Engaging Faith Communities as Partners in Improving Community Health

THE CARTER CENTER

CDC
CENTERS FOR DISEASE CONTROL AND PREVENTION

Engaging Faith Communities as Partners in Improving Community Health

Highlights from a CDC/ATSDR Forum Addressing:

Separation of Church and State;
The Science Supporting Work With Faith Communities;
And Exemplary Partnerships

U.S. Department of Health and Human Services

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CDC/ATSDR Faith Interest Group
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Centers for Disease Control and Prevention
Public Health Practice Program Office
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Forum Agenda

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Overview of Sponsors	Michael Hatcher, MPH
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Panel 2

Science Supporting Work with Faith Communities	Moderator George Roberts, PhD
Social and Organizational Capacity	Rev. Gary Gunderson (Interfaith Health Program at the Carter Center) Nancy Ammerman, PhD (Hartford Seminary, Center for Social and Religious Research)
Religiosity/Spirituality and Health	David B. Larson, MD, MSPH (National Institute of Healthcare Research) Gail Weaver, PhD (University of Texas at Galveston)

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Exemplary Partnerships	Moderator Mimi Kiser Qairo Ali & Ken Williams (CDC's Religious Partnership History) Rev. Melvin Tuggle (Heart Body & Soul/Baltimore) Rosalind Cottrell (Project Vision/Tennessee) Patricia Poindexter (Witness Project/Arkansas) Annie Voigt (International Lessons Learned)

Closing Address	Paul Wiesner, MD (Dekalb County Board of Health and NACCHO)
Final Remarks	Edward Baker, MD, MPH

Introduction

There is a faith and health movement spreading across this nation. It can be seen in the growth of congregation-based nurse programs, health ministries, and interfaith service organizations engaging in health-related activities. Through these faith-based structures, faith groups and communities are receiving the benefits of health education, counseling, and a wide variety of support services and systems to advance and promote health and well-being. This work grows out of the health tenets that exist within every faith tradition.

Partnerships between faith organization and the health system, be it medical care or public health, are not new. These partnerships, however, are not as common as we hope them to be. The information presented here is intended to expand understanding and collaboration between faith organizations and health organizations. The individual capacity of these organizational sectors is impressive, but their combined capacity to promote community health is enormous.

Faith communities nurture and provide social support for the well-being of those that share their faith, and they reach out to those in need within their neighborhoods and throughout the world. Inequities that create disparity in the determinants of health for individuals, families, and populations capture the attention of faith organizations and public health.

Partnership development is an ongoing activity for the Centers for Disease Control and Prevention (CDC) and the Agency for Toxic Substances and Disease Registry (ATSDR). Public health leaders recognize the need to expand community collaboration for improving health. The faith sector, made up of people and organizations of faith, represents the values of the community and is key to addressing many of the social health issues of today. Interventions that seek to change behaviors or social norms must consider the community values and the underlying influence of faith practices in the community if these interventions are to be effective. It is for this reason that the forum *Engaging Faith Communities as Partners in Improving Community Health* was held in November of 1997.

The forum addressed three topic areas.

- First, is the issue involving separation of Church and State, an important consideration for effective collaboration between public health and faith. This is a critical question because CDC and ATSDR, like many portions of those representing public health at the community level, are governmental agencies.

- The second area of interest is understanding what science has discovered regarding the influence of faith on health at the individual and community levels. A key consideration here is the social and organizational capacity of faith organizations to address community health.

- The third section is a description of current partnerships and best practices of faith and health collaborations involving CDC or other federal agencies.

Opening

On November 24, 1997, Dr. David Satcher, former Director of the Centers for Disease Control and Prevention and current U.S. Surgeon General, opened the forum. Following his remarks were three expert panels representing legal views, faith and health research, and the best practice of faith and health collaborations. Excerpts of Dr. Satcher's address and the panel discussions are presented in the following pages.

