

Engaging Faith Communities as Partners in Health Care

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Abstract

This paper discusses how faith communities have been, and are continuing to be engaged as partners in primary health care and community health promotion in Australia. A conceptual model of faith community nursing was developed using participatory action research in a demonstration project engaging five faith communities (8-10,000 people). The paper highlights the possibilities and pitfalls learned throughout the process pertaining to engagement of, and working with, faith-based partners. Descriptive elements of the author's doctoral research provide a case study to elaborate guidelines and benchmarks for partnerships. The paper aims to provide practical points for the listener to engage with faith communities in health care at their local level using this service delivery model as an exemplar.

The paper discusses common questions about engaging the faith community:

- Would people access a health service based in a faith community?
- Would faith communities see they have a relevant place in providing health services?
- Would existing health services partner with a faith community to provide a relevant service?
- What would such a partnership look like?

The latter half of the paper addresses issues to consider when engaging faith communities in viable health care partnerships. These issues include policy, networking, funding, education and partnership issues. To collaborate across organisational boundaries is time-consuming and difficult, but it is possible. The need for quality, sustainable, accessible health care makes the investment worthwhile. Combining perspectives, resources and skills, creates creative synergy and collaborative advantage. Some essential standards for faith community/government /private sector partnerships include: collaborating for the right reasons; engaging the right people; providing sufficient resources to create a stable partnership; developing trust and respect between partners; maintaining agreed structures of accountability; facilitating effective communication; and ensuring that even volunteer structures operate in a professional manner. The faith community nursing project is a viable

example that engages faith communities, which can be readily duplicated. Interested persons can locate information at <<http://www.afcna.org.au>> or contact the author.

Keywords

Partnerships, religion, capacity building, nursing, faith community

Introduction: Why begin such a project?

The health care system in many western countries provides excellent body care yet it is impoverished when it came to providing support for the mind, spirit and social relationships of the person (Chiu et al. 2004; Taylor 2002; van Loon 2001). Many health professionals hold a personal worldview that endorses a holistic perspective of the person as an integrated whole — body, mind and spirit (van Loon 1995; van Loon 2005), and are frustrated by the lack of capacity to provide that care within the tertiary health care setting. Constraining factors include philosophical differences in the understanding of health and illness, lack of time; escalating workloads, expanding job descriptions; onerous documentation systems; and the demands of technology-focussed facilities that prioritise body care (O'Brien 2003; Thoresen and Harris 2002). Searching the literature on holistic health care uncovered a body of work on Parish Nursing (also known as Faith Community Nursing — FCN) from the US, which had its revitalisation in the search for holistic health service delivery models in the 1970s (Stewart 2000; Tubesing 1976; Westberg 1984, 1990b; Westberg 1990a). Thus began the process of envisioning such a model for the Australian context.

Several questions had to be answered:

- What documented needs could faith community nursing (FCN) address?
- How would an FCN project be developed and structured?
- Would Australians access a health service based in a faith community?
- Would faith communities see they had a relevant place in providing health services?
- Would existing health services partner with a faith community to provide a service?
- What would such a partnership look like?

What documented needs can faith community nursing address?

To commence a new form of health service delivery that sought to address adverse health indicators and support the determinants of health required the creation of a narrative that spoke to the community, faith communities, the nursing profession, the health system and government structures, about what faith community nursing could potentially achieve. Faith Community Nursing sought to promote some of the social preconditions for health while addressing the social determinants of illness such as crisis and loss events; major life changes and transition periods; poverty; unemployment and under-employment; conflict and breakdown within the family; lack of social support structures; inadequate life skills (such as communication, conflict management, relationships, parenting); loneliness and isolation (particularly for the elderly);

mental illness; harsh environmental conditions (AIHW 2003). Faith community nursing aimed to address some of the environmental and socioeconomic determinants of health to build community capacity and support health behaviour change, by providing a model of service delivery that was effective, appropriate, accessible, and sustainable.

