Faith Matters - the contribution of faith to health and healthcare in the post 2015 agenda

This paper is submitted by the Christian Medical Fellowship (CMF), a network of 4,000 doctors and 800 medical students in the UK. We have a strong interest in global health, with over 170 of our members currently living and working in low income countries and hundreds more who are involved in regular short-term visits. Through the International Christian Medical and Dental Association (ICMDA) we are affiliated with over 80 national Christian medical organisations around the world, many of which are in low-income countries.

Introduction

CMF appreciates the opportunity to engage in the reflections on how to address the health needs of the world’s population post-2015. In this submission we focus on two issues:

1. The important link between faith and health to individuals and communities; the influence of faith cannot be ignored in the quest to improve the health of the world’s population.

2. The essential role of faith based organisations in healthcare provision.

Although CMF is an association of Christian doctors, our members regularly work closely with individuals and groups from other faiths. While examples given in this document are often of Christian organisations, the general principles set out apply to other faith groups as well.

Faith and health

Faith and spirituality play a vital role in the health and well-being of communities and individuals worldwide. A recent demographic study covering more than 230 countries and territories estimated there are 5.8 billion religiously affiliated adults and children around the globe, representing 84% of the 2010 world population of 6.9 billion. While the vast majority of people in the world exercise faith in a supreme divine being, and have links with a religious community of some form (temple, mosque, church etc), every person has a ‘world-view’ and invests faith in something.

These figures challenge the secularisation thesis that has been influential in the West since the 1960’s; the view that as people ‘develop’ the role of religion and faith will decline. In our world post 9/11 religion and faith are having more influence; the Arab Spring of 2011 and subsequent events highlight the fact that the global development agenda can no longer afford to be faith ignorant.

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3 Worldviews, Gray A, International Psychiatry Vol 8 No 3 August 2011; 58-60
The WHO definition of health reminds us that human beings are not biological machines; rather we have a wide range of interconnected components and areas of need:

‘A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’. 

Evidence from over 1,200 studies and 400 reviews has shown strong associations between faith and a number of positive health benefits, including protection from disease, coping with illness, and faster recovery from it. One large study in the US found an average increase in life expectancy of seven years (14 for African Americans) for those who regularly attend church. The study investigators attributed the benefit to be due to more protective relationships, including marriage, and to healthier behaviours.

The Global Burden of Disease Study 2010, just published, is the largest ever systematic effort to describe the global distribution and causes of a wide array of major diseases, injuries, and health risk factors. The results show that non-communicable diseases, such as cancer and heart disease, are becoming the dominant causes of death and disability worldwide. Many of these diseases have a strong lifestyle component and lifestyle choices are in turn profoundly influenced by faith beliefs and faith communities. Anxiety, depression, substance abuse (including alcohol and tobacco), dietary habits, exercise patterns, social and personal capital, are all affected by our beliefs, values and religious practices, as individuals and societies.

Not only does faith bring positive health benefits to the individual but also to communities. Local faith communities such as churches, mosques and temples are often a focus for community action and bring the social capital that builds civil society and forms the bedrock for development and community health. DFID has stated in its paper ‘Faith Partnership Principles’,

‘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 perhaps 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’

Faith communities have several important features;

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4 Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948. The Definition has not been amended since 1948.


6 Hummer RA et al. Religious involvement and U.S. adult mortality. Demography. 1999 May; 36(2): 273-85. (US study following 21,204 representative American adults over nine years, and correlated death rates with religious activity and a large range of other data. Income and education had surprisingly little impact on life expectancy)


8 The global burden of disease – let’s not forget the spiritual dimension [http://www.cmfblog.org.uk/2012/12/14/the-global-burden-of-disease/](http://www.cmfblog.org.uk/2012/12/14/the-global-burden-of-disease/)

• **Knowledge and understanding** - they appreciate the importance of faith to daily life, and health, and bring the specific knowledge relevant to the local population’s faith needs.