Opening Address

Dr. David Satcher, Current United States Surgeon General, Then Director, Centers for Disease Control and Prevention

At the heart of all faith organizations are places of worship where people come together to practice their faith. Through these special places, be they cathedrals, chapels, churches, mosques, pagodas, synagogues, tabernacles, temples, or other meeting places, the health of individuals, families and communities can be improved. Partnerships with faith organizations include, yet extend beyond, places of worship to religious community-based health and social service organizations, hospitals, and community foundations that are founded on a religious mission of health and healing.

Engaging faith organizations in the work conducted by CDC and ATSDR is not new. CDC has a growing history of engagement with faith organizations, but as good as our current efforts are, such collaborations are not common in enough communities across the country.

Paraphrasing Dr. Benjamin Elijah Mays, "We are what we aspire to be and not what we now are. We are what we do with our minds, and we are what we do with our youth." In partnership development, we aspire to have all public health agencies involved with faith organizations in their communities. We are still in our youth in this quest. As our efforts mature, we must rigorously apply our science and draw upon the combined strengths of public health and

National religious groups with a recorded membership of 1 million or more as of 1997

Yearbook of American & Canadian Churches 1998

Roman Catholic Church	61,207,914
Southern Baptist Convention1	5,691,964
United Methodist Church	8,495,378
National Baptist Convention USA	8,200,000
Church of God in Christ	5,499,875
Evangelical Lutheran Church in America	5,180,910
Islam	*5,167,000
Church of Jesus Christ of Latter-Day Saints	4,800,000
Presbyterian Church (USA)	3,637,375
African Methodist Episcopal Church	3,500,000
National Baptist Convention of America	3,500,000
Lutheran Church - Missouri Synod	2,601,144
Episcopal Church	2,536,550
Nat'l Missionary Baptist Convention Amer.	2,500,000
Progressive National Baptist Convention	2,500,000
Churches of Christ	2,250,000
Orthodox Church in America	2,000,000
United Synagogues Conservative Judaism	**2,000,000
Greek Orthodox Archdiocese No./So. Amer.	1,950,000
Buddhists	*1,864,000
American Baptist Churches in the USA	1,503,267
United Church of Christ	1,452,565
Baptist Bible Fellowship International	1,500,000
Union of American Hebrew Congregations	**1,300,000
African Methodist Episcopal Zion Church	1,252,369
Christian Churches and Churches of Chris	1,071,616
Pentecostal Assemblies of the World	1,000,000
Union of Orthodox Jewish Congregations	**1,000,000

*Encyclopedia Britannica Book of the Year 1998
**World Almanac 1998

It's not impossible to dream of thousands of congregations working alongside public health, sharing an understanding that health is a seamless whole—physical, mental, social, spiritual—that poverty and illiteracy and addiction and prejudice and pollution and violence and hopelessness and fatalism are forms of brokenness, diseases that require the deployment of both their assets in building whole, healthy communities.

William H. Foege, MD, MPH

our partners to create new avenues to work together. It is through diverse community collaboration and action—not confrontation—that we will find common ground for effective resolution and prevention of many of our most difficult social health concerns, such as teen pregnancy, violence, human immunodeficiency virus (HIV) infections, sexually transmitted diseases (STD), and the use of tobacco and other substances.

Through partnerships 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.

Separation of Church and State

The panel addressing issues of the separation of Church and State and the legal guidelines around these issues was moderated by Fred Kroger of CDC's Office of Communication and included: Daniel Riedford, CDC's Office of General Counsel; Leon West, The Congress of National Black Churches, Inc.; and Jerry Dell Gimarc, South Carolina Department of Health and Environmental Control.

Daniel Riedford, CDC Office of the General Counsel

Mr. Riedford outlined the legal framework in which government organizations or agencies may participate in programs with religious organizations, using a three-part test developed by the Supreme Court to examine the constitutionality of government efforts.

The Supreme Court's three-part test is an exercise in common sense. First, the program has to have a valid secular purpose, which translates for CDC as a valid public health purpose. If a project does not involve good public health goals and objectives, CDC cannot and should not take part—regardless of whether the project involves religious organizations.

Second, the primary effect of the program should neither advance nor inhibit religion. The primary effect of any program sponsored by CDC should be for the betterment of public health, either by education, intervention, or other mechanisms. If the program does not meet this goal, then the project should not be undertaken.

