EMORY | ROLLINS SCHOOL OF PUBLIC HEALTH | Interfaith Health Program
Hubert Department of Global Health

Title Promoting Health: Challenges for Faith Organizations

Author Fred Smith

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Background Dr. Smith was the Associate Director of the Interfaith Health Program following the retirement of Dr. Droege. He presented this lecture at Yale in the late 1990s laying out more explicitly the connections between IHP's work, a Christian vision of social justice, and the legacy of the US Civil Rights Movement.

Note: The text below is transcribed from an audio recording of Dr. Smith's lecture. The transcription attempts to capture both his words and the questions asked by audience members. However, there are a few points where this is not possible due to the quality of the recording.

Intro: "...shuffling back, up and down the hill. The individuals at the Divinity School thought I was nuts. They couldn't figure out why there should be a Public Health approach in ministry. The individuals in the Public Health school thought I was nuts; they couldn't figure out what faith had to do with anything. And why would someone want to have spiritual health, spiritual life integrated with physical health? It just didn't work [for them]. So I'm happy to know that fifteen years later there is somebody who—those of you in this room in particular—who know about the connections, who can confirm (at least on that issue) that I'm not crazy. Others might say something a little different. But I'm pleased to introduce Fred Smith. We met about five years ago through some work that he and I were both doing with the Children's Defense Fund. At that time it was a focus on children. Then we met again and had a conversation about substance abuse. And I was impressed with him because it seems as if he was able to make connections between those things which are spiritual and those things which are natural, or human—everyday-like. We have been in and out of touch with each other over the last five years, more out of touch than in touch...that's the way those things go. So when we wanted to talk about spirituality and health and what the role of faith was in health, I thought that he was a good candidate because he has been working both at the Carter Center and other **[???]** with interfaith collaboratives around substance abuse and violence in children, [and] that he would be at least a good person for her to talk to. I was pleasantly surprised that the invitation was extended to him. You have a copy, or at least a summary, of his experience and some of the things he has done over time. I think it will be an insightful presentation from him; I'm glad that he's here to have a conversation; and he should give confirmation that I'm not crazy on the issue

of faith and health. But he will come with a presentation."

Fred Smith: Of course you have to know that what I am before I am anything else is a minister of the Gospel of Jesus Christ. I've worked for the Interfaith Health Program, and I respect the faith of everyone, but to me to be interfaith means that you also appreciate and affirm your own faith without belittling or denying anyone else's. So I would like to begin, if you don't mind—it is my custom—with a word of prayer:

> Heavenly master, thank you for this opportunity for us to gather together in this place. Thank you for the opportunity for us to share ideas and concerns, that we may further the development and further the bringing and the making of *Shalom* here on earth, now. Amen.

I want to do several things today. (Ordinarily you would find me moving around, but my boss demanded that we tape this session. So I'm going to try my best to spend as much time as I can behind this podium.) I want to do several things. One, I'd like to give you an overview of information of the Interfaith Health Program, formerly of the Carter Center. Then I would like to discuss with you the concept of health that we are—not developing, but that we are coming to the realization of, and as a matter of fact we have changed our mission statement as it relates to that. Then I want to talk about a new focus that we want to move towards as it relates to the Healthy People 2010 goals. Then I would like very much to entertain questions. I'm an educator, and I'm a dialogical educator, so I am much more comfortable in dialogue than I am with presentation—not with preaching, but with lecturing. [Laughter in audience.] So to prevent me from preaching today, I hope for us to spend as much time as possible in dialogue around questions that you have, and I will do my very best to try to answer those, or at least to facilitate a conversation among ourselves that could get to those points.

The idea of the Interfaith Health Program began in 1987 as the Nation began to debate the Healthy People 2000 goals. One of the questions was, how do you deal with the gap between the "have's" and the "have not's"? How do we help hard-to-reach and underserved populations to achieve the goals that have been set forth for the Nation? President Carter at that time, as well as Bill Fagey, who was the former head of the CDC under President Carter, and at that time the Director of the Carter Center, felt that one of the ways in which this could be achieved is through challenging the faith community to step into that gap. And so they developed a conference at the Carter Center around 1989 where some 300 different denominations and faith groups, as well as people from the public health service and county and state health departments who were interested in achieving those goals, came together to begin to explore what were the possibilities, what were the ramifications of bringing together the faith community to achieve the Healthy People 2000 goals, especially as they related to those who were underserved in our Nation. As a result of that dialogue—we brought together Hindus, people from the Muslim faith, as well as Christians, Catholics, and so forth, to discuss what that meant. One of the things we discovered [was] that at the root of almost every major religion in the world is a concept of wholeness, a concept of wholeness that is also the concept that the World Health Organization and other people begin to talk about health in a more holistic way. We thought and we believed in at that time that there was some intersection, some limited domain of collaboration was possible

between faith entities and public health entities.

