THE ROLE OF FAITH-BASED ORGANIZING IN HEALTH CARE

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Abstract

This paper seeks to explore the cross-section of religion and public health. First, I explore the way in which certain religious principles correlate with some moral and philosophical reasons promoting public health. Here, I seek to answer whether or not a case can be made for social justice in global health. I specifically look at the ideas proposed by Norman Daniels and responses to those ideas by other public health theorists. In the second part of the paper, I explore the role that religious and faith-based partnerships can play in the delivery of health care (specifically in underserved rural and urban areas). Here, I argue that religious and faith-based grassroots organizations are: (1) the most prevalent, well connected, and efficient grassroots organizations in underserved areas; (2) have the infrastructure in place for the government to use for health care delivery; (3) are excellent avenues, to advocate for certain preventative health measures. I also present a case study that further illuminates the idea of health care delivery through religious and faith-based organizations. The case explores the story of a faith-based initiative in Bronx that targeted HIV/AIDS prevention. This outreach in Bronx presents two different uses of faith-based organizations: using already-present grassroots infrastructure for health care delivery, but also for preventative health education. Ultimately, this paper seeks to promote the idea of governments and health care practitioners delivering health care – and initiating conversations regarding health – through the infrastructure in place by religious and faith-based organizations.

Keywords: Religious grassroots, public health, organizing

Introduction

Scholars of health care often study the intersection of public health and social justice – the ethics of health care delivery, quality, and accessibility. An important topic in this arena is health care ethics and addressing different inequities and inequalities in the quality and access of health care: disparities, for example, between different social, racial, and age groups. Having studied the realities of health care inequalities today, for students to then ask the question of how to solve such inequalities is only natural. What are the mechanisms by which we can make health care equally accessible for all peoples? How can we work toward developing quality health care for everyone who needs it? However, before simply exploring what we can do, another question arises: what are the moral underpinnings of *why* we should do something. In that sense, before figuring out what one needs to do to repair the flaws of health care accessibility and outcomes, one must understand the moral implications of public health. Before one can act, one must feel compelled to act. One such driver of morals for many people is religion and faith. The case can be made that faith-based values and religious communities can be used as a springboard to effect change in the realm of global health.

This paper seeks to explore the cross-section of religion and public health. I look at two specific facets of this cross-section. First, I briefly explore the way in which certain

religious principles correlate with some moral and philosophical reasons promoting public health. Here, I look at sources seeking to answer whether or not a case can be made for social justice in global health. I specifically look at the ideas proposed by Norman Daniels and responses to those ideas by other public health theorists. In the second part of this paper, I explore the role that religious and faith-based partnerships can play in the delivery of health care (specifically in underserved rural and urban areas). My argument here is that religious and faith-based grassroots organizations are: (1) the most prevalent, well connected, and efficient grassroots organizations in underserved areas; (2) have the infrastructure in place for the government to use for health care delivery; (3) are excellent avenues, to advocate for certain preventative health measures. Aside from using readings that have covered this topic, I also present a case study that further illuminates the idea of health care delivery through religious and faith-based organizations. The case explores the story of a faith-based initiative in Bronx that targeted HIV/AIDS prevention. This outreach in Bronx presents two different uses of faith-based organizations: using already-present grassroots infrastructure for health care delivery, but also for preventative health education. Ultimately, this paper seeks to promote the idea of governments and health care practitioners delivering health care – and initiating conversations regarding health – through the infrastructure in place by religious and faith-based organizations.

I.
The Morals: How Religion Advocates for Just Health

Before delving into the question of how religious communities can effect change in the realm of public health, it would first be helpful to see what religious *values* have to say about global health care ethics. For lack of space – and for clarity's sake – I will only focus on Christian theology. The case studies that I will explore later in this paper are rooted in church movements and most literature on domestic faith-based organizations in the realm of health care delivery is concerned with studying Christian grassroots organizations.