In the future, the FCN model may assist in addressing the decreasing levels of 'Tier 1 health status', and 'Tier 3 health system performance' indicators, as well as addressing the decreasing 'Tier 2 Determinants of health' evidenced by shorter life expectancy, higher death rates, more likelihood of disability and increase in risky behaviours such as smoking, excessive drinking and obesity that are present in rural Australia (AIHW 2005c). Rural faith communities could be supported to provide programs that improve such social determinants and promote health and community capacity. FCNs could also facilitate local community support for the frail and needy that is beyond the capacity of district and community nursing programs to deliver. With the exception of Indigenous Australians (whose health improvement remains marginal (AIHW 2003) non-Indigenous Australia's aggregate health statistics are improving. A recent report, *A Picture of Australia's Children*, demonstrates that implementing a holistic range of measures such as improving family structures, education and early learning, socioeconomic status and social cohesion does improve the health status and infant mortality of children (AIHW 2005b). Thus it indicates that holistic preventative measures can advance health. As Australia's population ages and families are more fragmented and geographically spread, such support is less available to those in need. The length of stay in Australian hospitals has decreased to an average of 3.4 days (AIHW 2005a), so many people are in need of additional social support within the community and most nursing organisations cannot meet that support need because it is time consuming and resource intensive. Currently, many FCNs are filling that gap, supplementing and complementing existing health services.

How the FCN research project was structured

This research project sought to create a legitimate, sustainable and practical response to the problems of episodic and fragmented health care; alienation and loneliness of the aged and chronically ill and the need to create a method of community health that promoted and provided whole person health and contextual care. This could be achieved using the research method of Participatory Action Research (PAR) (Argyris 1991; Hart 1995; Lincoln 1985; Reason 1988).

The groundwork for the research commenced in 1996 with a public seminar attended by 100 people that introduced the concept of faith community nursing to South Australia. Seminar participants were invited to join a demonstration project to develop a model of faith community nursing tailored to Australia's sociocultural, health and religious context. The project began as an inter-faith venture but the only groups to join the demonstration project were from Christian faith communities (van Loon 1999). After 12 months of preliminary work to help local nurses understand what was involved, gain support from regulatory authorities, the health system,

insurers, key health professional groups and obtain commitment from the faith communities and their structures of authority, the demonstration project commenced in February 1997 in five faith communities one Anglican, two Roman Catholic, one Lutheran, and one faith community agency working with homeless youth (Teen Challenge). Two parishes were located in metropolitan Adelaide, and two in a semi-rural township. They varied in size from less than 100 members to 3000 members (totalling a population of at least 8-10,000 within the combined reach of the project nurses). All the faith community nurses (FCNs) volunteered their time to a maximum of 8-12 hours a week. All four congregations received small local government grants (AUD\$1–3000) that covered start-up expenses. The bulk of the financial burden for the service was and continues to be born by the faith communities (see Appendix 1 for the data on comparative costs).

In the participatory action research process, theory is embodied in the narrative rather than theory as a set of propositions (Reason 1988). Data was collected from many and varied forms such as interpretive data from patient/client and participant interviews, collective reflections, reflective journals, case studies, observations, quantitative data on cost benefits analysis and demographic data (Crotty 1998; Denzin 1994; Lincoln 1985). Data was collected at monthly meetings over a two-year period with the five participating FCNs. At these meetings we discussed aspects of the emerging role as it met the local needs of each community.

Each PAR cycle involved conceptualisation of issues through discussion, negotiation, exploration of opportunities, assisting possibilities and examining constraints (Hart 1995). Then the group created action plans by selecting options that they implemented each month. Each participant monitored his/her actions through self-reflection, journaling, statistical data collection and feedback from interested parties such as their clients and stakeholders. Narratives were deconstructed to search for coherent concepts and themes, then reconstructed based on criteria of significance that relates to their contexts and overall perspectives (Ghaye 1993). The reconstructed concepts were linked and, as such, provide the basis for a generalisable conceptual model that informs Australian FCN practice allowing for replication, modification and research in other faith and geographic contexts.

The First Series of Cycles — Conceptualised faith community nursing in the Australian context. This involved clarifying and articulating faith community nursing in the Australian context to provide audiences with information from the theoretical literature around parish nursing, congregational health, health ministry and pastoral care.

The Second Series of Cycles — Supported the commencement of the Faith Community Nurse role. This involved identifying faith communities where potential FCN/PN programs could commence, and creating the structures to support commencement. The 'Australian Faith Community Nurses Association' (AFCNA) was developed to provide education, support,

networking, resource development, procurement and distribution; consultancy; political action and lobbying; promotion and publicity of the emerging faith community nursing role.

The Third Series of Cycles — Development of the Faith Community Nurse role. With this cycle the faith community nurse demonstration project commenced, as did the professional development of AFCNA to support and sustain the developing role.

The Fourth Series of Cycles — Refining and resourcing the FCN program. This cycle continued to refine the role and began documenting and improving practice so it would continue to meet legal, professional, ethical and social standards.

Would Australians access such a health service?