Also interesting and [something that] had not [previously] been was that many people at that conference had not had opportunities to discuss, with people of other faiths and people from the public sphere, the issues of health. In fact even more alarming [was that] people in the faith community, even in the same denominations, had not had opportunities to share that kind of information. So they felt that it was necessary to have a place where this could happen. Many people believe that the Carter Center, being on neutral ground and which had the respect of many people, was such a place for that to happen. And so with funding from the Robert Woods Johnson Foundation, the Interfaith Health Resource Center was created. And its mission was to identify best practices by faith communities, as related to health, and to disseminate that information as broadly as possible. Well, what happened was that our director happened to be a person who was very much involved in the movement to address hunger in the United States; in fact, [he] was the creator of *Seeds Magazine*. I myself had been working with the Southern Christian Leadership Conference and had been very interested in movements, the Civil Rights Movement and others. So we thought right away not in terms of programs, but in terms of movements. What we began to discern was that around the country there was a lot of activity beginning to bubble up—this was in 1992, 1993—around faith and health. Granger Westburg in Chicago, the Parish Nurse movement—all these things were really beginning come into fruition. So we asked a question that H. Richard Niebuhr asked: What's going on here? That became our question. We wanted to first identify what was happening, what was going on. Is there a faith and health movement? And so in the first two years of the organization we convened some 40 meetings in 40 different cities in metropolitan areas around the country. We would bring together a group about this size—30 or 40 people in the faith community from state, county, hospitals—who we thought [knew if] something was going on in that community. We began to convene those groups, and we found one of the greatest tools that we had was the ability to convene, the ability to bring people who wouldn't ordinarily come and sit at the same table, at the same table. What we found was a similar experience [to what] we had at our larger conference, that people had not been in communication with one another. There were all sorts of exciting and great things happening in different locales that other people knew nothing about in that same situation. What we also found by that, because when we did that, people wanted to continue to meet. So very often what happened was a council: the Faith and Health Group began to pop up all over the country, just as a result of our convening those meetings. At the end of the two-year period, we had some 100-150 people that we called our Circle of Colleagues. We had some sites that we determined around the country were really involved in the collaboration of faith and health. And so we said, "Yes, there is a movement going."

What was the next step? Well, what would continue to move us? What would help the community grow? So the next phase of our operation was to determine what was the infrastructure necessary to maintain a faith and health movement. We began to look. The first was evaluation…accountability. You had two very different systems: a science-based public health system that was interested in quantification of outcome and measurements, and you had a faith-oriented value-based organization—faith organizations who were very interested in making sure that they achieved the values on which their organizations were based. Very often times there were two different meaning systems, and very different languages being spoken in terms of

faith and health. So how then, do you hold one another accountable in collaborative efforts? And so we began a process of trying to identify cutting-edge evaluation and accountability technologies, or methodologies that can be used to measure faith and health collaborative work. One of the faith and health articles that you have in front of you today, the one with all the pictures on it, is a summation of that work over the last three years that we've been doing [on] faith and health. We found that in a faith community, people told stories; people testified; people did anecdotes, and that was the measurement of our success. We found in many hospitals and county health departments, they want the numbers. They want to quantify success and outcomes. So what we have been trying to do is find ways in which to quantify stories, to take qualitative and quantitative measures together that would be acceptable to both entities. And we've been working with the Pacific Institute of Research and Evaluation, Barry Kibble's work on *Results Mapping and Outcome Engineering*, one of those methodologies and techniques. In order for collaboration to happen, we have to learn to talk to each other; we have to learn to hold one another accountable. So much of the work that we've been doing over the last three years—and this is what I do. I am a coordinator of our whole community's collaborative. We [have] about 50 sites around the country where we have been trying to institute these measurements and pilot these kinds of issues, programs, and collaborations.