In terms of seeing how religious values line up with arguments in place for global health care ethics, it is also important to review some of the ideas of modern-day philosophers and bioethicists like Norman Daniels. Specifically, it is imperative to see how people have responded to Daniels idea of "justice in health." Simply put, Daniels finds that health care is morally important as it has an impact on opportunity:

The central moral importance, for purposes of justice, of preventing and treating disease and disability with effective health care services (constructed broadly to include public health and environmental measures, as well as personal medical services) derives from the way in which protecting normal functioning contributes to protecting opportunity. Specifically, by keeping people close to normal functioning, health care preserves for people the ability to participate in the political, social, and economic life of their society. It sustains them as fully participating citizens – normal collaborators and competitors – in all spheres of social life (Daniels, 2).[114]

If we boil this down, we can see that Daniels presents health care ethics as a case for social harmony; it is a point of view that stresses community strengthening. He justifies the necessity for "preventing and treating disease and disability [amongst individuals] with effective health care services" because of the effects that those individuals will have on their society. Calling it a "return on investment" style of ethics would be a gross exaggeration, because Daniels does not give any us any means to measure what individuals will have a *greater* return on investment – he does not judge the potential of each member of the

[114] Daniels, Norman. "Justice, Health, and Health Care." *The American Journal of Bioethics*, Vol. 1 #2. Spring 2001.

community but rather finds it morally essential that each member have an equal opportunity to contribute. It is also important to note that Daniel's moral basis for just health is, for the most part, cabined to a domestic level.

Others have responded to Daniels, specifically taking up his charge to propose a moral basis for *global* health ethics. While the aforementioned passage from Daniels' piece gives a *reason* for why health care should be delivered to all peoples, it does not give a *means* of application. Two impeding factors, according to Daniels, impede communities from delivering and promoting health care globally. Nations must, as Gorik Ooms and Rachel Hammonds write, navigate the middle ground between Scylla and Charybdis – nationwide health care ethics and global health care ethics:

> We agree with his call to resist "the pull of cosmopolitan intuition" since, as he argues, too much focus on global responsibility, without a strong affirmation of the primacy of national responsibility could erode the latter. We also agree that the global institution necessary to govern the relationship between national and global responsibility is lacking, and we argue that this deficiency should provide sufficient impetus to create such an institution (Ooms and Hammonds, 30).[115]

Ooms and Hammonds boil down Daniels argument to show that he has two main concerns with global health care ethics: (1) a focus on *globalized* health care ethics may potentially erode the integrity and stability of national health care, and (2) there is no institution that is in place to regulate and/or equally and efficiently distribute health care. For purposes of this paper, the second concern is of more importance. To the first, one can contend that efficient regulation and sustained economic incentives can maintain both national and global health care programs. However, this notion of a "global institution" is the more imperative. Daniels contends that the development of such an institution poses itself as the greatest challenge of global health care (Daniels, 354).[116] Here, Ooms and Hammonds also respond, disagreeing with Daniels "rejection of international human rights law as a potential compass" for global health care (Ooms and Hammonds, 30). To them, the development of a global infrastructure to regulate and/or equally and efficiently deliver health care is not only feasible – economically, politically, etc. – but also an essential element to global health care ethics. For now, let us table this idea – that of an "international human rights law" or international infrastructure to aid global health care – and return again to the aforementioned quote from Daniels article on the moral basis for just health.

In returning to Daniels' moral basis for just health, we can see parallels between religious teachings and Daniels' idea of individual opportunity adding to the potential for community cohesion and advancement. The case has been made in papers and research for years that there is a relationship between religion and medicine. In many ways, religion, science, and medicine have had a co-dependence of sorts, each discipline influencing the other. The growing trend of "spiritual but not religious" has revived the role of spirituality in conjunction with allopathic medicine; yoga, ayurvedah, homeopathy, prayer – these are a few examples of where religion and spirituality has again become prevalent in the realm of medicine (Rosner, 1811).[117] How does this, then, relate to Daniels idea of just health? What does religion and spirituality have anything to do with preventing diseases and disabilities amongst individuals to promote community cohesion and development? Daniels' notion of just health can fall into the larger umbrella of certain religious values; in many ways *all*

[115] Ooms, Gorik and Rachel Hammonds. "Taking Up Daniels' Challenge: The Case for Global Health Justice." *Health and Human Rights*, Vol. 12 #1. 2010.
[116] Daniels, Norman. *Just Health: Meeting Health Needs Fairly*. Cambridge University Press, 2007.
[117] Rosner, Fred. "Religion and Medicine." *Arch Intern Med*, Vol. 161 #15. 2001.

religions are in place to promote social harmony. If not explicitly community development, religions at large do stress – in stereotypical terms – "to treat others as you would have them treat you." In that sense, just health can be a component of this Golden Rule; a religious person would hope to be helped if they needed help as much as they are expected to help others if others are in need.

