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Interview with Barbara Baylor

Angela Monahan[1] and Jessie Washington[2]

Editors' Note: We are pleased to present the sixth in PHRS Bulletin's series of featured interviews with influential contributors who have shaped the field of public health, religion, and spirituality.

We present an interview with Barbara Baylor, MPH, current Chair of the American Public Health Association's Caucus on Public Health and Faith Community and former Minister for Health Care Justice at the United Church of Christ's National Settings, Cleveland, OH. Mrs. Baylor was interviewed for the PHRS Bulletin by graduate student Jessie Washington of Emory University, working in conjunction with Angela Monahan, an ASPPH/CDC fellow at the Department of Human and Health Services and a co-editor of the PHRS Bulletin.

Angela Monahan: You've had a long career in many aspects of public health. A substantial portion of that work has involved faith communities. How did you become involved in work that connects public health with faith communities? What do you see as the relationship between public health and faith communities?

Barbara Baylor: In 1980 I stumbled on the field of public health as I was trying to decide what master program would complement my BA in Sociology – at the time I was considering a Master of Social Work (MSW). I was given the opportunity to interview for the Assistant to the Director position of a new community church-based health promotion program by Mr. Curtis Jackson, a Health Administrator in the Gillings School of Global Public Health, UNC-CH and the Director of the Health and Human Services (HHS) Program, General Baptist State Convention, Raleigh, NC. Mr. Jackson was looking for someone who had a public health/health education degree and experience. I had no idea what a "health educator" was but in my mind, I thought that it was someone who could train and educate about health. I did not know or have any understanding about public health or health education. But, I still felt that I could do the job because after all, it sounded like Social Work and my degree in Sociology seemed to prepare me for this. I got hired and it fueled my interest so much that later I pursued an MPH in Health Behavior and Health Education from the Gillings School of Global Public Health, University of North Carolina at Chapel Hill. While working with the HHS Program also met Dr. John W. Hatch, a professor at Gillings School of Global Public Health, who was instrumental in leading the movement for health promotion programs in churches, particularly African-American churches. Hatch later became my academic advisor while I was a student in the Department of Health Behavior and Health Education at UNC-Chapel Hill. He shared riveting stories with me of his work in public health and always told me to publish. I also met Mrs. Ethel Jackson, a health education specialist who had worked at Duke University alongside Dr. Eva Salber and her early work in community education using lay advisors [3] and later as a Clinical Assistant Professor in the Department of Health Behavior and Health Education in the Gillings School of Global Public Health, UNC Chapel Hill. Ethel, an innovator of the lay health advisor concept helped to mentor and further

Barbara Baylor

guide me as I introduced this concept within the denomination of the United Church of Christ and subsequently developed our Denomination's first lay-health advisory program called "Healthy Connectors".

All three of these persons were instrumental in shaping my thoughts and experiences in public health and understanding the value and importance of faith-health partnerships. I have come to embrace the Lay Health Advisor Model[4] as one that promotes capacity building in faith communities, institutionalized and sustains health ministries, and opens doors for further conversations with public health entities. Working on this project has been the single most important event that fueled my passion for public health work.

One of the things I learned during my time at the General Baptist State Convention was the difference between social work and public health and their different approaches. I surmised that Social Work, at that time seemed to operate from a top-down which provides assistance mainly within the confines of a system. Public Health seemed to be more of a bottom-up approach with emphasis on key involvement from the community for solutions. It became clear to me that faith communities, faith leaders, and lay leaders in partnership with health and human service agencies could enhance their effectiveness as key influencers in working to promote public health and health equity. It's not a new practice for churches to engage in health and wholeness work as most faiths have within their sacred teachings references to health, wholeness, and healing, and many local churches, faith organizations and denominations have founded and continue to operate health programs, hospitals, clinics, and major health systems. As my work unfolded, especially with faith communities, I began to see the relationship between public health and faith as a natural partnership, but one that must be developed. The relationship cannot be one-sided. One model that I like to use when talking about faith-health partnerships is found in Communities in Action: Pathways to Health Equity[5] published by the National Academies of Science, Engineering and Medicine. This model depicts the context of structural inequities, socioeconomic and political drivers, and determinants of health, with fostering multi-sectoral collaborations as one of the major themes. Fostering multisectoral collaboration appeals to my sense of how faith communities can be included as vital organizations who can help change health and social policies and implement health programs in diverse communities. As we continue to build faith/health relationships, may I suggest that prior to asking a church for permission to utilize its space for a health program that we want to promote, consider having a deep conversation with the pastor and church leaders about the church's culture, traditions, perceptions, and attitudes. Without this conversation, you may lessen the chances of buy-in and success.