• **Sustainability** - they will still be there when donors and aid organisations have moved on and moved out.

• **Coverage** - they are present in many communities and often reach marginalised groups who fall under the radar of larger organisations, eg those in very remote areas, people who are elderly, have disabilities or are dying.

• **Community agenda** - because they are embedded in the local community and culture, they are able to identify the real needs of local people, rather than following an agenda drawn up by governments and external NGO’s.

One example demonstrating the importance of faith communities is Tearfund’s work with local churches and local faith based organisations in long term development, disaster preparedness and disaster relief.  

Local churches have enabled Tearfund to respond effectively to emergencies in a number of countries. When disaster strikes, it is the local church that is amongst the first on the scene. They have many valuable resources, including people who can be mobilised as volunteers, leaders who are well-known and respected, and buildings which can shelter displaced people.

There are times when faith has a negative impact on health. Some individual believers facing illness may rely on prayer alone, rejecting the use of effective medicines, while members of certain religious groups may refuse blood transfusion and vaccination. Religious leaders have sometimes held judgemental views about HIV and mental health, which has been harmful. Such potential negative impact on health, directly linked to personal faith and faith community leadership, only strengthens the case to engage local faith communities in health promotion.

### Faith-based organisations and health

In addition to local faith communities, faith-based organisations (FBO’s) make an enormous contribution to healthcare. The term faith-based organisation is used in this document to describe NGO’s related to religious traditions and includes international organisations such as Tearfund, World Vision, Christian Aid, Islamic Relief, Jewish World Services, local institutions such as mission hospitals, and national associations such as the Christian Health Associations present in 17 African nations.

Such organisations sometimes work alone but usually in association with local and national government health services, and international bodies such as the Global Fund.

Numerous independent operational reviews have documented the key role FBO’s have played in improving health over past decades, and more recently in helping reduce child and maternal mortality, especially from malaria and HIV/AIDS. In parts of sub-Saharan Africa FBO’s provide a

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10 [http://tilz.tearfund.org/webdocs/Tilz/Topics/DRR/Publications/The%20local%20church%20%26%20its%20engagement%20with%20disasters.pdf](http://tilz.tearfund.org/webdocs/Tilz/Topics/DRR/Publications/The%20local%20church%20%26%20its%20engagement%20with%20disasters.pdf)


13 (a) Towards primary health care; Renewing partnerships with faith based communities and services. Geneva. Report of WHO consultation with faith based organisations (FBO’s), 17th-18th December 2007 [www.who.int](http://www.who.int)  


(c) WHO-CIFA consultation. NGO mapping standards describing religious health assets. 2010.
national average of 30% of health facilities, with a much higher percentage in some rural settings such as Tanzania and Kenya where they provide 40% and 60% of healthcare respectively. The African Religious Health Assets Programme (ARHAP) study commissioned by the Gates Foundation concluded that religious entities played key roles in providing:

- Facility-based health services alongside state health services at district and national
- Training centres for the health workforce (eg 60% of nursing cadres in Uganda)
- Non-facility based health related activities such as home based care and HIV prevention, care and support
- Co-ordination, fundraising, capacity development, health service supervision and acting as funding channels
- Advocacy
- Health promotion and education by trusted leaders at a local level

The Study also noted anecdotal evidence demonstrating the religious commitment of health workers positively impacted both their work ethic and quality of care.

A study by PEPFAR of USAID concluded that FBO’s possess unique functions and capabilities that can be mobilised:

- Well-established health service delivery networks and infrastructure
- Clear commitments to serve local communities
- Wide range of programs, skills, experiences, and knowledge that contribute to a strong sustainable, multi-sectoral response
- The abiding trust of local communities
- Capacity to mobilise an army of volunteers in any corner of the globe

In addition to the above, we note:

- The MDGs have been important in the work of FBO’s, particularly in focusing attention in reducing child and maternal mortality together with prevention, access to treatment and care of HIV, TB and malaria. Studies consistently show the differences in mortality rates and service provision between better off, and less well-off communities, and these are the very communities in which FBO programmes usually work. FBO’s often go where others choose not to, enabled by willing staff who seek to serve others while giving up a greater level of personal comfort. CMF supports initiatives which prioritise services for the poorest and marginalised.