The 2001 Australian Bureau of Statistics national census found 73.5 per cent of all Australians nominated a religious affiliation. Of these, 67.9 per cent nominated a Christian religious affiliation (ABS 2004). While the question of religious affiliation is not designed to measure the degree of participation in particular religions and philosophies, it does indicate a possible willingness to access services in accord with one's nominated religious affiliation. In Australia, outside of government, religious organisations are the biggest providers of services, such as schooling, health services, aged care services and community support facilities (ABS 2001). So obviously faith communities do see health care and social services as relevant to their mission and purpose. Thus the impetus to forge partnerships with faith communities in providing accessible, affordable and sustainable health care is feasible, because people will access services.

Higher levels of social capital lead to fewer psychological and physical illnesses (Baum 2000) and faith communities provide many of the structures that build social capital. Hughes uses three helpful distinctions developed by Michael Woolcock, an Australian sociologist working with the World Bank to describe the connections that give rise to social capital (Hughes 2001, 2001b). These include:

1. *bonds* — family and close friendships where people can obtain reliable practical support to sustain the activities of daily living
2. *bridges* — a network acquaintances and broad connections that facilitate access to a wide range of resources
3. *linkages* — to organisations and institutions, in which one has confidence, to obtain resources and develop social connections and functions.

Faith communities pay a great deal of attention to bonds within the community and bridges between individual communities and other structures within the denomination locally and globally, and to their local cultural or geographic community. They have some linkages between themselves, social services and aged care services that are conducted under the auspices of their denomination e.g. Centacare, Anglicare, Westcare, Wesley Uniting Care, etc., but there are seldom good linkages developed between faith communities and local,

state and federal governments in Australia. A part of this problem is likely to be based around concerns regarding accountability structures in faith communities, which have been damaged by the actions of individuals within faith communities who have been accused of perpetrating sexual abuse, ignoring it, or diminishing the reports of sexual abuse and family violence within their communities. Churches have historically worked from positions of trust and forgiveness, which have left them vulnerable to locating and dealing with the perpetrators of abuse. They have lacked transparent, impartial accountability structures and this must be addressed if people are willing to access service provided by a faith community.

It is helpful that Australian faith community nurses are registered by state and territory registration authorities. As such they are legally and professionally accountable to these authorities for standards of ethical practice and competence to perform within their stated scope of specialty practice. Thus a partnership using nurses provides a community safeguard and reassurance to governments that when they partner with faith communities to deliver quality health services well developed legal structures of accountability are in place. Consequently, working with registered nurses to develop this FCN model of health care is an important bonus in the development of community trust essential to people accessing services (van Loon 1999a).

Would faith communities engage in the provision of primary health care services?

The Christian faith has a long history of hospital, health and community services and the nursing profession in particular has its historical roots in the deaconess and sister roles of the Christian church (Donahue 1985; Grierson 1981; Iveson-Iveson 1982; Kelsey 1988; Olson 1992). Historically, this faith has provided health and healing services, but the philosophical divide between body, mind and spirit, led to separation of care for each dimension, the spirit to religion and mind and body to medicine (Numbers and Amundsen 1998). It is now difficult to discern the difference in focus between many faith-based and secular health services as both prioritise body care and a technological orientation to that care. Community demand for curative technologies has led to expectations that reinforce the fixation on biomedical management of health and illness. This paradigm has stimulated healthy people to do nothing about maintaining their health, and encouraged ill people to abdicate responsibility for their disease management to specialist medical care (van Loon 1999). With an ageing population, decreasing tax base, spiralling costs for pharmaceuticals and procedures, it seems both prudent and necessary to look for partnership models in health service delivery that pay attention to, and nurture the preconditions for health, if we are to continue developing sustainable, affordable and accessible health improvements in the future (van Loon 1998).

The growing global attention on the social determinants of health and community-based initiatives has opened the possibility for faith-based organisations within society to become

active partners to advance the health and welfare of communities, strengthening the possibilities of collaboration between governments, not-for-profits and faith communities.

Faith communities are located across all cultural, religious, ethnic and socioeconomic groups of the society and serve a diverse range of rural, remote, urban and metropolitan communities. Churches are generally culturally specific and therefore able to provide health messages and care in a culturally sensitive manner. Many have as part of their mission a mandate to teach and heal, and an ethic of social justice and compassion (Solari-Twadell 1994). They readily recognise the underlying causes of disease are social, economic and spiritual in nature as well as biophysical (Djupe 1994). Therefore maintaining health is also about providing justice, assisting the peace process, addressing poverty and inequity, nurturing the integrity of the environment and the individual's spiritual wellbeing (Christian Medical Commission 1991). Christian faith communities have a mission to do justice, action kindness, and promote the welfare and wellbeing of individuals and families who need assistance or healing. Such philosophical values are important and integral to whole person health care (van Loon 1999). Thus the mission and purpose of government and faith communities are compatible, so partnerships are feasible.