The second pillar of infrastructure that is necessary to maintain the movement of leadership that we found [was] that where faith and health worked and where these collaborations were successful, you had people in leadership positions who understood and were very interested in the work of faith and health. This includes pastors; this includes people in the county health department, people in the hospitals. In order for it to happen, people had to have understanding of how health related to faith and how faith related to health. So we developed what is called the Faith and Health Consortium. We work in the Pacific School of Religion, the GTU at Berkley, and the Berkley School of Public Health. We developed one in Pittsburg Seminary and the University of Pittsburg School Public Health. I facilitate the Atlanta Consortium that is made up of the Rollins School of Public Health, the School of Nursing and Division of Religion, as well as the Candler School of Theology, the Interdenominational Theological Center, the Morehouse School of Medicine, and Columbia Theological Seminary. We work together; we come together. Professors are appointed by their President to the working group, as well as other interested members of the community. Community is a very big part of that as well, and we try to develop interdisciplinary coursework, as well as to further and ask research questions to deepen our understanding of faith and health. The idea is that the outcome of that would be [that there would] be more believers [chuckle, chuckle], you know, who have a deep appreciation of health as it relates to their faith—not as separate entities, but actually integral to one another.

In fact, when we began our program we had five goals in mind. We called them gaps, the Five-Gap Analysis. Anytime we went into a site or a city, these were questions that we brought to it. One is that everything that we need to know, much of what we need to know about health is already known but is not generally applied. So there is a gap between what we know and what we apply, or what we do. I mean, you can eradicate—the Carter Center has a disease eradication program where we can eradicate whole diseases just by applying knowledge that is already known. The second was that there is a big gap between what almost every faith community

believes is the essence of their faith and what they do. [Laughter in the audience.] So there is a gap between what we know and understand as our faith teaches us and what our actual ministry to the world is. That's gap number two. Gap number three is that there are models of excellence all over the country, you know, around faith and health, but they are not generally applied. We call this "bringing to scale," that if you can identify some interventions or some health models where what needs to happen is not to create new interventions or new health models, but to take the ones that you have and bring [them] to scale to make them generally applicable. Gap number four was that we found that there are many faith communities doing all kinds of exciting things, but they are doing them in isolation. They don't publicize what they do; they are very turf-oriented. So you have people that we found in the same city doing very similar things, but they work in isolation from one another. One of our main tenets is to increase collaboration within faith communities and with others in the area. The [fifth], which is a more philosophical issue, is that there is a very big gap between our present wants and our future needs. People are not future-oriented in the decisions that they make today, such as relates to health and other issues [like] ecology, and so forth. This is one issue that is very much lacking, and so one of the philosophical stances that we take is to help people understand that the decisions you make today, how it's going to impact future generations as it relates to faith and health. So this is sort of the operative scheme that we've been operating under so far.

Well we're at a junction or a turning point now in our program. First of all, why our program has been—I use the word—"successful," is that we have been institutionalized. We're no longer at the Carter Center; we're now a program of the Rollins School of Public Health. We've been moved from the Carter Center, some soft money, to the Emory School of Public Health, so that we're now a program in—an endowment has been filed for a Chair in Religion and Health at Rollins. So now I am a faculty person at the School of Public Health, but also at Candler School of Theology where I teach Christian Education and ***[???]*** education. The big significance for us as we began to do our work is that the health language became very limiting. To use the word "health," we know what it means—some of us know what it means, but it means different things to a lot of different people. And many people, especially in the faith community, see health as totally outside of the realm of what it is they need to do. When I first got into the work, [at] one of the first meetings that I went to somebody explained to me, "You know, we've got to get those preachers to do something more than save souls. All they want to do is sit around and pray." I said, "HEY!! Hold it! Let 'em keep prayin'! Let 'em keep saving souls!" Because what we have found is, and the research bears it up now, is that people who go to church live longer and are healthier. Scientific double-blind studies have shown that prayer—and this is what the scientists had to find out—that prayer really does work! So that when people pray, they're not doing nothing, they're doing something that now has scientific verification that it actually happens.

