

The contribution of faith-based health organisations to public health

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Religiousness and spirituality are recognised as important factors to consider in both health services research and clinical practice. A large and growing number of studies have examined the relationship between, for example, religiousness and spirituality and physical and mental health, and many of these point to a positive relationship between them. Increased psychological well-being, lower prevalence of depression, substance misuse and suicidal ideation, as well as better physical health, are reported in those who are religious when compared with control groups (Koenig *et al*, 2001).

In spite of the current recognition of the importance of this relationship, its clinical applications have not been well explored. In particular, few studies have analysed the nature of the work carried out by faith-based health organisations, or investigated their public health impact. The purpose of this brief paper therefore is to consider some of the work familiar to the authors in this field.

Health services provided by faith-based organisations

Since early times, medicine and religion have been closely associated. In ancient Mesopotamia, Egypt, India, China, Greece and the Americas, priests were commonly responsible for healing practices. There was great respect for medicine among the Jews, who were forbidden to live in towns where there was no doctor. During the Middle Ages, medicine was taught in schools maintained by the Church, or in monasteries; and in Europe many hospitals were founded, most of them connected with religious orders (often Catholic or Islamic). They were regarded as charitable guest-houses and instruments of pious benevolence; medicine was seen as evidence of God's love in the face of human suffering. This tradition of caring for sick people through religious hospitals has continued until the present time, in the numerous religious-based charitable hospitals that currently exist across the world (Risse, 1999; Koenig *et al*, 2001). According to the Catholic News Agency (2010), the Catholic Church manages 26% of healthcare provision in the world, through a total of 117 000 facilities such as hospitals, clinics and orphanages.

The European Study of the Epidemiology of Mental Disorders compared European and US data and found that, among those consulting with mental health problems during the previous year, 6.9% of Europeans had seen religious advisers (ranging from 12.2% in Germany to 2.1% in Spain), compared with 18.8% in the USA (Kovess-Masfety *et al*, 2010).

A study carried out by the World Health Organization (WHO) estimated that between 30 and 70% of the health infrastructure in Africa is currently owned by faith-based organisations. Yet there is often little cooperation between these organisations and mainstream public health programmes. Christian hospitals and health centres, for example, provide about 40% of HIV care and treatment services in Lesotho, and almost a third of the HIV/AIDS treatment facilities in Zambia (Karpf, 2007).

A report on integrating mental health into primary care by the WHO and the World Organization of Family Doctors (Wonca) (2008) specifically commented on the importance of mental health services provided by faith-based non-governmental organisations in Australia and in Uganda, where 59% of respondents sought help from religious leaders for depression, compared with 0.6% who consulted a traditional healer and 2.3% who visited a public health facility.

A study that analysed trends in the healthcare literature on spiritual, pastoral and chaplain care on MEDLINE between 1980 and 2006 found that there was an increase in the rate of published articles in this field, especially on spiritual care, and that this was particularly noticeable in nursing, mental health and general healthcare journals. However, in the last decade there was a decrease in the number of papers published within the field of pastoral care (Harding *et al*, 2008).

In Brazil, where healthcare facilities provided by religious organisations are common, a census carried out by the Brazilian government in 2002 found that there were 1718 'philanthropic hospitals' in Brazil, mostly run by religious organisations, with 155 503 beds, which represented 32% of all Brazilian hospitals. Most of these provided a service for low-income patients and were in small towns (over a half of these were the only hospital in the town) (Crisóstomo, 2002). Their funding was mostly from the Unified Health System (SUS), although some services were financed by private health insurance. In Brazil there is a universal health system (the SUS) funded by the government, which provides basic and complex healthcare. It is commonly a partnership between public and private sectors in terms of service provision.

Psychiatric hospitals related to spiritism (a French branch of spiritualism common in Brazil that accepts mediumship, believes in reincarnation and 'Jesus ethics', and has a strong emphasis on the practice of charity) are common in Brazil; about 50 were built throughout the country between 1930 and 1970. The majority of philanthropic mental health institutions located in the state of São Paulo (the most populous state in Brazil) are linked to spiritism (Moreira-Almeida & Lotufo Neto, 2005).

In most of the Catholic hospitals there is a chapel for the celebration of mass; visits are made by a priest for the distribution of the Holy Communion, and there are duty chaplains who respect the beliefs of non-Christian patients, their families and other visitors. Spiritist hospitals also offer counselling to patients, 'passes' (laying on of hands), talks based on ethics and spiritual issues, prayers, and other forms of spiritual healing.

Impact on health

A systematic literature review of articles published between 1990 and 2000 identified 53 studies evaluating the effectiveness of faith-based health programmes, all of them from the USA. It showed that most were focused on primary prevention (50.9%), general health maintenance (25.5%), cardiovascular health (20.7%) or cancer (18.9%). Results showed reductions in cholesterol and blood pressure, weight and disease symptoms, and increases in the use of mammography and breast self-examination – suggesting that this kind of intervention can improve the health of the population (DeHaven *et al*, 2004).

A very clear example of the role of religious organisations in health promotion and prevention is the work of the Children's Pastoral Care (CPC), an organ of the National Conference of Brazilian Bishops (CNBB). The CNBB has been identified as one of the most important organisations around the world working in health, nutrition and education of children under 6 years of age; its work involves families and communities, and the CNBB tracks monthly over 1.5 million children in about 3300 towns all over Brazil. The data from an information system that collects and analyses the indicators of coverage and the impact of the CPC have shown a positive effect of these interventions, when compared with areas not covered by the CPC. In 2006, approximately 260 000 volunteers supported the development of 1.8 million children and the care of 95 000 pregnant women in more than 42 000 communities in Brazil.