The Supreme Court's three-part test:

1. The Statute or other government action must have a secular purpose.
2. The principle effect of the action or statute must neither inhibit nor advance religion.
3. The statute or government action cannot foster excessive government entanglement with religion.

91 Supreme Court Reporter 2105

Finally, the program should not foster excessive government entanglement with religion. This is not as clear-cut as the first two criteria, but there are some helpful sign-posts. The shorter the time frame and the more focused the goal of the program, the less likely it is to run afoul of this rule. Complex and long-term projects necessarily require a heightened level of government oversight and involvement in the partner's activities, which is likely to lead to excessive entanglement.

After Mr. Riedford presented the basic legal framework for considering government partnerships with religious organizations, the two other panelists presented the guidelines their organizations have developed to maintain faith and health partnerships within this framework.

Leon West, the Congress of National Black Churches, Inc. (CNBC), National Violence and Drug Prevention Program

Mr. West spoke about work his organization has done in partnership with the U.S. Department of Justice and other federal agencies to address anti-drug and anti-violence issues.

CNBC is a coalition of eight historically black religious denominations with churches that represent 65,000 local congregations and a membership of more than 19 million people. Our violence and drug prevention program looks at the questions of prevention, control, rehabilitation, community-based service delivery, and roles that congregations can engage in to make this happen. The delivery of social services and providing outreach to the community are not new roles for the church. Often, we find that the role of the church is to help people cope with issues and things that they can't deal with alone.

The CNBC provides information, technical assistance, and training for clergy and congregations so they can build an extended ministry that deals with some of the social and economic problems of the nation, and indeed, the world.

The partnership we have formed with the Justice Department evolved from mutual concerns regarding drugs and violence. It is guided by the separation of church and state issues previously outlined by Mr. Riedford.

In this partnership, the service delivery done by the CNBC does not require the active involvement of the Justice Department, but in accepting federal moneys to do our work (through a cooperative agreement, for example), it does involve accounting standards, such as annual audits and quarterly reporting. A faith organization participating in a partnership with a government agency must adhere to certain accounting and reporting standards. Reporting regularly and having a strong administrative and management structure within the religious organization means that a program will require less oversight from the funding agency and can avoid excessive entanglement.

Other factors to consider when developing service opportunities in such partnerships include ensuring that the program does not inculcate religious values, limit employment on the basis of religion, or make religious training a mandatory part of the program's activity.

Jerry Dell Gimarc, South Carolina Department of Health and Environmental Control, Office of Planning

Ms. Gimarc described the South Carolina Department of Health's partnerships with the faith community and the subsequent development of "Parameters for Working with the Faith Community."

The South Carolina Department of Health and Environmental Control has been successfully working with the faith community for about 10 years. To guide a state agency in this collaboration, there are a number of principles or parameters. In partnership with a faith organization, a government entity must not promote, or be perceived as promoting, a particular faith. An equal opportunity clause applies as well, that each faith group should have equal opportunity to receive programs or services from the health department.

If the health department responds to a request to hold a health fair for one faith, it must be prepared to offer a health fair upon request by another faith. In addition, if it initiates a program and offers it to one group, it must offer the program to all groups.

Different faith groups and different congregations within faith groups have differing demographics. If the health department has valid reasons to prioritize sharing programs or resources with certain faith groups based on health risk factors because these faith groups have more of the population at risk in their church, mosque, or synagogue than others, the department may do so. Other faith groups, however, must be served in the same way as additional resources become available.

Another issue to consider is: How does one work on public health strategies when part of the public health message is not acceptable to a particular faith group? For example, what do you do if you have a collaboration with women in faith groups having a tenet that prohibits them from touching themselves and you are promoting a message regarding early detection of breast cancer and the importance of self-examination? Another example is teen pregnancy prevention or HIV/AIDS prevention where the only acceptable church teaching is abstinence or monogamy, but that does not allow the full complement of public health messages. In such collaborations you must re-examine the message and find an approach that is acceptable to everyone in your audience.

