Faith & Health

Six years ago, when the Interfaith Health Program was established, we hoped—*and expected*—to find, document and recommend many examples of health projects conducted by religious groups. We discovered dozens, but almost before we could capture their "best practices," they had mutated and blended: A soup kitchen turned into a homeless shelter that turned into a substance abuse recovery program that turned into a job training program ... and in delightful, hopeful, energetic ways these complex and innovative structures expressed the phenomenal convergence of faith and health. How could it be otherwise? There *is* a movement here: alive, growing, drawing in more and more of the nation's 350,000-plus houses of worship and sending out millions of their faithful who serve the full spectrum of humankind, the infants and elderly, in the name of a compassionate and loving God.

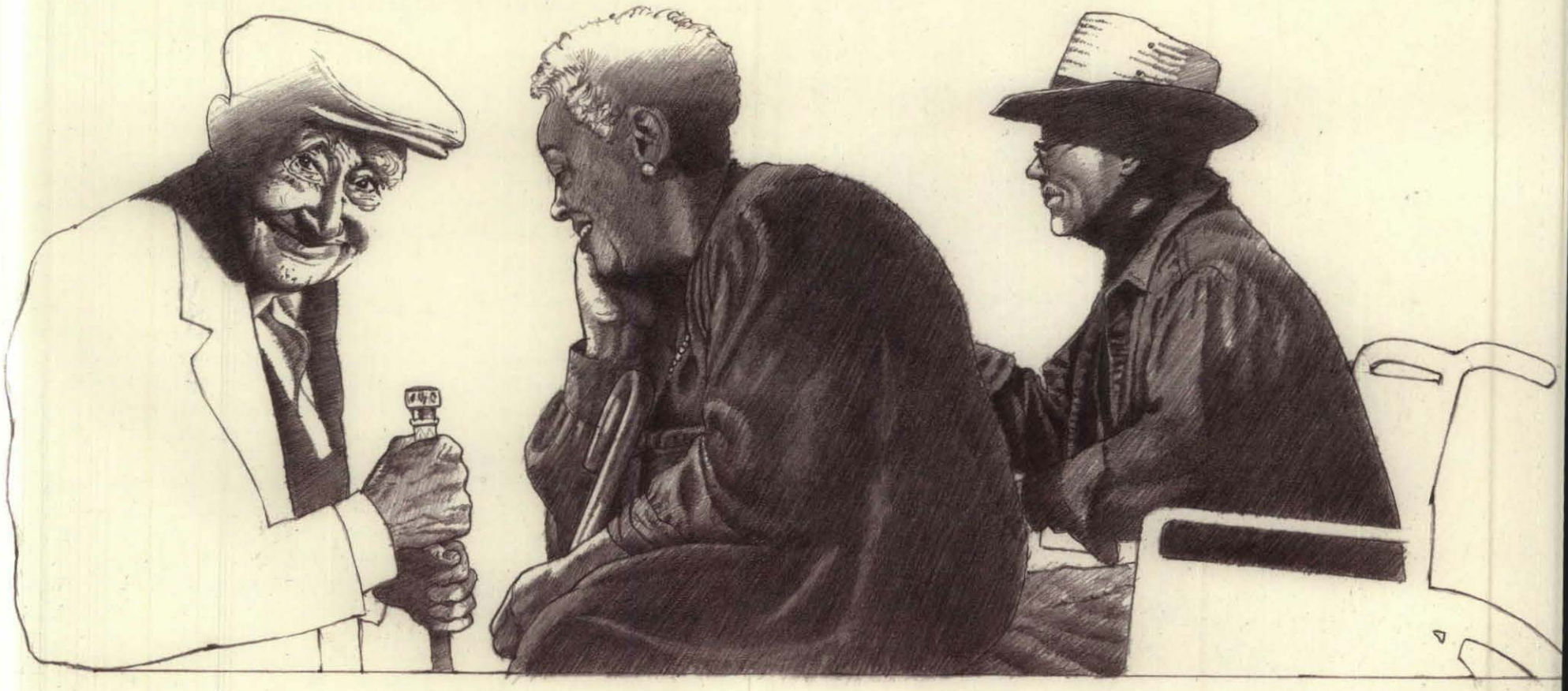


ILLUSTRATION BY BOB BRAUN

A Movement Toward Wholeness

By Gary Gunderson

With more than a third of a million houses of worship scattered across the United States, and a health sector that represents about 14 percent of all economic activity, it is no wonder that faith and health should intersect. Nor is it surprising that their union is becoming not a collection of clever projects, but something new and alive. Thus our question: How can we help it grow?

SOME SEE THE MOVEMENT and think of infrastructure: organizations, money, training programs, volunteers, computers, and so on. Frankly, that part strikes us as easy to understand. What is hard are the relational networks. How are all these activities connected, related, coherent?

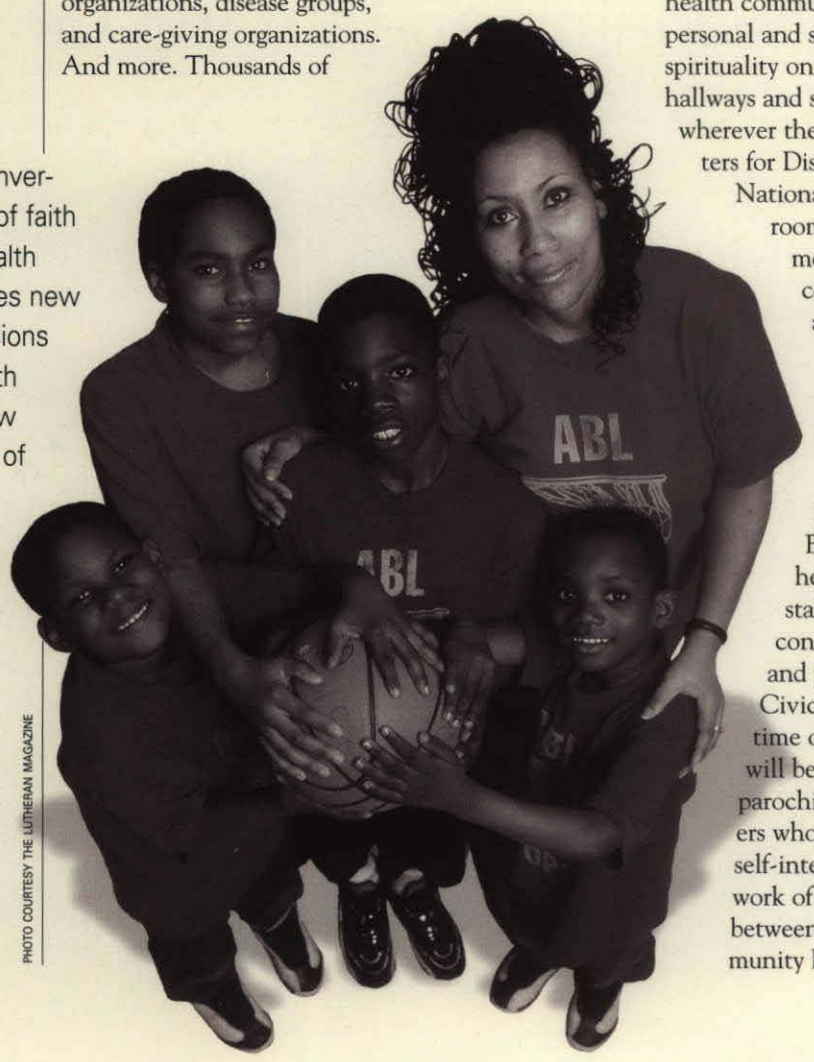
Spirituality is not primarily about longevity but about perspective—understanding where we fit, who we are in relation to everyone and everything else. Integrating spirituality into health strategies will not be simply adapting another biomechanical tool into the medical kit.

Our colleague Bill Foege, senior health policy fellow for The Carter Center, often points out that you don't need to know where you are to be there. But if you want to go somewhere else, you do. Likewise, you don't have to know anything about a movement to be part of it. But if you want to move quicker, deeper, and more effectively, you need to know what's happening, who the key players are, and how you can effect change.

Our work at The Carter Center—the mission of the Interfaith Health Program—is to build the capacity for collaboration between faith and health organizations. This implies a change in health's understanding to reflect the perspective of faith. It also implies a change in faith's understanding to reflect the insights of health.

THE HEALTH COMMUNITY is broader than the public health sector, of course. It includes hospitals, clinics, government and service organizations, insurance firms, research and development organizations, disease groups, and care-giving organizations. And more. Thousands of groups and agencies contribute to the health of people and communities. As important as they all are, we regard public health as the primary partner of faith communities.

The faith community is equally diverse and complex. There are 4,000 U.S. connectional systems—denominations, orders, faith-based agencies. There are ecumenical and social service organizations in every village. There are thousands of health and educational organizations owned by religious groups. As important as all these are, we regard the 365,000 congregations that blanket the rural and urban landscape as the primary partners of the health community.



The convergence of faith and health presages new dimensions of health and new visions of faith.

PHOTO COURTESY THE LUTHERAN MAGAZINE

HOW THESE TWO COMMUNITIES relate to each other in the next century will reflect what we hope, experience, fear, and aspire now in the formative years of the movement. The two communities have a parallel history marked by often surprising interwoven strands. A review of either's history reveals influences from the other. What is new is the active, open exploration of this cross-fertilization of ideas and practices.

That promises chaotic moments, but a long-term forecast of as-yet-undreamed-of organizations, ideas, and projects.

Margaret Wheately, in her landmark book, *Leadership and the New Science*, writes that organizational change which appears to be wild and unpredictable often organizes around deeply held visions lived out by committed people doing what they think is right. The faith and health movement seems to be forming around those committed groups of people who are trying to live out their sense of rightness (and, we believe, righteousness) around four basic tasks:

1 LINKING PERSONAL SPIRITUALITY TO PERSONAL HEALING AND WELLNESS. Much of the millennial fascination with spirituality is shallow and even silly. But we find many deeply reflective individuals in all sectors of faith and health communities who offer strong arguments—personal and scientific—for the salutary effects of spirituality on health. This dialogue animates the hallways and sometimes the main presentations wherever the movement gathers, be it at the Centers for Disease Control and Prevention, the National Civic League, hospital board rooms, The Carter Center, or the 44 medical schools that currently offer courses on the subject. Institutional and public strategies are being influenced by people who are demonstrating the links between faith and health.

2 ALIGNING HEALTH STRATEGIES WITH FAITH-BASED STRUCTURES. Widespread health-improvement strategies call for stable structures, creative organizations, converging systems, and wise regulatory and political policies. Marc Freedman of Civic Ventures argues that we are in a time of great institutional creativity that will be defined either by common hopes or parochial fears. The fears are fueled by leaders who focus too narrowly on institutional self-interest. Common hopes come from the work of people who live on the boundaries between large-scale organizations and community health-and-faith structures.

The skeleton of the faith-and-health movement is comprised of the collaborative structures that connect organizations. The movement is mostly made up of many separate organizations that work together in external, often ad hoc, structures. We will never find a permanent home in which everyone is comfortable. We don't need one. The skeleton locally, and at every level of community, is a connectional structure that permits us to learn from and to work with one another.

3 REDEFINING THE SOCIAL RESPONSIBILITIES OF GOVERNMENT. In an era of downsized, less-committed government, the faith-and-health movement cannot avoid being deeply involved in the changing relationships among public, private, for-profit, and charitable entities. Government policy changes have direct, if unpredictable, effects on our corporate quality of life, especially the life of those described by Jesus as "the least of these." Religious groups are drawn in to this unstable mixture not only by their charitable capacities but also because they cannot duck issues of justice, equity, or fairness. Informed as well as compassionate, they are asking rigorous questions about health *outcomes* in a language flavored and influenced by faith in a *just* God.

4 REVITALIZING THE MISSION OF CONGREGATIONS. The landmark study, *American Congregations*, notes that local congregations preceded the formation of denominations, indeed the formation of most permanent organizations in America. "This is not to say that America is distinctively religious," write authors James P. Wind and James W. Lewis. "But it is to say that American religion has been, and by and large remains, distinctively congregational."

Wind, who is president of the Alban Institute, suggested at a recent Carter Center meeting that the lens of health may now offer thousands of congregations a way of revisioning their mission and relationships to their surrounding communities; such new vision may, he added, revitalize both.

At the heart of congregational life is faith formation—learning about, experiencing, and expressing faith. Says Susan Thistlethwaite, president of Chicago Theological Seminary: "The real difference in churches is not along the older doctrinal continuum of liberal vs. conservative but between those who are alive because they have internalized the call 'to love God with your whole heart and your neighbor as yourself' and those who are dead to this call. When the call is alive, it is visible in a vital worship life ... and clear sense of purpose in mission."

It is modern to expect radical, rapid change in almost everything that matters. But congregations move slowly, adapting at a different pace. That is the heart of the gift congregations provide to their communities, the strength to endure.

Sociologist and religion researcher Nancy Ammerman thinks of congregations as living members of a community's social ecology—"living networks of meaning and activity, constructed by the individual and collective agents who inhabit and sustain them."

They adapt and change, she adds, "even as they breathe life into all who depend on their neighborhoods. They accompany, convene, and connect. They story, bless, and give sanctuary. They pray. These strengths mingle and blend over time, uniquely reflecting the communities in which they are expressed. This flexible expression makes possible the final strength—to endure."

Tiny, seemingly insignificant events in history can shape—and often have *shaped—the destiny of future generations. This is why it is so important that we think of this burgeoning faith-and-health movement in its wholeness, stretching our awareness of its many facets and relationships. Whom we relate to now, learn from now, collaborate with now will certainly have extraordinary implications on our capacity to relate, learn, collaborate—and accomplish—tomorrow.* F&H

The Role of Faith Communities in the Faith & Health-Movement

Health and healing are at the heart of every faith tradition we know. That is why there has been more cooperation than conflict between faith communities and health leaders over the centuries of their parallel history of healing. Faith groups started the first hospitals and have invested billions of dollars in care facilities for the broken and needy; they have trained chaplains and placed them in both religious and public facilities. The relationship between faith communities and medicine has been mutually beneficial, as long as each side respected the other.

The relationship between faith communities and public health, though new and somewhat awkward at times, has much greater potential than the relationship to medicine. The latter depends on mutual respect and cooperation in building and maintaining institutions of healing, such as hospitals. The relationship between faith communities and public health depends on collaboration in achieving common goals, such as the improvement of community health. Most faith communities support the broad agenda of public health, but they have their own health agendas, based on unique traditions. They want to be partners with public health, not simply stepping stones to the community. Public health is also eager for collaboration, but the relationship can become tense when a public health goal, such as "safe sex," runs counter to the moral guidance of some faith traditions. Thus the relation of faith communities to public health is messier than with medicine, where the partners rarely talk to each other, but much more productive in achieving beneficial health outcomes.

The articles in this section sample health programs and activities in the faith community.

- Dr. Kenya Nu-Man, a Muslim physician in Oakland who works with seven Bay Area mosques engaged in health ministries, is profiled *(right)*.
- "Strong Partners" tells how foundations formed from the sale of religious hospitals are using their resources to improve community health *(page 5)*.
- Denominational efforts to improve children's health is the theme of "Caring for All God's Children" *(page 6)*.
- Atlanta Health Ministries details a coalition of Atlanta congregations that is making a difference in community health *(page 8)*.

