Partnerships Between Public Health Agencies and Faith Communities

See also Morabia, p. 341; and *AJPH* Faith-Based Organizations section, pp. 361–386.

The special section of this issue of *AJPH* (pp. 361–386) highlights the wide range of existing and potential partnerships between public health agencies and faith communities across domains of public health practice and religious traditions. The work of religious institutions serves as a determinant of population health in a key way by providing social capital to individuals and communities. Despite longstanding historic distrust and skepticism (in both directions) between people and institutions associated with the respective faith-based and public health sectors, partnerships have arisen in which the interests of both are aligned for the health of their communities.

Partnerships between the faith-based and public health sectors are not new: they are longstanding and extend back many decades.[1] These multifaceted partnerships have been largely overlooked, however, in the wave of individual-level, etiologically focused research on religion and health that has emerged over the past three decades. In this special section, we turn from a focus on individuals to a focus on organizations.

This special section stresses the perspective that religion is a social determinant of population health because it operates through the work of social institutions.[2] That is, religious congregations and faith-based organizations are players in their communities; they present a visible, public face to their communities by providing leadership and capacity for service to others. These social capital assets are of special value in communities of color and of poverty and elsewhere that social and economic resources are in short supply.

The goal of this special section is to have participants with firsthand knowledge of such partnerships highlight the effectiveness of partnerships between faith-based organizations and public health agencies throughout the United States and globally. Authors describe the formation of a respective partnership, its key players, and the context from which it arose; the development of its working structure and organization; the range of public health needs addressed; the results of research or evaluation projects; conflicts that have arisen and how they were handled; lessons learned from both positive and negative experiences; proposed best practices; and distinctive contributions that each partner brought to the relationship. All articles were peer reviewed. National leaders in public health have written accompanying editorials.

There is historical context for such partnerships. One example is the British National Health Service's post-World War II collaboration with the Anglican Sisters of St. John the Divine to provide maternity care to London's impoverished East End; the *Call the Midwife* series on public television was inspired by one National Health Service midwife's memoir. The earliest US denomination-wide, congregational health education program was the Health and Human Services Project of the General Baptist State Convention of North Carolina, which was established in 1978. It evolved from earlier work by University of North Carolina professor John Hatch, a community organizer with the Tufts-Delta Health Center in Mound Bayou, Mississippi,[3] and from Granger Westberg's ideas about mobilizing church and community resources to serve as patient advocates.[4]

In 1989, the Carter Center held an interfaith meeting of hundreds of congregations to address health disparities; from this meeting emerged the Interfaith Health Program, which is now at Emory University.[5] This work has since been adapted by programs in medically underserved communities, the most influential being the Congregational Health Network, in Memphis, Tennessee, which was founded in 2004.[6] The Congregational Health Network drew on the expertise of Gary Gunderson, who built on earlier successes, including the North Carolina Churches Project and the African Religious Health Assets Program,[7] to establish a grassroots partnership network that honored the autonomy of communities in identifying how best to meet their health needs. Both this program and the North Carolina Churches Project were influenced by faith-based public health activism during apartheid era South Africa; this was led by a group of South African expats who later relocated to the University of North Carolina School of Public Health, including Sidney Kark, John Cassel, and Guy Steuart.

Today in public health it is widely recognized that the social, economic, and political conditions of inequality strongly shape population health. Accordingly, an important route to reducing population health disparities is to reduce poverty and social inequality by empowering people, communities, and their central institutions. Faith-based organizations

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and religious groups both have strong traditions of working for social justice and against inequality, including that stemming from religious discrimination.

Some consistent best practices can be identified throughout this work and elsewhere[7]:

- Taking a ground-up approach to empower stakeholders in the community to take the lead in defining existing strengths and identifying community needs; prioritizing listening and restraining top-down approaches.
- Respecting domain expertise and working together to meet stakeholder-identified needs and address population health disparities.
- Acknowledging faith-based leaders as allies and change agents (not adversaries or obstacles) who can represent and shepherd their communities to make positive health-related changes, alongside their own faith-related goals and ends.
- Recognizing that sometimes ideological differences will be present; these should be acknowledged but should not constitute barriers to finding common goals elsewhere and discerning where partnerships will be most productive.
- Nurturing and maintaining long-term partnerships and networks so that they can be called on when crises arise and trusted partners are needed.

We recognize that some observers in both communities may be skeptical about the utility of such partnerships or will call to mind undeniable examples of stances taken by some religious groups that often seem harmful to public health, such as refusing vaccines or limiting women's reproductive health care. With this special section, we provide examples, perhaps less publicized, that show the history and potential of collaboration between public health and faith-based organizations. Professionals in these two domains have a deep understanding of the nature and power of organizations and how to get things done on a large scale when the actors share common commitments and responsibilities and participate together across sectors. AJPH

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CONFLICTS OF INTEREST

No conflicts of interest.

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Radiotherapy and Thyroid Cancer in the 1970s: Controlling a Media Snowball

See also Bavli and Shvarts, p. 398.

In 1973, Michael Reese Hospital in Chicago, Illinois, mailed letters to select former patients urging them to be evaluated for thyroid cancer. Like many other hospitals, Michael Reese had used radiation treatment for a variety of benign conditions, often in the tonsil-nasopharyngeal region, until it fell out of fashion in the 1960s. One of the late effects of these interventions was thyroid cancer. When a hospital worker found records of patients who had received such radiation treatment, hospital officials wrote to warn them of the risk, to urge them to see a physician, and to ask forgiveness.

In this issue of *AJPH,* Bavli and Shvarts (p. 398) show that when the media got hold of this alarming announcement, things began to snowball. The deluge of reporting, the political heat, and the anxiety generated by the news in countless former patients and their families and loved ones eventually prompted federal agencies, including the US Food and Drug Administration and the National Cancer Institute (NCI), to act. In 1977, for example, the NCI launched a national education program, beginning with practical advice to physicians concerning detection, diagnosis, treatment, and follow-up, trailed later by a public education program urging Americans at increased risk for developing irradiation-related thyroid cancer to be examined by a physician.

Bavli and Shvarts suggest that this media reporting had two other effects. It helped to identify hitherto unknown individuals at risk, because many former patients came forward in response to news of the danger, and other hospitals were prompted to look at their past

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