As the question of just health is viewed as an ethical one, it is important to understand that as Kant or Rawls can be used to provide ethical guidance, so to can historically religious teachings. Indeed, religion can be simplified as a moral compass for believers. If this compass is used in the realm of health care, what do we find? Often, headlines are populated with religion *countering* health care – prohibitions on treatment, lifestyle, etc. However, beyond the negative impacts that religion may potentially have on one's health, there is definitely a role that religion plays in being a source of energy and motivation for both health care providers and recipients alike, especially in instances where health care has the potential to come up short (Pera and Van Tonder, 176).[118] The entire concept of clinical chaplaincy has developed, in some part, from works such as *Pastoral Care* by Pope Gregory the Great, the writings of theologian and medicine Avicenna, etc. Simply put, religion has a fundamental role in shaping the way peoples, historically, have come to view medicine and health care:

> "The whole redemption is a work of healing; therefore the whole of theology, but particularly of moral theology, has an essential therapeutic dimension. Christ the Savior is also the Healer. He came to heal the individual person in his or her relationships, but he also proclaimed an all-embracing kingdom and therefore a healthful world to live in. Christians are, in Christ, healers. They have a mission to heal themselves, to heal each other and to join hands to create a healthier world (Pellegrino and Thomasma, 39)."[119]

Here we can see a concept where the entirety of Christian theology is seen as being one with a predominantly "therapeutic dimension." In essence then, Pellegrino and Thomasma have found the Christian religion as one that has a moral compass that inadvertently directs its followers to "heal" those around them. Does this strictly to mean heal someone physically? Absolutely not – but as bioethicists, it would make sense that people like Pellegrino find a health-based dimension in Christian theology. Further interesting is when we take a deeper look into Christian history, there are multiple instances where Jesus "healed" people – physically – and helped them to reintegrate themselves into a society that had counted them out (i.e., leper, deceased person, the hungry, etc.). So through physical, health-based, medical-like healing, Jesus was able to provide members of a society with opportunity. In some ways, Pellegrino and Thomasma touch upon this; while Jesus "came to heal the individual person" there is still an "all-embracing kingdom" that he stressed that they could be a part of. How does this fit into Daniels' idea of a community-based moral principle advocating just health? Does Daniels thoughts not also parallel this interpretation presented by Pellegrino and Thomasma? Indeed, Daniels' moral basis stresses the same ideals, except the wordage is obviously far more secular without the religious undertones. But to both moral bases presented here – that proposed by Daniels and that proposed by Pellegrino and Thomasma – there is a constant: healing individuals is beneficial to society at large.

At this point, we can accept the premise then that both groups of people – those similar to Daniels, Ooms, and Hammonds and those similar to Pellegrino and Thomasma – have found a *reason* for just health. Whatever be the impetus behind those reasons, religious

[118] Pera, S. A. and Susara Van Tonder. *Ethics in Health Care*. Juta, Limited. 2011.
[119] Pellegrino, Edmund D. and David C. Thomasma quoting Bernard Häring in *Helping and Healing: Religious Commitment in Health Care*. Georgetown University Press. 1997.

or humanist, we move on having a sound moral basis for just health. In healing members of the community in an equitable way, we can more fully realize the potential of our communities. The question now returns to where we left off earlier: how do put these morals into action? How do we answer a call for social justice in public health?

Daniels questioned the development of international infrastructure to regulate and/or equally and efficiently distribute health care. Ooms and Hammonds disagreed with this questioning, claiming that international human rights law could be a starting point to developing a global entity that would make it easier to respond to global health care challenges. What many people forget is that there is already an incredibly intricate, active, and large infrastructure in place – both domestically and globally – that has the power to effect change in the realm of health care: that of faith-based organizations. Simply put, social movements led by religious peoples and groups (faith-based organizations, religious grassroots movements, neighborhood partnerships, etc.) are effective in many places all over the world with the infrastructure and networking already in place. Often times, these movements lack the funds or credibility to actually be effective in the field of public and community health. However, if ethicists like Daniels found a way to reconcile their just health theories with the reality of faith-based infrastructure already present in the field, a lot of questions of *how* could be potentially answered.