In every case, from individual initiatives to denominational programs, the emphasis is on "applied faith," the functional, life-changing belief patterns of a people who recognize health as multidimensional: body-and-soul, mind-and-heart. F&H

Who is to be more feared: the husband who beats you or the authorities who might deport you if you seek their protection? For possibly hundreds of immigrant women in California's San Francisco Bay Area —many of them Muslim—Kenya Nu-Man, M.D., is...

THE ONLY GOOD Alternative

The Only Good Alternative
Stepping Together

By Karen Hill • *Photography by Jason Grow*

Dr. Kenya Nu-Man, a 39-year-old obstetrician/gynecologist, is founder of Stepping Together, a nonprofit Islamic group serving Oakland and the other 10 cities in Alameda County. She's a native of New York City who came west to attend medical school at the University of California-San Francisco, then decided to stay. She converted to Islam 18 years ago. She's divorced, the mother of a 4-year-old girl, with three part-time jobs: an ob/gyn clinician at the Alameda County Medical Center; the medical director of a women's center for recovering addicts; and an HIV/women's health researcher.

"When dealing with domestic violence, one of the traditional treatments is to separate the wife and husband. While this can be effective, it's a very difficult step for Muslims because family is so important."

Stepping Together is a small group, six or seven people, with a big agenda: "To just improve life," Nu-Man said in a recent telephone interview. "I'm so blessed and fortunate to be able to do the things I want to do," she said. "I owe this to Allah. I don't feel good if the people around me are hurting."

In addition to domestic violence, the 13-year-old group tackles poverty, homelessness, the reorientation of people coming out of prison, drug abuse, a variety of health problems, and teen issues. Stepping Together is raising money for a women's shelter and a prison halfway house. It sponsors health fairs, the most recent in East Oakland where 40 women received free mammograms and breast exams—women who could not have paid the $200 such tests usually cost. It provides food, shelter, and clothing for people in crisis.

Money comes from grants and donations, but group members also help. They know how to navigate and network through the array of available social services and charities on behalf of those who need help but fear asking for it, or who simply don't know where to begin.

The group helps anyone but works more and more with Muslims because members share that culture with those seeking their help. They can help with a deft touch, without pushing people into uncomfortable or unfamiliar situations. About half the Muslims they help are immigrants.

There are no firm, recent numbers on Alameda County's Islamic population, but about 800,000 Muslims live in California, some 16 percent of the 5.1 million in the United States. Many of California's Muslims live in the northern half of the state, "heavy in the Bay Area," Nu-Man says.

Sometimes Stepping Together simply helps other agencies learn to operate within Muslim religious and cultural parameters—simple things like remembering to offer a nonpork alternative to the pork chops and bacon-seasoned green beans served for dinner at a prison halfway house or not pairing a Muslim with a roommate who smokes.

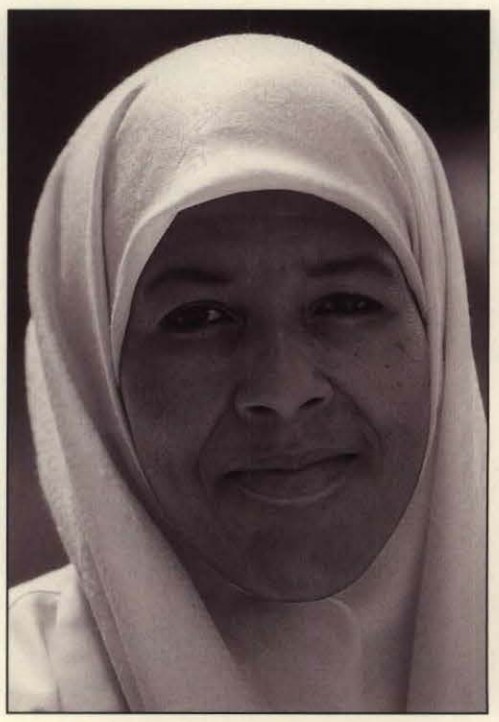
Sometimes it means patiently knitting a network of new friends for an immigrant wife trapped in a bad marriage, far from anyone she knows and trusts.

"There are five pillars of Islam, and one of them is charity," Nu-Man says. "Charity is the responsibility of every Muslim, on whatever level he or she can do it. That's one of the things that's in our favor.

"But for the most part in this country, charitable groups are run by people of other faiths, not focused on Muslims, and Muslims who needed help have had to turn to these programs, even though their workers didn't understand some of the decisions not to access help or delay help. We do understand."

Sometimes, that means understanding just how tightly Muslim culture binds together the family, and how reluctant a woman will be to break those cords even in a very bad situation.

Sometimes it means understanding that an immigrant woman, usually the dependent of a husband with a green card or permit to work in the United States, is in real danger of deportation if she leaves him. If she involves the police, he may be deported as an undesirable.



Sometimes the family may have been in this country for several years; the prized green card has lapsed, but friends and assets are here. If a woman calls the authorities, she or her family could be sent back to a homeland they no longer know, where life might present an entirely new set of problems.

"When dealing with domestic violence, one of the traditional treatments is to separate the wife and husband," Nu-Man says. "While this can be effective, it's a very difficult step for Muslims because family is so important. And then there's the green-card status."

It's a quandary she understands all too well. "I was the victim of domestic violence, and it's a very difficult thing," Nu-Man says. "I had one experience being hit while holding my daughter, and that was enough. But my personal experience gives me an understanding of what these sisters are going through."

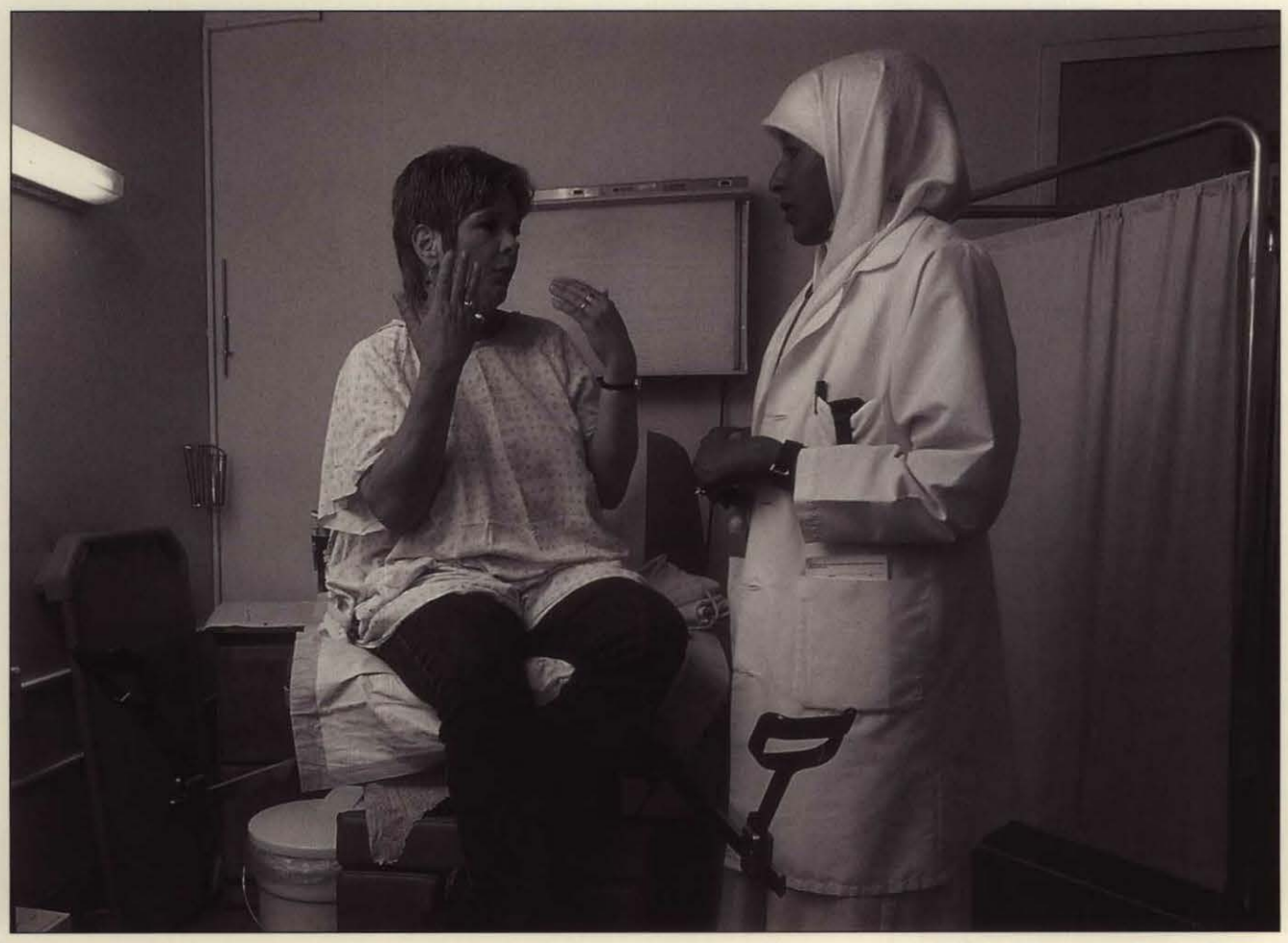
"In a severe situation, a police report will be filed," Nu-Man says firmly. "But for a woman to bring an outside entity into her family ... it's hard. We find other Muslim women who can help her while she accepts the eventualities that her marriage isn't going to work, that her husband isn't going to change. They can help her get a job, help with her children, support her. It's an ongoing, long process."

That support is crucial, Nu-Man says, because domestic violence is a "silent issue" in the *masajics*, or congregations.

"We're just now hearing the *imams* (wise men) talking about domestic violence," she says. "Five years ago, they were saying, 'We can't talk about this.'"

Those who think it's OK to hurt a spouse, who cite one verse in the Koran that speaks of it, she says, just don't get the big picture. "Muslims are supposed to be loved; oppression is not allowed. In the *Sunnah*, or history of the Prophet Mohammed's life, he gives us explicit examples of how to behave. He had several wives, but he didn't abuse any of them. He was gentle and compassionate and respected them."

An ob/gyn physician, Kenya Nu-Man examines a patient at Alameda County Medical Center, one of her three jobs.



Often, immigrant women are especially bewildered because their husbands didn't hurt them back home, Nu-Man says.

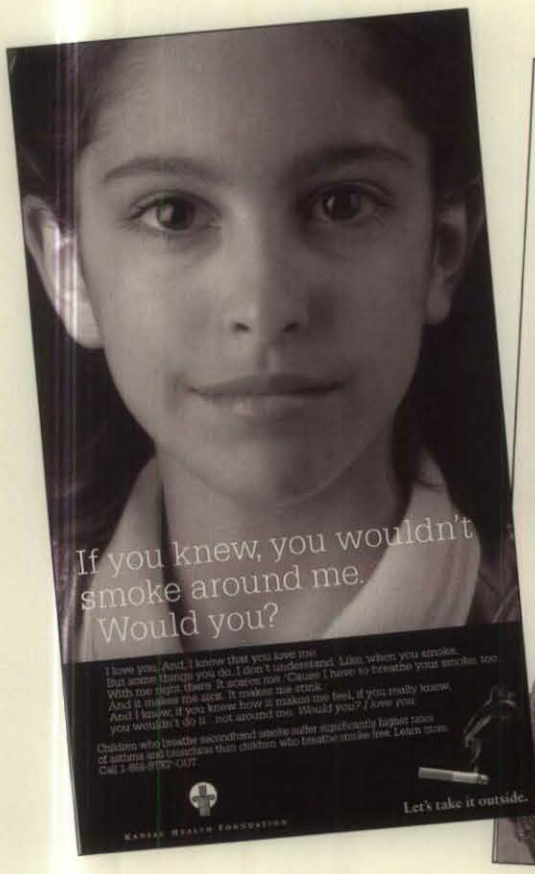
"The problems come because they don't have enough financial resources, they're worried about their green-card status, they're trying to operate in a society they're just not familiar with," she says.

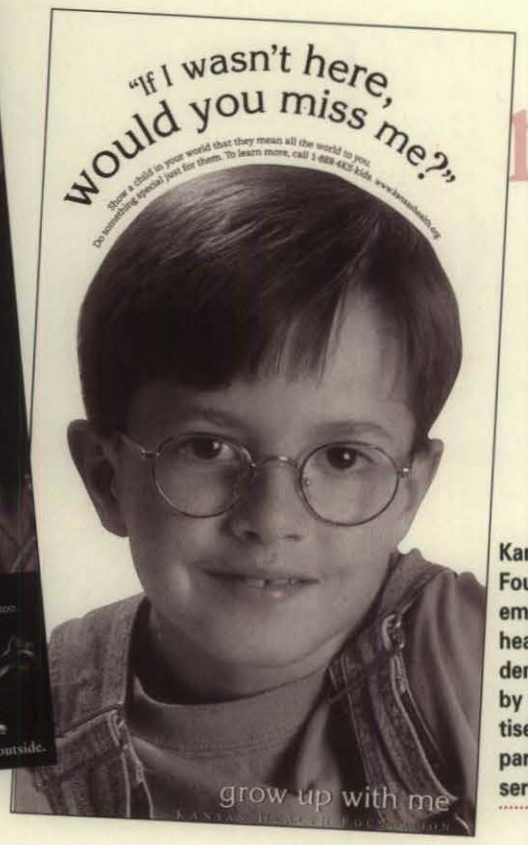
Nu-Man cites a typical case:

A friend of a friend calls for help. Her husband has beaten her, but she's afraid she'll be deported if she leaves him. They don't have enough food for their 4-month-old baby.

The help this family needs and gets—food, clothing, friendship—has nothing to do with religion, Nu-Man points out. Religion comes into play only as it leads those in need to people they're comfortable asking for aid.

Focusing on the results, she says, is one way that groups of all faiths can join together in charity. "As best we can, given the differences that there are, we can work to meet the one common goal of all faiths, which is to help people improve their lives." F&H





Kansas Health Foundation's emphasis on health is demonstated by these advertisements, prepared as public service spots.

A Health Resource

Kansas Health Foundation seeks the health of the public

WICHITA—In the mid-1980s, Wesley Medical Center was among the largest and strongest hospitals in Kansas, a high-profile symbol of the Methodist church's commitment to providing health care.

So when hospital management proposed selling the facility to a for-profit corporation and deploying the assets in other health-related areas, the idea was met with much consternation. In a sense, Wesley Medical Center had been caught in its own success.

While Wesley was profitable, its directors were concerned about the future in a market with a growing number of empty hospital beds. They decided the best long-term course would be to sell the hospital and invest the assets with the Kansas Health Foundation.

"As we thought about a different mission and what we could do, it occurred to us that it might work to convert the hospital's assets and broaden the mission," recalls Don Stewart, former Wesley Medical Center president and now a vice president and senior advisor to the Kansas Health Foundation.

Through an "intense educational process," Stewart and others outlined a new direction in which the foundation would support health maintenance, preventive care, and public initiatives to keep people healthy.