Jessie Washington: For many years, you were involved in health-related leadership activities of the United Church of Christ (UCC), serving as the Program Manager of Healthcare Justice for the UCC National Headquarters in Cleveland, Ohio from 1997 to 2012. In that capacity, you helped provide national leadership and advocacy for efforts, such as the affordable care act. Additionally, you wrote daily, and weekly briefs related to COVID-19 as education and information for UCC local churches, conferences, and members. Can you tell us about all these efforts and some of the things you feel you were able to accomplish? Any highlights or takeaway lessons that should be known and remembered by other public health professionals and students?

Barbara Baylor: The UCC is a mainline Christian denomination, and like many other denominations it does believe that care for the poor is mandated by the gospel and that the promotion of justice and doing justice is a core value. Because of this belief, my role as Minister for Health Care Justice was easier. I was commissioned to help our over 5,000 UCC

congregations across the country understand health and wellness in a holistic way and as issues of economic, environmental, and social justice. My work at the national UCC setting was not always stand-alone. I was part of a greater coalition of health ministers from major denominations and interfaith organizations who, through our collective action, engagement, and advocacy, focused on how we would participate in public life to impact social policies relating to many social justice issues.

While at the UCC, I served as staff liaison to our UCC parish nurses, UCC doctors, mental health ministries, and disabilities ministries. I also worked with the Council on Racial and Ethnic Ministries – designated desks who represented UCC racial and ethnic members: African American, Asian and Pacific Islander, Native American, and Hispanic/Latinx. These designated desks provided a common platform which allowed them to maintain cultural identity, traditions, and history, and share their views, experiences, and concerns on many justice issues. I was able to interact with all these affinity groups and work on policy and programming on many national issues of concern to them which included the Affordable Care Act (ACA), mental health parity, stigma faced by those living with disabilities, and racism in medicine. Because of the disparities within racial and ethnic communities on health care, I was given approval to create a "Health Table" within the Council on Racial and Ethnic Ministries (COREM) to specifically address issues of health disparities and inequities.

My greatest joy was assisting the denomination and its members to understand the issues relating to health care reform and the Affordable Care Act (ACA) and to work feverishly to help pass this law. As a member of a successful national interfaith coalition called Faithful Reform in Health Care, we increased support exponentially across the country for health care reform through faith communities. One of the things that we did in this coalition was to develop a faith-inspired vision for health care reform, which became a national vision. Developing a shared vision is another theme under the Communities for Action: Pathways to Health Equity Model. The vision that we developed continues to be a viable vision today as many faith organizations continue to do the work for a just healthcare system for all. We did a lot of grassroots lobbying and advocacy, wrote tons of educational pamphlets and messaging, and made many visits to the hill to meet with legislators. We once were invited to meet with Nancy Pelosi, and she gave her congratulations to this national faith coalition as an important body that helped to solidify and secure the passage of the ACA.

Much of my work entailed traveling the country participating in meetings and conferences, and speaking to congregations and regional conference offices about the importance of health care reform. Early in the Affordable Care movement, I developed a newsletter called the Healthy Voice which shared information about many diverse issues and offered examples of programs and activities on health care. I developed a training called Healthy Connectors, modeled after the Lay Health Advisor Model, to train trusted lay leaders and congregations around the country. This training was expanded to include other denominations.