One of the things that we need to begin to understand, need to think about [and] talk about, is our language. What do we mean by health? One of the things that has happened that has been on my heart and my soul, is that when we talk about healthy communities, when we talk about urban health, when we talk about developing the collaboration between faith and health, language is a crucial issue. And so one of the issues—I was with a friend of mine; I call him my personal rabbi, Barry Kibble. He's actually a sociologist and all this kind of stuff. One

day we were sitting and talking—he's the one who helped us develop our evaluation work. We were sitting around talking and he said, "You know, Fred, in the Hebrew tradition people were more oral than they were visual. The Greeks, you know, brought the visual thing." But he said, "In the old days, the Rabbis, when they were speaking The Word, sometimes they would go into catatonic fits, just by the power of the spoken word." Take the word *shalom*, for instance. Real power, because *shalom, sha-* means "the power of God," "the fire of God," and *–lom* has to do with the water of the earth. So you take *shalom* and—plghth—ground it in the power of the earth, and that's peace. That's wellness. Now look at that word *shalom*. One of my favorite scriptures is Jeremiah, the 29th Chapter. This is a very important scripture, because here you had people who were in exile, people who had been taken captive and placed in a foreign city. And many of these areas I go into, many people there are captive. They are foreigners in their own cities, you know. And health, when you look at it, especially from a public health perspective, you are talking about people who want to get out, people who are doing everything to get out of their city. I mean, they're not concerned about their own cities; they just want to make it so they can escape it. And as Judith Wilson coined, people who are left behind are the truly disadvantaged, because as soon as people get enough education and enough money, they move out and leave the infrastructure, leave the poorest of the poor behind. And so this was very much like the situation of the people who were taken captive into Babylon, the ones who escaped. And the prophets were telling them any time, now, they could leave. And I'm going to read—here is the advice that Jeremiah gives them:

> What you need to do is to build houses; then marry and have sons and daughters.

You'll notice he says "*Marry*, and *then* have sons and daughters." Not, "have sons and daughters and then marry." [Laughter in the audience.] (I work in, you know, teen pregnancy and stuff like that, too.) [Chuckle, chuckle.] But then he says:

> Give your sons and daughters in marriage.

And then he also says:

> Plant gardens and eat the fruit of those gardens [economic development], but above all, seek the peace, seek the welfare of the city. Because in its peace, in its welfare, you will receive your own peace and your own welfare. Pray for the *shalom*, for the welfare, for the peace of the city.

So I began to look at that word *shalom*, that fire of God that's grounded. A book by Perry Yoder**,** *A Shalom: The Bible's Words for Justice, Salvation and Peace.* Look at that word. He found that in the Hebrew Scriptures there are three very different meanings, very different inflections of that word. One of them had to do with the material realm, had to do with prosperity and health. To be *shalom* means to be able to pay your bills and not have folks calling you up day and night, stressing you out. To me *shalom* means to live in a house that is not lead-infected and that has enough heat in the wintertime and air conditioning in the summertime. To have *shalom*, you know, means to be able to have proper nutrition, to have the proper food and

not have to worry—prosperity. *Shalom* means physical health and healing. It means to be healthy, to be whole mentally and physically. These are some *shalom* issues, but also *shalom* also means social relationships. It means just relationships. A big part of the Hebrew Scriptures is dedicated to talking about the oppressed and the poor. You know, racism and sexism and ageism all contribute to the detriment of our health and our well-being. So *shalom* also has to do with social justice. But also *shalom* has to do with straightforwardness, speaking the truth, moral integrity, righteousness. So *shalom* has to do with our own personal character—I like to call the word "moral integrity." And so when you talk about for us and for me the word *shalom*, to seek the *shalom* of the city is a challenge that the church has toward promoting health, and that is to seek the economic well-being of the city. It means to deal with the issue of racism, to deal with the issues of sexism and ageism, and every other kind of –ism that disrupts social relationships and social well-being. And it means to help people to come to be able to know and to speak the truth and to have more character and honesty. All those things to me, *all* those things mean health, but it's a broader, spiritual, holistic understanding of health than is at the very center of most of our—not all of our—religious understandings and self understandings of what our teachings are. And so this is where I want to move to.

Now, one of the things that was very important to me as I began to study that, is I began to look at some of the work of Aaron Antonovsky who looked at survivors of the Holocaust. What was it that helped people in the worst, most captive situations be healthy? And as you know, he developed the notion of the sense of coherence. For him, a sense of coherence had to do with the disease spectrum. People who had a sense of coherence had less stress in their lives. Now really he was one of the fathers of the wholeness, or the well-being movement. And people began to think about that only in personal in terms. People began to think about wholeness and well-being as something that emanates from the inner self. Well that's true in a way, but that's not the whole story. Because the inner self is set in a context, set in an environment, and a person's relationship to their environment has a lot to do with their ability to generate health individually as well as socially.

