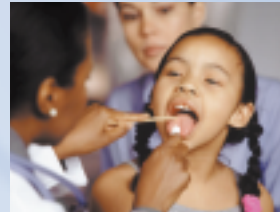
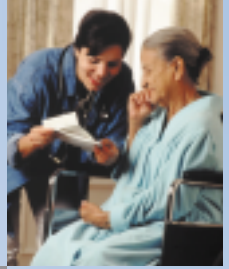


Sharing a Legacy of Caring

Partnerships between Health Care and Faith-Based Organizations



DEVELOPED BY:

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Georgetown University Child Development Center
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IN COLLABORATION WITH:

U.S. Department of Health and Human Services
 **HRSABPHC** Bureau of
Health Resources and Services Administration Primary Health Care

WINTER 2001



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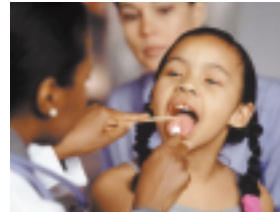
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ON THE HORIZON OF THE 21ST CENTURY, healthcare professionals are being called upon to revisit the concept of “community” to effect change across America’s landscape. There are many compelling health crises and social ills that beg us to do no less than join together to build the bridges necessary to better address the needs of the vulnerable and underserved.

Cooperative partnerships between health care and faith-based organizations are a revolutionary concept. Faith-based organizations are trusted entities within many communities. They provide spiritual refuge and renewal and have served as powerful vehicles for social, economic and political change. In the same vein, health care organizations that are community-based deliver high-quality, patient-sensitive medical care along with a host of other enabling services to diverse, needy populations. While these institutions share many commonalities, collaborations between the two have evolved slowly. The Faith Monograph developed by the National Center for Cultural Competence for the Health Resources and Services Administration’s (HRSA) Bureau of Primary Health Care (BPHC) and its Faith Partnership Initiative addresses the various issues that surround partnership and collaboration between these two cultures.

There are approximately 43 million individuals in this country who are without health insurance and many more that are without access to comprehensive, continuous, and culturally competent primary health care. There are persistent disparities in health outcomes between our poor and non-poor, our minorities and non-minorities. The BPHC is committed to 100% access to quality health care and 0 disparities for this nation. This is a bodacious goal and sustainable partnerships are necessary. Traditionally, our nation’s public health safety net providers have shouldered the responsibility of caring for these individuals and helping to meet their health and medical needs. They have demonstrated remarkable ingenuity in eliminating many of the cultural, linguistic and geographic barriers to access that routinely prevent the underserved from seeking care or understanding how to navigate the intricacies of the health system. Safety net providers are dynamic in that they have embraced an inclusive definition of health that recognizes it as a state of complete physical, mental, and social wellbeing, and not merely the absence of disease. These providers recognize that their success is dependent on their ability to ensure that all health, psychosocial, cultural, and educational needs are met in the context the community. They are forging new partnerships with non-traditional stakeholders and sharing resources in order to achieve community health goals. We, at the BPHC, applaud their tireless efforts.

Increasingly, we are seeing spiritual mores incorporated into the holistic model of disease prevention and health and wellness promotion. We know that faith-based organizations are vital to the communities in which they are located and that now more than ever, they should be engaged as partners in the movement for *100% Access and 0 Health Disparities*. Historically, these institutions have served alongside the safety net as providers of health and social services for many, particularly the disadvantaged and indigent.

This legacy of caring, shared between safety net providers and faith-based organizations, is the premise of this Monograph. It is offered as a guide to developing successful, substantive and mutually beneficial partnerships that will lead to improved health outcomes for individuals and communities. The challenges to effective collaboration are at times daunting, but there is much work to be done and we cannot do it alone.

Henry Ford once said, “Coming together is a beginning, staying together is a process, and working together is success.” The health of an individual, and the subsequent community, is impacted by many non-biological variables—environmental, social, mental and spiritual. Partnerships between health care and faith-based organizations are important because by working together we can better address the broad spectrum of human need. These alliances will require us to be respectful of our diverse experiences and cognizant of new skills and roles, necessary for teaching and learning community building. There are many invaluable lessons to be learned at all stages of partnership development. These opportunities should be encouraged and embraced for their immeasurable potential. This publication is an insightful exploration of the dynamics of such organizational relationships.

I extend my sincerest thanks to the National Center for Cultural Competence, and to the panel of experts that comprised the Faith Monograph Workgroup. The work they have done is tremendous!

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Definition of Terms

It is difficult to find universally accepted and recognized definitions for some of the terms used in this monograph. The following terms are thus defined for the purposes of this document:

- **cultural competence**—there is no one definition of cultural competence. Definitions of cultural competence have evolved from diverse perspectives, interests, needs and are incorporated in state legislation, federal statutes and programs, private sector organizations and academic settings. The NCCC embraces a definition of cultural competence (Cross, T., et.al., 1989) that subscribes to the following beliefs:
 - there is a defined set of values, principles, structures, attitudes and practices inherent in a culturally competent system of care;
 - cultural competence at both the organizational and individual levels is an ongoing developmental process; and
 - cultural competence must be systematically incorporated at every level of an organization, including policy making, administrative, practice/service deliver and consumer/family levels.
- **faith-based organization**—any group/organization created by or for a religious or spiritual group including, but not limited to, individual places of worship, groups of community or tribal elders/spiritual leaders, intra- or interdenominational community coalitions, faith connected health and human service agencies, denominational hierarchies/governance bodies, religious orders and schools of divinity.
- **health**—complete state of physical, mental, spiritual and social wellbeing and not merely an absence of disease (World Health Organization).
- **health care organizations**—any entity with the main purpose of addressing delivery of health and medical services including, but not limited to individual health care practitioners, group practices, community-based health centers, home health agencies, free clinics, state and local public health programs, private clinics, hospitals, vertically integrated health care systems, managed care organizations, professional associations and university medical, dental, nursing and other health professional schools.
- **linguistic competence**—the capacity of an organization and its personnel to effectively communicate with persons of limited English proficiency, those who are illiterate or have low literacy skills, and individuals with disabilities. This capacity may include, but is not limited to, bilingual/bicultural staff, telecommunications systems, sign or foreign language interpretations services, alternative formats for materials, and translation of legally binding documents, signage and health education materials (Goode, et.al., 2000).
- **religion**—a set of beliefs and practices related to the issue of what exists beyond the visible world, generally including the idea of the existence of a being, group of beings, an external principle or a transcendent spiritual entity (Adapted from Random House Dictionary of the English Language, 1967).
- **safety net**—the safety net, as defined by the Bureau of Primary Health Care, is a national network of providers of primary health care to underserved and vulnerable populations, including non-traditional partners. Activities that support the maintenance of the safety net include enhancing quality, improving cultural and linguistic competence and providing enabling services.
- **spirituality**—the experience or expression of the sacred (Adapted from Random House Dictionary of the English Language, 1967).



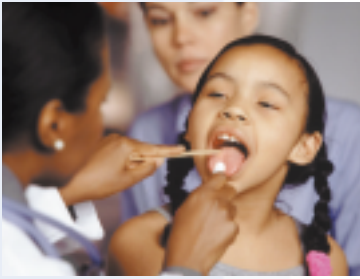
I. Purpose of the Monograph

THIS MONOGRAPH IS INTENDED TO HELP HEALTH CARE POLICY makers, administrators, governing and advisory boards and providers explore the potential for developing partnerships with faith-based organizations. It is also intended for leaders in faith-based organizations who seek to develop partnerships around health issues to help them understand the interests, potential concerns and successful models from the health care organization's perspective.

The monograph showcases the types of partnerships that can support community and individual health by strengthening the community safety net. It clarifies concerns and misconceptions about the appropriateness of collaborations between health care organizations that receive government funding and faith-based organizations. Finally, the monograph introduces the challenges and benefits that arise when two organizations, each with its own distinct purpose and culture, forge new relationships for a common goal.

Although a growing body of literature supports the benefits of a holistic approach to health and the inclusion of spirituality in patient care, this topic is not within the scope of this monograph. The resource section of the monograph provides information for those interested in pursuing this topic. The monograph is not meant to be a step-by-step blueprint for developing partnerships between health care organizations and faith-based organizations. This topic will be addressed by other publications of the Faith Partnership Initiative.