On two separate biennial UCC General Synod meetings (the event in which board members, conference delegates, clergy and lay leadership, youth, staff, and administrators come together for worship, education, advocacy, and voting on resolutions for the Denomination), I successfully invited former Surgeon General David Satcher and the late Congressman John Conyers to speak and keynote our health care justice workshop and luncheon. Additionally, I successfully wrote and submitted a resolution supporting single-payer national healthcare reform and included in that we should be adopting the unnatural causes curriculum as a way to help build capacity and the understanding of the broad issues that were related to health and racial disparities. This resolution passed and became part of the policy of the UCC.

As public health and national bodies began to seek ways to better coalesce racial and ethnic ministries within local denominations to discuss racial-ethnic health disparities and inequities in health and health care, I was invited to bring the COREM Health Table to a national meeting organized by Families USA, Washington D.C. to discuss racial and ethnic health disparities and how local churches could partner better and coordinate with one another to find solutions to that ever-looming issue that we continue to work on today.

One of the many things I learned during my employment at the UCC was that not everyone, including local churches, is on board with working on social justice issues or believes the church should be involved in social justice movements. When I was working on health care reform, I was flooded with emails and calls from churches who were not happy that we were even working on that issue and thought that we needed to keep politics separate from religion and faith. This was one thing I had to come to grips with and realize that it's okay if not everyone is on board, but you do the best you can and try to provide the information and education they need so they can make their own decisions that are good for themselves and their church in their particular community. I learned that it takes a concerted, intentional effort to work with congregations and make sure that you are aligning your message with the messages and actions of the church that you're trying to partner with. An important lesson learned is that faith communities are not homogenous bodies – everyone is different and comes from different social, economic, and social backgrounds. In our denomination, and I believe in others as well, there are major gaps between the work at the national offices and the local church. At times we see things at the national level that some local churches in different regions and parts of the country do not see and vice versa. In my work, I found that it could be challenging to get a rural church community to work on and see that health disparities include other issues like food insecurity or transportation – not just racial disparities. Helping our churches broaden their views and understandings of the social determinants of health and how they might consider ways to reduce the negative impact of these social factors in their communities gave me a sense of success.

Another important highlight of my time at the UCC was when COVID emerged and the UCC invited me back to the national setting in 2020 to help our churches understand the issues around COVID. I was able to write different daily briefs – I wrote over 75 – on topics that related to COVID and related issues. For instance, I wrote a brief on why black men do not want to wear a mask[6]. Several people commented on this widespread concern as they did not understand the historic ramifications of black men's faces being covered in our community. Additionally, I was also asked to develop our church's response to health equity. I did this by re-assembling a task force of the UCC affinity groups and members of the Council on Racial and Ethnic Ministries to develop the RED Task Force (Racial, Ethnic Health Disparities Task Force). The mission of the Task Force was to raise awareness and develop consciousness regarding racial and ethnic health disparities, trauma, and inequities by educating, mobilizing and empowering all settings of the UCC to advocate for just public policy and structural change through prophetic witness. I was also asked to co-write a resolution that was passed which responded to the CDC's declaration of racism as a public health crisis.

Angela Monahan: You've provided us with so much knowledge but is there anything you want to add that you think public health professionals, even public health students, should understand about the potentials for religious advocacy and partnerships with the public health community?

Barbara Baylor: When it comes to the church getting involved in the legislative process through advocacy and lobbying, many people believe that the church is not supposed to be getting involved on that level but do believe that faith and religious organizations are called to do charity work and they've always done that very well. I believe it's

important to help the faith community see the long-term value and benefits of policy goals, how and where they fit into the policies, and to grow their awareness and recognition that policy work is needed and is consistent with the charitable work that they're doing. For instance, many churches provide food for those who are hungry. Churches may need help in looking at what policies may contribute to the dilemma and how they might advocate for change, which is as important as feeding those that are hungry.

