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This is the second annual bundled issue released by the *PHRS Bulletin* – for more details please see Editors' Introduction: Fall 2021 Issue #5 (or online)

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Editors' Introduction: Spring/Summer 2022 Issue #6

WE are pleased to share with you the sixth mini-issue of the *PHRS Bulletin*. In this issue, we feature an interview with Barbara Baylor, the 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. Through this interview, she reminds us of how faith/health collaboration is crucial for public health activities ranging from impacting health through local and community initiatives to legislative policy change. In our second article, Doug Oman explores the often-ignored dimension of spiritual contributions to smallpox eradication, commonly lauded as one of public health's greatest historical triumphs. He uncovers both familiar and unexpected roles of religious motivation, as recounted in recent memoirs by distinguished public health leaders — Larry Brilliant and William Foege. Finally, in our resources article, we present some of the latest research at the intersection of religion, spirituality, and public health, as well as upcoming conferences and funding opportunities.

We are also very glad to be joined by a new co-editor, Ashley Meehan. Ashley is a graduate of Emory University's Master in Public Health program and this fall will begin doctoral studies at John Hopkins School of Public Health.

We wish you all a wonderful summer and look forward to sharing with you our next mini-issue, currently targeted for publication in late September.

Warmly,

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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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[2]^ Jessie Washington, MBA, MSW, is a third-year doctoral student in the Graduate Division of Religion at Emory University (jewash4@emory.edu).

[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

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[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

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How Religion Motivated Smallpox Eradication

Doug Oman[1]

The PHRS Bulletin publishes a wide range of article, with purposes ranging from education and pedagogy to advocacy to theoretical or historical reflection. In this piece, Doug Oman discusses roles of religion highlighted in two recent memoirs of smallpox eradication leaders, arguing that the public health field needs histories that better address and integrate the role of religious and spiritual factors.

How many of us in public health know that religion performed diverse and perhaps crucial functions in motivating global smallpox eradication, often hailed the greatest public health triumph in history? Religion's roles in smallpox eradication are seldom recounted in public health teaching and discourse, perhaps because previous histories have emphasized technical and managerial strategies, ignoring religion or framing it as an obstacle. But such truncated views of history do not optimally prepare us for a global, multicultural future in which religion remains a powerful force. Happily, as described below, a much wider range of religion's roles in global smallpox eradication – sometimes astonishing – can be gleaned from two complementary and recently published memoirs by smallpox eradication leaders William Foege (2011), later director of the Centers for Disease Control and Prevention, and Larry Brilliant (2016), later the founding director of Google's philanthropic arm, Google.org.

Larry Brilliant (left) and William Foege (right)[2]

It should not cause surprise that religion played important motivational roles in the historic smallpox eradication campaign of the 1960s and 1970s, as religion is among the most powerful human motivators– perhaps most commonly in ways that support health and well-being (Oman & Syme, 2018). Healthy lifestyles, for example, can be motivated by concern for stewarding one's body as a sacred "temple." Such shared concern for bodily health undergirds the widespread collective partnering between public health professionals and religious communities (e.g., Idler et al., 2019; Kegler et al., 2007; Whyle & Olivier, 2017). And religion is often a key influence on discernment of personal "calling" (Dik et al., 2009; Oman, 2018). But as described in these memoirs, especially by Brilliant (2016), religion's motivational functions in smallpox eradication extended far beyond conventional categories.

Global smallpox eradication is one of humankind's greatest triumphs: Smallpox had killed, often horrifically, approximately one third of a billion people in the 20th century alone (Henderson, 2011, p. D8) – a number that dwarfs the recent toll from COVID-19, and even dwarfs the 1918 influenza pandemic. Spread by respiration and face-to-face contact, the inhaled smallpox variola virus invaded the body's respiratory tract, proceeding to lymph nodes, bone marrow, and bloodstream, and commonly producing pustules covering large areas of skin, fever, nausea, bleeding, and death for about one-third of victims. "Textbook descriptions miss the often catatonic appearance of patients attempting

to avoid movement, the smell [and] isolation imposed by the disease…. Although many diseases and conditions are tragic, smallpox was in a class by itself for the misery it inflicted on both individuals and society" (Foege, 2011, pp. 22-23). Smallpox was "by far, the most persistent and serious of all the pestilential diseases known to history… more feared than any of the [other] great pestilences – more than plague or yellow fever or cholera or malaria… there was no treatment" (Henderson, 2011, p. D7).

But in the late 1960s, there was no overabundance of motivation for pursuing the patient, persistent work of eradication, perhaps because so many people viewed full eradication as a longshot if not impossible. Even within the World Health Organization (WHO), many leaders viewed global eradication as "an impossible goal" (Henderson, 2011, p. D8), or perhaps a "wishful fantasy" (Foege, 2011, p. 53). Only by a narrow margin of two votes did the World Health Assembly vote in 1966 to create a special program for smallpox eradication, to which WHO would contribute $2.5 million per year. Fearing that it would fail, Marcelino Candau, WHO's Director-General from 1953 to 1973, had opposed launching the program (Henderson, 2011). And India – a main focus of Brilliant's and Foege's memoirs – was viewed as exceptionally challenging, due to its mode of government, size, population density, poverty, and cultural complexity – a place where even the WHO's optimistic program leaders "expect[ed] to see smallpox make its last stand" (D. A. Henderson, quoted in Brilliant, 2016, p. 143). "Smallpox in India was different… In India, it seemed, smallpox was inevitable" (Foege, 2011, pp. 83-84).