II. A National Initiative to Eliminate Racial and Ethnic Disparities in Health

DESPITE RECENT PROGRESS IN OVERALL HEALTH STATUS OF THE nation, all segments of the U.S. population have not equally benefited. A long-standing and well-documented pattern of disparity continues to plague racially and ethnically diverse populations in this nation as it relates to the incidence of illness, disease and death. This pattern of disparity is evident in both health care outcomes and utilization (Goode and Harrison, 2000). The Initiative to Eliminate Racial and Ethnic Disparities in Health was launched in 1998 under the auspices of the Department of Health and Human Services (DHHS) to address this critical problem. It targets six areas of health disparity including cancer screening and management, cardiovascular disease, diabetes, infant mortality, HIV/AIDS and child and adult immunizations.

The initiative to eliminate health disparities has been significantly strengthened by the establishment of public health policy and dedication of resources. Healthy People 2010, the new set of goals and objectives, was designed by the DHHS to help the nation achieve the vision of Healthy People in Healthy Communities. The elimination of health disparities is one of two overarching goals. The Health Resources and Services Administration (HRSA) took leadership in responding to these goals with an initiative, referred to as *100% Access and 0 Health Disparities*, to challenge the nation's public health systems to create new approaches, including non-traditional partnerships to eliminate health disparities.

As articulated in Healthy People 2010:

“Over the years, it has become clear that individual health is closely linked to community health...Likewise, community health is profoundly affected by the collective behaviors, attitudes and beliefs of everyone who lives in the community...Partnerships, particularly when they reach out to non-traditional partners, can be among the most effective tools for improving health in communities”

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, 2000

The elimination of health disparities among this nation's racial and ethnic groups is an exigent goal that the health care community cannot accomplish in isolation. Since many of the determinants of wellbeing span the boundaries of health care and medicine, eliminating health disparities call for new and non-traditional partnerships across diverse sectors of the community (Goode and Harrison, 2000). The formation of community-based partnerships is a viable strategy to address the inherent challenges and opportunities to achieve the goal of *100% Access and 0 Health Disparities*.

III. Leadership and Innovation: Making 100% Access and 0 Health Disparities a Reality

THE BUREAU OF PRIMARY HEALTH CARE (BPHC), WITHIN THE Health Resources and Services Administration of DHHS, plays a significant role in the initiative to eliminate health disparities. Consistent with its mission, the BPHC is a national leader in delivering care to underserved groups including Medicaid beneficiaries, uninsured and vulnerable populations such as migrant and seasonal farmworkers, individuals who are homeless and those living in public housing. The BPHC funds a comprehensive network comprised of more than 3,000 non-profit health centers and 4,000 clinicians that provide care to more than 12 million people throughout the U.S. and its territories. Despite the scope of this health care safety net, it only reaches approximately 20% of those without access. Given that an estimated 43 million people in the United States do not have access to regular health care, it is not possible for the BPHC to meet the enormity of need for every individual and every community with federal resources alone.

Therefore, in February 1999, the BPHC launched the Faith Partnership Initiative, an innovative effort to increase the capacity of underserved communities to develop new partnerships to expand the safety net of care. The BPHC's Center for Communities In Action is spearheading this program, which builds upon strategies identified in the Healthy People 2010 goals for the elimination of racial and ethnic disparities in health. **Figure 1** (see page 4) depicts a rich array of potential partners that have a vested interest in improving community health, including the faith community.

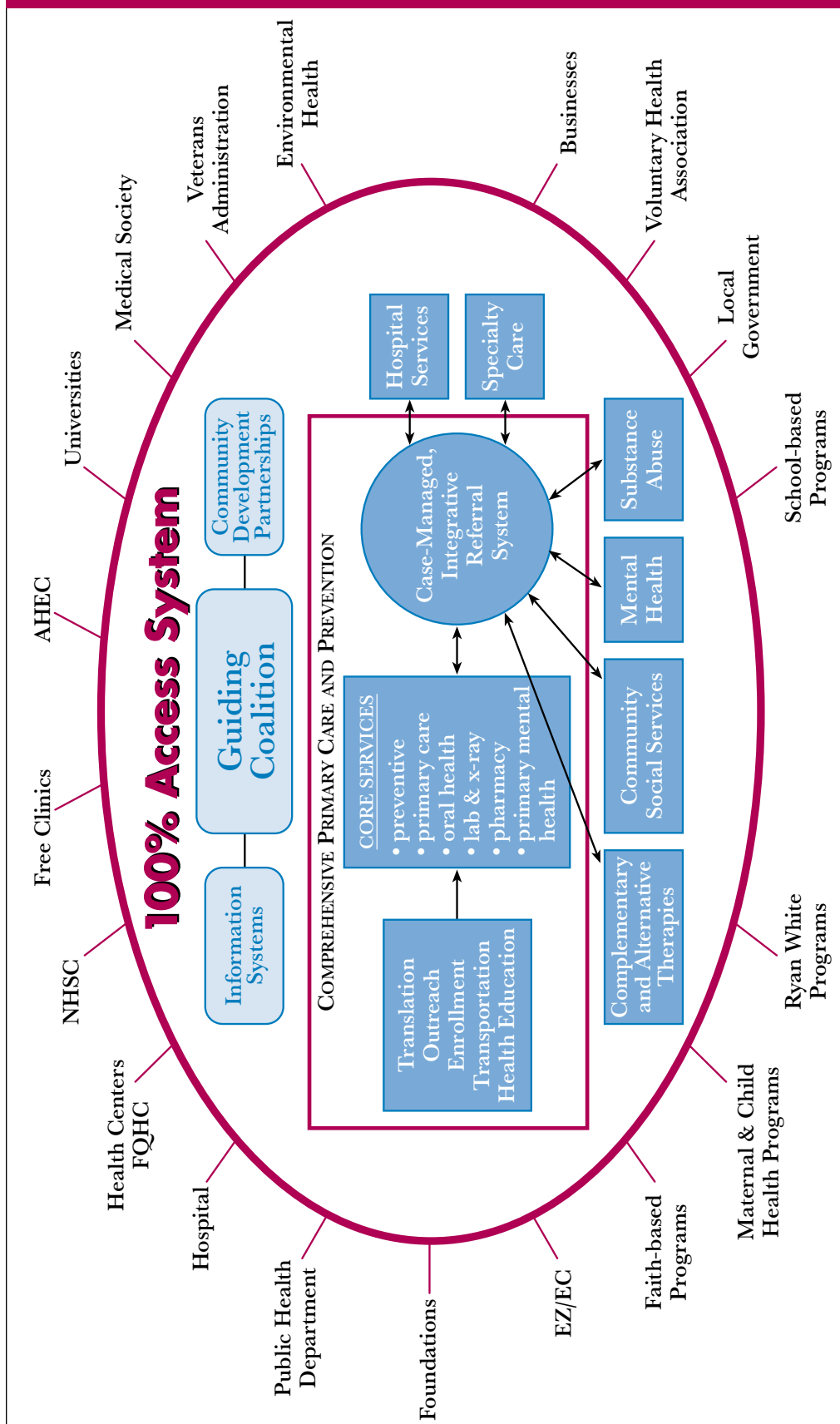
“Our vision is that every person, in every underserved community will have access to primary and preventive care and through improving the delivery of care and patient self-management of disease, there will be no disparities in health status due to race, ethnicity and income.”

MARILYN GASTON, M.D.
Assistant Surgeon General
Public Health Service
Associate Administrator, Bureau
of Primary Health Care
HRSA/DHHS

SOURCE: BULURAN, 1999.



FIGURE 1 INTEGRATED PRIMARY CARE COMMUNITY-BASED HEALTH SYSTEM





IV. A Shared Legacy of Caring

THE FAITH PARTNERSHIP INITIATIVE IS DESIGNED TO PROMOTE collaboration between health care and faith-based organizations to encourage alignment of health, fiscal and other assets. Faith-based organizations are a natural choice: they have a legacy of providing safety net services in many communities, but have not traditionally been viewed or enlisted as partners to improve community health, and they represent an enormous resource with thousands of health and educational organizations and more than 365,000 congregations that span the nation.

