PARTNERSHIPS

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Backing onto Sacred Ground

SYNOPSIS

It is widely recognized that the health of individuals and communities is determined by the interaction of physical, mental, social, and spiritual factors. Public health leaders can find precedent for the resulting holistic strategies in the collaboration with religious structures that characterized the early years of public health. The modern context is more pluralistic, democratic, and complex in terms of its institutional array of partners.

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Etiology creates strange—or at least surprising—bedfellows. The Healthy Communities movement reflects an understanding that disease and injury are caused by a complex array of processes rooted in social factors. These factors include the present context but also recognize that any time-bound set of relationships reflects an even more complicated confluence of events and processes that may find their genesis many years in the past. Human beings are complicated creatures partly because they act not only rationally but also out of fears and hopes for the future. The communities that form among humans are even more complicated.

Something is sacred when it is the locus of ultimate value. For public health, epidemiological data confer ultimate value on community-scale determinants of health. For most religious groups, it is scripture affirmed by worship and expressed in the social relationships in family and community that is sacred. The common ground between public health and religious groups is regarded as sacred by both.

ENGAGING PUBLIC HEALTH IN COMMUNITY RELATIONSHIPS

It is not surprising that rational decision makers in leadership positions would seek to avoid the complexity of community in favor of simpler models based on service delivery. In recent years, however, public health thinkers have begun to seriously consider these complexities. One landmark in this process of engagement was the occasion of the 25th anniversary of the Robert Wood Johnson Foundation, one of the leading philanthropies committed to community health improvement. The anniversary celebration gathered about 500 public health experts to reflect on a remarkable set of projections about trends in health and health care developed by the Institute for the Future, a research institute in the San Francisco Bay area. Predictably, much of the discussion focused on technologies and reimbursement options driving the health care system, but there was also a discussion of the growing consensus about the determinants of health that could have revolutionary implications, if taken seriously. Briefly, participants noted that many disciplines now recognize that health is determined by four basic currents:

- Physical factors, including toxins, injuries, infectious agents, and genetics.
- Mental factors, which also contribute to both the onset and treatment of physical ailments.
- Social factors, including both socioeconomic factors and what participants called "sociability."
- Spiritual factors, which are significant on an individual basis and also affect the capacity of a social system to function in a healthy way.[1]

Public health experts and their peers in criminal justice, education, religion, city planning, and other related disciplines are finding their way toward a remarkably similar understanding of what might be called a "fully human citizen." It now widely recognized to be bad science to posit a causal pathway that omits physical, mental, social, or spiritual dynamics.

However, we are far from understanding how to deal with such an inconveniently complex thing as a fully human citizen. One of the speakers at the event had a business perspective and noted that only the first two factors are "actionable" and could be considered in a serious projection of health care trends. So, predictably, the trends projected were very nearly straight-line extrapolations of the current assumptions regarding social dynamics and social values in play.

If social factors and spirituality are constants, not variables to be engaged with a logical strategy, then it is quite unlikely that the overall determinants of health operating in a community are going to change in any measurable way. Health professionals find themselves playing a game of ameliorating the worst effects of negative factors and tinkering at implementing opportunities. The business observer would be correct: if one can do nothing about social and spiritual determinants, they are a distraction from serious strategy. The history of public health suggests that one can engage these determinants by building coalitions with social and religious structures.