United Methodist Church Building in Washington, D.C., housing offices of many nonprofit and faith organizations[7]

There is a national event every year in D.C. called Ecumenical Advocacy Days where thousands of people come from all over the country to learn about the importance of grassroots lobbying. During this meeting, participants make appointments to visit their legislators or staffers to talk about social justice concerns from a moral frame. I'd like to note another resource – right next door to the Supreme Court building is the United Methodist Church Building which was built by the Methodist church to look at the issue of alcoholism many years ago. It then became one of the only major spaces in Washington D.C. that houses nonprofits and faith organizations who come from all over the country. Mainline denominations and interfaith faith organizations house their policy offices here. In 2011, the Pew Forum on Religious and Public Life put out a report that said faith-based advocacy and lobbying to influence lawmakers had increased fivefold since the 1970s. Here we are in 2022, so you can just imagine how much more work there is for the faith community's involvement in advocacy activities.

Jessie Washington: Some of your work with UCC involved international teams going to places such as Ghana, South Africa, Micronesia, and the Territory of Puerto Rico to identify and propose community solutions on identified health policy issues. Where did religion fit into the picture? Were different religions and indigenous traditions involved in these discussions? What were the accomplishments of these efforts?

Barbara Baylor: The international work that I was involved in as the Minister for Health Care Justice was one of the most rewarding pieces of work that I was honored to be a part of. I had the privilege of being a member of teams that went to Ghana, West Africa, South Africa, the Vieques Island in Puerto Rico, Centro Romero Center, U.S./Mexico Border in Tijuana, and Micronesia, Marshall Islands related to a number of social justice issues including HIV/AIDS and other health challenges, human rights, economic crisis, poverty, climate change. We found that we had similar faith tenets all over the world and our goal was to work on these issues together. Our goal was always to listen and learn about the social, cultural, and economic conditions that shaped the issues. I remember our motto was "We came to see about you", meaning again that in faith we are listening, learning, and supporting their efforts and assisting where we could. We were there to strengthen the bonds of partnership between us, churches, and global churches. We met with many church communities and political leaders to identify what the role of the church could be in responding to some of these realities. Here is a highlight from my international work as a team member to Micronesia and the Marshall Islands in the late 90s. The U.S. had conducted atomic and thermonuclear weapons testing on that island from 1946 to 1985 and exposed the residents to unexpected radioactivity. We went over there to listen and learn from citizens and elected public officials, but we also witnessed the continued devastation and the physical, mental, social, and spiritual health effects on that island. Listening to the people was so important during this trip because they shared with us that they felt like the

nation, and in particular the United States, was not listening to what they were trying to say about their increased rates of diabetes, the Cholera outbreak, land that had become so denuded so nothing would grow, climate change that was drying up the water, poor drinking water, increasingly high rates of teen pregnancy, and good water supply. When our team returned, the UCC Policy Office decided to set up a meeting with some of the leaders from the Marshall Islands and U.S. senators. Our policy office flew them here so they could get answers from senators, and they could discuss the horrors and devastation of the testing. As a result of that meeting, there was increased funding to address their issues. There was already some funding being mandated since we had recognized some of the devastation, especially around healthcare, but these new funds were over and above. This goes back to the question you asked me earlier about advocacy – this is another way of doing direct advocacy and providing the people that are the victims of poor policies and programs to come and share their stories and have people intentionally listen and ask questions.

Angela Monahan: Can you tell us more about representing UCC with former First Lady Michelle Obama's launch of Let's Move Faith and Communities and anything about Michelle Obama's vision of how faith communities can or should relate to public health?