At a special conference, Methodist clergy and laity "voted overwhelmingly to allow the conversion," finalized in 1987.

Over the past 10 years, the Kansas Health Foundation has validated the confidence and vision that fostered its rebirth.

The foundation has supported community health assessments, parenting education, childhood development, research, nutrition education and substance abuse prevention programs, as well as served as an advocate for public health in many other areas.

It has also provided health care scholarships and supported curriculum development, endowing a distinguished professor chair at the University of Kansas to further community-based health promotion activities.

At the same time, the foundation is working to expand public awareness that "health care" means more than doctors and hospitals only. The quality—and perhaps the future—of people's health is at stake.

"People see the hospital as the health resource," Stewart says. "In fact, it's the illness resource. We spend billions of dollars on illness care in this country but very few dollars on preventive care. Allocating more of our assets to a public health agenda may help turn that around, and we'll all be healthier because of it."

In the Name of Hope and Healing

Wheat Ridge Ministries seeds global ministries

CHICAGO—Where there is healing, there is hope. And where there is hope, you'll often find the footprints of Wheat Ridge Ministries. The Lutheran-affiliated organization takes its name from the Colorado town where it founded a tuberculosis sanitorium in 1905. The facility was sold in 1960, and Wheat Ridge Foundation was formed with headquarters in Chicago. The word "ministries" replaced "foundation" five years ago "to give our constituencies a different mindset that we weren't just an organization with money to give away but that we're relating to the larger community with a broad view of wellness and wholeness," says Dr. Rich Bimler, president of Wheat Ridge Ministries.

When Wheat Ridge was established 37 years ago, the board of directors moved the institution from physical treatment for individuals with a specific disease to a holistic model that kept its former global outreach.

Today, Wheat Ridge seeds a variety of initiatives related to broad health issues, from wellness programs in California to medical assistance for abandoned children in Brazil.

"We are Lutherans seeding new ministries of health and hope in the name of the healing Christ," he says. "We use 'health and hope' as an umbrella term for our mission."

That mission primarily involves seeding a project or idea with dollars and providing consultation to help get started.

"We look for the unique kind of health and hope ministries that maybe somebody else isn't funding," Bimler says. "When that particular niche is filled, we look for something else. Our interest is to support, encourage, and enable ministries to happen rather than manage and control them."

But money is only part of the Wheat Ridge story. "We are strongly committed to partnering, collaborating, networking people with gifts to people with needs in a faith community," Bimler says, "and that includes providing people resources. We have 20 area representatives and staff associates who are involved in various health and hope ministries through consultations, visitations, support, and affirmation."

The wide range of Wheat Ridge Ministries not only fosters community wellness but brings a new perspective to faith as well. "We continue to encourage Lutherans to become involved in different styles of ministry and to become aware of what's going on in the rest of the world," Bimler says. "We want to help people celebrate life—in the name of the healing Christ." F&H

With a global vision and a commitment to partnering, supporting, encouraging and enabling, rather than controlling, Wheat Ridge "wants to help people celebrate life—in the name of the healing Christ."

A Broad Definition of Community Health

Mary Black Foundation funds a wide spectrum of projects in its South Carolina setting

SPARTANBURG, S.C.—What is health? To the trustees of the Mary Black Foundation, the broad answer includes wellness promotion, disease prevention—and rebirth of a city park.

During most of its 11 years, the Mary Black Foundation's primary function was to raise money for Mary Black Memorial Hospital in Spartanburg, the first private, not-for-profit medical facility in the state.

When the hospital was sold two summers ago, the foundation, as the beneficiary of the sale, emerged as an expanded, full-time philanthropic organization dedicated to promoting community health.

At the first talk of a sale, "we began to look at how we would respond," recalls Jan Yost, president of the foundation. "Whether one creates a new foundation or the proceeds go into an existing one, there first needs to be a long, serious look at how those assets can best be used in the community. Rather than simply scatter funds, we wanted to strategically place them."

Instead of earmarking funds for indigent care, the foundation elected to direct its activity toward disease prevention and health promotion. "That's what our health care delivery system hasn't been doing well," Yost says.

Further, the trustees needed to decide on worthy initiatives, then solicit for proposals that would remedy the defined problem. "We want everyone to know where we want to go and we want to go there together," he adds.

One result was a blueprint for a Family Support Center addressing a range of needs, from prenatal care to senior citizen activities.

Another grant is aimed at safety for elderly persons. Working with the Red Cross, the homes of senior citizens are audited for safety, and volunteers make whatever repairs are necessary.

The third grant provides a place for families to walk, jog, play, and gather. Cleveland Park had gone to seed. The grant not only helped restore the park, but it also illustrated the foundation's broad definition of a community health asset.

After the sale of the hospital, says Yost, "There was real tension to get the money out into the community quickly, but we wanted to do it right. Somehow you have to do both at the same time. You can't wait years to make your first grant, but if you do it in the first month or two, you know you're not prepared.

"The concept of charity has changed," she adds. "Today's need is to use your funds to achieve some sort of a change and difference in the world, rather than just give to things that feel good and sound good to you.

"You have to figure out the best way to use the money you have because the needs are always far greater than the money." F&H

JOHN BYRUM PHOTO

A youngster plays in Cleveland Park, a project funded by the Mary Black Foundation.

Faith Active in Love

Caring FOR *All* God's Children

By Gary Goettling

There could not have been a worse time for a fire at Forest Elementary. Classes were in session last year at the suburban Minneapolis school when the alarm sounded. While all 150 children were ushered safely from the building, they found themselves coatless and shivering in the bracing Minnesota winter.

Fortunately, they knew exactly where to find shelter, at a community "outpost" just across the street.

The staff at St. James Lutheran Church quickly welcomed the children, wrapping them in quilts meant for missions overseas, until worried parents and caregivers could take them home.

A GROWING NUMBER OF DENOMINATIONS are re-evaluating their responsibilities both inside and outside of their respective faiths, and establishing greater roles in their communities. In a sense, they are reaffirming the moral obligations of their faith to deal with wider community issues such as poverty, health, and neighborhood cohesiveness. For these congregations, the avenue of choice for addressing those issues is through those most affected by them—children.

This shift in priorities is striking in its simplicity and embraces the belief that healthy children are the indispensable foundation of healthy communities. Further, health is broadly defined with particular emphasis on the preventive maintenance of young minds and bodies.

In fact, the capacity to mitigate most of the primary health risks in children is already within reach of faith groups and congregations, according to Paul Boumbulian, vice president of Parkland General Hospital in Dallas.

"The more important thing congregations can do is provide a supportive environment for families and help parents provide proper stimulation to their children," he says. "The best people to do that are the parents, but families have a lot of difficulties these days. Congregations can provide support for those families and can do some of the stimulation also."

Proper stimulation includes affection, comfort, and nurturing—cuddling a baby, for example—activities that get neglected in some families, for whatever reasons. Churches with day care or other kinds of child care service can provide beneficial stimulation through the warmth and caring of its staff and the ambiance of its facilities.

"It's really basic stuff, and it doesn't cost anything," Boumbulian says. "Even the poorest congregation can do something to support families and assist in the stimulation of children."

Such stimulation during the first three years of a child's life is critical, he adds, because that's when the biological pathways that establish a child's coping skills are set. "If the brain has a chance to develop properly, the child has a better chance of being able to cope more effectively with life not only physiologically, but also from the standpoint of emotional intelligence. Fewer of them drop out of school, wind up in jail—all those horrible things for which we pay a high social cost."

The United Methodist "Bishop's Initiative on Children and Poverty" has inspired many churches to increase their ministries. First Methodist in Chambersburg, Pa., has strengthened its longtime community outreach, with programs ranging from suppers for its downtown neighbors to after-school tutoring *(above)* for children.

Neglect also carries a high dollar cost, believes Judson Hawke, speaking from the standpoint of traditional medical care. A pediatrician for 45 years, Hawke was active in The Carter Center's Atlanta Project and is currently associated with Scottish Rite Children's Hospital in Atlanta. In his view, an active, preventive approach to health care not only avoids the physical and emotional toll from illness, but it's "the best way we can cut down the cost of health care. Prevention costs less, and the 'cure' is a whole lot better."

Safety and preventive health measures already exist such as using child safety seats in automobiles, keeping household chemicals out of reach, and making sure a child is properly immunized.

Yet even such basic safety measures are not always applied, often because people hold the mistaken belief that "it can't happen to me," Hawke says. "There's tremendous power in prevention. The faith community can truly begin to push this issue and help to bring about a paradigm shift from after-the-fact care to preventive medicine."

SAFE HAVENS FOR CHILDREN

THE EVANGELICAL LUTHERAN CHURCH OF AMERICA (ELCA), 5.5 million members strong in nearly 11,000 congregations, has adopted seven initiatives to guide its members into the next century. The first is a three-year plan called "Help the Children."

"Our first strategy in that initiative is to invite each of our congregations to declare itself a 'safe haven' for children," says Joanne Negstad, executive director of Lutheran Services in America and leadership team chair for the ELCA initiative. "We have two goals. One is that children be free from fear, and the second is that children be safe to grow. Our churches seemed the right place to begin because they are among the few places where parents and children and families come together. So we want them to be safe places not only in terms of physical safeness but in terms of people safeness."

It's no accident that the students escaping the fire in their school sought refuge at St. James Lutheran, a literal and spiritual example of a safe haven. The church has been engaged in several partnerships with the school, including after-hours sessions where children are tutored, read to, or simply provided adult attention. On a neighborhood level, the church sponsors a street carnival during the summer "where people can come and enjoy being together," Negstad says.

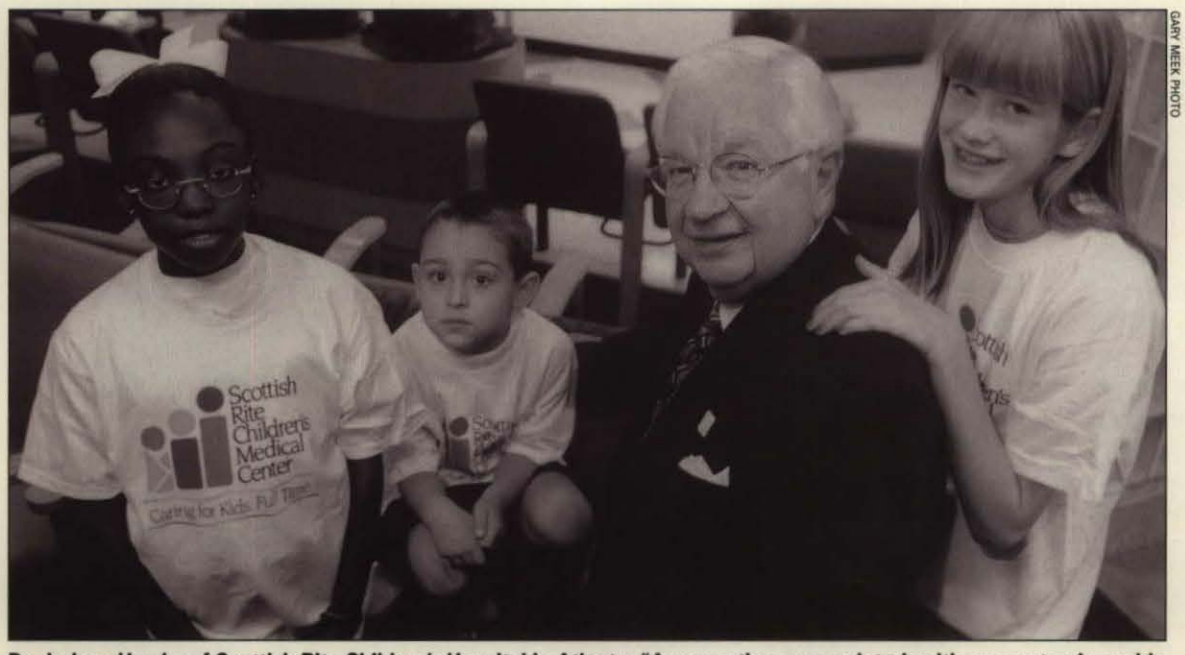
"That congregation has reframed its life as a mission outpost in the community. That's the kind of thinking we're supporting on behalf of children."

A safe haven, in the context used by Lutherans, is more than simply accessible church facilities and greater participation in church life. It also connotes more-active, higher-profile contributions from the congregation to the community at large.

"A safe haven means creating a faith-based teaching and learning environment that welcomes all children and their caregivers," says Negstad, noting that the ELCA plans to expand the number of church-sponsored schools by 50 a year over the next three years.

In addition, the safe-haven philosophy "advocates policies of justice on children's issues, directs our resources to provide a sanctuary for children after school and helps create a community that is free from violence.

"But we're also concerned that the concept of safe havens not be perceived as an inward effort," she says. "Congregations should see themselves as a place for children of the whole community, not just those of families who belong to that particular congregation."



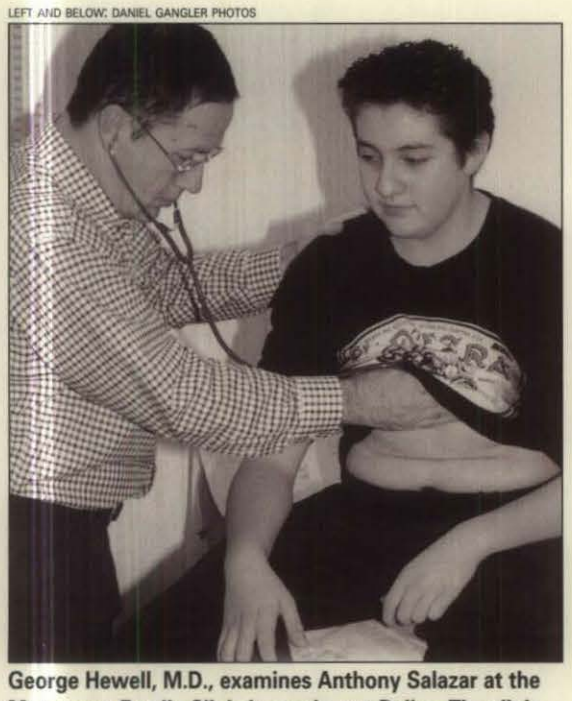
GARY MEEK PHOTO

Dr. Judson Hawke of Scottish Rite Children's Hospital in Atlanta: "A preventive approach to health care not only avoids the physical and emotional toll from illness, but also prevention costs less, and the 'cure' is a whole lot better."

WHILE SOME CONGREGATIONS may see child safety strictly in terms of physical violence affecting mostly other people in distant places, Negstad argues for a broad interpretation.

"Families everywhere are struggling over power

LEFT AND BELOW: DANIEL GANGLER PHOTOS



George Hewell, M.D., examines Anthony Salazar at the Metrocrest Family Clinic in northwest Dallas. The clinic, which provides low-cost health care to those in need, is a ministry of two United Methodist Texas churches.

issues, economic issues, and children are often paying the price," she says. "It's common to have two parents working to pay the bills, and though both are very concerned about their kids, there is stress on that family's life. The children may be ignored and their emotional needs not met as well as their material needs are met."