RELIGION AND PUBLIC HEALTH: AN HISTORICAL PERSPECTIVE

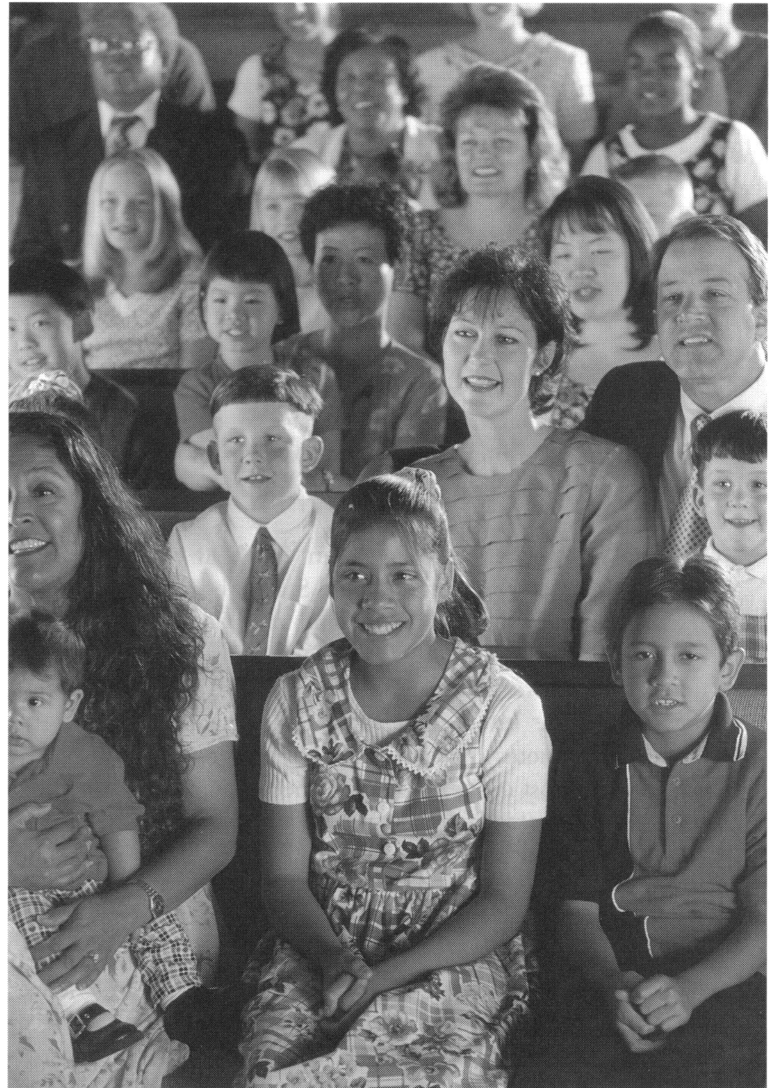
The public health profession has its historic roots in the middle 1800s in the understanding that the environmental factors in disease could be engaged through rational social change. The modern Healthy Communities movement harks back to the early days of public health, in which strong alliances with the religious community were common.

The watershed in the development of public health strategies and institutions was the struggle with tuberculosis (TB).[2] The disease had similar implications within religious circles, shaping our enduring community strategies and the institutions such as hospitals that channeled the further development of health activities.[3] This is the crucible in which the faith and health movement as we know it today was formed, not, as some would argue, the earlier tradition of mercy. Patterns of collaboration, government-religious engagement, interdisciplinary research, and interfaith institution-building are all found here.

Only a hundred years ago the primary causes of death were infectious diseases, which is no longer the case at all. Until the latter part of the 1800s, epidemic diseases such as cholera and tuberculosis were felt to be associated with various moral failings, an idea reinforced by millennia of religious thought. As scientists began, in the mid-1800s, to prove that epidemics were instead linked to environmental factors (especially sanitation and water), the focus turned to community efforts, to social choices and not just individual moral failings.[4] Urban growth, much of it coming from immigrants crowded into abysmal housing, created a fertile stew for infectious disease. Thus, the early years of the American Public Health Association were filled with papers about sanitation, recognizing common cause with "moralists and priests," as one paper put it.[5] Earlier moralistic attitudes made the shift with the new science of environ-

mental risks by overlaying science with moral injunctions that came very close to identifying godliness with good sanitation, the kingdom of God with sewers.