Personal Vocation

On the level of the individual, Brilliant's (2016) and Foege's (2011) memoirs narrate how religion provided personal motivation, leading each of them to a sense of calling. Foege, a minister's son who grew up "in a series of parsonages" (2011, p. 12), describes a more conventional process of discernment, recounting inspiration from Albert Schweitzer, a Nobel Prize winning missionary doctor, and a series of mentors. Less conventionally, he records his longstanding early interest in pursuing public health work in medical missions, and being "disturbed… that church groups did so much medical work in developing countries," perhaps as a "useful proselytizing tool," "yet took so little responsibility for disease prevention… churches should be working because of what they believe, not because of what they are trying to get other people to believe" (pp. 28-29).

Brilliant's path was arguably far more surprising. Whereas Foege was "motivated by a deep Christian faith," Brilliant was "dragged" to India by his wife of three years, so that he could meet her spiritual teacher (guru; Brilliant, 2016, pp. 167, 299). A newly trained physician, Brilliant had little interest, viewing his personal "journey [as] about putting science and medicine to use in order to help ease suffering" (p. 107). Unexpectedly, however, Brilliant's wife's guru, who had a high reputation in India, and to whom Brilliant too eventually became devoted, one day for no apparent reason informed Brilliant that he would "work for the United Nations… you are going to go to villages and give vaccinations against smallpox" (p. 126). Possessing "no experience in public health" (p. 126), Brilliant was utterly baffled. He had "no experience in public health, no training past internship… no training in epidemiology [and] had never even seen a case of smallpox" (pp. 142-143).

Only because of his guru's ongoing insistence – surely a form of religious motivation, although not stereotypic of career discernment – Brilliant "kept going back to WHO, more than a dozen times by taxi, bus, rickshaw, and train," a journey each time of "a dozen hours if everything went right" (p. 140) – and was repeatedly told that "hiring you is quite impossible" (p. 138), based on his near complete lack of proper background, as well as Indian legal restrictions on who could be hired by WHO, not to mention the fact that he was "younger by at least a decade than any foreigner…

ever hired" by the regional WHO office. Eventually hired as an administrative assistant in the smallpox program, Brilliant was only sent into the field to do vaccinations as a last resort when a key field worker suddenly fell ill.

Collective Motivation and Leadership

Brilliant (2016) also recounts how smallpox eradication in India reflected the pivotal role of religious leadership, but in unexpected ways. On the same day that Brilliant's guru informed him that he would work for the United Nations, his guru also told him that "smallpox… will be unmulan, eradicated from the world. This is God's gift to humanity because of the dedicated health workers. God will help lift this burden of this terrible disease from humanity" (Neemkaroli Baba, quoted in Brilliant, 2016, p. 126). Because of his reputation for infrequent but accurate public prophecy, Brilliant's guru's prediction proved catalytic for motivating skeptical Indian officials. As explained by Brilliant (2016, p. 231):

> Most of the time, when I entered a new town I went straight to meet the civil surgeon or medical officer. The minute I started talking about smallpox, the Indian official's eyes would glaze over and he would politely usher me out of the office. I attached a huge picture of Maharaji [my guru] to the windshield of my jeep, [something] I wasn't supposed to do. But when these Indian doctors noticed his picture, they would ask, in that very Indian way, "Who is this guru, and who is he to you?" I would tell them the story of Maharaji's prediction that God, through the hard work of dedicated health workers, would make smallpox disappear. They would then ask some variant of "Is that the same guru who [made various specific well-known accurate prophecies]…" After I confirmed that he was, the real work started; I was escorted back inside, where the local medical officer and I could have another cup of chai and an honest conversation, not about gurus and prophecies, but about early detection, early response, reporting, and vaccination.

Previous histories of Indian smallpox eradication have failed to recount such dynamics of religious motivation (e.g., Brilliant, 1985; Henderson, 1980; World Health Organization, 1980).[3] An initial emphasis on technical and managerial historiography may be understandable, but ongoing elision of spiritual/cultural dynamics seems inadvisable, for as Foege (2011, pp. 52-53) explained:

> [I]n retrospect, the belief that it could be done seems like the most important factor in the global eradication effort. The technology and the infrastructure were necessary, but the planning and hard work required to use them to full effect rested on the faith that eradication was possible. We all know the adage that some things have to be seen to be believed. In fact, the opposite is often true: some things have to be believed to be seen.
>
> The fact of smallpox was so ingrained in human experience that we had our work cut out for us to convince people that eradication was not a wishful fantasy. The shift from doubt to belief was not unlike a religious conversion; it involved not just facts, but emotion, too. A person suddenly transformed by the vision of what was possible could not be stopped…. Like a communicable disease, the belief in smallpox eradication was infectious, with an incubation period, various degrees of susceptibility, and an increasing rate of spread that finally infected many who came in its path. Once this condition was shared by a critical mass of people, no barrier was insurmountable.

It may be impossible to know if collective religious motivators such as described by Brilliant played a critical role in enabling smallpox eradication. But to wonder seems natural. Foege (2011, p. 192) writes that "In retrospect, achieving the eradication of smallpox might look inevitable.

In fact, though, the chain of events included so many opportunities for failure that success was not a given — and we knew it. We had no guarantee of success and were humbled so often that humility became a daily emotion." The possibility that religious endorsements could have tipped the balance hardly seems extraordinary when set in the context of millennia of interactions between religion and public health (Holman, 2015; Porter, 2005).

Better History

Presently, however our understanding the interplay of cultural, religious, and technical factors in eradication is handicapped by the strong muting or exclusion of religious motivations from most histories of smallpox eradication. Improved and rebalanced histories would better inform practice and help guide the much-needed mainstreaming of proper attention to religious factors in public health training (Oman, 2018). Moreover, as lamented by Foege (2011, p. xix),

> We lose our histories far too fast. In the dozens of public health efforts in which I have been involved throughout my career, the histories have rarely been written soon enough. Within years, sometimes within months, people's accounts begin to differ. Often the participants simply do not keep journals or record their notes…. participants at the 2006 reunion of the first smallpox workers… were invited to record oral histories. Many commented that they had forgotten details, and their accounts were incomplete. Based on this experience, the CDC decided to collect oral histories from the people involved in the 2010 H1N1 influenza phenomenon right away, in 2010. This is a wise practice, for much that might benefit future generations can be learned from eyewitness accounts of important events.

