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Title A Partnership for Healthier Communities: Health Professions Schools, Seminaries, and Faith Communities

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Background This article was published in the Summer 1998 edition of *Partnership Perspectives*, the peer-reviewed journal of Community-Campus Partnerships for Health. The article outlines IHP's *Faith Health Consortium*, a ground-breaking initiative that brought together schools of public health, seminaries, and faith communities to build collaboration for learning and programming to improve community health. Dr. Droege coordinated the Faith Health Consortium while at IHP.

A PARTNERSHIP FOR HEALTHIER COMMUNITIES: HEALTH PROFESSIONS SCHOOLS, SEMINARIES, AND FAITH COMMUNITIES

The Chamblee-Doraville Ministry Center (CDMC) is an ecumenical agency located in the heart of a rapidly growing multiethnic community in Atlanta. When I stop by to see Sam, the director of CDMC, he's almost always on the phone with a volunteer, one of the international clergy with whom he maintains close contact, somebody from another agency with whom he's collaborating, or someone with a special request. Anybody who serves the public in that region of Atlanta will tell you the community is healthier because CDMC reaches into every corner of that international village like a shining beacon to all in need.

Not content to respond only to requests, CDMC recruited a coalition of 21 multiethnic congregations from a wide variety of faith traditions to improve health in their congregations and the community. Two lay volunteers from each congregations were trained as congregational health promoters. St. Joseph's Hospital placed two parish nurses, each fluent in a second language, to support the health promoters. Students from health professions schools and a local seminary are gaining first-hand experience of a faith/health partnership at CDMC through field education and clinical pastoral education.

This is one of many community-campus partnerships for health in which the community partner is faith-based. This makes a difference on the campus as well as in the community, with seminaries included in the mix of health professions schools. Why seminaries? Because faith communities have a health mission and seminaries have field education and intern programs that place students in the community. The purpose of this essay is to explore the potential of such partnerships to improve the health of communities.

Congregations: Centers of Health and Healing in the Community

Congregations are stable and enduring institutions in the community, even when the only place they can afford to assemble is a home or a store front. They endure because their members want to be there and want their children to be there. They endure because the faith that binds members together is at the center of their lives and gives meaning to everything they do. They endure because their members give freely of their time and money to further the mission of their congregation in the community. No other institution in the community claims such loyalty, which is precisely why they endure when all other social structures crumble.

Many cultural and ideological differences separate congregations, but a concern for health and healing is not one of them. Every faith tradition places health and healing close to the center of its mission. Take Christianity as an example. It tells the story of a world that begins in wholeness, falls into brokenness through self-serving behavior, experiences the grace of healing in the person of Jesus and those who act like him, and ends in a restoration of wholeness that brings harmony and peace. The pattern of this story is not greatly different from that of other faith traditions, each with a mission of health and healing that reflects the heart of God.[1]

Congregations are health places simply by doing what they have always done, long before there were health professions schools or health agencies in the community. Congregations gather people and bond them around common beliefs and commitments. They worship God and pray for each other and the world. They are advocates for family values and social justice. Congregations in some traditions, such as Mormons and Seventh Day Adventists, are models of how faith groups can empower people to assume responsibility for their own health. Research supports the salutary effect that a faith commitment can have on the health of congregational members. That in itself improves the health of the community, even if congregations had no outreach ministry.

Mormons and Seventh Day Adventists were the pioneers, but they are no longer isolated examples. Health ministry programs abound in faith communities throughout the nation. Thousands of congregations have parish nurses on their staff. Health committees are as common as youth committees. Lay people are being trained as congregational health promoters. Community health fairs sponsored by congregations are commonplace in cities of every size. The potential for improving community health through these structures is enormous.

Health ministry in many congregations is focused exclusively on the personal decisions people make to improve their own health. They need a greater challenge. Beyond changing

lifestyle choices, congregations can play a major role in transforming social structures. The fundamental problems we face are moral and spiritual. Congregations have the moral authority and the power of faith to change personal and social behavior.