The Faith Partnership Initiative seeks to enlist these organizations to support the *100% Access and 0 Health Disparities* campaign by creating a partnership for health that strengthens the safety net in every community. The Faith Partnership Initiative's goals are to:

- resonate the role of faith institutions as major new partners in the care-giving process;
- stimulate and build partnership networks with faith-based organizations that desire to have an impact upon and that are dedicated to improving health and social well-being;
- provide access to tools and techniques that foster collaboration between faith-based organizations and BPHC-supported health centers; and
- create opportunities for faith-based institutions to engage in productive dialog with public and private sector stakeholders.

The Faith Partnership Initiative supports the development of key community partnerships needed to strengthen the safety net and extend it to the large number of people without access to health care.





V. Why Reach Out to the Faith Community?

IT IS QUITE NATURAL THAT THE BPHC WOULD IDENTIFY THE FAITH community as potential partners in addressing the issues of access and health disparities. BPHC funded health centers and faith-based organizations share a *common legacy of caring* for some of the most underserved and vulnerable members of society. They also share a common legacy of working to improve their own communities. Driven by a mission to serve all, regardless of ability to pay, health centers have filled the gap in health services to poor and medically underserved individuals. They serve as the entry point to the health care system for millions of Medicaid beneficiaries, the uninsured and people throughout the U.S. and its territories.

Historically, faith-based organizations have also served as an important gateway to services and care-giving for those living in poverty and in social exclusion. They have taken strong leadership roles in communities and provided job training, housing, economic development, educational support, meals and spiritual support to those in need. Just as health centers have addressed the gaps in health care, faith-based organizations have filled the gaps in the delivery of supportive services commensurate with the World Health Organization's broad definition of health including physical, mental, spiritual and social wellbeing. Faith-based organizations can bring needed resources, expertise and a shared legacy of caring for these most vulnerable members of society to assist in achieving the goal of *100% Access and 0 Health Disparities* for the nation.

BPHC's vision, as articulated by Dr. Marilyn Gaston (Buluran, 1999) delineates three specific approaches to achieve *100% Access and 0 Health Disparities*. These three approaches are to:

- A. increase access to primary and preventive care;
- B. improve delivery and quality of care; and
- C. improve patient self-management of disease.

Partnerships with faith-based organizations provide health care organizations with a new set of opportunities and supports for addressing each of these approaches. This monograph provides examples of how successful partnerships between health care organizations and faith-based organizations can address one or more of the approaches that are needed to achieve *100% Access and 0 Health Disparities*.

A. Increasing Access to Primary and Preventive Care

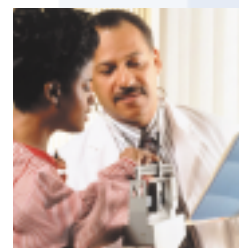
Access to health care is a complicated issue with many contributing factors. While the financing of services often receives the focus in discussions of access to care, it is only one of many issues that must be addressed to increase access to primary and preventive health care. The following aspects of access must also be addressed:

- **availability of the services**—access is limited when providers and services do not exist within a community.
- **geographic location**—access is limited if services are located too far from patients or in places that are not easily reached by available means of transportation.
- **times and logistics of services**—access is limited when services are only offered during the normal business day or at other times when patients have work, family or other commitments.
- **cultural competence**—access is limited when services are provided in settings that are not welcoming and acceptable in terms of culture, race and/or ethnicity.
- **linguistic competence**—access is limited if patients cannot communicate in the language in which they are proficient.

Partnering with faith-based organizations can help health care organizations and their communities expand access through addressing any or all of these five aspects of access.

Availability of Services

Many underserved areas do not have enough providers and resources to ensure 100% access to health care. Faith-based organizations can help expand the base of services in a given community in a number of ways. First, they frequently have well-established volunteer networks that bring both person power and infrastructure to the task of improving individual and community health. These volunteers may include retired health care and social service providers who can expand the pool of providers with little additional cost. These volunteer networks also often serve as extended social support to members of the community. Partnering with support networks can help extend limited health resources by increasing capacity to provide time-consuming and resource intense services needed to successfully manage chronic health conditions. For example, such partnerships can support ongoing and aftercare services for patients with substance abuse and behavioral health problems and medication, diet and weight management for patients with diabetes.



Partnerships with faith-based organizations have particular application in rural areas, where access problems are often related to lack of providers and services. While 25% of the population of the United States lives in rural areas (places with fewer than 2,500 residents), only 9% of the nation's doctors practice in these areas. Yet the needs are tremendous. Injury-related death rates are 40% higher among

rural populations; heart disease, cancer and diabetes rates exceed those for urban areas; and timely access to emergency care and availability of specialty care are problematic (U.S. Department of Health and Human Services, 2000). Faith-based organizations have been able to augment the capacity of health care systems through programs such as parish nursing and the provision of other home health care and support services such as transportation or meals that allow people to manage their health needs at home.

More Hands to Help

Health care organizations in Montana have a challenge in providing services to a population that is spread out geographically. In this frontier state, 80% of communities have less than 3,000 inhabitants and nine counties have no physician. Love, In the Name of Christ (Love, INC) in Bozeman, MT, consists of 18 churches and as many denominations with a combined volunteer force of 900 individuals. Its mission is to meet the needs of the people of Bozeman. These volunteers help address health and related needs in ways that are very difficult for local providers and health clinics. They provide transportation to health care and home health care for those returning from the hospital to these very remote areas, a volunteer effort that enhances access by increasing service availability.

Geographic Location

Faith-based organizations may be located within the neighborhoods in need of more geographically accessible services. They may offer use of physical facilities at no or low cost to health care organizations for expansion of services including health promotion and screening. While many health care organizations cannot afford to expand to multiple sites on their own, partnerships with community faith-based organizations may offer opportunities to bring services closer to patients and the neighborhoods in which they live.

Times and Logistics of Services

For many patients, particularly those employed in jobs with limited or no paid leave time, accessing health services means choosing between addressing the medical needs of their families or themselves and providing income necessary to support their families or themselves. Volunteers from faith-based organizations may be engaged to extend the times services can be offered including evenings and weekends.

Cultural Competence

The demographic makeup of the United States is constantly changing as a result of immigration and population increases among racially, ethnically, culturally and linguistically diverse groups. In 1999, a total of 26.4 million residents, or approximately 10% of the population, were born outside of the United States (Brittingham, 1999). This diversity creates an impetus for health care organizations to become culturally competent in order to address the wide range of health beliefs, practices and access issues. Sometimes the availability of services is less of an issue than their acceptability to segments of the community. In some communities, culturally diverse groups have been disengaged from or distrustful of health care organizations. When there is such a history, issues of cultural competence and trust must be addressed.

Faith-based organizations can bring important expertise and resources to partnerships with health care organizations. In fact, those that serve particular racial, ethnic and cultural communities can take the role of cultural brokers, helping health care organizations learn about and make connections within these diverse communities. In this way, partnering with a faith-based organization can lead to health care organizations engendering greater trust and providing more culturally competent services.

Linguistic Competence

According to the 1990 Census, 32 million people in the United States, or 13.8% of the population, speak a language other than English at home. Of this group, nearly 45% indicate they have trouble speaking English. Most current Census data indicate that there are over 300 languages spoken in the United States and this trend is expected to continue (Brittingham, 1999).

Access is severely limited when patients receive services in a language they do not understand. This concern is exacerbated as the number of people in need of health care services who have limited English proficiency has risen in the last decade. Individuals with limited English proficiency are both over represented and underserved in the nation's health care system.

Many health care organizations are struggling to respond to these challenges. Faith-based organizations can help in this effort, by recruiting individuals within the community who speak the language(s) of diverse patients. These recruits can then be trained to be effective medical interpreters and translators who can work side-by-side with health care providers to enhance access to individuals with limited English proficiency.

Reestablishing Trust

A local health clinic serving a Native American population began to use mammography services on site. At first this new service seemed well accepted, as many of the women in the tribe came to be screened. As a result of the mammography and follow-up care, a few women were subsequently diagnosed with lesions or breast cancer. Soon after, the clinic staff noticed that the women stopped coming for mammograms. The staff learned that those diagnosed with breast cancer believed that the machine had caused the cancer, creating fear among their peers. The clinic staff used health education materials to dispel these beliefs and reassure the women. When their efforts were unsuccessful, clinic staff discussed the situation with the tribal spiritual leader, who then performed a ceremony to rid the machine of spirits that could negatively impact the women. The spiritual leader and other tribal leaders also urged the women to return for exams. Female tribal leaders led the way by getting mammograms themselves. With this message coming from trusted and safe sources, the women in the community once again felt comfortable using this important health screening technology.

