Many Faiths, Common Action: Increasing the Impact of the Faith Sector on Health and Development

A Strategic Framework for Action

Presented by the **Center for Interfaith Action on Global Poverty**
On Behalf of the **Global Initiative for Faith, Health, and Development**
With Counsel from **GivingWorks Inc**.

CENTER FOR
INTERFAITH ACTION
on global poverty

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This report has been developed with the guidance of the Global Initiative Steering Committee and members of the Task Force to Advance Multireligious Cooperation on Health and Development, a group of 83 distinguished individuals representing faith-based, government, academic and civil society organizations from across the world. For a full list of Steering Committee members and Task Force participants, see Annex 1. While this report reflects the collective wisdom of the Task Force, all contents are not necessarily endorsed by all Task Force Members or their institutions.

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May our collective efforts make a tangible difference to those living in extreme poverty.

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Part 1: Background

I. Introduction and Executive Summary

Motivated by shared values of compassion and service, the faith sector plays a vital role in advancing causes of health and development across the world. Faith-based institutions, faith communities, and individuals of faith are active across the world, engaging at local, national and international levels. Faith entities tackle a broad range of development challenges, including peacebuilding, education, economic development, and health.[1] WHO estimates that faith-based organizations provide roughly 40 percent of all health services in sub-Saharan Africa.[2] In remote locales and in areas affected by political crisis or conflict, faith communities are often the only functioning service providers.[3] Faith institutions are often the most established and longest standing civil society structures among the world's poor and are deeply imbedded in the social fabric of the communities in which they serve.

Collectively, the faith sector comprises the assets and attributes to make a valuable and distinctive contribution toward health and development causes. Faith actors possess a broad set of strengths, rooted in their core values, extensive presence, and position in society. Their unique and holistic perspective on human wellbeing and emphasis on social, emotional, and spiritual, in addition to physical wellbeing serves as a vital complement to the priorities and approaches of the mainstream development community. The sector is well positioned to contribute to both the supply of and demand for health and development solutions. On the supply side, the faith sector's nearly ubiquitous presence, deep-rooted community relationships, and established service delivery networks can facilitate "last-mile" distribution, a challenge that has long plagued development assistance. Faith institutions also have significant influence on individual attitudes and behaviors and thus can encourage demand for and utilization of life-saving goods and services. Faith institutions are ingrained pillars of civil society; strengthening their role and engagement is consistent with the growing emphasis on country ownership, community buy-in, citizen accountability, and sustainability.

Stronger engagement of the faith sector is necessary to accelerate progress on urgent health needs and persistent development challenges. Despite many successes, substantial challenges on global poverty and human health and development remain. Given current trajectories, many countries will not reach the 2015 Millennium Development Goals (MDGs). Further, the global financial crisis threatens to slow or even reverse gains.[4] There is now widespread recognition that an "all hands on deck" approach to mobilize *all relevant stakeholders* is necessary to advance global health and development. If engaged and resourced, the faith sector is a powerful asset in this effort. Within the development community, there is an increasing recognition of the crucial role played by civil society and, specifically, faith entities to advance global health and development goals.[5] Several major development players are seeking to better engage faith actors around health and development, including various bilateral entities, UN agencies,[6] the World Bank, and the Global Fund to Fight AIDS, Tuberculosis, and Malaria.

The faith sector could have even greater impact if it were more systematically mobilized and better resourced. A host of constraints stemming from within the faith sector and its interaction with secular development actors have thus far prevented realization of the sector's full potential. Faith actors often do not fully participate in policy planning mechanisms,[7] they frequently work independently of government service delivery infrastructures, and their efforts often go unrecognized.[8] The faith sector is underresourced relative to the level of services it provides. Internally, the sector is fragmented, resulting in potential overlaps and gaps in services and a failure to capture potential synergies. Local congregations are perhaps the most

under-leveraged asset of the faith community. More effectively mobilizing and equipping this geographically diffuse but highly-committed cadre of change agents is a challenge and key opportunity for the sector.

Greater collaboration, both within and among faiths and with secular partners, holds particular promise for improving impact. Collaboration can help unlock the rich potential of the sector and accelerate progress towards the MDGs. The shared core values that unite faith traditions provide a foundation for such action. Though not appropriate in every context, collaborative approaches can expand coverage, improve cost efficiency, amplify advocacy, and catalyze learning. Collaborations among multiple faith traditions, for example, can facilitate engagement with secular donors and actors by providing a "politically neutral" partnership platform and consolidating points of contact. In some cases, especially contexts where a single faith predominates, collaboration between entities of the same faith tradition may be more appropriate and feasible.

The Global Initiative for Faith, Health, and Development (GIFHD) is envisioned as a multi-year process to accelerate widespread faith sector engagement. Convened and supported by the Center for Interfaith Action on Global Poverty, GIFHD seeks to create an international faith sector platform to serve as a bridge between faith and secular development communities, to give voice to the concerns and capacities of the faith sector, and to advocate for the full engagement of the faith sector with governments, bilateral and multilateral institutions, other civil society actors, and private philanthropy. The GIFHD Task Force was convened to frame the challenges and opportunities for action and collaboration for faith-based institutions and communities and to lead a process to maximize their impact on global health and development challenges. The Task Force consists of 83 highly distinguished individuals representing faith-based, government, academia and secular civil society organizations from across the world (see Annex 1 for a complete list of Task Force members). Principally authored by CIFA and GivingWorks Inc.,[9] the report incorporates the collective wisdom of the GIFHD Task Force.

This Strategic Framework for Action makes recommendations to further enhance the reach and efficacy of the faith sector's considerable efforts to promote health and development. The report focuses on two areas of action thought to hold promise for increasing impact: (1) increasing large-scale collaboration both within and among faiths and with secular partners and (2) increasing large-scale mobilization of religious congregations for common action on health and development issues. Additionally, the report articulates to the secular development community how investment in and engagement with the faith sector can dramatically advance health and development efforts worldwide. This thinking benefits from a rich heritage of preceding efforts at the intersection of faith, health and development, and we gratefully draw on the lessons and recommendations of some of these studies and initiatives. This is, however, not an attempt to provide a complete survey of the excellent work in this domain.

Recognizing the distinctive and powerful assets within the faith sector, this report proposes three primary clusters of recommendations and accompanying sub-recommendations to enhance the impact of the faith sector on eradicating poverty and disease:

- **Strengthening mechanisms that facilitate collaboration:** This includes building and strengthening multireligious and cross-sector coordinating bodies, as well as expanding the use of common programming platforms.
- **Enhancing the faith sector's direct health and development impact:** This includes equipping and mobilizing congregations as effective agents for health and development; strengthening the advocacy potential of faith actors; improving the quality of faith-based service delivery; and enhancing the faith sector's role on critical cross-cutting challenges, including conflict pre-

vention and resolution, crisis response, and promoting the health and development of women and girls.

- **Improving the enabling environment for faith sector engagement:** This includes enhancing the evidence base for the work of the faith sector; promoting greater understanding and knowledge exchange among faith actors and between faith and secular actors; and developing standards to mitigate potential risks that might otherwise impede collaboration.

These recommendations are complemented by specific actions that can be taken by faith-based organizations themselves as well as governments, donors, NGOs, and academics. Together, these stakeholders are the intended users of this report. Given the wide diversity of actors, we hope that these recommendations can provide an impetus for strengthening their collaboration and their collective impact.

II. Defining a "Faith Sector"

The so-called "faith sector" is composed of a rich and complex mosaic of actors, including diverse individuals, institutions, and networks. These actors vary in size, mission, role, geographic scope and technical capacity – some operate on shoe-string budgets, while others administer over one billion dollars annually. While we refer to a "faith sector," there is presently no coherent sector and the landscape of faith actors is highly fragmented Although they have extensive common ground and common cause, it is unusual for faith-affiliated organizations to function in a "sectoral" manner for common action, and to coordinate across sectors, an exception being in disaster response. However, we argue that the shared core values that cut across faith traditions and inspire the work of different actors offer a foundation for greater and sustained coherence and collaboration, and for greater impact on health and development. For the purposes of this report, we will use the term "faith sector" to refer to diverse faith actors as well as stakeholder institutions working together to increase engagement and impact of faith-based organizations on health and development.

Components of the Faith Sector

There is also no generally-agreed taxonomy of faith actors, due in part to the high degree of diversity within the sector.[10] Some organizations are loosely inspired by faith principles, while others are formally linked to religious institutions. The degree of structure also varies, as the sector includes both defined religious denominations with hierarchical leadership structures as well as decentralized "movements"[11] of individuals with shared principles and interests. "Hybrid" faith entities, such as health facilities partially staffed, resourced, and managed by government, add further complexity.[12] Recognizing these challenges, this Framework focuses on six broad typologies of faith organizations operating at different levels of society, as depicted in Figure 1.

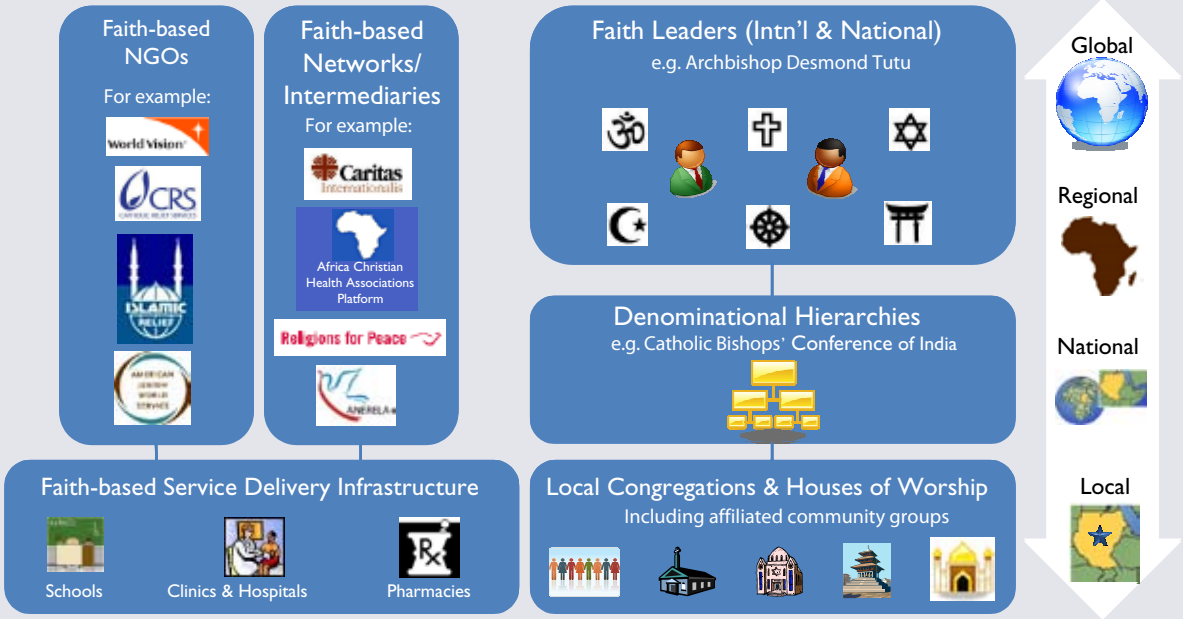
Due to the extreme diversity, it is difficult to generalize about whole categories of actors. However, broadly speaking, different categories of actors have different attributes and strengths that make them more or less suited for particular health and development roles. Potential roles for each category of actor are explored in greater depth in Annex 2.

