

ON FAITH, HEALTH AND TENSIONS AN OVERVIEW FROM AN INTER-GOVERNMENTAL PERSPECTIVE

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Faith groups are major providers of health care and health-related services around the world. Faith-based providers of healthcare will often maintain that their approach to health is built on a holistic perspective, employs holistic approaches, and that the care extended to patients is also provided in order to offer a support system to help the family cope during the patient's illness and in their bereavement. In so doing, many faith-based and faith-inspired health care givers will reference an approach intended to address the needs of patients, their families, and their communities, which is carried out with a view of the whole of the person: body, mind and spirit; individual, familial and communal.

In line with the World Health Organization's definition of palliative care,² faith-based or faith-inspired health care tends to be built on approaches which blend different forms of care and intervention – including the spiritual – while also seeking to make use of available community resources. Faith communities can exert powerful leverage to reduce vulnerability to ill-health, since the major world religions express a commitment to respecting the dignity of every person, regardless of age, gender, sexual identity, ethnicity, social position, or political affiliation. Areas of convergence exist, therefore, between the core values informing faith-based responses to health and the rights-based understanding of health that now dominates the health policies employed at governmental and inter-governmental level. The rights-based approach to health, as the name implies, is founded upon respect for and promotion of the fundamental human rights of persons as they are expressed in the Universal Declaration of Human Rights. A rights-based approach to health would therefore seek to promote respect for persons, gender equality, informed consent, confidentiality and so on.

In an article published in *The Seattle Times* in February 2012, Monica Harrington, Deborah Oyer and Kathy Reim write that 'nearly 18 percent of all hospitals and 20 percent of all hospital beds in health systems nationwide are owned or controlled by the Catholic Church'. 'In some isolated areas' they continue, 'the only hospitals available are Catholic-run'. This is a reality in the United States of America, a country whose total net Overseas Development Assistance disbursements (aid provided overseas) was \$30.7 billion in 2012.³ In other words, this is a donor country, not classified as least developed, underdeveloped, or poor.

A growing body of evidence points to the significant role of faith communities in health delivery world-wide. It is estimated that faith-based organizations (FBOs)⁴ provide an average of 30 to 40 percent of basic health care in the world.⁵ This figure tends to be much higher in contexts of conflict and humanitarian emergencies (e.g., Sierra Leone, the Democratic Republic of Congo and Syria) where organizations such as IMA World Health inform us that almost 70 per cent of the basic health care can be provided by FBOs (particularly Christian ones, which

are relatively more numerous and have a history of service delivery which, in some instances, extends back into colonial and missionary times).⁶

Religious institutions manage significant health infrastructure (hospitals, clinics). More broadly, health assets such as home based and community care capacity in most parts of the world have strong links to faith communities. In some cases (for example, Catholic-run hospitals) they are owned by religious bodies, while in others religious communities and principles are important in less direct ways. This is of special concern in the world's poorest communities where religiously owned and operated health facilities play particularly important roles as service providers.⁷ These range from small-scale clinics and dispensaries to major teaching hospitals, such as the Aga Khan University Hospital in Nairobi. The Catholic Church, for instance, has over 120,000 social and healthcare institutions world-wide in many developing countries, and considers itself 'one of the key partners of the State in healthcare delivery, providing services in remote areas to rural low-income populations, enabling them to access services that would otherwise be out of their reach'.⁸

Broadly, the benefits of faith-based health care include wide-reaching and continued community presence which often leads to intimate knowledge of local community contexts, and qualities of compassion, spiritual nourishment and/or culturally consonant forms of faith-inspired nurture. Disadvantages are perceived as including inadequate financing, which undercuts the quality of care; and lack of inclusion with government strategies and/or government-run health facilities and systems. Given that there are increasing efforts to integrate the provision of health services – as part of overall strengthening of the national health systems – having faith-based health providers outside of the acknowledged national health 'grid' renders them more vulnerable to fragmentation, and may increase the burden of efficient management.

