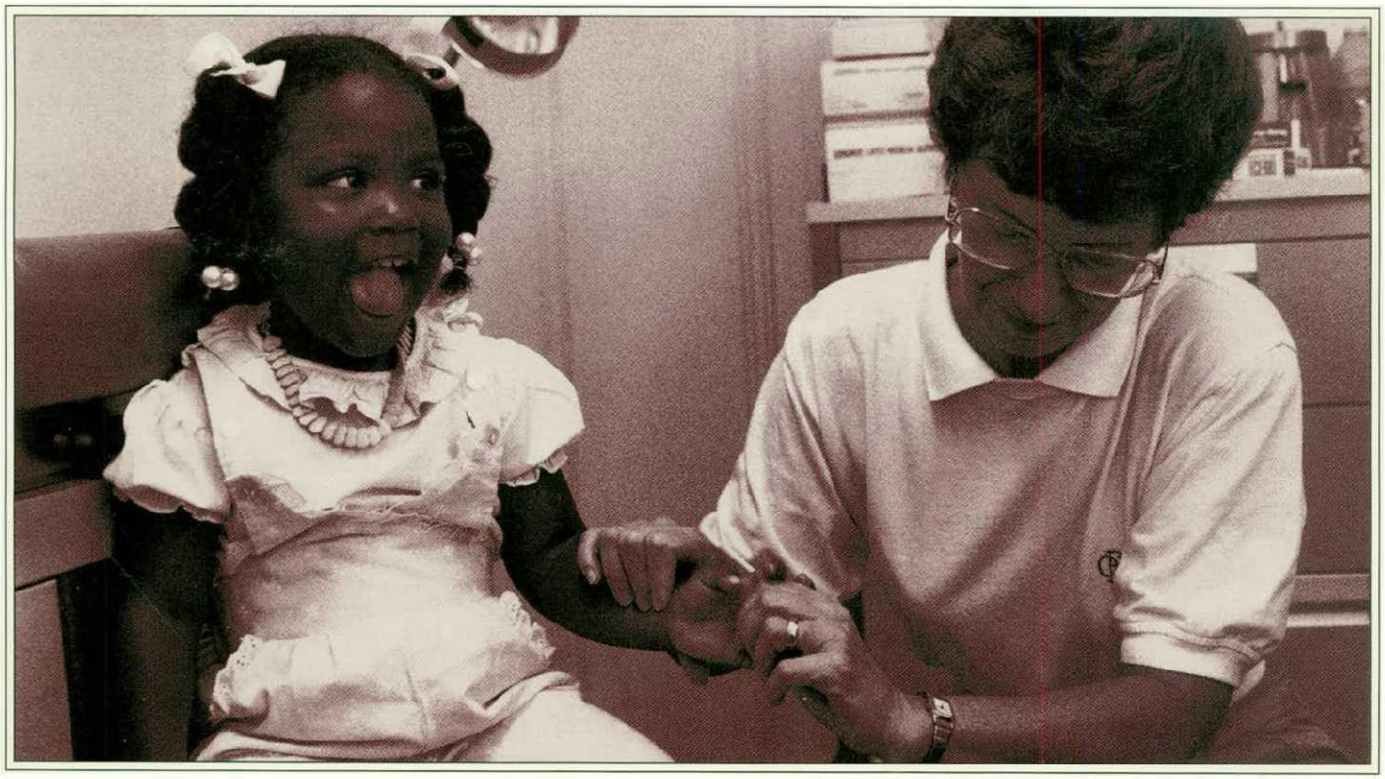
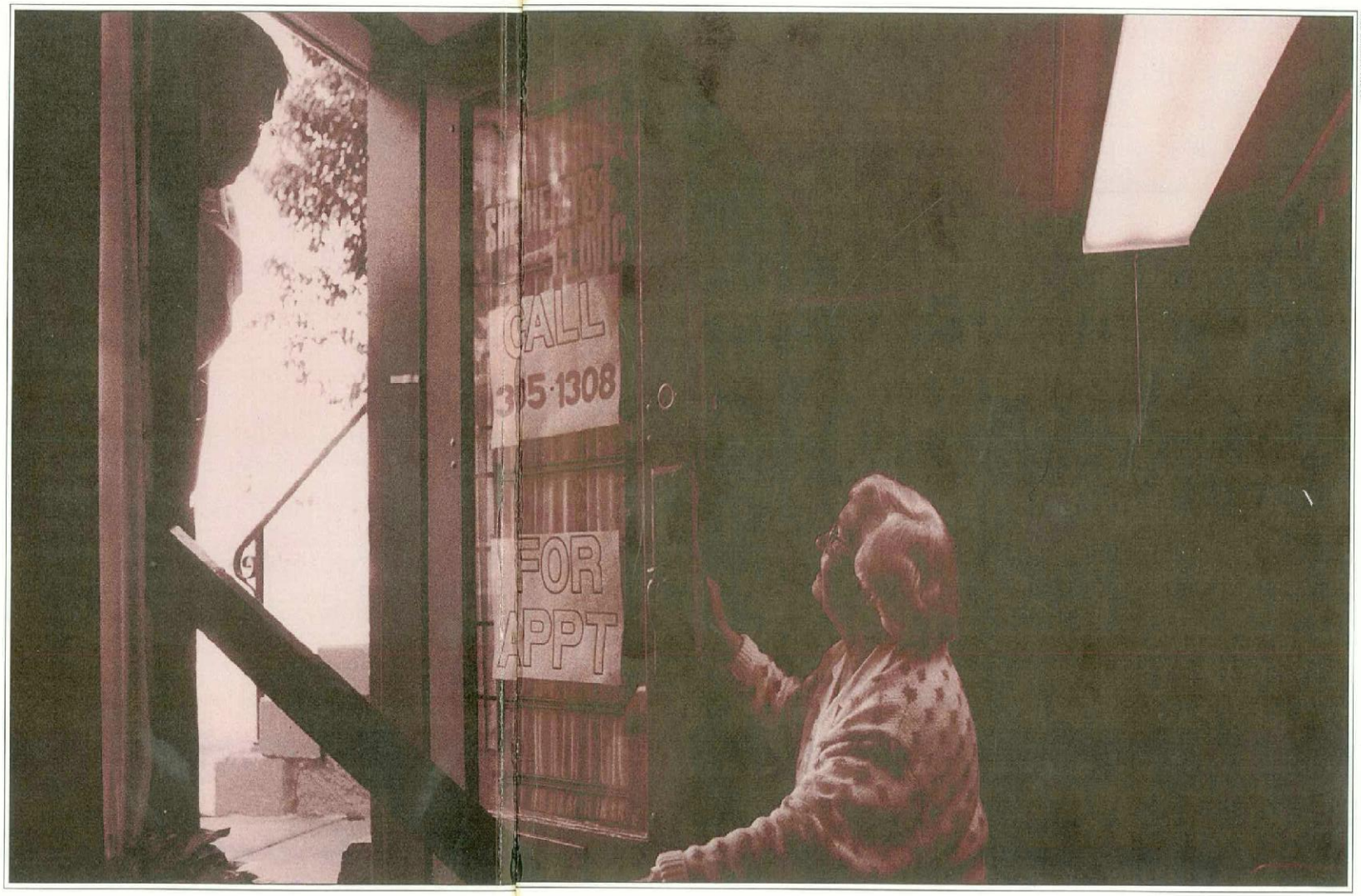
EMORY | ROLLINS SCHOOL OF PUBLIC HEALTH | Interfaith Health Program
Hubert Department of Global Health

The Challenges Of Faith & Health

The Report of the National Conference
Of the Interfaith Health Program
The Carter Center



I WAS RAISED with the saying, "Some things have to be seen to be believed." It took me a long time to realize that that was backwards, some things have to be believed to be seen. What are some of the things that we can believe? It's not impossible, today, to dream of the future where thousands of congregations actually see themselves as a redemptive force in the world."

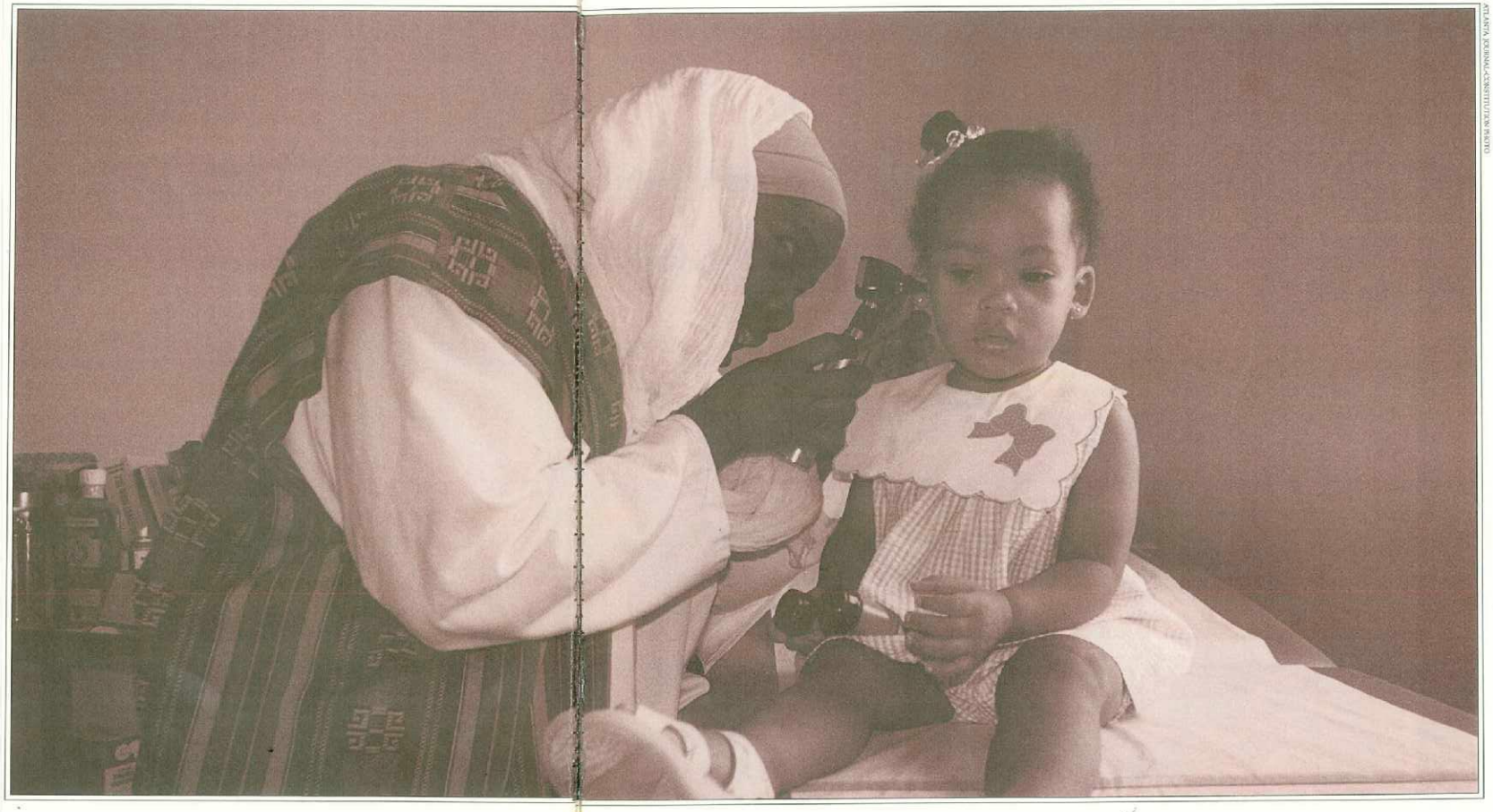


PAUL OBREGÓN PHOTO

Seventh Baptist Church in Baltimore is one of many congregations that sponsor community health clinics.

IT'S NOT IMPOSSIBLE
to dream of thousands
of congregations
willing to explore
servanthood,
to listen to the needs
of the community
before they act.
We can dream
of a future where thousands
of congregations
are replacing fatalism
with hope and belief,
a future in which
we understand the cost
of acts of omission."

In Atlanta, Muslim women have a health-screening and wellness program to help mothers and infants.

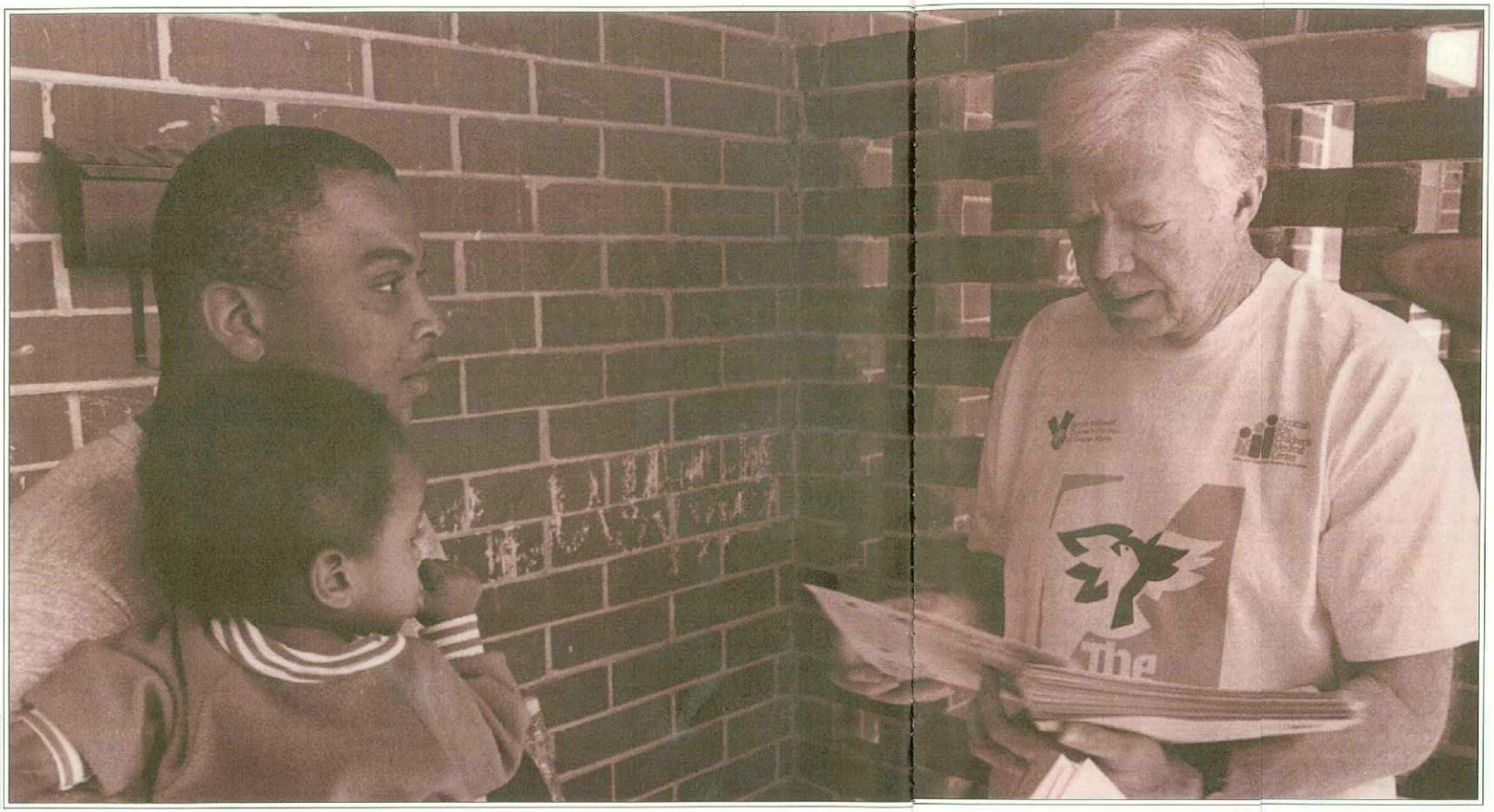


ATLANTA JOURNAL-CONSTITUTION/KEITH

WE CAN DREAM NOW
of collaboration
with government.
And we can dream
of a future where thousands
of congregations inspire
government to renew
its search for justice,
that inspire government
to make democracy work,
that act as guardians
of our children and the rights
of the child,
that change social norms,
that insure that people
can use their potential—
congregations that see all
of this as part of health."

At The Free Synagogue in Evanston, Ill., healing services—part of the congregation's emphasis on wellness—draw 5-10 people once a month.

JIM WARD / PHOTO



MICHAEL SCHWARZ PHOTO

IT'S NOT IMPOSSIBLE
to dream of thousands
of congregations
that see health
as a seamless whole—
physical, mental,
social, spiritual—
that see poverty and
illiteracy and addiction
and prejudice and
pollution and violence
and hopelessness
and fatalism and
conflict as brokenness,
diseases that require
that redemptive force offered
by the faith community."

—William Foege, M.D.
SENIOR FELLOW FOR HEALTH POLICY
THE CARTER CENTER
EXECUTIVE DIRECTOR, INTERFAITH HEALTH PROGRAM

As part of the Atlanta Project's effort to combat poverty and its degrading effects on people in the city, President Jimmy Carter and hundreds of volunteers visited thousands of homes in an anti-violence effort called "TAP into Peace."

The Opportunity for Faith

It is time to recognize the possible and act to aid the "least of these"

By Jimmy Carter
PRESIDENT, UNITED STATES OF AMERICA
FOUNDER, THE CARTER CENTER OF EMORY UNIVERSITY

DURING ONE OF THE FIRST CONFERENCES that we sponsored at The Carter Center—called Closing the Gap—we tried to measure the gap between what we know how to do in health care and what we actually do. We learned that there is a tremendous percentage of early deaths and lost years of service through illnesses that are totally preventable and caused exclusively by our own personal habits. Many people cause their own physical deterioration, their own early death, by refusing to change their habits, or because of addiction.

Since then, Closing the Gap's findings have been incorporated into the literature of the health professions.

One study that strongly impressed me had been done in the suburbs of San Diego. A vast array of analysts had gone into a poor neighborhood to ascertain why there was such a high incidence of illnesses and early deaths. They considered factors that might cause such suffering: environment, level of income, diet, access to medical care, use of medical care, the workplace.

Surprisingly, a large portion of the suffering was unexplained. They couldn't attribute it to known causes. Finally, psychiatrists and psychologists determined it was because the people had lost hope. They were fatalistic. They felt that nothing they did would beneficially effect their lives. They had never really witnessed success. So if a girl was tempted to have early sex, or if a boy was tempted to begin taking drugs, they did so, *because* they had no faith that their decisions could beneficially affect their future.

This is, I believe, a pervasive problem. People don't know where to turn to get that sense of beneficial self control, to find, in its most basic sense, "faith."

Quite often, afflictions that are most persistent are found in those who are most vulnerable, most illiterate, most susceptible to the uncertainty of the future. People like this, if given an opportunity to turn to someone they trust, will do so. If they have a family physician, they will go to him or her, because they have trust. But there's another element of even greater trust that hasn't been tapped. That is the rabbi, the minister, the iman who understands the living conditions of those who suffer unnecessarily. These are the men and women most qualified to turn defeat into hope and despair into faith.

I SEE THE COMMITMENT in all religions to alleviating human suffering and to preventing and curing illness, to be a common ground on which faith groups can communicate. This is not a time to talk about theology; it is a time to discover and to assess things that actually work.

This past summer and fall, The Carter Center sponsored mini-conferences in nine cities. We wanted to hear success stories on a micro basis, we wanted to learn what works in a single community, whether it be Hindu or Muslim or Protestant or Catholic or Jewish or Baha'i.

Now it is time to translate what we've learned,

from research and from listening, into action. And to discover how we can project the results of our study into a much broader acceptance and use within this country, and later to other nations.

Seventy-eight percent of all faith communities in this country have some kind of health program within their congregations. How do we expand those? How do we learn from them? How do we multiply them and replicate them?

It can be done. It must be done. But it won't be easy.

Preventive medicine hasn't caught on in the consciousness or the ideals or the awareness of the American people. They are not convinced that it is possible to control one's own destiny in health care.

Despite our wonderful technological developments, despite our many years of study, the incidences of cancer remain almost the same. Why haven't our research and our technologies helped? Because the plague of cigarette smoking continues. Now cigarette manufacturers are concentrating their advertisements on the poorest and the most vulnerable among us. And as they run out of poverty-stricken neighborhoods, inner-city neighborhoods, in which to sell their deadly products, they are shifting their advertising program to Third World countries. It is estimated that, by the end of this century, tobacco will be the number one killer of people in the entire world.

Those are the kinds of things that challenge us, and that also offer us an opportunity to do exciting things. Wouldn't it be wonderful if a few key faith groups—a Baptist church, a Catholic mission, a Jewish congregation, a Muslim center—could adopt one small, close-by area, and make sure that every single child in its "parish" was immunized against the basic diseases before he or she is two years old. Or that there was no hungry person in that small geographical area. Or that every person had a basic medical examination. Or that every woman who became pregnant would get prenatal care. Or that every elderly person was contacted every day and had a feeling of confidence that someone would come to help in time of need.

The *Albany (Ga.) Herald* this week reported that the local fire station had bought a very inexpensive computer program that could dial telephone numbers. Every morning it calls several dozen older people, vulnerable people. All the firefighter has to do is push a button and the machine dials everyone on the list. If one of the phones doesn't answer, a firefighter or a volunteer goes and checks on that person. The newspaper reported that a woman was saved from death because, when she didn't answer her phone, someone checked on her.