III. The Faith Sector's Collective Strengths and Assets

As a whole, the faith sector brings considerable and distinctive strengths and assets that can directly advance the causes of health and development. Key commonly-cited strengths include:

Moral motivations and shared values – Perhaps the defining shared characteristic that cuts across the faith sector is the fundamental values that motivate and guide its engagement in health and development. These values, which inspire a long-standing and unyielding commitment to progress, include: a tradition of compassion; respect for individual dignity; respect for the family; commitment to building community; and pursuit of social justice for marginalized and vulnerable populations.

Figure 1: The Landscape of Faith Actors



Holistic perspective on human wellbeing – Faith actors' holistic approach to human health and development integrates ethics of peace, hope, harmony, and solidarity, and values social, emotional, and spiritual outcomes. These outcomes are a vital complement to the physical and economic focus of other health and development actors. For example, faith actors' provision of psychosocial support (especially during times of loss and crisis), both contrasts and complements a primary secular focus on physical health outcomes (often through biomedical means).

Ubiquitous presence – Faith entities are active in every country and at all levels of society. They have extended networks that bridge borders and connect developed and developing countries. Faith entities serve even in the most remote areas where public or private service providers may be absent.

Credibility and trust – Seen as a "voice of conscience" within society, faith leaders and institutions have significant stature and influence, both within and beyond their congregations and communities. Recent studies show that faith organizations are more trusted than any other local institutions, including police, government, and NGOs.[13] This high degree of credibility enables faith entities to "speak truth to power," and trusted community relationships enable them to positively influence the attitudes and behaviors of individuals.

Highly-committed constituency – Faith communities are often mobilized as local providers, as a financial resource base, or as an audience for key health and development messages. Motivated by faith, staff and volunteers often work under difficult conditions with few resources[14] and are resilient in the face of challenges and setbacks.

Infrastructure assets for health and development – Faith institutions manage important physical assets and service-delivery channels, including schools, clinics, training centers, and hospitals. At the congregational level, houses of worship often serve as *de facto* venues for community convening and organizing, as well as distribution points for goods and services to support local communities.

IV. Obstacles to a Stronger Faith Sector Role in Health and Development

Despite its substantial strengths and the vast extent of its current contributions, several internal and external constraints have thus far prevented the faith sector from fully realizing its global health and development potential. These include:

Variable capacity – Much like secular development actors, there is wide variation in the capacities of faith-based organizations. Many are highly-professional operations with sophisticated systems and approaches and substantial technical expertise. Others lack requisite programming, monitoring and evaluation, and administrative skills. Tangible and sustained progress on the MDGs will require consistently strong skills and expertise, high-quality services, and more uniform knowledge of what works (*and* what does not) from both faith-based and secular health and development actors.

Evidence gaps – Some country-specific studies, such as the World Bank's 2003 evaluation of religious service providers in Uganda, suggest that religiously-affiliated health services are high quality and cost effective.[15] However, at an aggregate level, across countries and health and development services, much of what is known about the quality and impact of faith-based service provision is anecdotal at best. Systematic documentation of results is a challenge for many faith entities, due in part to a strong preoccupation with implementation, insufficient knowledge of complex donor reporting requirements, and stretched capacity.[16] Further research into the workings and effectiveness of the faith sector, as well as more rigorous documentation by faith-based actors will be critical, particularly as funding decisions are increasingly based on evidence of impact, sustainability and cost efficiency.

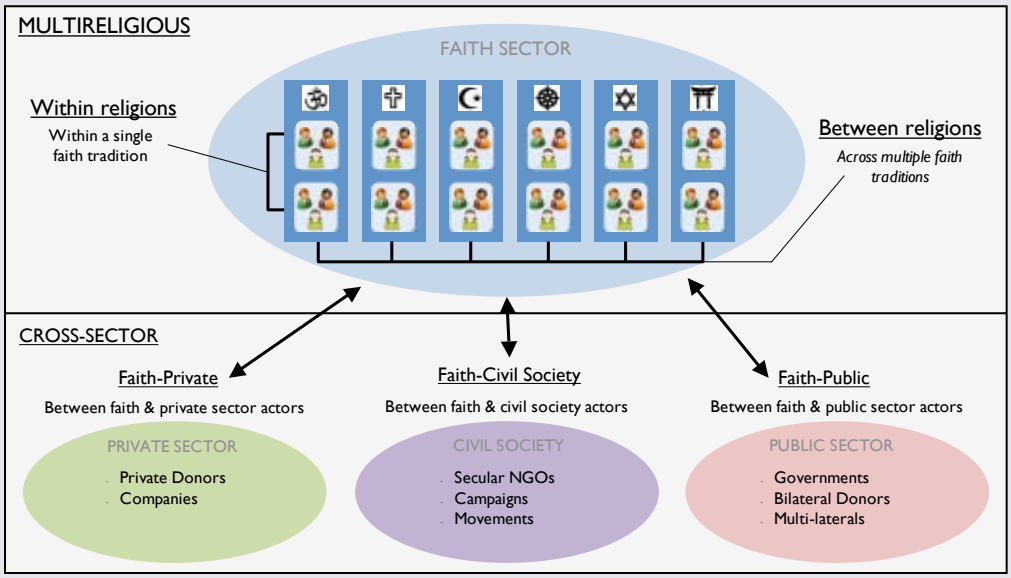
Insufficient funding – While comprehensive data on the scale of development resources channeled through faith entities is lacking,[17] many in the sector suggest that funding is not commensurate with the share of services they provide. During the first eight rounds of Global Fund grant-making, faith-inspired organizations received only 3.1 percent of disbursements.[18] This level of funding would seem to be far below a fair share for the sector, given that one in five organizations involved in HIV/AIDS programming is faith-based,[19] and that faith-based organizations provide an estimated 40 percent of HIV/AIDS treatment and care in sub-Saharan Africa.[20] Some FBOs are concerned that funding for faith entities, as well as NGOs generally, could further decline as donors increasingly concentrate on government health systems strengthening and direct budget support for governments.

Real and perceived risks of faith sector involvement – While faith identity underlies many of the sector's key strengths, some (mis)interpretations of theology may run contrary to and impede progress on internationally agreed health and development goals. Misguided interpretations of faith risk the following negative consequences:

- Fueling violence and intolerance;
- Fostering stigmatization, including against persons living with HIV/AIDS;
- Restricting the rights and responsibilities of women;
- Misrepresenting or undermining elements of the medical response;[21]
- Limiting services only to members of a particular faith;
- Encouraging religious conversion through the provision of assistance.

While these risks have real manifestations in today's world, they may be perceived as more widespread than they are in reality. Destructive and misguided actions taken in the name of religion are often the focus of media attention, overshadowing the positive contributions of faith-based actors. Furthermore, interpretations are changing rapidly in many faith contexts, with gender equality and equity, for

Figure 2: Types of Faith Sector Collaboration



example, becoming more accepted and valued. Nevertheless, faith institutions must explicitly recognize these risk factors and proactively encourage positive and supportive expressions of faith.

V. Scaling the Faith Sector's Impact through Multireligious and Cross-Sector Collaboration

Collaboration is a key strategy for engaging faith actors and realizing their full potential. Collaboration can expand the reach, coverage and utilization of health and development support services. For the purposes of this report, collaboration is defined broadly to include four main types of partnerships: (1) multireligious partnerships, both within and between religions; (2) faith sector-private sector partnerships; (3) faith sector – civil society partnerships; and (4) faith sector – public sector partnerships (see Figure 2).

The focus on collaboration in this report does not aim to supplant the health and development work of individual faith actors, nor does it assume that partnerships are inherently preferable. Rather, it seeks to highlight the many opportunities where, if properly implemented, collaboration can further and enhance the development impact of the sector. However, it is important to note that collaborations may risk raising transaction costs and complicating management for participating partners. These concerns need to be explicitly weighed against potential synergies and efficiencies of combining efforts. Furthermore, not all partnership models will makes sense in all country contexts. In countries where a single faith is predominant, for example, collaborations within a faith tradition, rather than between faith traditions, may hold more promise. Similarly, where secular NGOs are quite active, cross-sector coordination may take precedence over faith-only collaborations. In each case, the comparative advantages of prospective partners and the potential value of collective action for specific health and development needs should drive decisions on collaboration.

Benefits of Collaboration

By strategically combining the strengths of either multiple faith actors or faith and secular actors, collaboration can

help scale and sustain health and development results.[22] Figure 3 highlights some of the key benefits of collaboration, as well as the means through which these benefits are derived. It is these potential benefits that support this Framework's focus on collaboration as a key strategy for enhancing impact.

Barriers to Collaboration

Despite the potential benefits of collaboration, partnership among faith actors and between faith and secular actors are under-utilized. While there are examples of successful collaborations both within and across sectors, they are not happening with the frequency or at the scale envisaged by the Task Force. Faith sector partnerships today primarily occur within rather than across faith traditions, limiting the potential for greater impact. Furthermore, the vast potential for collaboration with governments, donors, civil society, and the private sector remains largely untapped. A multitude of barriers has thus far constrained collaboration on a wider scale. Figure 4 highlights some of these barriers, organized according to social factors (relational and perceptual issues), operational factors (barriers stemming from differences in programmatic priorities and approaches), and structural factors (issues with the composition of and dynamics of relevant institutions).

The recommended shifts and proposed actions of the Strategic Framework that follow (Part 2) are situated within the context of, and are formulated in response to, the above strengths, opportunities and obstacles to stronger faith sector engagement.

Figure 3: Benefits of Collaboration

COLLABORATIONS CAN:	THROUGH THE FOLOWING MEANS:
Expand coverage of interventions	• Growing the pool of available resources (human, financial, material) • Coordinating implementation to ensure coverage of excluded and/or underserved populations
Improve cost efficiency	• Capturing economies of scale and pooling purchasing power • Increasing throughput from "fixed cost" delivery infrastructure • Avoiding costly overlaps in service provision
Amplify advocacy and communications	• Aggregating multiple actors to influence policy decisions • Reinforcing public messaging at various levels (local, nat'l, int'l) and from various sources (faith and secular)
Catalyze learning	• Systematizing the collection of data and information • Facilitating knowledge exchange and best practice sharing
Develop trust and tolerance	• Providing a foundation for building relationships and mutual respect
Facilitate cross-sector engagement	• Creating "politically neutral" platforms for secular entities to engage the faith sector (as opposed to partnering with single faiths) • Lowering the transaction costs (for donors, governments, secular NGOs) through consolidated points of contact

Figure 4: Barriers to Collaboration

SOCIAL FACTORS	OPERATIONAL FACTORS	STRUCTURAL FACTORS
Lack of familiarity – Ignorance about a would-be partner's strenghts and strategic potential	**Differing operational norms** – Differences in approaches to program delivery, results monitoring, and financial tracking, for example	**Fragmentation of actors**÷ – Diffuse and difficult to navigate sectors with weak organizing structures
Preconceptions and stereotypes Presumptions about a potential partner's level of commitment or quality of work, for example	**Divergent priorities** – Conflicting (or often changing) views about which issues or approaches should be given precedence	**Competition**** – Rivalry among actors for resources or recognition
Suspicion and mistrust** – Fear of hidden motives, such as proselytizing, or a history of tensions between two groups	**Lack of a shared language*** Differences in the common lexicon and technical terminology	**Exclusion of actors**§– Under-representation or systematic exclusion of some actors from collaborative mechanisms
Desire to maintain boundaries – Faith actor's concern about being co-opted or instrumentalized, as well as secular actor's unease about potentially over stepping religion/state boundaries	**Uneven capacity** – Concerns about skill gaps (e.g. technical expertise, management capacity, M&E), or the ability to administer funds†	

*Marshall, K. and Van Saanen M., "Development and Faith," The World Bank, 2007

†For example, critics of PEPFAR's funding of FBOs highlihted "the limited capacity of many indigenous FBOs to absorb large grants and use the funds effectively. "Berkley Center, "Mapping the Role of Faith Communities in Development Policy: The US Case in International Perspective," 2007.