Emotional changes in family life can be illustrated with the ritual of the family meal, once a staple of home life, but now comparatively uncommon, Negstad says. But she also understands that while changes cannot be avoided, they can be managed.

"We need to look at what family life is like these days. It's not the same as it was a generation ago, and it will be different a generation from now. We need to be accepting of those changes, but at the same time understand the basic things we need as human beings and the basic needs of children. We must help people with the realities of family life in ways that allow them to nurture each other and live in healthy relationships."

RESHAPING THE UNITED METHODIST CHURCH

THE COUNCIL OF BISHOPS OF THE UNITED METHODIST CHURCH has embraced an even more ambitious task. Its development and endorsement of "The Bishops' Initiative on Children and Poverty" is aimed at reshaping the 8-million-member church into a ministry to children and the impoverished.

The document outlining the initiative states: *"For the first time in history it is actually possible to create a world in which all children share in at least the basic opportunities for life. The technical resources are available to protect children from the most common diseases, to provide them with the necessities of food, shelter, clothing, and health care. For the most part, we know what to do and how to do it. What is lacking are the vision and the moral will. Vision and moral will are the responsibilities of the church."*

One aspect of the Initiative is "A Church for All God's Children," an effort to identify "activities that a church can adopt to become more welcoming to children and those who live in poverty, as well as addressing their needs," says Mackie Norris. "The original Methodist theology was founded with an emphasis on helping widows, orphans, and poor people."

Norris, a consultant to the council, will evaluate activities arising from the initiative. They are grouped into nine imperatives that begin with educating the congregation to the needs of children—a priority, since all other actions follow—to preventing child abuse and helping children grow as faithful Christians.

Creating awareness and sensitivity are especially important, says Norris, and statistics help make her point: Poverty afflicts one-fifth of all children in America, where a child dies from gunfire every two hours; malnutrition kills 35,000 children worldwide every day; child labor, often under dangerous conditions, is used in some parts of the world to manufacture goods for affluent Western nations.

Specifics supporting other areas are evolving but typically include activities ranging from child-proofing church facilities to sponsoring parenting classes, after-school activities, and health programs. Congregational task forces are essential to guide the process and develop local programs that further the aims of the initiative.

Local congregations are more likely to embrace the initiative when it's presented as an ongoing ministry rather than a program with limited duration, Norris says.

"Some congregations get on-stream sooner than others and will implement the initiative in different ways, depending on the demographics and location of the congregation," she says.

"If a congregation's median age is 59, for example, there may be some things they cannot do as easily as a church with young adults and children. But there are some things they can do, like providing after-school reading, mentoring—anything that brings children into the life of the church."

Another attribute of creating a "church for all God's children," particularly for the small and medium-size churches that comprise the majority of Methodist congregations, is that it doesn't add new demands on the budget. Rather, it is a way of defining and carrying out the church's mission.

From the standpoint of drawing children—and by extension poor children, too—into the church, a congregation may only need to brainstorm ways youngsters can be more involved.

"Do you send all the children off to children's church, or are there ways to involve them in worship services that help them express their own understanding of theology?" Norris asks. "After-school programs, tutoring, intergenerational Bible study groups—there are many things a church can do to reach out to children."

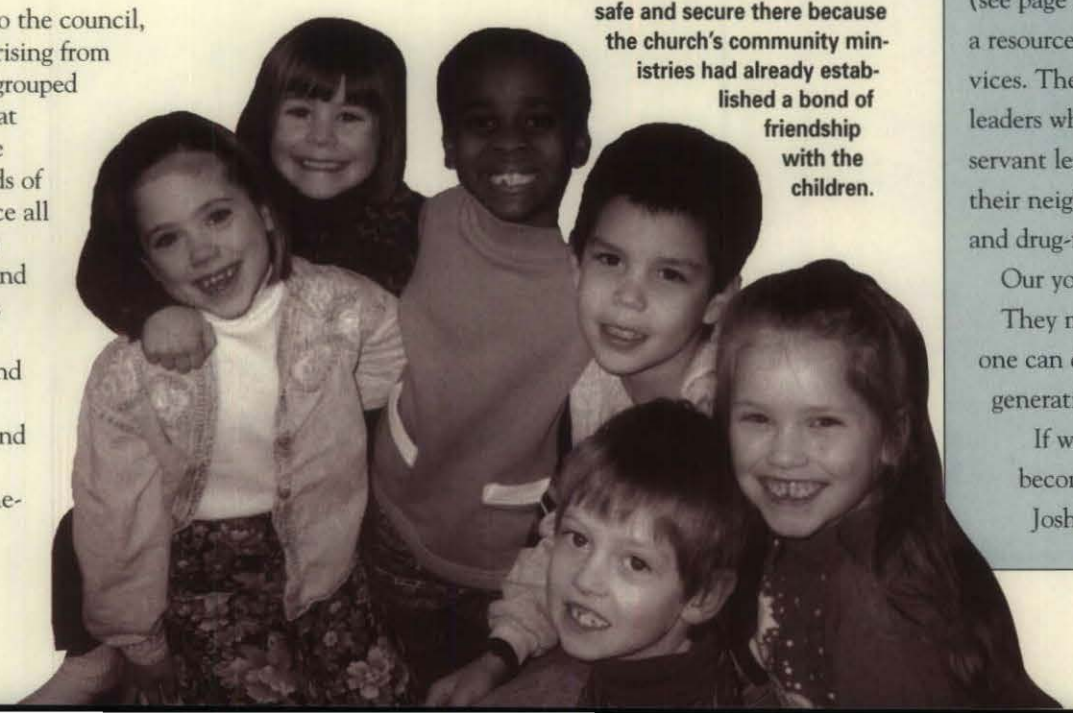
Reaching out to children has never been more important. Consider that in the time it has taken to read this article, a half-dozen children in the United States have been placed at risk through abuse or neglect. It is a problem that crosses economic and social lines.

Organizing church and community volunteers to provide "safe corridors" for children walking to and from school is one no-cost idea tied to the initiative. Regularly scheduled parent-support groups and parenting classes are two others.

"We all share the pain and the pleasure that children bring," says the ELCA's Negstad. "We need to get out of our little walls and our life that can be so compartmentalized and share those relationships on a broader base in community."

Mackie Norris expresses it another way: "After all, who can turn their back on children?" F&H

When a fire broke out in their school, children at Minneapolis' Forest Elementary crossed the street to St. James Lutheran Church. They felt safe and secure there because the church's community ministries had already established a bond of friendship with the children.



Children of Promise

By Rev. Fred D. Smith Jr., Ph.D.

THE JOSHUA-RAHAB GENERATION

MANY IN THIS GENERATION of young people suffer as much from moral poverty as they do from social economic poverty. Moral poverty is the absence of at least one caring adult to teach a young person right from wrong. Moral poverty is the abandonment of youth to unhealthy street cultures such as gangs, the black-market drug economy, and prostitution by those who are supposed to love them. Worst of all, moral poverty is the abuse of young people by their guardians, as author John Diliugio reminds us.

Society as a whole has no expectation that they will match the achievement of previous generations.

This generation suffers from such low expectations it has been called the X Generation. Some perceive many children born in our inner cities and suffering from economic and moral poverty as a nihilistic threat because they are without hope, meaning, or love. They have been seen as super predators. In the language of public health, they are "children-at-risk."

The church in its prophetic role has the responsibility of changing their name—from children-at-risk to *Children of Promise*, from the X Generation to the *Joshua-Rahab Generation*. How? By reframing their stories in light of the Judeo-Christian narrative of hope (the complete story is told in the Old Testament, Joshua 1-7).

After the death of Moses, Joshua led the children born in the wilderness into the land that God had promised. They became the chosen generation, Children of the Promise.

Today's youth may be wandering in the wilderness because we have failed them. We of the Me Generation, obsessed with self-actualization, have left them alone to raise themselves.

Yet they, too, have a birthright born of the blood, sweat, and tears of their forebears. They deserve a promissory note that only our generation can provide.

I am proposing a discipleship program that will develop young leaders who are courageous and strong. Called "The Children of Promise Faith Communities Program," it is being implemented at Atlanta Health Ministries (see page 8). Its purpose is to activate youth as a resource rather than as a client for our services. They will be trained to become spiritual leaders who impact a generation by discipling servant leaders. They will work with others in their neighborhoods to create a violence-free and drug-free "Beloved Community."

Our youth must take the land.

They must be trained to disciple others. No one can do it for them, but they need our generation to equip them for the task.

If we accept the challenge, they will become God's Gang, a holy hip-hop Joshua-Rahab Generation. F&H

Faith IN Action
Health Ministries in Atlanta

By Gary Goettling

AT THE BEGINNING, all was not well in the planning for a Health and Wellness Day at St. Anthony's Catholic Church.

When the West End Atlanta church's head congregational health promoter, Melba Hill-Paschal, started calling around for help, she discovered that "nonprofits don't offer services for community programs anymore."

"We may not be able to agree on how communion is done or other doctrinal issues, but we can agree that the health of our constituents and of our communities is important to us."

Then she called Ruth Harris, her counterpart at Shilo Baptist, and like St. Anthony's, a participant in Atlanta Health Ministries.

"She had done screenings at her church," Hill-Paschal says, "and together we worked it out where I borrowed some of her materials and literature, and she provided all the supplies for us to do the diabetic and blood-pressure screening."

FOR SOME CONGREGATIONS, sponsoring outreach health ministry programs is a great idea, but fraught with great difficulties. Management and coordination of such programs can be tricky. The sheer enormity of the need may stretch already-thin resources beyond the capabilities of a single congregation or even a small community of churches. Plus, as Hill-Paschal discovered, nonprofit groups that once supported health-related services either must charge for their help, or they don't have sufficient staff to offer the help that's needed.

A group of African-American churches in the south metro area knew from experience the value as well as the constraints on their community health initiatives. They had been one of three congregational coalitions supported by The Carter Center's Interfaith Health Program. Now they were ready to launch a program of their own, Atlanta Health Ministries (AHM).

AHM provides an organizational and managerial framework to foster cooperation and resource-sharing among 14 member churches, with offices located at Capital View United Methodist Church.

Atlanta Health Ministries is a resource center for congregations, says Fred Smith, associate director of the Interfaith Health Program at The Carter Center and coordinator of its Communities Collaboration Programs. "It helps each church in its health ministry by providing technical assistance and training and identifying funding opportunities. It also identifies interns from seminaries and schools of public health who want to work through faith communities."

WITH ASSISTANCE from the Interfaith Health Program, AHM was awarded a Faith-in-Action Grant to fund a coordinator and a number of ministries related to the elderly such as home visits and transportation services. Other AHM initiatives include after-school programs, summer camp and mentoring for young people.

Support from the Cecil B. Day Foundation is helping establish a Youth Ministry Development Program that will provide peer outreach for unchurched community youth. Up to 50 young people will receive leadership training for the ministry. The Day grant supports the program on a schedule that requires the church to assume an increasing portion of its cost over time.

Those young people will also have an opportunity to hone their leadership skills at an upcoming "youth and parent convocation," according to Smith. Sponsored in conjunction with the Interdenominational Theological Center, a coalition of black seminaries, previous convocations have been well-publicized and well-attended.

"It's a huge event that draws hundreds of young people and parents to share their perspectives on issues such as teen pregnancy, violence prevention, peer pressure, sexuality, and nutrition," says Smith. "Some of the young people also perform dances or sing, so it's a fun occasion as well."

The AHM structure also helps congregations extend their reach and broaden their ministries that contribute to community health.

Says Smith, "We hope to train a couple of people for each congregation as lay health promoters whose responsibilities would be to coordinate comprehensive health-education programs. Special emphasis would be placed on issues such as breast and prostate cancer, nutrition, blood-pressure screening, and child safety. We also hope to include more health fairs and similar educational activities."

ALTHOUGH THE IDEA of church coalitions is not new, AHM has a unique focus in its health mission and provides a unifying framework to promote greater efficiency and services coordination.

The basic health-ministry structure of AHM mobilizes the resources of both clergy and laity. A Health Ministries Council, comprised of pastors, is primarily concerned with structural issues such as funding and staffing. Lay health promoters in each congregation focus on health awareness in their respective churches.

"Lay health promoters and the pastors' board work together as one organization in AHM," Smith explains. "AHM represents a new understanding of healthy congregations.

"At one time, the measures of success for a pastor were how fast the congregation grew, the size of the church's budget, and—in many cases—the number of ministries it supported," he says. "That's changing. The successful church in the next century will be one that does those things but also—perhaps primarily—promotes health as broadly defined. The successful church of the future will be a place where people can go to be healed and to remain healthy—not just the church members but all the people in the neighborhood around it."

"We may not be able to agree on how communion is done or other doctrinal issues, but we can agree that the health of our constituents and our communities is important to us," Smith concludes. "So as we work together on this issue of health, we can develop greater understanding and familiarity with one another and bring down some of those walls between people of different belief systems." FOCUS ON HEALTH

GARY WEEK PHOTO

A work group from Atlanta Health Ministries meets with Chamblee-Doraville health promoters.

HEALTH CARE FAIR

Recently a back-to-school Health Care Fair was held in Shallowford Gardens, a low-income housing unit in northeast Atlanta. It was sponsored by 25 congregations of a multiethnic coalition that had its origins, like Atlanta Health Ministries, in The Carter Center's Atlanta Interfaith Health Program.

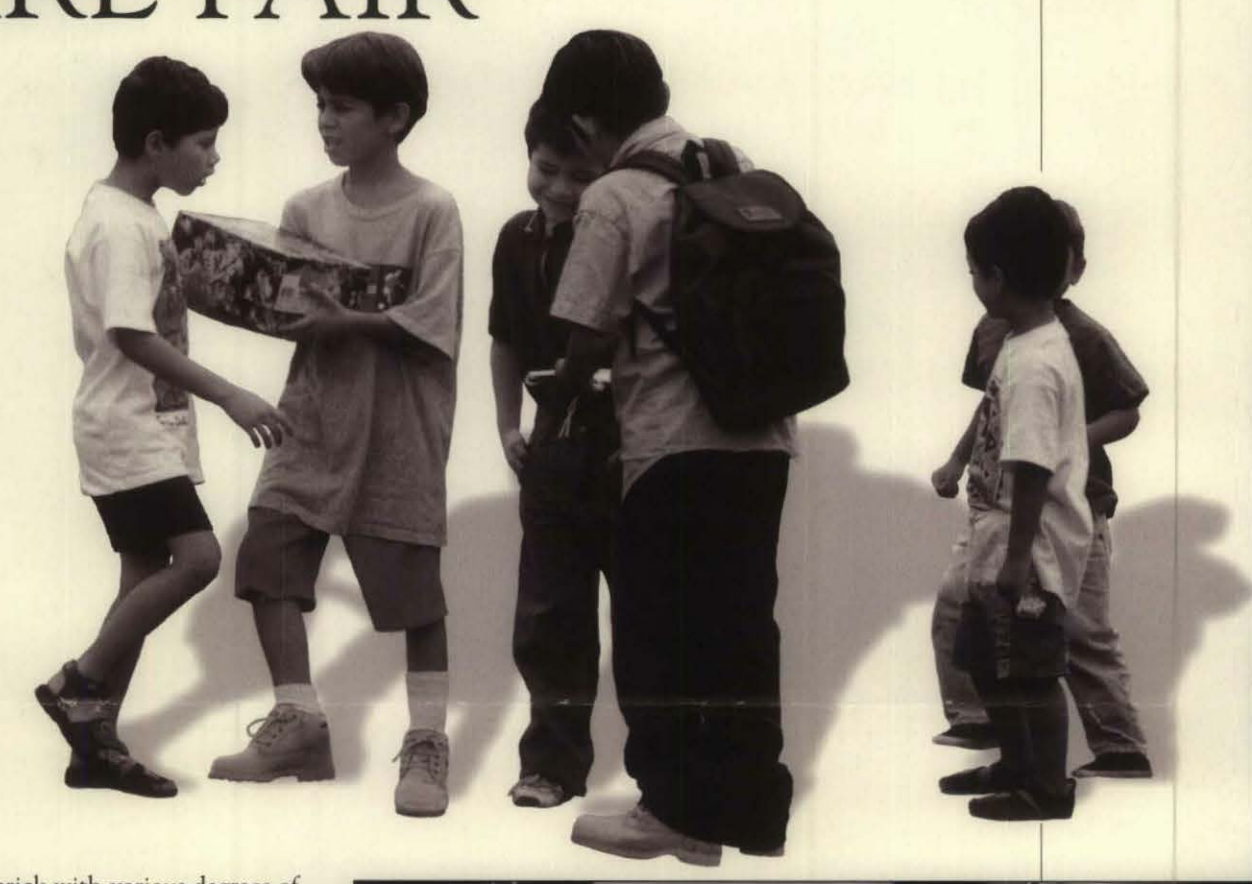
Sam Bandela, a native of India who has international experience as a coordinator for Habitat for Humanity, is the director of a ministry center that houses the coalition. He has collaborated with St. Joseph's Hospital in hiring a parish nurse with community health skills to train and coordinate the activities of congregational health promoters.