Moreover, there are numerous instances where faith leaders and faith communities may lag behind evolving understandings of the more universal application of human rights standards. Notably, such instances can involve: girls' health (e.g. religious leaders may sanction early marriage when girls' mental and physical health ill-prepares them for the responsibilities thereof); women's reproductive roles (e.g. religious voices can be among the loudest proclaiming that reproduction and high fertility are women's only duties); approaches to domestic violence and rape as a weapon of war (where not all faith leaders or communities have taken a proactive and/or clear stance in opposing sexual and gender-based violence); approaches to lesbian, gay, bisexual and transgender (LGBT) people (against whom faith-inspired and faith-based discrimination is rife in many communities); and approaches to mental health (where some faith-based voices may at best disregard and at worst discriminate against mental ill-health).

As will be elaborated later, the bulk of the contentious issues in the relationship between faith and health involve reproductive health, including approaches to HIV and AIDS as a largely sexually transmitted pandemic. Secular public health actors and institutions and human rights activists often blame religious leaders and religiously-inspired proclamations for faith-based resistance to and ignorance of family planning (especially the use of modern contraceptives), and for faith-based opposition to women's empowerment and attention to women's health needs. Issues involving adolescent sexuality (e.g. access to comprehensive sexuality education and access to contraception) and abortion continue to generate significant tension at the community, national and intergovernmental levels.

Nevertheless, numerous publications point to how the HIV and AIDS pandemic, which initially sparked tensions with religious communities (writ large) around approaches to condom use as a necessary part of prevention strategies, has in fact been catalytic to changes in perception, rhetoric, and engagement by and of faith communities. Many point to enhanced appreciation by more secular health actors of the significance of faith-linked roles at community

levels, and of faith-based actors' appreciation of scientific developments in this field, both of which have prompted changes in public health strategies.⁹

THE SOCIAL CAPITAL OF THE FAITH AND HEALTH NEXUS

Amartya Sen, winner of the 1998 Nobel Prize for Economics, set in motion a paradigmatic shift which moved international development from being all too often regarded as no more than a matter of hard core economics. His efforts were part of a wider movement within the international development world to broaden understandings of the multiple dimensions involved in modernization and approaches to development work. Among other changes, this shift has encouraged greater focus on social, cultural, and (to a lesser degree) religious dimensions, including a broader understanding of what is involved in 'social capital'. Sen argued that domains of identity and behavior, and freedom from want and fear were essential parts of what human development aims to achieve, in order to generate the social capital which enables sustainability.¹⁰

What I argue here is that where and when faith both forms and informs values and praxis, *especially ensuring access to and affordability of holistic and comprehensive health care, i.e. ensuring a rights-based approach which secures the dignity of the human being and her/his community*, then that faith contributes significantly to social capital. In turn, when secular development processes engage with faith-inspired and faith-based mechanisms to enhance the advocacy of and build national capacities which realize the range of human rights relevant to health, this is a form of investment in social capital. And this is part of the business of international development partners, particularly the United Nations.

Investments in this form of social capital have long term – and often difficult to quantify – returns, which can also be non-linear. There can be setbacks too, created, for instance, by the confluence of religion and politics (discussed in more detail below). Such setbacks may occasion their own challenges for governments, societies and economies. Yet, whatever the outcomes, this form of investment in social capital, which is dependent upon relationships and issues which touch the very core of our humanity, has often received little systematic attention in international development praxis, and less attention still in the domain of health.

In a scoping report on the role of faith-inspired institutions and initiatives in the areas of maternal health and HIV, authors Anne Smith and Jo Kaybryn note that such faith community institutions are diverse in their size, forms, structures, outreach and sense of identity. Echoing what many earlier extensive reports have noted, the report affirms that 'faith groups often have extensive reach and access throughout many countries, through the services and infrastructure they provide, although estimates of the extent of faith-related involvement in health care vary considerably'.¹¹ The report was commissioned by the Joint Learning Initiative on Faith and Local Communities, which is an international network of practitioners, policy advisors and academics that gathers evidence and makes policy recommendations concerning the impact and effectiveness of faith-based activities in the field of health and development.¹²