÷ For example, a study of HIV/AIDS partnerships in Kenya, DRC, and Malawi identified fragmentation within the Christian faith entites and donor groupings as a barrier to effective collaboration. Haddad B, et al. "The potential and perils of partnership," ARHAP, 2008

§Karam, A., "Concluding Thoughts on Religion and the United Nations, Redesigning the Culture of Development," CrossCurrents, September 2010.

**Haddad B, Olivier J, De Gruchy S. 2008. The potential and perils of partnership: Christian religious entities and collaborative stakeholders responding to HIV and AIDS in Kenya, Malawi and the DRC. Study commissioned by Tearfund and UNAIDS. Interim Report ARHAP.

PART 2: RECOMMENDATIONS

Given the broad scope of the GIFHD initiative, the recommendations that follow are necessarily high-level. There is a growing body of literature that delves into greater depth on particular issue areas, regions, faith actors, and partnership arrangements. This framework selectively highlights directional and catalytic changes that can significantly raise the collective impact of the faith sector. It will be up to individual organizations to adapt and translate these recommendations within their own contexts.

Recommendations are presented in three clusters: (1) mechanisms to support collaboration; (2) approaches to improve the efficacy of the faith sector's direct health and development interventions; and (3) enabling conditions for a stronger and more effective faith sector. Unlocking the untapped power of collaboration is a theme that cuts across the recommendations. Accompanying many of the recommendations are practical examples of faith sector efforts that model the directional intent of these recommendations.[23] These examples have been culled primarily from the suggestions of Task Force members. Many of the examples are drawn from the health arena and sub-Saharan Africa, due in large part to the intensity of the sector's efforts in that space. However, many of the principles and practices described are applicable and adaptable to other issues and/or regional contexts.

VI. Recommendations to Support Collaboration within the Faith Community and with Secular Actors

A. Strengthen mechanisms that facilitate collaboration among faith and between faith and secular actors

Collaborations sometimes emerge "organically," particularly at the grassroots level, where shared community-wide needs and pre-existing relationships can motivate collective action. In cases where potential partners are dispersed across different geographies, sectors or faith traditions, successful collaboration requires proactive facilitation and nurturing.

A1. Build and strengthen multireligious and cross-sector coordinating bodies. Coordination bodies play an important role in convening faith actors, harmonizing efforts (where appropriate), and facilitating engagement with public sector and external partners. Multireligious fora exist in many countries, but vary greatly in terms of their reach, stature and capability. In some cases, existing bodies (such as Interreligious Councils as well as networks created by Religions for Peace and Interfaith Action for Peace in Africa) can be strengthened or expanded to meet unmet needs. In others, new bodies will have to be developed. Sufficient donor funds should be made available for developing and strengthening national multireligious action and coordination platforms, and particularly to support their training, policy advocacy, monitoring and evaluation, and convening functions.

The Interfaith Action Association is a new multireligious collaboration developed by the Center for Interfaith Action on Global Poverty (CIFA)[24] that facilitates full coordination of the faith sector with the public sector for health and development cooperation on a national scale. In 2009, CIFA worked with top Muslim and Christian leaders of Nigeria to create the Nigerian Inter-faith Action Association (NIFAA). With technical support from CIFA, this independent Nigerian-led multireligious NGO brought national networks of faith leaders together in the struggle against poverty and disease. NIFAA is now actively mobilizing Muslim and Christian faith leaders against malaria, having trained thousands of faith leaders to deliver sermons in support of Nigeria's anti-malarial campaign. Working closely with the gov-

Box 1: Sarva Dharma Sansad's (Parliament of Religions) Common Minimum Program

Launched in 2007, Sarva Dharma Sansad (SDS) brought together religious leaders of all the major faiths in India around a set of common principles known as the Common Minimum Programme. These well known socio-spiritual activists sought to move beyond the interfaith dialogue initiatives to social action. A broad consensus emerged around seven critical social issues that formed the basis of the Programme, including opposing deeply harmful social ills such as castism, female feticide, communalism, blind religiosity, and corruption.

United by these shared principles, SDS members campaigned against smoking, resulting in a government ban against surrogate advertisement of liquor and tobacco and as well as on-screen smoking in films. Members also organized marches against female feticide, held seminars on the livestock industry and food security, and initiated programs around stigma-associated diseases (e.g., HIV, leprosy), including bringing eminent religious leaders together with patients and members of the gay community to send a message of humanism.

Source: Communications with Swami Agnivesh and Manu Singh, SDS

ernment's National Malaria Control Program, NIFAA has trained imams, pastors and priests in several states and the Federal Capital Territory.[25] Where existing denominational structures of faith actors exist, a network of these structures offers another model for coordinating diverse faith actors.

A2. Expand use of common programming platforms to focus on shared priorities. Collaborative programming models organize partners around shared goals. Organizations participating in common platforms can either implement programs jointly or independently pursue shared principles and actions established by the platform. For example, the multi-sectoral policy analysis model followed by Religions for Peace brings together a range of stakeholders from across sectors to analyze a pressing societal problem, determine the required roles to address specific issues underlying the problem, and identify where partners are best positioned to contribute.[26] Another model is Sarva Dharma Sansad's Common Minimum Program (see Box 1), which unites faith leaders of all the major faiths in India around a set of common principles.

B. Better integrate faith actors into established national planning and funding mechanisms

In an era of country-led processes and demand-driven approaches to development, bilateral and multilateral donors increasingly rely on consultative mechanisms to shape policy and resource allocation decisions. The faith sector's access to and participation in these mechanisms varies significantly from country to country. In some countries, such as Uganda, faith actors are well-represented and have the opportunity to influence the quality of policy dialogue and share in resource flows.[28] In many other countries, despite providing a substantial share of services, faith-based providers have little input into or access to national health and development strategies and resources. The faith sector is a crucial and distinctive component of civil society, and it needs to be purposefully integrated into national strategies for state and non-state actors.

The sector itself needs to more clearly articulate how its presence, trust and track record in many communities makes it a powerful agent of social transformation. Bilateral and multilateral actors can also do more to proactively ensure appropriate representation and consultation of faith actors. Engaging with multilaterals and government often requires the ability to navigate complex procedural and bureaucratic requirements. Large multilaterals, such as the Global Fund, can more proactively invest in building the capacity of faith sector actors to meaningfully participate in funding and planning platforms. Faith sector coordination mechanisms (see Recommendation A) and international faith-based development organizations can also work to develop the capacities of local organizations.

VII. Recommendations to Enhance the Faith Sector's Direct Health and Development Impact

C. Engage and mobilize local congregations

Congregations at the local level are well positioned to address one of the most persistent development challenges: directly reaching end-users with educational messages, services, and goods.[29] Effectively organizing and equipping these traditionally fragmented and geographically-diffuse communities as agents of economic and social development is a high priority for the faith sector and the broader development community.

C1. Better equip faith leaders to promote positive changes in health and development attitudes and behaviors. Social and cultural aspects play a critically-important role in the achievement of health and development outcomes. For example, preventing malaria through the use of bednets, fighting the spread of disease through personal hygiene, and ending violence against women each depend on individual attitudes and behaviors. Social stigma (another factor rooted in attitudes) often prevents at-risk or afflicted individuals from seeking assistance and can stifle open dialogue on sensitive issues that could otherwise help address these conditions.[30]

As trusted advisors to congregations, faith leaders can play a key role in shaping these attitudes and behaviors; but these leaders need to be equipped with practical and accurate knowledge, tools and resources. Box 2 describes scalable tools that help faith leaders incorporate health messaging into their sermons by linking faith teachings and public health principles. Coordinating messaging and outreach with public sector health and development campaigns will assure the broadest and most effective dissemination and facilitate large scale adoption by congregations.

Mobilizing large numbers of congregations is key to successful large-scale community outreach on health and development. Multireligious mechanisms that can quickly train thousands of congregational leaders (and through them reach millions of congregants) have proven to be a powerful tool for reaching a large audience with key health and development messages and interventions. For example, the Programa Inter Religiosa Contra a Malaria (PIRCOM) in Mozambique is one such mechanism. Organized in 2007 by CIFA, PIRCOM educates faith leaders to mobilize their communities against malaria. To date, over 27,000 faith leaders have been trained, 38 interreligious councils established, and over 1.9 million congregants reached.[31] Box 3 illustrates similar mobilization efforts around HIV/AIDS in the Arab region.

C2. Equip and deploy more local volunteer faith actors in developing countries. Today, faith communities widely deploy volunteers to help improve the situation of those most in need. The challenges to further growing this con-

Box 2: Tools for Faith Leaders: Sermon Guides and *The Sunday Pack*

In August 2010, the Center for Interfaith Action on Global Poverty and IMA World Health published a sermon guide: *Stopping a Killer: Preventing Malaria in our Communities.* The book is a resource for Muslim and Christian faith leaders to understand the dangers of malaria and what they can do to help save the lives of the people in their congregations. It includes suggestions on how to protect and treat those most vulnerable to the disease, as well as specific tools for health messaging within faith communities. Adaptable for use in a wide variety of contexts, the guide includes recommendations for malaria prevention and treatment in line with international standards. The series of sermon guides, developed in close consultation with Christian and Muslim faith leaders, provides a theological grounding for the health messaging. (http://www.cifa.org/initiatives/faith-based-behavior-change-communication-tools-bcc.html)

The Sunday Pack is a guide for Christian faith leaders in Lesotho to use to educate their congregations about HIV/AIDS and prevent the spread of the disease within their communities. Jointly developed by Catholic Relief Services, World Vision, UNAIDS, and the Lesotho Interfaith Association of Religious Leaders on AIDS, the year-long curriculum includes 52 different topics for use across 52 Sundays in a year. *The Sunday Pack* blends biblical texts with health messages that accord to international standards.

Box 3: CHAHAMA – The Network of Faith-based Organizations in Response to HIV/AIDS in the Arab Region

In the Arab region, a change in the religious discourse on HIV and AIDS has emerged towards compassionate, human rights-based messaging, supported by scripture from the Quran and the Bible. These changes are manifested in the Cairo Declaration (2004), written and signed by 80 prominent religious leaders from 19 Arab countries; the Tripoli Declaration for Women Religious Leaders (2006) focusing on the rights of women and children around HIV; and the establishment of CHAHAMA, the Network of Faith-based Organizations in Response to HIV/AIDS in the Arab Region.

Through CHAHAMA, thousands of female and male Muslim and Christian religious leaders in the region are training their peers as well as the public through the use of HIV-training kits specific to the Muslim and Christian faiths. The program has trained 30,000 Imams in Morocco alone, helping to transform religious discourse and resulting in a significant reduction of stigma which in turn may be linked to a 24-fold increase in usage of HIV voluntary counselling and treatment of HIV between 2001 and 2008. Similar achievements are reported in Algeria. CHAHAMA also engages on harm reduction, training its leaders on outreach to vulnerable groups. The CHAHAMA movement also supported the enactment of a progressive HIV law in Yemen in 2009. This initiative is supported by the UNDP HIV/AIDS Regional Programme.

Source: Khadija Moalla; see also www.chahama.org, www.harpas.org

tribution are three-fold: (1) identifying willing volunteers with talents to share; (2) building and supplementing their skills as necessary; and (3) connecting and deploying them to communities that have need for their particular talents. Relying on local volunteers in developing countries can help, as these volunteers are readily available, highly committed to progress, and have an intimate understanding of needs in their societies. Equipping these individuals with the required skills and knowledge is the key challenge. In India, several faith-based and secular organizations (including the Christian Medical Association of India, Catholic Health Association of India, Voluntary Health Association of India, and St. John's Medical College, and Society for Community, Health Awareness, Research and Action) have been training community health workers since the 1970s and 1980s. These trainings employ participatory, community-based learning strategies and have produced many well-known community health worker manuals and publications.[32] World Vision's Community Care Coalition and Channels of Hope (Box 4) offer additional models for local volunteer mobilization and training on the issue of HIV/AIDS.