In the early stages of the public health response to TB, the movement was filled with lay people and community organizing strategies built on religious leaders and congregational structures. Although social activists preceded medical technicians, by the turn of the century leadership began to be preempted by physicians, with women and clergy receding into the background.[6] By the mid-1900s pharmacology had largely replaced social action as the core competency of public health.[4] Historically, the religious community can view the public health infrastructure as an expression of mainstream US spirituality as mediated through the dominant religious organizations that supported and interacted with the public health profession in its formative decades. Likewise, the extensive religious institutional infrastructure can be viewed by the public health community as a reflection of its influence on shaping the form and function of religious assets in the US social milieu.



A Modern Perspective

Today, etiology once again drives the renewed relationship between public health and the religious community. One hundred years later, greater sophistication regarding the determinants of health makes the relationship even more central for health professionals than when diseases such as TB required instrumental relationships in order to provide services or to support necessary community initiatives. Landmark analysis by Foege and McGinnis in 1993 established that, today, the primary causes of premature death are not infectious but behavioral: violence, teen pregnancy, injuries, substance dependency. Analysis of disability patterns leans even more toward behavior and social isolation as causes. It is not surprising that the last 10 years have seen a large number of initiatives driven by this science toward engagement with the religious community.

There are four streams of activity oriented around faith and health: the link between personal spirituality and healing; the link between faith structures and public health; the broad renegotiations of social roles among public, private, not-for-profit, and voluntary organizations in our society that are redirecting the flows of cash, time, and political warrant; and the changing vitality among congregations and faith structures of different kinds. We are especially interested in the minority of congregations that find their life in service to, and change in, the community—about 10% to 15% in most communities.

The first of these streams is more closely aligned with individualized medical health perspectives, but the other three can be easily identified in most Healthy Cities and Communities campaigns in local areas. Each of the three reflects complementary but distinct motivations and priorities. For instance, clergy may encourage their membership to be involved in community improvement campaigns, including Healthy Cities and Communities, but their primary identity and goals remain religious and the interest in Healthy Cities and Communities is an expression of these goals. Likewise, many communities have

existing social service networks that were established by religious congregations decades ago. Now these networks are bearing an increasing load and may view the Healthy Cities initiative as reinforcement for their existing community commitments. The four streams of faith and health activity need not conflict unless they are not recognized.

RELIGIOUS RESOURCES FOR HEALTHY COMMUNITIES

Public health leaders who are not familiar with the religious community are often surprised by its scale, durability, and vitality. It is helpful to recognize six facets of religious expression that pertain to healthy communities:

- *Congregations.* There are between 265,000 and 350,000 congregations in the United States (because they are not required to register and many remain informal, the number is difficult to know.[7] The lower numbers are those that can be found in the phone directories.) The Interfaith Health Program of the Carter Center notes that perhaps 10% of congregations provide most of the religious services significant for public health (food, shelter, counseling, rehabilitation, child care and so on).

- *Connectional systems such as denominations.* The United States is unusual in that it has more than 2,000 organized systems reflecting the particular social and political milieu marked by pluralism, democracy, and an attempt to keep religious structures separate from government. There is enormous variety among the connectional systems, which vary widely in terms of how they select, train and support leaders, handle funds, own associated institutions, and relate to other community actors.

- *Interfaith and ecumenical systems* such as the social service agencies. In most communities, religious groups have developed collaborative agencies that provide social services and frequently participate in Healthy Communities activities.

- *Structures owned directly and indirectly by religious groups.* Throughout the century, religious organizations have accumulated many billions of dollars of assets not only by charitable donations, but also because of political policies that have favored non-profit providers. Although the form of these assets is in flux today due to a changing policy environment, in many communities, religious hospitals and foundations are major forces in shaping community health strategies, including Healthy Communities campaigns.[8]

- *Structures influenced by religious values.* If one considers the power of influence, not simply legal control, a larger fraction of community organizations can be understood as reflecting religious values.

- *The members.* Surveys of religious values and commitments are notoriously ambiguous. As many as 150 million people claim to attend worship services monthly; half that claim weekly. Most lay people express their religious values not purely inside religious organizations but in the way they do their weekday job, provide community leadership, volunteer, and participate in common institutions such as schools and business groups.