Now from here we looked at it systemically. One of the last articles that he wrote in 1992 looked at what he called, what I would call, what he called, what everybody called, "salutogenesis" where there are five aspects—I think it's very important as we move toward these Healthy People 2000 goals I'm going to get to. One is the relationship between the self and the environment. Are people integrated in their environment or are they isolated in their environment? That's very important. If people are integrated—you know what I mean by integrated? That means that the school system works for you, that the medical system works for you, that the economic system works for you and you don't feel that you are estranged from those major systems that have such an impact on our lives. That makes for health.

The second is the communication from these environments to the individual, messages about health, about smoking, about economics, about education. Is that information that I can use or are you just talking noise? If it makes no sense to me, and if I'm isolated from the community, and if my culture is incomprehensible, and I'm a part of the histomatic system, then oftentimes the information that's communicated by the larger world, the larger system, is nothing but noise. And you wonder why you get non-compliance when the doctor tells the person to do something. You wonder why African-Americans and others are not interested in participating in

church projects because of the Tuskegee Institute and other things. Because the information, because the isolation and economic boundaries and other things are not doing anything but talking noise. You know what noise is? Noise is my son's rap music! [Laughter in the audience.] I don't understand it! It makes no sense to me—I want to hear the Temptations, not noise! [More laughter.] And the other part of that is internalization of that noise. What happens when you hear noise? I get mad; I get fidgety; I get anxious. Well, you get information to use. You get integrated because it settles you; it equips you to work.

Now, the other part is output. Once a person has internalized the messages from the system, then they have to respond, as in output. A lot of that is based upon the resources that are available to you to respond with, as well as your ability to integrate the information. So oftentimes output people are isolated and do not meet the criteria that the environment has set for them, so they wind up in jail. They wind up poor; they wind up in poverty; they wind up captives in their own cities.

Then what is the feedback then, is the final part of that program. What is the feedback? If you do the similar type of output that goes along with the information that you received from the system, it's positive. If not, it's estrangement, or being totally ignored, benign neglect. For me, these are the essence of what makes for *shalom*. These are the areas of intervention that need to happen for that. The interesting thing about what we're going to now with Bill Clinton and the new initiative of Healthy 2000 goals is eliminating racial disparities in health. You all are familiar with that. Those are the goals that are happening. And they have all kinds of interesting disease categories that they deal with, obtaining information, cultural competence, and so forth. But the fact is, one of the reasons why they do that is, if you look at the health statistics, African-Americans in particular, Hispanics as well, are at the bottom of almost every health statistic there is. People say that's because of class. Well, if you look at the studies, look at the research, even when you control the social economics, you can *reduce* that disparity, but it doesn't eliminate it. So there's something else that is going on there.

Some of the work that is done by Ernest Johnson down at the Morehouse School of Medicine really turned me onto this. When he did his dissertation, he looked at—he did a lot of studies on—the issue of anger and anxiety in its relationship to physical health. And he said it's a risk factor just to be black in this country. That did not hit home to me until I went over to Africa and met a friend of mine who was from Dallas, and he said he had to go back there; he had to go back after being in Dallas. I said, "Why?" and he said, "Because I got tired of thinking about being black every day." You know, there are situations that people live with, many of us live with, as part of every day life that [are] anxiety-making—you know, discrimination, and so forth. Even if it's only imagined, the setting is set that breaks that issue of coherence. You know, that happens. The studies that he is doing is that what you find out is that people have life events. When you are poor, when you feel that you are discriminated against, you have life events. You have expressions of anger that increase the blood pressure, that make you more susceptible to stroke and to high blood pressure and to hypertension. So it's not a genetic issue; it's an environmental issue. It's an issue of racism itself that is important that we're going to have to deal with. One of the challenges, then, of the church [is that] that's an issue that we're going to have to deal with.