C3. Mobilize faith-affiliated resources in developed countries to support developing countries. Many faith traditions emphasize the value of giving and compassion, and faith actors in developed countries can help channel the generosity of faith communities to help those in need in developing countries. For example, Islamic Relief partnered with an Egyptian medical association to recruit physicians to serve in other Muslim countries.[33] Saddleback Church's P.E.A.C.E. Plan mobilizes congregational resources in the U.S. to support health projects in the developing world. Nearly 8,000 people have volunteered more than 2.5 million hours, and roughly $9 million has been raised for P.E.A.C.E. projects (as of October 2008).[34] Ensuring that volunteers do not displace local talent is critical, and the P.E.A.C.E. Plan works specifically to support the capacity of local churches to continue the work after volunteers have left.

Life for Relief and Development,[35] a Muslim-American humanitarian relief and development organization, collects food, personal items, and financial donations from faith communities in the United States to support families and projects in impoverished communities overseas. Life often works with local religious leaders to identify beneficiaries in the community, irrespective of faith affiliation, and at times uses houses of worship to distribute assistance. Faith-based organizations in developed nations need not directly administer assistance in beneficiary communities. As described in Box 5, Buddhist Global Relief mobilizes financial support from its constituents but collaborates with established partners on the ground to implement projects.

Box 4: Training of Faith and Non-faith Community Workers to Provide Community-Based Services: World Vision's Community Care Coalitions and Channels of Hope

As part of its HIV/AIDS Hope Initiative, World Vision utilizes its "Community Care Coalition" (CCC) model to strengthen traditional safety nets that provide care for orphans and vulnerable children. The program complies with UNICEF's international standards.

The community care coalitions bring together churches,other faith communities, government, local businesses, and other NGOs to recruit and train volunteer home visitors who take responsibility for identifying, monitoring, assisting, and protecting orphans and vulnerable children while referring and connecting them to services in their community. World Vision's role is to mobilize and build the capacity of these coalitions as well as help train and equip home visitors and link them to other sources of support. According to World Vision, "multiple evaluations in Africa have found community care coalitions to be an effective, scalable model for providing care and support to orphans, their caregivers, and households." In 2009, more than 73,000 home visitors cared for orphans, vulnerable children and chronically-ill adults in Africa, 64 percent of whom were volunteers mobilized from churches or local faith communities.

Another model employed by this initiative is Channels of Hope (CoH). Recognizing the critical need to equip faith communities to expand and sustain their response to the HIV/AIDS epidemic, CoH "mobilizes the infrastructure, organizational capacity, pool of current and potential volunteers, and moral authority of local faith communities towards positive action on HIV and AIDS." Channels of Hope was found to be "effective in reducing stigma and increasing positive action among faith leaders" in Uganda and Zambia. In 2009, roughly 34,000 people in Africa and 10,000 in Latin America and the Caribbean participated in HIV-related church

Source: World Vision, An Overview of the HIV and AIDS Hope Initiative (February 2009); World Vision, World Vision's Channels of Hope Methodology: Empowering Local Churches in Their HIV Response (July 2008); World Vision, Hope Initiative: 2009 Annual Report (March 2010). Accessed at: http://www.wvi.org/wvi/wviweb.nsf/maindocs/052F3121CB381D7E8825753C00794E64?opendocument"

C4. Strengthen congregations' monitoring and information gathering roles. Response to health and development needs is partly hindered by a lack of timely, uniform, and reliable information about priority needs at the community level. Aggregated national-level statistics often fail to cover remote or at-risk populations where data is more difficult and costly to collect. Even with regular monitoring, national statistics are often made available too late to support a timely response to priority needs. Congregation members can help to address these gaps by flagging emerging community needs and providing valuable feedback on the efficacy of local service delivery. Such information can serve as early warning signals for governments, donors, and civil society – and also promote accountability mechanisms. Congregations will require user-friendly mechanisms to facilitate information gathering, but these need not be costly. For example, simple self-reporting templates distributed to congregation members or informal polling of local faith leaders could surface issues that may warrant more rigorous investigation. Mobile phone text messaging applications also offer an easy and affordable platform for data collection. Collected data could potentially be aggregated and integrated into national monitoring systems. It is especially important that safeguards are in place to ensure that locally-collected information is both valuable and used appropriately – which will be critical to building trust among congregations.

D. Amplify the advocacy reach and influence of faith institutions

The faith sector collectively represents an enormous grassroots constituency that can be mobilized to influence policy. If mobilized, the faith sector can systematically harvest and widely publicize stories from the ground, giving a stronger voice to local communities in need.

D1. Strengthen the faith sector's policy influence through collective advocacy. Multireligious advocacy campaigns can amplify the advocacy messages, reach wider audiences, and build a broader coalition for change. Multireligious advocacy can also provide a neutral and thus more politi-

Box 5: Mobilizing Faith Communities in Developed Countries in Support of Local Development Efforts

Founded in 2007, Buddhist Global Relief (BGR) provides relief to the poor and needy throughout the world regardless of nationality, ethnicity, gender, or religion, with a particular focus on alleviating global hunger. As a small FBO without the resources or personnel to establish relief operations in impoverished regions, BGR collaborates strategically with local partners to implement projects. First, BGR mobilizes the Buddhist community to give towards its proposed projects. BGR then partners with reliable relief and development organizations already operating on the ground to implement projects, providing grants and collaborating closely with them to help shape their projects. BGR's partners include major international relief agencies, such as Save the Children and the Red Cross; country-based relief groups with an established reputation for effectiveness, such as the Sarvodaya Women's Movement in Sri Lanka; and smaller or emerging agencies that focus on a more local level or address very specific needs, such as Lotus Outreach International.

Source: Kim Behan and www.buddhistglobalrelief.org

cally palatable platform to engage secular policymakers and partners. For example, the Jubilee 2000 campaign was instrumental in raising international awareness and securing commitments from donors for debt relief.[36] Initially, Christian entities were Jubilee's key constituents, but it quickly expanded to include a broad base of faith and non-faith actors. Jubilee 2000 has also inspired various multireligious successor campaigns, such as the UK-based Jubilee Debt Campaign and the Make Poverty History Campaign. Another collective advocacy platform is the Ecumenical Advocacy Alliance (Box 6), which mobilizes diverse Christian communities on issues of HIV/AIDS and food security.

D2. Leverage the advocacy influence of global faith leaders for health and development. Global faith leaders are opinion leaders with ethical, cultural and political influence, as well as thought leaders who interpret faith texts and spread ideas. Some have influence that transcends their individual faith communities and geographic boundaries. Global faith leaders often have the stature to advocate directly with decision makers. Public speaking venues and books are additional channels for global faith leaders to mobilize grassroots support. For example, published in 2002, *The aWAKE Project*, was a collection of stories and essays from faith leaders and secular contributors about the HIV crisis. The book was designed to educate and mobilize readers at a grassroots level to address the AIDS crisis in Africa.

E. Ensure quality of faith-based health and development services

Given the lack of reliable data, few conclusions can be made about the overall quality of faith-based health and development services on a global scale. Anecdotal views suggest

Box 6: International Advocacy Network: The Ecumenical Advocacy Alliance

The Ecumenical Advocacy Alliance focuses on raising awareness and building a movement for justice within churches, as well as mobilizing people of faith to lobby local and national governments, businesses, and multi-lateral organizations. Comprising an international network of churches and church-related organizations, the campaign's two primary priorities are HIV/AIDS and Food Security. Food security campaigns target reform of international aid and trade, as well as the empowerment of women in agricultural production. The HIV/AIDS campaign pressures international bodies to provide universal access to treatment, the reduction of stigma associated with the disease, and education about root causes.

The Alliance partners "with many organizations who share common goals on these critical issues, believing that the more we work together, the stronger our voice is for justice." The Alliance unites tens of millions of Christians around the world and includes large international organizations such as the Caritas Internationalis, World YWCA and Lutheran World Federation, as well as large and small national organizations such as Madras Christian Council of Social Services (India), Finnish Evangelical Lutheran Mission, Tearfund (United Kingdom), Presbyterian World Service and Development (Canada).

Source: http://www.e-alliance.ch/

that the overall quality of faith-based services can be high, but also quite variable. In some cases, quality of care and services is constrained by limited resources, or by gaps in technical capacity.

E1. Support broader adoption of international best practices on service delivery. There are several promising models for building the capacity of faith-based service providers and for ensuring that their services align with international standards. Self-guided learning tools could be further developed and disseminated to support wider adoption of best practices. Advanced online technologies, such as interactive online tutorials and webinars, could also support dissemination. These various capacity building tools and resources could be organized and shared via an online portal. For example, UNIFEM's Virtual Knowledge Centre to End Violence Against Women is a one-stop shop for "the leading tools and evidence on what works to address violence against women and girls," and includes tools for programming, links to expert organizations, training sessions and events, and information about leading initiatives.[37] Other approaches for building the skills of service providers include targeted workshops (including highly scalable train-the-trainer models), mentorships, and "expert exchange" programs. Faith-based health networks can play an important role in improving the service quality of member health service providers (e.g., hospitals, clinics, health centers). For example, Christian Health Associations (CHAs) are active within and beyond Africa and provide capacity building services for faith-based member health service providers. The African Christian Health Association Platform is a regional network that unites various country-level CHAs (Box 7). This regional model could be readily scaled to service non-Christian faith-based health delivery institutions as well.

E2. Engage in critical self-reflection to ensure services reflect the values of one's faith tradition. Deeply rooted in a system of values, many faith-inspired organizations seek to deliver services in a manner consistent with their beliefs. Faith-inspired service providers are more likely to consider the moral and spiritual dimensions of service delivery. This can mean prioritizing poor and marginalized populations, serving the whole person, and treating beneficiaries with dignity and respect. In this way, some faith-inspired service providers bring certain intangibles that make them distinctive from their secular counterparts.[38] Faith-inspired service providers consider it important to maintain this distinctiveness. As illustrated by the experience of the Baha'i-inspired organization, Health for Humanity (Box 8), good intentions are best advanced when accompanied by self-reflection. In September 2010, The Art of Living Foundation brought over 400 religious leaders of all faiths together in Bangalore, India to strengthen their commitment to the dignity of people living with HIV/AIDS and to prevent any form of stigmatization or discrimination.[39]

Box 7: Building Capacity of Service Providers – African Christian Health Association Platform

The African Christian Health Associations Platform (ACHAP) is a networking forum for Christian Health Associations (CHA) and Networks from sub-Saharan Africa. In addition to facilitating networking and communication among CHA and networks and creating a stronger advocacy voice, ACHAP actively works to build the capacity of CHA and networks and their member health service providers around a range of issues, including medical and technical skills and organizational capacity, management, governance, financial, human resources, and health information systems management, and advocacy. ACHAP uses a range of modalities to deliver capacity building services, including:

- Trainings, such as in seminars, workshops, conferences
- Cross-country exchange programs
- Provision of targeted technical support
- On-site mentorship
- Distribution of resource materials

Source: Interview and ACHAP website (http://www.africachap.org/x5/)

Box 8: Integrating Values for Service Provision: Health for Humanity

For years, Health for Humanity, a U.S.-based Baha'i-inspired NGO, provided training, equipment and ongoing support to ophthalmologists in developing countries, with special attention to helping increase the rate of cataract surgery in countries where it is a major cause of blindness. Health for Humanity's review of its efforts in several countries revealed that their assistance often resulted in increasing the availability of such services to populations that already had access to high quality care. This was because the trained doctors responded to patients seeking their services rather than proactively reaching out to underserved populations.