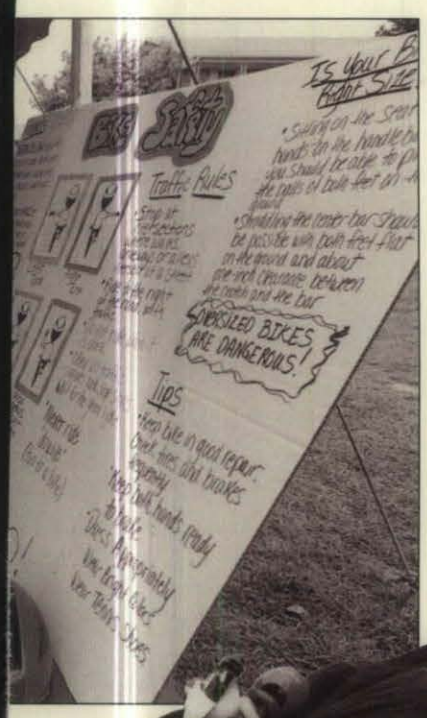
Under the direction of the parish nurse, Jean Murphy, the Health Care Fair was designed to meet the multiple needs of mostly immigrant children preparing for their first school experience in the United States. Rather than expecting the mothers, most of whom do not speak English, to bring their children to public health agencies for their children's preschool health screenings, Jean Murphy enlisted public health nurses to come to Shallowford Gardens, where most of the children reside.

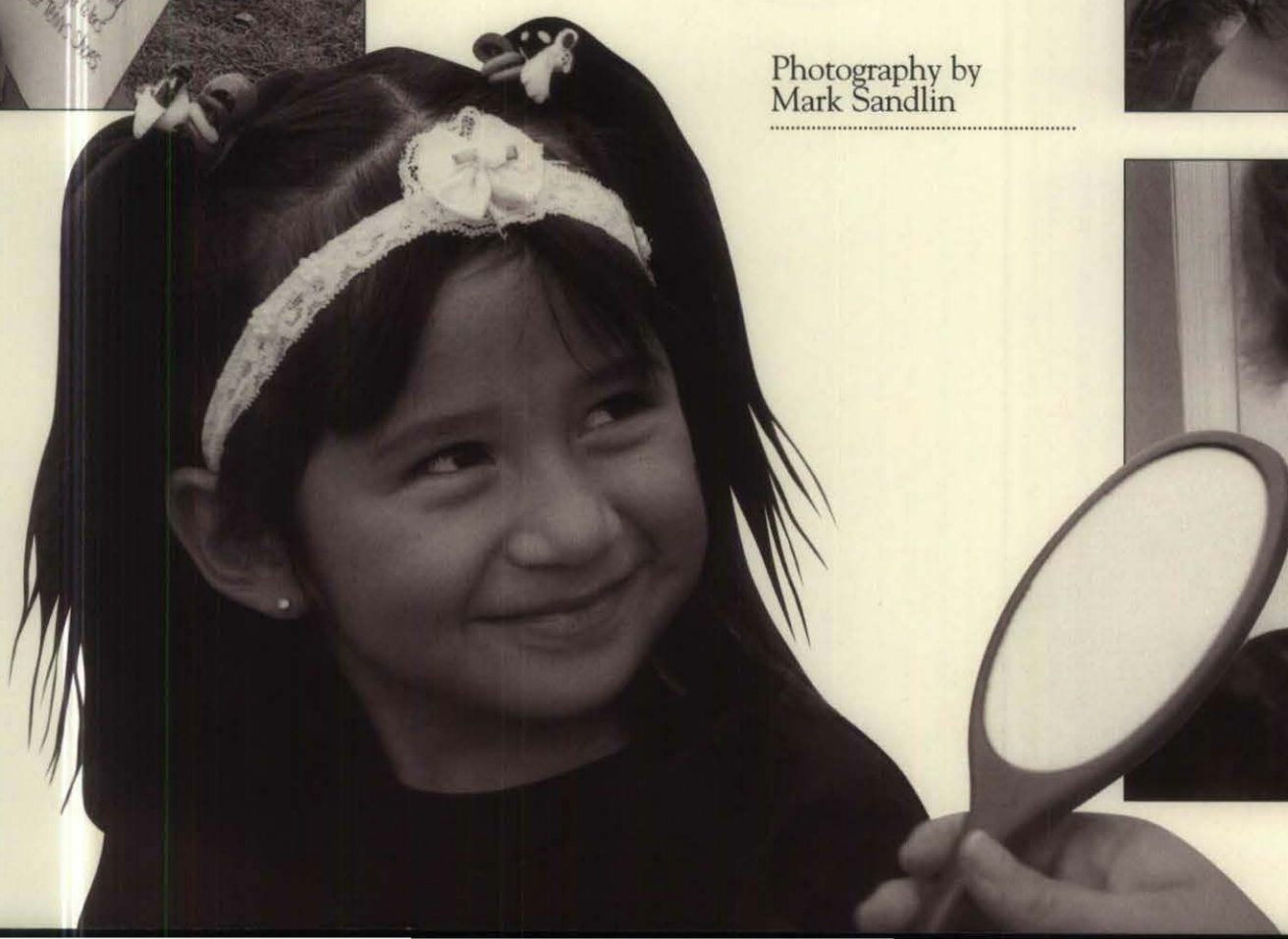
There were opportunities galore: messages on bike safety and the danger of drugs; low-cost bookbags and shoes; head-lice exams and haircuts; blood pressure checks, and *ouch!*, the scary blood screening for diabetes, which even adults were squeamish about but submitted to.

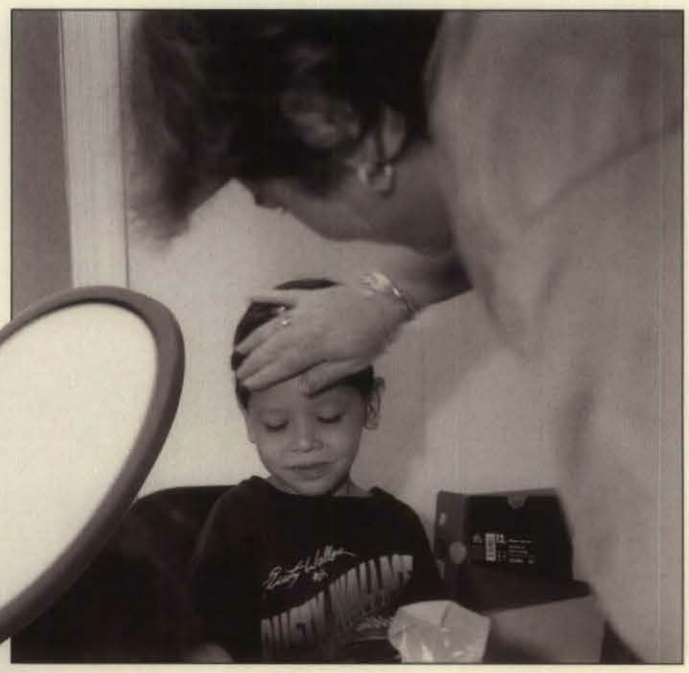
Like their parents, the youngsters took the needle's prick with various degrees of courage. And for those seeking the excitement of something special, there was face painting, which added fun and diversity to the day.

The Health Care Fair is not just a one-time event for the children in Shallowford Gardens. The Chamblee-Doraville Ministry Center provides an after-school program for them throughout the school year. FCH









Photography by Mark Sandlin

The Role of Public Health in the Faith & Health Movement

These photographs were taken at an Atlanta Health Care Fair, which helped mostly immigrant mothers prepare their children for school *(page 9)*. The fair exemplifies how public health and faith communities can collaborate to improve health. Such collaborations have long been accepted by many public health leaders; examples of successful partnerships can be found across the country. Recently, however, new efforts have expanded the recognition and advantages of faith/health partnerships. In this section, we examine the mission of public health, what it contributes in partnerships with faith communities, and how it is promoting such partnerships among public health professionals.

The governmental public health system is comprised of more than 3,000 public health agencies located at the city or county level. Their size and the services offered are influenced by the size of the population served. A substantial number of these are small (42 percent have 10 or fewer employees), serving communities with less than 50,000 residents. Ninety percent of health departments serving communities with a population greater than 500,000 have more than 100 employees. All are supported by state and federal health agencies that provide technical assistance and fiscal resources.

Public health's role is to:

1. Promote delivery of preventive health care to individuals and provide primary health care to families lacking a source of medical care.

2. Collect and deliver information about health conditions in a community and ways of preventing and controlling the ill effects of diseases, injuries, and other health hazards.

3. Convene people and organizations to improve community health through social action based on public health science.

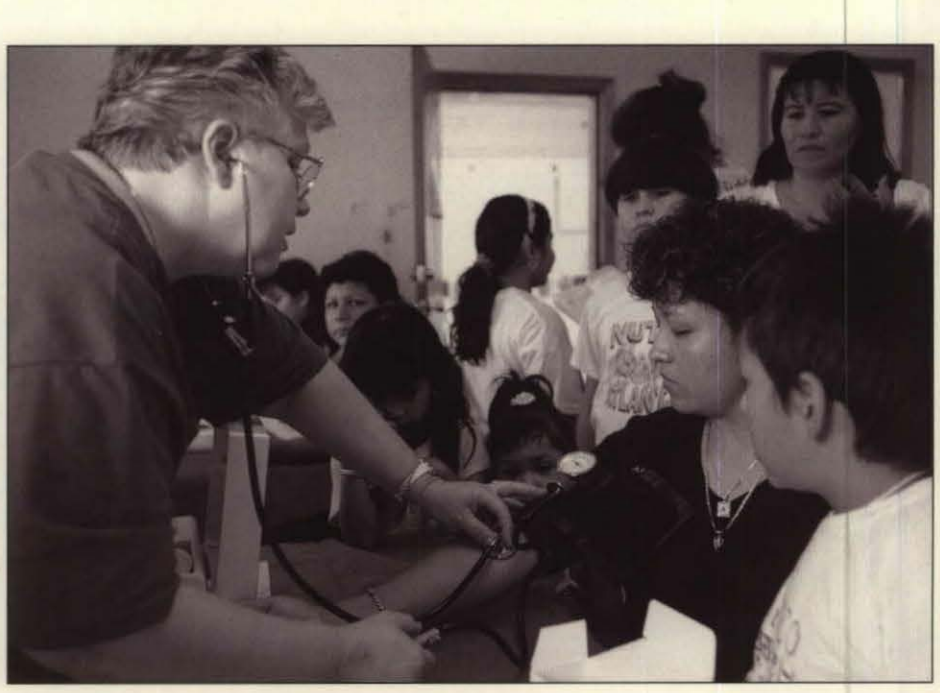
"It is clear that community participation and collaboration are the cornerstones for effective public health action needed to resolve our present-day health problems."

—Edward Baker, M.D., M.P.H.
Assistant Surgeon General and Director of the Public Health Practice Program Office at the Centers for Disease Control and Prevention

Two significant developments within the public health community give prominence to the value of partnerships with faith communities.

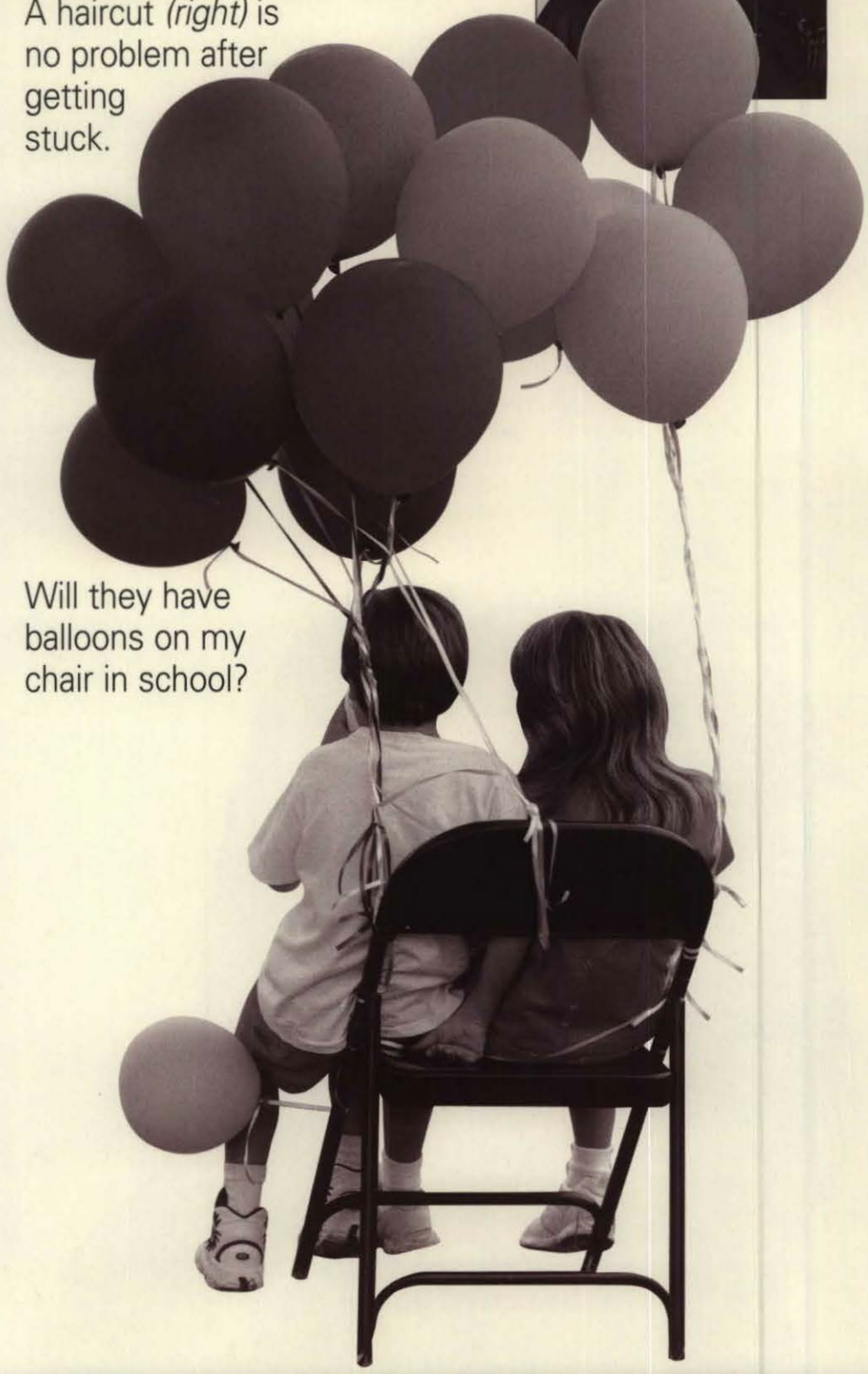
1. "A Caucus for Faith and Health *(page 11)*" outlines the Caucus on Public Health and Faith Communities established by the American Public Health Association.