Of course, not all roles of religion in smallpox eradication in India or elsewhere were prima facie salubrious. For example, Foege (2011, p. 59) described a novel smallpox outbreak with cases mysteriously distributed throughout a Nigerian city, which turned out to come from a church group that had refused vaccination based on religious convictions. More dramatically, Brilliant (2016) describes how a tribal chief in a remote Indian village firmly resisted vaccination, explaining that "only God can decide who gets sickness and who does not. It is my duty to resist your interference with his will" (p. 333). But the chief was no stereotypical religious bigot from central casting. After he and his family were ambushed, physically restrained, and vaccinated by force, he collected his wits and then offered hospitality to those who moments earlier had assaulted him and his family. "We have done our duty. We can be proud of being firm in our faith… You say you act in accordance with your duty… It is over. God will decide. Now I find that you are guests in my house. It is my duty to feed guests" (p. 333). Brilliant noted that the chief "was so firm in his faith, yet there was not a trace of anger in his words," commenting that "it felt to me like a post-graduate course in cultural relativity" (p. 333). There followed a discussion between the chief and Indian members of the vaccination team (e.g., "You live by God's will. I, too, have surrendered to God's will – that is what the word 'Islam' means… But what is God's will?… Could we bring the needle if it were not God's will?… It is God's will, and my dharma is to protect your children from smallpox," pp. 334-335). Soon after, the remaining villagers came forward to be vaccinated.

Additional anecdotes scattered throughout these memoirs show many other roles played by religion. For example, Brilliant reports eradication team interactions with priests at temples dedicated to Shitala, the Indian Goddess of smallpox. Whereas most of the eradication team's physicians expected the priests to hide smallpox cases, Brilliant (2016, p. 189) "was pleasantly surprised by [the priests'] cheerful willingness to help the eradication effort." Similarly, leaders of Jainism, a religion that teaches nonviolence to all living creatures, despite their concerns that animal lives

were taken in creating the vaccine, were persuaded to back the eradication effort (see Brilliant, p. 344). And after Brilliant noticed the vaccination scars on the arms of the Dalai Lama, His Holiness explained that he had been vaccinated four times during the Tibetan smallpox epidemic of 1948 because "each of the four Buddhist sects wanted to make certain that their vaccine was used to protect me" (p.263).

The full spectrum of religious roles in smallpox eradication is clearly much wider than presented in most smallpox histories. Only by collecting and reflecting upon accounts of these manifold roles can we understand their full significance for future public health efforts. Yet one implication seems clear: Religion can be a powerful collaborative force for disseminating not simply recognition of the value of meritorious public health initiatives, but also an active belief in the ability of such efforts to succeed. In social science terms, religion can powerfully boost collective efficacy (Butel & Braun, 2019; Tower et al., 2021; see also Oman et al., 2012, p. 279, n. 1), in some cases by bringing to bear beliefs in "divine agency… as a guiding supportive partnership requiring one to exercise influence" (Bandura, 2003, p. 172; see also Pargament et al., 1988). Such belief in our collective capacities is indispensable for facing today's most daunting public health challenges, such as global climate change and resurgent pandemics. Culturally and spiritually rich, balanced, and instructive histories of past victories can fortify us for such challenges. Between them, these two valuable memoirs by Brilliant and Foege not only outline technical aspects of smallpox eradication, but set before us helpful portraits of many diverse functions served by religion and spirituality, factors that need better recognition in public health as key partners in the challenging work ahead.

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[1]^ Doug Oman, Adjunct Professor, School of Public Health, University of California, Berkeley (DougOman@Berkeley.edu).

[2]^ Images were recombined from versions accessed in May 2022 through Wikimedia Commons for Brilliant (link, original author Cashinj, CC BY-SA 4.0 license) and Foege (link, original from CDC, in public domain).

[3]^ Perhaps the only exception, first published in the 1970s, is a brief narration by Brilliant of key events involving his guru (Brilliant in Ram Dass, 1979, pp. 163-169).

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Resources & Updates: Spring/Summer 2022

PHRS Staff

Editors' Note: This section emphasizes resources at the intersection of religion/spirituality and public health, as well as major organizations that at times address these intersections. Please see the "Resources" tab on the PHRS website for more content, and please send new potential content to this section to: phrsadm1@publichealthrs.org and phrsadmin0@publichealthrs.org

New Research

- May 2022: Special Issue *Journal for the Study of Religion, Nature, and Culture*: Religion, COVID-19, and Biocultural Evolution. (Eds: Crews and Taylor)
- April 2022: Religious/spiritual struggles and well-being during the COVID-19 pandemic: Does "talking religion" help or hurt?. (Upenieks)
- April 2022: Associations of Changes in Religiosity With Flourishing During the COVID-19 Pandemic: A Study of Faith Communities in the United States. (Jacobi, Cowden, Vaidyanathan)
- March 2022: Health Effects of Religion, Spirituality, and Supernatural Beliefs in Mainland China: A Systematic Review. (Pan et al.)
- February 2022: Narratives and counter-narratives in religious responses to COVID-19: A computational text analysis. (Idler, Bernau, and Zaras)
- February 2022: "People Are Not Taking the Outbreak Seriously": Interpretations of Religion and Public Health Policy During the COVID-19 Pandemic. (Johnson et al.)
- January 2022: Keeping the Faith: Religion, Positive Coping, and Mental Health of Caregivers During COVID-19. (Sen, Colucci, and Browne)