Given these observations, HOH included training on values-based leadership for ophthalmologists as it launched its program in Mongolia. These doctors increasingly view themselves not only as clinicians but also as agents of transformation. Involved doctors now engage in regular reflections on the results of their practice. The benefits of values-based leadership were discernible across the spectrum of service delivery, including improved facilities, better patient services, rethinking of treatment and payment policies, and the extension of services and training to areas outside of the capital Ulaanbaatar. The Ministry of Health has recognized this as necessary for fundamental change and is considering how to integrate it into medical training.

Source: Dr. John Grayzel

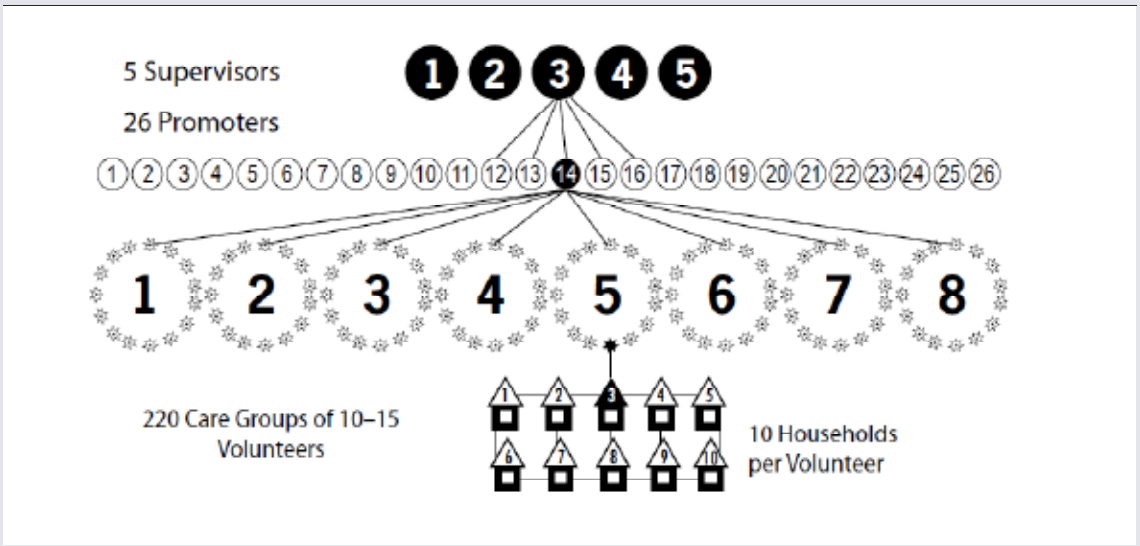
F. Mobilize the faith community to promote the health and development of women.

It is increasingly recognized that the advancement of women and girls is key to overall societal progress. Too often, however, women and girls are subjected to neglect, discrimination and even violence, preventing them from realizing their potential. Faith communities themselves have sometimes contributed to the poor status of women by promoting or failing to dispel negative gender stereotypes.[40] Faith communities at all levels of society can also be uniquely influential in reshaping social and cultural norms affecting women and girls. Faith-affiliated community groups can help motivate and model behavior change, but these efforts need to be supported through training and resources. In the health arena, a notable example of women empowering women is the Care Group model developed by World Relief in rural Mozambique and elsewhere (see Figure 5).[41] Community volunteers are trained and organized into "care groups" of 10-15 members. Supported by the care group, each volunteer in turn reaches out to 10 households with outreach and coaching on good nutrition, hygiene, birth spacing, and immunization. By deploying these volunteers and sustaining efforts through the peer influence of groups, the goal is to regularly reach every household with a child under five or a woman of childbearing age. Evaluations indicate that these behavior change interventions reduced childhood mortality rates by over 50 percent.

In addition to being key to achieving specific health and development outcomes, the engagement and empowerment of women is also essential for achieving peace and universal human rights. For example, Religions for Peace has developed *Restoring Dignity: A Toolkit for Religious Communities to End Violence Against Women*. This toolkit recognizes that all faith traditions "speak to the fundamental dignity and inalienable rights of every human being," and that faith leaders often play a role as respected and influential community leaders. *Restoring Dignity* equips local religious leaders with tools to engage in advocacy and lobbying efforts, hold community meetings, and prevent violence against women in their communities through proactive intervention and education.[42]

At national and regional levels, efforts are underway to craft a common agenda of action and advocacy among the faith and development communities. At the global level, the 2008 Women, Faith and Development Alliance summit catalyzed $1.4 Billion in new public and private investments for women and girls to reduce poverty.[43] The United Nations announced in July 2010 that it would merge four women-focused agencies into a single entity. The birth of this new multilateral agency provides an opportunity to articulate and advocate a global multireligious strategy for women's advancement.

Figure 5: Care Group Model



Source: Sarla Chand and Jacqui Patterson, Faith Based Models of Improving Maternal and Newborn Health, USAID, September 2007. Graphic Source: World Relief (Graphic by Baer)

G. Strengthen faith actors' critical role in the prevention and resolution of conflict as well as crisis response

As the experience of conflict-affected and fragile states has shown, violent conflict can slow or even reverse progress on health and development. Given the public trust engendered by faith institutions, and the risk that religion is misused as a divisive tool, the faith sector is well positioned to contribute to conflict prevention and resolution. The intersection of faith, peace and conflict is a thriving field of work, and the select examples that follow are illustrative of the many models being pursued to leverage the positive potential of faith for peace.

G1. Draw upon the expertise of faith-based actors in the prevention of violent conflict. Faith communities can play a key role as natural "early warning" voices, as they are often in regular touch with communities at the most local levels and can see warning signals as they develop. As respected entities not party to a conflict, they may also be well situated to help defuse mounting tensions before they erupt into violence. Faith-based actors can also play a greater role in helping to develop policies for preventing and addressing violent conflict. Policymakers would benefit from reaching out and listening to faith actors to help them better understand root causes and flashpoints, and to explore ways of supporting faith-based peacebuilding efforts.

G2. Encourage multireligious approaches to peace mediation. Most religions include teachings on forgiveness, reconciliation, and compassion for the weak and vulnerable. While religious differences have often been misused to foster and perpetuate conflict, religion can also help restore relationships and encourage reconciliation among former adversaries.[44] Multireligious approaches, particularly within conflict-affected countries with multiple faith traditions, can be particularly effective in mediating conflicts. When leaders of multiple faiths speak in one voice, they can invoke the conscience and commitment of the entire community. For example, representing the seven major faith traditions

in Africa, Interfaith Action for Peace in Africa has successfully deployed peace delegations composed of widely-recognized faith leaders to promote peace in conflict-afflicted countries.[45] Religions for Peace has also mobilized faith communities and leaders to help transform or reduce conflict in some of the world's most troubled places.[46]

The Community of Sant'Egidio, a lay Catholic movement with more than 50,000 members in over 70 countries, has played an active peacemaking role, most notably in the peace agreements in Mozambique in 1992 and efforts in Guinea in 2010. It has been described as "a movement more than an organization…clearly Catholic but also committed to a broad spirituality and to including people from many religions (and none)."[47] According to one observer, "Sant'Egidio's peace work goes well beyond negotiations, because they see peace as much more than cessation of fighting;" they work with poor and destitute populations, including prisoners, immigrants, elderly, shunned ethnic groups, children, and HIV patients.[48] With peace often stymied by painful memories, the Community of Sant'Egidio helps heal memories through its "deep and long-term commitment to listening and caring for those involved."[49]

G3. Support grassroots initiatives that target next generation faith leaders. The challenge remains to ensure that institutions and communities of faith embrace and accept one another, and build healthy and thriving societies in which people, irrespective of faith, can enjoy the fundamental rights of health, education and protection. There is an acute need for initiatives that promote tolerance and mutual respect among young people of faith, as next-generation leaders. Organizations such as the Interfaith Youth Core (IFYC) build mutual respect and pluralism among youth of various faith traditions by empowering them to work together on issues of common concern. In India, a multireligious and cross-sector group developed a special course on peace and values education for primary and middle school students (Box 9).

Box 9: *Living in Harmony*: A course on peace and value education in India

Living in Harmony is a carefully graded series of eight books on peace and value education intended for primary and middle schools in India developed by a diverse faith and non-faith team. It incorporates the concern for the peace education expressed in the national curriculum framework, which stated that "education for peace seeks to nurture ethical development with values attitudes and skills required for living in harmony within one's self and with others." This series is designed to sensitized students to the need for harmony and mutual respect among individuals and communities. It aims to help young learners recognize their own responsibilities towards their environment and to instill in them the values that are vital to a meaningful socially productive life. Each book incorporates these values through stories from history, folk tales, religion, fables, real life events and world literature. The main focus of these school educational text books is to inculcate and reinforce universal human values of peace, love, truth and cooperation to cultivate the knowledge, skills and attitudes needed to achieve and sustain a global culture of peace.

Source: Krishnan, Mini (Series Editor). Living in Harmony – A course on Peace and Value Education, Oxford University Press, India, 2010 (Revised)

G4. Support multireligious collaboration in rebuilding communities. In the aftermath of crises, be they natural disasters or violent conflict, communities are devastated: infrastructure is destroyed, social services are in disarray, families are torn apart, and spirits are weakened. Faith institutions provide an anchor in such distressed communities. At times of greatest need, people frequently turn to their faiths to restore hope and help meet immediate needs.

Driven by common and acute needs, the post-crisis environment can create opportunities for people of different faiths to work together towards relief and reconstruction, thereby building relationships that can alleviate social tensions and extend to other health and development goals. In the Philippines, Habitat for Humanity is building houses in Mindanao for both Muslim and Christian victims of the armed conflict, including ex-MNLF fighters. Carried out by

Box 10: Interfaith Collaboration Post Crisis: Aceh in the wake of the tsunami and civil strife

The Indonesian province of Aceh has been host to a massive relief and development effort since the December 2004 tsunami. Until a ceasefire was called immediately following the tsunami, Aceh was also the site of a 29-year civil war between the government and the Free Aceh Movement. Many among the "first responders" were faith-inspired organizations, both global relief institutions and Indonesian-based organizations (notably the vast Muslim organizations, Nahdlatul Ulama and Muhammadiyah), as well as various churches and religious councils.

Aceh's population is roughly 99 percent Muslim. As such, non-Muslim organizations that partnered with the local Muslim community found greater overall acceptance by the local population. Starting almost immediately, interfaith alliances and partnerships emerged across various reconstruction contexts. For example, Catholic Relief Services (CRS) built mosques alongside Muslim villagers; the Salvation Army, Caritas, Islamic Relief, and CRS built over 10,000 new houses; and Mormon and Muslim groups worked together on rehabilitation.

One prominent multireligious collaboration was between Muhammadiyah, which counts over 30 million members and runs over 12,000 secular and religious schools, and World Vision. This partnership focused on building schools throughout Aceh to provide social stability and rebuild the educational infrastructure. World Vision and Muhammadiyah demonstrated that by combining efforts they could attract greater resources and have more lasting impact. World Vision accrued greater credibility working alongside Muhammadiyah, while the World Vision partnership brought international recognition and resources to Muhammadiyah's work. Additionally, Muhammadiyah's standing in the community was vital to encouraging Muslim parents to send their children to the schools.