2. A recent forum of the Centers for Disease Control and Prevention on "Engaging Faith Communities as Partners" is the basis for "A Forum for Faith and Health *(page 12)*," which tells how a "Faith Interest Group" at CDC generated this forum for employees to demonstrate the value of faith/health partnerships.

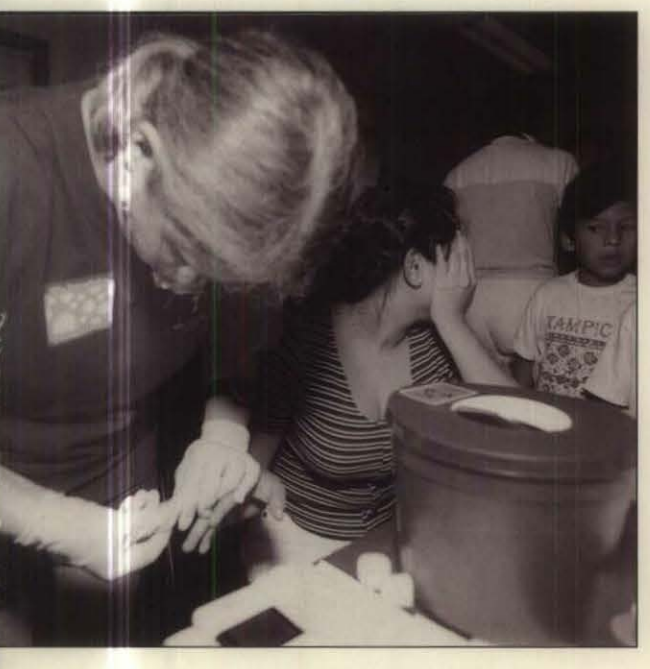


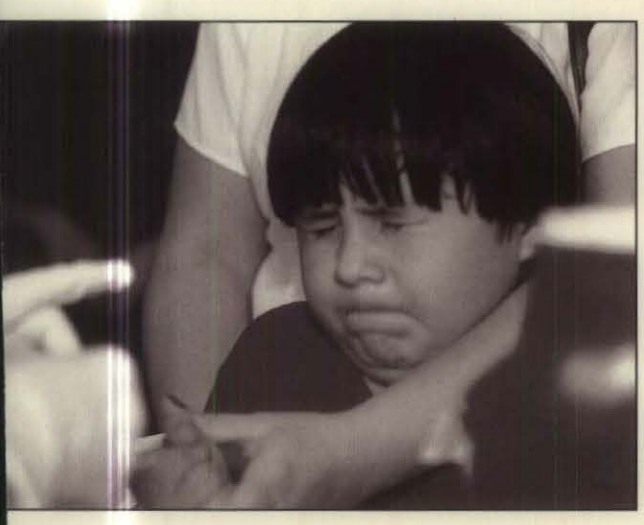
Getting stuck with a pin to draw blood is no fun for children or parents, even if they understand it's for their own good.

A haircut *(right)* is no problem after getting stuck.



Will they have balloons on my chair in school?





A Caucus for Faith & Health

The separation of church and state is as American as apple pie. So is the sharp division between religion and science. So it came as no small surprise that Caswell Evans, D.D.S., M.P.H., incoming president of the American Public Health Association, challenged participants at the 1994 meeting to "expand the public health envelope through faith community/public health partnerships."

Evans urged the assembly of mostly government workers to find creative ways to collaborate with faith groups.

"A rich fabric of faith organizations exists in the cathedrals, storefronts, synagogues, temples, and mosques of our communities. They may be evangelical or philosophical, but they are all dedicated to improving the human condition," Evans told the group. "That is exactly what public health is about—improvement in the human condition."

Evans' words received a ringing endorsement from David Satcher, M.D., M.P.H., U.S. Surgeon General, and William Foege, M.D., M.P.H., Carter Center health policy fellow, both former directors of the Centers for Disease Control and Prevention (CDC). The strong positive response of those attending the session was a signal of the latent interest in faith/health partnerships on the part of public health professionals, many of them people of faith who were drawn to public health as a "calling" as much as a profession.

Evans proposed a permanent Caucus on Public Health and Faith Communities, which was approved in January 1996. The first Caucus paper sessions were held at the 1996 annual meeting.

Because of the enthusiastic response, five sessions were scheduled for the 1997 gathering. Below are excerpts from remarks made by panelists at the opening session of this caucus. The topic: "Mobilizing the Faith Community: Opportunities and Obstacles." *(See "APHA Caucus" on page 14 under Organizations.)* F&H

Appreciate Diversity

Rev. Kenneth Robinson, M.D.
Assistant Dean, University of Tennessee Medical School;
Pastor, St. Andrews AME Church

To more effectively partner with the faith community, public health must recognize the enormous diversity among congregations.

There are differences in their understanding of authority and administration, their doctrines and policies, their fundamental mission, and their interest and skill in working with other congregations and agencies. It makes no sense to go to an African-American church in the inner city with public health materials that are in direct conflict with doctrines of that church.

In some congregations, it is best to approach the pastor; in others the laity.

There are different types of churches, each with a unique polity and style for health ministry. Social-gospel churches are committed to curing the ills of society and meeting the needs of the distressed, the oppressed, the disenfranchised. They are open to outreach efforts. Evangelistic churches are committed to spreading the gospel. They might see health care as a means by which to share weightier matters than the care of the body. Such churches may be interested in health education campaigns to foster their broader agenda. Liturgical churches might find on-site, structured programs most ideal. Study-and-fellowship churches place significant emphasis on personal growth and development. An effective public health initiative in that setting might address issues of individual lifestyles and personal responsibility.

As institutions with a long tradition of health and healing, faith groups are ideal partners for public health, but we must remember that the partnership is a two-way collaboration rather than regard faith groups as a means to foster a public health agenda. They are the conscience of the community, advocates for the poor and underserved, and often the first place the needy go for help.

Public health professionals must be sensitive to both the gifts and the needs of the faith community and respond appropriately. We must nurture the relationships that will build this partnership around a common, enduring vision. F&H

Focus on the At-Risk

Nancy Zionts,
Senior Program Director, Jewish Healthcare Foundation

We use the resources of our foundation, created by the sale of a religious hospital, to mobilize faith communities in using public health strategies in responding to the needs of the elderly, the indigent, and the underserved.

This mission is at the heart of Jewish tradition. Practically, that expresses itself in grant-making in our community—community planning, community convening, and policy and advocacy work—all focused on populations that are most at risk.

This is the right time for faith-based health foundations to be mobilizing faith communities. Economic forces in managed care and a consensus about the importance of community health put faith communities at the center of any future strategy to improve health.

Recently, the Jewish Healthcare Foundation convened six other Jewish foundations with a similar mission to explore ways of working together. The assembled foundations represented close to $1 billion dollars in health care assets, and that is only six among 100 new faith-based foundations.

Imagine what might be accomplished if those funds are used with care and wisdom to mobilize the churches, temples, and mosques that already are the most stable, trusted social institutions in underserved communities. F&H

Set Future-Oriented Goals

William Foege, M.D., M.P.H.
Distinguished Professor of International Health,
Emory University School of Public Health,
Senior Health Policy Fellow, The Carter Center

It took almost 100 years before medical missions in foreign countries began to think in terms of disease prevention. That long period of incubation culminated in the remarkable story of what happened when a missionary reported a case of smallpox in a small Nigeria outpost. Since the vaccination supply was limited, the missionaries served as a surveillance team to report on such outbreaks, and the small supply of vaccine was used to contain them.

This shift from mass vaccination to surveillance containment changed the strategy for smallpox eradication in the world.

That was 30 years ago, and it has taken us that long in this country to get to the same place.

What are our opportunities now?

- First and foremost, train religious and public health professionals to integrate their disciplines.
- Second, annually update and continually inspire the next generation of public health students.
- Finally, encourage faith groups to do what CDC cannot do: advocate for programs in public health. What if we lobbied for child-health programs, for equity in mental health treatment, for anti-tobacco legislation, the way the faith-based, hunger lobby Bread for the World advocated in 1985 against reducing child survival money in the U.S. budget? Forty-thousand letters to members of Congress not only reinstated the money the White House had removed but also added $100 million more.

The challenge for the future is to unite the community of faith and the community of public health in writing the history of public health for the next thousand years.

We must keep the focus on health, not religious differences.

We must broaden our scope until there is no part of life beyond the interest of public health workers.

We must find the resources, both public and private, to support faith/health programs.

We must have impeccable science.

We must accept ambiguity, the messiness that is part of any movement, confident that—just as with evolution—what works gets repeated.

We do not know what stars look like today. All we know is what they looked like a thousand or a million years ago, because that is what we see. Five hundred years from now, people will know next to nothing about us, but the world in which they live will be a direct result of what we do today.

We will continue to shine if we get it right. F&H

A community health system consists of a complex network of loosely connected organizations; primary are public health agencies, hospitals, long-term care facilities, and community-based social service agencies such as food banks and homeless shelters. Equally important for community health are schools, parks and recreation areas, public safety, and, of course, faith-based organizations.

A Forum for Faith & Health

The Centers for Disease Control and Prevention (CDC), a government agency with a public health mission, is sensitive to the constitutional principle of the separation of church and state. Yet in late 1997, the CDC sponsored an educational forum on "Engaging Faith Communities as Partners in Improving Community Health."

In his remarks, David Satcher, M.D., M.P.H., director of the CDC (now U.S. Surgeon General), noted that engaging faith organizations in the CDC's work was not new; he encouraged participants to explore ways to broaden and deepen those relationships.

The challenge government workers face is to serve as guardians of the constitutional principle separating church and state without violating the vision of faith that enhances the health of people of faith. To the extent that they succeed, state-sponsored faith/health partnerships will flourish."

"In partnership development, we aspire to have all public health agencies involved with faith organizations in their communities," Satcher told participants. "They represent the values of communities, and these values are at the heart of many of our most difficult social health concerns today, such as teen pregnancy, violence, HIV, and tobacco use. It is through diverse community collaboration and action—not confrontation—that we will find common ground for effective resolution and prevention of these social health concerns."

Three panels discussed faith and health issues.

One topic, "The Science-Base Supporting Faith and Health Partnerships," stressed that CDC-supported programs—and partnerships—must be based on the best science available for evaluating their effectiveness.

Another panel focused on "Practice Models in Faith and Health Partnerships." After a review of religious partnership history at CDC, some examples of CDC partnerships with the faith community were presented.

The other panel, far from sidestepping the issue of church-state relationships, addressed the issue in light of CDC's partnership mission. From this discussion of church and state issues, including theoretical and practical points of view, we draw our excerpts.

"The church has a vision of health that goes beyond the mere absence of disease, a vision that cannot be confined to a narrow view of physiological mechanisms or reduced to numbing statistics of rates, proportions, and risk factors. Because it is a vision of wholeness,

A VISION OF HOPE

and a vision of holiness, it is a vision of grace. And because it is of grace, it makes us whole and hopeful."

Dr. Robert McKeown
Epidemiologist, Co-Chair,
S.C. Faith and Health Work Group

A Tradition of Faith & Health Partnerships

Jerry Dell Gimarc
Senior Planner, South Carolina Department
of Health and Environmental Control

South Carolina has a long history of partnership between public health and faith communities. Teen pregnancy prevention was the first program sponsored jointly by the State Health Department and a faith group. Training lay health advocates in rural churches quickly followed. The State Health Department contracted with an interfaith group to manage a successful program in prenatal care and care of families, currently located in a church.

The state and faith communities jointly sponsored AIDS Care Teams, health promotion in congregations, and breast cancer awareness programs.

Though the constitutional issue of separation between church and state was never raised, a question about purchasing an advertisement in a religious publication prompted the Executive Management Team to develop guidelines to protect faith/health partnerships from violating the establishment clause.

These guidelines function as questions to check off when making decisions about forming partnerships with faith groups.

- Can this partnership be perceived as promoting a particular faith?
- Do we respond in the same manner to all requests? For example, if we do a health fair for a Baptist group on Saturday, are we willing to do a fair for a Jewish or Seventh Day Adventist group on Sunday?
- Can payments to a congregation for services, such as the use of a facility or the provision of food for a sponsored event, be justified by objective criteria, such as convenience of location or availability of space?
- Have we made a good-faith effort to notify all faith community groups about the availability of programs and services in their area?

Ruth Martin discusses DHEC's teenage pregnancy report with representatives of faith organizations.

These guidelines are general. Legal counsel may be needed for specific questions. For example, what if a congregation asks the state to print a manual for a health promotion program that has demonstrated its worth? The relevant legal question is whether the material in the manual was general enough for all faith communities to use. If not, printing the manual could be perceived as promoting a particular faith.

The South Carolina Department of Health believes it can best fulfill its mission to improve the health of citizens throughout the state through partnerships with faith communities, many of them strategically located in underserved rural areas. Those with responsibilities for these partnerships, most of whom are themselves people of faith, profoundly respect the vision of faith communities and know well that their vision fosters hope and health. As government workers, they face the challenge of serving as guardians of the constitutional principle separating church and state without violating the vision of faith that enhances the health of people of faith. To the extent that they succeed, state-sponsored faith/health partnerships will flourish. F&H

For the "Betterment of Public Health"

Daniel Riedford
Office of the General Counsel, The
Centers for Disease Control and Prevention

In the First Amendment to the Constitution known as the "Establishment Clause" the Founding Fathers stated:

Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof…

Those sixteen simple words have lead to thousands of court decisions about what is and is not proper for the government to do in regard to religion.

Fortunately, the Constitutional standard can be summarized in simply:

- Keep religion out of government
- Keep government out of religion.