Suppose a congregation convinced parents and children to fight the presence of guns; suppose a church made a commitment to provide the kinds of alternatives needed to reduce the violence that afflicts the poorest among us. These are the kinds of things that are very exciting, and very redemptive.

But are they impossible?

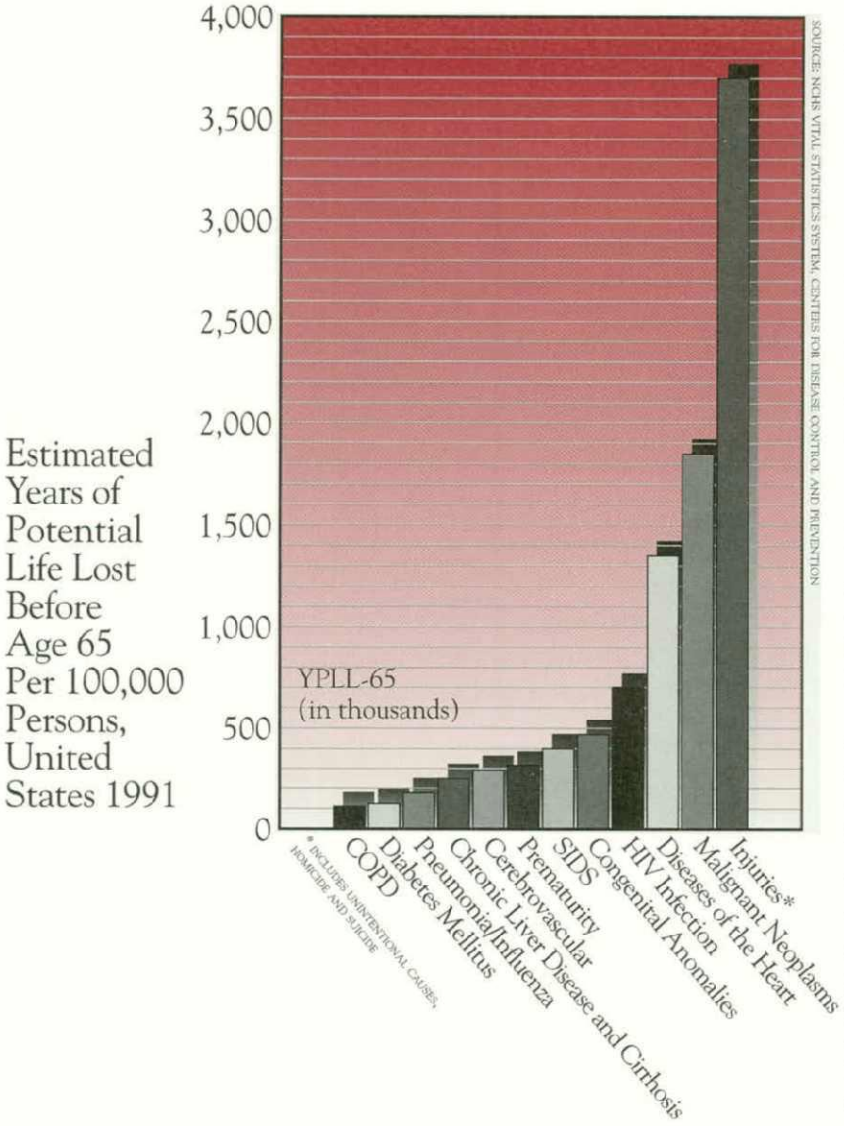
I WOULD SAY THAT NONE of them is impossible. It takes innovation and study and cohesive efforts, but such work is possible. A house built for a family in need; calling elderly people in the morning to make sure they are okay; giving a simple medical examination—these may require different levels of commitment to achieve. But they are all achievable. They just take initiative.

How do you spread that word?

This is a special year in health care. It will be the number one news story of 1994, barring some cataclysmic, unpredictable event of nature. It is a good time for us to be ready to move forward because there's going to be a constant lowering of expectations or commitments on behalf of the government. And every time the President's proposal is toned down, every time one of its elements are eliminated, it lowers the potential for universal health care.

And that opens up an opportunity for faith groups to step in.

A house for a family in need; calling elderly people to make sure they are okay; giving a simple medical examination—these may require different levels of commitment to achieve. But they are all achievable. They just take initiative.



"Where will it be done?"
It can be done within the faith communities.

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NOT LONG AGO IN CAMBRIDGE, Mass., at the funeral of Tip O'Neill, President Gerald Ford and I had a long conversation at breakfast. Our main topic was health care. We are motivated by my wife, Rosalynn, and by Betty Ford. We want to help with implementation of health reform legislation, but we have some amendments we want. Betty Ford is interested in substance abuse, which hasn't been adequately emphasized. Rosalynn is interested in increasing the emphasis on mental illness.

Substance abuse and mental illness are closely related. So I have little doubt that Betty Ford, Rosalynn Carter, Jerry Ford and Jimmy Carter will form a little team to make sure some beneficial amendments are made to health care reform, and to make sure that health care reform passes.

The Carter Center is committed to that kind of effort. And we hope the faith communities will become our partners. This combination of emphasis on a national news media scene and in local communities can be very effective. It has been that kind of publicity that has been the foundation of Habitat for Humanity's success.

This is a chance for us—The Carter Center and the faith communities—to share our knowledge, our experience, our backgrounds, our successes, our failures, and for us learn how we can form a coalition.

We're not trying to invent new programs. There are enough programs for the nation to last the next 10 or 15 years. But how can we take successes and expand them to other areas? Every religious congregation, every faith group, is looking for a way to serve God, in its own highly individualistic way, by alleviating suffering among its fellow human beings. If an idea or a concept or a vision can be presented through any means to that group with the chance of success and a demonstration of its real need and fairly good proof that it has already been accomplished, we have a wonderful chance to multiply what we know a hundred fold or, perhaps, a thousand fold. In that way, we could truly serve our God, by alleviating the suffering of our neighbors, particularly of those who are the least among us.

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The Challenges of Faith & Health
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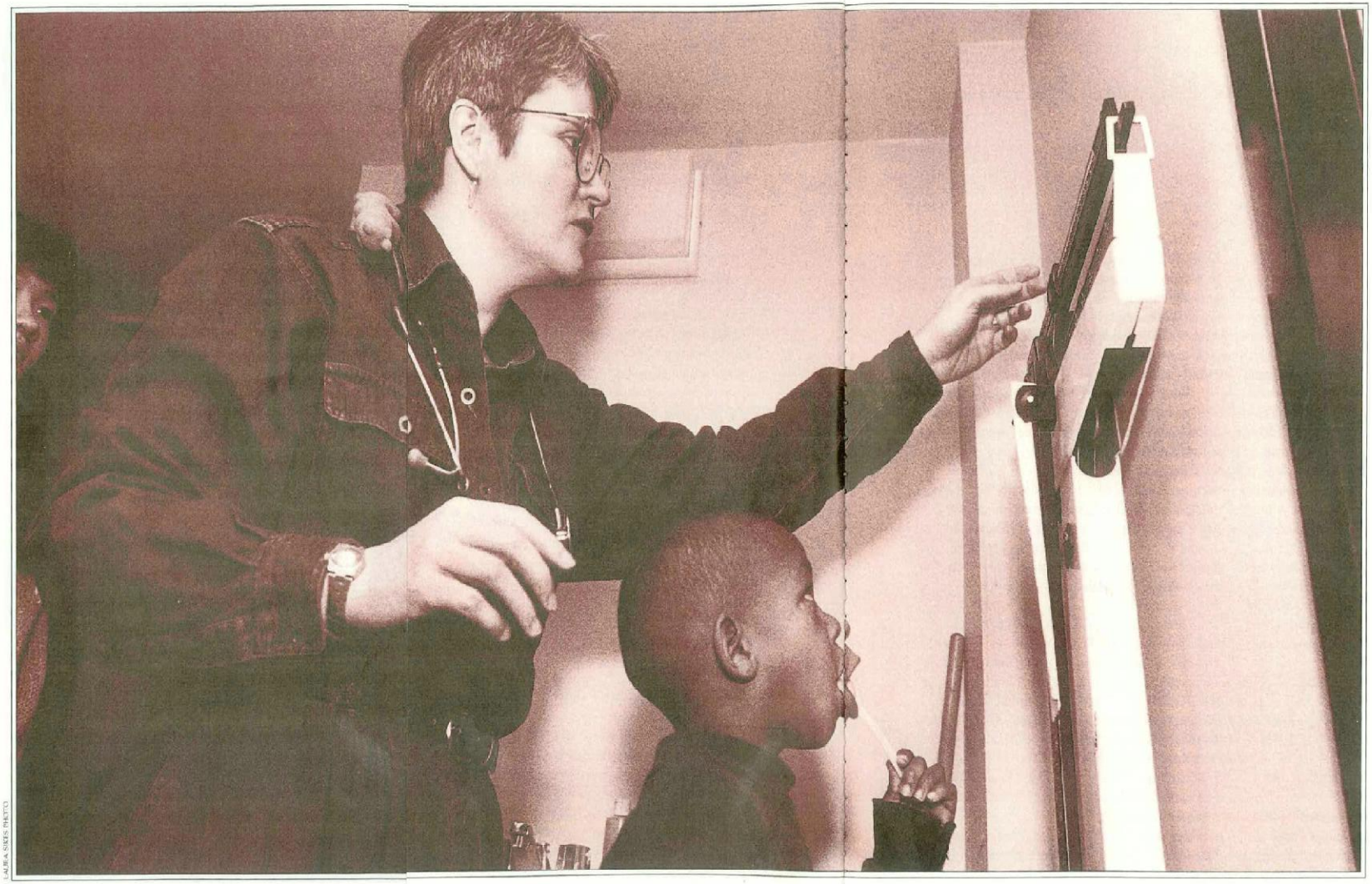
COVER PHOTO BY LAURA SIKES

Bridging the Gaps



Volunteer doctor Mary Schipper, working out of New Song Church in Baltimore, is among the thousands of professional caregivers who donate their services to neighborhood clinics and community wellness/prevention programs.

LAURA SIKES PHOTO

Tools for Change

The interfaith health movement can improve the lives of millions—if it can seize its opportunity

By Gary R. Gunderson
DIRECTOR OF OPERATIONS, INTERFAITH HEALTH PROGRAM
THE CARTER CENTER OF EMORY UNIVERSITY

I RECENTLY VISITED 20 CITIES in the United States, meeting with people who work on a daily, basis in the field of faith and health. And I discovered something exciting, encouraging, remarkable. It is this: At a time when so many are so fearful and anxious, every day, somewhere, somehow, someone is meeting the problems of our society head-on. And providing solutions.

Cancer, random violence, poverty and AIDS, grinding stress and rising costs of health care fill us with the dull sense that its only a matter of time until it all collapses. We are tempted to call for faith to comfort us in our sure demise or, at the very least, to serve as an anchor to slow the drift into social catastrophe, to hold on to the past. The people who work on the frontlines see a quite different role for faith today, one that begins with the assumption that God is the author of the future, God is driving us forward, that the very structure of the created universe beckons us to seize the opportunities for better health and wholeness. We lean into the future with expectation.

Nancy Griffin sings the image for me:

" when you're leaving the harbor,
do you call out to the shore,
or greet the waves of the ocean
as your best friend"

It is the eyes of faith that recognize the future as our friend and our challenge.

Indeed, we are acknowledging a movement in faith and health that has the capacity to bring increased wellness to millions of people. Speaking of a movement only a few miles from where Martin Luther King Jr. pastored is a bit presumptuous, perhaps. At the very least, it challenges us to measure our efforts and our commitment by a larger standard than mere good intentions. We don't want just one piece of legislation, or just one program in every church. We know we can do better, and we must.

What is a movement? It is a twining of anger and hope. Our anger is rooted in the fact that more than two-thirds of all years of life lost before the age of 65 are wasted unnecessarily. We are outraged because many of these lost years result from organized greed—some of it legal, as in tobacco and handguns; some illegal, as in substance abuse. We know that other people are dying and leading unnecessarily wasted lives due to apathy, ignorance and habit. Our public health science fuels our anger because it has clarified what can be done to eliminate the suffering.

Those of us in the religious community feel embarrassed and ashamed, for we have too long drifted with the tide, accepting our failure to feed and immunize children, confront gunrunners and tobacco-pushers, shackle environmental abusers. We are outraged that in 1994 the mentally ill could possibly remain outside the range of health care reform. Our faith traditions challenge us with the knowledge that this is not what God intends. We have drifted with the silent tide when we could speak against these evils.

Now our faith and our science compel us to seize the moment and work together because it is the right thing to do. In the shadow of Ebenezer

We are a movement in faith and health that has the capacity to bring increased wellness to millions of people. We know we can do better. We must.

Church, we are reminded that it is always the right time to do right.

We have largely abandoned the language of public faith to those who would harness God as they might an old horse in hopes that He would pull us back to the past, away from all that makes us uncomfortable with our present and all that we fear about the future.

But we're not here to advance toward the past. Far from resisting the future, God beckons toward the opportunities. "Come forward," I imagine God saying to us, "Come forward and reclaim a little territory from death, just this street, then the block and the city. Reclaim it as I intended all along."

This and nothing less, is what calls together the people of faith and the people of science.

I speak of a movement, but it is not something we at The Carter Center are orchestrating. The thought reminds me of a time about 10 years ago when a solar eclipse was scheduled to track through the Atlanta area. This was big news, but only one company figured out how to make money from the event. Some genius at Wendy's passed out zillions of little gizmos that allowed you to see the eclipse safely without frying your retinas. In effect, they treated the eclipse as "brought to you by Wendy's." The faith and health movement is not brought to you by The Carter Center. But we are compelled by all we believe to be part of it.

A MOVEMENT NEEDS at least three things: a brain, a skeleton and a heart.

A movement isn't one until it has a common idea that is generally understood by those thinking of themselves as part of it. Our underlying conceptual framework of the movement is found in public health science and in our five-gap analysis (see page 20).

The skeleton of the faith and health movement reflects the underlying science. The most important thing it tells us is that there is no magic bullet, no one pill or plan, no one act capable of winning wellness—wholeness—for millions. The movement is about prevention and collaboration. It is not defined by what we can do by ourselves, but what we must do together. This fact shapes our strategy and the tools we choose.

Thus the skeleton of the faith and health movement is the collaborative structures between organizations. The movement is mostly made up of many separate organizations bound together by external, often *ad hoc* structures. We will never find a common home where everyone is comfortable. We don't need it. The skeleton locally, at every level of community, is a collaborative structure that permits us to learn from each other and to work with each other.

On our 20-city tour, we consistently saw structures that were emerging to fit the needs of better health. For the most part, these structures were responding to the need for practical collaboration across boundaries that tend to keep faith groups apart.

Collaboration assumes that different groups need not blend or unify. It is not built on the naive idea that collaborators could ever expect to find a common vocabulary, or single faith. It does not assume that we will naturally drift together; it assumes the opposite, knowing from painful history that it is more natural to distrust and fear, more natural to drift apart into ever defensive circles of us and ours.

The current movement toward collaboration is so clear sighted about human communities as to be almost cold-blooded.

I stress this because it is easy to be mistaken for a fool when one is merely working seriously for the future. Only a fool believes that any one faith, any one science, any one governmental agency has the power, resources or insight to bring healing to one community. Only a fool would say, "Follow me, I have *the* answer." Or maybe only a fool would follow.

We say a quite different thing. We say, let us come together in humility, each of us challenged by the opportunity for making progress, each of us needing the other's participation in order to see

movement achieved.

The cornerstone of any collaboration is respect for the integrity of the component partners. This is especially true in the area of interfaith health, because the movement finds common cause among groups that do not have a common world view. Again, this is not a matter of manners and civility. If you want to work together in this field, you'd better respect the integrity of your co-laborer.

The cornerstone of any collaboration is respect for the integrity of the partners. This is especially true in interfaith health, because the movement finds common cause among groups that do not have a common world view.

Here collaboration often breaks down, because it takes time to respect someone. Respect for someone different from you—operating out of a different faith tradition or scientific perspective— takes time.

- ¶ You can't respect someone you don't understand.
- ¶ You can't understand someone you haven't listened to.
- ¶ You can't listen to someone you haven't spent time with.

It can be somewhat threatening for a Christian to find common ground with a Muslim or Jew; not easy for a public health scientist to recognize the religious role in healing and prevention. In general, it takes a person comfortable enough in his or her own world view that new thoughts are not feared.

The movement of faith and health will support, not eclipse, underlying religious and scientific structures. It depends on strong, coherent, confident congregations that understand their own traditions and are capable of challenging their members to act on the central ethical claims for health. A congregation that sounds and acts just like a public health agency is not very useful to the public. A public health agency that tries to sound and act like a church is not very useful to the faith community.

It is so easy for the quick collaboration to run roughshod over the others' world view. This happens when houses of worship are viewed as mere delivery points for health interventions; or conversely, when public health agencies are viewed as mere funding agents to support church programs. A little perspective could help here. If a religious tradition has survived for 3,000 years, it deserves credit for knowing something about how the world works. On the other hand, for 2,900 of those years, people were generally satisfied with a life expectancy of about 50 years. Public health science deserves most of the credit for extending that to 75 years in only a century. Maybe public health scientists know something, too.

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RESPECTING THE IDEOLOGICAL INTEGRITY of the partner leads to two other practical corollaries:

- ¶ respect for the survival logic of the partner and
- ¶ limited domain collaboration.

Collaboration is often quite difficult because organizational survival is often quite difficult. For ten years, I ran a small nonprofit organization that rarely had more than a couple months financial reserve. Although I believed in collaboration then as strongly as I do now, in many cases I had little room for maneuver. My first responsibility was the survival of the organization. Smart collaborators begin with a tough-minded understanding of the organizational needs of the other partners, especially the bread-and-water of organizational life: money and attention (which lead to political and volunteer support). Simply asking, "What does your organization need out of this collaboration for you to participate?," will go a long way. Don't assume you know what someone else needs.

A practical corollary to respecting the integrity of your partners is what I call "limited domain collaboration." Because collaboration is difficult and time-consuming and can be threatening: don't overdue it. Simply don't organize anything that doesn't really need to be organized.

One model for limited domain collaboration is the Tucson C.A.R.E Fair.

Silver Dalmer and Becky Melland have quietly built a remarkable coalition of normally contentious and defensive agencies from every part of the community. Once a year they come together to offer hassle-free service to anyone in need. This is

done with little money and no ongoing structure. The agencies participate because the rules are clear and the commitment limited. Monday after the fair, everyone goes back to his or her normal contentious habits. But slightly changed for seeing what is possible when the interests of the clients are put first.

Limited domain collaboration is especially important in dealing with religious organizations, which are overwhelmingly volunteer-driven. It is crucial to keep the collaborative structure in the role of being a servant of the partners and not vice versa. Successful collaborations do not attempt to win the *heart* of the collaborators, but remain as temporary conduits for their common goals. The heart of the movement is provided by religious traditions trying to live up to the best of their faith.

Do not attempt to transfer the religious fervor to a secular collaboration. Neither should a church attempt to convince a public health scientist to replace data with faith.

It is like trying to teach a pig to sing: it doesn't make for good music and it annoys the pig.

It is enough, more than enough, to find ways to work together for the health of the community.

When we imagine what could happen if we applied all we know in preventative technique and community policy, we can speak of many extended years of active, productive life.

THE MOVEMENT OF FAITH AND HEALTH reflects a convergence of science and faith. When we imagine what could happen if we applied all that we know in preventative technique and community policy, we can speak of extended life span, and certainly extended years of active, productive life. Freed from preventable diseases and supported by healthier life choices and wise environmental policies, we can see a healthier day ahead. This is a vision worth working for, one that can call out our best, our *very* best labor.

But the span of human life will remain limited, very limited. Each and every faith tradition treats life as precious, as something to protect, respect, and, where possible, extend. It takes no arcane theology to support this. It is at the center of every faith. But in no faith is life the *ultimate* value. Life is subservient to the ultimate value, about those things that precede us, that last after us, that are not only worth living for, but can also call us to spend our lives on behalf of something more important than merely living.

WHAT IS THE SYMBOL of the health and faith movement? We could think of great symbols: the immunization needle, the scientist at the test tube, the preacher at the pulpit. Stirring, perhaps, but the most accurate symbol may be, instead, the committee meeting, the most despised tool for change we have. I learned this from my dad, who died a few months ago at age 86.

He believed in church, community and country. He wasn't much of an orator. But he was a great committee member at his churches, in his community organizations, and with government. I learned from him that if you care enough about your values, you'll show it by the committee meetings you attend.

Most of us would much rather walk through the valley of the shadow of death than sit through another committee meeting. But that's what all our theology and science boil down to: finding the collaborative tools that allow us to come together and do the right things for the wellness of our fellow human beings. It is so simple, yet so difficult, that we must learn from each other and encourage each other.

How do you confront HIV and violence, hunger and TB, mental illness and the politics of greed and privilege? You form a committee and get to work.

We have a brain, a skeleton and a heart. What gives life is how these things are given breath in communities—yours and mine—through the individual and the collaborative actions that express our faith.

The Five Gaps Analysis

The challenge of the missing pieces identifies the opportunity

By Gary R. Gunderson
DIRECTOR OF OPERATIONS, INTERFAITH HEALTH PROGRAM
THE CARTER CENTER OF EMORY UNIVERSITY

THE INTERFAITH HEALTH PROGRAM began in January 1993 with a sense of accountability to two powerful statistics:

¶ As much as two-thirds of the years of life lost before the age of 65 are preventable using currently available knowledge and technology.