There is an increasing mutual recognition of the need for constructive engagement between and by faith-based and secular organizations around health care. This is driven by many factors, including the increasing visibility, investment and policy engagement of major international development organizations (e.g., World Vision International, Caritas Internationalis, Catholic Relief Services) in international platforms such as those provided through the United Nations and the World Economic Forum, among others. The increasing focus given to the nexus between faith and health care is driven by considerations of effectiveness and efficiency of

health care provision in general, and is rooted in considerations of religion as a critical component of social and cultural dynamics of community mobilization, attitude and behaviors in particular. Elena Fiddian-Qasmiyeh (from the University of Oxford's Refugee Studies Centre), and Alastair Ager (Columbia University) note that 'faith groups are often central to strengthening resilience and reinforcing the local processes of identity and connection that comprise the social fabric of communities disrupted by disaster or conflict', including through the latter's capacities to be 'first responders' when disaster strikes, as well as through the psychosocial support, or 'psychological first aid'.¹³

CRITICISMS AND CONCERNS

As noted above, criticisms of the nexus between faith and health often center around the lack of recognition of the serious social, political, cultural and economic considerations that exacerbate gender inequalities and thereby prevent women accessing health services. The areas of contention focus particularly – albeit not only – around the continuum of sexual and reproductive health.

The ways in which faith groups have responded to HIV and AIDS over the last three decades is an important area of study in its own right, and it also provides a lens to analyze the broader dimensions of the faith and health nexus. The response to HIV and AIDS constitutes the largest and most challenging health undertaking by the faith sector to date. It is also the most extensively researched area of faith-based engagement. In various ways, the response to HIV has provided a learning opportunity for the faith community, informing its ongoing response to HIV and approaches to other health challenges. It has highlighted areas of best and worst practice in tackling the disease and helped faith leaders and communities to reflect on their key strengths and weaknesses. In many respects faith groups have been found wanting: in their approach to sexual and reproductive health and HIV prevention; in their stigmatization of affected populations; in their harmful use of religious rhetoric, among other areas.

More positively, the faith response to HIV has accelerated the professionalization of FBOs, improved monitoring and evaluation practices, strengthened FBO and inter-faith cooperation, and fostered partnerships with secular agencies. Furthermore, the global response to HIV has confirmed the need for an inclusive, comprehensive, multi-pronged public health strategy that involves a wider body of stakeholders than the medical community alone. It has reinforced the importance of involving faith groups, as civil society actors, in tackling health emergencies at community as well as governance levels; and it has provided pointers of the effectiveness of the holistic and community-based care approaches that faith groups typically deploy.

Whether we speak of the intergovernmental arena which is populated by actors such as the World Health Organization or other UN or EU counterparts dealing with health matters, or we view the bilateral development world, the actors tend to be largely secular entities, with an ethos based, in most cases, on relatively secular human rights principles. This may explain some of the ongoing tensions inherent in the outreach between secular and faith-inspired health entities. Many of these tensions inform the broader development dynamics and are not limited to health matters alone. These include concerns about understanding the motivations behind the work undertaken in the name of 'the divine', 'God', 'faith' or 'religion' and the religious.

In some cases this is framed as a deep-seated suspicion on the part of secular development entities, particularly inter-governmental ones, about the dangers of proselytization. This involves both a perception that the primary motivation of faith-linked actors is conversion, and worries that proselytizing can undermine traditional societies and provoke inter-communal

tensions. Such concerns can translate into an unwillingness and unease in any action that might be perceived as favoring or even pushing a particular faith or religion – especially transnationally. Thus, from the secular health providers' points of view, engaging with faith-inspired or faith-based actors must be undertaken only after careful vetting of the true motivations behind all such initiatives.