The Application: How Faith-based Organizations Can Play a Role in Just Health

In turning to faith-based organizations, I would again like to reflect on the three key points I brought up at the beginning of this essay. Faith-based organizations are: (1) the most prevalent, well connected, and efficient grassroots organizations in underserved areas; (2) have the infrastructure in place for the government to use for health care delivery; (3) are excellent avenues, alongside schools, to advocate for certain preventative health measures. Also, it is worth once again pointing out the fact that certain moral bases for advocating just health can be found in religious theory. As an aid, I also use two examples of faith-based organizations to support the idea that they can both actively and preemptively promote health within their communities.

Income inequality, historical inequity, and racial divides have led to extremely predictable community layouts in predominantly black and poor neighborhoods in America. One such reality that is often reflected upon by social theorists is the number of liquor stores that can be found in low-income neighborhoods. Liquor stores are more commonly found in low-income neighborhoods than in affluent ones. While this is a predominantly economic-based divide, it is worth considering that historical and institutional racism has resulted in more poor black Americans than White Americans. This may come as a surprise: why would poor people waste their money on alcohol? The answers are fairly straightforward. Zoning laws and taxes in poorer neighborhoods are simpler to deal with and liquor stores have an easier time buying property in these areas (Wilson, 72).[120] Another reason that cannot be ignored is that liquor stores in poorer neighborhoods make a lot business – historically, it is *poorer*, and often times black, Americans who are the top consumers of alcohol:

> Psychology suggests that drinking often goes beyond the need to have a good time. Alcohol is often used as a therapy of sorts, or more accurately, a temporary solution that will eventually cause more problems than it solves. Who is more likely to drink than someone who has a lot of problems they'd like to forget if momentarily (Wilson, 72).

[120] Wilson, Byron. *44 Questions for Black America*. iUniverse, Inc. 2005.

Here one can see the connection between social frustrations and drug abuse. In societies where work is difficult to come by, money is scarce, and education is weak, substance abuse is heavily common since alternatives are limited. If we accept this premise – that socioeconomic shortages cause people to turn to *anything* else (sadly, usually drugs), than I would like to suggest another point. This same reason that many people abuse drugs (frustrations with work, families, etc.) is the same reason why many people turn to religion. The numbers prove this idea.

In a study comparing Chicago's "black poor ghettoes" to those in other cities, it was found that within Chicago, the number of churches was more than three times that of pharmacies, twice that of childcare centers, and thirty times the number of banks.[121] In other ghettoes outside Chicago, the numbers of church prevalence were higher. Small organizations, like churches, can be found in these sorts of neighborhoods not only because rent is low, but also because of the same aforementioned reasons that people turn to drugs. It is, in Marxist terms, an opiate of different sorts – a means for people to escape the harsh realities of living life poor. But unlike liquor stores, churches – not simply as places to find spiritually fulfillment – provide much more:

> … many poor neighborhoods, despite being poor, have a high density of (literally) low-rent businesses. That's why they're there, because the rent is low. And while they're low rent [sic], they do provide basic goods, employ people, establish social connections, generate taxes, and generally provide both foundation and circulation within the neighborhood (Moser, no page).

In essence, this supports my initial point that faith-based organizations are, at once, both the most commonly found and most well connected groups in underserved and poor communities. Simply put, with nothing else to turn to – no jobs, broken families, etc. – many people in historically poor communities either turn to drugs or religion. The beauty of faith-based organizations is that they have the power to (like Daniels stressed) help people realize their fullest potential and help to contribute to their community. There is an element of service and redemption found in the work of faith-based organizations, and it is this element that can and should be tapped by government health care providers. As mentioned earlier in this paper, these small-scale organizations are those that have the most efficient and effective infrastructures in place in underserved communities.[122] Another interesting point to note is that *internationally*, Christians, Muslims, Hindus, etc. can unite with their religious communities to effect change in the realm of public health care.[123] If governments were to divorce themselves from conversations on theology and exclusively deal with faith-based organizations from a sectarian standpoint, much of the just health theories covered earlier in this paper could be put into action.

A whole different benefit of partnering with faith-based organizations is that both domestically and globally, they give health care providers much-needed cultural competency.

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[121] Moser, Whet. "Chicago's Poor Neighborhoods: Everything Deserts" in *Chicago Magazine*. 26 September 2012.

[122] Rowland, Michael and Lolita Chappel-Aiken. "Faith-Based Partnerships Promoting Health." *New Directions for Adult and Continuing Education*, Vol. 2012 #133. Spring 2012. pg. 25.