I want to continue with that. One of the things that I am working on, that I have been

interested in, is the notion that's going on about reconciliation, the discussions about apologies for slavery and reparations. What does that have to do with health? When I went down to the coast of the Western Cape in South Africa**,** first time I was there, and I sat in those dungeons where they collected my forefathers and foremothers, and when I heard the stories about that some biogenetic thing in me was triggered; emotions came out that I had no explanation for. Those emotions are in every one of us. So this is a social issue. It's social justice issue. It's an issue of reconciliation, and when we look at the scriptures from a Christian perspective, and many others as well, one of the purposes is to break down the dividing walls that are between us, to bring them down and reach reconciliation based on justice. The Templeton Foundation now is spending $10 million on forgiveness research, because what they are finding is that unforgiveness causes heart attacks, causes hypertension, causes all kinds of disease and so forth, sleep disorder—unforgiveness. I think that in many of us, many of us who are African-American, Asian, Hispanic, whose past wrongs in this country have not been addressed and dealt with, carry around with us the seeds of our own health problems. [I'm] not blaming the victim, but it's a part of an unresolved issue of social making. It is a problem of *shalom*. It is a problem of peace in the deepest sense of understanding of peace. It's a problem of economic bondage and slavery that continues even to this day in many parts of our country. It's a problem of not having all of humanity recognized and an apology…Tony Hall in congress is putting forth a proposal in Congress to do a reference, an apology for slavery from the U.S. Congress. He is catching all kinds of hell. And people say, "What difference does that make?" But if you look at it, if you talk to many, it makes a great deal of difference. When you apologize to someone, you've said that you are human, that you are a fellow human being. I think that at a deep level it makes a difference. Reparation—it's more symbolic, because you could never pay for what has happened, but to make positive statements—and that's what *shalom* is, is to make it whole again. Perry says, *shalom* means everything is all right, means okay, means things are as they ought to be.

We talk about, what is the vision for health? I like to go back to the Garden of Eden, you know, that was destroyed when human relationships were destroyed. Or to the future in Revelations, where it talks about God's throne, God's power, God's throne based in the center of the city; and a river of light flows from the throne; and the tree of life grows on either side of the river; and it bears its fruit every month; and its leaves are good for the healing of the Nation. This is the vision of the water that flows from the sanctuary outside the gates down to the Dead Sea, the lowest place in the world where nothing lives, and the water is becoming fresh again, because the spirit of God—spirituality, the spirit of God—flows into dry and dead places and brings life again. To me that is the work and the challenge of the faith and health movement. It is having volunteers. It is having facilities in which to do your programs. It is doing nutrition studies. It is taking blood pressure. It is all of that, but it is also dealing with human relationships. It is also seeking justice. It is also bringing life to dead places. To me, that is what I mean by faith and health. That's what I think a relationship between spirituality and health is. And I think this is what the cutting edge—we're only at the tip of the iceberg of the faith and health movement now. Much of what we're doing now is very rudimentary. But we are moving toward points, and we're really understanding what health is and what the genesis, what the real determinants of health are. And when we really look at those things we can really

see what roles that the faith community can play in bringing health to the larger community. And I'm not just talking about the Christian church; I'm talking about the Muslim church, the Jewish, Hindus, Buddhists. We work with all these different groups, at some levels Nirvana, the oneness of all, you know. All of these things are important for us as we go forward. Amen.

Question: One thing I have noticed is that you haven't mentioned the word "government." I'm wondering, what do you see the relationship being with, like, the Department of Public Health?

FS: Yes, well see that's our work. We develop partnerships between Public Events and Forums in South Carolina. We work with the State Department of Public Health in developing—they're doing a 2000-church survey finding out what faith communities are doing and developing partnership. In Atlanta I work with the State Department of Public Health on team initiatives, where we are looking at developing a contract—right now it got kicked down by the Attorney General but we're still going to do it—where we're going to be, again, identifying what the capacities that faith communities have for healthy youth development work. In the Bay Area I cite the two county health departments actually funding the work there. So that our prime objective, our "prime objective"—sounds like an episode of Star Trek [chuckle]—is to develop, is to identify, delineate, and find ways in which to work with the Federal Government. That's why I talked about the Healthy People 2000 goals, because the genesis of our project was with the Federal, and then State and faith communities around achieving common goals.

Question: I noticed in some other publication they talked about a soup kitchen—uh-huh—something—uh-huh—substance abuse, job transfer, and that's a transition that a group that I work with in something community-type setting, and I'm interested in finding out about other churches, or other, say, faith organizations that are doing work of that sort. Do you have websites or databases?