¶ 145 million people in the United States belong to a faith group, each of which claims a priority on the protection of life and promotion of health.

World spending on health totalled about $1,700 billion in 1990, of which 87 percent was spent in the established market economies. In the United States, we spend an average of $2,700 per person in the name of health, compared to about $41 in developing countries.[1] Only a tiny fraction of health expenditures go toward prevention: less than five percent in the United States.

Much of the current debate in the United States about the health crisis is driven by frustration over the enormous and escalating expense of dealing with disease and disability. Thus it is a health-care debate, or maybe even a "disease-care" debate. The Interfaith Health Program is concerned about that problem, especially as it results in many low-income families receiving inappropriate or too little care. However, we are even more tantalized by the unmet opportunity offered by prevention and promotion. Access to the current get-sick-and-get-cured system of dealing with disease is only part of the issue. The point should be how can we reach better health *outcomes*. Looking toward *outcomes* moves the discussion immediately toward prevention and promotion.

We believe the confluence of faith groups and public health science has the power to move the debate toward a strategy that is, well, *healthier* than the current model. While the debate over how to allocate the approximately 14 percent of our Gross Domestic Product currently flowing to disease care is worth influencing, the health and faith movement also offers tangible action handles for congregations, communities and collaborative structures of all kinds. It is increasingly clear that improving health is not something that must be delegated to others, but is also something in which we, personally, and in our associations and communities, can engage.

The Bread for the World Institute estimates that 150,000 organizations and congregations operate feeding programs. A National Council of Churches survey found that more than 70 percent of congregations responding claim at least one health-related activity. Clearly, hundreds of positive models of health programs, innovative technologies and creative initiatives are underway throughout the country. The question is not, "Could there be a large-scale shift in health?" It is, instead, "What is preventing it from happening?"

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WE BELIEVE FIVE INTERRELATED GAPS prevent improvement in the nation's health. Our city meetings indicated the five-gap analysis is a useful way for community leaders to understand and set priorities, especially for collaborative action. The con-

cept rests on the scientific work of the public health community and the theological work of each faith group. It integrates knowledge and commitment toward a common goal of improved health.

Gap One

Between Knowing and Applying

Access to the current get-sick-and-get-cured system of dealing with disease is only part of the issue. We are more tantalized by the unmet opportunity offered by prevention and promotion.

THERE IS A CHASM between what is known and what is applied. It is important to help faith groups understand the determinants of health and the opportunities for applying today's health tools toward improving the lives of their congregations and their communities. Despite our amazing medical technology, the greatest advances in health will reflect our understanding of social injustice, life-style choices, public policies and disease prevention.

Until relatively recently, the human species did not understand how infectious diseases were spread, and thus how to prevent them. Only in the last century have we learned the role of sanitation, diet, environmental regulation, food content laws, workplace safety and other factors in contributing to health. The developed market economies are applying many of these tools. One indication of their efficacy is that in 1990 in the developing world, 12.4 million children under age five died. Had those children faced the mortality risks of children in the established-market economies, the number of deaths would have been cut by 90 percent, to 1.1 million. Public health strategies work. Prevention researchers know the remaining 10 percent is open to significant improvement.

For instance, only very recently has handgun violence begun to be widely viewed as a health issue, even though data indicate as a cause of death and injury it ranks second only to auto accidents in youth ages 10-24. Almost none of what is known about reducing handgun risk, even from the lives of children, has been implemented. Now public health scientists and their colleagues in faith groups are finding ways to implement what we do know and work together to explore what we don't.

Even where health risks are clearly understood, such as with tobacco, much remains to be done in breaking the cycle of greed and addiction that fuels the largest single killer in our society. We know it would save lives to eliminate all advertising of tobacco products and establish a high per-pack tax that would discourage adolescent smoking. But we do not *do* what we *know*.

Hunger is a serious threat to one in ten Americans even though the short-term answer is known —even institutionalized—through food programs such as the Women, Infants and Children (WIC) program. But we do not choose to implement fully, or in this case, fund, the known solution.

Experts in every health field can list techniques and knowledge that is yet to be widely applied. We do not know everything, of course. The same expert listing unapplied knowledge also has a list of questions still beyond our grasp. However, the reservoir of knowledge that can be applied justifies an optimistic view for the possibility of significant gains in health.

Gap Two

Between Believing and Doing

IN MUCH THE SAME WAY that unapplied science defines the public health opportunity, a similar gap in unapplied faith challenges religious groups.

We recognize a gap between what every faith affirms as its concern for social justice and health and what it does. It is important for faith groups to identify and act on their tradition of social justice and health responsibilities, not as secular agenda imposed by outside forces, but as a centuries-old priority to care for the sick, the poor and the oppressed.

Gap Two recognizes the common ground of humility among faiths traditions. We all must confess to core beliefs left untended, central ethical

commitments kept in the shadows. What faith tradition does not affirm the importance of alleviating and preventing suffering? What tradition has *no* concern for protecting the weak, the poor and oppressed? What religious group does *not* affirm acts of charity, justice and mercy? What group does *not* affirm the value of wellness as an ideal to be achieved by all?

Yet, which of us has fully implemented those beliefs?

The possible most-common-denominator collaboration among faith groups challenges us to live up to our undone beliefs and . . . become better partners in the field of health.

There are good reasons why sincere people of faith see things differently, why worship differs, why there are different expectations of God's action in this life and beyond. This is why interfaith dialogue frequently is conducted tenderly and often abstractly. These discussions tend to find an inoffensive least-common-denominator that is so lacking in substance as to be powerless, even boring.

The faith and health movement offers a quite different experience. This is true because each of the faith traditions shares a common ethic directly related to the health opportunities found in prevention and promotion. The challenge to improve health felt by all major faith groups, including Native American religions, is quite similar. Thus we are all impelled to act, but also to act in a way that turns out to be quite harmonious with other faiths. At the same time, most traditions must confess that they have not lived up to their own beliefs at this point. The faiths share a common experience of falling short of their own theological standards.

This ethical confluence makes possible a most-common-denominator collaboration among faith groups. Gap Two challenges us to live up to our undone beliefs and suggests that in doing so we become better collaborative partners in the field of health.

When powerful rivers converge the water is rarely placid. The interfaith health confluence can be turbulent, too. There are issues of life and death that deeply divide religious communities. Abortion, euthanasia, sex-education and safe-sex campaigns find sincere people of faith in conflict. This often makes collaboration with public structures like schools and health departments fragile. But even in the most contentious health issues, the fact that both sides have sincere roots in core commitments to life and wholeness offers a ground for dialogue. In Tacoma, Washington, pro-choice and antiabortion religious activists are meeting quietly to see whether there is any route toward understanding.

The health and faith movement is broad enough, with enough tangible life-giving agendas, to find grounds for collaboration and learning even when we are divided on other specific concerns.

As President Carter has noted, religious virtue is in danger of being synonymous with self-righteousness. The answer is not less faith, but more faith. This is the key to understanding Gap Two: the gap between what every faith affirms as its concern for social justice and health and what it does. Until this gap is confronted, the shallow reserve of good intentions are incapable of doing the sustained heavy lifting required to initiate and continue community-based activities. When faith groups draw on their deepest spiritual wellspring, it is possible to envision a broad range of health activities that make tangible differences in the lives of people.

Gap Three

Between Discovering and Replicating

AROUND THE COUNTRY, many creative people are tackling all sorts of problems successfully. Nearly everything that ought to be done, is being done *somewhere* by a church, synagogue, mosque or temple. Almost any problem has been successfully confronted somewhere.

A local problem demands a specific response with an equally specific set of existing resources: volunteers, staff, money, alliances, building space. A general answer is not very useful. What is needed is a relevant model —or several of them—

that can shed light on what might work here.

The third gap exists because successful working models are rarely known outside their particular circle. While there are many networks within faith and health communities, it is rare for successful models to be widely recognized outside an unpredictably small circle of "birth network" relationships. Within a city, it is common for one group to be successful while others—even those working in the same field—know nothing about their project. The reason, of course, is that project leaders are up to their ears in the urgent problems of the day. They have no time to explore others' approaches.

There is a large body of successful program experience that could be adapted far more widely than it is. What if every soup kitchen emulated the best? What if every public health department replicated the most efficient models for equipping and mobilizing the faith communities? What if every congregation ran a home visitation program as good as the finest? What if every faith-based advocacy organization were as smart and effective as the most successful one?

While none of our faith groups can do it all, the evidence is that we can raise our standards higher.

Faith groups have often been satisfied with being recognized for their good intentions. The successful models around the country challenge us to measure ourselves to the standards of the best practices.

Most congregations stay within a predictable and relatively timid menu of activities. Gap Three recognizes that many of the most difficult, intractable problems of our time are being dealt with successfully in communities around the country. While none of our faith groups can do it all, the evidence is that we can raise our standards higher.

Gap Four

Between Isolation and Community

THE FIRST THREE GAPS are perpetuated by the fourth: faith groups working in isolation from each other and their colleagues in public structures. Although we live in a sea of instant and distant communications of the most intimate nature, we are often unaware of important news from down the block.

Those actively working on a health project can be oblivious to colleagues nearby with similar commitment but different vocabulary. We are so easily isolated by habitual barriers of denomination and religion. But even within the circle of a theological family, we find ourselves isolated by traditional barriers of race, culture and economics. As we look across national boundaries, we still find the flow of cooperation and learning tripped up by barriers of language and distance.

Gap Four is both a gap in learning and a gap of cooperation.

As long as there is isolation from the challenge of other faiths it is unlikely that any of us will proceed very far in applying what is already known or implementing our own commitments to social justice and health. Limited to the small circle of those who look, pray and work just like us, we are deprived of most of the menu of best practices that could be used to implement our ethics.

We gain enormously by the particularity and diversity among faith groups. At the point of putting our faith into action in health, Baptists have much to learn from Muslims, Jews from Mennonites, Catholics from Seventh Day Adventists. And vice versa. The fact is: None of us can fulfill our own commitments to social justice and health without learning from the practices of others.

Learning from others is hard enough. Cooperating is harder. Remarkably, at the community level, there is an increase in hands-on cooperation around health-related projects. While there is often a genuine benefit in a project remaining tightly identified with a particular faith group (a Chicago synagogue has a kosher food pantry for the 15 percent of Jews living under the poverty line, for instance), there is often much to be gained from a less sectarian approach.

Gap Four can be a community health risk all by itself. In St. Louis, a metro-wide study of health has been completed—the 34th similar study done

in the city. Its findings are not dramatically different in diagnosis of problems or prescription for answers. Why were the earlier reports not implemented? Like many cities, St. Louis' metro-wide health action runs aground on the shoals of racial division. White suburbs are unwilling to discuss, much less pay for, the prevention or alleviation of inner-city suffering, especially if the children are a different color. St. Louis is not the only community incapable of confronting its health problems because of racial isolation. Many communities demonstrate how Gap Four is institutionalized in our voting precincts and the jurisdiction of our public agencies.

Gap Four—*isolation*—perpetuates the others.

Gap Five

Between Present Wants and Future Needs

THE PATH TOWARD A HEALTHIER humankind extends long beyond our individual lives. Even the things we now know demand decades to implement and bear fruit: We know, for example, we could eliminate half of all deaths from hunger within a decade. Eliminating the other half demands far more fundamental changes in the economic logic of our world. We don't know how to do that, even if we take the steps toward alleviating the hunger we can reach.

Gap Five recognizes the difficulty in acting in light of our connections to those living far away from us in terms of distance or time. If we find it difficult to give up tobacco products that we know are likely to destroy our own bodies and those we love, how can we find the motivation to give up the habits of abuse and self-indulgence that hurt people we will never know? Tobacco warns us: even while we restrict marketing practices in the United States, our government supports aggressive marketing of tobacco products overseas.

If we find it difficult to give up products we know destroy our own bodies and those we love, how can we find the motivation to give up habits of abuse and self-indulgence that hurt people we will never know?

Gap Five can best be crossed by people with deep spiritual roots. Those of us at home in the older faith traditions already find it possible to feel connected across time and distance to people who preceded us. We have some sense of linkage with people from other cultures and countries that share our core beliefs. This may have scant impact on our daily patterns of consumption, but it offers a meaningful point of contact beyond the small circle of us-and-ours. Imagine the implications if only we would say, "As a Muslim I will take no action that will diminish the ecological health of any other Muslim." Or, "As a Baptist I will consume nothing that would diminish the future wholeness of any other Baptist."

In both the global and domestic context, violence and civil conflict represent a large and growing health risk, especially for children. War and HIV will claim roughly the same number of children in Africa this year. In the United States, handgun injury is a leading cause of death for children above 10 years of age. Gap Five recognizes that a divided community will take years to heal.

It is intellectually dishonest and theologically shallow to imply that a movement composed only of those alive now has the power to make all the health gains possible. Where is the boundary of human wholeness? None of us knows.

Gap Five demands a depth of thought that could come from a most-common-denominator relationship between people of different faiths. For instance, the long-term perspective of "deep ecology" thinkers draws deeply from Buddhist thought. It suggests a way beyond the short term "cleanup" agenda that is too practical—at least, too immediate— for the earth's own good. In a similar way health activists need a balance to our eagerness to do only the urgent health agenda, leaving the long-term global connections to someone else.

Gap Five reflects our spiritual immaturity, the dim understanding that we are part of the created order and responsible for it. Our actions will ripple out beyond the span of living years and beyond the circle of those we can know personally. If we act foolishly, we will inflict more suffering than we will ever know. If we act wisely, we will do more good than we can comprehend.

The Five Gap Agenda

It is time to move from analysis to strategy

A GAP CAN BE ENVISIONED DIFFERENTLY. It can represent something missing, an empty space; or it can be thought of the way American pioneers on their westward journey often saw the gap between two mountains: as an opening, an opportunity, a pathway to a better, more productive time.

In this latter interpretaton, the Gap Five analysis opens up strategic opportunities for the interfaith health movement by becomeing a useful tool for understanding the barriers to greater health in many communities. It can be used to identify local constraints, especially when applied in conjunction with other community health evaluations. It can also be used to develop an action agenda as each gap hints at its own solution. Each congregation, neighborhood, city, state or religious organization can find its hands full by asking:

¶ What do we know that we are not applying?

¶ What do we believe that we are not acting on?

¶ What models have worked elsewhere that could be adapted here?

¶ How can we reach beyond ourselves to learn and collaborate with others?

¶ What can we do in the present to honor our connections and responsibilities to the future?

Certainly, there is a *movement* of faith and health that has national, indeed, international implications. It unites what would otherwise remain an incoherent and scattered phenomenon. From it flows an activist agenda aimed at improving health outcomes through:

¶ disease and injury prevention

¶ health promotion

¶ empowerment of individuals and nonspecialists

¶ community action

¶ social justice

The Five Gap framework offers a useful intellectual skeleton for the movement.

This burgeoning movement of health and faith is broad, active and creative. However, it is not an isolated, new movement, but one built on synergy of existing interests. It is driven by underlying currents in science, faith and politics that lean against the overspecialized, isolated view of different problems. There are unifying themes breaking down false divisions between issues and professions. This is important, since it recognizes that the drive toward collaboration is powered not only by the *external* wish for coherence, but also by *internal* understandings of the component partners. For instance, as the "anti-hunger community" gains more experience and understanding of the problems of the hungry, it finds itself dealing with the homelessness, mental health and substance abuse issues that afflict many of the hungry. Hunger activists find themselves working with mental health and substance abuse specialists. The same phenomenon is true in issue after issue.

The current movement of faith and health rests on ancient commitments to charity, healing and caring for the sick and weak that flow through every major faith tradition. However, modern science has given faith groups new knowledge of pre-

vention and health promotion. This is what sets the modern movement toward health apart from its earlier precedents. As much as two-thirds of years lost to disease before the age of 65 are preventable by applying current knowledge. This suggests an immeasurably different world than one in which disease struck unpredictably and injury was so common that life expectancy was barely half of that expected today. While some faiths have long advocated prevention as a higher call than alleviation of suffering, none of us realized quite how much of common suffering was actually preventable. Faith groups are beginning to understand that their ethic has far more application than they thought.

That insight is drawing the scientific community into dialogue with faith groups as it deals with the limitations of curative science. It is widely understood that public health science has had enormous impact on life expectancy and suffering, mainly through improved diet, sanitation, immunization and access to primary care. However, a healthy lifestyle is not something that can be given to somebody else. Until an individual actively seeks to improve his or her own health, many of the most successful strategies will not be implemented.

The drive toward wellness moves past "scientific knowledge" toward the cultural and religious basis of human behavior. If you want people to act differently, unlock the mystery of why people do things at all. This is not *certainly* religious territory.

THUS THE DRIVE TOWARD WELLNESS quickly moves past "scientific knowledge" toward the cultural and religious ground of much human behavior. If you want people to act differently, even in their own self-interest, unlock the mystery of why people do things at all. This is not uniquely religious territory, but it is *certainly* religious territory. From stopping smoking, to confronting handgun injuries, from changing diet to engaging substance abuse, the key is human behavior choices. Behavior is a relatively new priority for health science in the same way that prevention is a relatively new priority for faith groups.

The creative edge of the faith and health movement is at the community level where local leaders engage local priorities and opportunities. This does not deny the importance of national policies established by political, professional and religious bodies. In some areas, such as the prevention of handgun injuries and deaths, national action has no substitute at the local level. In this case, anything but a national handgun policy is like immunizing alternate families on a block.

Nevertheless, on many issues local leaders are finding new ways to confront opportunities for health. Typically, the experimenting and learning is happening locally. This does not lessen the need for professional expertise, intellectual rigor and careful thought. It does mean that the best thought is more likely to be found within the context of a local application.

Scientific knowledge is discovered and refined through a constant loop of hypothesis and testing. The learning edge of the faith and health movement is the plethora of creative initiatives underway all over the world. Unlike scientific process, much of the experience of community health activists is not presently examined carefully or objectively against the test of effectiveness. The challenge is to envision the broad movement as a singular phenomenon capable of learning from itself and sharpening its best practices. The inter*faith*, inter*disciplinary*, inter*national* and cross *cultural* nature of the movement erects many barriers to this learning process. This is why collaborative structures, especially at the community level, are such crucial tools.

What Is Our Task in Health?

People of faith must rediscover their sense of community, equality and interconnectedness

By William Foege
SENIOR FELLOW, THE INTERFAITH PROGRAM OF THE CARTER CENTER

CHURCHILL USED TO SAY, "Play for more than you can afford to lose and you will learn the rules of the game." We in the arena of faith and health understand that the stakes are high. A national discussion of health-care is underway; vital decisions must be made. Opportunities abound.

I recently coauthored, with Dr. Michael McGinnes (of the CDC?), an article that appeared in the Nov. 10, 1993 edition of the *Journal of the American Medical Association*. Its title: "Actual Causes of Death in the United States."

It is based on a simple premise: the cause of death listed on a death certificate and the actual cause of death are often two different things. Death certificates, in other words, are misleading. When the death certificate says that the person died of a heart attack, it doesn't say anything about 30 years of smoking. It doesn't say anything about the peer pressure a 15-year-old encounters to start smoking. It doesn't say anything about an executive at R.J. Reynolds making a conscious decision to kill people for money.

When a death certificate says intercranial hemorrhage, it doesn't say that the woman fell down the stairs because she was drinking. It doesn't say she started drinking, and became an alcoholic, because she was alienated from her family and from society.

Our article, which looked at the death in the United States from this perspective of *actual* cause—and found, for example, that more than 400,000 deaths are caused by smoking, even if death certificates say "emphysema," or "lung cancer," or something related to that—our article is an outgrowth of a meeting we had at The Carter Center in 1985. "Closing the Gap" was our attempt, nine years ago, to look at health in the United States. In that meeting, we asked, "What would happen, what would change, if we applied what science knows?"

This nine-years-later update discovered, in essence, that half of the deaths in the United States are premature. They could be delayed by our own actions. For instance, the leading cause of death is tobacco; the second most common cause—300,000 deaths—is diet; the third—100,000 deaths—is caused by alcohol. This means that today, in the United States, 5,400 funerals are being conducted. One thousand plus are due to tobacco. Two thousand due to tobacco, diet and alcohol.

Our health-care delivery system isn't constructed to solve that problem, and faith groups haven't organized to solve it on the other hand.

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IS IT LIKELY THAT THE HEALTH-CARE SYSTEM will organize to practice preventive medicine? Is this part of health care reform? Although some very large businesses, with thousands of employees and rising health benefits expenses are seeking preventive alternatives, and some insurance companies, to hold down costs, are urging preventive measures, the overall answer is NO.

The health-care system is too immersed in

technology. It is too involved in reacting to problems. It is too organized around curing diseases when they strike. It is not designed to promote wellness or to ensure continued good health.

Hippocrates, the father of medical practice, said, "The function of protecting health must rank above that of restoring it." In 1923, Ghandi said, "I am hard-hearted enough to allow the sick to die if you could tell me how to keep the well from getting sick."

Yet we as a nation simply do not put enough money into prevention, nor do we have an understanding of its potential.

Is it likely that faith groups will help change that condition?

Only if we want it to happen.

Do we have the power to do it?

Kipling wrote that words are the most powerful drug we have.

So this spreading the word about the potential of prevention is one opportunity for faith groups.