Meeting the Needs of New Refugees

Since the 1980's, a growing wave of Jewish immigrants from the former Soviet Union has been arriving in major U.S. cities, such as Chicago. Among this population is a large number of older people with significant health problems and who also face linguistic challenges as most speak Russian and Yiddish, an Eastern European Jewish language.

A program in Chicago, called the ARK, provides a culturally and linguistically competent venue for these newcomers to address their health and other needs. The ARK grew from a partnership between a rabbi and the director of a local health clinic to better serve the poor and elderly in the Albany Park neighborhood of Chicago. Services include a medical clinic with volunteers; a partnership with Mount Sinai hospital so any ARK patient without insurance may have procedures performed free of charge; a home visiting program; a dental clinic; an eye clinic; and a pharmacy where medications are free to those who need them and cannot afford them.

ARK volunteers include senior citizens, many of whom speak Yiddish and whose families immigrated to the United States early in the century, who can relate to these newcomers' experiences. As with many immigrant groups who have experienced government persecution in their countries of origin, a government clinic or government agency may not have been acceptable to the new Russian immigrants. The ARK provides a venue to access treatment and preventive services they need without arousing the fears of government persecution and religious discrimination they have brought with them from their previous experiences.

Health, healing and holy all come from the same word.

B. Improving the Delivery and Quality of Health Care

As Dr. Gaston noted, eliminating health disparities will take more than improving access to quality health care. Services will also have to be delivered in different ways to have an impact on disparities. There are three arenas in which partnerships with faith-based organizations may help health care organizations deliver care in ways that may reduce disparities:

- Developing culturally competent and culturally specific service delivery models;
- Incorporating spirituality into the delivery of health care that supports the holistic concept of health as defined by the World Health Organization; and
- Expanding and increasing the impact of health education and prevention efforts.

Developing culturally competent and culturally specific service delivery models.

A one-size-fits-all approach does not effectively apply to health care delivery models. Researchers have discovered that the use of standard concepts, theories, instruments and procedures are often inappropriate for culturally diverse groups (Caldwell, et al., 1999). In fact, recent literature reviews reveal there is an emerging body of literature that substantiates differences among racial and ethnic groups in response to health education and other interventions (Goode and Harrison, 2000). For example, research indicates that cancer prevention and control activities targeted toward Asian and Pacific Islander Americans must consider the influence of culture, acculturation, and English and native language tobacco-related media. Studies suggest that Asian and Pacific Islander Americans respond better to intervention and education strategies that feature peer interactions with lay Asian Americans of corresponding ethnic backgrounds and that consider cultural and

linguistic factors (Chen, 1998). Among African American women, it has also been demonstrated that a weight loss program designed around this group's culturally based health beliefs, values, food choices and preferred kinds of social supports can be effective when other weight loss programs are not successful (McNabb, et. al., 1997).

For many ethnic and cultural groups, "healing" is distinguished from "curing." Healing involves restoring balance to the individual within the community, while

Linking Spirituality and Health Promotion

The Lowell Community Health Center in Lowell, MA, has developed a partnership with a local Buddhist temple to provide community health education and outreach in the growing Cambodian community. For example, Cambodian health center staff have partnered with the Buddhist monks to address smoking as a health issue. The temple has been designated smoke free, except for incense. Public service announcements about smoking directed to the Cambodian population include scenes from the temple with the monks talking about tobacco related health issues. These initial collaborative efforts with the Cambodian community and the temple have led to a fuller partnership: a new health center at the Cambodian Mutual Assistance Association has received BPHC funding that will offer a monk on-site with a meditation center, mental health services and opportunities for community members to work with traditional healers.

curing is a medical approach designed to rid the body of physical disease. In many cultures, non-traditional healers and alternative therapies are a key component of the healing process, so service delivery models that do not incorporate the more holistic concept of healing and culturally appropriate healers may not be viewed as credible. It may be difficult for health care organizations to directly employ and compensate traditional healers. However, this challenge is being met by some health care organizations through partnerships with faith-based organizations that have created community models of care that incorporate spirituality and traditional healers.

Incorporating spirituality into care delivery to support the holistic concept of health as defined by the World Health Organization.

For much of the world, physical health, emotional and spiritual wellbeing are inextricably intertwined. Consequently, many individuals from diverse backgrounds do not respond well to care that does not incorporate the spiritual dimension. While many U.S. health care providers are generally not comfortable with- nor skilled at- including spirituality in their practice, many are now gradually recognizing the importance of spirituality in health and healing. More than 50 U.S. medical schools now offer elective courses in spirituality and 19 have been awarded grants from the National Institute for Healthcare Research to develop curricula in spirituality and medicine (Baird, 1999). Moreover, partnerships with faith-based organizations can help health care organizations incorporate spirituality into the delivery of care, thereby achieving the World Health Organization vision of health.

Expanding and increasing the impact of health education and prevention efforts.

Clearly one approach to assist in the elimination of health disparities is through prevention and health education. Such efforts must be tailored to the specific populations and take into account culture and language. For example, the Back to Sleep campaign, targeting Sudden Infant Death Syndrome (SIDS), has been hailed by the Surgeon General as the most successful public health education initiative in recent times. Since this health education effort began in 1994, it has been credited

Honoring Religious Beliefs: A Health Care System Responds

Dearborn, MI, is home to a large population of Arab Americans, including many recent immigrants, with a large Islamic constituency. Both ethnicity and religion create an important cultural context within which health care and support services must be designed to be effectively delivered for this Arab community. The ACCESS Community Health Center was specifically founded to address these needs by creating networks with other health care organizations and Islamic faith organizations to deliver health care services and health education approaches that are culturally and linguistically competent. One effort includes a collaboration with Oakwood Health Care System, a comprehensive regional network that serves more than 1.2 million people in southeastern Michigan and that includes one of the largest teaching hospitals in the Dearborn area. "Collaboration whenever possible" is one of the health system's guiding principles.

The hospital operated by Oakwood Health Care System in Dearborn found that while a large percentage of its inpatient services were being delivered to Arab Americans, existing services did not consider the special dietary needs, linguistic issues and pastoral support needed to create an effective care delivery model for this population. Oakwood Health Care System then partnered with ACCESS, Arab American community leaders and local mosques and churches to develop a culturally competent approach to inpatient care delivery. The results: Arab language TV channels in patient rooms, availability of meals that meet Islamic dietary laws and counseling to terminally ill patients and their families that supports their Moslem faith. These two health care organizations have also partnered with other community agencies to develop a culturally specific domestic violence prevention program that includes English and Arabic language health education materials with text that incorporates Moslem religious principles and is written at literacy levels that will reach the largest number of people possible.

Caring for the Whole Person

In the 1980's, Reverend Otis Moss, pastor of the Olivet Institutional Baptist Church in Cleveland, OH, had a dream of addressing the health disparities in his primarily African-American community. He recognized that an effective approach to addressing these inequities was to promote individual, family and community health, healing and wholeness in a spiritually supportive environment. He envisioned a facility in his community that provided affordable, quality health care in a private practice setting which incorporated the spiritual dimension. Because the church had already created the Olivet Housing Corporation, a partnership between the corporation and University Hospitals of Cleveland made Rev. Moss' dream a reality.

Under this arrangement, the church provided the land for the medical center; with foundation support the University Hospitals provided resources to build the new facility. The result is the Otis Moss Jr.-University Hospitals Medical Center, which now houses the Olivet Health and Education Institute. The church leases the building to the University Hospitals, which staffs the medical center. The Medical Center Board has ensured that physicians practicing within the facility are knowledgeable about and open to including the spiritual dimension in health and healing. The Institute operates a chapel within the medical center and through counseling and education, encourages the expression of spirituality through such activities as prayer, meditation and fasting. Institute programs include: From Stress to Healing (a lifestyle wellness series); Freedom to Change (nutrition and spirituality), Understanding Prayer in Health; a breast cancer education program and education programs for men. Institute staff partner with health professionals. They conduct joint case reviews that help maintain the holistic focus of the Medical Center's philosophy of health care.