The Church has a vision of health that goes beyond the mere absence of disease, a vision that cannot be confined to the narrow views of physiological mechanisms, as important as they are, or reduced to numbing statistics of rates, proportions, and risk factors. Because it is a vision of wholeness, because it is a vision of hope, and because it is a vision of holiness, it is a vision of grace. And because it is of grace, it makes us whole and hopeful.

Robert McKeown, PhD
South Carolina Turning Point,
Faith Health Work Group

In South Carolina, we're going beyond thinking of the faith community as merely the site for a program; instead, we're developing insight into what we bring and what they bring to a partnership for public health improvements. These are things that we keep having to learn and relearn. What I want us to understand about our partnerships with faith communities is how complementary we can be in our work together.

The Science Supporting Work with Faith Communities

George Roberts, from the Center for Injury Control and Prevention, moderated the panel addressing the scientific rationale behind public health efforts to build partnerships with the faith community. Panelists included: Gary Gunderson, Carter Center's Interfaith Health Program; Nancy Ammerman, Hartford Seminary's Center for Research on Religion and Society; David B. Larson, National Institute for Health Care Research; and Gayle D. Weaver, University of Texas.

Social and Organizational Capacity

Gary Gunderson, Director of the Carter Center's Interfaith Health Program

Rev. Gunderson described the alignment of religion and health assets as a faith and health movement that can change communities and is currently growing in the nation.

There are a number of movements in United States history, movement meaning "a fundamental thing moving in the social structure that has the power to change policies, to change the way we relate to each other," like the freedom movement of the 1960s or the earlier movement to prohibit child labor. The growing confluence of faith and health amounts to the sort of movement that has the capacity to change millions and millions of lives in the United States and around the world.

This movement has four main aspects:

- The relationship between individual spirituality and individual health. Numerous studies rooted in medical research document this link, but rarely do studies frame the data in a public health perspective.
- Religious structures acting in communities for the express purpose of improving and contributing to the health of those communities;
- A broad-scale realignment of social responsibilities and a new understanding of enduring accountability for community structures; and
- Congregational vitality, occurring in a strong, active minority of congregations—a revitalization of the social structure, the root from which the faith community's involvement with public health must be generated.

Many churches are already active in health promotion and related services. A survey of 635 Black churches in the Northern United States found that two-thirds of the churches operated one or more community outreach programs and more than half had more than two programs. Many of the churches had ongoing ties with a variety of secular agencies, suggesting that religious organizations may be able to serve as bridges among various systems

Thomas, 1994

The basic strengths of congregations valuable in community health improvement initiatives are:

- the strength to **accompany**, to be present in the lives of other people;
- the strength to **convene**, to convene interests that would otherwise not come together around specific problems or opportunities;
- the strength to **connect** people to resources. This strength is in the complex lives of the congregation's membership and their connections to one another;
- the power to **frame**, providing a framework of meaning around experience and data;
- the power of **sanctuary**, providing a safe place to gather;
- the power to **bless**, to sanction. In understanding why people don't act in their own self-interest, the religious perspective is that we do not respond primarily to threat; we respond to that which blesses us.
- the power to **pray**, to find meaning between the holy and being human; and
- a very different **sense of time**. Congregations are enduring institutions that have the power to persist for the long cycles needed to produce community change.

Recognizing the unique capacities of congregations, beginning in 1983 the Robert Wood Johnson Foundation has provided matching, start-up grants of $25,000 (now totaling over $38 million) to 1,100 interfaith coalitions that develop networks of volunteer caregiving services. Through the Faith in Action initiative, volunteers are trained to help people in need: the elderly person living alone; the physically or mentally disabled; the terminally ill; and the family caregiver needing relief. "The real value of this program is the crucial informal support service that the volunteers, a community's natural resource, are providing. These services help people who would otherwise be isolated stay connected to the social support network in their communities."

Paul S. Jellinek, PhD, Vice President
Robert Wood Johnson Foundation

Partnerships today involve a deeper dialogue within which we move toward one another at the point of our strengths, the enduring, strategic strengths that will allow us to build a deep collaboration for the health of our communities.

Nancy Ammerman, Center for Social and Religious Research, Hartford Seminary

Nancy Ammerman has studied congregations and the complex role they play in communities.