Is it likely that the American Medical Association will address poverty, illiteracy, ethnicity, environmental degradation? It doesn't have that inclination. But faith groups could meet those opportunities.

THE SECOND OPPORTUNITY for faith groups is in what is called the social realm. It is really the health realm.

¶ The inability to read is a health problem.

¶ Being poor is a health problem. Death rates are higher for those lower on the social economic level. Poverty is a health problem.

¶ Violence is a health problem. Violence reflects problems with health, but also causes health problems.

¶ Ethnicity is a health problem (120 bloody conflicts in the world today bear that out). Environmental degradation is, at its core, a health problem.

¶ Acid rain, ozone depletion, rain forced destruction—these affect human health.

Is it likely that the American Medical Association will effectively address poverty, illiteracy, ethnicity, environmental degradation? The fact is, it doesn't have that inclination.

But faith groups could indirectly address those opportunities.

A THIRD OPPORTUNITY EXISTS. We need, in the field of health, a unified theory that expresses all science knows about health . . . health in cells, health in organs, health in people, health in human potential, health in communities, health in environments, health on our globe, a theory that takes all the pieces and puts them together in a unified presentation.

And my argument is this: Faith groups could articulate such a unified theory.

I can assure you they wouldn't be competing with anyone. Certainly, the AMA isn't planning to write one.

So what do we need to know? As C.S. Lewis used to tell us, we should both *celebrate* and *cerebrate* the world. We can celebrate, but at the same time, our world is so dynamic, it is changing so rapidly, we have to *think* about what is happening, we have to understand trends and harness change.

Science continues to race ahead of ethics, of social values, of theology. For instance, infant mortality rates are often used as a measure of the health system. That isn't true. They're a measure of social values. Science now can prolong life indefinitely. But does the quality of life matter? What is our theology of dying? Any wealthy woman today can have a safe abortion. A poor woman cannot afford one, isn't covered by government medical care, and must resort to birthing a baby she'll later neglect, mistreat or abandon. How do our ethics apply to the health of that woman and the health of that unborn child?

Science now gives us personal power. We know more now than we did 10 years ago about what we can do to insure ourselves a healthy future. For example, 20th century science only offers a man my age six years more than my grandfather had at the same age. But if I don't smoke, if I drink only in moderation, if I do certain things with my diet, if I exercise, I can live 11 years longer than the person my age not doing those things. The

power I have now exceeds what tertiary-care science can give me.

ON THE GLOBAL SCENE, there's a narrowing in the gap between the mortality rates in developing countries and developed countries. Since 1950, life expectancy in the developing world has gone up 23 years.

At the same time, the gap is widening between what we could deliver and what we do deliver in the developing world. We have so many intervention techniques, and they're cost effective, so inexpensive . . . and we can't get the resources.

There's an enormous gap between the average American investment and what is happening in health in the developing world. I met last night with the Swiss Ambassador to the U.N. He pointed out that Swiss citizens, on the average, give $2 per person to UNICEF. We in the United States give 20 cents per person. He said, "If you would simply come up to our standard of giving, that would be half a billion dollars a year from U.S. citizens to UNICEF."

Medicine has limits in vision—it has yet to recognize violence as a health problem. Faith groups, unhindered by politics and endowed with vision, could be the force of change.

TODAY FAITH GROUPS seem to be exhibiting greater awareness of social—health—problems. There's growing interest in the homeless, in the problems of AIDS, and, certainly, with violence. Everyone's interested in violence. But who offers real solutions? Politicians have limits on the speed they can move in this area. Medicine has limits in vision (it has yet to recognize violence as a health problem).

Faith groups, unhindered by politics and endowed with vision, could be the force of change. I would like to see the National Rifle Association confront the churches—that would be the defining

The 10 Leading Medical Causes of Death . . .

Heart Disease	720,000
Cancer	505,000
Cerebrovascular Disease	144,000
Accidents	92,000
Chronic Pulmonary Disease	87,000
Pneumonia and Influenza	80,000
Diabetes	48,000
Suicide	31,000
Liver Disease, Cirrhosis	26,000
AIDS	25,000
TOTAL	2,148,000

. . . And Lifestyle Factors Leading to Half of Them

Tobacco	400,000
Diet, Sedentary Lifestyle	300,000
Alcohol	100,000
Infections	90,000
Toxic Agents	60,000
Firearms	35,000
Sexual Behavior	30,000
Motor Vehicles	25,000
Illicit Drug Use	20,000
TOTAL	1,060,000

The nation's investment in prevention is estimated at less than 5 percent of the total annual health care cost.

SOURCES: NATIONAL CENTER FOR HEALTH SERVICES, ESTIMATES FOR 1990 BY DEPARTMENT OF HEALTH AND HUMAN SERVICES, THE CARTER CENTER

moment in changing the violence equation in this country.

Already, faith groups are certainly offering innovative programs in many areas. We have to figure out how to replicate that. We're also seeing more coalitions among faith groups. On the plane yesterday, I read an *American Journal of Public Health* article on the success of a religious coalition of Catholic, Baptist and Episcopal groups in cardiovascular risk factor screenings. So, despite our diversity, we can work together.

This is true domestically. It's true internationally.

But are we willing? Are we ready to try?

There are many tests awaiting us. Demanding from us, in fact, a united voice, a voice of faith over politics and myopic vision. I'll single out one: medical care reform.

Here is a truly important social change we've needed for so long. Our medical care system has been an embarrassment to this country. But three things are still missing, I think, in the discussion of medical care reform. I believe faith groups could change this.

Number one, we still don't talk about outcomes. All of the discussion is on access, quality and cost—those aren't the same as outcome. If we concentrated on outcome, we'd understand that a person needs access and quality, but he/she needs other things as well.

Number two, we don't have a correct sense of why we're debating medical care reform. In most people's minds, it comes down to cost. That's not the main issue. The reason we should be having this discussion is for health reform. Medical care reform is only part of the process of getting health reform.

Number three, I've heard no discussion about the fact that medicine used to be a service profession. Over the years, we've forced physicians to become entrepreneurs—it's not their fault—and doctoring has become a business. And I hear no discussion of using health care reform to get us back to that service-profession ideal.

Faith groups could address these issues of health reform. Faith groups could make a difference.

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HOW? CAN WE OVERCOME our differences long enough to make a difference? Can we listen to each other long enough to speak with a single voice on questions of health?

We can, if we keep reminding ourselves of what we believe. Ghandi said, "I have trouble"—speaking of himself—"living up to the convictions I stand for." He also said, "I have to keep being reminded of what I stand for." Religious groups have already revealed the ingenuity, the creativity, the passion to discover better ways of healing.

And we can if we keep on learning—sometimes the hard way. About 18 months ago, I overheard on CNN a report on a boy of 5 who had taken the family car to drive to New York. The state patrolman said, "I saw this car go by and I thought it was a runaway car. I didn't see anyone in it." He followed, finally realized someone was in it, he turned on his siren and lights. The car pulled over. The policeman walked up to the car and there was a 5 year old boy at the steering wheel. In the back seat, in a seat belt, was his three-year-old sister. They had decided to go to New York to visit friends, had gotten the mother's keys out of her purse, and had driven out of the driveway and down the road.

Finally, they interviewed the boy. The interviewer asked, "Have you learned anything from this?"

And the boy said, "Uh, huh."

"What?" said the reporter.

"I learned how to drive," said the boy.

It's time we learned, in practical ways, how to close the gaps between the what we know and what we actually deliver, between what we believe as faith groups and how we live, between the best examples of faith in action and the way we work on an everyday basis.

It's time we learned, in practical ways, how to close the gaps between the best examples of faith in action and the way we work on an everyday basis.

And it's time we learned, in practical ways,

how to close the gap between today's wants and tomorrow's needs.

I RECENTLY REREAD THE STORY OF ARCHIMEDES; it's a great story. The king wants a new crown, so he gives gold to the artist Salini and asks him to mold one. Salini comes back with the crown and the king loves it. It's just perfect. But the king's a smart man. He worries that Salini has stolen some of the gold. So he weighs the crown. It weighs just as much as the gold he gave the artist. But he keeps worrying: "Did Salini figure out a way of stealing some of my gold and diluting what's in the crown?" He finally goes to Archimedes, the leading scientist of the day, and he asks, "Do you know a way to test this?" Archimedes thinks about it for several weeks. One day, as he got into the public bath the water overflowed the tub, he suddenly realized how he could test the king's crown. He ran naked through the streets yelling, "Eureka"—it's easy to get sidelined here, wondering what kind of an insight I would have to have before I would ... At any rate, he put the crown in water and measured how much water was displaced. He then submersed an equal weight of gold. And they weren't the same.

I've always liked this story because it has science. It's a detective story. But this time when I read it, a totally different reaction came to mind. This is a 20th century metaphor that tells us how we're stealing the resources from the future and we're passing our actions off as a crown of glory and scientific achievement.

If we are to be good ancestors, if we are to actually think about a child being born 500 years from now, and if we are to be the responsible human beings that we're supposed to be, then we have to change that.

It's going to require a minimum of three mindsets:

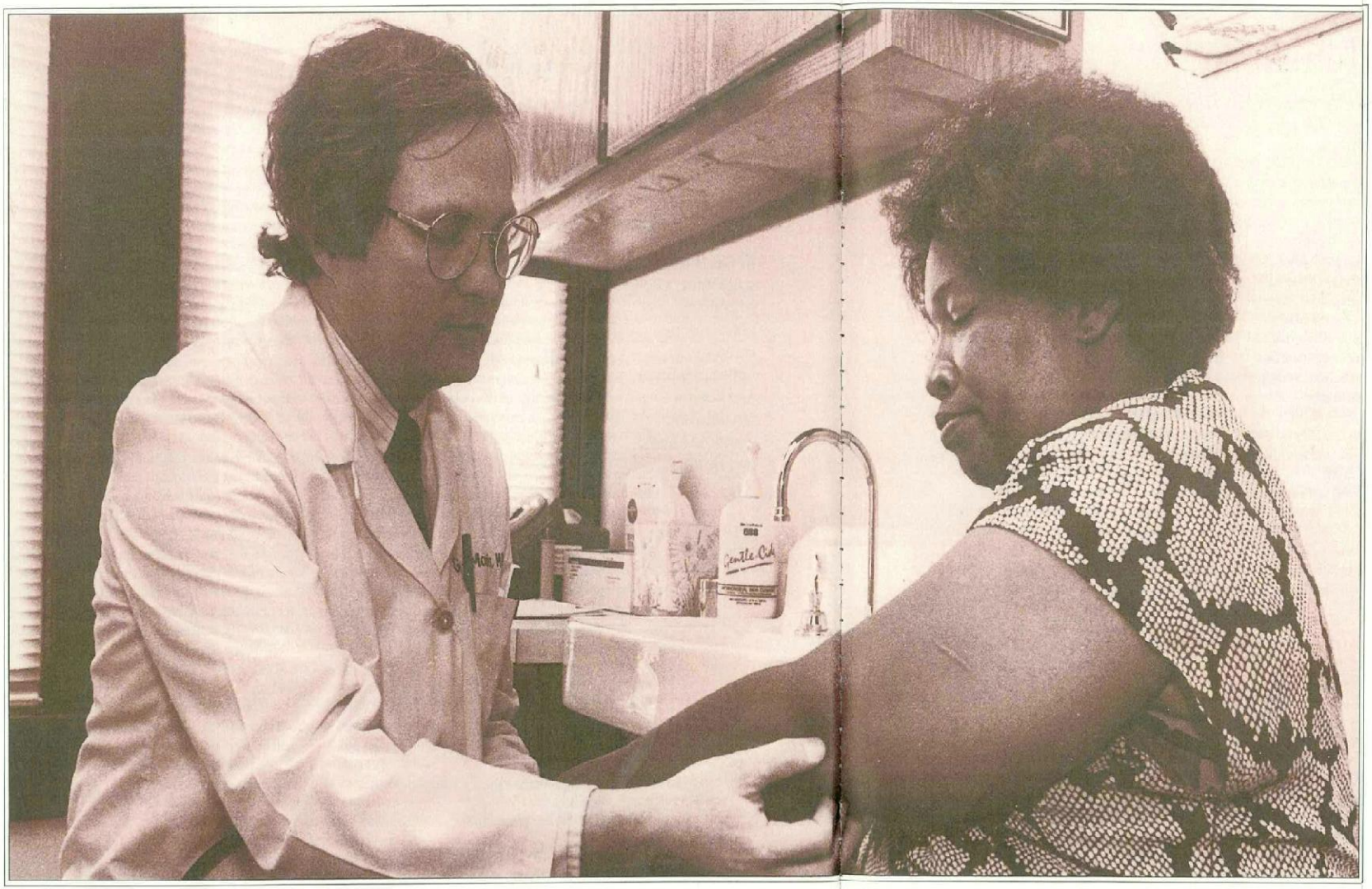
First, a sense of community that transcends geography and time. Ghandi said, "We should seek interdependence with the same tenacity that we seek self-reliance." Interdependence means we are comfortable thinking of Africans and Asians as family, and we feel kinship with those born 200 years ago and those coming 200 years in the future. This is a role of faith. We understand community and we understand time. We could provide leadership between the wants of today and the needs of tomorrow.

Second, a sense of equity, a sense that all people share in the bounty of this world. We glibly say, "God wants us to enjoy this." And it's true, He does. But if it's true, that means He wants everyone to enjoy it. Ironically, equity is hard to find outside of government programs. Think about that. Government is the only organization that represents all of us, but yet the sense of all being equal, in the sight of the Creator, is very much the teaching of the faith community.

Third, a sense that all things are interconnected. Hair spray and the ozone layer, hamburgers and the rain forest, health in Zaire and gross national product in Atlanta. Faith groups have this view of unity and purpose. Ghandi said that people often become what they believe themselves to be. We in the faith community need to believe ourselves the servants of both the present and the future. We in the faith community need to believe ourselves the interface between science and health, freedom and equity, generic solutions and individual concerns, medicine and healing, technology and ethics, individual greed and social need.

If we are able to believe ourselves as servants who bridge these gaps, the mission of faith groups will be ever clearer, our sense of purpose ever stronger, and our redemptive force will ensure the world will be forever better.

We in the faith community need to believe ourselves the interface between science and health, freedom and equity, medicine and healing . . .



A Time For Faith To Act

At the Church Health Center in Memphis, founder Dr. Scott Morris examines Rita Stokes. The center, largely staffed by volunteers, is an interfaith project sponsored by a growing network of more than 100 congregations.

Time for a Turnaround

Violence is a deadly plague of our society; our kids are killing our kids

By Mark Rosenberg
DIRECTOR, NATIONAL CENTER OF INJURY PREVENTION
THE CENTERS FOR DISEASE CONTROL

A DECADE AGO, the Centers for Disease Control started looking at violence as a public health problem. Today, there is no question that we have a crisis of violence in America. Five or six years ago, you had to tell people the statistics to convince them how bad it was. That's not true anymore. Once newspaper stories about a kid being shot at school, about a young baby being killed in a drive-by shooting—once these were from "other parts" of the country. No longer. Now these are your headlines, my headlines, our headlines.

So danger is there, everywhere, and the danger is clear. It's widespread. Make no mistake about it. Violence is epidemic.

If you compare homicide rates in the United States with the 17 other highly industrialized countries around the world, you'll note some major differences. Of the other industrialized nations, Japan, for example, has 1.2 homicides per 100,000 people. In England and Wales, it is 2 per 100,000. Australia has a high rate, 5 per 100,000. But these are insignificant when you consider United States: here the rate is 8.4 per 100,000 and growing.

Let's examine that figure more closely. The U.S. rate for white males more than doubles the next highest rate. But the rate for young Black men hardly fits on the charts. Between 1986 and 1988, murder rates for black males went up by 38 percent. Now they're even higher. And they're going up faster than ever before.

By the way, being Black does not cause high rates of homicide. There is no connection between race or ethnic status in homicide. We break the statistics into Black and White because the figures are easy to come by; however, if you factor in socioeconomic status, violence rates for Whites and Blacks are about identical. The differences go away.

What do the differences reflect? They reflect discrimination, poverty, lack of opportunity for jobs and lack of actual jobs, lack of opportunity for education, social disintegration, easy access to guns, living in an environment where drugs and alcohol are prevalent and living in a social environment where there is decay and apathy. Does this sound similar to other health problems? Sure. It's a common story, but again, *race is not the cause*.

LET'S CONTINUE OUR ANALYSIS, then. When you study the data, what stands out is a picture of homi-

Dr. Mark Rosenberg, director of the Center for Injury Prevention and Control at CDC, is board certified in both psychiatry and internal medicine, and has additional training in public policy. He was educated at Harvard and completed residencies in internal medicine at Massachusetts General Hospital, in psychiatry at Boston Beth Israel Hospital, and in preventive medicine at CDC. He is on the faculty of Morehouse and Emory schools of medicine. His research and programmatic interests have concentrated on injury control and violence prevention. An avid photographer, he has published a pictorial essay of six patients that includes interviews: Patients, the Experience of Illness.

We have a problem in our society that doesn't occur in other industrialized countries. Our children are killing our children.

cide in this country that is very different from what most people believe. Most people think that homicide is sort of accidental—that most homicide victims are people who get caught in a late-night robbery attempt that ends in a crossfire shootout at the convenience store.

When we analyze thousands and thousands of cases, we discover this is not, in fact, the picture at all. Most homicides occur among people who know each other. They occur among "friends" . . . among acquaintances, people who argue, people who fight. They are usually in the home, not at the convenience store, not on the street—in the home.

Today's typical homicide is not felony-related. It's not related to a drug deal. It's just two people who know each other, they disagree, the argument escalates, they're drinking—alcohol's an important factor. One friend has a gun. He grabs the gun and "bam," that's your homicide.

A few other facts about the faces of this particular epidemic. For years, homicide rates climbed pretty steadily. In the 1970s, they reached a peak and, in the 1980s, began a brief decline. In the mid-'80s, crack was introduced. Crack became a real catalyst. Alcohol had been the main catalyst; now crack wrapped itself around these other risk factors—poverty, illiteracy, discrimination, joblessness; it took them and just sped up the process of friend killing friend. Homicide rates started to take off. They're now higher than they've ever been and accelerating faster than ever before.

The people who are affected are primarily young. And they're getting younger. FBI data show that perpetrators are getting younger and victims are getting younger. It used to be that when we talked about young people being murderers and being murdered, we were talking about young people in their 20s, even early 30s. That's not the case anymore. Now the highest rates are in the 15-to-24-year-old age group and there are many, many reports of 12-year-olds killing other kids and of 5-year-olds bringing guns to school.

We have a problem in our society that doesn't occur in other industrialized countries. Our children are killing our children.

It's horrible.

It's the first time we've faced it and it's the face of this epidemic: the face of a child.

Children have always fought. You know that. But now, when kids fight, the fights are more likely to be fatal. What makes the difference? They're not fighting with fists, they're fighting with guns.

Which brings us to the other critical element in this epidemic of violence.

Guns.

How critical are guns?

Extremely. Firearms play a central role in the escalating rates of violence. In this country, we have a vast amount of firearms in circulation. Every 20 years, starting about 1950, the number of firearms in circulation in this country has doubled. From 1950-1970, it doubled; 1970-1990, it doubled. We now have about 217 million guns out there—not quite, but dangerously close to one for every man, woman and child in this nation.

❧

In 1988, for the first time, more teenagers in this country, Black and White teenagers, died from firearm injuries than all diseases combined. Firearm injuries are the second leading cause of death for young people. Starting at 10 years old, firearms are the second leading cause of death for our kids.

Think about it for a moment: here's a very dangerous, very deadly consumer product that we basically leave unregulated.

Gun-regulation. We haven't addressed it. We haven't touched it.

We've done very well regulating those who can drive cars. This is one of the unsung miracles of modern public health, our success story of motor vehicle injury prevention. In this country, we began a focused effort in the 1960s. We created the National Highway Traffic Safety Administration. We put money into research. And we basically stopped the carnage on the highways. You don't even hear that term, "carnage on the highways," anymore. Over the past 25 years, we've probably

saved about a quarter of a million lives. The way we've done it, is not by banning cars. What we've done is make cars safer. We have safer roads. And we have safer drivers. We don't have as many drunk drivers on the road anymore—we have too many, I admit. They are still there. The problem has not gone away. But it's been reduced. We license drivers. We register cars.

We made a significant investment in research and analysis and regulation and it's paid off.

We can do the same thing with firearms.

At the CDC, we've tried to transform the debate about firearms and gun control from a political, philosophical question. We want to get away from the cliche that "if you are a Conservative, gun control is bad; if you are a Liberal, gun control is good."

What is the possibility of transforming the debate to one of science and public health? What chance do we have to start to put into place regulations that will make a difference?

To regulate guns will clearly require the same approaches we used on cars: different steps, lots of interventions based on research, experiments with what works, what doesn't work. Our efforts worked incredibly well in the area of motor vehicle injuries. So well, in fact, that firearms now surpass motor vehicles as the leading cause in injury death in six states.

If it's worked with cars, why can't it work with guns?

The risk of having a gun in your home is very, very high.

Consider:

¶ If you have a firearm in your home, odds are 43 times higher that it will be used to kill someone that lives in your house, than to kill an intruder.

¶ If you have a gun in your house, the risk of suicide by someone in your house doesn't double, doesn't triple, doesn't quadruple, it goes up fivefold. The most likely victim is your child.