It is interesting to note that these same secular entities have relatively less concern about active measures to advance human rights, for those are assumed by most secular development partners to be universal and indivisible, and are backed by international conventions which governments are signatories to. As to the latter fact, some faith-based actors take serious issue with this and point to the reality that some governments have signed onto such Conventions with reservations precisely based on religious and cultural considerations. Other faith groups will also point out that reinforcing international treaties and declarations is not the priority of a faith entity.

It is important not to dismiss the concerns about the potential for religious exploitation of vulnerabilities, just as it is important to appreciate that the strength of faith-based and faith-inspired health providers is precisely in their rootedness to their faith, and thereby to their communities' very core essence and values. It is also important to stress that these concerns should be addressed in a more studied fashion and should not be allowed to stand in the way of important partnerships needed to address critical matters of health and human dignity.

An elephant in the room of any conversation or initiative which brings together the secular and the faith-based or faith-inspired, is the particular intersection of religion with politics. Religion can be the motivation, or the rationale or the instigator behind many forms of political activism, political parties, and general dynamics of governance. Civic, military and government tensions rise and fall within and between nation-states, based in some ways, in some parts of the world, on religious arguments and interpretations. In other words, religion is very much part of the public space in many countries, with consequences which can impact strongly – and diversely – on considerations of peace and stability.

This geo-political reality informs some of the concerns around religious and faith-based actors, including in health care contexts. Some of the most challenging recent instances involve health care workers –including in contexts of humanitarian crisis – who were unable to provide necessary services to extremist religious actors. In some cases, health care workers have found themselves targeted in contexts of political and economic tensions in which religion plays a role. For example, in Muslim-dominated northern Nigeria in 2003, the political and religious leaders of Kano, Zamfara, and Kaduna states brought the immunization campaign to a halt by calling on parents not to allow their children to be immunized. These leaders argued that the vaccine could be contaminated with anti-fertility agents, cancerous agents and HIV. In analyzing the context, Ayodele Samuel Jegede notes:

Embarrassed by the political undertone of the boycott, the prominent Islamic scholar Sheikh Yusuf Al-Qaradawi, President of the International Fiqh Council, said: 'In fact, I was completely astonished about the attitude of our fellow scholars of Kano towards polio vaccine. I disapprove of their opinion, for the lawfulness of such vaccine in the point of view of Islam is as clear as sunlight'. Sheikh Qaradawi said that the same polio vaccine has been effective in over 50 Muslim countries, and blamed [them] for creating a negative image of Islam: 'They distort the image of Islam and make it appear as if it contradicts science and medical progress'.¹⁴

Another emerging concern centers around competition over resources. This is most keenly felt among more secular NGOs who perceive the increasing number and range of partnerships with

faith-based and faith-inspired actors to be another factor in conditioning and determining the allocation and distribution of foreign aid. The argument often is that the pool of international development aid is already diminishing, and the pie is cut, so to speak, already among so many. The counter to this argument however, is the fact that not all faith-based actors are lacking in resources, and indeed, in many cases, their entrenchment within and service to communities enables some form of 'greater return' on the investments made. Moreover, some would argue that certain international faith-based organizations today, are among the most resource-rich – not only financially but also in terms of human and labor wealth, enhanced by volunteer and in-kind contributions. So, far from taking away from the available financial resources, these actors may indeed be expanding the available resource pool, and/or contributing to maximal outreach of the limited resources, given their centuries-old extensive community base.

Yet another area of contention revolves around gender equality issues. For many of the health activists and researchers working on gender rights, gender equality and the entire spectrum of reproductive health and reproductive rights (including sexuality education, sexually transmitted diseases, HIV, maternal health, family planning), this is fertile ground for contention and boundary setting between secular and faith-based health engagements. A common understanding among many gender equality activists is that religious practices and related cultural norms are often opposed to gender equality and to related human rights discourse.¹⁵

When UN agencies and faith-related groups engage around health, there are many areas of shared concern. These include but are not limited to, maternal and neo-natal or child health, malaria, tuberculosis, polio, HIV treatment and care, disability-related health issues, many aspects of gender-based violence, and engaging men and boys around family health matters. However, as the spectrum of health issues moves closer to issues of gender identity, gender equality, comprehensive sexuality education, domestic violence, some aspects of family planning such as modern contraception, and access to safe, legal abortion, we find the domain of interaction far more contentious.