[123] Of course, there are several minorities within these religious groups. Howeveen then, sectarian groups can unite with themselves or work can be done to supersede those sectarian differences. It is also worth considering how in a growingly pluralistic America, there is a greater interest in inter and intra faith movements, so overcoming sectarian divides to solve public health issues seems to be feasible. For further reading, please consult the introduction of the article "Finding common ground: the boundaries and interconnections between faith-based organisations [sic] and mental health services" by Gerard Leavey, Gloria Dura-Vila, and Michael King in *Mental Health, Religion & Culture*, Vol. 15, No. 4, published April 2012.

Many cultural components of people can be found in their religious practice: languages, beliefs, customs, mannerisms, social structures, etc. To be sensitive to these cultural nuances can be of great benefit to health care providers solely on the basis of the fact that it will give them more credibility when they challenge community members to change their lifestyle habits (practice safe sex, eat healthy, cut smoking, etc.). Faith-based organizations can be especially useful domestically in immigrant communities where language and cultural barriers prevent the dissemination of information regarding health care. For example, in tackling the stigma of HIV/AIDS in immigrant communities, partnering with faith-based organizations can lead to fostering communities of support and prevention as opposed to those of judgment and ignorance:

> Recent studies have underscored the potential role immigrant churches in HIV prevention and care initiatives, given their visibility and authority within ethnic and mainstream communities … The religious and cultural norms that often alienate groups living with or perceived to be at risk for HIV from the church may concurrently guide engagement with these very same groups … (Kang, et al., 270).[124]

This role – of shaping community members' perceptions on certain health related issues – may be the single most important aspect of partnering with faith-based organizations. Through them, health care professionals and providers can disseminate information more efficiently and engage communities in essential health related topics. Obviously, government mandated health care education is effective, but the likelihood of people skipping commercials on TV or ignoring emails is higher than that of them ignoring sermons and programs at their places of worship. In that sense, faith-based organizations offer an incredible opportunity to be a springboard for conversation and preventative medicine. Even today, over fifty percent of health programs offered through faith-based organizations are focused on primary prevention.[125] However, the key to making these programs even more effective is having the government pour funding and resources into them. The problem is not in a lack of infrastructure or reach, but rather in an allocation of resources; instead of government mandated health programs that deal with bureaucracy more than they deal with people – it makes sense to help organizations that have actual influence.

Case Study: REACHing out in the Bronx[126]

In the tail end of 2008, the Centers for Disease and Control Prevention initiated a coalition in Bronx as part of their Racial and Ethnic Approaches to Community Health (REACH) program. This initiative, led by the Institute for Family Health, specifically focused in the Southwest Bronx, this program targeted almost 280,000 people, of whom more than 41% lived below the poverty line and 95% were Black and Latino. Sixteen percent – compared with 9% in the rest of New York City – were diagnosed with diabetes.

The program had a rigorous faith-based component, seeking to engage the greatest number of people it could. Partnering up with seventeen different churches of various denominations – from Baptist to Seventh Day Adventist to Catholic – and of various sizes – the congregations ranged from twenty to a thousand members. Each church received $3,000 a

[124] Kang, Ezer, John Chin, and Elana Behar. "Faith-Based HIV Care and Prevention in Chinese Immigrant Communities: Rhetoric or Reality?" *Journal of Psychology and Theology*, Vol. 39 #3. 2011.

[125] DeHaven, Mark, Irby Hunter, and Jarret Berry. "Health Programs in Faith-Based Organizations: Are They Effective?" *American Journal of Public Health*, Vol. 94 #6. 2004.

[126] Kaplan, Sue, Charmaine Ruddock and Neil Calman. "Stirring up the Mud: Using a Community-Based Participatory Approach to Address Health Disparities through a Faith-Based Initiative." *Journal of Health Care for the Poor and Underserved*, Vol. 20 #4. 2009 (all information in the following section is from this article).

year to aid in the health programs. The program had two key goals in working with faith-based organizations:

> (1) To use the capacity and resources of local faith-based institutions to change the knowledge, attitudes, and behavior of community members concerning health promotion, disease self-management, and navigation of the health care system; and (2) to mobilize clergy and church members to seek changes in law, regulation, and policy to promote equal access to care (Kaplan et al., 1112).

Ultimately, the goal of this program was not necessarily to deliver tangible health care resources (while that was done too) but *rather* to change perceptions and raise awareness of diabetes and other illnesses before more and more people were afflicted by it. A specific means of raising health care awareness was in the printed literature that the coalition supplied to the churches, which the coalition expected to be distributed at services. Furthermore, clergymen – specifically the senior pastors in the congregations – delivered information from the pulpit regarding not just health care awareness but also food for thought on racial inequalities in the health care system at large. The ultimate goal here was to excite the congregation members to take charge and demand social justice in public health.