Congregations are the most pervasive voluntary organizations in our society. As voluntary organizations, they are primary instruments in what sociologists and political scientists have come to call the "generation of social capital." They are places where we develop relationships of trust and communication. Often they are the only voluntary organizations to which the most disadvantaged in our society have access, including access to opportunities to develop their civic skills, chair a meeting, speak in public, write letters, and express their opinions. Congregations are effective deliverers of social services, offering benefits to the community such as meeting spaces, vans for transportation, bulletin boards, copying machines, public address systems, paper, and telephones, i.e., all sorts of material infrastructure that can be mobilized.

There is an amazing constellation of expectations that make congregations especially effective in the delivery of social services.

In addition to this material infrastructure, congregations offer an infrastructure of volunteers. Not only can congregations mobilize volunteers, they are places where people learn about the things that can and need to be done. We expect congregations to do this sort of thing. People in need often go to congregations to find places to get assistance. But people who want to offer their services as volunteers also go to congregations.

> ***Beyond their involvement in existing health activities, churches and other faith-based institutions have much to offer to health promotion planners: They have credibility and roots in urban low-income communities. In many devastated neighborhoods, churches are among the most established community institutions, having served several generations of parishioners. Church leaders are often regarded as leaders who remain dedicated to the community***
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> **Freudenberg, 1997**

Finally, congregations provide moral and spiritual capital to the community. We trust them to inculcate important values of how people should live their lives, especially when we think about raising children. Congregations are an important part of the community for establishing those values and moral spaces where we think about and create meaning in our lives. Also, we are increasingly discovering the power of ritual to provide people with a sense of their own ability to be actors in the community. Congregations are providing resources to communities, giving them a base to support strong and healthy individuals.

Religiosity/Spirituality and Individual Health

David B. Larson, National Institute for Healthcare Research (NIHR)

Since 1991, NIHR has been conducting and mobilizing scientific research on the relationship between spirituality and physical, mental and social health. Dr. Larson's remarks are based on systematic reviews of peer reviewed literature.

Despite Gallup survey data, or how extensively patients want spirituality addressed, we continue to leave it out of clinical medicine.

About 80% of patients would like to have their spiritual needs addressed in their care, but less than 20% ever see it addressed (King & Bushwick, 1994). Most patients believe that prayer helps in terms of healing. Yet, our systematic reviews of literature in various fields showed that, overall, religiosity and spirituality are the forgotten factors in health and health research.

> So strong is the connection between faith and well-being that more than 30 medical schools in the United States now offer courses on spirituality and medicine.

Is religiosity harmful or beneficial? In a review of psychiatry studies, we found that more than 80% of the time, the more active in church or the more one prayed or had a strong belief in God, the more beneficial this was when weighed against other single factors. Only 3% of studies found a negative clinical relationship (Larson, 1993).

Reviews of the literature reveal the importance of working with churches, synagogues, and mosques for addressing secondary and tertiary clinical prevention issues. There are four areas that warrant further research:

1. Illness prevention. A recent study in *The American Journal of Public Health* found that at its 30-year follow-up, one-third fewer church attenders were dead than non-attenders. Were the church attenders healthier by selection bias? No, but the more they went to church, the less they smoked or drank and the more they exercised (Strawbridge et al., 1997).

2. Coping with severe and chronic illness. In 50% of aging people, religiosity is a very important factor (Koenig et al., 1992). Before having bypass surgery, 96% of patients prayed; most of them felt this was the most important thing that got them through their surgery (Saudia et al., 1991). In women with gynecologic cancer, nearly 80% turn to God, and more than half of them will increase their faith (Roberts et al., 1997).

3. Surgery and follow up. For bypass surgery patients for whom God is very important, at 6-month follow-up, none was dead. For the remainder of the sample, one in 10 was dead (Oxman et al., 1995).

4. Intervention outcomes. For prisoners who had at least monthly Bible studies in the year before their release from prison, recidivism at one year follow-up was 14 % compared with 41% in the matched comparison group (Johnson et al., 1997).

As health professionals, we cannot continue to leave faith out of public health. It is time to bring these together.