Source: Excerpted/adapted from "Faith Roles and Interfaith Cooperation in Post-conflict, Post-disaster Aceh," Elizabeth Laferriere, Berkley Center graduate assistant

Christians and Muslims working side-by-side, these "peace builds" contribute to improving relations between the two communities as they rebuild communities together.[50] Given the inflow of assistance from overseas, post-crisis situations can also provide a foundation for forging ongoing relationships between and among international and local faith actors. As described in Box 10, the post-crisis situation in Aceh gave rise to mutually-beneficial multireligious collaborations between international and local partners.

VIII. Recommendations to Improve the Enabling Environment for Faith Sector Engagement

H. Develop the evidence base on the extent and effectiveness of the faith sector's engagement on health and development

Although faith institutions have been part of the service delivery infrastructure for decades, clear and comprehensive evidence of the effectiveness, scale, and reach of this work is scarce. Box 11 presents specific questions about the faith sector's role and impact that have not been addressed or have only been answered in part by existing research – and where further investigation is required.

The paucity of *analytical* evidence has made it difficult for faith actors to make the case for investment to increasingly evidence-based donors. As a result, funding and action are often based on individual decision-makers' perceptions and experiences rather than a clear understanding of the comparative advantages or disadvantages of faith entities.[51] There are currently several "hubs" focused on gathering data and evidence on the contribution of faith actors,[52] but the challenge remains to integrate the various work and data streams and promote the use of these insights by practitioners, funders and policymakers.

H1. Improve performance evaluation and asset tracking. While some faith institutions, particularly large international faith-based NGOs, have adopted sophisticated monitoring and evaluation (M&E) practices, M&E is not systematically practiced across the sector. Even among those who do track performance, the methodologies employed can vary significantly, and donors are often hesitant to fund organizations whose M&E practices diverge from their pre-

Box 11: Illustrative Knowledge Gaps for the Faith Sector

- What proportion of vital services (e.g. health, education, water) is being delivered by or through the faith sector?
- How well do these services reach underserved populations (e.g. rural poor)?
- What are the quality, impact and cost of services delivered through the faith sector?
- How does the approach, quality, cost and impact of faith-provided services compare with public and private delivery channels?
- What are effective models of congregation-based social mobilization?
- To what extent are health and development messages incorporated or highlighted in congregational communications? And how do these messages impact communities' attitudes and behaviors?
- What skills and capacities help faith leaders be most effective agents of behavior change in their communities? What are effective ways of enlisting their support for advancing the health and development of the communities they serve?
- What are effective practices with the potential for replication or scale in other settings for faith actors, both individually and in partnership, to address health and development challenges?

ferred methods. Faith-affiliated networks (e.g., Christian Health Association Platform) and faith-inclusive coalitions can play an important role in supporting more systematic performance evaluation of member institutions – and in aggregating and learning from such data. An online repository of best practices and resources for M&E could also be developed (as part of a broader capacity building portal proposed in Recommendation E1). Unless there is better data on the involvement and effectiveness of the sector, faith-based providers will simply not be on the radar of policymakers and funders.

Several promising initiatives are helping to address these information gaps at country, regional and global levels. For example, UNAIDS and the Catholic Medical Mission Board have published studies that analyze the effectiveness of the Catholic Church's response to HIV in Southern Africa and India, respectively.[53] The ARHAP program (see Box 12) is compiling baseline information on the nature and extent of religious health assets and services in sub-Saharan Africa. The Berkley Center and the World Faiths Development Dialogue are undertaking a global mapping exercise of the activities of faith-inspired organizations across regions and on select issues, having completed several reports to date.[54] Additionally, the recently-launched Joint Learning Initiative into Faith Communities ("JLI-FC"), spearheaded by Tearfund, seeks to build an evidence base which will provide insight into the role and impact of local faith communities (e.g., local faith institutions and informal faith-inspired groups) on civil society. Secondly, the JLI-FC aims to provide actionable recommendations to all development actors who wish to engage with local faith communities but are unsure of how to access them, when to partner with them, and how to overcome potential challenges. Information on faith-affiliated services will ultimately need to feed into national and regional statistical data systems. To this end, a joint WHO and CIFA initiative is seeking to fully map faith-based health facilities on a national scale using the revised WHO Service Assessment Methodology.[55]

H2. Build a global research network specializing in the intersection of faith and development. Research on the faith sector's role and efficacy in health and development is currently fragmented and incomplete, and there are few mechanisms to inform practitioners about emerging findings. Concerted collaboration among major academic and research centers can help address these gaps. Some UN Agencies have made significant progress on mapping UN and FBO partnerships.[56] Georgetown University's Berkley Center tracks the engagement of faith actors around global policy challenges and brings together stakeholders to examine best practices and advance collaboration. ARHAP, with its hub at the University of Cape Town in South Africa, links several academic centers and offers a promising

Box 12: Building the Knowledge Base: The African Religious Health Assets Program (ARHAP)

"ARHAP seeks to develop a systematic knowledge base of religious health assets (RHAs) to align and enhance the work of faith health leaders, public policy decision-makers and other health workers in their collaborative efforts to meet the challenge of disease such as HIV/AIDS, and to promote sustainable health, especially for those who live in poverty or under marginal conditions." While it has been variously estimated that faith communities provide between 30-70% of health services in sub-Saharan Africa, the precise nature and amount of the faith sector's contributions are unknown. Furthermore, until religious health assets are systematically included in national and international databases of health service sites, the full capacity of these programs can never be leveraged, as they are not included in health-system planning at the national or international level.

The guiding question behind ARHAP's work is, "In the context of major health crises (linked to environmental and social conditions), given the widespread engagement of faith-based organizations and initiatives in health activities, what criteria, categories and related assessment tools will engender a richer, more dynamic and more productive view on "religious health assets" (RHAs), their contribution to health, and their alignment (or lack of it) with public health systems?" Until a comprehensive picture of the faith community's capacity can be attained, it cannot be fully utilized nor incorporated into national and international health-system planning.

Source: http://www.arhap.uct.ac.za/about.php

regionally-focused model of research collaboration. Similar efforts could be developed and strengthened in Asia and Latin America, and their knowledge pooled and disseminated through a global research network and repository. Beyond compiling relevant research, there is also an opportunity to develop international rosters of experts specializing in the intersection of faith and development. For example, the National Roster of Theologians over Population and Development developed in Venezuela has assembled religious scholars who can authoritatively address the theological underpinnings of various health and development concerns.

I. Promote mutual understanding and knowledge exchange within the faith sector and with secular actors

While the faith and secular development communities frequently share a common empathy, they can also represent different methodologies and worldviews. Specific differences in approaches and sensitivities (e.g., reproductive health) should not obscure real opportunities for "respectful dialogue"[57] and pragmatic collaboration.

I1. Foster a shared literacy among faith and secular development practitioners. Building a shared understanding of the similarities and differences in development approaches and the potential roles and structure of faith actors is a crucial first step to bridging the gaps between faith and development actors. A set of core knowledge that both faith and secular development actors should possess about one another should be clearly established.[58] This body of knowledge can then be incorporated into formal staff orientations (for faith, NGO, bilateral and multilateral workers) as well as the curricula of leading theological and development learning institutions. However, for many, the practice and interpretation of faith is deeply individual. As such, the trainings should also include an awareness of the limitations of the generalizations. Trainings could give particular focus on identifying areas of agreement, the distinctive value added of different groups, and opportunities for cooperation.

There are many examples of efforts to improve mutual literacy among faith and secular actors. For example, the Venezuelan Network on Faith-Based Partnerships on Population and Development in partnership with the UNFPA Country Office is preparing a syllabus and accompanying handbook for theological institutions to build awareness among clergy on issues of rights, health and development. Similarly, MAP International's *HIV and AIDS Curriculum for Theological Institutions* integrates HIV/AIDS topics into theological training. This curriculum originally grew out

Box 13: Partnership Toolkit: *Scaling up effective partnerships: A guide to working with faith-based organizations in the response to HIV and AIDS*

Produced by Church World Service, Ecumenical Advocacy Alliance, Norwegian Church Aid, UNAIDS, and World Conference of Religions for Peace, this resource is intended to provide background information and case studies, counteract myths, and give practical guidance to those who want to collaborate with faith-based actors on joint projects related to HIV and AIDS. The guide is intended for UN staff, government officials, positive people's networks, NGOs, development partners, foundations, and the private sector.

The need for such a guide was highlighted in several workshops and studies that "identified lack of information and misinformation as major factors inhibiting scaling up existing faith-based projects and developing joint initiatives." "The guide reviews the relevant teachings and structures of five major world religions: Buddhism, Hinduism, Christianity, Judaism, and Islam. Examples of current responses, potential obstacles, terminology and case studies are intended to give practical advice for initiating or expanding collaboration at local and national levels."

Source: Scaling up effective partnerships (http://www.e-alliance.ch/en/s/hivaids/mobilizing-resources/faith-literacy/)

of workshops sponsored by UNAIDS, the World Council of Churches and MAP International, and was attended by academic deans, principals, and theologians.[59] In India, the creation of *Health Action*, a national monthly by the Catholic Health Association of India with a multi-sector editorial body and distribution, has helped advance shared health literacy among faith actors and the broader civil society. A number of specialized UN bodies (UNAIDS, UNFPA) have also developed specific frameworks for partnerships with faith-based actors, including outlining respective roles and responsibilities and offering partnership guidelines.[60] The partnership toolkit described in Box 13 educates faith and development actors about the other's structure, approach, terminology and potential roles on HIV/AIDS. Similar toolkits specific to other issues or geographies could also be developed.

I2. Create an online repository of existing knowledge. Knowledge about the faith sector is dispersed among academic institutions, faith-based actors, and development practitioners and partners. An online portal could help compile and track independently evaluated quantitative and qualitative knowledge and evidence on faith and development. To make knowledge more accessible and actionable, such a portal could organize research according to a user-friendly taxonomy, summarize key findings, and publish best practices. This resource could be accessible to both faith organizations and secular actors, including donors. Platforms are emerging to serve some of this function. For example, the Berkley Center's Knowledge Resources portal provides "an overview of the world's religious traditions and their impact on society, politics, and world affairs." This online portal organizes resources related to organizations, people, programs, publications, events, and more.[61]

I3. More widely disseminate knowledge and information that can enhance effectiveness and facilitate collaboration. Formal knowledge-sharing networks can be an efficient mechanism for building communities of practice. The ACT Alliance[62] is a network of more than 100 churches and church-related member organizations. The Alliance sponsors technical and programmatic working groups on a broad spectrum of humanitarian assistance and development issues at the national, regional and global levels. Alliance groups identify and document best practices, develop policy positions, share information, and/or surface opportunities for collaboration across the Alliance.

The rapid spread of modern social networking technologies have opened up the possibility of connecting the collective wisdom of geographically-dispersed faith and development communities. Wiki information-sharing platforms and list-servs can connect a range of faith-affiliated development change agents, including congregational leaders, community-based volunteers and staff in faith-affiliated agencies. Participating practitioners can share latest practices, and provide counsel and solidarity.

Box 14: Mapping On-the-Ground Efforts: Interaction Haiti Map

In the immediate aftermath of the January 2010 earthquake in Haiti, thousands of NGOs became involved in recovery efforts, creating real coordination challenges. InterAction, the largest alliance of U.S.-based international NGOs, launched a web-based mapping platform that seeks to map all of its members work in Haiti. The mapping platform aims to be an "effective, flexible and sustainable means of capturing information on NGO activities" that ensures transparency and accountability, facilitates coordination between actors, helps NGOs and donors make decisions about where to direct resources, and highlights the global reach of NGOs to donors, the media, and the public.