What existing health services do faith communities provide that can be partnered?

One important strength of faith communities lies in their interconnected relationships across generations that are developed over time. These social connections help people find meaning, hope and nurture and are well documented as promoting mental health. Faith communities provide a place for people to gather together regularly formally and informally, voluntarily over many years to develop support, provide care to each other and the broader cultural or geographic community they serve (van Loon and Carey 2002). Such community cannot be simulated. It is nurtured over many years and in our culture there are very few institutions that can cultivate and nurture community as well as the faith community (van Loon 2000). In the *Australian National Church Life Survey 2001* most church attendees said their communities were forward-looking and planning focussed new directions to meet community needs (Bond 2002). This indicates a positive responsive perspective in Australian churches with a desire to adapt and remain relevant to the society (Bond 2002). It seems feasible to partner with faith communities to complement and supplement existing health services and augment the deficits the current health system cannot meet.

The *Australian Community Survey* (Bellamy et al. 1998) conducted in 1998 used a random sample of 2000 Australians asking them if religion was important to them, and if so, why it was important. Seventy two per cent of adults said religion was important, and 55 per cent said it was important in provision of values such as encouragement, care and concern for others. The most strongly affirmed function of the faith community was to 'encourage good morals', which was confirmed by 93 per cent of the sample, with 47 per cent seeing it as the most important function (Bellamy et al. 1998). The change in values between the 1983 and 1995 *World Values Surveys*

highlight a great reduction in the level of confidence Australians have in institutions such as the legal system (drop from 62 per cent in 1983 to 34 per cent in 1995), media (dropped from 28 to 17 per cent), federal government (dropped from 56 to 26 per cent) and banks (80 to 21 per cent) (Hughes 2001b). A total of 65 per cent of those surveyed felt faith communities contributed a lot to their local community and an especially important role they served was the development of supportive friendships from which people obtain practical support and help when needed (Hughes 2001a). Such values will resonate with organisations wanting to promote community health and nurture social values of justice compassion and care for each one another.

Most faith communities have material resources that they make available to the community and already undertake many programs that promote social capacity and community health. Two US studies illustrate this: A survey of 100 urban churches in six large US cities found 91 per cent of congregations actively served their community, making buildings available for programs such as day care, food banks, clothing drives, tutoring, after-school care, health care, job programs, counselling, substance-abuse and recovery programs. On average, each congregation supplied 5300 hours a year in community volunteer work — the equivalent of about two and a half full-time workers and \$140,000 a year in subsidies to community programs from their own resources (Cohen and Jaeger, 1997). A second US study found 80 per cent of all faith community programs were targeted outside of their membership to the local community with most programs focussed on the needs of youth and children. They note if government or for-profit agencies conducted these programs at least \$100,000 would be required to replace the average volunteer services, staff support and space provided (Dilulio 1997). Such findings demonstrate the cost effectiveness of partnering with faith communities in practical health and social service programs.

Faith community nursing as a replicable health service delivery model amenable to partnership between faith communities and other services

Faith community nursing, or parish nursing as it is known in the US, was begun by Reverend Granger Westberg who worked within a university teaching hospital and medical school in Chicago, US (Westberg 1984). He noted the fragmented care people were receiving and advocated a return to addressing the link between spiritual well-being and physical health. In 1973 he began Holistic health centres which were medical centres in congregational settings (Tubesing 1976). They were very effective, but very expensive to operate and thus unsustainable. On reflection Westberg realised that the link between the faith community, the medical community, other health professionals and the client was the nursing profession (Westberg et al. 1990a). He commenced a trial in Chicago in 1984 between Lutheran General Hospital and six ecumenical congregations in the area, which positioned a nurse in each congregation as part of the pastoral care team. The congregations provided the facilities, the hospital provided the faculty and educational support, and both parties contributed to the salary

costs (Westberg 1984). From that point parish nursing has grown to become the fastest growing specialist nursing group in the US (Small 1998).