Gayle D. Weaver, University of Texas Medical Branch

Gayle D. Weaver discussed a study of the relationship between religiosity and health status in African-Americans.

From many quarters comes evidence that our view of health should be expanded to encompass mental, social, and spiritual well-being.

Institute for the Future

The relationship between religiosity and health is an important one, particularly for African-Americans, because historically religion and the church have played an important role in their survival in this country. Recent research shows that the church continues to be a very important institution within the African-American community.

The following information is from a study of a large sample (1,018) of African-American adults and is a description of:

- the level of religiosity;
- the relationship between religiosity and demographic factors;
- the relationship between religiosity and various health characteristics;
- and implications of these findings for promoting healthy lifestyles via the faith community.

For this study, we used a religiosity scale that measured 10 behaviors and beliefs related to religious practices. The mean religiosity score of this sample was 25.99 (out of a possible range of 0–40). Women over age 65 had the highest mean religiosity score (30.9).

Surprisingly, we found that the two groups with the highest mean religiosity score were those who rated their health as fair or poor. The group that had the highest mean score also reported 2 to 3 major health problems. Those that scored lowest on depressive symptoms had the highest religiosity scores. Like other studies, those reporting drinking less alcohol, not smoking, and a lower degree of stress had the highest mean religiosity score. Exercise, however, was not significantly related to religiosity.

This study points to considerations related to outreach and the unanswered question of health status disparity. The more frequent church attenders were found to be over 45 years of age. Consequently, if health promotion efforts are to reach at-risk youth and young adults, there is a need to engage churches in approaches that reach beyond the walls of the church. The findings also raise an obvious question that warrants further investigation—given their high degree of religiosity, why is there such a disproportionate amount of mortality and morbidity among African-Americans? Social scientists and health care delivery professionals must develop new strategies to better understand how we can meet African-Americans' health needs.

> ***The church can serve a role in bringing about a much better lifestyle, a much better health condition for all concerned. But it has to be a situation where the ministry and the key laity in churches are educated and empowered with all the information about particular diseases and all the things that the health community would like to impart so that they might play the ambassadorial role that you [the public health community] seek.***
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> **Rev. George LaSure**
> **CDC forum participant**

Exemplary Partnerships: Case Studies

Mimi Kiser from the Carter Center's Interfaith Health Program moderated the panel of case studies. Panelists included: Ken Williams, CDC; Mari Brown (for Qairo Ali), CDC; Rev. Melvin Tuggle, Heart, Body and Soul, Inc.; Rosalind Cottrell, Memphis, Tennessee; Patricia Poindexter, CDC; and Annie Voigt, CDC.

CDC's HIV Prevention Faith Initiative

CDC's response to the Autoimmune Deficiency Syndrome (AIDS) epidemic was partially determined by recognition that social systems and social networks play central roles in shaping beliefs, behaviors, and attitudes toward social health issues. The process of advancing the prevention agenda through social systems was initiated with several new cooperative agreements: in 1988 with the National and Regional Minority Organizations Cooperative Agreement; the next year with the National Organizations Grant Program; and in 1995 with the National Partnerships Program Cooperative Agreements.

The mission of the HIV Prevention Faith Initiative, now in existence for approximately 10 years, is to support and foster HIV prevention program activities and partnerships involving faith communities as part of an integrated and comprehensive response to the HIV/AIDS epidemic on the national, state, and local levels.

Program objectives are:

1. to increase the number of faith-based organizations that support HIV prevention;
2. to increase the number of governmental and non-governmental partnerships and collaborative prevention activities with the faith community;
3. to increase faith community participation in the HIV prevention community planning process; and
4. to disseminate current and accurate HIV prevention scientific and evaluation information to faith communities.