¶ If you have a gun in your home, the risk of homicide to someone in your home triples. If you ever argue with your spouse, with your children, especially if there's been any history of physical pushing or shoving, the risk of murder with a gun in your home goes up 20 times.

Gun regulation offers some remedies in those case. Intervention can change the statistics.

We also need to understand that there are lots of things we can do to affect the behavior of young people. Nurses in prenatal program can go into the

If you have a firearm in your home, odds are 43 times higher that it will be used to kill someone that lives in your house, than to kill an intruder.

home and instruct parents in child care and parenting techniques; that can make a real difference in child abuse and reduce the chances of subsequent violent behavior. At later ages, programs like Head Start, then mentoring and Big Brother/Sister programs, can become opportunities to teach children and young people nonviolent conflict resolution.

We can increase and make more effective programs that control drug trafficking and point out the dangers of alcohol abuse.

There's lots that we can do to build community while changing the environment in which our most violence-prone children and young people live. But perhaps most important, we can insure educational opportunities, we can provide jobs. We can give hope.

This is time of crisis, but also of opportunity.

❧

FOR THE PAST SIX MONTHS, a task force constituted by heads and deputies of various Federal government departments has been working on this problem. Its members include representatives from Health and Human Services, Justice, Labor, (these kids need jobs), Housing (because public housing is riddled with the problem), Agriculture (the problem is rural as well as urban) and Drug Abuse Enforcement. This is the first time I can recall such attention to the issues of violence from this high a level.

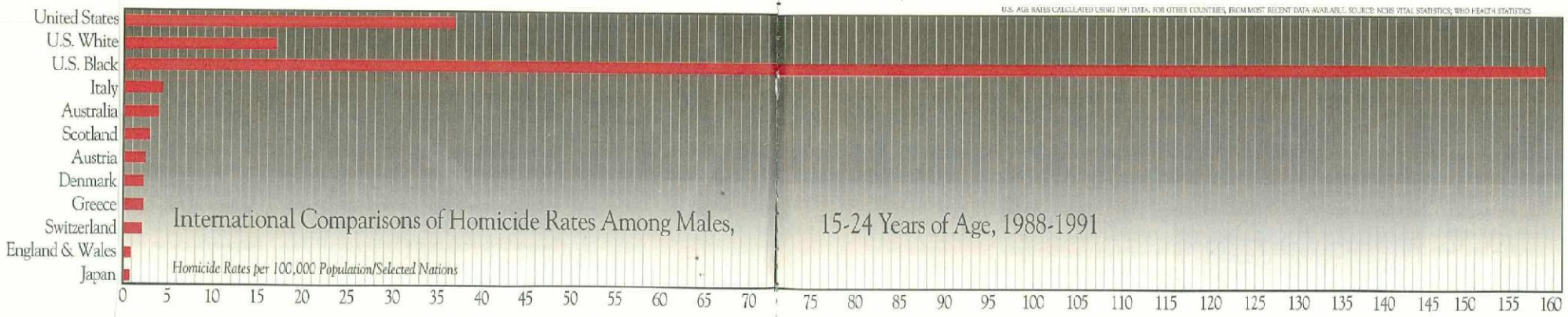
The task force has looked at family violence, youth violence, sexual assault and hate violence or intercommunal violence; it's considering the role of the media and guns.

Nevertheless, even if government gears up, even if you hear the President talk about it, violence prevention is not going to take root unless it becomes local, community, personal, individual.

The Crime Bill being debated in Congress represents action on the issue of violence: its provisions—more police officers, stiffer sentences for violent offenders—offers a partial solution. People are scared to death right now and rightfully so. A 14-year-old kid who's hopeless with a gun in his hand is a very scary, very dangerous person. We need to help people feel secure.

Community policing, where police learn their neighborhood and walk on foot through a neighborhood and participate in neighborhood activities might be good. Locking up people after three violent-crime felonies might be good. The average

Violence prevention is not going to take root unless it becomes local, community, personal, individual.



International Comparisons of Homicide Rates Among Males, 15-24 Years of Age, 1988-1991

time served for a violent felony today is about two years. So keeping them in jail for a little longer after they've killed or raped for the third time, that might be a good idea.

What I want clearly understood is, more police and stiffer sentences are not enough. Not by themselves. We have more people in prison now than ever in the history of this country and the homicide rates are the highest.

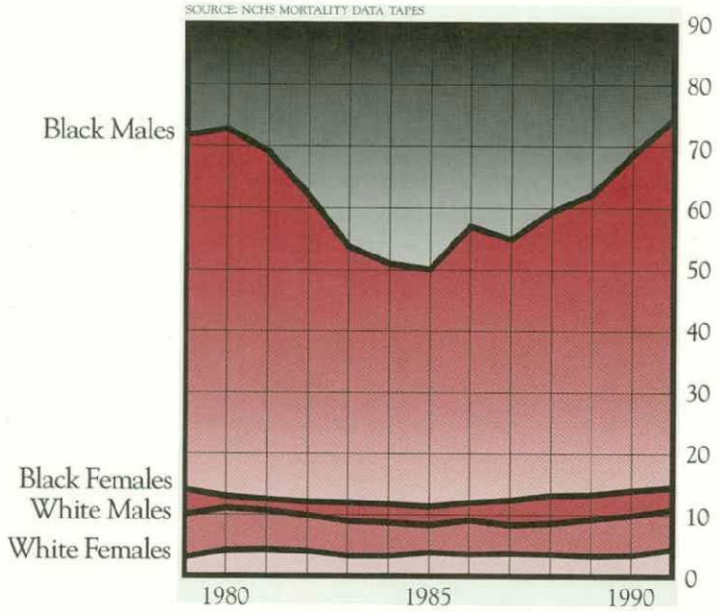
I'm optimistic that we can find ways to work together to reduce the levels of violence plaguing our nation . . . to curb the epidemic of firearm abuse.

THE PUBLIC HEALTH APPROACH emphasizes three things. First, prevention—taking action before victims become victims and perpetrators become perpetrators; second, intervention: letting science help; and third, integrating the leadership: public health working with community, community working with criminal justice, criminal justice working with scientists; Black working with White, conservatives working with liberals—that's probably the most radical, and where I find the most resistance.

Personally, I believe our intervention can make a very big difference. Personally, I'm optimistic that we can find ways to work together to reduce the levels of violence plaguing our nation. Personally, I am convinced we have the willpower and the scientific understanding necessary to curb the epidemic of firearm abuse.

Recently President Clinton spoke in Memphis on the subject of violence. His words mirror my hope: "We will, somehow, by God's grace, turn this around. We will give these children a future. We will take away their guns and give them books. We will take away their despair and give them hope. We will rebuild the families and the neighborhoods and the communities. We won't make all the work that has gone on here benefit just a few. We will do it together, by the grace of God."

Homicide Rates by Race and Sex United States, 1979-1991



"The Prevention of Youth Violence - A Framework for Community Action," a CDC pamphlet, compiles examples of community-based activities to reduce violence. For information on it and other CDC materials related to violence, contact the Centers for Disease Control, ADDRESS, 404 488-4690.

Time to Join Forces

Integration, not separation, of church and state promises better health for all

By Jocelyn Elders
SURGEON GENERAL OF THE UNITED STATES

SEVENTY PERCENT of the premature deaths in our country are the result of social and behavioral problems, as well as environmental problems—problems that have solutions, problems that are preventable. Yet less than five percent of our health-care dollars are spent on keeping us healthy—that's the liberal figure, the figure that includes *everything*. In truth, less than one percent is spent on things like prenatal care, immunization, family planning and health education. Yet those are things that keep us healthy. In fact, we spend most of our health-care dollars on prolonging dying, rather than preventing illness.

Today two powerful forces have come together in the first stages of a union that could change that. The interfaith community and the public health community. Together they—together *we*—can ignite a revolution that changes national attitudes about health-care and preventive medicine.

In the United States, we pride ourselves on the doctrine of separation of church and state. But we need an integration of church and state in the arena of public service. We need to blend those things that the interfaith community do well, and those things that the public health sector do well. Put them together to make things happen. Government has had all these targeted, single-line programs; faith groups have had all these isolated, individual efforts. What we must do now is find a way to sew together everybody's quilt pieces, the faith community's quilt pieces and the government's quilt pieces, so that every American is covered by a quilt of health-care.

My brother started me along that track. He is a United Methodist minister in Arkansas. "Sister, if you want to get something done in this state," he told me when I came to the Health Department, "you need to hook up with the network of churches. I'll take you to meet the ministers." We met and we talked. Not everyone agreed with everything I wanted to do, but they voted to support our plans for school-based clinics.

Another example: I had been health director in Arkansas only a short time when Rev. Bill Robinson of Hoover United Methodist Church told me he was having little success assembling an AIDS task force of minority persons. So I helped him find people he needed.

That cooperative effort led to cooperation in

The first African-American and only the second female to be Surgeon General in the nation's history, Dr. Joycelyn Elders is the former director of the Arkansas Department of Health. Elders, the oldest of eight children of a teenager mother and sharecropper father, grew up in Schall, Ark. She graduated at age 18 from Philander Smith College before going into the U.S. Army. After graduating from the University of Arkansas Medical School (UAMS) in 1960 with her M.D. in pediatrics (she later earned a master's degree in biochemistry from UAMS), she had a successful career as the country's only Black pediatric endocrinologist, publishing 150 papers on various topics. She has long been an outspoken advocate of school-based health clinics and early sex education.

drug programs, an AIDS program, an abused women program, day-care centers, our Hold Out The Lifeline programs—all those programs that we supported and were involved in with Reverend Robinson—we were so busy together, Rev. Robinson thought he worked for the Health Department for the next few years.

Early on he invited me to meet with the Ministerial Alliance, a group representing the Black ministers of Little Rock. I remember coming over that noon. I presented the things that I wanted to do and I asked them what they thought about it and I asked them to help me.

I went also to the religious forum; it's mostly white ministers. I talked about school-based clinics, health education and condom distribution, and afterwards the Catholic priest stood up. He said, "Most of you know that some of the things that Dr. Elders is talking about are against our teaching. But," he went on, "I know we've got a crisis in our community and that requires crisis intervention and I support Dr. Elders." After that powerful statement, everybody voted to support the program.

One person, one person can lead to change.

Churchgoers, people of faith, can make a difference.

I quickly caught on to that fact. I changed the way I operate. I couldn't work just 8 to 5 weekdays. I found myself doing more work on Sunday. My brother would say, "My sister is a member of my church but we don't see her anymore. She's too busy speaking in everybody else's church."

Here we are, the richest country in the world, fighting about how we're going to pay for health-care reform, and there's no national debate about how are we going to pay for all of those bombers we don't need.

YOU ALREADY KNOW that there's a health-care crisis in the United States. A fearful, far-reaching crisis. More than a million people in America are HIV positive. That's 1 in every 250 people. In Washington, D.C., 1 in 77 high school students are HIV positive. Teenage pregnancy is a major problem. More than 1 million children become pregnant every year, more than 500,000 births. We have millions of homeless people in our society—about a third of them are mentally disabled. Another third of the homeless are children. Many of these children are hugless, too: nobody cares about them, nobody loves them. In our society, it's easier to get drugs than hugs. It's also easier to buy a gun than to find a good friend, to find a good minister, to find a good teacher.

In the richest country in the world, 3-5 million children go to bed hungry every night. These children are among the 38 million people in our society who have no access to health care.

So here we are, a society fighting about whether we need health-care reform and how we're going to pay for health-care reform, and there's no national debate about building bombers—nobody's asking how are we going to pay for all of those bombers and missiles and tanks we don't need.

We believe every American has a right to health care. That's the basis of the Clinton administration's push for reform. Every American, not just those who can afford it, needs to be assured of medical coverage. Every American has that right, I told a group of lawyers; that's what we are fighting for, I said. One of them asked, "Who gave them that right?" I replied, "If every criminal has a right to a lawyer, why shouldn't every sick person have a right to a doctor?"

I'll ask you that same question. Why shouldn't every sick person have a right to a doctor? If you believe in that right, it's time we joined forces and got started. Together. Because we're more effective, both of us, when we work together.

What do I see as the role of the interfaith community?

I urge you to continue what you're doing; do more; and, to be really successful, focus on prevention. If we were ever going to improve the health of our country, we've got to invest in prevention in public health, government, business—and faith communities—have to invest in prevention. Much more must be set aside for underserved communities. The poor require more than a gold credit card.

Health-care reform won't fix all our problems. It won't end homelessness; it won't end teenage pregnancies; it won't end child abuse and woman

abuse; it won't end the illicit sex that leads to AIDS. These and hundreds of other serious ills we've got to try to prevent. We in public health are working on that. You need to work on that, too. And through our partnership, the partnership of the faith community and our public health agencies, we can marshal the power to make changes.

In your communities, you've got prestige and influence. You've got access. We've got scientific knowledge and know-how. Will you allow us to add our technical skills to your pulpits and projects?

As ministers and laypersons active in the mosques, temples, synagogues and churches of your communities, you are in positions of leadership. Will you lead? Or will you wait to find out which way the wind's blowing and jump out in front.

It's time for you to be counted, time for you to be committed, time for you to be involved. For the children. For the elderly. For the people with AIDS. For the homeless. For the helpless and the hopeless.

THE AREA OF CHILDREN'S RIGHTS offers an example. Kids have few lobbyists. So they get the local, state, and national budget leftovers. People are all for programs for children . . . until the discussion turns to money: how much will it cost to provide prenatal and infant nutrition? To provide day-care? To provide head-start programs for everyone? To insure quality care for the abused, the battered, the neglected and the abandoned? How much will it cost? Can we afford it?

As a nation, we spend $23 million an hour on defense. We bailed out the savings-and-loans at a cost of $8.7 million an hour. Our children—our nation's future—get $1.3 million an hour and it isn't enough to provide a good start, a healthy start.

Our partnership needs you to insure we have sound programs and policies that make a difference in the lives of children, of elderly, of everyone in your communities and our nation.

To do that, you need to get out and go to work. You've got to employ your wonderful resources in the cause of health-care and prevention. You've got the space. You've got the people. You've got transportation. You've got recreational facilities that are closed more hours than they're open.

We want you to focus on education. We can't keep a society healthy that's ignorant, so we've got to better educate our children. We've got to start early. We've been doing too little too late. Children are half as tall as they'll ever be by the time they're three. They know half as much as they'll ever know by the time they're four. Hope, will and drive has been determined by the time they're 5. We need you to help us get early childhood education for all children. Eighteen percent of Medicaid children do not receive early childhood education—85 percent of other children do. Many of you have wonderful facilities for early childhood education. You need to make sure those facilities are used for the children who need them.

It's time for you to be counted, time for you to be committed—not just concerned. When you're committed, you give your time, your talent and, yes, you give your money. It's time for you to be involved. For the children. For the elderly. For the people with AIDS. For the homeless. For the helpless and the hopeless. For all who need preventive care and health-care and have no one to turn to.

We all know that opportunities are like hair on a bald head. They only appear once. Right now you've got somebody in the White House who's concerned and committed. You've got a First Lady who's concerned and committed. And you've got a Surgeon General who is concerned and committed.

Can we, together, interfaith and public health, make the changes that are needed so desperately? Have we the willpower, the stamina, the courage, to fight for the health rights of every American? I'm reminded of the story of the man who's dancing with a bear. He's obviously tired, and somebody asks why he keeps on dancing; he says, "When you're dancing with a bear, you can't get tired and sit down. You have to wait until the bear gets tired and sits down; then you can sit down."

I feel like I've been out here dancing a long time. Now I'm looking for some new partners for this old bear, so we can wear him down, so we can retake possession of our children and our communities, so we make this wealthiest nation on earth also the healthiest nation on earth.

Time to Challenge the Systems

It is our willingness to put our lives on the line that will make the difference

By Donna Willis, MD
THE DISCOVERY CHANNEL

I AM A MINISTER'S DAUGHTER, *a minister's grand daughter. I grew up in church. So I can't remove myself from my faith. As a medical scientist, I am trained to look at the hard data, to process in objective measurements. Yet I grew up hearing and visualizing greater realities.*

LET ME PAINT A PICTURE of two medical students, two medical students from different generations. One is named David, one is named Donna. One was born into a family who suffered the Holocaust. The other's family suffered slavery. These two medical students matriculated, one at Johns Hopkins, the other at Loma Linda. Their paths collide in Baltimore.

The medical student, David Levine, looked at the community around his college, and asked, "How can this be a prestigious institution when its community—where it is supposedly a citizen—has the worst statistics of death and disability in the state of Maryland and among the ten worst in the nation? How can this be?"

David began a project to reduce hypertension in a 44-census tract area around world-renowned Johns Hopkins University School of Medicine. For his allies, for his working partners, he identified more than 300 houses of worship, because churches are stable, temples are stable, mosques are stable in the community. Even when businesses leave and people leave, the houses of worship stay. In his hypertension project, he taught non-health professionals to make a difference. To do those kinds of things for their members that would give hope and confidence, health and well-being.

About this time Donna arrived in Baltimore after graduating from Loma Linda.

I entered Baltimore on the television tube, a medical correspondent, and that's the way I hooked up with David. He looked at me and said, "We need you to help us."

Help you do what?

As I sat there, I saw in David's research data that by training non-health professionals, his project had cut hypertensive death rates in half. By training non-health professionals, he had cut hospital use rates in half. By linking academia with faith community, he had improved the health of the Johns Hopkins neighborhood. And it dawned on me, "David has proven one person can be a tool for change."

So I say to you, "You're a tool for change."

David took on a community with severe health problems. He made a difference. One person can make a difference.

"Who are you going to take on?"

My job is to do my part where I am. Your job is to do your part where you are.

Dr. Donna Willis is the medical correspondent for NBC Television. She also hosts the Learning Channel of the Discovery Channel. She received her medical degree from Loma Linda University in California, did residency at Mayo Clinic and got a masters in Public Health at University of Michigan.

I urged my father, "Let your church be a model for change." And that's what it became. Now that church sponsors senior citizen dwellings. The church did it—a $2 million project. The little church did it. They're getting ready to build a skilled nursing facility.

If you're committed, you can do miracles.

What do we do?

We start out with a basic fundamental principle of individual commitment because individual commitment leads to institutional commitment. And institutional commitment means freeing up resources, personal and tangible.

In your faith, are you ready to talk or to be a tool for change? Are you ready to make a difference?

IN THE INTRODUCTION TO the *Breath of Life, Heart, Body and Spirit Workbook*, it says, "Visualize your nation, your city, your community, your family. Picture. Visualize. What do you see? How can you apply your talents, skills and education to enrich your nation, city, community and family?"

We often ask kids to name the truly great men and women of their lifetime—politicians, war heroes, sports figures, maybe parents and special friends. So they picture their heroes. Maybe one is Michael Jordan swoooooshing through the air. We tell them how he was once cut from the team, he wasn't good enough. They say, "Then how did he get to be a superstar?" And then we began to teach discipline.

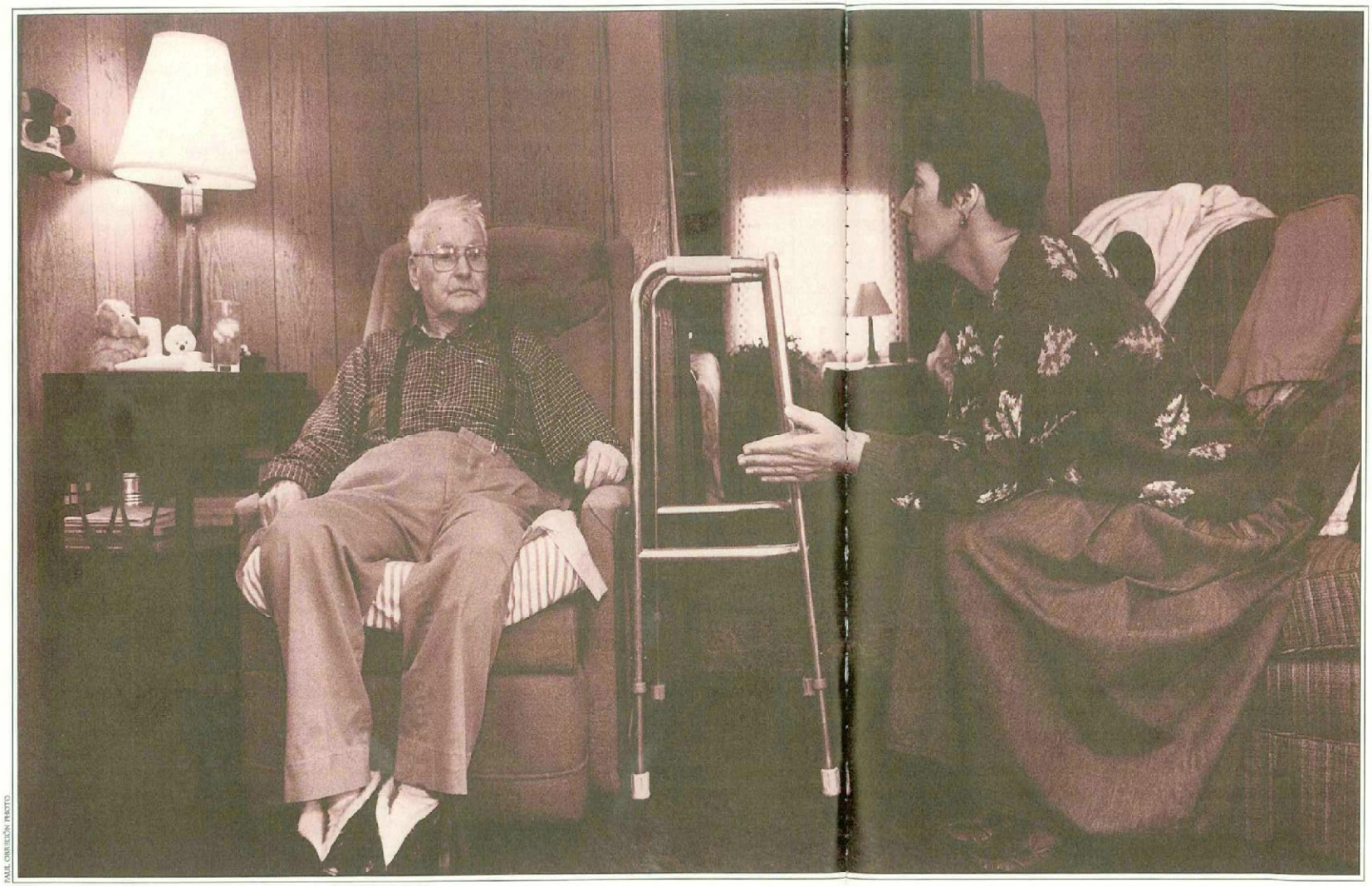
On our TV show, we stress that people have different personalities and temperaments and styles of learning. If you understand that, you can organize any group of people to do anything, because you build on their strengths. You don't harp on their weaknesses.