The Australian Faith Community Nurses Association Inc. (AFCNA) was developed alongside the research as a education and support network. With the support of the International Parish Nurse Resource Center <<http://www.ipnrc.parishnurses.org>> in the US, AFCNA was established in February 1996, constituted and incorporated in 1997. AFCNA's role was to provide nurses with support, information, education, resources, professional standards and networking opportunities, to assist them to function in the specialty role. AFCNA provides free consultancy to faith communities wishing to commence an FCN role, lobbies and promotes the FCN role in the community to churches, media, government and other health professions. AFCNA produces a quarterly newsletter, continuing education workshops, and a website <<http://www.afcna.org.au>> to keep people networked and informed. It provides a four- to five-day 'Introduction to Faith Community Nursing' course, for nurses and faith community representatives who want to commence this role. It orientates them to all the aspects of autonomous, legal, ethical, holistic, professional community-based nursing practice from a Christian worldview. AFCNA has developed standards for this specialty that are dovetailed to the Australian Nursing and Midwifery Council standards, competencies and codes of conduct for Registered Nurses (Australian Nursing and Midwifery Council Incorporated 1998, 2002, 2003). AFCNA also provides documentation masters and resources to ensure faith communities have recognisable audit trails of documentation that are legal and accountable (van Loon 2005). Thus the legal and professional frameworks for healthy partnership using this model have been put in place to ensure the longevity of the role and public accountability.

What does a faith community nurse do?

The Faith Community Nurse (FCN) role can be tailored to meet the local needs of people, the health care system and faith communities. The research group defined, enacted, revised and refined the FCN role to meet local needs (van Loon 2000). The FCN functions are briefly described using the acronym HEALTH.

Health promotion — The FCN seeks to create and strengthen individual and community capacity, facilitate resilience and nurture the relationships that keep people connected in community. Programs focus on relationship building, health promotion, illness management, disease prevention, nurturing holistic wellbeing, aiming to empower active participation in the management of personal and community health. This encourages the faith community to become a source of healing to its membership and the wider community.

Education and counselling — Through various formats the faith community nurse will educate and counsel individuals, small groups and the community on lifestyle issues, relationships, health enhancement, illness risk reduction, disease management, environmental awareness, social

justice issues and any other health and well-being issues that are pertinent to the group of people the faith community nurse serves. This is achieved through a variety of teaching and learning strategies such as: conferences, camps, workshops, seminars, small groups, printed resources, newsletters, bulletin boards, individual teaching, audiovisuals, etc.

Advocacy — Personal and small group advocacy and assistance are important aspects of the role, helping people navigate the health system, listening, advising when required or requested, supporting, recommending referral as needed, visiting, and monitoring of progress. The role involves offering knowledge of viable options to assist the individual to make informed choices in a supported environment. It includes a willingness and ability to advocate on behalf of a client or their carer(s) should the need arise. The faith community nurse is able to negotiate access and assist entry into the support networks that people maybe unaware of. These support structures include family resources, congregational resources (e.g. transport, meals, cleaning, visits, other supports) food kitchens, self-help groups, support groups, government agencies, legal aid, financial planners, home care, shelters, nursing homes, health professionals, etc.

Listening — The faith community nurse collaborates with other lay caregivers and professional health services to assist individuals and communities to promote health and wellbeing and redefine illness patterns, aiming to prevent disease. This is achieved best by listening to what people believe are a problem or issue and what they want to do about that. Sometimes it involves assisting them to obtain what they require, but more often the process is one of 'walking alongside' a person to empower them individuals to take personal control, rather than doing 'it' for them. In this process people feel empowered to maintain independence, autonomy and personal control.

Training and coordination — Health and healing is enhanced in a supportive community that sustains social networks, provides physical resources, assists in orienting mental wellbeing and promoting spiritual equanimity. Therefore much work is done to coordinate and develop support networks of volunteers that can provide the human and physical resources required to provide the context that sustains health and wellbeing. The faith community nurse organises and trains groups of ancillary workers and volunteers to facilitate congregational support and help individuals, families and groups who may need regular visiting, or more physical support. This enables a tangible network of care to extend deeper into the community, enabling people to stay in their homes longer and maintain their independence.

Hope and spiritual support — The mission of each faith community nurse will be determined by the cultural and faith group within which he/she is working. The aim of all teaching, counselling and education is to empower people to maintain wellbeing of body, mind and spirit. All health education is aimed at assisting people in the process of becoming, to find their inner essence and nurture their growth toward wholeness. This may be achieved through religious and

personally worship, sacred readings, sacraments, rituals, symbols, prayer, meditation, music, reading, the arts, healing touch, and specific healing rituals used by that faith community.