Giving a Blessing

In the Dallas, TX, area, an important prevention message was not reaching the Latino community. Despite standard public education efforts, local Latino families in the area were not using infant car seats, which can significantly reduce child injuries. Recognizing this problem, the Greater Dallas Injury Prevention Center (GDIPC) approached the Santa Clara Catholic Church for help. GDIPC learned that many Latino families perceived the car seat as a place that isolated the child from the warmth and protection of their parents. In essence, standard car seat safety messages were at odds with closely held cultural beliefs that a child should be close to parents and was safest in their arms. GDIP asked a Santa Clara parish priest for help. One Sunday, the priest held a special Mass that included the blessing of the car seats. GDIPC took about 30 car seats to distribute to families who did not own one. Families believed that the blessing ensured a measure of protection for their children. While acknowledging and respecting cultural beliefs, the blessing provided spiritual guidance to families to make the behavior change that was key to the health and safety of the children within their communities.

with a 40% reduction in the incidence of SIDS cases nationwide. However, it has not been equally successful across all segments of the U.S. population. The SIDS rates among African American and Native American populations have not decreased, and in some geographic areas have actually increased. Current studies indicate that there has not been an appreciable change in sleep positions in these communities (USCPSC, 2000). Such studies provide strong evidence that health education must address cultural and linguistic differences in order to be effective and to impact infant mortality, one of the six areas of health disparity.

In some cultural groups, health professionals may not always be authorities and key sources of information about health, child rearing practices and lifestyles. Elders, traditional healers or leaders in the faith/spiritual community may be far more credible sources of information and guidance. When health care organizations partner with faith-based organizations, they can tap the power of that credibility to deliver health messages and encourage behaviors that prevent health problems. Health care organizations can learn from those faith-based organizations to enhance their knowledge and skills in developing culturally competent approaches to health education and prevention. Finally, faith-based organizations provide settings and person power to reach out broadly in the community to conduct health education and prevention efforts, extending the reach of health care and expanding its impact.

C. Improve Patient Self-management of Disease

Many of the disparities in health care outcomes relate to the patients' self-management of their diseases. In diseases such as diabetes, heart disease and hypertension, for example, changes in diet, exercise, and life style contribute to improved outcomes. Yet these types of behavioral changes are difficult to achieve and require effective health approaches and ongoing support to be sustained. Simply providing patients with "the facts" has not proven to be an effective approach especially when such approaches do not take into account how culture affects health beliefs and practices. Many cultural groups rely on natural networks of support within their communities as a valued

source of information for health related issues. Partnerships with faith-based organizations provide health care organizations with resources to create the kinds of programs, services and support networks that will improve patient self-management by:

- Promoting healthy lifestyles that reflect religious, spiritual or moral values;
- Assuring that lifestyle changes recommended are consistent with religious or spiritual beliefs and cultural practices; and
- Creating support networks to help sustain lifestyle changes.

Promoting healthy lifestyles that reflect religious, spiritual or moral values.

The faith community has traditionally played a key role in shaping lifestyle behaviors and promoting moral and healthy living. Faith-based organizations are thus important partners in bringing about changes in behaviors to enhance health in individuals and the community

Speaking Out for Health

In 1995, a shared vision for community eventually led to what is today a strong community driven collaborative effort to improve the health and social conditions of the Haddington Community in Philadelphia. That effort, called the Haddington Community Health Project Collaborative, began in 1995 as a result of discussions between Rev. Frank Lilley, pastor of Greater St. Matthew Independent Church and the president of To Our Children's Future with Health, Inc., a community organization dedicated to improving the health of the community with a special focus on children. The 45-member collaborative now consists of a number of faith-based institutions, hospitals, community health centers and health care providers, schools, community-based organizations, legislators and area housing development representatives. Recently, 13 community churches have come together as a subcommittee of the Haddington Community Health Project Collaborative, called the Faith-based Initiative, to lend their support to current and emerging issues of importance to the community residents.

This community has clearly identified the enormous power of partnerships, particularly in addressing the well-documented disparities in cancer rates among the African American community. Prostate cancer is a major concern, yet the Haddington community noted a reluctance among African American men to go for annual physicals including prostate cancer screening. As a result, one of the many health initiatives conducted by the Collaborative throughout the year, is an annual Men's Health Night Out. Held at Greater St. Matthew Independent Church, the event provides health promotion and prevention screening activities for men. These health promotion activities are embedded in a program of a live jazz band, dining and dancing with their companions. This program has been especially successful through the personal endorsement of the church's pastor, Rev. Frank Lilley. Using his position as a religious and community leader, Rev. Lilley helped overcome the reluctance of his male congregants to get screening for prostate cancer. His success is an example of how the sender of the message is vital to the level of response. Rev. Lilley's understanding of his role in promoting the health of the community and the community's respect for him as a credible voice opened doors that may not have otherwise opened. Bringing the power and respect of the pulpit to support health in a community is one key asset that can be tapped by health care organizations through partnerships with faith-based organizations.

at large. Such institutions and their leaders can teach by example (e.g. serving healthy foods at events) and can use what some religions refer to as the “power of the pulpit” to work toward behavioral change. By connecting health issues to the values and priorities of a community, a faith-based organization can help health care organizations develop effective approaches to improve patient self-management of disease that reflect religious, spiritual or moral values.

Assuring that lifestyle changes recommended are consistent with religious and spiritual beliefs.

When lifestyle changes are presented only from the medical viewpoint, they may lack relevance to the cultural and social context in which patients live. In fact, certain recommendations may appear to patients to contradict closely held cultural

or religious beliefs and practices. When faith-based organizations partner with health care organizations, they can help make sure that information is presented in ways that are congruent with patient beliefs. This approach can support behaviors that may be different from traditional ways by sanctioning them within a given cultural or religious belief system.

Creating support networks to help sustain lifestyle changes.

Faith-based organizations often comprise natural networks of support for patients. These support networks can be tapped and helped to provide the kinds of ongoing and often intensive support needed to sustain behavioral changes for improved health outcomes for such issues as smoking cessation, weight loss and dietary changes and aftercare for substance abuse. Such networks can also promote health and assist in supporting behaviors that prevent or reduce the risk of disease and disability.

A Comprehensive Approach to Community Health

Pittsburgh’s East End is 80% African American and is largely a low income, underserved area. Teen pregnancy, poor academic performance, high unemployment, and high percentage of children living in poverty have historically characterized the East End. In 1990, Pittsburgh Pastoral Institute, a mental health agency, and East Liberty Family Health Care Center, two agencies comprised primarily of white staff members, acknowledged a shared problem: there were significant limitations in comprehensive health care services for the growing African American population they served. These agencies came to recognize that the African American church was the one “long term, indigenous institution in the Black community that encounters and embraces individuals, families and extended families from birth to death in a holistic way”, (Rogers and Ronsheim, 1998). Thus, they reached out to the faith community by inviting the director of Christian Life Skills, Inc. to discuss their concerns. Christian Life Skills, Inc., a community organization, had developed a network of churches and church-based groups in the East End community to provide mentoring, life skills training and other support services for youth and families.

These partners worked together over the next decade to create a broad and strong safety net entitled Families and Youth 2000 to improve the health of residents of Pittsburgh’s East End. The collaborative partners had to work through issues of trust and control, which were manifest in such issues as employment policies and race and culture. They learned to deal with the organizational “cultures” of new partners such as university systems. The partners also learned about diverse “cultures” among families, informal networks of support and communities.

Today, this collaborative ministry provides a broad array of services to address the holistic view of health for individuals and the community in a spiritual and cultural context that resonates with the African-American community. Services include counseling, therapy, health care, mentoring, life skills, youth leadership education, training, youth development activities, job skills programs, home management training, ministry to single mothers, data management and tutoring. These services are provided by a network of agencies and churches in the community. Pittsburgh Pastoral Institute serves as the fiscal agent for the collaborative (Rogers and Ronsheim, 1998).



VI. Strengthening the Safety Net

THE PROGRAMS AND PRACTITIONERS FUNDED BY THE BPHC MAKE up the third largest primary health care system in the United States. Unlike other health care systems, the BPHC is known as a national *safety net* because its mission is to provide comprehensive preventive and primary health care to the nation's most vulnerable and underserved populations. Through the Faith Partnership Initiative, the BPHC is providing leadership, innovation and resources to expand the scope of the safety net for this nation's communities. Partnerships between faith-based organizations and health care organizations are a viable strategy to achieve the vision of "healthy individuals in healthy communities", a vision where everyone benefits.