*Intergovernmental and Global Dynamics Post 2015 and twenty years after the ICPD*¹⁶

The United Nations has varied records of partnership and engagement with FBOs and religious leaders. Indeed, some, like the United Nations Population Fund (UNFPA), have a legacy which goes back to the 1970s involving research aimed at ensuring that the language of UN advocacy – in this case around health – is strengthened by the teachings of religion. Others, like the World Bank, UNAIDS and UNICEF, cultivated these partnerships largely around advocacy, care and service delivery respectively, more towards the late 1990s and into the new millennium. Yet others, such as UNHCR and the Department of Political Affairs, are relatively recent entrants into this awareness of the potential of and actual outreach to the faith-based world and keep the engagement around uncontroversial areas such as protection of displaced peoples and refugees, as well as mediation efforts.

An important nuance here is that the experience of outreach to and with faith-based actors can differ *within the one* Office/entity/body/agency. The headquarters office of one agency (invariably based in New York, Geneva, Vienna, Rome etc.) will often harbor a greater degree of concern and hesitancy about engaging with faith actors than their national office in a developing country. The latter often appreciates the value of such partnerships as intrinsic to community engagement and efficacy of delivery. Headquarter offices often have to grapple more with broader geo-political concerns, given they are more directly connected to their Executive Boards, which are composed of the multiple countries/governments which form the United Nations. Headquarters offices are, therefore, directly engaged in intergovernmental

dynamics, whereas national/country offices of the UN tend to deal with the one government and the local communities more immediately.

Consequently, the overall approaches towards such partnerships vary widely. Most UN development agencies and humanitarian relief actors are relatively more cognizant of the potential and value of such partnerships. Indeed, it is safe to say that the more openly 'political' the mandate of the UN body, the more the acknowledgement or 'fuss' made about partnerships with faith-based and faith-inspired actors. It is also fair to argue that, in general, the overall norm concerning such engagements tends to err on the side of suspicion at worst, and caution at best.

What is irrefutable, however, is that no matter what the level of experience, transparency of the track record, or even acceptability of the discourse of partnership, there is little dispute that the UN Population Fund (UNFPA) has raised the visibility of this conversation with faith influenced actors within the UN system. UNFPA has been a driving force behind convening the UN system to call for a collective platform within the broader organization to reflect critically and in a studied manner on the purpose, objectives, methods, lessons learned and pros and cons of such engagements. These efforts are visible in a myriad of ways and were enabled from the very outset thanks to support of one donor government – Switzerland; and are now continuing with support from the Norwegian Agency for Development Cooperation (Norad). UNFPA was the first UN agency to undertake a systematic mapping of its own historical engagement with FBOs (which was published in 2008). This inspired other UN sister agencies to undertake similar – and even better – initiatives documenting their respective outreach with FBOs and religious communities. UNFPA also launched the UN's first Global Interfaith Network and database for population and development issues.

In 2008, UNFPA's Principal invited the United Nations Development Group peers to formalize the UN Inter-Agency Task Force on Engaging with FBOs for Development (IATF-FBO), which brings together several UN agencies at least twice a year, and hosts many consultations with FBOs, academia and think tanks, around issues common to the development-religion nexus. Many of these consultations are documented in print by UNFPA. In addition, UNFPA, together with UNAIDS, convenes UNICEF, UNDP, UNHCR (on a rotating basis), under the auspices of the UN Staff College for a yearly Strategic Learning Exchange in which both UN staff as well as FBOs meet to share and critically assess concrete case studies of partnership and lessons learned, with a view to enhancing the delivery towards common goals and seeking to identify and overcome challenges.