The FCN creates partnerships with clients

The FCN collaborates with clients as participants in care rather than consumers of care. The word consumer is common in health system language and connotes a person who devours resources. The FCN role does not focus on provision of a consumable service, but rather seeks to create a partnership that empowers the individual or group to control and sustain their own health. We have found overwhelming numbers of people with chronic health needs want to foreground wellness and locate new ways of living, rather than get information and tests that foreground their illness, which are necessary and readily obtained from a doctor. What they needed was a safe holding space to discuss the social aspects of their illness in confidence. They want to speak about care options, impacts of illness on their relationships, and obtain assistance in clarifying how they can live and function as normally as possible within their family and community. Consequently, FCNs work from a position that privileges the person as the expert in their own care and we work from a framework of capacity building to sustain strengths. Health is not achievable in isolation and attention to the social context of care is essential to the healing process. The FCN assists in nurturing, sustaining and healing relationships between the individual and significant others, family, church family, the environment and 'God' (however the client perceives God).

At all times, the FCN seeks to empower the individual to maintain control of their life. Empowerment of the faith community focuses on creation of an environment characterised by support, care, justice, compassion and empathy. In such an environment the aim is to treat all people with dignity and respect, regardless of ability, colour or creed. It should be noted that this role is based within a faith community, but the care of an FCN/PN may be accessed by all the community. There are numerous examples of FCNs who are working with clients who are not members of their faith community. Assistance is personally requested, or referrals come from family, friends, pastoral care team (includes priest/pastor), community agencies, local government and other health professionals (see Appendix 1 for summary data from research indicating where most referrals come from and costs of service). All clients receive assistance within the confines of the nurses' ability to meet the need. Most FCNs volunteer their professional service on a part-time basis because they believe in their role and its mission and purpose so some on-going care needs to be referred on to services that are funded. FCNs endorse a holistic perspective of the person and can see that holistic care is possible and central to the FCN's role.

Issues that facilitate faith community engagement in health care

Each of these points could be elaborated into an extensive discussion, but for the purposes of this paper I highlight in point form the issues that surfaced in the faith community nursing

project that must be attended to if governments wish to engage faith communities in viable health care partnerships. These issues include:

Policy issues

- Develop policy support for accountable community health programs based out of faith communities at all levels of government — federal, state and local
- Provide salaried coordinator positions in each state/territory where faith communities can obtain support and assistance in organising the accountability structures and processes they need to move into partnership with government agencies.
- Provide clear policy guidelines on how the partnerships should be framed, enacted and evaluated, so outcomes can be articulated and where possible evidenced
- Address the current crisis in premiums for professional indemnity and public liability insurance which are creating significant constraints on the capacity of many faith communities to provide accessible services by volunteer professionals
- Language use across the partnership should be non-discriminatory, culturally sensitive and inclusive, accommodating the needs of clients from indigenous groups and those from culturally and linguistically diverse backgrounds.

Networking issues

- Development of regional networking and liaison opportunities between governments and faith communities regarding health and social services
- Continuity of communication and meeting arrangements once these networks are established to keep faith communities and other partners in the feedback loop.

Funding issues

- Government needs to improve access to seeding funding and ongoing grant funds, with suitable accountability mechanisms in place to ensure outcomes are evident
- AFCNA use professionals who volunteer their skills and knowledge to undertake their work, but to date they have been unsuccessful in obtaining significant grant monies to further the work, because they are excluded from many philanthropic funding opportunities due to their taxation status. This requires changes in the capacity for faith communities to apply for *deductible gift recipient* status, which would open up funding opportunities from the philanthropic sector
- Ecumenical organisations such as AFCNA struggle to obtain the financial support they need to develop quality products. This is in part due to the culture within faith communities to prefer sponsoring their denominational organisations rather than ecumenical groups. This can lead to duplication of effort, which appears unnecessary during the early stages of new pilot projects.

Education issues

- Increase understanding of the legitimacy of faith and spirituality in health care. There needs to be mechanisms to facilitate understanding of how religion provides a framework of hope, meaning, purpose and love on which people can build their lives.
- Government should sponsor roundtable discussions where diverse groups share best practice initiatives across the health care continuum. Detail how faith communities can be involved and open discussions about what additional projects may be needed so there is a collaborative approach to meeting defined needs.
- Faith communities need to share information and educate the community regarding the benefit of whole-person care and programs such as faith community nursing and other faith-based health and social service initiatives
- Faith communities provide a forum for people with existing illness to share their stories and bring a human face to hopeful living with chronic illness and disability. Such stories raise public awareness, develop inspiration and stimulate understanding and self-help.
- Increase general community knowledge and understanding of disease, illness and disability to reduce discrimination and stigmatisation associated with some illnesses thus increasing opportunities for recovery and healing. This requires accessible information that moves across the continuum of care. FCNs provide an excellent gateway to disseminate information into the faith community which is the most likely group to support disenfranchised people. Such information could assist in understanding specific health and illnesses topics, debunking myths around violence, abuse, mental illness, ageing, disability and specific diseases that are associated with disenfranchisement in our culture.
- Develop educational curricula and programs to assist faith communities to learn about health, healing and illnesses and how the FCN role can advance their mission and purpose. (AFCNA has already commenced this work)
- Governments could develop curricula to address subjects such as mental illness for adults and children suitable for use and adaptation by faith-based organisations
- Health service partners could provide continuing education for volunteers as to how they might address the unique needs of individuals with specific illnesses
- Open access to needs analysis within regions and allow faith communities to be a part of that loop so they receive information.