Benefits to Those Served

Individuals and families served by partnerships between health care organizations and faith-based organizations receive these benefits:

- culturally and linguistically competent primary and preventive health care and health education services;
- improved health outcomes because services are delivered in contexts that build trust leading to consistent follow-up;
- better connections with community support networks to provide treatment and sustain healthy lifestyle changes;
- inclusion of spirituality in beliefs and practices related to health and healing;
- convenience when services are delivered closer to home and at flexible times; and
- health care providers who have an understanding of the interactions between health issues and an individual patient's constraints based on religious and spiritual beliefs, values and practices.

Benefits to Health Centers

The benefit of faith partnerships to community-based health care organizations is being able to more effectively meet their mission of providing the services and supports that lead to increased access and better health outcomes for the populations served.

In particular, resource sharing can enhance the capacity of health care by providing:

- additional space or access points for screening, referrals, health

"...the Bureau is wise and prudent for saying let's start connecting with the faith institutions, for they are beginning to emerge as a major leader ... involved in what they refer to as a holistic approach to health with a focus on the whole person. They're concerned about education, housing, job development, economic and commercial development, and social justice issues, which all contribute to the health of an individual and a community..."

CAPTAIN JAMES GRAY
Acting Director,
Center for Communities in Action
Bureau of Primary Health Care
HRSA/DHHS

SOURCE: BAIRD, 1999.



education and promotion and follow-up services with limited additional cost;

- volunteer support to organize health promotion programs and to provide child care and transportation to partnership services;
- additional partners who have credibility in their communities to deliver health promotion and preventive health messages; and
- access to existing community networks that provide patient support during illness and aftercare.

Political benefits of partnerships with faith-based organizations include:

- new partners, hence, increased community support for health centers;
- better community awareness of health care organizations and their value to communities;
- increased ability to engage diverse stakeholders in planning processes that support improved community health; and
- new and additional collaborators to advocate for a community health agenda at the local, state and national levels.

Benefits for the Community

When faith-based organizations and health care organizations partner, the entire community benefits. These benefits include:

- improved health of citizens, including fewer persons disabled by chronic conditions that are not appropriately prevented or treated;
- a healthier workforce;
- the creation of health care related jobs and the purchase of goods and services that provide for economic reciprocity within communities; and
- a consortium of key community stakeholders who can participate in other planning and program efforts that can strengthen the community safety net.



VII. Perceived Barriers to Partnerships

GIVEN THE EFFECTIVENESS OF PARTNERSHIPS BETWEEN health care and faith-based organizations, why are they not more common? Why, in fact, is a special initiative needed to foster these relationships? There have traditionally been a number of issues that have made health care organizations hesitant to pursue such relationships. Most of these concerns, however, can be addressed with careful discussion within health care organizations and with any potential partners. Given the benefits of such partnerships, it is time to move beyond concern to action.

The following questions and answers have been provided to respond to concerns about legal, financial and resources issues associated with partnerships between health care organizations and faith-based organizations.

Q Is it permissible, based on constitutional and legal grounds, for organizations receiving government funding to partner with faith-based organization? How do such partnerships relate to separation of church and state?

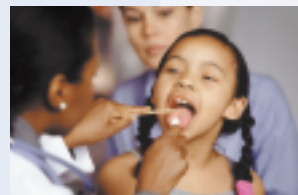
A There is a long history of partnerships between faith-based organizations and government-funded efforts. In fact, the Supreme Court has ruled that such partnerships are permissible within certain bounds. See pages 20-22 to understand the structure within which such partnerships are permissible and to learn how multiple government agencies support and enhance such partnerships.

Q Will working with any one faith-based organization be seen as an endorsement of the religion related to it, possibly alienating other groups in the community?

A If the opportunity for partnership is open to all and if the partnership clearly addresses a community need, health care organizations need not be seen as preferential.

Q Will new partnerships stretch already thin resources further?

A Any new effort may initially stretch an organization's resources and level of effort of personnel. However, partnerships with faith-based organizations can actually provide opportunities to leverage additional resources of the faith community. It is important, however, that such partnerships exploit neither partner (See pages 23 and 24).



Q Will partnerships with faith-based organizations increase liability problems for health care organizations?

A Liability issues need to be explored. There is evidence, however, that when services are delivered in culturally and linguistically competent ways, there are actually fewer liability issues (Cohen and Goode, 1999).

Q Will faith-based organizations keep the same level of accountability in terms of business standards, financial records and reporting requirements that health care organizations must maintain?

A All organizations have to be accountable for their business practices. The amount of record keeping, reporting and other related requirements will vary depending on the nature of the partner organization, and the partnerships and mandates from funders and applicable local, state or federal statutes. These are important issues that need to be addressed up front. Each partner's respective responsibilities should be clearly delineated.

The following questions and answers have been provided to respond to political concerns that may arise regarding partnerships between health care organizations and faith-based organizations.

Q Will traditional community partners frown on partnerships with faith-based organizations?

A Many concerns are allayed when health care organizations clearly articulate the goals and objectives of such partnerships and the benefits to the community as a whole.

Q Will partnerships diminish the power and influence of health care organizations?

A Carefully designed partnerships should strengthen rather diminish the power and influence of all organizations involved. Partnerships can increase the number of stakeholders that are concerned with and advocate for issues of concern within communities. These partnerships should be viewed as complementary, not competitive.

Partnerships with faith-based organizations may also challenge the attitudes and belief systems of health care organizations and their personnel. The following questions and answers have been provided to respond to such concerns that may affect the comfort zone of health care providers.

Q How does religion and spirituality relate to the scientific discipline of health care?

A Professionals can begin to understand partnerships with faith-based organizations as a way to address individual patient needs in areas in which they are neither trained nor comfortable. This issue may become less of a

concern in the future as many medical schools add courses about spirituality in medical care. Health care organization staff can learn from the growing literature on the importance of the spiritual/religious component in both healing and health promotion.

Q What if members of the faith-based organization try to proselytize patients, providers or other staff?

A Health care and faith-based organizations must establish principles upon which they agree. These principles form the basis for policy that specifies how each organization and its employees and constituency groups will conduct business. These types of issues should be discussed openly between the partners until they agree on principles and establish a comfort zone. Based on current statutes and regulations, proselytizing is clearly prohibited when government funding is involved in joint activities.

Q What if the religious tenets of the partner seem to inhibit the delivery of health messages to patients that the health care organization deems important?

A Health care organizations must avoid making assumptions about what faith-based organizations will or will not support. For example, a recent survey of interdenominational African American clergy found that 76% had discussed HIV/AIDS with their congregations and were supportive of schools or other institutions addressing issues of sexuality that the clergy did not directly address (Coyne-Beasley and Schoenback, 2000). Frank discussions must occur during the initial meetings and negotiations. The partnership should have structures to assure a venue for continued discussions of this nature. Health professionals need to be able to articulate the underlying goal of health messages and then collaborate with the faith community to find an acceptable way to promote messages to meet that goal. If an understanding cannot be reached on a particular issue, it may be necessary for health care organizations to find other partners in the community who can help deliver that message.

“Congress shall make no law respecting an establishment of religion or prohibiting free exercise thereof...”

FIRST AMENDMENT,
CONSTITUTION OF THE UNITED
STATES OF AMERICA

Does the Constitution Allow Partnerships Between Faith-based Organizations and Government-funded Health Care Organizations?

Government-funded agencies and programs must always give thought as to whether partnerships with faith-based organizations create legal problems based on the Constitution. The Constitution’s First Amendment contains the well-known establishment clause. While this clause firmly establishes the separation of church it does not prohibit government and religion from interacting. The interaction between government and faith organizations is hardly a new issue. The Supreme Court, in decisions going back almost 30 years, has addressed this issue in numerous cases. There is only the requirement that in any such relationships the government remain neutral.

The Supreme Court has developed a series of three tests, all of which must be met, to allow a relationship between government and religious/faith-based organizations:

- First, the action undertaken in the relationship must be secular in nature.
- Second, the primary effect of the action must neither advance nor inhibit religion.
- Third, the action must not foster excessive government entanglement with religion.