Barbara Baylor: That was an honor to meet her. Mrs. Obama had always recognized the value of faith-based and community organizations. She was aware that faith communities were an essential partner in solving the problems that lead to childhood obesity. Again, a lot of our churches were already working with children on exercises and meal programs, but she invited different health ministers to be on a team to come to Washington to provide input to the Let's Move Faith and Communities toolkit that she was developing. She wanted us to come talk about what would and wouldn't work in faith communities. I was invited to go to help work on that toolkit and it provided lots of resources and guidance on how faith-based and neighborhood organizations could initiate, expand, and coordinate activities that made the communities places of wellness for kids and families. All of us were tasked to go back to our individual denominations and then work with our local churches to organize programming using the Toolkit. One of the things I organized in 2010 were UCC wellness walks in our local churches. During that year's General Synod, UCC Churches who embraced the Let's Move movement and committed to walking were given walking trackers made available by our Pension Boards. Special workshops that year on different modes of exercising and movement were held, including Tai Chi, Zumba, and Yoga – all in keeping with Mrs. Obama's Let's Move Faith and Communities. It was largely successful and even after the Obamas left the White House, there were churches and individuals still incorporating Let's Move in schools and in the community. That was an honor just to be asked to be a part of that whole Let's Move moment.

Jessie Washington: Regarding the American Public Health Association, you've often served in leadership positions for the Caucus on Public Health and the Faith Community. Currently, you're listed online as the Chair, Governing Council Representative and Membership Chair. How has your experience been in your different roles, and what have been some of your most memorable accomplishments or lessons? Looking forward, what do you envision or wish for the future of the Caucus?

Barbara Baylor: People often ask me why there is a Caucus on Faith in APHA and to give some context, the Caucus was started in 1996. If you think about what was happening in the 1990s, we witnessed the beginning of health care reform and the major policy initiative of Former President Bill Clinton[8]. It was the most contentious major policy initiative that he tackled. During that period, there were more than 35 million Americans without health care and skyrocketing

health costs were making it difficult for employers with health care benefits to continue to provide them. There was also backlash from groups who saw this as a plan to socialize medicine. Additionally, during this time, the AIDS epidemic emerged as a global public health crisis. AIDs had significant implications for treatment, health insurance coverage and hospital costs. The Gulf War Syndrome was coined after veterans had come back from the war with various illnesses. Some of them were denied full disability and pay. Lastly, we also had the continuing fight for safe abortions where we saw increased protests and violent attacks on clinics and health professionals.

Against the backdrop of this context, in 1994, Dr. Caswell Evans, who was the former president of the APHA at that time, had in his platform that APHA needed to establish a Faith Caucus. Subsequently, the Caucus was formed, and we use this platform at APHA as a way of bringing attention to the role that faith can play in the social, economic, and political justice movements by creating and encouraging these meaningful dialogues between public health entities and faith communities. The Caucus continues to espouse the historic work of the faith health movement which began in the 1980s by Dr. Bill Foege, former Executive Director of the Centers for Disease Control and Prevention, who enlisted the assistance from former US President Jimmy Carter to establish the Interfaith Health Program at Emory University. The faith health movement began with the goal of fostering partnerships between faith and public health, with an emphasis on helping faith communities close some of the gaps that keep them from fulfilling their potential to assist in preventing disease and improving health[9].

The Faith Caucus, affiliated with APHA, promotes public health as a science, by facilitating, modeling, and providing a platform during the annual meeting to encourage public health leaders, scientists, faith leaders, and lay leaders, to present their research and data for capacity building models that include education, information, training, and best practices. The Caucus acknowledges that faith and science can and do coexist and should not be in conflict with one another. As Chair of the Caucus, I am committed to working with faith communities and public health leaders to close some of the gaps that were identified by the Interfaith Health Program. Our goal is to help faith communities move beyond charity work towards building and strengthening their capacities to sustain the programs and activities they undertake, continue to provide a platform for faith communities to promote, replicate and apply their knowledge of what works in communities, assist faith communities in framing their programming and activities in science language for written manuscripts and scientific presentations, and to provide educational forums and workshops where diverse faith communities can come together to dialogue, learn from one another, and explore faith strategies. One of the most memorable things for me regarding the Caucus is that every year during the annual APHA meeting, we sponsor an Interfaith Celebration – a safe space for the expression of all faith communities to share their traditions, cultural experiences, stories, reflections, and music. It's a reminder that everyone's personal faith is important to them. The Interfaith Celebration calls for the faith community to speak in one voice on matters of faith and social justice. Also, I'm happy to say that the Caucus is now involved in the global vaccination efforts because we are now a member of the Jerusalem Impact Vaccination Initiative, an international coalition to support faith organizations' preparedness and the implementation of mass COVID-19 vaccinations that is needed globally as a part of the national deployment and vaccine plan. We have also worked collaboratively with the Global Maternal Child Network, an APHA working group, to develop a joint policy statement on support for faith-based engagement and approaches to improve global childhood routine vaccinations in the age of COVID-19 and beyond.

