

Vicky Lavy on the strategic role of faith-based organisations



FAITH-BASED ORGANISATIONS AND GLOBAL HEALTH

key points

Caring for the sick has always been a hallmark of the Christian Church

Priorities have moved from service provision to teaching and training

Both faith-based organisations and the local church have important roles in health and healthcare

We have come a long way in the past 175 years. In 1840 Dr John Illott was sent out to West Africa by the Church Missionary Society. His farewell instructions told him that his duties were confined to the health care of the missionaries and did not include the health care of the African people amongst whom they worked. Nor did they include any part of the missionary activity engaged in by his colleagues. He was told in unambiguous terms, 'You are not, strictly speaking, a missionary.'¹

Happily, attitudes have changed. Mission societies, which initially sent only ordained men to save souls, began to realise that caring for the sick was an integral part of bringing Christ's presence into a needy world. Today it is estimated that faith-based organisations (FBOs) provide 40% of the healthcare in Sub-Saharan Africa,² and it is reported that in India, 80% of Christians relate their conversion to a mission hospital experience at some point in their family history.³

Early days

Caring for the sick and dying has been a hallmark of the Christian Church over the centuries. In AD 259 the Christian community cared for plague victims in Alexandria, often losing their lives in caring for those infected. In the middle ages, monasteries provided hospitals and leprosaria all over Europe. Some early pioneers travelled across the world to bring care in Christ's name; in 1568 two Jesuit priests built the first Christian hospital in Japan and in 1699 Bernard Rhodes of Lyons, a monk trained in medicine and surgery, took his skills to China. There are records of other brave individuals but it was not until the middle of the nineteenth century that

mission agencies started sending doctors in greater numbers. It is estimated that over 1,500 British doctors went to serve overseas between 1850 and 1950.⁴ Over 200 of these were women, who pioneered obstetric care in Asia where women were shut off from the help of male doctors, starting with Fanny Butler who set off to India in 1880.

Present day

Since 1950, hundreds more doctors have served overseas, many of them from CMF. A third of the membership responded to a survey in 2010 and of these, 230 (20%) had served overseas long-term in the past. Currently almost 200 members are working in resource-poor settings in 56 countries around the world. Hundreds more make short-term contributions, most commonly to train and teach.

In 2008 the Gates Foundation commissioned The African Religious Health Assets Programme (ARHAP)⁵ to carry out a wide-ranging study looking at the contribution of religious entities to health in Sub-Saharan Africa.⁶ They found that the proportion of services provided by faith groups of all kinds varied across the continent, ranging from 25% in some Francophone Muslim countries to as much as 70% in parts of East and Southern Africa.⁷ Mission hospitals and church-based clinics are the main providers of facility-based services.

In addition to facility-based care, faith-based entities provided training centres for the health workforce (eg 60% of nursing training in Uganda), community activities such as home-based care, advocacy, and a channel for funding. A study by PEPFAR of USAID⁸ highlighted the enormous contribution that FBOs have made in the fight against HIV, with a wide range of programmes, skills and knowledge, a clear

commitment to serve local communities and the capacity to mobilise an army of volunteers in any corner of the globe.

There are very few studies analysing the care given in faith-based hospitals and clinics and more research is needed. One study published in the *International Journal of Obstetrics and Gynaecology*⁹ looked at the role of FBOs in the area of maternal/newborn health care in six African countries. It was found that the services provided by FBOs were similar to those offered by governments, but the quality of care received and the patients' satisfaction were reported to be better, due to better service quality, staffing levels, supplies and cleanliness. The ARHAP study contains much anecdotal evidence that people prefer to be treated in mission hospitals, where they feel staff are motivated by their faith to treat patients with dignity and respect, give spiritual care and have a commitment to serve the poor.¹⁰

Experiences from Malawi

This was certainly my experience during the ten years I lived and worked in Malawi. Most people, including Christians, Muslims and others, wanted to be treated in mission hospitals. They were more confident of receiving safe, compassionate care at mission hospitals than at the government facilities, where staff were often demoralised and supplies were erratic.

My husband, Chris, was involved in building the Beit Cure International Hospital, a Christian hospital providing surgical treatment for disabled children. One of the international donors was anxious about funding an overtly Christian hospital in a country with a Muslim president, fearing that it would create tension. However, on the ground there was no problem; everyone welcomed the advent of free care for these needy children who would otherwise never receive treatment. Muslim businessmen donated funds towards the building of the hospital and non-Christian patients were happy to receive prayer. I remember asking the Muslim watchman why he attended staff prayers and he said he was happy to be at a place where faith was valued. I think he also enjoyed the singing!

Changing roles

Many Christians working overseas in low-income countries today are not working in faith-based settings, but in government hospitals and universities, or secular organisations. They may be involved in teaching, research, policy development and disaster response as well as in day-to-day clinical care.

Many mission hospitals have been handed over to governments, others are run by the national Church rather than a foreign mission agency. There is a greater emphasis on primary health care and community development alongside hospital-based care. The early pioneer missionary often worked in isolation, a 'jack-of-all-trades' and sole provider of health care, but now that most countries have medical schools, there is a need to provide specialist training and to integrate with national institutions

and structures. In the early days, the missionary had all the knowledge and power, but now works in partnership as a servant and guest.

Local church

The Christian contribution to healthcare does not consist only of work done by health providers; the local church plays a big part in the health and well-being of individuals and society. Worldwide, the local church is present in more communities than any other organisation and it is often a focus for community action and social cohesion, which form the bedrock for development and community health. It has wide coverage, reaching marginalised groups who often fall under the radar of larger organisations, and immense sustainability; the church will still be there when donors and aid organisations have moved on and moved out.

Local congregations are involved in many kinds of health-related activity: home-based care for HIV sufferers, refuges for the homeless, care of orphans and vulnerable children, as well as disseminating health information, changing attitudes and promoting healthy living. Tearfund has worked with local churches in its disaster relief work in twelve different emergency situations around the world.¹¹ When disaster strikes, it is the local church that is first on the scene. Tearfund's partners played vital roles, doing everything from distributing relief materials to digging water channels, to praying for victims and lobbying governments.

Faith matters

It is encouraging that the UK government's Department for International Development is increasingly recognising the role of FBOs and the need to work in partnership with them. Their 'Faith Partnership Principles' paper begins:

*'Faith makes such an important contribution to development...Most people in developing countries engage in some form of spiritual practice and believe that their faith plays an important role in their lives. Faith groups can inspire confidence and trust. They are often seen as a true part of the local community and more committed to it than other groups. Indeed, they are often the first group to which the poor turn in times of need and crisis and to which they give in times of plenty.'*¹²

God is at work in the world through his people. They have made an enormous contribution in the past and are transforming lives in the present. What of the future? The international health agenda is under discussion, as we approach the deadline for the Millennium Development Goals in 2015. CMF has recently contributed to the discussion with a paper, 'Faith Matters – the contribution of faith to health and healthcare in the post 2015 agenda.'¹³ We have argued that whatever the specific development goals may be, the importance of faith must not be neglected, and the contribution of faith-based organisations must be encouraged and supported.

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