FS: —Exactly. Look at the back, if you look on the back of, you know, you'll see HIPnet. In fact, that's a good source. We have a book called, *In Every Congregation*, ***except you don't have one [???]*** here, right now, but that tries to identify, that identifies what we think are some of the best practices in faith and health. We also have a discussion group on listserv going on where we have national conversations—actually it's international now—talking about faith and health and identifying who's doing what. Right now we're looking at training is how our discussion is going now, but we've looked at other different issues as well. So on the back, if you plug into our internet site, you both find all the documentation that we do, but also can become part of our ongoing conversation, with both scholars—because we have scholars—as well as people who are practically in the field. And what often happens on that site is somebody asks a question. "Do you know somebody that's doing so-and-so?" And you get a response from people around the country, even around the world now, on what's happening in that area. But yes, our initial, again, mandate was to identify those sites. I can talk about one of the programs that I am working with in Atlanta is called Atlanta Health Ministries. And you'll see that in that site. In one of these publications it talks about the health ministries that we're doing

in Atlanta. In fact, I'm the Director for the Atlanta Health Resource Center that works with about a dozen churches who are trying to find ways in which to do youth ministry. Okay, we just mentioned development project; we have outreach work with the homeless population. In fact, I was planning on telling you today, we have a parish nurse that's assigned by a hospital to a group of African-American churches who are going to start training homeless people to do blood pressure screenings. And then we're going to move on to help them do to other things within the homeless communities, and so forth. We have a soup kitchen; we still have a soup kitchen, and we still have a clothing closet. Now we're going to start with the health and then we'll begin to mobilize them to do it. But there are a lot of things going on all over the country, and the issue is that question, "Do you know?" and how to take it to the next level.

Question: Some people something about a publication…

FS: Yes, once I go back and I'm going to ask Wanda to call our office and we can send a supply of publications up. But yes, but the one site located on the back is IHPnet, www.IHPnet.org. And you can request there; you can become a part of our ongoing conversation, and one of the things we do is we document very well, so we have a number of different publications on many different areas in this field that you can plug into.

Question: I'm interested in [something] and I was wondering if you could talk a little about your experience in that and what you do when certain faith beliefs kind of contradict what is normally thought of as public health measures.

FS: Yes, well one of the things that I first emphasized is that you don't need to get every congregation involved to make a difference. In fact, what is Biblically true is that it is the remnant that makes a difference. So we say that if you get ten percent of the congregations to do the work that needs to be done, then you've done a lot, that's first of all. The second is, one of our principles is called Many-Domain Collaboration. There are some things that we won't agree on; we just won't. And so we don't even try to collaborate on that, and we don't even try to change people's minds about it. But there are some things that we do agree on. We do know that abstinence works. And you won't find many churches that argue with that, okay? So, in fact in Georgia they've done an abstinence curriculum that the State fosters. And churches will walk with you on that. I've found that if you can get them to walk with you on something we all agree on, then you are more likely to get a hearing of things you don't agree on. So this issue of building relationships, not trying to convince somebody of the rightness or wrongness of your position. I would begin first of all with those who are willing to work with you on any area, you see, and that was our approach. The reason we are working in Georgia is because folks got in fights about passing out condoms to avoid teen pregnancy, all that kind of stuff. Instead of fighting with the churches about this let's first of all let's find out what churches are already doing to prevent teen pregnancy, 'cause they're doing a lot of stuff. You know, let's find out what their capacities are for doing more. And then let's try to find what institutions that can help churches to do more. And then eventually, we may be able to come to some agreement, at least through facilitation, and we may *not*. But the issue is not what we disagree on; the issue is what

we do agree on.

Question: It seems that there is often a breakdown when people start to think about the relationship between salvation and health, because health is something which is totally this world all the time. And I was wondering if you might be able to comment on that.