(e) Faith Partnership Principles – DFID. op cit

14 ARHAP, op cit
15 A Firm Foundation, PEPFAR, op cit
• FBO’s are a key part of the ‘non-state’ sector providing many examples of national government/FBO working relationships providing care where it is not otherwise available, especially for those who are poor and disabled (including those with surgically remediable conditions and requiring palliative care).

• FBO’s play a key role in ensuring that the spiritual component of health is addressed. As doctors, we know full well the crucial importance of spiritual support especially in end of life care. In some societies such needs are met by chaplaincy teams attached to hospitals. However, when populations face mass disaster or displacement the needs must be addressed by those providing medical care. After the 2010 Haiti earthquake, one large and well respected non-faith based NGO conducted a comprehensive survey of patient feedback on its healthcare provision; amongst positive praise, numerous patients critically highlighted the absence of spiritual support in the aftermath of the disaster.\(^{16}\)

• FBO’s, together with local faith communities, are a key part of civil society, providing many examples of good practice where communities take a greater part in identifying need, monitoring service delivery and contributing to it through voluntary activities. In addition FBO’s contribute to increasing levels of accountability and good governance. FBO’s provide immense resources of social capital that are a key resource for national and local planning and service provision.

• FBO’s have particularly important roles in fragile states where government services often collapse. FBO’s, through their presence over decades and even hundreds of years, provide consistent and trusted care. FBO’s do more than just ‘fill the gap’, they are often instrumental in national and international advocacy by providing a voice to represent the marginalised in unstable states and situations.

• FBO’s must commit to providing healthcare in a way which is impartial, based on medical need, and without discrimination on any other basis.

**Targets beyond 2015**

**CMF submits that the post-2015 goals and policies should:**

1) *Recognise the important role of personal faith, and therefore local faith communities, relevant to all post-2015 development targets, and especially in the area of health. This is applicable to all countries, rich and poor alike.*

2) *Adopt a holistic approach to health and development, recognising that physical, emotional, social, environmental, and spiritual factors all play a part in individual and community health and well-being.*

3) *Recognise the important role of local faith communities in actively supporting good health through healthy spiritual practices, health education and promotion and health provision.*

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\(^{16}\) Personal communication, see also Worldviews *op cit*, and The contribution of faith-based health organisations to public health, Schumann C, Stroppa A, Moreira-Almeida A, International Psychiatry Vol 8 No 3 August 2011;62-63
There should be intentional engagement and consultation with local faith communities, ensuring their voices are heard and their contribution is maximised.

4) Recognise the essential long term role of FBO’s in healthcare education and provision, especially in the poorest and most marginalised sectors of society. International donors and national governments should be encouraged to support FBO’s and promote their inclusion in developing national, regional and local health policies.

5) Require all FBO’s to commit to impartial delivery of healthcare, based on medical need, and without discrimination based upon race, gender, sexual orientation, ethnicity, national origin, or religion.

6) Recognise that healthcare workers must be free to support individuals in their faith and also to share their own personal faith in appropriate ways without fear of persecution or disciplinary action.

7) Recognise that faith is an individual choice, freely made. National governments, and the international community, should strive to promote and protect individuals’ rights to practise their chosen faith and gather with others in faith communities, as well as the right of an individual to change faiths.

8) Commit to an evidence based approach in the provision of healthcare by FBO’s and other organisations.¹⁷

¹⁷ For example, Joint Learning Initiative on Faith and Local Communities. http://www.jliflc.com/