

Faith-Based Partnerships for Population Health: Challenges, Initiatives, and Prospects

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In 1999, former U.S. Surgeon General Dr. David Satcher stated, “Through partnership with faith organizations and the use of health promotion and disease prevention sciences, we can form a mighty alliance to build strong, healthy, and productive communities.”¹ This sentiment was recently seconded by Dr. Howard Koh, Assistant Secretary for Health.² Despite the contentiousness surrounding establishment of the White House Office of Faith-Based and Community Initiatives (OFBCI) under President Bush, repurposed as the Office of Faith-Based and Neighborhood Partnerships (OFBNP) under President Obama, the subsequent creation of a Center for Faith-Based and Neighborhood Partnerships (the Partnership Center) within the U.S. Department of Health and Human Services (HHS) signifies that faith-health partnerships are no longer hypothetical; rather, they are an ongoing part of the national conversation on public health.

This brief overview summarizes the scope of existing efforts among faith-based and public health institutions and organizations to work in partnership to further the health of the population. These intersections between the faith-based and public health sectors are more diverse than many public health professionals may realize, and of greater longstanding than the past two presidential administrations.^{3,4}

CHALLENGES

Many may recall the controversy surrounding the OFBCI, established under Executive Orders by President Bush.^{5,6} Less recalled is that legislation authorizing the OFBCI, known as “charitable choice,” originated during the Clinton Administration.⁷ While the intention of the legislation and the OFBCI was simply to enable religious organizations to provide services “on the same basis as any other nongovernmental provider”⁷—no provision authorized federal funding for any program—and while supported by both Democrats and Republicans, these details got lost in the uproar. Concern was voiced, early on, that the OFBCI was an effort by the religious right to create a mechanism to access federal funds. In truth, much of the religious right was opposed to the OFBCI and lobbied to eliminate it.⁸

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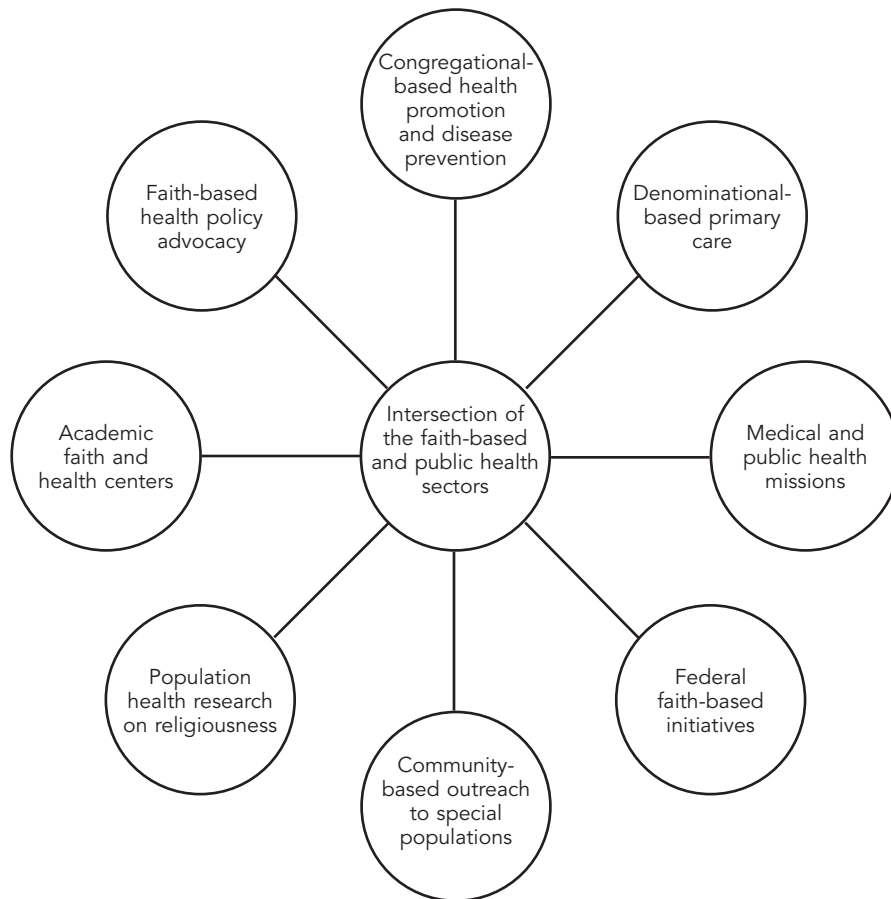
Over time, with a new director, lower profile, and track record of success, public glare faded and the OFBCI became an accepted part of the White House infrastructure. It was retained by President Obama,⁹ with an advisory board containing national leaders known for progressive viewpoints. While at one time there were concerns about how the federal faith-based concept would play out, when it comes to public health initiatives, at least, the track record appears clean. Early concerns were overstated, but, to be fair, not all were due to fear mongering; the history of organized religion’s forays into the public square are not entirely innocent. However, with legal and constitutional boundaries surrounding what is and is not permissible well vetted,¹⁰ the Obama Administration and HHS recognize this model as a means to strengthen the nation’s public health efforts.