A small percentage of congregations, less than 10% in any community, are leading the way with outreach ministries to improve community health. The needy in any community will tell you where they are located. These are the congregations that feed the hungry, sponsor refugees, house the homeless, fight for social justice, and care for the sick in body, mind and spirit. They are the congregations that collaborate with other congregations, which is why programs for the hungry and homeless are almost always interfaith. They are the congregations that join secular community agencies as advocates for policy change. They are healthy congregations working for a healthy community.

It takes healthy people to make healthy congregations, which is why self-care is so essential. But it also takes healthy congregations to make healthy communities. Healthy congregations are concerned about more than the health of their members. They understand their health mission as broadly inclusive of all humanity, including those not yet born, but they will concentrate on improving the health of those within their reach. I know of no congregation that would not trumpet this as the ideal, but only a limited number serve as exemplars of the lofty mission.

What Health Professions Schools Can Learn from Faith Communities

Health professions schools are not likely to even consider what they have to learn from faith communities. If health is the issue, they are the experts. They know the science. They know the strategies for improving health in the community. They know the outcome studies that show what works and what doesn't. With an elitism that borders on arrogance, health professions schools tend to view congregations as nothing more than a community base for implementing health programs and research projects they have designed for the public good. Quality programs and research are needed, but health professions schools can learn much from congregations about the nature of the public good and how to avoid an approach to communities that is often perceived as manipulative and self-serving.

First, congregations can teach health professions schools the value of trust and commitment in improving community health. Ultimately trust in and commitment to God empowers congregations to attack the social ills that lead to broken communities. Penultimately congregations know that mutual trust and commitment must be the bedrock of partnerships to improve community. Communities in general, and faith communities in particular, are fed up with academics who are more interested in publication and institutional advancement than they are the public good.

Health professions schools can also learn from congregations that stable and enduring service organizations, not time-limited projects dependent on external funding, build healthy communities. Congregations are often the last surviving social institution in communities were poverty and its attendant social problems breed crime, violence and feelings of hopelessness.

Social programs come and go, many quite excellent in addressing particular problems, but usually with a life span no longer than the external funding that keeps them going. Paul Wiesner, nationally known director of the country board of health where CDMC is located, warns anybody who will listen against pouring money into free-standing community projects. Enabling healthy congregations to build healthy communities is a goal that health professions schools might well consider as one of the most effective ways they can use their expertise in program development and research.

A Faith-Health Consortium of Seminaries and Schools of Public Health

An example of how health professions schools can work collaboratively with congregations is the Faith and Health Consortium (FHC) recently established by the Interfaith Health Program of The Carter Center. The Consortium consists of five schools of public health in major universities (Berkeley, St. Louis, South Carolina, Pittsburgh, and Emory), each linked with one or more seminaries. The purpose of the FHC is to encourage faith/health course offerings with a service learning component and research of faith/health practices in the community.

The Consortium is a community-campus partnership with a unique focus on the link between health and faith at both theoretical and practical levels. The spiritual dimension of health has received considerable public attention of late, so much so that almost everybody is aware of research that shows the salutary effects of spirituality on health. The contribution of congregations to community health has received little attention and is the particular focus for the FHC.

Both seminaries and schools of public health have a practice base in the community. Both generate field education and intern opportunities for their students in the community, but seminary and public health students rarely have any contact in their respective placements. The purpose of the FHC is to create opportunities for cross-professional training at faith-based service organizations and congregations. Seminaries are natural campus partners for faith-based community organizations, but schools of public health belong in the partnership when health is the focus and community health the goal.

The value of such collaboration is obvious. Seminarians can help public health students understand how congregations work, how they relate to the community, and what they have to contribute to a community-campus partnership. Public health students can help seminarians understand public health science and strategies, the value of outcome studies, and key factors contributing to community health.

Collaboration on the campus and in the community will prepare current and future religious and health leaders to look for opportunities to work together for community health. Everybody agrees that collaboration among community organizations is essential for improving community health, but we know very little about the kind of research needed to measure the effectiveness of community collaboration. This type of research fits particularly well in the

context of a faith/health community-campus partnership, and such research is sorely needed if we are to be successful in improving community health.