Source: http://www.interaction.org/about-interaction; http://haiti-aidmap.org

Knowledge sharing networks can also keep organizations abreast of what others are doing. In the wake of the unprecedented earthquake response in Haiti, InterAction developed an interactive map that documents the various programs of InterAction member NGOs in Haiti (Box 14). Practical tools such as this may help minimize duplication and catalyze cooperation among faith and development actors.

J. Manage and mitigate potential subjects of risk and disagreement

Collaborations within the faith sector, and especially between faith and secular actors, have thus far been limited by differing views on "thorny" issues, such as those presented in Box 15. On these subjects, faith and secular actors could benefit from an explicit and mutually acceptable norms arrived at through direct and honest dialogue.

Box 15: Potential Subjects Requiring Norms and Standards

- Transparency and accountability (e.g. M&E, reporting , financial tracking; segregation of funds)
- Proselytizing: balancing what is appropriate along a continuum of behaviors, with the right to maintain and express one's religious identity and inspiration
- Maintaining appropriate faith-state boundaries: protecting the autonomous voice and moral credibility of the faith community from political and governmental dictates
- Non-discrimination in service provision (e.g. on the basis of religion, class, ethnicity or gender)
- Respect for partners' autonomy and religious identity
- Sound partnership arrangements (e.g. clearly defined expectations, identifying and monitoring outcomes)

J1. Define shared norms and standards to guide multi-religious collaboration. A clearly enunciated and tailored set of standards for faith and secular partners can help build mutual trust, ensure a level playing field and articulate mutual expectations and requirements. Voluntary and peer-endorsed professional standards have proven vital for other communities, and can guide the development of standards for faith sector collaboration. For example, the SPHERE Standards and the Code of Conduct for the International Red Cross and Red Crescent Movement and NGOs in Disaster Relief establish standards on religion and aid non-discrimination, respect for beneficiaries and their cultures, NGO independence and accountability. The US President's Advisory Council[63] has made recommendations in many areas including respecting Church-State separation while encouraging the community contributions of many faith-based actors.

IX. Proposed Actions for Increased Engagement of the Faith Sector

The following tables suggest concrete actions that various stakeholders can take to advance the recommendations of the Strategic Framework over the short- to medium-term. This is not intended as a workplan, but rather a set of promising actions for implementing the proposed recommendations. Further work will be required to develop specific implementation workplans with metrics and milestones for each of the opportunities identified in full consultation with relevant stakeholders. Table A suggests categories of organizations that may be best-placed to drive such efforts.

Table A: Recommendations to Support Collaboration within the Faith Community and with Secular Actors

RECOMMENDATIONS	PRIORITY ACTIONS	RELEVANT STAKEHOLDER PARTICIPATION					
		Faith Sector	UN and Multilaterals	Secular NGOs	Developing Country	Donor Gov'ts	Academia
A. Strengthen mechanisms that facilitate collaboration	Implement scalable multireligious collaboration **"demonstration projects"** (e.g., the Interfaith Action Association) within targeted issue areas to provide models on effective approaches to collaboration.	■					■
	Define a **harmonized global partnership action plan** for the 2011-2012 period with GIFHD and other faith bodies.	■	■	■	■	■	■
	Work through the **UN Inter-agency Task Force and the UN Office of Partnerships** to facilitate cross-agency coalitions and networking and identify specific programmatic opportunities, particularly with UNICEF, WHO, UNFPA, UNAIDS, UNDP, World Bank.	■	■				
	Organize **country-level cross-sector dialogues** (through UN Resident Coordinator system and national bilateral missions) to build relationships and explore potential partnerships with faith sector in country.	■	■	■	■	■	
	Convene follow-up **GIFHD Task Force meetings targeting specific issues** for interested member organizations to develop joint action plans and collaborative approaches on implementation.	■	■	■			
B. Better integrate faith actors into established national planning and funding mechanisms	Expand use of **national strategies for faith sector engagement** as a formal mechanism to integrate faith-based actors and activities into country-led health and development planning processes. (Pilot with selected countries).	■	■	■			
	Convene a **consultation** of private and public donors to explore new opportunities and financing instruments for funding the work of faith sector actors.	■	■	■			
	Make **case to Global Fund** for better inclusion of faith sector; support country level capacity building for CCM members, public officials and faith actors to assure full engagement of faith sector in Global Fund programs.	■	■	■			

■ Suggested participating stakeholders

Table B: Recommendations to Enhance the Faith Sector's Direct Health and Development Impact

RECOMMENDATIONS	PRIORITY ACTIONS	RELEVANT STAKEHOLDER PARTICIPATION					
		Faith Sector	UN and Multilaterals	Secular NGOs	Developing Country	Donor Gov'ts	Academia
C. Engage and mobilize local congregations	Conduct **case studies of congregational mobilization** to identify best practices and guidance for replication in various contexts. Coordinate through Joint Learning Initiative.	■					■
	Identify, collect and develop tools to train and support **faith leaders to incorporate health and development messaging** into their preaching and teaching.	■					
	Design **simple self-reporting templates and informal polling mechanisms** that can be used by congregation members to surface potential health and development concerns.	■	■		■		■
D. Amplify the advocacy reach and influence of faith institutions	Define a clear and shared **messaging platform for GIFHD Task Force members** to advocate with Governments and other relevant target audiences.	■					
E. Ensure quality of faith-based health and development services	Develop and conduct a high-level **capacity and skills diagnostic**, tailored for distinct types of faith actors, to identify priority capacity gaps and training and resource needs – for application at the country level.	■	■				■
F. Mobilize faith communities to promote the health and development of women and girls	Develop **training tools and curriculum** to build awareness and understanding of gender equity issues among faith leaders at various levels, and to increase their positive impact on development for women and girls.	■					■
G. Strengthen faith actors' critical role in conflict prevention and resolution and post-crisis response	Develop youth-focused **curricula emphasizing mutual respect and tolerance** that can be integrated into national educational curricula and faith leader training.	■	■		■		■
	Make **case to Global Fund** for better inclusion of faith sector; support country level capacity building for CCM members, public officials and faith actors to assure full engagement of faith sector in Global Fund programs.	■	■	■			

■ Suggested participating stakeholders

Table C: Recommendations to Improve the Enabling Environment for Faith Sector Engagement

RECOMMENDATIONS	PRIORITY ACTIONS	RELEVANT STAKEHOLDER PARTICIPATION					
		Faith Sector	UN and Multilaterals	Secular NGOs	Developing Country	Donor Gov'ts	Academia
H. Develop the evidence base on the faith sector's engagement on health and development	Conduct **case studies of congregational mobilization** to identify best practices and guidance for replication in various contexts. Coordinate through Joint Learning Initiative.	■	■				■
	Identify, collect and develop tools to train and support **faith leaders to incorporate health and development messaging** into their preaching and teaching.	■	■			■	
	Design **simple self-reporting templates and informal polling mechanisms** that can be used by congregation members to surface potential health and development concerns.	■					■
I. Promote mutual understanding and knowledge exchange within the sector and with secular actors	Define a clear and shared **messaging platform for GIFHD Task Force members** to advocate with Governments and other relevant target audiences.	■	■	■			■
	Develop and conduct a high-level **capacity and skills diagnostic**, tailored for distinct types of faith actors, to identify priority capacity gaps and training and resource needs – for application at the country level.	■					
F. Mobilize faith communities to promote the health and development of women and girls	Develop **training tools and curriculum** to build awareness and understanding of gender equity issues among faith leaders at various levels, and to increase their positive impact on development for women and girls.	■					■
	Develop a **communication and outreach strategy** to build broader awareness and understanding of the faith sector's role in health and development. The strategy should identify specific outreach channels and audiences.	■					
J. Manage and mitigate potential subjects of risk and disagreement	Co-author with key secular partners a proposed set of **norms and standards for faith-based engagement.**	■	■	■	■	■	■

■ Suggested participating stakeholders

Annexes

Annexes

Annex 1: List of Task Force Members

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Annex 2: Roles Differentiated by Faith Actor

ACTOR	DESCRIPTION	POTENTIAL ROLES
Faith-based NGOs	▪ Faith-inspired NGOs inhabiting both the faith and secular development worlds, requiring them to work effectively in both domains ▪ Connected to faith constituencies, but can sometimes operate independently of faith hierarchies and exercise some autonomy and flexibility ▪ Some larger international FBOs maintain sophisticated bureaucracies with significant technical and management capacity	▪ Administer programs, including service delivery, advocacy and research/analysis ▪ Mobilize faith constituencies for volunteer, financial or advocacy support ▪ Facilitate greater linkages among local faith efforts and between local faith efforts and the broader development community, including knowledge exchange, partnership brokering, and resource mobilization ▪ Build capacity of local faith efforts
Faith-based networks and intermediaries	▪ Operate nationally, regionally, or globally, and comprised of faith-inspired members, sometimes representing different faith traditions and diverse perspectives. ▪ May represent large faith-inspired constituencies	▪ Mobilize and represent a collective moral voice; engage in advocacy ▪ Mobilize constituencies for volunteer, financial or advocacy support ▪ Coordination and brokering among faith members and between members and the broader development community, including as a platform for knowledge sharing, networking, coordination and resource mobilization ▪ Provide member-support services (e.g., capacity building, technical assistance, standard setting)
Faith-based service delivery infrastructure	▪ Includes "hard" service-delivery infrastructure (e.g., schools, clinics, and hospitals) ▪ Variable degree of alignment with national service delivery infrastructure ▪ May have a long history of local service provision, tradition of working with marginalized populations, and deep local knowledge	▪ Operate "on the front lines" to provide direct services to local communities ▪ Influence behavior through service delivery

Annex 2: Roles Differentiated by Faith Actor (continued)

ACTOR	DESCRIPTION	POTENTIAL ROLES
International and national faith leaders	▪ Often visible, well-respected public figures ▪ Opinion leaders with cultural and political influence, as well as thought leaders, who interpret faith text and spread ideas ▪ Influence can transcend faiths and geographical boundaries	▪ Moral voice and a platform they can use to influence and inspire their followers as well as others ▪ Can influence followers directly, or through local leaders via denominational hierarchies, where they exist ▪ Advocate with policymakers
Denominational hierarchies	▪ Variation in degree of organization and centralization of authority across faiths ▪ Can be influential political and cultural figures	▪ Guide, coordinate and support the work of their local faith communities ▪ Channel for communicating concerns rising from local faith leaders and laypersons upwards to national and international faith leadership ▪ Advocate with policymakers
Local congregations and houses of worship	▪ Congregations and their leaders have deep community roots and serve as regular gathering places for congregants ▪ Local faith leaders are often trusted community figures and can sometimes influence national policies	▪ Local faith leaders can be effective change agents, mobilizing congregations by influencing attitudes and behaviors and inspiring action, and engaging in advocacy ▪ Congregational members can be mobilized locally or across borders to donate, volunteer, advocate, or monitor their communities ▪ Houses of worship can serve as the infrastructure for gathering people or as a distribution channel

Endnotes

[1] Marshall, K. and Van Saanen, M., "Development and Faith: Where Mind, Heart, and Soul Work Together," The World Bank, 2007.

[2] Bandy,G., Crouch, C. et al., "Building From Common Foundations: the World Health Organization and faith-based organizations in primary healthcare," 2008, Eds. Ted Karpf and Alex Ross. Several estimates suggest that FBOs provide at least 25 and as much as 70 percent of health services in Sub-Saharan Africa (Schmid B, Thomas E, Olivier J and Cochrane JR., "The contribution of religious entities to health in sub-Saharan Africa," ARHAP. 2008.)

[3] Schmid, et al., "The contribution of religious entities to health in sub-Saharan Africa," 2008.

[4] United Nations, Millennium Development Goals Report: 2010.