And once you've got them captured, you can convince them that they can be public health workers. David proved that.

And you can convince them its time to see the problems—the problems of your community, your neighborhood, your street. They're there, around every church, every temple, every mosque. When the religious community takes care of Jerusalem, then it can go to Judeah. And once it's done that, it can go to Samaria.

In your faith, are you ready to talk or to be a tool for change? Are you ready to make a difference? If one can do it, you can do it. You are accountable. Now be a tool for change.

Signs of Hope and Challenge



PAUL CHRISTIAN PHOTO

Diane Green, a parish nurse for St. John's Baptist Church in Charlotte, N.C., visits homes, counsels, helps community residents discover new avenues to health-care and preventive medicine. Nationwide, thousands of congregations are involved in the growing Parish Nurse movement.

Acting in Hope

Substance abuse: There is a healing power that can bring wholeness to all

Felton May
RESIDENT BISHOP, THE UNITED METHODIST CHURCH

IN 1989, FOR THE FIRST TIME, the Council of Bishops of The United Methodist Church allowed a bishop from one episcopal region to address a specific problem in another region. As a result, Bishop May spent 1990 working with 14 congregations in southeast Washington, D.C., and neighboring Prince Georges County, Md., an area gripped in a vice of drug and alcohol abuse, and violence. ❧ Bishop May, a native of Chicago, was educated at Judson College and Crozer Theological Seminary. He became involved in faith and health issues in the late 1960s when he established methadone support groups while serving as a pastor in Wilmington, Del. His interest reached a new level in 1989 when, "it became obvious the church needed to speak. This is a spiritual issue," he says, "one that affects the social fabric of our nation. If we do not have good health, our nation will come apart at the seams." ❧ Bishop May has returned to Harrisburg. But the work done during his year in Washington is being replicated by United Methodists across the country through a program, "Communities of Shalom," that links congregations and community organizations.

MY CONVERSION EXPERIENCE was the result of watching a television expose on drugs in Washington, D.C. I had turned it on mistakenly; I wanted to watch Bill Cosby. I sat there looking at the blinking lights and the ambulances carrying a young man from the streets of Washington to a hospital and I said, "I can't watch this mess." So I switched to Cosby and the Huckstables. They were saccharin sweet and I said, "I can't watch this either." So I went back to "48 Hours."

And suddenly I realized that I was caught between two lifestyles.

That began a long journey of trying to discover what it meant to bring wholeness and healing and well-being to those that were addicted to illegal drugs, alcoholism and violence.

I finally decided to say to the Council of Bishops of United Methodist Church that I could no longer be a bishop while people were dying on our streets. I could no longer pacify congregations or wipe the noses of recalcitrant pastors. I needed to be where the life and death issues of the world seem so powerful. So in my middle-age, I took a one-year assignment to work with 14 congregations in the southeast community of Washington, D.C.

I came into a room of about 100 people ready to lay upon them the best programs that the denominations of this country had designed. In all my Episcopal glory, I told of the wonderful things I was going to do. A woman stood up and pointed her finger at me. She said, "Bishop, if you expect to get to first base, I hope that you haven't brought us another bunch of programs.".

She said, "This is a serious matter. Drug abuse in Washington is a serious matter and there is no

"Drug abuse is a spiritual problem and unless you are a spiritual man with spiritual answers, you're not going to get to first base."

program that you can bring that's going to help it."

She said, "It's a spiritual problem and unless you are a spiritual man with spiritual answers, you're not going to get to first base."

Everybody applauded.

I felt like, nobody points a finger at a bishop and gets away with it. I was warm. My ego was out of shape. After all, I was sacrificing my life to be with these people.

The next morning I visited St. Elizabeth's hospital. We wanted to set up housing for pregnant teenagers. The chaplain, Clark Ange, a good United Methodist pastor, said, "May I say something to you?"

I said, "Yes."

He seemed nervous. He said, "Bishop, in this arena of chemical dependency and alcoholism and violence, we have our backs against the wall. Psychiatrists, psychologists, psychotherapists, doctors, nurses, social workers, we have our backs to the wall. It is a serious problem.

"It is," he said, "a spiritual problem. Unless you have spiritual answers and you are a spiritual person, you're not going to get to first base."

I said, "Clark, God spoke to me last night and she said exactly the same thing."

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THE ISSUE IS A SPIRITUAL ISSUE. What madness is it that affects this nation. Could it be that we are in a state of denial and that chemical dependency and alcoholism and violence are simply the manifestation of our irreligious modality within this "nation under God"?

Gerald May, who wrote "Addiction and Grace," says that we are all addicted, that there is something in our psyche that stands between us and God and that something gives us momentary satisfaction because we do not believe that God—the God of history—truly exists. We have this inability, May says, this inability to love God with all our hearts and souls and strength and mind, and our neighbors as ourselves. We don't know what it means to be our neighbor's neighbor.

For what healthy person could ignore what we know?

What whole person could withhold energies and resources and wisdom and creativity from solving the problems that are before us, and that are all solvable?

Chemical dependency and alcoholism and violence can be cured. They are diseases. The Pan-Methodist Coalition—United Methodist, African Methodist Episcopal. African Methodist Episcopal Zion and Christian Methodist—has framed the finest curriculum that I have ever seen. We have material stacked up in warehouses, the best video tapes, we have anything that you would want. And so do the Presbyterians and the Lutherans and the Episcopalians. It's all there. Yet, our synagogues and churches, by and large, do not take advantage of it because the faith community, those who claim to believe in God, are in a state of denial.

That is a judgmental statement. But how else can this madness be explained?

We choose to ignore it.

It is a M-E-S-S. A MESS is Misery and Evil, Side-by-Side. A mess cannot be managed; it can only be cleaned up.

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THREE ISSUES MUST BE JOINED if we are to come to grips with the root causes of chemical dependency and alcoholism and violence. They are:

1. The spiritual malaise in our country. It is fostered by undisciplined and compromising people who claim to believe that there is a higher authority called God.

2. Racism. Sexism and ageism.

3. Poverty, unemployment and underemployment.

We have lost what it means to affirm the sacredness of a single human life. We are unable to live out the words of the Declaration of Independence and our Constitution.

Yet I believe the people who have faith in God can, indeed, bring wholeness and healing and well-being to our nation. I believe there is hope.

Chemical dependency, alcoholism, violence are only manifestations of our national sickness. But there is a healing power that can bring a cure.

Look at hope, h-o-p-e: four letters:

"H" stands for help and healing and holiness, that is, to live out what it means to be created in the image of our God and not hedonism without responsibility.

"O" is for opportunity, opportunity for everybody to be what God created him or her to be.

"P" is for peace with prosperity, as opposed to pestilence and peril and poison, and

"E" is for empowerment, where those dear folk in Washington acquire sufficient wisdom and sufficient strength to design programs to care for their communities. Let them be empowered and not imprisoned. And let us also recognize the potential of our own empowerment: we can achieve much, if we but believe we are acting in God's will.

Chemical dependency, alcoholism, violence—they're only the manifestation of our national sickness. But there is a healing power that can bring wholeness and a cure to all, and that is to put our lives where our faith in God truly is.

Shining in Hope

Violence: In Los Angeles, an effort that focuses on "keeping the good in the hood"

Romie J. Lilly II
EXECUTIVE DIRECTOR, SOUTHERN AREA CLERGY COUNCIL

IN THE TWO YEARS SINCE A GANG TRUCE BROUGHT PEACE to the Los Angeles area, little has been done to provide opportunities for these young people. "It's horrible what's happened here," says Romie Lilly, the associate minister and Sunday School teacher at Inglewood's Central Baptist Church, "and they haven't been helped." ❧ Lilly, a native of Dallas, Texas, earned a degree in journalism from the University of Southern California; he is working toward a masters degree in religious education at Golden Gate Baptist Theological Seminary. Lilly feels faith groups in particular have shrunk from a responsibility to stem the cycle of violence. The Southern Area Clergy Council, with 70 churches and 75 pastors, was formed in 1989 to address this problem. ❧ After their community was racked by civil unrest following the Rodney King verdict in 1992, the council began a campaign, "Keeping it Good in the Hood." Half a million flyers promoting the positive effects of non-violence and the negative effects of violence were distributed. The following effort is "Making it Good in the Hood,"an entrepreneurial training program. "It's simple," says Lilly. "If young entrepreneurs can be helped to start their own businesses, they can employ people."

The darkness of indifference, racism, poverty, illiteracy, injustice, exploitation, sexism, all hover over us. The faith community must expose these ills to light.

ON FRIDAY, WE BURIED a young man named Tony. Tony was one of the architects of the Los Angeles Gang Peace Treaty; he was shot down while trying to raise money to keep alive his organization, "Hands Across Watts."

Where does the violence end? When are we going to deal with it? What is our level of commitment? When are we, as people of faith, going to commit the forces and resources to make a difference?

In the United States, a child is killed by gunshot every two hours. There were 803 gang-related homicides in Los Angeles in 1992. But this was only 27 percent of the homicides in the county. Who committed the other 73 percent? Why aren't we focusing on them? It's easy to condemn rap singers Tupak Shakur, Snoop Doggy Dog, Ice Cube and Ice T for their violent lyrics, their images and their actions, but as Tupak said, "I didn't make this world, I was given it."

What are we going to do?

I believe faith groups can deal with violence by confronting issues like domestic violence: child abuse, elder abuse. If these areas can receive focus in sermons, in lectures, in conferences, if we can create a realization that this is a sin, we need to begin. Pastors need training in domestic violence counseling, providing conflict resolution, establishing ministries to the battered and the batterer. Churches and congregations need to be involved with youth, not just condemning them. They need to visit schools in the morning, at lunch, and in the afternoon. Most of the violence occurs during these periods. They need to provide programs that keep youth busy and satisfied.

These are the kinds of activities.

It can be done. I'll give you an example. In Compton we have a prescription for violence prevention. We call it "keeping it good in the hood"—it's a slogan suggested by young people in our neighborhood. The "hood," for those of you who don't know, is the neighborhood.

Our "good in the hood" program grew out of our worries about the Rodney King trial. Our community was hit by civil unrest in the spring of '92, and months later, as the federal trial began, we asked ourselves, How can we prevent another '92?

We decided to try to create a mindset that would allow people to receive the verdict with dignity and respect and without retaliation. We didn't have a big budget and we didn't control the media. But we did have 70 churches associated with the Southern Area Council. Their pastors began to spread the word from pulpits, through Bible studies, in many activities. Everywhere that people gathered, they would hear about "keeping it good in the hood."

We developed a flyer in English and Spanish. We listed 10 things that would be negatively affected in our community if riots repeated. We also shared the positive values of nonviolence. We distributed half a million flyers. The Police Department, the Justice Department, they helped get out the information about "keeping it good in the hood."

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WE DON'T TAKE CREDIT for all the success, because the verdicts were favorable. But we believe our communications helped. On the day the verdicts were announced, crime was at a minimum. The police chief said the Southern Area Clergy Council contributed significantly.

Our success can be replicated in communities across this country. We have time, but this may be America's last chance. Victor Hugo wrote, "If the soul is left in darkness, sins will be committed, but the guilty one is not the sinner, but rather he who created the darkness." The darkness of indifference, racism, poverty, illiteracy, injustice, exploitation, sexism, denominationalism all hover over us. The faith community must raise these ills up to light wherever they exist. It must confront them head on and show that the people of faith are committed.

God and humankind are watching us to see if we will let our light shine.

Messages of Hope

Adolescents at Risk: It is time to dare to take the risks of love

Marie Sandusky Peterson
COORDINATOR, ADOLESCENT HEALTH PROGRAM, ARKANSAS DEPARTMENT OF HEALTH

A CERTIFIED FAMILY NURSE PRACTITIONER, Marie Peterson holds a degree in nursing from the University of Tennessee at Knoxville, and masters degrees in nursing and public health from Emory University in Atlanta. Before joining the Arkansas Department of Health in 1993, she served as the clinic coordinator and health care provider in a clinic for homeless persons and for a primary care center in Atlanta. She has a broad background, combining clinical, academic and church-based experience. She has taught at the university level and has served as a volunteer in a prison ministry, a homeless housing agency and a church homeless shelter. She has worked as a clinician in poor communities on extended trips in Africa and South America. In addition to her current responsibilities, she works one day each week as a clinician in the School Based Clinic at Central High School in Little Rock. Her work among the teenagers focuses on intervention, she says, to prevent homelessness. She is also concerned with the HIV and AIDS crisis careening toward the adolescent population. "Historically, issues of adolescence have not been addressed well by governmental agencies," she says. "State health folks tend to wrap programs around children and the elderly. But the teenage years are not as easy. Their problems relate to social issues. When the churches get involved," she continues, "they can add a compassion that is sometimes lacking in our bureaucracies."

THE OTHER DAY I SAW A CARTOON: A couple has awakened in the middle of the night. They are sitting straight up in their beds with terrified looks on their faces. Their hair is standing straight up on end. The caption reads, "At 3:15 a.m. on the eve of their son's thirteenth birthday, the Nutleys suddenly realized that he is about to be a teenager."

If we are completely honest, we have to admit: teenagers scare us. They grow disproportionately, at extraordinary rates. They dress creatively and do weird things to their hair. Some even develop their own language.

These outward signs of adolescence are frightening enough, but when we look at the developmental issues and tasks they face during these years, our fears increase.

Peer relationships become more important to teens than those of the primary family. Whether or not they choose to become sexually active, they are developing a sexual identity. They feel they are immortal and they like to take risks — this is a bad combination.

Teenagers, like infants and toddlers, must work through developmental stages and tasks in order to advance into a healthy adulthood. However, for

obvious reasons, it is not as easy to celebrate the passage through the stages of adolescence as it is to celebrate the first wobbly step or first spoken words.

WHEN LOOKING AT THE HEALTH RISKS that can arise during adolescence, it is important to keep in mind the normal developmental issues. Eighty percent of teenagers in this country make it through these stages with differing degrees of ease and reach adulthood with varying levels of health. Twenty percent, however, are at risk of not making it.

What risks can have an impact upon the health of our youth? Consider these: (1) adolescents are at risk of early death; (2) they are at risk of not reaching their full life potential; and, (3) they are at risk of poor health during adulthood as a result of unhealthy behaviors during adolescence.

The number one cause of death for teenagers is motor vehicle accidents. Number two is homicide—every day, more than seven teenagers are victims of homicide. The number three cause of death is suicide.

THE NUMBER ONE CAUSE OF DEATH for teenagers in this country is motor vehicle accidents. Every day 39 youths aged 15-24 are killed in motor vehicle accidents. The number two cause of death is homicide, and in some states, homicide is replacing motor vehicle accidents as the number one cause of death. Every day, more than seven teenagers are victims of homicide. The number three cause of death is suicide. Studies have indicated, by the way, that as many as one third of teenagers who commit suicide were struggling with issues related to sexual preference. Do our kids have a place to receive counseling and support for this and other complex questions they are asking about life?

MILLIONS OF TEENAGERS unable to advance through the normal processes of high school, college, job, and family? The reasons for their failure are many; among the most significant:

- TOO EARLY PARENTING. Every day, teenagers give birth to more than 1300 babies.
- SUBSTANCE ABUSE. More than 134,000 teens use cocaine one or more times a week.
- DROPPING OUT OF SCHOOL. Every day of the school year, more than 2,500 teens drop out of school.

IF TEENS BEGIN SMOKING OR ABUSING ALCOHOL, or if they develop poor physical exercise habits or unhealthy eating patterns, they are more likely to develop diseases such as cancer or heart trouble as adults. Teens who engage in sexual behaviors are at risk of developing sexually transmitted diseases, the most serious of which is AIDS. The number of cases of HIV infection, as well as other sexually transmitted diseases, is on the rise in this age group. Every day 600 teens contract gonorrhea or syphilis.

As a person of faith and a public health professional, I believe abstinence is still the best choice for adolescents. However, we must face the fact that by the age of 18, about three-fourths of teenagers in this country have become sexually active. Over a third say they used no form of sexual contraceptive at first intercourse.

While we must continue to find creative ways to teach and preach the message of abstinence, it is also our moral obligation to teach teenagers how to protect themselves from too early parenting, sexually transmitted diseases, and now — most importantly — HIV and AIDS. This has literally become a matter of life and death. We no longer have the choice to bury our heads in the sand on this issue, because, if we do, we will find ourselves continuing to bury our children.

WHAT DO THESE TRENDS tell us about the spiritual and emotional issues teenagers are facing?

Far too many teens are taking life-threatening risks and are demonstrating that they do not value human life. They are killing each other, and they are killing themselves. The dropout rates, the substance abuse problem, the amount of unprotected intercourse indicate that far too many teens are living for the present moment with little hope that they can advance through the "system" and be-

Far too many teens are taking life-threatening risks. They are killing each other, and they are killing themselves.

come productive, fulfilled members of society.

What can interfaith and health collaboratives do to address these issues? What can we do to support teens as they struggle toward adulthood? How can we show them love and attention, and help to foster their faith in God and hope for a brighter future?

Community leaders in Arkansas have developed three programs for youth that I believe offer promise.

The first is the Regional AIDS Interfaith Network (RAIN), which provides information about congregation-based care teams in Arkansas. RAIN also provides education about AIDS, especially to teenagers. The organization has found that most teens have received their education about sexuality from television. RAIN is helping to address the questions teenagers are having about sexuality.

This is a message of hope.

The second program is Hold Out the Lifeline. This program addresses the problem of increased infant mortality by urging churches to assist women, particularly teenagers, in receiving regular prenatal care.

This is a message of hope.

The third program is the Black Community Developers; Neighborhood Support Center, a program of the Hoover United Methodist Church of Little Rock. Projects of this initiative range from a shelter for homeless persons to a substance-abuse program for women that also includes a day care. One important outlet is the Youth Activity Center (Y.A.C.). Hoover United Methodist Church is in an area surrounded by gang territories. The Y.A.C. program offers an alternative message of love, faith in God, and of the importance of doing well in school. Last week, I met a young woman who had been a drug addict and had dropped out of school. She was at risk of joining a gang. As a result of her involvement in the Youth Activities Center, she was off drugs, back in school, and didn't have much time to speak with me because she was working on her homework.

This is another message of hope.

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IF WE ADMIT THAT TEENAGERS SCARE US, we also need to realize that our youth are also afraid. They face difficult years. Many are at risk—and know it. But as we sang last night,

"One day we will all be one;
but this is not that day.
Dare we take the risks of love
and join to face our fears."

And dare we take the risks of love and help our teenagers face their fears.

Causes for Hope

Poverty: Through boldness and action, change will come

James Solomon Jr.
DIRECTOR, SCHOOL AS THE CENTER OF THE COMMUNITY PROJECT

WHEN JIM SOLOMAN BECAME COMMISSIONER of the Department of Social Services for the state of South Carolina in 1983, he wanted to change the world. He recognized most assumptions about poverty were seriously flawed and inaccurate at best, that few programs differentiated between the working and non-working poor, and most did not address the root causes of systemic poverty. ❧ Solomon, an academic with degrees from Morris College and Atlanta University and additional studies at the University of South Carolina, established the Institute of Poverty and Deprivation to function as a collaborative entity among state agencies working with the poor. "My notion was that if colleges and universities could have institutes, so could state agencies," he says. Solomon retired in 1992, but the institute is still going strong. Each year it identifies a particular concern, solicits grants, holds conferences and serves as a clearinghouse within the arena of poverty and response by state government. ❧ Recently, Solomon has been working informally with a small group of fellow South Carolinians—church leaders, members of the state assembly and leaders in other public and private arenas—"trying to get people of influence to begin talking about the root causes of poverty." ❧ He is also directing the School as the Center of Community Project for Columbia College. "We are testing ideas," he says. "We are identifying concerns, strengths and weaknesses in two schools and regenerating a sense of community where people look out for their neighbor as well as themselves."

IN THE UNITED STATES TODAY, most people fail to recognize that their standard of living is made possible—is subsidized—by the working poor. The things they buy—the things you and I buy, from produce at the grocery store to hamburgers at McDonalds—would not be so cheap if they weren't brought to us by people who earn less than they need to live in the U.S. economy.