Within these guidelines, federal departments and agencies have developed policy and guidelines that govern their relationships with faith-based organizations. Numerous programs have been created between faith-based organizations and agencies or programs receiving public funds. For example, the federal government has long funded denominational colleges and universities with the requirement that those funds not be used for religious purposes.

PUBLIC SCHOOLS

PUBLIC SCHOOLS HAVE OFTEN PARTNERED WITH FAITH-BASED ORGANIZATIONS IN THEIR communities around issues such as crisis counseling, mentoring programs, and “safe havens” for children while going to and from school. In December, 1999, the Department of Education distributed a new set of guidelines developed jointly by the American Jewish Congress, the Christian Legal Society and the First Amendment Center that suggest how religious organizations and public schools can work together without violating the First Amendment of the Constitution.

This document provides greater detail to the three guiding principles set forth by the Supreme Court, noting that cooperative programs are permissible only if:

- participation in cooperative programs is not limited to religious groups—any responsible community organization may participate;
- a student’s grade, class ranking or participation in school programs will not be affected by his/her willingness to participate or not participate in such a cooperative program; and
- student participation in a cooperative program cannot require membership in any religious group or acceptance of any religious belief or participation in any religious activity.

In addition, when cooperative programs are operated in facilities of religious institutions, those programs cannot allow any actual opportunity for proselytizing during the time of that joint program.

WELFARE REFORM

FEDERAL WELFARE REFORM HAS LOOKED TO THE FAITH COMMUNITY FOR POTENTIAL partners in carrying out the new approaches to serving those receiving welfare benefits. Section 104, the “charitable choice” provision of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, encourages states to partner with independent organizations to provide welfare services and forbids the exclusion of faith-based providers. In fact, if the state involves any independent organizations, then it must not discriminate against faith-based providers. Section 104 requires states to protect the autonomy and religious character of such participating providers. These rules apply to the federal welfare block grant funds. If a state’s constitution prohibits funds from being awarded to religious organizations, then the state must keep its funds separate, while assuring that federal funds are used in compliance with Section 104. The law secures the following rights to participating faith-based organizations:

- control of religious mission—they retain the right to keep, change and express their religious convictions;
- control of employment policy—they retain the right to use religious criteria in hiring, firing and disciplining employees;
- maintenance of religious atmosphere—they retain the right to keep religious art, symbols, icons, etc. in their service location;
- control of governing boards—they retain the right to constitute such boards in the way they judge best and may not be compelled to create them to meet ethnic, gender or cultural diversity criteria;
- control of internal governance—they may not be required to form a separate 501c3 corporation to provide welfare services;
- independence—they retain their legal status as independent organizations;
- limited audits—they can keep federal funds in a separate account to confine audits to those funds; and
- legal remedies—they can bring civil suits in state courts to order alleged violators of their rights to comply with Section 104.

Section 104 also specifies that religious organizations that receive federal funds directly, not via vouchers, may not use them for sectarian worship, instruction or proselytizing (Carlson-Thies, 1996).

CENTERS FOR DISEASE CONTROL AND PREVENTION

IN 1997, THE FEDERAL CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) sponsored an educational forum called “Engaging Faith Communities as Partners in Improving Community Health.” The CDC now funds an initiative of community-based HIV prevention programs for African Americans that are designated for faith-based organizations. The community-based HIV Prevention Services program awards four Cooperative Agreements with faith, spiritual and religious-based community organizations to create effective community-based HIV prevention programs for African Americans.

DEPARTMENT OF HOUSING & URBAN DEVELOPMENT

ON NOVEMBER 30, 1999, SECRETARY OF HOUSING AND URBAN DEVELOPMENT (HUD) Andrew Cuomo hosted a public forum on “The Role of Faith and Justice in Public Policy”. During his keynote speech, he urged faith-based organizations to “argue for a seat at the table in the name of justice, not for crumbs in the name of kindness.” “Tension over the role of religion in government is always present when governments enter into partnerships with faith-based organizations,” he said, “ but it’s a resolvable issue.”

HUD has a long history of such partnerships. More than 1,000 organizations provide housing for people with AIDS. Close to one third are faith-based organizations of which two-thirds receive funding from Housing Opportunities for Persons with AIDS. Non-profit faith-based organizations operate 40% of HUD’s Section 202 housing for the elderly program. HUD awarded a total of \$114 million in grants to faith-based organizations for the homeless and special needs programs (Department of Housing and Urban Development, 2000)

HUD has evolved the “true beneficiary” theory. For some time, HUD has taken the position that when services and food are provided by faith-based organizations to the homeless or other poor people, the true beneficiary is that ultimate recipient, not the religious institution. This theory allows for effective community programs and partnerships involving HUD funds and faith-based organizations. HUD guidelines include these stipulations:

- The program may not discriminate against any employee or applicant on the basis of religion or give preference in employment on the basis of religion.
- The program may not discriminate against any person applying for publicly funded services on the basis of religion.
- The program may not provide any religious instruction or counseling or conduct any religious services, engage in religious proselytizing or exert religious influence on participants in the program.

BUREAU OF PRIMARY HEALTH CARE

WHILE THE BPHC IS A RELATIVE NEWCOMER TO THE GROUP OF FEDERAL DEPARTMENTS and agencies that encourage partnerships with faith-based organizations, it supports an array of innovative activities. Most of these activities are under the auspices of the Faith Partnerships Initiative.

For example, the BPHC’s Faith Partnership Initiative is funding a series of activities with faith-based organizations to address health disparities in racially and ethnically diverse communities.

- **Congress of National Black Churches, Inc.**

The BPHC has a Cooperative Agreement with the Congress of National Black Churches, Inc. (CNBC), which represents congregations serving 19 million people. The project is designed to build an infrastructure so that CNBC affiliates will be prepared and ready partners with health care organizations.

- **Summit Health Research and Education, Inc.**

BPHC also has a contract with Summit Health Research and Education, Inc. (SHIRE) to address one of the health disparities. The project is entitled *Managing Diabetes in Communities of Color Through Expanding Partnerships with Faith-based Organizations*. The goal of this project is to connect faith-based organizations and their community partners to the health providers linked to the BPHC-funded health centers, particularly those participating in the Diabetes Collaborative.

- **Christian Community Health Fellowship, Inc.**

In addition, BPHC has a cooperative agreement with the Christian Community Health Fellowship, Inc. to support the development of research and evaluation tools to test “best practices” among faith-based health care organizations serving the nation’s poorest urban and rural populations.



VIII. A Meeting of Cultures

ORGANIZATIONS HAVE CULTURES THAT DEVELOP OVER TIME based on their vision, mission and values, as well as the broader context within which they exist. While faith-based organizations and health care organizations may share many fundamental values and seek common goals related to strengthening the safety net, they also have very different cultures that each should respect. Faith-based organizations are driven by a religious, spiritual and moral core of beliefs. Health care organizations are rooted in using the benefits of science and technology to address the health of those they serve. Each partner must be clear with the other about what brings them to the table and how each views the path to enhancing the health of the community.

An organization's culture is impacted not only by its mission, policy and structures, but also by the diversity of its work force. A complex array of factors converge within the work force of faith-based and health care organizations including, but not limited to, race, nationality, ethnicity, culture, language, gender, age, sexual orientation, education, class and political affiliation. The challenges of developing relationships across these cultural differences may also face those trying to build partnerships. Rogers and Ronsheim (1998), in describing the experiences of developing a partnership among four African American churches, a neighborhood health center, a church-based community grassroots organization and a counseling and therapy agency note:

“In addressing patterns—such as culture, race, trust and control—common to these divergent systems, several key factors transcend the differences and make possible effective interaction. The factors include time, good communication, relationship building, and mutual respect.”

Trust is essential with any new partnership. Yet the process of establishing trust requires a commitment of time from both partners. It is important to set a tone that honors and supports all partners and their missions, as well as the cultural backgrounds of all individuals involved. The partnership must be developed within the context of fulfilling mutual goals and not simply using one another to pursue the goals of one organization while “plundering” the resources of the other. Gary Gunderson, (1999) director of the Interfaith Health Program at the Rollins School of Public Health, Emory University, provides excellent guidance to thinking about how to bring the faith and health cultures together in partnership for health goals. He suggests that there are two “right” steps to frame the early stages of such coalitions:

- Reframe health as a domain of opportunities, not problems.
- Reframe community health as a social challenge dependent on strong and enduring partnerships, not just stop-gap arrangements.