Partners and Activities:

- The AIDS National Interfaith Network (ANIN), through their "National AIDS Ministry Capacity Building for Prevention Project," is active in the assistance to local, regional and national AIDS ministries to better enable them to present prevention messages and modalities to a wide variety of people within the American religious community. Some of these efforts include: the Red Ribbon Project; Council of National Religious AIDS Networks; National Interfaith Quilt Program; and National Skills Building Conferences.
- The Balm in Gilead is a national organization that works through Black churches to stop the spread of HIV/AIDS in the African-American community and to support those infected with, and affected by, HIV/AIDS. Through the cooperative agreement, the Balm in Gilead operates the Black Church HIV/AIDS National Technical Assistance Center, producing the HIV/AIDS Christian Education Curriculum and *Who Will Break the Silence: Liturgical Resources for the Healing of AIDS.*
- The University of Texas School of Public Health and its subcontractor, Catholic Charities USA, have been working together to increase the capacity of 1400 Catholic Charities USA agencies to deliver effective HIV prevention information to vulnerable populations.

Contact: Qairo Ali , HIV Prevention Faith Initiative
National Center for HIV, STD, and TB
Division of HIV/AIDS Prevention
404-639-5224

The Witness Project

Established in 1991, the Witness Project-™* is a community-based, breast and cervical cancer education program in Arkansas. It is based out of the Arkansas Cancer Research Center at the University of Arkansas for Medical Sciences.

The goal is to raise community awareness about monthly self-breast examinations, clinical breast examinations, annual mammograms, and annual Pap tests. The educational programs of this initiative on breast and cervical cancer are presented in churches and community centers. The Project's motto is that in church, people "witness" ("to speak to

*Use of trade names is for identification only and does not represent endorsement by the Public Health Service or by the U.S. Department of Health and Human Services.

others" and "to spread the word") to save souls, and at the Witness Project-™, they witness to save lives. At the heart of the program are African-American women, witness role models and lay-health advisors, who talk to other women about the importance of early detection of cancer. The witness role models are breast and cervical cancer survivors. They teach that it is okay to talk about cancer; they teach that the disease is neither a punishment from God, nor a death sentence, both of which are cultural mores. The lay-health advisors teach self-breast examinations. The intervention is designed to work within a framework that honors cultural and local beliefs, recognizing the importance of religion and spirituality in the lives of women.

For every 100 participants in the Witness Project-™ who did not normally get routine mammograms, an average of 24 received one within 6 months following the intervention. Of every 100 women who did not regularly do self-breast examinations, 70 said that they did it as a result of the intervention. The Witness Project-™ is now being replicated in other states. A video has been produced that explains the program; there is also an implementation manual with text, slides, video, and script.

In church, people "witness" to save souls, and at the Witness Project-™, they witness to save lives.

Contact: Patricia Poindexter
National Center for Chronic Disease Prevention and Health Promotion
Division of Cancer Prevention and Control
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Project Vision

Project Vision, a health promotion program based out of Early Grove Baptist Church in Memphis, Tennessee, aims at preventing and controlling risk factors associated with cardiovascular disease, hypertension, high cholesterol levels, obesity, and sedentary lifestyle. The target population is youth aged 5–18 and adult women. Interventions include educational classes that teach students how to modify recipes to be heart healthy, exercise classes with babysitting for the children of participants, blood pressure and cholesterol screenings, and health education sessions that are conducted monthly (smoking cessation, hypertension, physical activity, and nutrition).

Lessons learned about health care delivery and health care programs in underserved/inner-city urban populations include the following:

1. Know what the communities' past experiences are with similar programs;
2. Know the credibility of sponsoring agencies and organizations;
3. Know other competing priorities of the community at the time the activities are initiated, i.e., poverty, crime and racism;
4. Know the experiences of and have familiarity with the target community; and
5. Understand the social and political influences within the community.

Evaluation showed a 20% increase in knowledge of cardiovascular disease and its risk factors within the community. The educational component in the school system showed a 30% increase in the knowledge of risk factors as they relate to cardiovascular disease

We have fewer people dying in our community, and we are pleased and we are thankful that CDC had a model that we could buy into and they were flexible enough to allow us to be the community that we will always be—a little bit strange, a little bit diverse, and real Southern.

Rosalind Cottrell, Project Vision

prevention. A usage rate of 86% on the days the recreation center was open was observed. As a result of Project Vision, the community has also learned how to deal with health issues, as well as with environmental changes, through advocacy and policy development.