While it is necessary to feed the hungry, provide for homelessness and care for the disabled, neither present programs nor welfare reform address the causes of systemic poverty.

A few pilot programs are attempting to ensure a job for every able-bodied adult who needs to work. But such efforts, even if successful, will not solve the problem of the working poor, nor provide support for those who cannot work: the elderly, the ill, the disabled.

Indeed, assumptions about the causes of poverty are seriously flawed unless they, first, distinguish between the working and non-working poor; second, take into consideration the need to provide support above the poverty level for those who cannot work; and, third, ensure that the able-

While it is necessary to feed the hungry, provide for homelessness and care for the disabled, neither present programs nor welfare reform address the causes of systemic poverty.

bodied of future generations are equipped with the skills required in the workplace.

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WITH THIS BACKGROUND, I'd like to share brief descriptions of three efforts in South Carolina to address the problems of poverty. They are structured to complement one another and complement full employment efforts. Each is an essential component of a comprehensive approach that, together with full employment, will substantially reduce, perhaps even eliminate, systemic poverty.

The first program employes a task force that is working to educate persons in influential sectors regarding systemic poverty and thereby cause each to examine and, we hope, to take action, to eliminate systemic poverty in their respective sectors of influence and power. This is not new to us. It was based on a North Carolina poverty project.

A second approach is the "Institute on Poverty and Deprivation." Established in 1984, the institute is housed in the South Carolina Department of Social Services but functions independently; its focus is on incubating organizations to address poverty issues.

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THE THIRD APPROACH establishes demonstration projects from which others can learn, that work to address a specific aspect of poverty. One such project is the "School as the Center of the Community Project," a collaboration of Columbia College, Richland County School District One, service delivery agencies and two schools. The project promotes the schools as the locus of health, education, human and social services, as well as community services. Faculties at the college, especially the Education Department faculty, together with the faculties of the two participating schools, are exploring innovative teaching techniques. Various neighborhood/community groups are working with project staff to regenerate the sense of community where individuals are not only concerned for their own welfare, but also for all the families and individuals in their neighborhoods.

This school-focus effort is also dealing with the barrier of the timely access to needed health services, both mental and physical. On the campus of these schools are stationed a social worker, a nurse and a mental-health counselor, all paid by state agencies but supervised by the principals.

These efforts should result in better health for both students and adults in these communities.

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THE DIVERSITY OF THESE THREE APPROACHES reminds us that not only must we take advantage of every opportunity to address the issues of systemic poverty, but we must also seek to create opportunities to do so. We must be bold in our actions, and we must be confident in our ability to make a difference. If we do this, then we, too, can acclaim, as did the soul singer Sam Cooke, that "a change is gonna come."

United in Hope

Hunger: The poor set our agenda; now join their cause

Anne Joseph
DIRECTOR, KENTUCKY TASK FORCE ON HUNGER

ANNE JOSEPH ORGANIZED the Kentucky Task Force on Hunger in 1974. Its goal is to eradicate hunger and poverty in the state. She helped Senator Walter Huddleston, a member of the Senate Agriculture Committee, prepare the Food Stamp Act of 1977 that eliminated purchase requirements for food stamps, making the program accessible to millions of Americans in need. ❧ A graduate of Hunter College, she holds certificates from New York University and the University of Massachusetts, and a masters degree in library science from the University of Rhode Island. She joined the League of Women Voters in Berea, Ky., in 1969 and served as a lobbyist for the state league. In the years since, she has served on the National Child Nutrition Project, the Welfare Reform Task Force of Kentucky, the Eastern Kentucky Hearing on Hunger, Kentucky Tomorrow: People's Committee, the Kentucky Advisory Council on the Homeless and the Governor's Task Force on Health Care Reform. ❧ "When I was growing up," she says, "there was always a concern for justice and equality. We didn't have a whole lot, but we always understood abundance was to be shared, that all people have a right to partake of the abundance of this land." ❧ Her work and interests have always centered around working for change. "Even those who do not see this as a moral imperative should see how shortsighted policies are that do not invest in children and families. Churches need to understand that faith is put into action by standing in solidarity with the poor—that it comes full circle to the richness and abundance of our creating opportunities for all people; that's what our faith speaks to."

THE KENTUCKY TASK FORCE ON HUNGER is an organization of low-income people and their advocates who work in partnership on issues of hunger and poverty. We're concerned about the systemic issues of poverty, about the injustices in our society. We work together to simulate change. Our work grows from our commitment to justice.

We are not a voice for the voiceless. We are a shared voice.

We struggle to be a prophetic voice, to live out our faith commitment, not simply to talk the talk, but rather to walk the walk. For if we are truly committed to social change, and a vision of the future that is different, then our work is to engage the hearts and minds and wills of all around us.

We do not name the problems. People living them do. Together, we work to resolve the problems. We are deeply committed to the concept that all families, all people, have a right—God-given, inalienable—to participate in the richness of our society, and that nothing less is acceptable. We

Hunger is an economic issue. If you don't have enough money, you don't have enough to eat. If you have enough money, you can eat what you wish.

must leave no child behind, no family, no senior citizen, no member of our family at large.

We believe that hunger is an economic issue. If you don't have enough money, you don't have enough to eat. If you have enough money, you can eat what you wish.

In America, about 5 million children under 12 go hungry each month and millions more are at risk, according to a study by the Community Childhood Hunger Identification Project. Twelve percent of families with children under 12 are hungry.

Hungry children suffer from 2-3 times as many individual health problems as well-fed children—unwanted weight loss, fatigue, headaches, irritability, inability to concentrate, which has a significant effect in school. Children whose families experience food shortages are at a disadvantage. The infant mortality rate is linked to adequate quantity and quality in the diet of the infant's mother. The United States ranks 21st among developed nations in preventing infant deaths, down from 16 in 1980. Black infants in the U.S. die at nearly twice the rate of white infants. Stunting and wasting in children result from inadequate nutrition. Hunger negatively impacts children's ability to learn. Low-income children in the school breakfast program show an improvement in standardized test scores and a decrease in tardiness and absenteeism.

Hunger and malnutrition exacerbate chronic and acute diseases and speed the onset of degenerative diseases among the elderly.

While we are working to do something about these sorry statistics, we're a long way from getting there. We need to find innovative ways to connect with those in our community and beyond—to keep on keeping on until we make a difference.

Our coalition is committed to adopting national policies that guarantee food security to all Americans.

We want all eligible low-income women, infants and children to receive assistance through WIC. We want to make the breakfast program available to all children and we encourage federal, state and local policies to ensure that the National School Lunch Program remains broadly accessible. We want to expand the summer food program; too few communities participate in this program.

We also want to make sure that the food stamps are accessible to all who are eligible and we support changes to ensure that children and their families will have enough to eat each month.

We also work in areas of welfare and welfare reform, a critical place for people of faith. Low-income people must help frame the issues. It's welfare people, we believe, who need to tell their stories, who need to define remedies.

Ours is an awesome agenda. But as Frederick Douglass said, "There is no progress without struggle. Those who want power without struggle, are those who want the gentle swell of the ocean without the mighty roar of its waves, they are those who want crops without the tilling of the soil. Power concedes nothing without a demand. It never has and it never will."

Encircled with Hope

HIV: Prisoners' many and varied needs present congregations many and varied opportunities

Mack Bonner, M.D.
STATE MEDICAL DIRECTOR, PRISON HEALTH SERVICES, MARYLAND

AS STATE MEDICAL DIRECTOR for Prison Health Services Inc., Dr. Bonner is responsible for the medical care of approximately 13,000 inmates incarcerated by the Maryland Division of Corrections. It is a population that is predominantly male, black, poor and underserved. Yet a population that has great potential. ❧ Dr. Bonner was educated at the University of Pennsylvania. The Philadelphia native also holds degrees from Temple University Medical School and the Johns Hopkins School of Hygiene and Public Health. ❧ A Seventh Day Adventist, he and his wife, a pediatrician, led their church to establish a well-baby clinic and WICK station in inner city Baltimore. "It is the thing I am most proud of," he says. "As a black person, I decided years ago that there were so few of us who are advantaged and so many who are in need, that I had to find a way of combining my faith and my calling." ❧ He is working to establish a church-sponsored after-care program to help inmates-leaving-prison and their families make the transition to free society.

BLACK AMERICAN MALES stand at a cultural intersection where the forces of poverty, family disintegration, undereducation, unemployment, poor housing, ill health, unhealthy life styles, antisocial behavior, racism and hopelessness all collide.

At that dangerous intersection, Black American males suffer the greatest burden of disease, disability and premature death in this country. The wonder is not that so many Black American males don't make it, the wonder is that any of us do.

AIDS is becoming a particularly insidious violator of Black males. In 1991, HIV disease was the second leading cause of death in American males between the ages of 25-44. It was the sixth leading cause of death for females in that same age group, their prime of life. It was the leading cause of death in our 25 largest cities in males 25-44—the leading cause of death in Atlanta, in Baltimore, in Los Angeles. In the 25 largest cities, AIDS was the leading cause of death among males of all races between the ages of 25 and 44.

In 1991 in the United States, 25,000 people died from AIDS—775,000 potential years of life were lost to AIDS.

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IN OUR COUNTRY, approximately 1.5 million people are locked up in prisons and jails. We have 25,000 of them in Maryland. Our prison population, like many others, is predominantly male and Black and young. The average sentence is five years but, the average time served in prison in Maryland is 1.9 years. This is a very sick population, despite its youth. We have a high prevalence of substance abuse, injuries, violence, but also hypertension and diabetes, asthma and seizure and, of course, HIV and AIDS. Eight percent of the prison population in Maryland is HIV infected: 1,600 prisoners who are infected with HIV.

All the enthusiasm and commitment in the world won't substitute for knowledge.

They are standing in the middle of this intersection.

This statistic reveals the changing face of AIDS. Fifteen years ago, AIDS was a disease of homosexuals. Now it is a disease of people of color, a disease of women, a disease of children, a disease of Black males.

Like no other disease in our lifetime, AIDS has invoked a flood of intense emotions and fear. AIDS combines issues of sex and death. These are fundamental issues of faith. Today, the community of faith must respond to the AIDS epidemic with compassion, with caring, with commitment and not least of all, with skill. So many have been touched by this dread disease. But the HIV-infected inmate epitomizes those who need our care and our services.

If we are convicted that those with HIV AIDS must be brought into our ministry of caring, what must we do?

First, we must be knowledgeable. All the enthusiasm and commitment in the world won't substitute for knowledge, so we must know about this disease, about its transmission, about its manifestations and, certainly, about its prevention.

Then we must act. Men and women in our prison systems need assistance in transitioning back to the free world. Once they get into their communities, there's a great need for advocates and for case managers and counselors, and just for people of good will who will assist in the transition of young men and women who need housing and medical care and food and employment.

Because the needs are many and varied, the opportunities for involvement and ministry are many and varied. But every congregation can and must do something. In addition to advocacy and case management and transition assistance, congregations can host AIDS programs. Federal and state governments support a large number of community-based organizations that deal with people affected by this epidemic. Your congregation can identify these organizations, host them, support them. You can house them or offer services for them. You can be involved in their activities and their outreach—the kinds of things they're doing for PWA's, people with AIDS.

You can encircle them with arms of love.

Transformed by Hope

The Elderly: Interfaith groups can, indeed, solve problems of the disabled and the aging

Virginia Schiaffino
EXECUTIVE DIRECTOR, NATIONAL FEDERATION OF INTERFAITH CAREGIVERS

FOR 10 YEARS, Virginia Schiaffino has helped tens of thousands of volunteers across the country find a place of service within their own communities. A graduate of Pratt Institute with a masters degree in administration from Purdue University, she originally worked in the food service industry. While directing a feeding program in an 18-story highrise for senior adults in New York City, she learned firsthand of the

plight of the elderly and disabled. ❧ "It became clear that we weren't doing enough to meet the needs of the people we said we were serving," she recalls. ❧ The experience lead to a second masters, this one in social work at Fordham University's School of Social Services. Her work with interfaith caregivers began in 1983 as a member of the program staff on a pilot project of the Robert Wood Johnson Foundation. The project resulted in a network of 25 interfaith coalitions that involved 900 congregations and 11,000 volunteers who provided assistance for 26,000 people. ❧ In 1987, the National Federation of Interfaith Volunteer Caregivers was formed. Under her leadership, it has grown to 400 projects in 45 states, Guam, Washington, D.C. and Canada. ❧ Most of the work carried out by interfaith caregivers is simple, having to do with helping the elderly and disabled carry out functions of everyday living—dressing, shopping, preparing meals, using the telephone, managing finances—all activities that exceed the capacity of health care agencies. ❧ "You have to be very committed to do this or it doesn't make any sense to you," says Schiaffino, "you work in support of the volunteers. And when one group is started, it quickly multiplies into others."

The interfaith program demonstrates that people of faith can provide the hands-on assistance that makes a dramatic difference in the lives of disabled elderly and their families.

Approximately 35 million Americans experience some degree of limitation in their activities of daily living as a result of chronic health conditions. The 33 million individuals who live in their own homes and are cared for by family, experience limitations ranging from having difficulty in carrying out the general activities of daily living—dressing, shopping, preparing meals, using the telephone, managing finances—to being unable to carry on the normal activities of someone their age. Sixty-four percent of all disabled people in the United States —about 35 million Americans—are elderly. Seventy-two percent of the elderly in this group are severely disabled; they may have cognitive impairment, may be bedridden, may be incontinent or may not be able to be left alone because they might hurt themselves. Elderly over the age of 74 are 2½ times more likely to be severely disabled than those between the ages of 65 and 74.

By AD 2000—only 6 years from now—14 million people will be over the age of 74 in this country; 3 million Americans will be 85 years of age or older. One of the fastest growing segments of the elderly population are those over the age of 100. The magnitude of the problem of very old people living with disability and living at home transcends any plan of health reform. It exceeds the capacity of health care agencies to respond. It is a problem that is personal—barring violence, illness, accidents, we are all going to be elderly: you and I will be the "greedy geezers" the media refers to today.

And the growing numbers of elderly are a problem that depends for relief upon the acts of friends, neighbors and volunteers.

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In 1984, the Robert Wood Johnson Foundation recognized this serious, expanding, and largely ignored, health problem. The foundation funded the interfaith volunteer caregiver program to explore the effectiveness of local interfaith coalitions in developing and coordinating volunteer services to meet home-care needs of the frail, elderly and disabled.

Religious groups were identified as a potential resource for several reasons. The country's 258,000

The Faith-and-Action Program underscores the importance of religious congregations in addressing the health-care struggles of millions of people living with disability and without adequate personal or social support.

congregations provide an established network with a preexisting commitment to social ministry. Ninety-two percent of all faith groups are known to conduct one or more service programs in health. Nine of 10 Americans identify themselves with some type of religious faith and 69 percent of all Americans are members of a church, synagogue, mosque or temple.

The Foundation's Interfaith Volunteers Caregivers Program discovered that thousands of religious congregations were ready to form caregiver projects. Within a year and a half, the 25 interfaith coalitions that received funding involved more than 900 congregations, recruited and trained 11,000 volunteers and provided assistance for approximately 26,000 severely disabled people.

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BASED ON THE SUCCESS of these local programs, the National Federation of Interfaith Volunteer Caregivers was established in 1987 to increase the number of caregiver programs. The federation now works with 400 projects throughout the United States. We are in 45 states, the Territory of Guam and the District of Columbia. Nationwide, about 90 percent of the people served are elderly, nearly half over the age of 75.

The interfaith program clearly demonstrates that people of faith can and will provide the hands-on assistance that makes a dramatic difference in the lives of disabled elderly and their families. Volunteers with proper training and support provide a broad range of services that include transportation to medical visits, preparing meals, light housekeeping, respite for Alzheimer patients and their families, grooming and personal care.

As concerned friends and neighbors, volunteers care for people as they would family members and, in many instances, volunteers become the family for the people they assist. Fifty-eight percent of the people served by these faith-group caregivers are elderly women over the age of 76 living in single family houses.

The Interfaith Volunteer Caregiver Program never intended that services provided by religious groups replace the formal health care and service programs of their communities. It was intended to assist that large portion of the population who are not affluent enough to buy services or do not qualify to receive the benefits of government programs. Working in partnership with formal service providers, the volunteers have been able to fill in the gaps and augment existing services. The collaboration between the religious congregations and health-care providers enhances and strengthens the capacity of both the congregations and the agencies in identifying and assisting people most in need of these services.

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IN OUR 10 YEARS EXPERIENCE with interfaith volunteer caregiving, we have learned that interfaith groups can, indeed, effectively work to address the needs of the elderly and people living with disability. We know that religious congregations need encouragement and support in developing these programs. Without assistance, congregations view effective caregiving as expensive, too complex, and too involved with legal liability. We have always known that a structure is needed that can support and nurture the faith congregations and their volunteers.

A key element in insuring that the project will endure and be effective is hiring a full time, paid director. For this, start-up funding is critical, since few congregations can come up with the first dollars needed to hire the staff person. In 1993, The Robert Wood Foundation announced a national replication program that will provide start-up grants of up to $25,000 to more than 900 interfaith coalitions to provide in-home assistance to individuals with chronic health conditions. The Faith-and-Action Program provides the invitation and encouragement to religious congregations to make a contribution that will transform the lives of the people coping daily with the realities of serious disabilities. The program sends a clear message that, as a society, we cannot be complacent about

The elderly, for the most part, speak in a very quiet voice.

the daily struggles of millions of people living with disability and without adequate personal or social support. The Faith-and-Action Program clearly underscores the importance of religious congregations in addressing this national health-care problem.

The elderly, for the most part, speak in a very quiet voice. In the competition for media spotlight, you can hardly hear them. They live in isolation and often they live alone.

If we are to be successful in meeting the needs of the elderly and people living with disability, we must recognize and support the efforts of people putting their faith into action.

Pleading for Hope

Mental Illness: The mentally disabled remain on the margins of our health-care debate

Claire Griffin-Francel
DIRECTOR OF CURRICULUM AND TRAINING, THE NATIONAL ALLIANCE FOR THE MENTALLY ILL

CLAIRE GRIFFIN-FRANCEL was a professor of psychiatric nursing when she was introduced to the other side of her profession. In 1983 her son, a university student, was diagnosed with mental illness. When he was hospitalized, the whole family felt the isolation and stigma that often attends such a diagnosis and confinement. Most painful of all was the isolation they felt from their church. ❧ A clinical specialist in psychiatric nursing, Griffin-Francel holds a diploma in nursing from Massachusetts General Hospital, a bachelor of science from the School of Nursing at Boston College and a master of science from the Graduate School of Nursing at Rutgers University. Her commitment as an activist on behalf of the mentally ill has led her to challenge faith communities to respond to affected families in their midst. ❧ She has served as vice president for the National Alliance for the Mentally Ill (NAMI) and now serves as director for the NAMI Curriculum and Training Network. Membership within the Religious Outreach Network at NAMI is by denomination. "Our focus is not mental health," she says, "it's on mental illness—what we can do to help families and persons, practical social justice and social action. We meet families who have become so embittered, everyone loses. We try to educate the people in the pew so that it lessens the stigma. Then they can move on from there. We just want them to understand what people need to obtain a quality of life."

RECENTLY, I VISITED the Holocaust Museum in Washington, D.C. It was an experience full of pain. An uncle died in Auchwitz, an aunt walked out when the Russians liberated the camp. As I went through the museum, I thought, where were the religious communities? How did they worship when these atrocities were happening? How could they meet with their congregations when Jews, gypsies, mentally retarded, mentally ill and physically disabled people were being eliminated systematically by the state? Could indifference and timidity on the part of the religious communities allow this to happen—or was it fear, tremendous fear?

How in the world, today, in this richest nation on earth, are we allowing mentally ill people to roam the streets homeless? How can we worship with this going on in our midst?

As I left the museum, it was fiercely cold; the temperature was 7 degrees. I looked out the cab window and saw homeless people pushing grocery carts with their belongings on the icy streets. They were hallucinating. Their lips were moving and they were gesturing—anyone could identify them as being in the one-third of the homeless population that suffers from severe, untreated mental illness.

My sadness increased. I thought of other homeless, faceless mentally ill, of the large population of people who suffer from life-threatening diseases because of societal neglect, because of failed public policies. How in the world, today, in this richest nation on earth, are we allowing this to happen? How can we worship with this going on in our midst?

OVER THE CENTURIES, mentally ill people have been neglected and stigmatized. They wandered, as lepers did. They were burned at the stake, as witches. Religious communities devised books so the mentally ill could be identified and banished. Today, they are like gargoyles, lurking over our urban centers. They are abused, neglected, killed on the streets. Who has responsibility for these living deaths? The answer is all who look away, ignore them and have hearts of stone.

My message is simple. The mentally disabled need justice. Our nation's mentally disabled need appropriate, rehabilitative treatment. Mental illnesses are treatable. People can recover a quality of life. It's not enough to give the traditional Thanksgiving baskets. We thank you for the food and shelter, but we want more. And we call faith communities to a higher level of responsibility.

AT NAMI, WE ESTABLISHED the Religious Outreach Network because families told us that their needs were not being met by religious groups. They were turned away by their clergy and lay leaders. At least 10 percent of the members of every congregation is affected by severe mental illness. My son, who suffers mental illness, has three siblings, two parents, and two aunts, two brothers-in-law and a niece—11 of us affected by the his illness. Families like ours are in many different congregations, invisible and unknown because of stigma.