Articles, Books, Commentaries, Interviews, and Webinars

- Webinar: June 16, 2022: Registered Reports and Funding in Consciousness and Religion Research. (Center for Open Science)
- Commentary: May 2022: Religion, cancer, and sub-Saharan African health systems. (Olivier)
- Commentary: May 2022: Religious Community in Public Health and Medicine. (VanderWeele)
- Webinar: May 2022: Bridging Faith and Science to Combat the Overdose Crisis Series. (Johns Hopkins Bloomberg School of Public Health)
- Book: December 2021: Religion, Virtues, and Health. (Krause)
- Funding: Call for Proposals –Open Science of Religion

Upcoming and Calls for Papers (newest first)

- **Deadline Approaching**: Special Issue *Religions,* "Religion and Public Health Threats in the 21st Century". Due July 31, 2022
- **Upcoming:** August 2022: 18th Annual Course on Religion, Spirituality, and Health. Duke University.
- **Upcoming:** November 2022: American Public Health Association (Boston, MA). Link to the Caucus on Public Health and the Faith Community here.

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Public Health, Religion & Spirituality Network

Editorial

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Bulletin Information

The *Public Health, Religion and Spirituality Bulletin* is a publication of the Public Health, Religion, and Spirituality Network (publichealthrs.org). Two issues appear per year, Fall and Spring/Summer, with a re-bundled Spring/Fall "annual issue" released in January each year, and are published online and open access in HTML and paginated PDF format. Visit the *Bulletin* website to register for new issue notifications (http://publichealthrs.org/bulletin/). Prospective contributors of articles should read Oman & Long's "Welcome" article (http://publichealthrs.org/a001) and contact us with ideas. The *Bulletin* Coeditors are Katelyn Long and Doug Oman, with Assistant Editors Angela Monahan and Ashley Meehan.

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Editors' Introduction: Fall 2022 Issue #7

We are pleased to share with you the seventh mini-issue of the PHRS Bulletin. This issue opens by profiling the Caucus on Public Health and the Faith Community, a caucus within the American Public Health Association (APHA), and one of the best places within APHA and its meetings to meet others concerned with religion, spirituality and health, and learn more about these topics. This profile is written by Barbara T. Baylor, chair of the caucus, who was also interviewed in our previous Bulletin Issue #6 (Spring/Summer 2022). Guest speakers at next week's Caucus events will include David Satcher (former US Surgeon General), and Howard Koh (former Assistant Secretary, Department of Health and Human Services).

A second article is from Julissa Soto, a Colorado-based public health leader whose work on vaccination promotion has won many accolades. Her article is structured as her responses to a series of questions, such as "How did your work begin?", "What does it mean for you to work at the 'intersection' of religion and public health?" and "How do you navigate tension points that can emerge when faith and public health work in partnership?" In contributing this article she is pioneering a new genre of article for the Bulletin – a genre that we hope you find enjoyable, informative, and useful for navigating your own faith/health "tension points" – and a genre that, if successful, might be a vehicle for featuring the contributions to spirituality and public health of an ever-expanding circle of colleagues.

Our third article features an interview dialogue with Dr. Mimi Kiser, for many years a leader of Emory University's teaching on faith and health, and deeply involved with its Interfaith Health Program since 1993 when the program began at The Carter Center. After three decades in the field, and in dialogue with her former student Dr. Stephanie Doane, Dr. Kiser reports that she has "never seen [as] many federal agencies take religion as seriously as they did during COVID-19, investing staff and programmatic resources… it has been phenomenal."

Finally, in our resources article, we present some of the latest research at the intersection of religion, spirituality, and public health, as well as upcoming conferences and funding opportunities. We also alert you to a newly published book on the history of a "spiritual dimension" of health within the World Health Organization (WHO) – a history beginning at the WHO's inception after World War II – and, according to the book, closely connected with many of the organization's ethical aspirations.

We wish you all a wonderful fall and winter and look forward to sharing with you our next mini-issue, currently targeted for publication in late spring.

Warmly,

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APHA 150th Anniversary Celebration: The Caucus on Public Health and the Faith Community Explores Faith Communities as Essential Partners in Community Public Health Programs and Research

Barbara T. Baylor[1]

Editors' Note: The PHRS Bulletin is pleased to spotlight goings-on in the growing world of research, practice, and education on public health, religion, and spirituality. In this article, Barbara Baylor gives a brief history of the Caucus on Public Health and the Faith Community, and highlights the Caucus' two special sessions taking place during the 150th Anniversary Celebration of the American Public Health Association.

The Caucus on Public Health and the Faith Community – an official caucus within the American Public Health Association (APHA) – began its work in 1996 under the growing recognition that tackling health issues is not the exclusive domain of federal, state, or local government workforce or public/private organizations. Today, the Caucus continues to espouse the historic work begun by the Faith Health Movement. Through its sessions at the annual meetings of the APHA, the Caucus provides a platform and facilitates opportunities for evidenced-based discussion and research, and promising new approaches that support the value of faith as a key to the delivery of effective community health services. The Caucus believes that promoting and enhancing collaborations between the faith community and the health community is an effective partnership for addressing physical, mental, emotional, spiritual, and social health challenges.[2] One does not need to be a member of APHA to join the Caucus on Public Health and the Faith Community.

This year on November 6-9, in Boston, MA, the APHA will hold its Annual Meeting & Expo, and will be celebrating its 150th Anniversary of creating the healthiest nation and leading the path toward health equity. During this celebration, the APHA Caucus on Public Health and the Faith Community will honor the legacy of faith and health partnerships by hosting two special sessions, including several distinguished and influential speakers, that focus on the role of the Faith Community in the ongoing work for health equity.