Those two elements reflect the Founding Fathers' philosophy that church and state should be separated. However, they do not mean that religion and the government cannot have anything to do with each other. Or the government be an adversary of religion and religious groups. The government is only required to be neutral. The Supreme Court developed a three-part test for deciding if statures or other governmental action invalidly advance or inhibit religions if:

1. The action has a secular purpose;
2. Its primary effect neither advances nor inhibits religion; and
3. It does not foster excessive governmental entanglement with religion.

This test is an exercise in common sense. A statute or other government action does not violate the Establishment Clause merely because its purpose happens to coincide with the tenets of one or more religions. For example, murder, adultery, theft, and similar offenses are forbidden by the Judeo-Christian heritage, as signified by the Ten Commandments. That fact does not detract in any way from the valid government interest in public policy safety and order that is served by laws making those activities illegal. Similarly, state programs that provide books, bus service, and lunches for students attending both public and sectarian schools may incidentally benefit the sectarian schools by allowing them to focus more resources on religious activities. However, the programs do not run afoul of the Constitution's Establishment Clause because their primary effect—increasing the opportunities for all students to learn—is neutral.

Finally, while the ban on excessive entanglements essentially forbids government sponsorship or active involvement in religious activity, the Federal government may provide grants and loans for the construction of academic facilities at colleges and universities, including church-related institutions, so long as the facilities are not used for religious purposes.

A government program that seeks to involve or interact with a religious group or organizations is required to have a valid secular purpose, which translates for CDC into a valid public health purpose. That standard applies regardless of whether the project includes religious organizations as partners. When the primary effect of any program sponsored by CDC is the betterment of public health, then the religious affiliation of CDC's partners should be a moot point.

No program should foster excessive governmental entanglements with religion. The shorter the time frame and the more focussed the goal of the program, the less likely it is to run afoul of this rule. Diffuse or vaguely-defined goals invite the blurring of program and religious agendas. Similarly, complex long-term projects necessarily require a heightened level of government oversight and involvement in partners' activities, which could lead to excessive entanglements.

Faith & Health Consortium: A Collaboration of Campus and Community

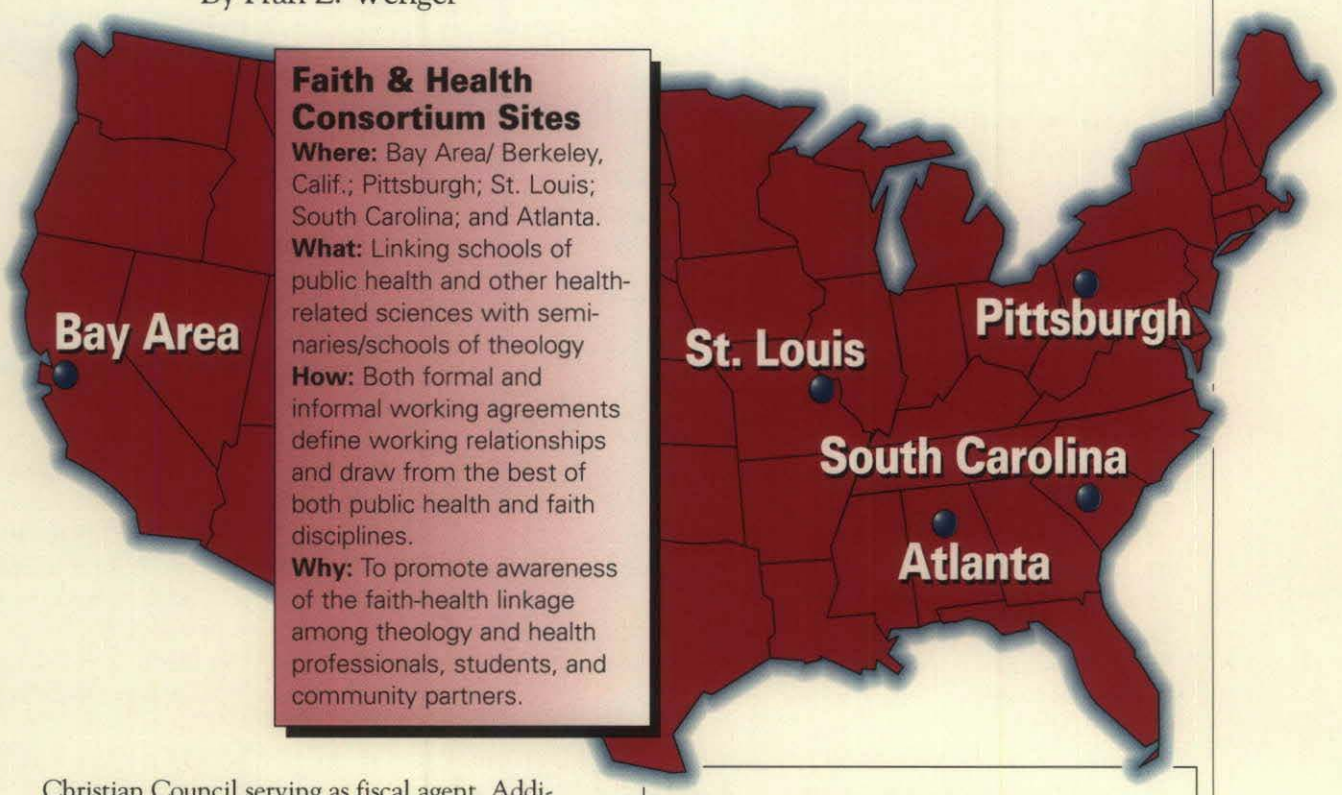
By Fran Z. Wenger

In the growing movement of faith and health, a new linkage is evolving among seminaries, health professions schools, and communities. There, in the academic environment where future religious and health leaders are trained, professors committed to both faith and health are shaping and sensitizing their students to these important dimensions in the development of human wellness.

With encouragement from The Carter Center's Interfaith Health Program and initial funding from the John Templeton Foundation, five Faith and Health Consortium sites have been created. Each promotes curriculum development that includes interdisciplinary educational ventures, continuing education for religious and health leaders, and research of best practices in faith and health programs where academic and community leaders collaborate toward the goal of perpetuating healthy communities.

Each consortium site is a community-campus partnership with a unique focus on the link between health and faith at both the theoretical and praxis levels. Collaboration on campus and in the community prepares current and future religious and health leaders to look for opportunities to work together for community health.

At each site, there is at minimum a relationship of a school of public health and a seminary or school of theology, with additional partners from schools of nursing, medicine, and/or social work, and community organizations, health initiatives, and congregations.



Faith & Health Consortium Sites

Where: Bay Area/ Berkeley, Calif.; Pittsburgh; St. Louis; South Carolina; and Atlanta.

What: Linking schools of public health and other health-related sciences with seminaries/schools of theology

How: Both formal and informal working agreements define working relationships and draw from the best of both public health and faith disciplines.

Why: To promote awareness of the faith-health linkage among theology and health professionals, students, and community partners.

Why and how did these sites develop? Consider South Carolina's Palmetto Faith and Health Consortium. State Department of Health professionals have a long history of working with faith groups to improve health. They welcomed the opportunity to join forces with the statewide Christian Action Council and faculty from the University of South Carolina and a local Lutheran seminary to establish a Faith and Health Consortium site.

Making a difference meant increased efforts were needed to develop future leaders and strengthen practicing professionals.

The South Carolina site of the Faith and Health Consortium (PFHC) now has a formal agreement between the University of South Carolina School of Public Health and Lutheran Theological Southern Seminary, with the South Carolina Christian Council serving as fiscal agent. Additional members include representatives of the University of South Carolina School of Nursing, Lutheran Homes of South Carolina, and the South Carolina Department of Health and Environmental Control.

The PFHC is implementing its first-year activities. These include:

- Sponsoring a conference for religious and health leaders on issues related to faith and health, disciplinary, and interdisciplinary curriculum development.
- Identifying practice settings where students, faculty, and practicing professionals can collaborate.
- Developing research methods and evaluation approaches to study faith-and-health linkages.

Making a difference is both a challenge and an opportunity for religious and health leaders in both academy and community to engage in leadership development for healthier communities.

"A recent study of black churches identified two strong indicators of church involvement in community outreach: the education level of the minister and the size of the church. The higher the level of education and the larger the church, the more likely the church would be to collaborate with the health department to address problems of community health such as violence prevention, AIDS prevention, and teen pregnancy. This confirms the importance of educating and training future health and religious leaders."

—Stephen Thomas, Ph.D.
Associate Professor, Emory University School of Public Health.

St. Louis Faith & Health Consortium

ST. LOUIS UNIVERSITY is unique among FHC schools: It is a faith-based Jesuit university that has its own School of Public Health, the only such school in Missouri. Located in the urban center of St. Louis, the university has distinguished itself as a health science institution, while at the same time acting upon its mission to serve the disenfranchised and marginalized through research and community service.

Sharon Homan, associate professor of biostatistics, leads the St. Louis Faith and Health Consortium. Honored as the 1996 Woman of the Year at St. Louis University, she was described as a person of "conscience, commitment, and accomplishment." Her leadership in forming St. Louis FHC is a natural progression of her research, teaching, and community service. As she personally and professionally wrestles with the injustices of society, she draws colleagues, students, and community residents into working relationships. She enthusiastically engages others in promoting the integration of faith and health.

Homan's recent article in *Health Education and Behavior* describes the partnership between a grassroots rural faith community, Whole Health Outreach, and the School of Public Health to prevent family violence and promote health. The faith dimension is at the core of the partnership, says Homan, and finds expression in a commitment to social justice supported by education, service, and research. "Faith has a central role in this collaborative effort of working with poor families in rural Missouri," Homan concludes. F&H

The Pittsburgh Area Consortium of Faith and Health

"My hope for the Seminary is that we will be a major player regionally, nationally, and internationally, pointing the churches and society toward the Kingdom of God. Such a dream can only happen as we work together in partnership, submitting ourselves daily to the unfolding of God's will."

—Carnegie Samuel Callian
President and Professor of Theology, Pittsburgh Theological Seminary

AT PITTSBURGH THEOLOGICAL SEMINARY (PTS), Callian's vision is finding concrete expression in the work of the Pittsburgh Area Consortium of Faith and Health (PACFAH), based on the PTS campus.

Under the guidance of Dr. Ronald Cole-Turner, professor of theology and ethics, PACFAH members use theology and the health sciences as the context for understanding the meaning of human health.

Partnering with PTS is the School of Public Health at the University of Pittsburgh. With strong leadership from Dean Donald Mattison and Assistant Dean Yvette Lamb, the school not only helped establish the consortium, it also has touted the values of this program in the larger public health community.

The consortium also has lively community participation. Doug Ronsheim, M. Div., director of the Pittsburgh Pastoral Institute, is a leader in Family and Youth 2000, a project that is strengthening families and youth in the East End of Pittsburgh. In addition, Ronsheim bridges the gap between community and academia by teaching a course, "Building Interdisciplinary Partnerships," in the School of Public Health. F&H

"The Faith and Health Consortium provides a creative forum to bring together a variety of individuals, institutions, and community organizations with differing points of view, bonded together by a common belief that the faith/health continuum enhances the well-being of individuals, families and communities."

— Rev. Doug Ronsheim

Faith & Health Resources

By Mimi Kiser, MPH, CHES
mkiser@emory.edu

WHAT ARE RESOURCES? Writing this column I asked myself, "What do people need to promote wholeness, to create whole communities?" The first definition of resource in the *Oxford English Dictionary* is "a means of supplying some want or deficiency; a stock or reserve upon which one can draw when necessary."

This raises another question when writing a resource column: *How do you know what people want or need? What well do they need to draw from?* And harder still, *what if the time they are reading the column is not "when necessary?"*

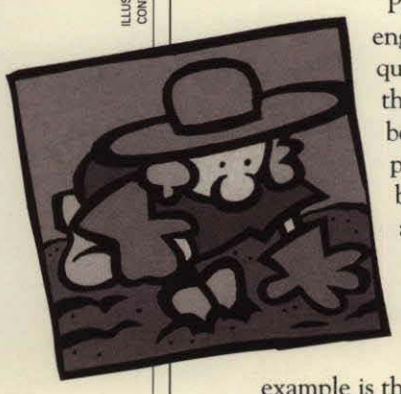
In our travels around the country, Interfaith Health staffers spend a great deal of time listening and learning from others. These encounters have enriched our understanding of what a resource is in the work of faith and health.

A resource we have discovered is a living thing, a being or a connection to a being, an experience. We meet people who are seeking others with whom they can share their vision. Hope—a key faith and health resource—is a shared experience. There are many who long to be inspired and inspire others, who need a place to share and hear others' stories. Most of us desire to know how to learn from others in a way that affirms our own hope.

I urge you to seek the living connections from this smorgasbord of resources, the people behind the program and the local groups and members of national networks in your community. Create opportunities to share the lessons learned and the inspiration that motivates us for ministry.

Journals

ADVANCES is a journal of mind-body health published by the Fetzer Institute. It is the most sophisticated periodical available for informed discussion of the latest research and most contentious issues in mind-body studies.



Particularly engaging in its quarterly issues is the practice of beginning with a provocative essay by a well-known authority and inviting responses to the essay by experts in the field. An example is the Fall Issue, 1993 (Vol. 9, No. 4) lead article, "Is There Evidence for Spiritual Healing?" Ten experts offered commentary, including Harold Koenig and David Larson, leading researchers in this area. Though most issues focus rather narrowly on the relationship of body and mind, relational and social factors are not ignored. The September 1994 (Vol. 10, No. 3) issue contained an oft-quoted essay by Aaron Antonovsky, "A Sociological Critique of the 'Well-Being' Movement," with comments by Larry Dossey and Theodore Pincus, among others. Each issue also contains abstracts of recently published field studies and book reviews.

■ Available from The Subscription Department AVN, P.O. Box 3000, Denville, NJ 07834.

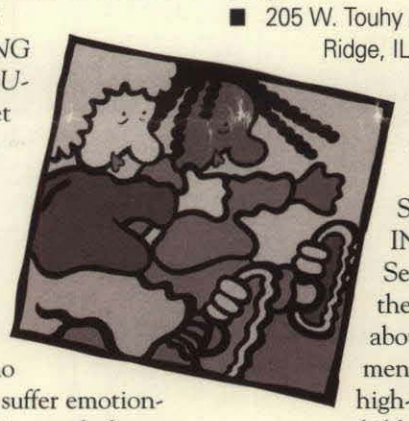
Books

HEALING AND TRANSFORMATION: INTO THE IMAGE & LIKENESS OF GOD by Kenneth Bakken and Kathleen Hofeller.

Dr. Bakken, a physician and Lutheran pastor, is a well-known author and lecturer on the church's health and healing ministry. Formerly on the faculty of Johns Hopkins School of Medicine, he has established holistic clinics on both the East and West Coast.

■ Available in October 1998 from Seraphim Communications, (800) 733-3413.

CULTIVATING WHOLENESS: A GUIDE TO CARE AND COUNSELING IN FAITH COMMUNITIES by Margaret Kornfeld.