Partnership issues

- The partnership context should facilitate cultural awareness, sensitivity and competence in both partner organisations. Currently there is a diminishment of any care that is not readily quantifiable or grounded in the scientific paradigm of evidence-based practice. There is an arrogance and at times patronising position held by some individuals and health services when it comes to issues of faith and spirituality, and indeed the use of volunteers. If partnerships are to succeed there must be mutual respect about the legitimacy of each different paradigm and what each brings to promoting holistic health.

- There should be adequate funding to grow the partnerships so players at several levels of both organisation can be involved in discussions about how the partnerships will work
- All partnering organisations must have in place safe, healing, welcoming, supportive and inclusive environments for clients
- Ensure referral pathways are clear and understood so clients can readily access the support they need from congregations and other agencies
- Both partners should work from an asset or strength base from which to build capacity
- Improving unity and cooperative efforts between faith communities in a region
- Having workable strategies to tackle one or two issues at a time within a region.

Possible guidelines when engaging faith communities in partnerships

The problems faced by health systems in many countries are best addressed by collaborating across organisational boundaries to find integrated solutions. Collaboration is difficult, time-consuming work, but it is in the public interest to work together between government, not-for-profit sector and faith communities to provide quality, sustainable accessible health care. Combining the perspectives, resources and skills of a variety of people and organisations, provides an inspired and creative synergy, which provides a collaborative advantage (Huxham 1996a, 1996b; Huxham and Vangen 2000). There are few essential standards for faith community/government /private sector partnerships that were uncovered during our FCN project. These include:

- *Collaborating for the right reasons*

Partner health services and faith communities recognise they have different purposes, goals and orientations which drive their services. Joint responsibility for development of health care should stem from a shared vision for community health and the possibilities working together can provide. This should lead to a joint commitment to the plans.

- *Engage the right people*

Choose the best people and empower them to make decisions, manage programs and people, monitor progress, facilitate communication and resolve conflict if and when it occurs. Provide them with adequate time and support, commensurate to their workload, to ensure desired outcomes are affected.

- *Sufficient resources to create a stable partnership*

Develop the connections at several levels of the collaboration such as education and training, service delivery, management, social, media coverage, research and evaluation. For power relationships to be equal within the partnerships each partner has to manage the relationships in their own organisation using cooperative and uniform measures, resolving problems quickly and reasonably. This requires listening and responding to people at each level of the partnership, recognising and accepting differences and maintaining flexible responses to problems that occur. All partners should provide the promised resources to meet the planned outcomes of the partnership which were negotiated at the commencement of the agreement. Pool and share resources to sustain

and support the FCN program and concentrate limited resources on improving relationships within the faith community/community that create the most impact on health outcomes.

- *Trust and respect between partners*

Don't have too many contract positions so there is a continuity of personnel which develops trust and reciprocity. All partners should behave with integrity and respect, and maintain confidentiality at all times. Acknowledge and, whenever possible, reward staff of all partners. Aim to understand the pressures and workloads of your partners. This is important at every level of the partnership. Search for ways to minimise work and maximise results within the time and resource constraints of each system.

- *Maintain agreed structures of accountability*

It is important that faith communities have transparent, credible and impartial accountability structures to deal with any complaints. The partnerships and programs need monitoring of monies and people so the highest moral and ethical standards are provided. Using Registered Nurses as FCNs minimises the arduous task of developing procedures because professional codes of conduct are already in place. AFCNA has set standards and performance criteria and provides documentation proformas that ensure faith communities can provide a legal and professional practice. Partners need to keep audit trails for grant monies and funds that underwrite the FCN programs. All systems of reporting should be open to scrutiny as is the case for any organisation.