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Heart Body and Soul, Inc. (HBS)

HBS is a partnership in East Baltimore, Maryland comprised of Clergy United for Renewal of East Baltimore (CURE), Johns Hopkins University Medical Institutions, Inc., Baltimore City Health Department, Baltimore City Public Schools, health care providers, community groups, the Mayor's Office, business community, neighborhood non-profits, community associations and churches. The program has existed for approximately 10 years.

CURE was founded by a group of ministers representing approximately 230 churches in East Baltimore, who realized the tremendous impact they could have on community health if they came together. CURE and its collaborative partners established HBS to include five essential characteristics:

1. community-based leadership and ownership of specific programs;
2. training and utilization of indigenous community health workers;
3. interdisciplinary community practice and training opportunities;
4. built-in evaluation; and
5. broad community development and long-term maintenance of effective strategies.

One of the goals of Heart, Body, and Soul was to train neighborhood health workers, and we did that by bringing people from out of our communities. We were trying to create a new health professional.

Rev. Melvin B. Tuggle
Clergy United for Renewal of East Baltimore

The HBS program trained a total of 29 volunteer lay smoking cessation specialists and an additional 272 church members to conduct their church's health screenings. The concepts underpinning the program have been adapted and diffused in several successful replications throughout the country. In 1991, the American Lung Association (ALA) supported the adaptation of the HBS program by 32 local lung associations in more than 40 church sites. Through the end of 1996, these local projects had reached nearly 55,000 people with tailored

information about smoking cessation. The ALA adaptation spawned a cadre of more than 25 African-American clergy who are embracing public health through programs like HBS. In addition, HBS has served as a catalyst for developing other successful public health programs. HBS was identified as a 1996 "Models that Work" by Health Resources and Service Administration's Bureau of Primary Care.

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Lessons Learned from International Health Initiatives

Religious-based community health programs have had a strong presence in international settings. Two examples are described below—one from Jamaica and one from Kenya—both church-based organizations that have developed effective community health and lay health advisor programs.

Jamaica
In the early 1970s, the Bethel Baptist Church Ministry began offering over 20 different services, each of which included curative, preventive, and rehabilitative aspects. Community health workers and volunteers assisted with child clinics, family life education, and health education. As a result of this program, 90% of teens and young adults used family planning services, with a documented decrease in adolescent pregnancies; the child immunization rate increased to 100%.

The Christian Medical Commission of the World Council of Churches has provided leadership to mission groups on the responsibility of medical missions to the community and commitment to the denominator, to the people who don't make it to the mission hospital or the mission clinic. Faith groups would not even think about going out to do medical work today without thinking about public health and community work on denominators.

William Foege, MD, MPH

Lessons learned:

- Health, in its truest sense, is an integration of the aspects of the self, body, mind, and spirit;
- Transformation (change) is only valid if it is carried out with the people, not for them.

Kenya
From 1975 to 1976, Kenya experienced severe drought and famine. In response, the Catholic Church trained community health workers to create awareness about preventable diseases, improve environmental health, teach recognition of and simple cures for the most common illnesses, improve child feeding practices, stimulate interest in self-reliance at the village level, and provide links between the community and static health facilities.

Lessons learned were:

- to start with priorities decided on by the community;
- to use outside resources at the beginning stages of a program;
- to work with community leaders; and
- to have a thorough understanding of the public health practices that are being promoted.

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Closing

Paul Wiesner, MD, Dekalb County Board of Health and National Association for County and City Health Officers

It is my belief that we in public health have much more affinity with the faith community than we have with the medical community. From the list of 10 essential public health services, only one is not in the domain of faith community activities—the enforcement of laws and regulations that protect health and ensure safety. The Dekalb County (Georgia) goals are to improve health status and the quality of life. Faith communities exist primarily to improve quality of lives.

Public health officials are aware that the core central factors in our work are epidemiology and social justice. Epidemiology reveals the inequalities of health status within our communities. We have to correct these inequities. Members of the faith community, frequently acting to reduce inequities, are natural partners for synergistic action.

If we are going to develop sustainable community health improvement activities, then we must invest in social and spiritual capital, civic engagement, and voluntarism. I believe there is actually an extraordinary confluence in ideas that bodes very well for the joint work of faith communities and public health.

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