FS: Well I think that's a good point because, first of all, again you don't go out and tell folks they're wrong, but if you begin to do a ***histological [??]*** study on the word of salvation, you see that the root word of salvation is wholeness and health. I mean, that is the root of the word that means "to be saved." And if you look at Biblical studies on the works of Jesus, when you talk about salvation what he saved people from was distress, and oftentimes illness and death. And so a Bible study, not to say somebody's wrong or put somebody down but to really begin to help people understand even better what they're own tradition or faiths say, I think is a helpful thing. Some people you're not going to convince. And you just need to get over that, but some people are open. Many people are open, you know, especially if you begin to speak a language that is common and begin to study and be aware that enlightenment and revelation do still happen. God still talks. He's still speaking. And so what I would say, and I would agree that the other thing is to, let people save souls into salvation because the studies say when they go to church they're healthier; they live longer; they become a part of social networks that can help in a time of illness, and so forth. You understand what I'm saying, that prayer really does work? So there's nothing wrong with folks saving souls. But one of the things you can do is help people understand the deeper understanding of what soul-saving is and what is meant according to their own traditions and scriptures. And that might help open them to revelation, but that's done in the context of relationships, not in adversarial I-know-more-than-you-do, and all that kind of stuff. It comes out of the context of relationships and working together on common issues and issues. I often, I grin when folks say that all preachers do is pray. Well, if that's they do, then I want them to pray some more and get more folks in your church praying because studies have shown that prayer works. So if that's all you can get them to do, then help them to pray for things that you want to happen. Pray for me! No, I'm serious. When we started our substance abuse program with Bishop ***May [??]*** and others, the first thing we did was to get congregations to pray. If that's all they're going to do, then pray well. Really! You know, because it's not a non-effectual thing. It's not doing nothing. It's doing something. But it's hard for churches to pray for something and not do something. It's hard for them not to do that. If you get churches to pray for something, it's hard for them not to do anything. I'm serious. You try it. If you've got a church praying for AIDS ministries, you've got them really praying for it, it's hard for them not to get involved in AIDS ministry. It's very difficult. Now some may accomplish that feat, but it's a very difficult thing to do. So you meet people where they are. And **you** need to understand what really the research is of spirituality, health, and religion. Those are all different things, you know. Spirituality, faith, and religion, and another thing is language. We get really confused about what spirituality is, what religion is, what faith is. Spirituality is that thing that holds us together. It's the thing that connects us, both to ourselves, to other people, to our environment, and to God. We are spiritual beings, whether we are religious or not. When we start to talk about, when we start to act on that spirituality, when we start to trust that spirituality,

that's faith. What we do is our faith, based upon our belief. And when we cognify that, put that in rituals and make a community, then you get into religion. There are a lot of folks in here who are religious who don't think that they are religious but they are religious because they have a history. Many times they have a founding leader; if you're doing Zen Buddhism or yoga or TM, you have a history that you talk about; they have rituals that you go through; you have beliefs and tenets that are part of it, but you're not "organized religion." But you are. There does not have to be an inch of spirituality in religion to be religious. There are a whole lot of folks are religious who are not spiritual, okay, and there are a lot of folks who are spiritual who have no faith, and vice-versa. So we need to understand, and that would be a good thing to do is really understand what is faith. Not all religious bodies are faith communities. Faith is a very specific thing. Some are spiritual communities who offer religion, and then religion is in their spirituality.

Question: I'm sure you can know how this translates from the other end, not just with the churches but working from the healthcare perspective in terms of, when you have people that come to see a healthcare practitioner, you know, and they have 15 minutes to see them, or whatever, and they are constantly reinforced that their health has nothing to do with anything else other than whatever bacterial culture came back from the lab, or whatever. And that is constantly reinforced by our society, by our advertisements, by pharmaceuticals, and, you know, anything. I'm not sure exactly what my question is, but how does that fit into what you are talking about?

FS: Well, it's problematic. Oftentimes you force people to go to two sets of practitioners. One they go to the doctor, and then they go to their minister or priest or their cultural healer. Because there they've only got 15 minutes to get what they've got to give, and then they go somewhere else to get the rest of it. A typical foundation now in medical schools are grants that they've given out so you can teach doctors how to talk to people about their religion and their spirituality. Because as soon as you do that you've created a deeper bond that would make the possibility of healing even greater. So one thing at our Faith and Health Consortium is how do you begin to train doctors to understand the relationship between faith and health, not to mention ministers and so on, so you can at least have a conversation to a spiritual being, which is the person that's in front of you. I think that has to go back to the training, to the schools like this, and the people—and many schools are doing it now. There are a lot of schools now that have training for doctors and religion and spirituality, so you can at least bring the subject up…Not that you have to try to convert anybody or anything.

Facilitator: We are about out of time. Thank you for coming and thank you for your participation.