For decades, those engaged in the work we are honoring have been rising to the challenge held out by former U.S. President Jimmy Carter, who asked: "What if congregations, mosques, and temples cooperated with each other to improve the health of people in the communities where they are located?"[3] In 1992, with a belief that faith communities could play a primary role in improving health, Dr. William Foege, former Executive Director of the Centers for Disease Control and Prevention (CDC), with the assistance of Former President Jimmy Carter, established the Interfaith Health Program (IHP) at Emory University in Atlanta, Georgia. The Program fosters partnerships between communities of faith and public health to close the gaps in preventing disease and improving health.

Yet even before that time, faith communities had been creating innovative programs and established health clinics, hospitals, and facilities. Some of the earliest hospitals were founded by major faith traditions, seen today in the myriad of Catholic, Lutheran, Baptist, Methodist, Presbyterian, Adventist, Jewish and other religiously branded medical centers, and in 1957, the Lutheran Evangelical Reformed Church and the United Church of Christ (UCC) formed Advocate Health Care. More recently academic faith and health centers have been founded, such as the Duke University Center for Spirituality, Theology, and

Health.[4] We have a broad and long legacy to honor!

First, on Sunday, November 6, 2022, 6-7 p.m. in the Boston Convention Center, the Caucus will host a Celebration titled: "United to Heal: An Interfaith Celebration of Holistic Healing and Peace". The Program is a multi-faith celebration that will honor diverse worship, prayers, reflections, and music. The event is free and open to the public. Several multi-faith cultures and traditions from the Greater Boston area have been invited to participate.

Second, on Monday, November 7, 2022, 10:30 a.m.-12:00 p.m. in the Boston Convention Center, the Caucus will host a special Invited Session titled: "Faithful Dancing with the Bears of Inequity: Past, Present, Future". The title is derived from a quote by Dr. Joycelyn Elders, former U.S. Surgeon General, who once compared the work of public health to dancing with a bear. She said, "You don't quit when WE get tired; only when the bear gets tired."[5] Historically, the Faith Community, which never tires of its dance with bears, has been integral to the success of social reform movements in the U.S.

"Faithful Dancing with the Bears of Inequity: Past, Present, Future", will offer a retrospective view on the decades of faith involvement in health care delivery, caring for the sick, health education, health promotion, disease prevention, and health equity and will focus on: 1) the value and importance of the faith community's role in the past, 2) the current faith health movement, research, and programming, 3) the continuing journey to rebuild trust and foster a sense of hope and mutual support between public health and faith, and, 4) the recognition that faith communities are more than physical spaces but are communities of faith filled with significant culture, history, and traditions which need to be passed on to future generations.

This rousing conversation will be moderated by Dr. Caswell Evans, the primary impetus in the formation of the Caucus on Public Health and the Faith Community and a former President of APHA, and Barbara T. Baylor, MPH, Chair of the Caucus. Our distinguished invited guests include:

- *Dr. Howard K. Koh*, Harvey V. Fineberg Professor of the Practice of Public Health Leadership at the Harvard T. H. Chan School of Public Health, former Assistant Secretary Dept. of HHS
- *Dr. David Satcher*, former Surgeon General of the U.S., former Executive Director of the CDC, Founder, The Satcher Leadership Institute, Morehouse School of Medicine
- *Dr. Somava Saha*, Founder and Executive Lead of Well-Being and Equity (WE) in the World, and Well Being In the Nation (WIN)
- *Mr. Jeffrey Simms*, Assistant Professor Health Policy, Gillings School of Global Public Health, University of N.C. at Chapel Hill

For more information about the Caucus and for membership, please contact
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[2]^Caucus on Public Health and the Faith Community

[3]^Quoted from former president Jimmy Carter's remarks in a video that introduced the Interfaith Health Program: Starting Point: Empowering Communities to Improve Health

[4]^Faith-Based Partnerships for Population Health: Challenges, Initiatives, and Prospects

[5]^Dr. Joycelyn Elders on Women in Leadership Positions. Symposium sponsored by University of California, Berkeley and San Francisco campuses

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Facing Challenges in Public Health Change for a Person of Faith in Colorado

Julissa Soto[1]

Editors' Note: We are pleased to present a new type of article that features a wide range of professionals working at the intersection of religion, spirituality, and public health. In this style of article, practitioners answer a set of questions in their own words to convey the motivation for their work, their successes and challenges, and advice to others who seek to engage in their communities.

Julisso Soto is a public health consultant in Colorado. For work on vaccination promotion among Latino communities and other bridge-building public health efforts, she was won many accolades from Colorado State and National leaders, and is recognized as one of the state's leading Latino immigrant advocates. She serves on the Health Equity Commission for the Colorado Department of Public Health and co-chairs regional programs that provide guidance on health equity and outcomes. She was recently awarded the Diversity, Equity and Inclusion Champions in Advocacy Award for Colorado Springs, Colorado, the Big Shot of the Year award from Immunize Colorado, a National Advocacy Award from Voices for Vaccines, the 2022 Excellence in Immunization Equity for the Immunization Coalitions and Partnerships in Minneapolis, and the Colorado Public Health Association's 2022 Award for Excellence in the Promotion of Health Equity.

Question 1: Very briefly, please describe your work for PHRS readers.

I act as a bridge between the Latino community, public health leaders, and religious leaders. In that sense, I'm a messenger, an intermediary, between these groups that do not have a good understanding of each other. So, I help make the connections to help them understand each other better, and I do it through the health tool of vaccination. One of the major projects I've led the past few years is "Vaccine Sunday" held at Catholic Churches in Colorado. These events take a huge amount of effort to put together because you have to work with all three groups, which, again, do not know how to work together well. The inability to know or work well together contributes to the mistrust, distance, and siloing that keeps our health system broken and health system disparities thriving for decades.