The outreach to faith actors around the 'Post 2015' process (2015 being the date in which 'new' international development objectives following from the millennium development goals will be agreed to at the intergovernmental level) can only be described as very varied, given the huge diversity of FBOs themselves. At the global level, the engagement of FBOs tends to be informed by the following dynamics:

(a) The size of the organization:

The bigger the FBO in question, the more likely it is that they have been active in UN-related outreach with civil society. Of particular note are organizations which have long partnered with diverse UN agencies on specific issues, such World Vision on child rights and maternal health, and Islamic Relief on humanitarian relief and emergency support in countries.

(b) Heavily dominated by Christian NGOs:

Christian NGOs have a relatively longer history of centralized organization and presence at the international level and, some would argue, a longer track record of providing social

services in countries other than their own, preceding colonial presence. They are thus the most visible at the international ‘policy tables’, conferences and meetings, including at the United Nations.

(c) Dependent on the responsiveness of the FBOs themselves:

This feature also reflects the extent to which some FBOs consider the global agendas on health, such as those spelled out by the Millennium Development Goals (MDGs), to be relevant to their own agenda setting and responsibilities. Some have been more willing to be engaged, and have articulated the MDGs or reference thereto, in their own strategic and policy frameworks. It is noteworthy, and possibly not a coincidence, that those FBOs are also the ones likely to be headquartered in the western hemisphere, and also relatively more comfortable in adopting human rights language and issues.

But many FBOs – and religious leaders – while serving large segments of the local populations at the most micro community levels have no interest in and no resources for a sustained presence in western headquarters. These religious actors will rarely feel the need to accommodate MDG or related discourse in their own agendas or outreach. Yet they are critically important development agents. In some ways, as is the case with many other NGOs, FBO engagement with the global development agenda to date is, arguably, almost class-based. The ‘elite’ and most powerful NGOs and FBOs are the ones at the table.

(d) Dependent on the outreach done by the different UN agencies and offices themselves: Some UN agencies have sought FBO input, deliberately organized outreach to their FBO partners, included FBOs in programme roll-outs, and developed some sort of guidelines for such engagement. Notable in this regard are more operational agencies such as UNICEF, UNAIDS, UNEP and UNFPA. Other UN offices have, at different moments, selectively reached out to some religious leaders and engaged them in certain advocacy efforts and/or in certain mediation initiatives when deemed advisable.

Tensions around sexual and reproductive health

... sexual and reproductive questions ... have been bitterly contentious. Whenever touchstone issues like abortion or homosexuality have been discussed, conservative alliances have sprung up, cutting bizarrely across denominations and faiths. Campaigns at the UN in pursuit of ‘family values’ bring together Christian actors – Mormons, Catholics, Protestants and the Russian Orthodox Church – as well as conservative Muslims. Moves by Brazil to introduce resolutions in favour of gay rights ran into a wall of opposition ranging from conservative American groups to the governments of Egypt and Pakistan. But liberal religious lobby groups also exist, and they team up with secular liberals.¹⁷

When it comes specifically to sexual and reproductive health and reproductive rights issues, there is no coordinated global faith-based engagement. Indeed, this continues to remain the single-most contentious area of rights in the entire development agenda. Both because of this, *and* indeed adding to it at the same time, is the reality that governments themselves (which are the main actors in intergovernmental negotiation spaces and who ultimately decide on what the Post MDG 2015 framework will look like) have very different positions on these contentious issues.

The difference in positions and many of the divisions between faith-based and faith-inspired organizations and groups – including around contentious issues – is not dependent on the faith itself (e.g. it is *not* Muslim-Christian or Christian-Buddhist). Nor are these differences uniformly along national lines (west-east, north-south). Instead, they are within each faith and

within countries, which is important to realize for national advocacy purposes. In other words, within one country, the position that a government will adopt in inter-governmental negotiations is dependent on the strength of the advocacy by and for human rights' actors within that country.