[5] The UN General Assembly's *Keeping the promise: united to achieve the Millennium Development Goals* (17 September 2010) makes a similar call to action: "We call on civil society, including non-governmental organizations, voluntary associations and foundations, the private sector and other relevant stakeholders at the local, national, regional and global levels, to enhance their role in national development efforts as well as their contribution to the achievement of the Millennium Development Goals by 2015, and commit as national Governments to the inclusion of these stakeholders."

[6] In particular, see UNAIDS' "Partnership with Faith Based Organizations: UNAIDS Strategic Framework" (http://data.unaids.org/pub/Report/2010/jc1786_fbo_en.pdf) and UNFPA's "Guidelines for Engaging FBOs as Agents of Change" (http://www.unfpa.org/culture/docs/fbo_engagement.pdf).

[7] A Global Health Council study of six countries found significant variation in FBOs' participation in national public policy planning on HIV/AIDS, ranging from low participation (e.g. India, Thailand) to much fuller engagement (e.g. Uganda). (Global Health Council, "Faith in Action: Examining the Role of Faith-based Organizations in Addressing HIV/AIDS," 2005.)

[8] Bandy, G., "Building from Common Foundations," 2008; The ability to map and fully account for religious health assets was a focus of the conference on NGO Mapping Standards co-hosted by CIFA and the World Health Organization in 2009.

[9] CIFA is a Washington, DC-based non-profit development organization committed to building the capacity of the international faith sector to increase its impact on poverty and disease. For more, please visit: www.cifa.org. GivingWorks Inc., a social impact consulting firm, has been engaged as strategic advisor to CIFA and GIFHD. For more, please visit www.givingworks.com.

[10] The Berkley Center, "Mapping the Role of Faith Communities in Development Policy: The US Case in International Perspective," 2007; Olivier, J. "An FB oh?": Mapping the Etymology of the Religious Entity Engaged in Health (presentation).

[11] For example, the Community of Sant'Egidio is a Catholic-led movement of lay people and has more than 50,000 members, in more than 70 countries throughout the world (www.santegidio.org).

[12] The Berkley Center, "Experiences and Issues at the Intersection of Faith and Tuberculosis," Draft, May 14, 2010 discusses "hybrid arrangements" in which faith-supported hospitals partner with government or NGOs, sharing responsibility for staffing, supplies, and/or the physical plant. Further, the "prevalence and sometimes fluid or ad hoc nature of these hybrid arrangements make it difficult or impossible to categorize certain health assets as either 'government' or 'faith.'"

[13] Based on the World Bank's Voices of the Poor work and recent Latinobarómetro polls.

[14] Schmid B., et al, ARHAP, "The contribution of religious entities to health in sub-Saharan Africa," 2008. For this and other references to this source, it is important to note that the focus of this study is specifically on health and sub-Saharan Africa. We believe many of the insights have wider applicability.

[15] Ritva Reinikka and Jacob Svensson, "Working for God? Evaluating Service Delivery for Religious Non-Profit Service Providers in Uganda," The World Bank Development Research Group, Policy Research Working Paper, May 2003. The study concluded that the "altruism factor" inherent in religiously-affiliated health care facilities in Uganda made a significant difference in the care that was provided relative to both for-profit and government facilities. The study also suggests that government subsidies of religious health facilities led to higher quality services and lower prices paid by consumers.

[16] Schmid B., et al, ARHAP, "The contribution of religious entities to health in sub-Saharan Africa," 2008.

[17] Schmid B., et al, ARHAP, "The contribution of religious entities to health in sub-Saharan Africa," 2008.

[18] Berkley Center, "Experiences and Issues at the Intersection of Faith and Tuberculosis," Draft. May 14, 2010.

[19] WHO, World Health Report 2004: Changing History.

[20] UN Secretary-General Ban Ki-moon, Investing in Our Common Future, Working Papers of the Innovation Working Group, Version 1 (Joint Action Plan for Women's and Children's Health).

[21] For example, there have been reports of faith leaders in Africa encouraging congregations to cease antiretroviral treatment in order to be healed by God. (Fiona Samuels, Rena Geibel and Fiona Perry, "Collaboration between faith-based communities and humanitarian actors when responding to HIV in emergencies," Project Briefing, No. 4, May 2010.)

[22] Tearfund outlines several potential benefits of closer collaboration between local churches and donors and governments in its report "In the Thick of It: why the church is an essential partner for sustainable development in the world's poorest communities," July 2009.

[23] These examples have not necessarily been vetted or formally evaluated for efficacy. For additional examples, visit CIFA's database of multireligious collaborations at: http://www.cifa.org/initiatives/database.html

[24] Andreas Hipple and Jean Duff, "The Center for Interfaith Action and the MDGs: Leveraging Congregational Infrastructures for Maximum Impact on Disease and Poverty." CrossCurrents, September 2010, pp. 368-382.; see also www.cifa.org

[25] http://www.cifa.org/initiatives/nigerian-inter-faith-action-association-nifaa.html

[26] Interview with William Vendley of Religions for Peace

[27] At the country-level, National Development Planning processes, National AIDS Councils, Global Fund Country Coordinating Mechanisms, and various bilateral donors' planning processes, are among the most important of these mechanisms.

[28] Part of the success in Uganda is attributable to the strong alliance built among the Christian (both Protestant and Catholic) and Muslim health provider networks as well as the engagement of other faith leaders, which allows faith-inspired health providers to speak with one voice and coordinate their efforts.

[29] The local church as a critical partner for achieving the MDGs is also explored in Tearfund; "In the Thick of It: why the church is an essential partner for sustainable development in the world's poorest communities," July 2009.

[30] Recognizing these complex social and cultural factors around HIV prevention, UNFPA published a training manual to encourage policymakers and development practitioners to partner with faith-based actors to address them. (UNFPA, Engaging Faith-Based Organizations in HIV Prevention: A Training Manual for Programme Managers, 2007: http://www.unfpa.org/webdav/site/global/shared/documents/publications/2007/HIVTrainingManual_eng.pdf)

[31] With funding from USAID/PMI and with implementing partners, Adventist Development and Relief Agency and CIFA, PIRCOM has concluded its first phase of the Together Against Malaria program.

[32] Provided by Ravi Narayan

[33] Interview with Abed Ayoub, Chief Executive Officer of Islamic Relief USA

[34] Hudson Institute, Center for Global Prosperity, "The Index of Global Philanthropy and Remittances: 2009".; See also http://thepeaceplan.com/

[35] www.lifeusa.org

[36] Jubilee 2000 was founded in the early 1990 by retired lecturer, Martin Dent, who saw an analogy between the biblical Jubilee and modern debt relief.

[37] http://www.endvawnow.org/

[38] The notion of "intangible" contributions of religious entities around health was studied by ARHAP in "Appreciating Assets: The Contribution of Religion to Universal Access in Africa", Report for WHO, October 2006. According to ARHAP, "Religious entities are perceived as contributing to health, well-being, and the struggle against HIV/AIDS in both tangible and intangible ways, and it is this combination that distinguishes them and gives them strength." ARHAP identified three areas of "intangible" assets, including Spiritual Encouragement, Moral Formation and Knowledge Giving.

[39] www.faithsummit2010.org

[40] Tearfund, "In the Thick of It: why the church is an essential partner for sustainable development in the world's poorest communities," July 2009.

[41] Sarla Chand and Jacqui Patterson, *Faith-Based Models for Improving Maternal and Newborn Health*, (USAID, September 2007.

[42] http://religionsforpeace.org/file/resources/toolkits/restoring-dignity-toolkit.pdf

[43] http://www.wfd-alliance.org/EVrelease

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[47] Katherine Marshall, "Creating Peace in War Zones," *The Huffington Post*, October 12, 2010, http://www.santegidio.org/index.php?idLng=1064&id=7716&pageID=64&res=1

[48] Katherine Marshall, "Blessed Peacemakers" (blog entry), December 1, 2008: http://berkleycenter.georgetown.edu/blogs/blessed-peacemakers

[49] Katherine Marshall, "Hope for Guinea" (blog entry), June 7, 2010: http://berkleycenter.georgetown.edu/blogs/hope-for-guinea

[50] http://www.habitat.org.ph/site/programs_peace.php

[51] Olivier, J. 2010. Exploring discourses of comparative advantage: valuing and evaluation HIV/AIDS-engaged religious entities in sub-Saharan Africa *Religion shaping development: inspirational, inhibiting, institutionalised?* 21-23 July 2010, Birmingham, UK: RaD.

[52] Georgetown's Berkley Center, ARHAP, the World Bank, denominational networks, and UN agencies, provide some examples.

[53] UNAIDS, *A Faith-Based Response to HIV in Southern Africa: The Choose to Care Initiative (2006) and Best Practice Report on a Concerted Faith-Based Initiative: Scaling Up Towards Universal Access to HIV Prevention, Care, Support and Treatment* (Catholic Bishops Conference of India, undated). Both monographs were prepared by Rev. Msgr. Robert Vitillo.

[54] http://berkleycenter.georgetown.edu/projects/global-mapping-of-faith-inspired-organizations-and-development

[55] See the Mapping Religious Health Assets Portal at: http://www.cifa.org/mapping/

[56] http://www.unfpa.org/culture/docs/global_forum_summary.pdf

[57] Much has been written on the notion of respectful dialogue and co-literacy. For example, ARHAP detailed the need for respectful dialogue among religious and public health practitioners, including advancing specific recommendations for developing religious and public health literacy and engendering respectful engagement in its "Appreciating Assets: The Contribution of Religion to Universal Access in Africa," Report for WHO, October 2006.

[58] The design of this should be informed by a baseline assessment of what secular and faith development practitioners know about the intersection of their domains, beliefs and practices. A group of thought leaders in both development and theology could be assembled to guide this design.

[59] http://www.oikoumene.org/resources/documents/wcc-programmes/justice-diakonia-and-responsibility-for-creation/ehaia/trainingteaching-material/hivaids-curriculum-for-theological-institutions.html

[60] Through a 3-year consultation process between UNAIDS Secretariat, the 10 UN Cosponsoring agencies and FBOs, UNAIDS developed the "Partnership with Faith Based Organizations: UNAIDS Strategic Framework" (http://data.unaids.org/pub/Report/2010/jc1786_fbo_en.pdf). UNFPA has also developed guidelines for partnering with FBOs, see: UNFPA's "Guidelines for Engaging FBOs as Agents of Change" (http://www.unfpa.org/culture/docs/fbo_engagement.pdf).

[61] http://berkleycenter.georgetown.edu/resources#

[62] http://www.actalliance.org/

[63] "A New Era of Partnerships: Report of the President's Advisory Committee on Faith based and Neighborhood Partnerships", March 2010.

About the Center for Interfaith Action on Global Poverty (CIFA):
The Center for Interfaith Action on Global Poverty aims to improve the capacity and effectiveness of the faith community in its collective effort to reduce global poverty and disease. CIFA does this through increased interfaith coordination, best practices and model sharing, innovative mobilization of resources, and influential advocacy to governments the general public.

About the Global Initiative for Faith, Health, and Development (GIFHD):
GIFHD complements CIFA's action focus to increase the engagement and impact of the faith sector on health and development. Convened and supported by CIFA, with initial funding from the F.I.S.H. Foundation, Inc., GIFHD serves as a bridge between global faith and development communities to support the full engagement of the faith sector by government, bilateral and multilateral institutions, other civil society actors and private philanthropy.

About GivingWorks Inc.:
GivingWorks Inc., a social impact consulting firm, provides strategy and management consulting and leadership coaching services to organizations advancing the public good. GivingWorks served as the strategic advisor to CIFA and the GIFHD Task Force on the formulation of this Strategic Framework. For further information, visit *www.givingworks.com* or contact *info@givingworks.com*.

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