Though the FHC has not been in operation long enough to generate new examples of faith-based community-campus partnerships, St. Louis University's School of Public Health (one of the five FHC sites) has an existing program that models the type of partnership the FHC will encourage in schools of public health and seminaries throughout the nation.

In 1993 Saint Louis University School of Public Health (SPH) joined with Whole Health Outreach (WHO), an ecumenical group of rural citizens, in a family health faith partnership. WHO began in 1989 as a parish nurse program in local Catholic churches but has expanded its services to a constellation of family health education and promotion services within ecumenical ministerial alliances. The SPH provides lay health worker training for WHO volunteers, program development and evaluation, grant writing, computers and training, as well as student interns and staff support.

The education objective of this partnership is to strengthen public health education at Saint Louis University in the areas of community-based family health promotion and violence prevention, reflective practice with a social justice orientation, and interdisciplinary approaches to the public health needs of the poor and underserved. The service objective is to prevent child abuse and domestic violence and promote healthy families in rural south central Missouri, a four county region sparsely populated, medically underserved, and economically depressed. The collaboration objective is to network with existing coalitions, agencies, and individuals to support WHO and its partnership with the SPH.

The accomplishments of this collaborative effort include: interdisciplinary seminars and field placement, implementation and evaluation of family violence prevention and intervention programs (school based violence prevention, Resource Mothers Program, women's shelter programs, coalitions and community education), and development of an integrated approach to health education (focusing on nurturing children from conception to age four years).

At the heart of the WHO/SPH partnership is a shared purpose by all participants to live in solidarity with the poor as an expression of a vocation to love and justice. Hope sustains and gives meaning to the daily commitment of faith required to renew life in a community permeated by violence and to promote healthy relationships at all levels. This faith component in a community-campus partnership, so essential in combating violence and promoting community health, will receive special attention in the FHC. How are virtues like hope, faith, and strength of purpose nurtured in a community? How can faith-based groups be integrated into collaborative efforts to improve community health? What are the outcome measures for evaluating the effects of virtue and the significance of participation by faith groups in collaborative efforts to improve community health?

In the conclusion of an essay describing this program, Sharon Homans makes a comment about relationships between campus and community that can serve as a guiding light not only to participants in the FHC but to all community-campus partnerships:

This partnership differs from research-driven community health promotion in that the relationship did not begin with the university team holding most of the resources and the community sharing in those resources as the research subject. The advantage of a research partnership is that well-designed intervention trials can be conducted using rigorous research methods. Incorporating well-designed research, which can be generalized to other communities, into partnerships such as the SPH and WHO partnership is more difficult. However, research is not the only function in this partnership; research is one component of the education function. Service and collaboration are equally important functions along with graduate and professional education.[2]

Recommendations to Promote Sustainable Partnerships between Health Professions Schools and Faith Communities

In the next few years the Faith and Health Consortium should produce valuable learning about how to promote sustainable partnerships between health professions schools and faith communities. However, the basic principles of mutual trust and commitment seem clear, and the following recommendations embody and give expression to these principles:

- Consult with a nearby seminary on how best to approach congregations and wherever possible include them in the proposed program and/or research project.
- Approach congregations as full partners in whatever community project is envisioned.
- Include congregations in program and research planning. Look to them for assistance in identifying the spiritual dimension of what is being explored.
- Include a training component in research design to teach congregational leaders the value of outcomes measurement in assessing the effectiveness of their health programs.
- Celebrate the success of programs with rituals of affirmation and hope.

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1. For documentation of this thesis, see Lawrence E. Sullivan, ed., *Healing and Restoring: Health and Medicine in the World's Religious Traditions* (Macmillan: New York, 1995).

2. Sharon M. Homan, et al, "Promoting Family Health and Violence Prevention in Rural Missouri: Linking Grassroots and Academe in a Faith Based Partnership," *Health Education and Behavior* (future issue)