As framed by Berit Austveg for a report to the Norwegian Ministry of Foreign Affairs (May 2013):

The SRHR controversies tend to come up not just when they are expected, such as at the Commission on Population and Development (CPD), at the Commission on the Status of Women (CSW) and in WHO's work on health in general and sexual and reproductive health more specifically. More unexpectedly they can be brought up during negotiations on issues such as disability, refugee situations and housing, and delegations can be caught unaware.¹⁸

The specificities of faith-based operations are such that it is relatively rare to find one FBO focused exclusively on only SRH issues. This feature differs markedly from more secular dynamics where there are a plethora of international organizations and institutions and groups who work exclusively on and around SRHR mobilization and related issues. This means that the FBOs are often working simultaneously on women's empowerment issues, on broader health issues, on climate change, on immigration, on sanitation, among others.

Identifying partners and common language around the sexual and reproductive health agenda specifically becomes much more complicated, less frequent, and remains relatively less publicly celebrated and advertised. Indeed, around these kinds of issues, it is most often the case that ongoing dialogue and individual trust building consultations undertaken over a period of time remain critical keys to success behind joint health endeavors.

In lieu of a Conclusion: Reflections on continued engagement between intergovernmental fora and faith-based entities around SRH

A noteworthy lesson learned is that if these most contentious issues are placed on the agenda of discussions between secular and faith-based actors without prior work having been undertaken on the other common areas of concern, it is mostly likely to result in failure to see eye-to-eye on many matters, and it is unlikely to lead to a developing consensus. More often than not, some of the same faith-based partners with whom this relationship of trust, and a template of common steps and strategic approaches has been developed, can become critical interlocutors in paving the way to identify, invite or bring to the table, their faith-based counterparts with whom these kinds of discussions can unfold, until a common syntax and joint programme can be reached.

While concerns about instrumentalization are articulated on all sides, some religious leaders and FBOs have vocalized the fear of being used somewhat more openly than their inter-governmental counterparts. Some representatives of the faith-based world have questioned why the UN and larger international community have, as it were, suddenly woken up to the importance of faith in the promotion of health. Some have even voiced their unease that this may be another passing fad which would seek to maximize the strengths of faith-based actors, or that it may even be a covert attempt to change the way faith-based actors operate and, as it were, to secularize the religious.

Nevertheless, given the realities of service provision, resource capacity and political presence, not to mention the potential of faith leaders and organizations to mitigate or aggravate a variety of health-impacting behaviors at the community level, being knowledgeable of the work of FBOs is necessary, if only to benefit from the social capital available for sustainable human development, human rights, and peace and security. Thus, an informed and systematic outreach

to key partners in the world of religion, where community service provision has been a reality for centuries, is essential.

CALLS FOR A 'SAFE SPACE'

Mutual suspicions between intergovernmental and faith-based actors, especially around sensitive sexuality-related issues, remain a feature of a large part of the reproductive health and gender equality developmental agenda. This to be expected after so many years of sometimes tepid and often ad hoc acknowledgement of each other. Sustained dialogues and partnerships remain necessary, where a common narrative can emerge that identifies what can be agreed upon, and what areas remain to be discussed. This can provide a context for a sharing of lessons learned resulting from the experience of witnessing mutual interventions. It can also offer opportunities for the acknowledgement of mutual strengths and achievements. This space for dialogue, not only to assess statistical data and evidence, but also to assess strengths and weaknesses with honesty, and to stand in witness to one another, can create a sense of trust and respect over time. The formula of trial and error based on actual engagement, especially around service delivery in the field, with a transparency of purpose, together with respect for respective *modus operandi* and accountability to joint agreements, appears to be the only winning formula available thus far.

Notes

1 The views expressed in this article belong to the author alone, and are not necessarily expressive of any organization, board, staff member, governmental or non-governmental entity.

2 World Health Organization, 'WHO Definition of Palliative Care' <http://www.who.int/cancer/palliative/definition/en/> accessed 1 July 2014.

3 Monica Harrington, Deborah Oyer and Kathy Reim, 'The role of faith in health-care delivery', *The Seattle Times*, February 10, 2012 http://seattletimes.com/html/opinion/2017478449_guest12harrington.html accessed 1 July 2014.