In a study conducted in the city of Criciúma (Brazil) with 2208 children below 3 years of age, it was found that pastoral visits were significantly associated with increased maternal knowledge about appropriate feeding methods during a child's episode of diarrhoea, the contraindications to formula milk, the interpretation of the growth curve and increased knowledge of immunisation schedules. There was also an increase in the duration of breast-feeding and the later introduction of bottle-feeding. In addition, the researchers found an increased number of infant weighings in the quarter that preceded the survey, and in the possession of measuring spoons for oral rehydration (Neumann *et al*, 2003).

Another study also found that mothers followed by CPC, when compared with a control group, had better knowledge about the management of diarrhoea and attended more prenatal consultations (at least six); their children were born with higher birthweight and they received iron supplementation more often during pregnancy (Neumann *et al*, 2002, 2003).

The mortality rate among children less than 1 year old in communities where there is CPC provision is up to 50% lower than in those where the CPC is not present. It has also been observed that there is a reduction in violence and criminality

in the areas served by the CPC. In order to disseminate the CPC programme more widely, the International Pastoral Care was established. Other Latin American countries, the Caribbean and Haiti already have branches of this organisation contributing to improvements in healthcare and education. Children's Pastoral Care was nominated for the Nobel Peace Prize 2011 in recognition of the work done by its founder, the paediatrician Dr Zilda Arns Neumann, and the achievements of the CPC (Coordenação Nacional da Pastoral da Criança, 2011).

Conclusion

Given these findings, and despite the overall shortage of studies on this subject, it is clear that faith-based health organisations are relevant to any consideration of public health worldwide, especially in low-income countries. There is limited but consistent evidence that points to their positive effect on health-related outcome measures. However, there is a need to know more about the nature and motivations of these organisations and to assess in greater detail their impact on healthcare provision and on public health (DeHaven *et al*, 2004).

Although there are some instances of mistrust between religious communities and health services, the data presented above would suggest that it would be very fruitful to foster this partnership for health promotion. Further studies in this vital field should therefore be undertaken, as faith-based healthcare is an important source of health provision worldwide.

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COUNTRY PROFILE

Mental health in Argentina

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Argentina, the second largest country in South America, is a federation of 23 provinces and its capital, the autonomous city of Buenos Aires. Its population is a little over 40 million, 50% of whom reside in its five largest metropolitan areas. The rural areas are extensively underpopulated. The city of Buenos Aires and its suburbs contain 15.5 million inhabitants, making it one of the largest urban areas in the world.

Although Argentina belongs to the high- to middle-income countries according to the World Bank, its socioeconomic inequalities are extensive. Sharp contrasts exist between the urban and rural areas. Between 29 and 33% of its population live below the poverty line.

During the 20th century, the country saw several military coups and administrations in between periods of precarious democratic government. Military regimes, repression of the opposition, hyperinflation and several collapses of the economy took a heavy toll on the mental health field. Importantly, more than one generation of professionals and academics were effectively exiled abroad, damaging the country's scientific system and research capacities. Argentina is currently experiencing its longest unbroken period of democracy in its history, and the most recent signs indicate a trend for academics and professionals to return, in response to improving conditions and government incentives, but the consequences of the earlier turbulent history cannot be ignored.

Argentina as yet lacks a national system for data collection for mental health. Each province has its own system. Data pertain mainly to the public system, and exclude the substantial private sector, making the information incomplete.

Policy and legislation

The National Mental Health Authority provides advice to government on policy and mental health legislation. However, it is not involved in planning, monitoring or evaluating the quality of services. These domains are under the independent responsibility of each province.

In 2010, the National Parliament approved the Law for Mental Health Services, which covered service planning and policies, mental health in primary care, as well as monitoring of compulsory admissions to hospitals. It is not yet clear how this change will affect existing services.

A survey by the World Health Organization (WHO) on the state of mental health services in Argentina gathered much useful information (some reported below), although it covered only ten provinces. Nine of these have explicit mental health policies drafted. A Federal Plan for Mental Health was drafted in January 2008, but is still vague and not widely supported by all the provincial authorities.

The budget for mental health is below WHO recommended levels. Allocations vary among the provinces, from 0.5 to 5.0%. Nationally, 68% of the mental health budget goes to psychiatric hospitals, leaving community services underresourced.

Six provinces have an official list of essential medications. However, the lack of clinical guidelines leaves the availability of medical treatment potentially subject to market mechanisms, with pharmaceutical companies exerting pressure for the approval of medication that is not necessarily supported by clinical evidence.

Service delivery

Health services are delivered by several systems that coexist in a structure that is subject to little formal regulation, being essentially a free market health economy. The federal state bears no responsibility for health cover for the population, which is instead devolved to provincial control. Each province has a public health sector that gives free cover. Its resources are limited.

The national social security system is financed by contributions from employers and workers. However, people who are unemployed are not covered by this. Private insurance plans, taken out independently by individuals, cover more than 12% of the population, mainly in urban areas. Pensioners and people with a disability receive cover provided by the