Julissa Soto (right) and a recently vaccinated and grateful friend

Question 2: How did your work begin? What are the personal stories that drive or motivate you?

Twenty-four years ago, I tried to get health care support for my sick kids, including in the ER. And I struggled with roadblock after roadblock to access care. The health system was incomprehensible to me and I was scared for the health of my kids. I realized our health system was not meant to be understood by anyone, much less the community that it should serve. I promised God then that I would one day try to figure out this health system and then help others understand and access it. And I'm still trying!!

Question 3: What does it mean for you to work at the "intersection" of religion and public health? What does this work look like "in public" and how does work at these intersections play out at personal level?

Monsignor Jorge de los Santos, the pastor of Our Lady Mother of the Church in Commerce City, Colorado, pegged it best speaking at a mobile vaccination event I organized there on Easter Sunday 2022. He said, *"Religion is not only about being in the church. Religion is about the common good. For the health of the body and soul. Then as we promote the good spirituality, then we promote good health for the people."* In other words, if our faith only promotes spirituality but ignores the intersection with human physical suffering like when people are left out of health care, then we are not following Christ's admonition to care for the least of our brothers and sisters. Spirituality becomes superficial and empty then. Faith without action is indeed empty. It is sanctimonious and hypocritical.

So, I bring Vaccine Sunday programs to churches vaccinating for COVID-19. And then, as I learned from that, "Vacunas en su Casa", I now bring other vaccinations to my community, working with state and county health departments. Vaccinations are needed, but hard to get or afford for my community.

I've also lowered the roadblocks for my community, lowered the roadblocks that pastors face in linking spirituality with health, and lowered the roadblocks for health departments that keep them from relationships with the community. These are relationships they [health departments] should have had, but never have had before.

I do this work by relying on and listening to God for guidance. I ask God to show me how to lower the roadblocks to be effective; to strengthen me from the resentment that comes with this work; and to resist attempts to rebuild roadblocks by pastors, health systems, and even community members. God helps me in this constant mediation in making our health system comprehensible and functioning for health.

Question 4: What have been some of the big "wins" you've experienced along the way? What factors were at play to make these "wins" possible?

Getting community members healthcare, starting with vaccination, where they have never had care before. Barrio by barrio. Building trust in a health system people have mistrusted for decades.

Rattling the cages of healthcare decision-makers who otherwise wouldn't be moving on the changes needed. I've learned that without the temerity of cage rattling, nothing changes. I have been very grateful for health leaders along the way who recognize how critical dedicated frontline work is and make my job so much easier, people like Jill Hunsaker Ryan, the executive director at the Colorado Department of Public Health and Environment, Kim Bimestefer the executive director of Colorado's Department of Health Care Policy and Financing, Annie H. Lee, the President and Chief Executive Officer of Colorado Access, and John Douglas, the executive director of the Tri-County Health Department

I also help pastors to take actions to truly address inequity in healthcare, not just ignoring it or talking about it as a distant goal. And to make these changes something that becomes THEIR vision, health care decision-makers and pastors, not just mine. Because it's not about Julissa. This happens through all the vaccination events that I organize. Communities get care, and cages get rattled to make things happen.

And then other miracles happen too. At a March 2022 vaccination event at St. Mary Magdalene Catholic Church in Denver, I asked the pastor what he needed for his people. He said a food bank. Something about the way he earnestly expressed this need and my own connection with God, told me: "well, this isn't vaccination, but it is health care. Let me see what we can do". I opened the appeal up to leaders in health care, and miracles happened. We celebrated the opening of the new food bank at St. Mary Magdalene this July 2022. God makes things happen through the miracles of genuinely working through people.

Question 5: What are some of the hardest challenges you've faced? What do you do in moments of great struggle?

One of the most significant challenges I face is holding health system decision-makers accountable to communities (cage rattling). And having to fight them when they are not leading. It's very challenging when health leaders don't like what you do but don't have a clue what to do themselves. If you don't have leadership ability, what are you doing? If you go shopping with no money, why are you shopping? We don't need public health leaders who are window shopping with nothing meaningful to buy. When they too often sit in isolation from the community, lamenting disparity, but resent exploring change that could make a difference. Some of the changes I advocate for are things like:

1) *Training staff that interact with people to be personable. Not having sterile/clinical attitudes or treating people indifferently or disrespectfully.*

2) *Training managers to hold staff accountable. Are health staff welcoming and warm, consistently making people feel they belong and are wanted? Staff must know this is a job requirement.*

3) *Having public health navigators regularly enter into the Latino community to connect with residents, business owners, and churches, especially before health events. It's important to make sure the community knows why the events are important to them and their families. It's also important to do health outreach before, during, and after health events. Letting people know the health system cares and can be trusted.*

4) *Speaking in Catholic churches that are predominately Latino (over 50% of Latinos are at least culturally Catholic) on Sundays, through the "Vaccine Sunday" and "Vacunas en su Casa" programs to reinforce caring for Latino health.*

5) *Scheduling mobile health events in the Latino community at times when community members are available. That means NOT 9am to 3pm Monday through Thursday, when it's only convenient for clinicians. Reaching the Latino community means weekends and evenings when people are more easily and regularly available.*

6) *Being innovative. Making events fun. For example, for children, during the Christmas season, bring Santa Claus! On Dia del Nino, have staff dress up as superheroes. For adults, have music — even dancing!*

These are things I advocate for with health system leaders. For health staff in the trenches of hands-on care, it's important to understand the new approaches of engaging the community, where the community is located, and when they're available. It's also important to decisively but compassionately address their resentment, impatience, and sometimes disrespect for the community and me.