Such approaches can help organizations develop a new way of creating a community vision and infrastructure, and can set the stage for the two organizational cultures to work together.

Gunderson also suggests, however, that some questions that partners may bring to the table early in the partnership reflect a lack of respect for the other entity, and can derail trust and ultimately collaboration toward common goals. These questions are:

- How can health systems use religious groups to substitute charity for paid medical services?
- How can government transfer financial responsibility for inconveniently expensive types of people to religious groups?
- How can religious groups secure new funding streams for community ministries they find difficult to fund otherwise?

Even though faith-based organizations bring many resources to the table, they cannot be expected to replace hard funding for many types of services and activities. There needs to be a weaving together of existing resources between the two organizations in the partnership and a commitment to collaboratively seek additional resources. A recent study by the Polis Center (Farnsely, 1998) raises cautions against assuming that there are extensive monetary resources in most congregations and notes that many small churches do not provide any social services.

Bringing together two organizations with unique histories and cultures is clearly a challenge. The work group of experts that developed this monograph recommend that as health care organizations explore the possibilities of partnering with faith-based organizations, they view the process as a continuum that develops over time. The examples of successful partnerships provided within this monograph demonstrate that the effort yields important gains for the health of individuals and their communities. These successful examples, however, reflect the culmination of much time and effort spent in developing the relationships needed to create and sustain them. With time, respect and mutuality, health care organizations and faith-based organizations can partner effectively.

IX. Taking Action

THE BPHC'S FAITH PARTNERSHIP INITIATIVE PROVIDES A FRAMEWORK and support for the very important work of strengthening the safety net within communities to assure that there is 100% Access and 0 Health Disparities as our nation moves into a new century and a new millennium. This monograph, as one of the actions of the Faith Partnership Initiative, provides the vision of the great benefits of such partnerships and addresses the attitudinal and practical concerns that may have prevented health care organizations from reaching out to create these potentially productive connections. Other products developed by the Faith Partnership Initiative will provide practical guidance on how to identify potential partners and begin doing the important work of creating these new collaborations. Driven by a common legacy of caring, health care and faith-based organizations can work together to build a stronger and more effective safety net for the health of underserved individuals and communities in our nation.

X. For More Information...

About Bureau of Primary Health Care programs:

The Faith Partnership Initiative
Center for Communities in Action
Bureau of Primary Health Care
4350 East West Highway, 3rd Floor
Bethesda, MD 20814
(301) 594-4494
(301) 594-4987 FAX

Office of Minority and Women's Health
Bureau of Primary Health Care
4350 East West Highway, 3rd Floor
Bethesda, MD 20814
(301) 594-4490
(301) 594-0089 FAX
www.bphc.hrsa.gov/omwh/omwh.htm

Jgray@hrsa.gov

www.bphc.hrsa.gov/bphc/faith/FaithProgramInfo.htm

About the topic of faith/health partnerships and the role of religion and spirituality in health:

The Interfaith Health Program
Rollins School of Public Health
Emory University
750 Commerce Drive, Suite 301
Decatur, GA 30030
(404) 592-1461
lmcphee@emory.edu
www.iphnet.org

This program, originally founded in the Carter Center, provides a wide range of information about faith/health partnerships, including a database of current partnerships.

About the National Center for Cultural Competence:

The mission of the National Center for Cultural Competence (NCCC) is to increase the capacity of health care and mental health programs to design, implement and evaluate culturally and linguistically competent service delivery systems. The NCCC conducts an array of activities to fulfill its mission including: (1) training, technical assistance and consultation; (2) networking, linkages and information exchange; and (3) knowledge and product development and dissemination. Major emphasis is placed on policy development, assistance in conducting cultural competence organizational self-assessments, and strategic approaches to the systematic incorporation of culturally competent values, policy, structures and practices within organizations.

The NCCC is a component of the Georgetown University Child Development Center, Center for Child Health and Mental Health Policy, and is housed within the Department of Pediatrics of the Georgetown University Medical Center. It is funded and operates under the auspices of a five-year Cooperative Agreement (9/30/00–5/31/05) within the Maternal and Child Health Bureau.

The NCCC is a collaborative project between the Georgetown University Child Development Center and the following Federal government agencies:

Health Resources and Services Administration

Maternal and Child Health Bureau (MCHB)

- Division of Services for Children With Special Health Needs
- Sudden Infant Death Syndrome and Other Infant Death Program
- Training Branch of the Division of Research, Training and Education

Bureau of Primary Health Care (BPHC)

- Office of Minority & Women's Health
- National Health Service Corps (NHSC)
- Division of Loan and Scholarship Repayment/NHSC
- Office of Pharmacy Affairs

Other target BPHC programs include Community Health Centers, Migrant Health Centers, Health Care for Homeless grantees, Healthy Schools, Healthy Communities grantees, Health Services for Residents of Public Housing, Primary Care Associations and Offices.

Office of Minority Health

- HRSA Cultural Competence Committee

Substance Abuse and Mental Health Services Administration

Center for Mental Health Services

- Child, Adolescent and Family Branch



The National Center for Cultural Competence
3307 M Street, NW, Suite 401
Washington, DC 20007-3935
(202) 687-5387 or (800) 788-2066
(202) 687-8899 FAX
cultural@georgetown.edu
<http://gucdc.georgetown.edu/nccc>

About the Examples of Partnerships

Listed below is contact information for the examples of partnerships between faith-based and health care organizations highlighted in this monograph.

More Hands to Help

The national clearinghouse for information on Love, INC is through World Vision.

Myrna Key, Ministry Coordinator
World Vision Incorporated
34834 Weyerhaeuser Way S
Auburn, WA 98001
Phone: (253) 815-2255 or 1-800-777-5277
E-mail: mkey@worldvision.org
Website: <http://web2.worldvision.org/worldvision/wvusufso.nsf/stable/loveinc>

Reestablishing Trust

Theda McPherson Keel
Wind Hollow Foundation
6739 D South Clifton Road
Frederick, MD 21703
Phone: (301) 371-8759
Fax: (301) 371-8769
E-mail: windholo@windhollow.org

Meeting the Needs of New Refugees

Miriam Weinberger, Executive Director
The ARK
6450 N. California
Chicago, IL 60645
Phone: (773) 973-1000
Fax: (773) 973-4362
E-mail: ArkMiriam@aol.com
Website: <http://www.arkchicago.org>

Linking Spirituality and Health Promotion

Dorcas Grigg Saito, Executive Director
Lowell Community Health Center
585 Merrimack
Lowell, MA 01851
Phone: (978) 937-9700
Fax: (978) 970-0057
E-mail: dorcasgr@lchealth.org
Website: <http://www.lchealth.org>

Speaking Out for Health

Reverend Frank Lilley
Greater St. Matthew Independent Church
5544 Race Street
Philadelphia, PA 19139
Phone: (215) 472-6537
Fax: (215) 472-6562

Honoring Religious Beliefs: A Health Care System Responds

Dr. Adnan Hammad
Health and Medical Director
Arab Community Center for Economic and Social Services
2601 Saulino Court
Dearborn, MI 48120
Phone: (313) 843-2844
Fax: (313) 843-0097
E-mail: ahammad@accesscommunity.org
Website:
<http://www.comnet.org/local/orgs/access>

Caring for the Whole Person

The Reverend Dr. Otis Moss
Pastor, Chairman
The Olivet Health and Education Institute
8819 Quincey Avenue
Cleveland, OH 44106
Phone: (216) 721-2850
Fax: (216) 721-2858

Giving a Blessing

Martha Stowe, Director
Greater Dallas Injury Prevention Center (GDIPC)
5000 Harry Hines Blvd, Suite 101
Dallas, TX 75235
Phone: (214) 590-4455
Fax: (214) 590-4469
Website: <http://www.ipcdallas.org>

A Comprehensive Approach to Community Health

Barbara Rogers, Project Director
Christian Life Skills, Inc.
Families and Youth 2000
100 North Braddock Avenue
Pittsburgh, PA 15208
Phone: (412) 371-7018
Fax: (412) 371-7718

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