals. Indeed, faith-based groups are at the forefront of developing palliative care services. Buddhism, Christianity, Islam, and Judaism reject euthanasia and assisted suicide, even when the patient requests it. Rather, these religions support the appropriate provision or withholding of specific intensive medical treatments upon the wish of the dying and provide palliative care, including spiritual support. Hindus teach that although a person can be released from suffering, by euthanasia for example, it is undesirable. WHO's description of appropriate interventions for palliative care recognises both spiritual and psychological aspects of care, whereas the overall description of health (omitting spiritual) by WHO is secular.

Recommendations

A disturbing dearth of analysis of health-care-related controversies between and within religions exists; innovative research and documentation processes and programmes are urgently needed. Our Series paper merely identifies some faith-related factors affecting policy and practice in health care; deeper research, consideration, and action are needed.

Clinicians should become better informed about the faith drivers that affect their patient's attitudes, prejudices, behaviours, response to illness, and desire for health-care services if they are to provide professional, compassionate, and empathetic care respecting a patient's autonomous wishes. These issues are complex and our paper is merely an introduction, providing references for deeper reading. Review of how different faith-inspired groups promote and deliver health care with integrity and professionalism is really needed, especially in poor, marginalised, and unreached populations that are not adequately served by government services. The accompanying review on faith-based health care in Africa in this *Lancet* Series is important. The Joint Learning Initiative for Local Faith Communities, the Berkley Centre for Faith and Health at Georgetown University, USA, the George Washington Institute for Spirituality and Health, USA, and the International Religious Assets Programme at Cape Town University, South Africa, are also making important contributions, but more needs to be done.

Faith leaders could review their interpretation of sacred texts carefully in view of contemporary biomedicine, especially when differing viewpoints are held within the same religion. Analysis of the interaction between culture, politics, and faith is particularly important so that faith leaders and faith faculties can become more aware of how their faith-based viewpoints might become manipulated. As faith leaders become more aware of the effect of their teaching on patterns of health care, they might be astonished at how influential they are. Faith leaders could use their faith messages more effectively to inspire their congregations to adopt healthy behaviours and access effective health-care services much more frequently and effectively.

Many international agencies and some national health programmes reject any faith dimension and omit any spiritual dimension to health care. Greater analysis is needed about the ways that pressure groups, with secular agendas, campaign to keep faith out of health in the same way as faith groups are identified, and often vilified, when promoting faith-based agendas for health care and health-care policy. Such policy conflicts are rarely reported in peer-reviewed scientific literature. At the very least, health-care policy makers could look above their secular silos at what has been achieved by engagement with faith-inspired health-care groups; they too might be astonished at the results.

Health professionals, faith leaders, and policy makers are urgently needed to move out of their discrete disciplines and work together for improving health care. Robust markers already exist to assess the prevalence of child marriage, FGM, and immunisation coverage, as outlined in the reports on the State of the World's Children by UNICEF. Similar markers exist for stigma and violence against women, as well as strong published work on the variations in uptake rates for HIV/AIDS services. These indicators need to be developed to provide increased analysis and understanding of factors affecting health care, both within and between faith groups. Collaborative research should be methodologically rigorous and provide an evidence base for changes in policies and programmes. The present, all too common, practice of berating or ignoring faith groups, often on the basis of hearsay, is totally unacceptable.

Contributors
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Faith-based health care 3

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

Jean F Duff, Warren W Buckingham III

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Partnership for Faith and Development, Washington, DC, USA (J F Duff MPH) and Buckingham Global Health LLC, Silver Spring, MD, USA (W W Buckingham III ABD)
Correspondence to: Ms Jean Frances Duff, Partnership for Faith and Development, Washington, DC 20016, USA
jeanduff@pfaithdev.org

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.

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]

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.

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

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. As governments and donors prioritise progress on health and increase health-related expenditures, 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, 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, multilateral bodies, 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

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 Maklele social mobilisation campaign, which increased immunisation rates in children under one year old from 6% to 75%.
- 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.
- 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.

international cooperation. The US Government Strategy on Religious Leader and Faith Community Engagement 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).

See Online for 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 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 contract through service-level agreements with states and international donors to provide health services in countries such as Zambia, the Democratic Republic of Congo, and Tanzania); 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 $38·1 million to the Global Fund for AIDS, Tuberculosis, and Malaria [Henderson G, Global Health Initiative, United Methodist Church, personal communication]).

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.

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.

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, UNFPA's Global Interfaith Network on Population and Development, UNAIDS' framework for faith-based and civil society partnerships on HIV 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. 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, as documented in the Berkley Center mapping.

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.

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 and their active role in an international consultation among UN agencies, donors, and faith-based groups on religion and development post 2015.

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 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. 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), 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. 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. Although disaggregated data for disbursements of PEPFAR funds to faith-based recipients are not available, country-level studies (eg, in Kenya) 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

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."

population-level faith networks such as the Nigerian Interfaith Action Association.

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, 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 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 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 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 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, the International Religious Health Assets Program, and the Berkley Center for Religion, Peace, and World Affairs. 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.

Panel 3: 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

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, including promotion of transparency and mutual respect, should be actively adapted to local circumstances. Established standards 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. 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, 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 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. 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 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.

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). 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. 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, 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. Programa Inter-Religiosa Contra a Malária 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."

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.[illegible] Channels of Hope, for example, has mobilised more than 390 000 local faith leaders for health and development.[illegible] 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).[illegible] 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[illegible] 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 WRR contributed to the design and substance of this Series paper and collaborated on the final manuscript.

Declaration of interests

We declare no competing interests.

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