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.
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?

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.

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 community health.

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.

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 interspersed struggles. 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 asset-unheadedness of organizations, ideas, and projects.

Margaret Wheaters, 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 Center for Disease Control and Prevention, the National Civic League, hospital board rooms, The Carter Center, or 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 care is a central 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 mutual 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 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.

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...
"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."

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 non pork 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 Muslims. That's one of the things that's in our favor."

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 debt check, without pushing people into uncomfortable or unfamiliar situations. About half the Muslims they help are immigrants.

An obstetrician, Kenya Nu-Man, 39, lives in Oakland. 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.

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."

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In addition to domestic violence, the 13-year-old group tackles poverty, homelessness, the recriment 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 each that 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 debt check, without pushing people into uncomfortable or unfamiliar situations. About half the Muslims they help are immigrants.

Sometimes the family may have been in the United States 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 deported as an undesirable.

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 debt check, without pushing people into uncomfortable or unfamiliar situations. About half the Muslims they help are immigrants.
A Health Resource

Kansas Health Foundation seeks the health of the public

ICTHA—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 had the foundation's blessing to pursue alternative uses for the site. The idea was 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.

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 health promotion activities. Allocating more of our assets to a public health agenda may help turn that around, and we'll all be healthier because of it."

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

When Wesley was sold two summers ago, the foundation, as the beneficiary of the sale, emerged as 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 changes 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."
The INTERFAITH HEALTH PROGRAM

This page could not have been a worse time for fire at Forest Elementary. Classes were in session last year at the suburban Minneapolis school when the alarm sounded. While 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 ushered the children, swapping the gals 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 these 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 minds and bodies.

In fact, the capacity to mitigate most of the primary health risks in children is already within the reach of faith groups and congregations, according to Paul Bombalum, 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 ambience of its facilities.

"It's really basic stuff, and it doesn't cost anything," Bombalum says. "Even the poorest congregation can do something to support families and assist 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 terrible things for which we pay a high social cost."

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."

A preventive approach to 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 child care service is 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 safety but in terms of people safety."

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 Lutheran, 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."

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

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."
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, Negrad 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, not what it was in 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 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 focused on social concerns, 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 Negrad. "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?"

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.
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 multiracial 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.

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.

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.
A Caucus for Faith & Health

T he 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 in the public health arena. "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.)

Focus on the At-Risk

Nancy Zients, Senior Program Director, Jewish Healthcare Foundation

W e use the resources of over half a century of foundation work, 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 our 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 $3 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.

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

I t 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 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 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 reinstituted 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.
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 Team, 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?

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 situated in underserved rural areas. Those with responsibilities for these partnerships, most of whom are themselves people of faith, probably have the most to gain from faith communities and know well that their vision fosters hope and health. As government workers, they face the challenge of serving in 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.

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

For the "Betterment of Public Health"

Daniel Rieckford
Office of the General Counsel, The Center for Disease Control and Prevention

To the First Amendment: Life 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 statutes or other governmental action invalidly advance or inhibit religions if:

1. The action has a secular purpose;
2. It's 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 coinciding with 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 religious buildings 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 organization 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 or not. 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 focused 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 programs and religious agendas. Similarly, complex long-term projects necessitate the balance of opportunities for all students to learn—is neutral.

A 12
The Interfaith Health Program
Fall 1984

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 new; he encouraged participants to explore ways to broaden and deepen those relationships.

"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-Bew 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 drew 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 nothing but statistics of rates, proportions, and risk factors. Because it is a vision of wholeness, it is 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 McKeeven
S.C. Faith and Health Work Group
I

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 religion 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 well-being.

With encouragement from The Carter Center's Interfaith Health Program and initial funding from the John Templeton Foundation, five Faith and Health Consortiums 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 level. Collaborators 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 or 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.

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:

- Spawning a difference 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-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 core 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 a personally and professionally aligned with the injustices of society, she draws colleagues, students, and community residents into partnerships and collaborative 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 and community 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. In addition, Ronsheim bridges the gap between communities and health professionals, students, and community partners.

The Pittsburgh Area Consortium of Faith and Health

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

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

"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, 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 health professionals, students, and community partners through a course, "Building Interdisciplinary Partnerships," in the School of Public Health.

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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.

1800 Cedar St., Ramona, CA 92065, (800) 280-9919 or (907) 227-9454

COALITION FOR HEALTHIER CITIES AND COMMUNITIES

A partnership of entities from the public, private, and nonprofit sectors that draws from local groups and faith communities through community-based development.


INTERNATIONAL PARISH NURSE RESOURCE CENTER

A reference center for information, education, and consultations related to the development of parish nurse programs.


SEARCH INSTITUTE

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


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 and agencies.

Cost: $10 from Martha Stowe at the Greater Dallas Injury Prevention Center, 6300 Harry Hines Blvd., Suite 300, Dallas, TX 75233, (214) 580-4461.

CONGREGATIONAL HEALTH MINISTRIES RESOURCES

The United Methodists list on their Web site a list of resources developed for congregations to use for developing a health ministry.


Available from The Subscription Department, APA, P.O. Box 3000, Denvers, NJ 07834.

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

This practical, comprehensive 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.


Review by Tom Droge

Michael Lerner is president and founder of Common-Weal, a health and environmental research institute in Bolinas, California. He co-founded the CommonWeal Cancer Help Program, which was featured in Bill Moyers' 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 traditional alternative medical therapies. 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 this as he guides us through the morsels 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 modern medicine while complementary therapies are used in addition to conventional cancer care. The latter 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, or their family and friends. It will 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 the working information. 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 is 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 sick for the first time at our health at that point. We remain the principal agents in charting the perfect food. "A Morning meal using both conventional and complementary methods of treatment. This book makes the journey much richer for the non-believer, and alternatives as they grow toward wholeness."


Review by Susan Thistlethwaite

President, Chicago Theological Seminary

Scripture calls us to be "restorers of broken walls, rebuilders of broken lives." But scripture does not tell us how to mix cement or how to mortar a wall. Our society does.

As social structures crumble around us, who can help rebuild them? The congregation can—the community's congregation. It is the eight strengths Gunderson describes. It seems that everyone today—government agencies, non-profit agencies, 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 Gunderson adds that the "humble-scale congregation is life 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 converse, 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 binding 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-church, "the committee meeting, the most despised tool for change we have" (p. 61), and the high-tech, "the use of the Internet" created 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 Faith & Health Program; discussion groups; and organizational link options. This book is a window into the Internet, chat rooms, and computers are recommended side-by-side with talking over coffee, keeping a Rolodex of names, 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 matters in a world where the root cause of violence is "rooted in tribalism—the reflex to fear those who are different, to defend an 'us' and smaller circle of people" (p.43). That means, of course, that many congregations are shaped by racism, sexism, homophobia, or classism need to be reformed across the boundaries of difference. Otherwise, the very power of the congregation to converse, 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 such a subject, as well as the kind of hope that starts deep in the problems and well up to the heart and turns 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. @

MORE HEALTH NOTES


They're all right about two ingredients: rice and red meat. Rice is a complex carbohydrate that boasts all eight essential amino acids, the building blocks of proteins that the muscles need. 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 Magazi

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 for 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. —Newweek

DO UNTO OTHERS ... Studies show that helping others helps those with illnesses. From 3,296 patients who had been in volunteer organizations nationwide, specific health benefits were reported from helping others. Among them: reduced stress, relief from headache, backaches, pain and stomach aches. They also experienced fewer symptoms of chronic diseases such as asthma and arthritis. Many also reported that eating and sleeping habits improved. —Finesse Magazine
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.