For my work with religious leaders, it's important to hold them accountable for the health of their congregations and communities. Helping them understand the intersection of spirituality and health. Within the Catholic community, we have Dominicans and Franciscans who tend to get it and this is not a hard sell. For the more conservative Catholics (Neocatechumenal Way), it's challenging for some reason.

In moments of great struggle with all of this work, I remember my ex. He used to beat me up regularly, all the time. That was truly hard. With my current work in public health, it's different; I don't get beat up all the time! Give me Public Health!

And more seriously, I turn the struggle over to God. I say, "God, this struggle I'm in is too much for me. I'm turning it over to you and going to bed". And when I wake up the next morning, I

have the energy and the insight I didn't have before.

Question 6: What has the work required of you that you did not expect?

Brutal hours, which have now become normal for me! Fridays, weekends, and evening hours. That's when people are available. When I started out, I didn't realize those hours and days of work would become the new normal. I've also been surprised by resentment from healthcare associates and even family members who don't get the work I am doing. And there is also huge resentment from anti-vaxxers. I knew they existed and thought we could give each other space. That sometimes doesn't happen. Anti-vaxxers can get in my face. One pulled up his shirt and showed me his gun, essentially threatening to use it if I didn't leave. And there are also pro-vaxxers who are afraid of anti-vaxxers. I can respect anti-vaxxers who are civil, but we should not be letting them dominate any of the conversation.

Question 7: How do you navigate tension points that can emerge when faith and public health work in partnership?

I do this by helping pastors understand that vaccination is a gift from God or He would not have given science, the knowledge, to develop it. It should be used then for what God intended it for. To protect life. Too many Catholic pastors (as well as Protestant) are subject to social media misinformation or don't understand enough about vaccination to advise their people. They need help to understand that COVID is dangerous, especially for the immunocompromised, the unvaccinated, and pregnant women. Promoting vaccination then is an act of charity that all people of faith are called to. I step in to provide the truth of vaccination so pastors have confidence to promote it and then work in partnership with public health.

Question 8: What has been life-giving about this work?

I know my Latino community is left behind. I see them crying for help when help is available, but not for them. That's when I know my work is making a difference. For example, when an elderly lady gets her first COVID-19 shot (see photo at right) or when a young Latina hugs me in gratitude because the shot didn't hurt and she wants to come back! (see photo above) This work gives me purpose in life.

Making a difference: Happiness at receiving first COVID-19 vaccination shot.

Question 9: If you were able to give advice to your younger self, perhaps when you were just starting this work, what would you say?

Know what you're signing up for. Remember that passion is not teachable. It's something you develop in yourself. Look for mentors who will help develop your passion. Beware of fakers who will mislead you that it's all about you and personal gain. Instead, look for spiritual mentors like Rich McLean, who supports me and can tolerate my eccentricities but knows good when he sees it. It also helps to have a mentor with a mission from God, too. I know God supports me. But I need human support too, support that is genuine, not fake, contrived, or conditional.

I would also say that like the Marines, you have to be ready to battle hitting the beaches. You're going to get resistance. Keep your strength in God so you don't wilt or succumb to giving up. This work isn't for everyone. For some people, having a desk job writing reports and organizing meetings is better. I've seen the work I do send people to the hospital for stress, because you will get resistance in change making.

Finally, know your work balance. Know yourself and use the gifts that God gave you. Don't expect the impossible, but don't give up on the possible

as God shows you. Understand you're not going to Cancun. You're going to the hood. And love it!

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Dynamic Dialogue: Mimi Kiser and Stephanie Doan-Soares Reflect on Their Journey in Religion and Public Health – Past, Present, and Future Opportunities

Ashley Meehan[1] and Angela Monahan[2]

Editors' Note: We are pleased to present an adapted group-conversation version of the PHRS Bulletin's series of featured interviews with influential contributors who have shaped the field of public health, religion, and spirituality.

We present a conversation between Drs. Mimi Kiser and Stephanie Doan-Soares. Mimi Kiser recently retired from the Rollins School of Public Health at Emory University, where she spent thirty years teaching and working with the Interfaith Health Program (IHP)[3] and on the leadership team of the Religion and Public Health Collaborative[4] for the university. Stephanie Doan-Soares completed her Master of Public Health degree at Emory University, working closely with Mimi and others at IHP. Stephanie recently completed her Doctor of Public Health degree at Harvard University's T.H. Chan School of Public Health.

Mimi and Stephanie were engaged in conversation for the PHRS Bulletin by Ashley Meehan, a PhD Student at Johns Hopkins Bloomberg School of Public Health and a co-editor of the PHRS Bulletin. Ashley received her MPH at Emory University's Rollins School of Public Health, with a certificate in Religion and Health. Ashley worked with Mimi at the Interfaith Health Program during her time at Emory.

Ashley Meehan: Mimi, it would be great if you can kick-off our conversation. Can you recap a bit about the history of religion and health at Emory University, and how you got started at this intersection?

Mimi Kiser: Yes, I'll start with some historical context for the Interfaith Health Program (IHP). In the 1980s and 1990s, there were two important themes emerging in public health. One was eliminating health disparities, and the other was around exploring social and behavioral determinants of health. At this time, there were two key people that helped shape this larger context, specifically for religion and health: Dr. William Foege, who was the director of the Centers for Disease Control and Prevention (CDC) from 1977-1983, and Dr. Gary Gunderson.

Mimi Kiser

In 1984, Dr. Foege had just left his position at CDC, and President Jimmy Carter had asked him to be the executive director of The Carter Center. One of Dr. Foege's early leadership activities at The Carter Center was a convening called, "Closing the Gap."[5] The convening was one of the efforts to frame for this social and behavioral knowledge and sector engagement that later informed a lot of new thinking of social determinants of health and setting a call to action addressing health inequities.