THE INTERFAITH HEALTH PROGRAM

The Interfaith Health Program was created in 1992 to encourage the dissemination of best practices by faith groups in health. There are more positive examples of religious health activities conducted by every hue and voice within the religious spectrum than can be catalogued (although we do try: **www.ihpnet.org**). One challenge faced by faith groups is the identical challenge faced by public health agencies: collaboration among partners in this movement usually involves the three following domains of activity.

- *A task* (or several): specific actions that are valued by all the partners. This can be promoting the use of car seats, enrolling children in government insurance programs, conducting gun buybacks, door-to-door immunization outreach, or conducting health education programs around mammograms or diabetes. The partners need functional relationships but do not need extensive or deep levels of trust or understanding.

- *Building capacity.* As collaboration continues, it becomes important to strengthen the partners. This shifts the focus from specific tasks toward roles. In order to understand how to appropriately strengthen the roles in someone else's structure, a much greater level of understanding and trust is demanded. For instance, within the last 10 years we have seen the emergence of the parish nurse, who is trained to work

in and through the local congregation.[9] The parish nurse functions as a health educator and promoter and, often, something like a community health nurse.

- *Boundary leaders.* Community collaboration rests on a critical mass of what the Interfaith Health Program calls "boundary leaders" who can do the "plumbing" among partners. Traditional leadership is exerted within a structure or domain, usually defined by some degree of power or control. Boundary leaders work in the spaces in between structures, a fluid and negotiated domain defined not by power but by voluntary cooperation.

In all Whole Community Collaboratives—the name the Interfaith Health Program gives to its local networks of leaders in various communities around the country—the training and placement of parish nurses is an important strategy favored by cooperating institutions, such as hospitals, as a way to advance health goals. However, placing an well-educated health professional in the context of a religious congregation may have broader implications than would be obvious. Power, authority, and financial relationships of existing roles are all affected. Clergy, secretaries, volunteer nurses, other home visitors, and youth workers may see their status, authority, and capacity changed in ways that neither the parish nurse nor the hospital may understand.

CONCLUSION

Building a healthy community is not simply implementing a bundle of ideas. It involves changing the behavior of linked community systems by realigning them and mobilizing them around modified values. The Healthy Communities model rests on a theory of social changes, not medical interventions. We have learned in the Whole Community Collaboratives that social changes are achieved partly by building—changing—the capacities of key roles in strategic organizations. This is especially true when those new capacities are designed to make collaboration more effective. The early and less threatening stages of capacity building involve add-on roles, such as parish nurses, that can be withdrawn or expelled easily. More fundamental and challenging capacity building involves training powerful and sensitive roles, such as clergy or youth workers. Training and funding changed roles demand a deep level of mutual trust and understanding.

Everything that matters in democracy assumes dialogue. Healthy Communities rests on participation and cooperation across all key sectors. In times of social transition, it is not the relationship among theories that is key, but the relationships among the humans trying their best to live their way toward a hopeful horizon. The relationships among communities of thought, disciplines, sects, parties, and interest groups are mediated through leaders capable of doing the plumbing at the boundaries between the social structures.

In the United States, it is popular now to speak of developing the "social capital" needed to build community. I find the financial metaphor unhelpful, but the point is key. Where do cooperative citizens come from? These are citizens—who are also members, believers—who are bilingual. They mediate and negotiate the relationship between religious and public structures, incarnate the values and articulate the horizon language through which the relationship lives.

Clergy are only a small fraction of this leadership, perhaps most important in terms of how they nurture lay people across many fields who can be boundary leaders. If a critical mass of these leaders exists, almost any theoretical structure will work. If they do not exist, the cleverest collaborative relationships dissolve in enmity. How religious congregations raise up these leaders is, perhaps, the most important point of intersection between faith and health disciplines, for if public health science is to be believed, the sacred ground for both turns out to be at the boundaries.

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