This practical, comprehensive, contemporary guide to community care and counseling aims to prepare those who would help all who suffer emotionally with an emphasis on wholeness, on the dynamics of change, on an inclusive understanding of spirituality, on community, as not only the context for healing but also the means by which healing happens, and on the caregiver/counselor, who these days is as likely to be a lay person as a member of the clergy.

■ The Continuum Publishing Company, 370 Lexington Ave., New York, NY 10017

Organizations

CHILDREN'S DEFENSE FUND provides a strong, effective voice for the children of America who cannot vote, lobby, or speak for themselves. They offer special resource materials for "Faithful Advocates" to implement Children's Sabbath celebrations every October.

■ 25 E St. N.W., Washington, DC 20001, (202) 628-8787, <www.childrensdefense.org>.

APHA CAUCUS ON PUBLIC HEALTH AND FAITH COMMUNITIES
The APHA annual meeting is Nov. 15-19, 1998, in Washington, D.C.

■ Chair is Yvonne Lewis, F.A.C.E.D. 2712 N. Saginaw, Suite 115, Flint, MI 48504 (810) 232-7733, E-mail: <yvonlewis@ hotmail.com>.

HEALTH MINISTRIES ASSOCIATION
A global interfaith membership organization, HMA is committed to encouraging, supporting, and developing whole-person ministries in faith groups and the communities they serve.

■ 1930 Cedar St., Ramona, CA 92065, (800) 280-9919 or (937) 227-9454

COALITION FOR HEALTHIER CITIES AND COMMUNITIES
A partnership of entities from the public, private, and nonprofit sectors collaborates to focus attention and resources on improving the health and quality of life of communities through community-based development.

■ (312) 422-2635, <www.healthy-communities.org>.

INTERNATIONAL PARISH NURSE RESOURCE CENTER
A reference center for information, education, and consultations related to the development of parish nurse programs.

■ 205 W. Touhy Ave., Suite 104, Park Ridge, IL 60016, (800) 556-5368, <www. advocatehealth.com/sites/pnursctr.html>.

SEARCH INSTITUTE
Search contributes to the knowledge base about youth development by translating high-quality research on children and youth into practical ideas, tools, services, and resources for families, neighborhoods, schools, organizations, and communities. Their materials are useful in faith communities.

■ 700 South Third St., Suite 210, Minneapolis, MN 55415-1138, (800) 888-7828, <www.search-institute.org>.

Manuals

CHILD ABUSE: EVERYBODY'S BUSINESS, A RESOURCE BOOK FOR FAITH COMMUNITIES
A resource for those who need to know where to turn if child abuse is suspected, this manual points out what the faith community can do to prevent child abuse. It was designed for the Dallas community but is a great model for what can be done in other communities.

■ Cost: $10 from Martha Stowe at the Greater Dallas Injury Prevention Center, 6300 Harry Hines Blvd., Suite 300, Dallas, TX 75235, (214) 590-4461.

CONGREGATIONAL HEALTH MINISTRIES RESOURCES
The United Methodists list on their Web site a host of reasonably priced resources developed for congregations to use for developing a health ministry. One recently updated manual is *Health for All Program Manual.*

■ <http://gbgmumc.org/programs/congmin> or by phone (800) 305-9857. Many denominations have health ministry resource materials. Contact the national office of your denomination.

VOLUNTEER MARKETPLACE RESOURCES, 1998 CATALOG
With more than 150 information-packed books, tool kits, workbooks, training manuals, and videos. It contains a special section on Mobilizing Ministries—an important approach to utilizing the assets of older adults in congregations, the way of our future!

■ Points of Light Institute, (800) 272-8306.

PRINCIPLES OF COMMUNITY ENGAGEMENT
A document of practical guidelines for public health professionals and community leaders for engaging the public in community decision-making and action for health promotion, health protection, and disease prevention.

■ Printable from this Web site address: <www.cdc.gov/phppo/pce/>.

READY. SET. IT'S EVERYWHERE YOU GO!: A GUIDE FOR DEVELOPING PHYSICAL ACTIVITY PROGRAMS AND EVENTS.

■ Free. Order by mail or fax: Centers for Disease Control and Prevention, NuPAC – Mail Stop K-46, 4770 Buford Highway, Atlanta, GA 30341, FAX (770) 488-5473.

Videos

THE HEALING TEAM: AN INTRODUCTION TO HEALTH MINISTRY AND PARISH NURSING
This 22-minute video depicts the various aspects of health ministry in congregations and community. It is a useful educational tool for faith communities and educational and health care institutions/agencies.

■ Video and shipping: $18. Bay Area Health Ministries, 70 West Clay Park, San Francisco, CA 94121, FAX (415) 221-8835.

THE JOURNEY TOWARD WHOLENESS
A six-part video series with leader's guide for parish nurses and other ministers of health and healing. (This resource is an adjunct to *Healing and Transformation*, *see Books*).

■ Available in October 1998, from Seraphim Communications, (800) 733-3413.

ILLUSTRATIONS FOR THIS SECTION ARE COURTESY OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION'S CAMPAIGN TO ENCOURAGE PHYSICAL ACTIVITIES.

F&H Bulletin Board

Choices in Healing: Integrating the Best of Conventional and Complementary Approaches to Cancer. By Michael Learner. Cambridge, Mass: the MIT Press, 1997

Review by Tom Droege
Editor, Faith&Health

Michael Lerner is president and founder of Commonweal, a health and environmental research institute in Bolinas, California. He co-founded the Commonweal Cancer Help Program, which was featured in Bill Moyer's prize-winning PBS series Healing and the Mind. Lerner served as special consultant to the U.S. Congress Office of Technology Assessment for its "Unconventional Cancer Treatments" study.

One-third of Americans use nontraditional medical alternatives. Alternative medical therapies now constitute a multibillion-dollar industry in the United States alone. Yet few people are sufficiently knowledgeable and dispassionate enough to guide patients in making decisions that are literally a matter of life and death for them.

Lerner is qualified to do that as he guides us through the morass of alternatives. Isolated success stories are not equivalent to scientific scrutiny in assessing the value of any therapy, conventional or unconventional. At the same time, psychological, social, nutritional, environmental, and spiritual factors should not be dismissed because there is insufficient scientific evidence to demonstrate their effectiveness.

Lerner makes a useful distinction between alternative and complementary cancer therapies. An alternative therapy is a substitute for medical treatment while complementary therapies are used in addition to conventional cancer care. Throughout the book, Lerner argues for integrating complementary approaches to conventional treatment. Though he freely offers his own opinions, his assessments are consistently balanced and fair.

This book will be valuable to health professionals in the field of cancer, but its chief value is for cancer patients, who must make the difficult treatment choices. The most successful cancer patients, both in quality of life and longevity, are those who become knowledgeable about their disease and assume the final responsibility for choices in their treatment. *Choices in Healing* is by far the best and most comprehensive introduction to the many alternatives that are available.

One of the goals of FAITH & HEALTH has been to encourage readers to become more responsible for their own health. Despite our best efforts, people will continue to be burdened with disease. Michael Lerner reminds us that we do not become less responsible for our health at that point. We remain the principal agents in charting the course of our healing, using both conventional and complementary methods of treatment. This book makes the journey much richer for those seeking information and alternatives as they grow toward wholeness.

Deeply Woven Roots: Improving the Quality of Life in Your Community. By Gary Gunderson, Minneapolis, MN: Fortress Press, 1997

Review by Susan Thistlethwaite
President, Chicago Theological Seminary

Scripture calls us to be "restorers of broken walls, rebuilders of houses in ruins." But scripture does not tell us how to mix cement or how to mortar a wall. Gary Gunderson does.

As social structures crumble around us, who can help rebuild them? The congregation can—the congregation that exhibits the eight strengths Gunderson describes.

It seems that everyone today—government, social service agencies, not-for-profits, health care providers—are all discovering religious communities. They want to "borrow the power to persuade" (p. 95) without understanding where that power comes from. The power comes from the "deeply woven roots" in community that religious congregations nurture. But usually "the humble-scale congregational life is far beneath the view of most global visionaries." (p.11)

Health is broadly defined in this book. Access or denial of access to education, housing, safety, employment and food are the fundamental indicators of an individual's prospects for well-being; Gunderson understands that they are also the fundamental indicators of society's prospects for well-being.

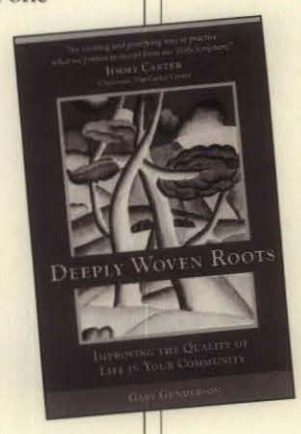
What he calls health is what the Hebrew Bible calls *Shalom*. God intends that the world be whole, well and one. The forces that break, divide, and impede Shalom are sin.

What religious communities can contribute is that in their being as congregations they have strengths that are not easily duplicated by any other force in society.

These strengths are: to accompany, to convene, to connect, to tell stories, to give sanctuary, to bless, to pray, and to endure. What they have in common is relationality. Congregations have the capacity to bind up the society and deeply connect people one to another. They extend "the capacity to participate in human community" (p.7).

Gunderson is not idealistic about religious communities. He observes that many congregations "are nearly toxic." "Families with members who are wounded, disabled, unusual in any way can tell chilling stories of how congregations deepened wounds rather than healing them" (p.18). In fact, in any community, about "10 percent of the congregation does almost all the significant community work."

One of the delightful aspects of this book is the calm integration of low-tech, "the committee meeting, the most despised tool for change we have" (p. 61), and the high-tech, the use of the Internet. I visited the Web site established by the Interfaith Health Program. It includes syllabi from schools of public health, medicine, nursing, social services, and theology, and a description of and invitation to the Faith and Health Consortium, a group of institutional partners envisioned by the Interfaith Health Program; discussion groups; and organizational link options. Throughout the book, E-mail, the Internet, chat rooms, and computers are recommended side-by-side with talking over coffee, keeping a Rolodex up to date, and singing. "Sol Alinsky warned that one should never go up against a group that sings together" (p.38).



Gathering and singing, convening, connecting, praying, blessing, enduring—these matter in a world where the root cause of violence is "rooted in tribalism—the reflex to fear those who are different, to define as 'us' a smaller and smaller circle of people" (p.43). That means, of course, that many congregations deformed by racism, sexism, homophobia, or classism need to be reformed across the boundaries of difference. Otherwise, the very power of the congregation to convene, to sing, to bless, to pray, to endure becomes the strength of the hate group, where these very powerful activities are used in the service of making the boundaries of 'us' and 'them' even more visible and rigid. The Klu Klux Klan has a Web site, too, and a very sophisticated one.

I wish the need to reform 'toxic' communities and some concrete recommendations on how to do that had been a more central aspect of this fine book. Good suggestions are scattered throughout; I thought they deserved a special section.

There are not many books I read that have the capacity to bring such moral clarity to a subject, as well as the kind of hope that starts deep in the problems and wells up to the heart and then to the head because you just found that in someplace, somebody is already doing what needs to be done. All we really need to do is learn about it and do it some more. Honestly. F&H

MORE HEALTH NOTES

OPPORTUNITIES ... About one-third of the children who qualify for government-assisted health care are not registered. Experts believe either parents are unaware of their eligible benefits or are afraid of enrolling in government programs. —*NPR News*

WHEW! People in the United States are breathing cleaner air today than they did 10 years ago. Among the improvements since 1985: Smog levels dropped 12 percent; lead levels decreased 86 percent; carbon monoxide levels declined 28 percent. Maybe the 1990 Clean Air Act is working after all? —*Shape Magazine*

PASS THE WHAT?... WHAT ABOUT STEAK? The world's most perfect food? A Mexican might think of rice, pinto beans, and jalapeno peppers. An Italian might envision a plate of white cannellini beans and rice laced with tomatoes. In Bombay, an Indian might choose curried chickpeas and rice.

They're all right about two ingredients: beans and rice. Rice is a complex carbohydrate that boasts all eight essential amino acids, the building blocks for strong muscles. Beans are an excellent source of protein and iron and contain B vitamins, folic acid, and zinc. Together they form the world's most perfect food: very low in fat, full of fiber, and given their nutritional punch, relatively low in calories. —*SELF Magazine*

AND WITH THOSE BEANS AND RICE ... Regular wine drinking cuts your risk of heart trouble by up to 50 percent, and moderate drinking can be more healthful than not drinking at all. Alcohol keeps the arteries clear by reducing the stickiness of blood platelets—tiny blood cells that can cling to fatty deposits in the arteries and promote clogging. And alcohol increases HDL, the "good" cholesterol.

Whether it's better to drink wine or beer or liquor hasn't been conclusively determined. But excessive drinking *is* known to be very detrimental to health. —*Newsweek*

DO UNTO OTHERS ... Studies show that helping others helps those with illnesses. From 3,296 responses of people surveyed in volunteer organizations nationwide, specific health benefits were reported from helping others. Among them: relief from chronic headaches, back pain, and stomach aches. They also experienced fewer or less-severe colds and relief from symptoms of chronic diseases such as asthma and arthritis. Many also reported that eating and sleeping habits improved. —*Fitness Magazine*

Faith & Health

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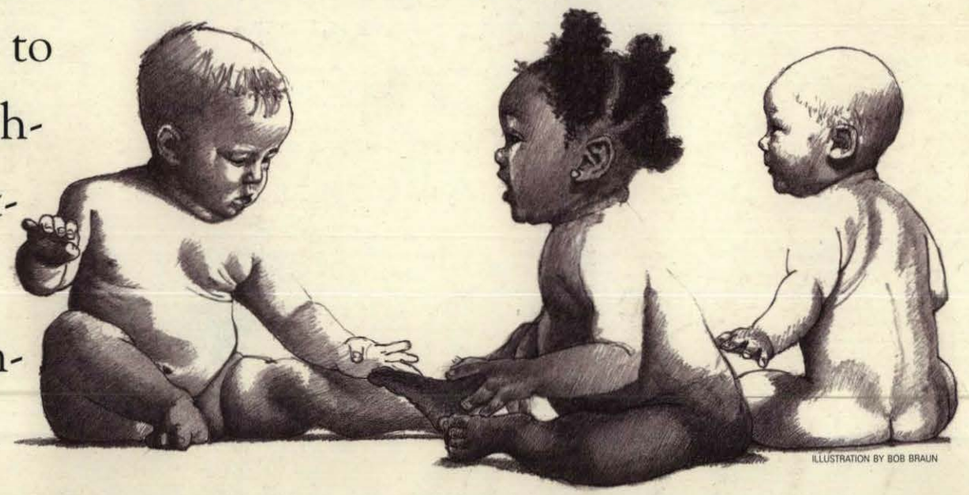
Faith & Health

A Publication of The Carter Center FALL 1998

It is happening everywhere. Health promoters, parish nurses, volunteer caregivers on hundreds of interfaith teams, bookstores selling spirituality and healing guides, Harvard Medical School packing "Spirituality and Healing" workshops. Public health agencies forming coalitions with religious networks to tackle teen pregnancy, substance abuse, tobacco-caused illnesses, depression and loneliness, violence. Youth ministers, religious hospitals, clergy, counselors, women's groups using health strategies to guide faith-based outreach to their communities.



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