- *Facilitate effective communication*

People should be accessible and informed at each level of the partnership. Plan methods to manage communication such as: round tables to share ideas, exchange information in newsletters and email groups, exchange contact details (within the legal privacy regulations). Try to understand your partner's priorities. All relationships should be characterised by open and transparent communication, where people are aware of their rights, responsibilities and roles because these are clearly articulated and documented. Staff must have a clear idea what is expected of them and have their skills recognised and respected. Clients and staff of all partners want their views heard and their contribution considered, especially when decisions impact their work or interest areas. When conflicts arise (and they will) there must be fair, transparent, ordered ways to resolve grievances. Ensure policy and processes that affect partners e.g. referral mechanisms and documentation systems use agreed accessible language, which is available across the health continuum to all partners.

- *Ensure that even volunteer structures operate in a professional manner*

Everyone wants an organisation that performs professionally. Clients want services that deliver what they promise and provide value for payments. The faith community should demonstrate its Christian values and principles in the way it discharges its services with

the highest ethical standards, respecting their employees and clients and acting responsibly in their interests. One of the key reasons FCNs burnout is the demand placed on them to provide a quality services at no cost in a voluntary role. This expectation can produce tensions within the FCN who wants to balance the desire for a professional service with a Christian values base with the lack of funds to provide the services.

Conclusion

The faith community nurse role provides an innovative and exciting case study of an affordable, accessible and sustainable service delivery model that is amenable to partnerships, while effectively anchoring the health care continuum into the broader community. The Australian Faith Community Nurses Association is willing and able to discuss way to move this role forward with any government, organisation, and community or individual that would like to proceed with this work. More information can be obtained from <<http://www.afcna.org.au>> or make contact with the author.

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Appendix 1. Summary of data from the FCN Demonstration Project

Statistical data FCN 1997/1998	Lutheran Church Hills Regional	Catholic Church Western Suburbs	Catholic Church Hills Regional (3 nurses)	Anglican Church Central Metropolitan	Agency for Homeless Youth (3 nurses)
No. members	663 members	2500 census	2727 census	123 members	2000 members/support
Cost FCN role /year	\$1250	\$1000	\$1500	\$1600	\$1000
No. of Visits	255 total 40 hospital/nursing home 128 in client's home 87 in office	200 total 200 in client's home	60 total 5 hospital/nursing home 55 in client's home	215 total 36 hospital/nursing home 166 in client's home	10 total (home, hospital, prison, courts)
Key reason for visits	Care management – 50% Social/pastoral – 50%	Care management – 95% Social/pastoral – 5%	Care management – 15% Social/pastoral – 85%	Care management – 25% Social/pastoral – 40%	Health care – 50% Social/pastoral – 50%
Age most visits	> 60 years	> 60 years	> 50 years	> 60 years	< 30 years
Average hours worked/ week	11.5 hours average 36 hours max., 6 hours min.	10 hours average 12 hours max., 8 hours min.	6 hrs average, 14-18 hrs for 3 FCNs 24 hours max., 4 hours min.	6.8 hours average 11.4 hours max., 4.5 hours min	12 hours average 20 hours max., 8 hours min.
Average kilometres/ week	12.2 km/week Between 9-49 km	25 km/week	62 km/week (between 3 FCNs)	45.4 km/week	Occasional use only No regular km/week
Phone calls for year	82 in 348 out	240 in 360 out	160 in 352 out	132 in 155 out	5 in 15 out
Time spent on documentation	1 hour/week	1.5-2 hours/week	4 hours/week	30 minutes/week	1 hour/week
Education time	2 hours/week	2-3 hours/week	5 hours/week	1 hour/week	1 hour/week
Publications	Bulletin tips weekly Poster display monthly	Bulletin insert monthly Poster display monthly	Bulletin inserts monthly Poster display monthly	Bulletin inserts occasionally	Poster display
Establishment costs	\$300 equipment \$265 insurance/year	\$500 equipment \$265 insurance/year	\$500 insurance	\$265 insurance/year equipment	\$500 insurance ()
Major health concerns FCN deals with in faith community and wider community	Ageing accommodation, arthritis/osteoporosis, cardiac, respiratory, grief counselling relationships, managing at home, medications, palliative care, chronic fatigue syndrome, suicide	Ageing accommodation, musculoskeletal – arthritis, fractures, joint replacements, cardiac problems, respiratory problems, mental health issues – unemployment and redundancy, suicide	Caring for the aged, ageing accommodation, arthritis, cardiac, respiratory, diabetes cancers, drug and alcohol issues mental health issues, grief/ bereavement, suicide	Ageing accommodation, arthritis, cardiac, respiratory, diabetes, cancers, mental health issues, grief/bereavement, surgical hospital admissions	Crisis accommodation, mental health, drug and alcohol abuse – intoxication foot pathology, nutritional deficits, relationships counselling, financial management, low self-esteem unemployment, epilepsy, first aid, suicide