More importantly, no matter how the OFBNP has evolved, two things are apparent: (1) faith-health partnerships are not new, and (2) they cover considerable ground. Collaboration between the faith-based and

public health sectors in the U.S. is as old as organized efforts in public health, dating to the 19th century.¹¹ The challenge of meeting national and global population health priorities should not be overwhelmed by the challenge to forge creative partnerships between these sectors, no matter how daunting.¹² Religious institutions, organizations, and professionals can be, and long have been, our allies in public health, as Dr. Satcher noted.¹

Before summarizing what is included in the Figure, what is not included is also notable; for example, groups or individuals who exploit the religious beliefs of the suffering for profit, those who espouse violence toward providers, and other unfortunate images that may come to mind at the intersection of the words “faith” and “health.” This commentary is not the place to discuss the sometimes troubled history of conflicts between people and institutions of faith and those of medicine and science. There is a different narrative to unpack that merits a wider airing; the ways that the faith-based and public health sectors continue to ally in

Figure. Points of intersection between the faith-based and public health sectors



efforts to prevent disease and promote health,¹³ both in the U.S. and around the world.

INITIATIVES

As shown in the Figure, the intersection of the faith-based and public health sectors contains multiple partnerships, encompassing recent initiatives and longstanding inter-sector relationships. These activities, as a whole, are representative of the fullness of what defines public health: (1) they entail public health research and education, delivery of primary care, and policy-making; (2) they target processes, impacts, and outcomes across primary, secondary, and tertiary levels of prevention; (3) they involve health educators, epidemiologists, biostatisticians, health administrators, public health nurses and preventive medicine physicians, environmental scientists, and others; and (4) they address the needs of diverse, underserved populations, especially racial/ethnic minority communities and older adults. Examples include:

- Congregational-based health promotion and disease prevention: The Health and Human Services Project of the General Baptist State Convention of North Carolina, dating to the 1970s, pioneered church-based health education to underserved communities.¹⁴
- Denominational-based primary care: The earliest hospitals were founded by the major faith traditions,¹⁵ seen today in the myriad Catholic, Lutheran, Baptist, Methodist, Presbyterian, Adventist, Jewish, and other religiously branded medical centers.
- Medical and public health missions: Christian missions providing medical and surgical care and environmental health development are most familiar, but other religions have traditions of global outreach (e.g., the Tobin Health Center serving Abayudaya Jews and their Christian and Muslim neighbors in Uganda).¹⁶
- Federal faith-based initiatives: One of the highest-profile initiatives of both the OFBCI and OFBNP has been the President's Emergency Plan for AIDS Relief (PEPFAR),¹⁷ a centerpiece of the nation's Global Health Initiative under the Obama Administration.
- Community-based outreach to special populations: Outreach encompasses many types of initiatives, from faith community (or parish) nurses¹⁸ to groups such as the Shepherd's Centers of America,¹⁹ a national network of interfaith community-based organizations serving older adults.
- Population health research on religion: Thousands of studies have identified religious correlates of morbidity, mortality, and disability, including social, epidemiologic, and community-based research on physical and mental health across all major faith traditions.²⁰
- Academic faith and health centers: These centers include the Duke University Center for Spirituality, Theology, and Health;²¹ the University of Florida Center for Spirituality and Health;²² the George Washington Institute for Spirituality and Health;²³ and the Emory University Interfaith Health Program²⁴ and its Institute for Public Health and Faith Collaborations,²⁵ all of which are involved in research and education.
- Faith-based health policy advocacy: The recent health-care reform debate, for example, was informed by policy statements from the U.S. Conference of Catholic Bishops²⁶ and from Jewish organizations across the denominational spectrum.²⁷

This summary is, by necessity, a skeleton overview. The public health literature is replete with accounts of faith-based partnerships, especially involving health promotion and disease prevention in conjunction with local health departments.²⁸

PROSPECTS

Can we identify ways to broaden this intersection between the faith-based and public health sectors? Two possibilities come to mind. First, the Office of the Surgeon General could use its bully pulpit to raise awareness of social-structural determinants of population health and disease, such as poverty and inaccessible preventive care.²⁹ These issues have proven intractable for decades; solutions may require a broader effort than is possible drawing only on federal and state government resources. In a time of fiscal challenge, especially, religious organizations and institutions could serve as partners in meeting needs that are presently unmet. This promise is at the heart of the Bush and Obama Administrations' efforts to promote charitable choice through offices in the White House and cabinet-level agencies, including HHS.

Second, to advance such efforts, the U.S. Public Health Service could consider developing a companion document for Healthy People 2020 that comprehensively summarizes evidence from research and intervention studies involving collaboration with faith-based communities, organizations, or institutions for each of its 42 designated topic areas.³⁰ Besides being a practical supplement, this document would provide, for the first

time, “a complete catalog of historical and ongoing public health programs and initiatives with significant faith-based content,” as well as “a useful baseline for the development of detailed goals, objectives, and implementation plans for federal faith-based efforts” related to Healthy People.²⁹

The faith-based sector has much to offer public health, yet it remains underused. The potential for good is considerable, but for good to come of it, the public health establishment must set aside any intrinsic misgivings (or misunderstandings) about faith-based organizations and professionals. Stereotyped portrayals of the faith-based concept and of the motives behind partnerships involving the public health sector do not map onto the longstanding history of collaborative work between religious and public health agencies and institutions. Moreover, without the involvement of the faith-based sector and other institutions of civil society, our nation will not muster the personal and tangible resources required to fully meet national³¹ and global³² population health goals and objectives.

But the burden is not just on those of us working in public health. The faith-based sector, too, must confront its own failings that impede such partnerships. Above all, the faith traditions must reclaim their prophetic voice regarding the health of populations. They must refocus themselves away from devotion to maintaining the status quo and toward being a force that, as Dunne said, “comforts th’ afflicted [and] afflicts th’ comfortable.”³³ They must live up to their sacred charge to act prophetically—to call citizenry and secular governments out of their complacency and neglect, in the name of justice and mercy—to address the needs of the underserved and to promote an ethic of prevention and communitarian concern for the health and well-being of all people.

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