The Religious Outreach Network is about families such as ours. We organize them geographically and denominationally. NAMI Catholics join together, NAMI Lutherans, NAMI Jews, NAMI Mormons, take on the mission of the network to educate the faith communities.

Our educational approaches, from film to public lectures, are designed to change attitudes. It's been, in some ways, successful, and other ways, very difficult.

In NAMI, we emphasize three levels of prevention in mental health. In the primary level, faith communities can reach out, identify people with illnesses and make referrals.

The secondary level of treatment offers an opportunity to help people get treatment, then follow up with visits and active expressions of concern. When my son, a freshman at Notre Dame, was hospitalized in South Bend, no one phoned, no one sent a card, no one said a word to us. We felt abandoned and isolated. No one brought food, helped us with transportation or anything.

The faith communities can do many things to help when people are in the secondary level of

prevention. But at the third level of prevention, the prevention of disability, that's where the faith communities can help most. In every congregation, there are employers who could provide work; there are people who could help with housing; people who could help pay for the costs of drugs for people who can't afford them.

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WE'RE AT A CRUCIAL TIME in health care reform. The Association of Manufacturers has asked President Clinton to take all mental health benefits out of health care. They say we can't afford them.

My questions are these:

Why is my son, who has a life-threatening illness of manic depression, less worthy than his sister who has asthma and a heart condition? Why should coverage of his health care be denied because his is a neurobiological illness?

We've been silent for so long.

Last night in a church in north Atlanta, I joined about 40 families who are part of the 100-family membership of the Northside Alliance of Mentally Ill. During the program, we heard stories of sons who had died, daughters who were in prison. We shared. We cried. Our stories were not happy ones. But these are stories told and retold all over the country.

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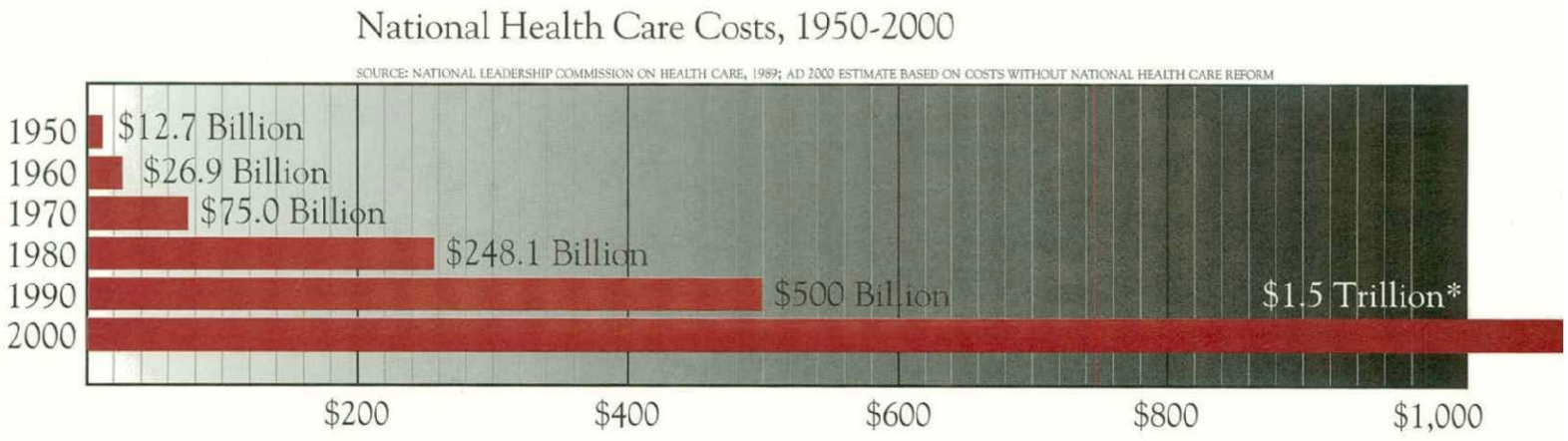
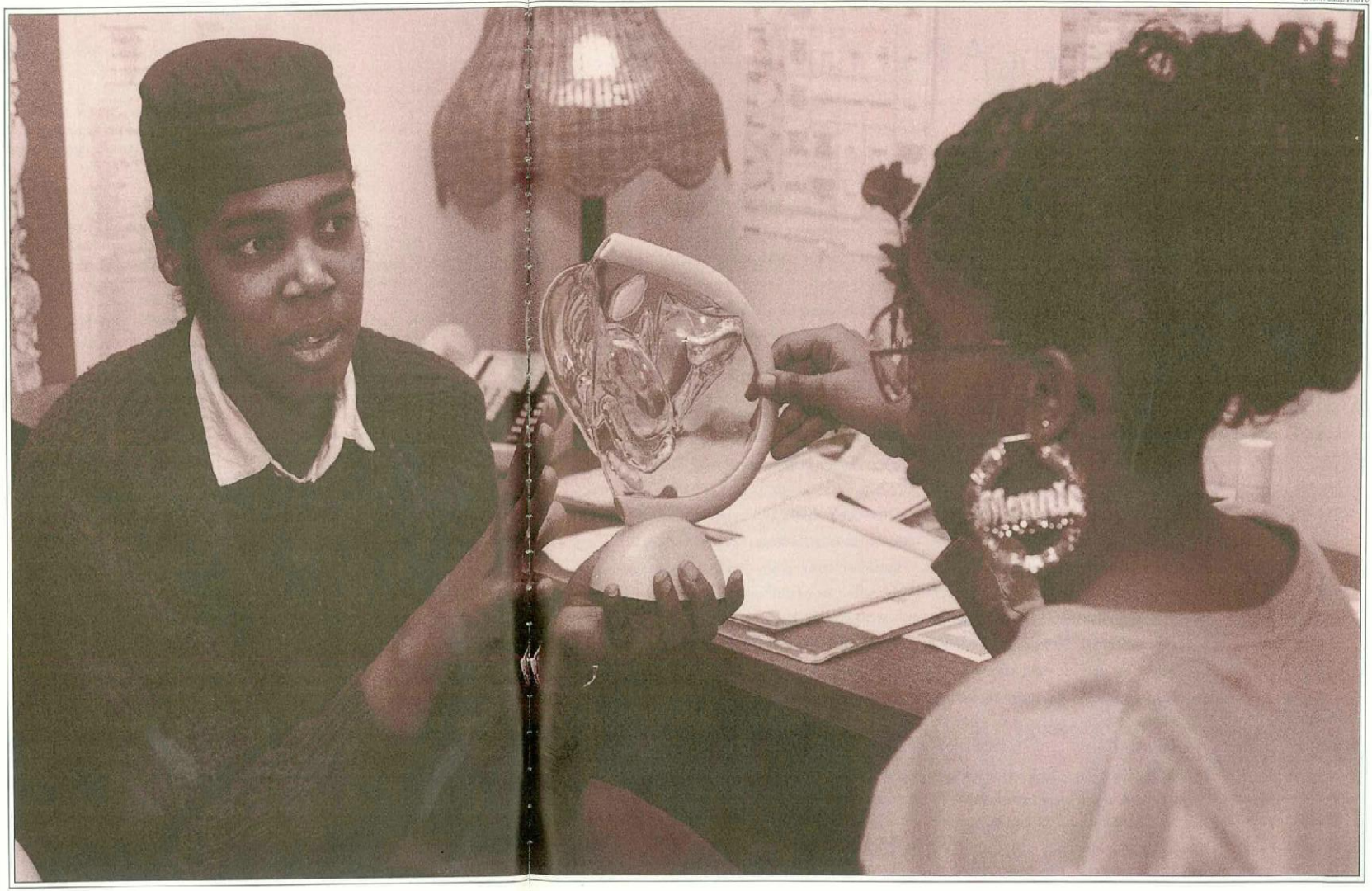
WILL YOU LISTEN? Will you react in a way different from that of the faith communities in the Germany of a half century ago? In a way different from the faith communities of a few days ago, when I rode along the icy streets of the nation's capital and watched the homeless stutter and mutter by?

Will you hear—and respond to—the stories of the mentally ill among us?



Dreams and Reality



LAURA SIKES PHOTO

AIDS prevention and birth control are among the topics discussed at the Young People's Health Connection, a sex education and prevention drop-in for teens housed in a Baltimore shopping mall.

A Movement, A Beginning

Now we can run and walk and talk

By William Foege
SENIOR FELLOW, THE INTERFAITH PROGRAM

I WAS INTRODUCED to a four-year-old girl once who was so amazed by my six-foot, four-inch height, she was speechless and she finally asked, "How old are you anyhow?"

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Have we asked the right questions?
What are the right questions?

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A FRIEND OF MINE at a church convention had trouble getting to sleep. He took several sleeping pills and, suddenly very tired, he went into the bathroom to get ready for bed. The door clicked behind him and he realized he was in the hotel hall. He had only the tops of his pajamas on. He heard the elevator rumbling to a stop and looked around for a place to hide. He found a sofa at the end of the hall. He sat down, pulled his pajamas down as far as possible, and fell asleep. The next thing he knew, he was being taken down the hall by two house detectives.

I asked him afterwards, "How did you feel as a church official, at a church meeting, about to be arrested for indecent exposure and drunkenness?"

His answer was, "Very, very inadequate."

That's the way I feel in trying to pull together the vision that has come from our meeting.

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THERE ARE DREAMS that we could not have talked about at the beginning that we can talk about now because we've had a chance to be renewed personally and to renew each other.

I was raised with the saying, "Some things have to be seen to be believed." It took me a long time to realize that that was backwards, some things have to be believed to be seen. What are some of the things that we can believe? It's not impossible, today, to dream of the future where thousands of congregations actually see themselves as a redemptive force in the world.

It's not impossible to dream of thousands of congregations that see health as a seamless whole—physical, mental, social, spiritual—that see poverty and illiteracy and addiction and prejudice and pollution and violence and hopelessness and fatalism and conflict as brokenness, diseases that require that redemptive force.

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It's not impossible to dream of thousands of congregations willing to explore servanthood, to listen to the needs of the community before they act.

We can dream now of collaboration with other congregations, other faiths, other organizations, and with government. We have to collaborate with government.

And we can dream of a future where thousands of congregations inspire government to renew its search for justice, that inspire government to make democracy work, that act as guardians of our children and the rights of the child, that change social norms, that insure that people can use their potential—congregations that see all of this as part of health.

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We can dream of a future where thousands of congregations are replacing fatalism with hope and belief, a future in which we understand the cost of acts of omission.

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PRIMO LEVI, WRITING about Auchwitz in his book, *The Drowned and The Saved*, tells about working with Alberto and Danielle in a warehouse. They had not eaten. They had had no water to drink. They were very thirsty. Levi and Alberto found, behind a pile of trash, a pipe with water condensing on the outside. During the day, they took turns going back and getting drops of water on their tongue. But they didn't tell Danielle.

Levi writes, "Danielle is dead now, but in our meetings as survivors, fraternally affectionate, the veil of that act of omission, that unshared glass of water, stood between us transparent, not expressed but perceptible and costly."

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We dream of a time without those costly omissions and we dream of a future where thousands of congregations feel a personal responsibility to reduce unnecessary suffering and premature mortality, not just in their community, not just in this nation, but in the world.

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THREE WEEKS AGO, my wife and I went to the funeral of a niece. Cindy had cerebral palsy. It was very severe. At 33 years of age, she died. As we were preparing to go to the church, 10-year-old Meridith, the niece of my niece, asked me to sign her letter. I asked who the letter was to. She said to Cindy. She wanted to put it in the coffin. I read the letter. It said, "Dear Cindy, now you can run and walk and talk."

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We dream of a time when a congregation will strive for absence of needless suffering.

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AND, FINALLY, WE DREAM OF A TIME when thousands of congregations invest in their children, 7 generations in the future, 14 generations in the future, 21 generations in the future. To start a movement of "ancestors united."

And we dream of this movement of faith and health multiplying like fish and loaves so that 100 years from now, our actions will be seen as the beginning of health-care reform in this country and the world.

Participants

The National Meeting of the Interfaith Health Program of The Carter Center

This report emerged from a series of nine fact-finding meetings held across the United States. The following participants in the national convocation served to distill the overall learning experiences and practices of hundreds of people and to stimulate the growing movement of interfaith cooperation and support in the arena of health and prevention.

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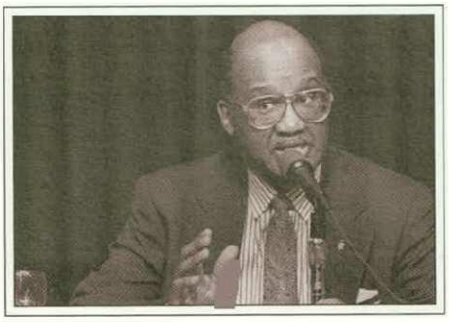

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The Carter Center

From its Atlanta base, the institution founded by President Jimmy Carter reaches around the world

"If The Carter Center could be remembered for one thing, I would like it to be for the promotion of peace and human rights for all peoples."

Former U.S. President Jimmy Carter

THE INTERFAITH HEALTH PROGRAM (IHP), a unit of The Carter Center, focuses on a broad range of activities aimed at challenging faith groups of different traditions to engage opportunities in health, especially in collaboration with each other and with the public structures that share their goals. The program builds on research of The Carter Center, going back to the 1982 "Closing the Gaps" conference that examined what could be accomplished if existing health knowledge were fully applied, and the 1989 "Church's Challenge in Health" meeting that explored the opportunities for greater involvement by faith groups in health activities. ❧ As President Carter says, "The religious community has the opportunity to be a key partner in revolutionary breakthroughs in health. The most exciting opportunities are not found in high-tech cures, but in new ways of preventing disease and promoting wholeness. These opporunities demand the full energies of religous organizations of all faiths." ❧ The IHP conducts research to identify the most effective strategies for health, publishes findings in papers and newsletters, and convenes meetings of leaders around key opportunities for action similar to the issues reflected in this report. ❧ The Interfaith Health Program also works in Atlanta with clusters of congregations in low-income neighborhoods, training congregational leaders and lay health workers in health promotion, disease prevention activities.

The Carter Center brings people and resources together to promote peace and human rights, resolve conflict, foster democracy and development, and fight poverty, hunger, and disease throughout the world. The nonpartisan Center, which is affiliated with Emory University, builds partnerships to address complex and interrelated problems. ❧ By drawing on the experience and participation of former U.S. President Jimmy Carter and other world leaders, by fostering collaboration and avoiding duplication of existing efforts, and by combining effective action plans with research and analysis, The Center can achieve goals beyond the reach of single individuals or organizations. ❧ The Center is guided by the principle that people, with the necessary skills, knowledge and access, can improve their own lives and the lives of others.

AS THE 21ST CENTURY APPROACHES, the world is in constant transition. Old walls have been torn down, but many barriers remain that keep people from living healthy, productive lives. The challenge is to create a world that gives every man, woman, and child the opportunity to live in peace.

The nonprofit Carter Center was established by Jimmy and Rosalynn Carter in 1982 to further this vision. Building on the strong academic base at affiliated Emory University, The Center forges partnerships and provides access to resources that change lives. In the developing world, The Center brings parties in conflict to the negotiating table, monitors multiparty elections in countries working to build democracies, works to alleviate human rights abuses, fights debilitating disease, and teaches farmers to grow more food on the same amount of land. At home, The Center is leading a citywide effort in Atlanta to address problems associated with urban poverty and decay and is sharing those successes with cities across the United States.

"I have watched The Carter Center's programs unfold and have been quite overcome by the extraordinary energy that President Carter brings to it," said former Emory President James Laney, now U.S. ambassador to South Korea. "That energy can only be fed by someone who is living out his deepest convictions."

Olusegun Obasanjo, former head of state of Nigeria and a member of The Center's International Negotiation Network (INN) Council, offers another view. "People who are engaged in conflict have found The Carter Center to be a meeting place and a talking place where they have been able to break the ice."

Certain principles guide Center programs:

¶ The Center's work is strictly nonpartisan.

¶ The Center does not duplicate the successful efforts of other agencies or institutions.

¶ It seeks practical applications for scholarly research.

¶ It takes on problems that have been neglected or ignored by other international organizations or governments.

¶ It collaborates with existing organizations to produce better results.

AMONG THE CENTER'S most visible achievements:

- MONITORING multiparty elections in Panama, Nicaragua, the Dominican Republic, Haiti, Zambia, Guyana, Ghana, and Paraguay.
- FORMING the International Negotiation Network (INN) of world leaders to address civil conflict in countries ranging from Ethiopia, Sudan, and Liberia, to Burma and Korea.
- ESTABLISHING the Carter-Menil Human Rights Prize to honor heroes defending truth and freedom around the world.
- WORKING WITH Ethiopia, Zambia and other countries to strengthen the economic and institutional foundations of their emerging democracies.
- ORCHESTRATING a campaign to eradicate Guinea worm disease in Africa, Pakistan, and India by 1996. As of 1994, the disease virtually has been eliminated in Pakistan and reduced by 90 percent in Ghana and Nigeria.
- HELPING families in Ghana increase corn production by 64 percent from 1985-93 and farmers in Sudan triple wheat production from 1985-90.
- DISTRIBUTING the drug Mectizan to 10 million people in Africa and Latin America to prevent river blindness.
- WORKING TO erase the stigma of mental illness for the 50 million Americans who experience this type of suffering each year.
- CREATING a network of faith groups in major U.S. cities to promote preventive health care in their communities.
- LEADING an effort that increased the worldwide immunization rate for children from 20 to 80 percent.
- LAUNCHING The Atlanta Project, a grassroots effort to fight urban social problems through initiatives in health, education, community development, economic development, housing, and public safety.

At a Glance

The Carter Center
The Jimmy Carter Library and Museum

- FOUNDED In 1982 by former U.S. President Jimmy Carter and Rosalynn Carter.
- DESCRIPTION A nonprofit, nonpartisan organization addressing issues of democracy and development, global health, and urban revitalization in the United States and abroad. A dynamic affiliation with Emory University provides a solid research and scholarship base for the Center's activities.
- LOCATION The Carter Center began operations in offices at Emory University in 1982. In 1986, a complex of facilities, offices and meeting spaces was dedicated about three miles from campus, east of downtown Atlanta. Four interconnected, circular pavilions house offices for the former president and first lady and for the Center's privately funded programs, including that of Interfaith Health. The complex includes the Cecil B. Day Chapel, an interfaith sanctuary for religious services and assemblies, and other auditorium and conference facilities.
- MUSEUM The Jimmy and Carter Library and Museum, located on the same site as The Carter Center, is operated by the National Archives. Open to the public, the Museum traces the history of the U.S. presidency and the Carter administration (1977-81). The library contains more than 26 million pages of documents from the Carter White House.
- FUNDING The Carter Center was built with $29 million in private donations from individuals, foundations, and corporations, which also support the multimillion annual operating budget. Although built with private donations, The Jimmy Carter Library and Museum is maintained by the federal government.
- STAFF Approximately 250 employees, based primarily in Atlanta. Field representatives have been stationed in Guyana, Liberia, Ethiopia, Nicaragua, and other countries.
- VOLUNTEERS Ninety volunteers donate at least one day each week to the Center. Volunteers give tours to guests, assist with special events, and work with Center programs.
- INTERNSHIPS More than 100 undergraduate and graduate students, mostly from Emory University, work with Center programs year-round for academic credit or practical experience in international and domestic public policy.
- VISITORS The Museum of the Jimmy Carter Library is open for tours Monday through Saturday from 9 a.m. to 4:45 p.m. and Sunday from noon to 4:45 p.m. The Carter Center is not open to the public except by business appointment or for special events.

MICHAEL SCHWARZ PHOTO

Every faith group
is looking for a way
to serve God
by alleviating suffering
among its fellow human beings.
Together, faith groups and
The Carter Center have a
wonderful chance to multiply
what we know a hundred fold
or, perhaps, a thousand fold.
In that way, we could
truly serve our God
by alleviating the suffering
of our neighbors,
particularly of those
who are the least among us.

—Jimmy Carter
PRESIDENT, UNITED STATES OF AMERICA
FOUNDER, THE CARTER CENTER
OF EMORY UNIVERSITY

In an Atlanta Project effort to immunize thousands of high-risk children against basic childhood illnesses, President Jimmy Carter and hundreds of volunteers canvassed dozens of communities. The Atlanta Project is an ongoing program of The Carter Center that combines the resources of business, civic and nonprofit organizations and religious groups in an effort to combat the evils of urban poverty.

Wouldn't it be wonderful . . .

if faith groups—a Baptist church,
a Catholic mission, a Jewish congregation,
a Muslim center—adopted one close-by
geographical area and made sure . . .
that every single child in the neighborhood
was immunized against the basic diseases?
. . . that there was no hungry person in that area?
. . . that every person had a basic medical exam?
. . . that every woman who became pregnant would
get prenatal care?
. . . that every elderly person was contacted daily?
Suppose these congregations convinced parents
and children to fight the presence of guns.
Suppose they made a commitment to provide the
kinds of alternatives needed to reduce the violence
that afflicts the poorest among us.
These are very exciting and very redemptive
options for the faith groups of our nation.
But are they possible?
We believe the answer is yes.

—Former President Jimmy Carter

Faith & Health

The Interfaith Health
Program of The Carter Center
Atlanta, Georgia