Angela Monahan: Any final thoughts about what public health professionals and students should know and learn going forward about faith, religion, spirituality, and public health? Any final overall summaries?

Barbara Baylor: Allow me to share a story from the sacred texts about the dry bones in the valley (Ezekiel 37) to illustrate lessons for public health students and leaders. The dry bones were the people filled with such despair, no hope, and pain, and they thought that their whole lives would never be the same. Then the bones were spoken to and regained their life. Today, there are persons in our congregations who feel the same way. Faith communities working alongside public health must help to eliminate pain and suffering and to promote a better quality of life for all. If we want to make a difference in the world, bring life to the dry bones, and remove disparities, racism, inequities, and injustices, we need to assist faith communities in advocacy efforts and help them to understand the role of public policy. Make sure you know the language of the faith community that you're working with and use their languages to develop messages that will work for them and other faith communities. We must be reminded though, that faith communities work in their own time and things won't change overnight just because they are working with you. As future public leaders, you must be consistent, transparent, and flexible when working with faith communities; and, for these partnerships to be successful, there have to be some benchmarks set to measure where we are going, how we will get there, and how we will know when we've been successful.

Using the story of the Dry Bones, I've spoken about my vision to many audiences over many years, here is a statement condensing several key themes that have guided and animated my work:

"How do we achieve health equity? By embracing the values that we as faith leaders and health professionals know work! Will these dry bones live? Yes. Our faith encourages us to address our dry bones situations with faith. If we fail to collaborate and communicate with each other to end disparities and inequities, we will continue the legacy of the dry bones. These bones must live so that together we can envision a day when preventable death, illness, injury and disability, health disparities, inequities, racism, and discrimination will be eliminated and that every person will enjoy the best health possible. We must all speak life into our families, communities, places of worship, and each other so that any dry bones around us can be transformed and connected to one another with love, strength, courage, and a determination to live." (B. Baylor)

This interview with Barbara Baylor took place over Zoom on April 22 and May 6, 2022. The transcript has been edited for clarity and brevity.

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[3]^Salber, EJ: Introduction to the health facilitator concept, in Service, C, Salber, EJ (eds): Community Health Education: The Lay Advisor Approach, Durham, NC, Health Care Systems

[4]^Eng, E., Parker, E., & Harlan, C. (1997). *Lay health advisor intervention strategies: A continuum from natural helping to paraprofessional helping. Health Education and Behavior.* 24(4), 413-417. https://doi.org/10.1177/109019819702400402

[5]^National Academies of Sciences, Engineering, and Medicine. (2017). *Communities in Action: Pathways to Health Equity.* *https://nap.nationalacademies.org/catalog/24*

624/communities-in-action-pathways-to-health-equity

[6]^Baylor, Barbara. (2020, June 24). Black Men Fear Wearing a Mask More than Getting COVID-19. *United Church of Christ.* https://www.ucc.org/daily_covid_19_brief_issue_58/

[7]^Image accessed in June 2022 through Wikimedia Commons for United Methodist Church (link, original author Elvert Barnes from Baltimore, MD, CC BY-SA 2.0 license).

[8]^Clinton Digitial Library, National Archives. Health Care Reform Initiative. Retrieved from https://clinton.presidentiallibraries.us/health-reform-initiative

[9]^Starting Point. Empowering Communities to Improve Health. A Manual for Training Health Promoters in Congregational Coalition, 1997. Interfaith Health Program, Carter Center