4 There is a great deal of discussion and debate around the definition of an FBO. It is used herein to reference faith-based or faith-inspired non-governmental organizations (NGOs), with legal standing, which are working to advocate for and/or deliver development and humanitarian services whether nationally, regionally or internationally (or indeed at all those levels). In this article, FBOs are distinguished from individual religious leaders or local faith communities, which operate in diverse contexts without being legally registered or established as a non-governmental entity.

5 See, for example, Lynn Alyward, *Global Health and Africa: Assessing Faith Work and Research Priorities*, Tony Blair Faith Foundation & World Faiths Development Dialogue, April 2012, pp. 37–41 <http://berkeleycenter.georgetown.edu/wfdd/publications/global-health-and-africa-assessing-faith-work-and-research-priorities> accessed 1 July 2014.

6 Hafner, Craig, 'Strengthening the Role of Faith-Based Organizations in Human Resources for Health Initiatives', The Capacity Project, Legacy Series 8, September 2009, Washington, DC: USAID http://www.imaworldhealth.org/images/stories/technical-publications/strengthening_fbos.pdf accessed June 30, 2014

7 See Gary Bandy, Alan Crouch, Claudine Haenni, Paul Holley, Carole Jane Larsen, Sian Penlington, Nicholas Price, Carolyn Wilkins. 'Building from Common Foundations: The World Health Organization and Faith-Based Organizations in Primary Healthcare' (Geneva: World Health Organization, 2008) http://www.cchh.org/bulletin/0608files/BuildingFromCommonFoundations_WHO_and_FBOs.pdf accessed June 30, 2014.

8 Archbishop Zygmunt Zimowski, 'Address to 65th World Health Assembly', Geneva, 23 May 2012 <http://www.zenit.org/en/articles/holy-see-at-world-health-assembly> accessed June 30, 2014.

9 For more on this, see Ted Karpf, 'Faith-based organizations play a major role in HIV/AIDS care and treatment in sub-Saharan Africa', Geneva: World Health Organization, 8 February 2007 <http://www.who.int/>

mediacentre/news/notes/2007/np05/en/; NAM Aids Map, 'Faith' <http://www.aidsmap.com/Faith/page/1693440/>; RAND Corporation, 'How Can Faith-Based Organizations Help Address the HIV/AIDS Epidemic in Central America?', RAND's Research Highlights, 2010 http://www.rand.org/pubs/research_briefs/RB9512/index1.html; Michael Schuenemeyer, 'Faith and HIV/AIDS: Engaging a renewed solidarity to save millions of lives', July 27, 2012 <http://www.faithstreet.com/onfaith/2012/07/27/faith-and-hivaids-engaging-a-renewed-solidarity-to-save-millions-of-lives/10987> [all accessed June 30, 2014].

10 See Amartya Sen, *Development As Freedom* (New York: Oxford University Press, 1999).

11 Smith, Ann and Kaybryn, Jo, 'HIV and Maternal Health: Faith Groups' Activities, Contributions and Impact', A Report by the *Joint Learning Initiative on Faith and Local Communities*, August 2013. <http://www.jliflc.com/~media/Files/Joint%20Learning/LHHIVMH/Microsoft%20Word%20-%20JLI%20-%20HIV%20and%20MH%20Report%20-%20Final.pdf> accessed June 30, 2014.

12 See the website of the Joint Learning Initiative: www.jliflc.com accessed 1 July 2014.

13 Fiddian-Qasmiyeh, Elena and Ager, Alistair (Eds.), 2013. 'Local faith communities and the promotion of resilience in humanitarian situations: A scoping study'. The Joint Learning Initiative and Oxford University Refugee Studies Center, Working Paper Series, No. 90, pp. 4–5. http://www.jliflc.com/en/learning_hubs/resilience_in_humanitarian_situations/ accessed June 30, 2014.

14 Jegede, Ayodele Samuel, 2007. 'What Led to the Nigerian Boycott of the Polio Vaccination Campaign?' *Public Library of Science Medicine* 4 (3) March 2007 <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1831725/> accessed April 25, 2014.

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