Midway through the program, a focus group to evaluate the program thus far was established, consisting of church members and pastor leaders. Through these evaluations, certain strengths and weaknesses of the initiative came to light. The first goal of the coalition was successful; specifically, the pastor's role in making changing congregational perspectives on health was essential. Many participants found that the connection of the health message to the spiritual message was especially fulfilling – stressing that good health was a means to a greater end than simply surviving. Consensus found that the second goal of the partnership was equally successful. Awareness was raised about systemic and intuitional racism and discrimination and the avenues to take in dealing with it. What participants particularly lauded was the setting: church was an extremely comfortable place to have conversations on inequality and it was easier asking questions without fear of judgment or misinformation.

However, while the two goals were met, participants recognized huge room for improvement. Of note were three particular concerns: (1) pastoral engagement and education, (2) dealing with bi-cultural and bi-lingual communities, and (3) sustaining the program. In terms of the first difficulty, the coalition leaders found that efficiency could be increased if pastoral education and engagement happened collectively, so that there was no discrepancy in leadership. Instead, pastors worked with the coalition leaders individually, resulting in some pastors feeling more prepared and engaged – and appearing as such – than others. Furthermore, while the coalition had taken the step of targeting Spanish-speaking churches, they had not fully translated all their written materials, and even in those that were translated, intra-lingual differences posed problems.[127] The "cultural" difficulties accounted for dietary preferences – tailoring dietary literature and food pyramids with foods those communities could recognize easier.

Finally, the third difficulty that the evaluation preempted was in finding ways to sustain the program. Luckily, many of the pastors had implemented the health programs into their own church budgets, the institutionalization a result of the programs' length and flexibility. However, carrying the program on further required money. Funding for grassroots programs is already scarce, but perhaps adding faith-based organizations into the mix makes potential donors – and specifically, the government – hesitant in becoming to heavily

[127] For example, the Mexican-Spanish word for orange is *naranja*, while in Peurto Rican-Spanish, it is *china* which means a *Chinese woman* in Mexican-Spanish.

involved. While there may be fear in becoming overly meddled with religious groups, there seems to be more to gain from working with faith-based organizations as demonstrated in this case. Promoting health, not proselytizing religion, is the goal here.

Conclusion

Moving Forward: Where to Go From Here?

In this paper, I focused on two essential components of faith-based organizing: the impetus for action and the action itself. I briefly explored theories of just health proposed by the likes of ethicists like Norman Daniels, Gorik Ooms, and Rachel Hammonds and put that in conversation with religious sentiments illustrated by bioethecists like Edmund Pellegrino and David C. Thomasma Here we found that much of the conversation on the moral basis for just health is to be found on both sides of the isle: both religious and non-religious people can share the same reason to promote just health. I found that this reason is rooted in the notion that helping individuals can result in a more cohesive society with a greater chance to realize its fullest potential. It is a mutually beneficial social health care model.

In the second half of the paper, I explore the action – with the moral compass set, how can navigate to a more just society in terms of health equality and equity? Here I suggested that faith-based organizations pose the greatest potential for grassroots work for the following three reasons: (1) they are the most prevalent, well connected, and efficient grassroots organizations in underserved areas; (2) they have the infrastructure in place for the government to use for health care delivery; (3) they are excellent avenues, to advocate for certain preventative health measures. I then explored a case study from Southern Bronx in which the CDC partnered with community health leaders to initiate a coalition with several churches in the area to raise awareness of both health related issues – such as diet, disease prevention, etc. – but also of issues dealing with inequality and systemic discrimination in the realm of public health.

As a theology student aspiring toward a career in public health, I already recognize the tremendous power of faith-based solutions to respond to our biggest health care challenges and to improve the delivery and outcomes of health care, especially in our highest-risk, most-vulnerable communities. We *do* need a more empirical and sophisticated understanding of how these models of delivery actually work, how effective they are, and how they can be improved and scaled. But ultimately, faith-based organizations present an in-place infrastructure that the government and health care providers can tap to effect change at the grassroots level. While the partnerships have begun, they are still in their early stages of development. Nevertheless, this is an interesting prospect to study and an especially exciting one to advocate for.

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