About ten years later, in 1993, Dr. Foege and Dr. Mike McGinnis published an article[6] in JAMA on lifestyle factors underlying the leading causes of death – not the diseases themselves, but the factors in people's lives underlying those causes. That was really a seminal representation of the

shift at the time to a focus on lifestyle and social determinants of health that undergird disease in a pretty significant way. This opened the doors for new strategic thinking and research about social contexts. I think this was partially spurred by the HIV epidemic, too. The emergence of HIV really forced public health to take the social and behavioral aspects of health more seriously.

So, that hopefully paints a picture of the context in 1992, when IHP was started at The Carter Center.[7] At its founding, the IHP was called The Interfaith Health Resources Center. It was oriented around the "Closing the Gap" conversation and practical in terms of guiding congregations and faith-based organizations in how to do public health. Dr. Foege brought Dr. Gary Gunderson into the mix, which is significant because Gary had a background in faith-based work, oriented in the social experiences of communities and the natural inclinations of congregations and religious institutions.[8] In the late 1990s/early 2000s, IHP transitioned from The Carter Center to the Rollins School of Public Health at Emory University where it continues to live today and has been a really great fit all these years.

I have never seen this many federal agencies take religion as seriously as they did during COVID-19.

– Mimi Kiser

So who am I, what called me, and how did I find this intersection? In the early years of IHP, I had gone back to school in a mid-career shift and was getting my MPH at Emory. Whenever there's a new field emerging, a lot of what moves and shapes it are the people who are inclined to generate ideas and put seemingly unconnected pieces together in new ways. In 1990, that is what was happening at The Carter Center and Emory. I was really drawn to think about the social environment, particularly around meaning and how one understood and valued oneself in making decisions about risk, as well as how the social environment, structures, and systems that influence peoples' learning and conceptualization of who they are and the value they have. I got involved in a faith-based youth sexuality education project, evaluating a middle school age program, and ended up doing my master's thesis on that. This was happening at the time when HIV/AIDS was really at the forefront in the early 1990s, and people were trying to think about how people could make different decisions about their risk. It was exciting for me to be thinking about social environments, particularly congregations and faith-based organizations, that youth find themselves in as they are discovering their emerging identities. Because of my work in that space, there was clear alignment with what IHP was becoming. I started working with IHP during its first year, and the rest is history!

I now want to shift to Stephanie, because a really big part of the work that grew at Emory was the interdisciplinary learning opportunities for emerging leaders, and Stephanie is now one of those leaders. Stephanie, you had some pretty unique experiences in the context of religion and public health learning and practice. I want to know how you came into this emerging environment and how it strengthened and built who you are today.

Stephanie Doan-Soares

Stephanie Doan-Soares: I could say I feel a sense of calling to this work, but it's not always very tangible. I grew up in a very Christian home and my faith has been very important to me. For

most of my life, I wanted to be a doctor. I was on the pre-med track in college, majoring in biology and I ended up taking this class in religion. It turned into a minor in religion, and eventually a double major in biology and religion. While that was happening, I realized I didn't want to be a clinical doctor. We organized a training in Philadelphia for religious leaders 10 years ago on trauma. Philadelphia is the sixth largest city, with one of the highest levels of deep poverty, a very high percentage of kids living in poverty, and astronomical numbers of homicides and incidents of gun violence. Who is on the front lines? Congregations and religious leaders. The question then was, how do we begin to educate our religious and lay leaders, and congregations, about mental health and trauma? We build a system of community supports out in the field, especially when so many people who are encountering and being involved in trauma, violence, and mental health issues, don't have access to or don't go to the health care system because there's so many barriers. Philadelphia has been a big leader in training clergy around trauma and mental health. What I learned from Guy Steuart has infused everything I've done, because the core is really how do we bring people together? If we can't bring people together and build the bridges and relationships to walk together, we won't be able to solve these compelling problems that we have.

I took a trip to South Africa to learn about the racial reconciliation efforts that were happening, and got to spend time at an HIV clinic. On that trip, I realized that public health was an entire field, so I came back for my senior year of college and finished out my dual degree in biology and religion, and started applying to public health schools. I applied to Emory and a few other places but when I went to the accepted students' day at Emory, Mimi introduced herself, IHP, and the work they were doing. This light bulb went off in my head that there was actually a way to put together the two things that I had been doing – biology, health systems/health structures, and religion. Trying to make sense of how all these things fit together was always a goal. I want my life to feel integrated and connected, so all of a sudden, meeting Mimi and hearing about the work of IHP made it clear that it was possible to put these things together. I ended up coming to Emory and during the summer before I started, I sent an email to Mimi and Gary and said "I heard you talking at the accepted student's day. I would love to get a job with you at the Interfaith Health Program." They interviewed me and decided to take me on as a graduate assistant. And that's how I got my start in this work.

Mimi Kiser: We are very happy that that happened. You started in 2005, and in 2006-2007, two things were happening. One was that we were being much more intentional about the academic environment around religion and health. We were trying to think through how to navigate interdisciplinary education between the School of Public Health, the Department of Religion, and the School of Theology. Out of this strategic planning came the Religion and Health Certificate and the Religion and Public Health Collaborative. I'm wondering, Stephanie, if you could speak to some of these applied experiences you had with IHP and how they've strengthened who you are and built capacity for the kinds of leadership positions that you've been in. What are some distinctive moments you remember in this applied religion and public health work? Now, we have a lot more courses in religion and health and students are doing extensive research projects, but your experience was really heavily immersed in the applied areas.

Stephanie Doan-Soares: One thing that was really important was being able to connect with your network of people. I was really influenced by you and Gary and others within IHP, but there was a group of people who were sort of on the fringe or the next level out. I think of Deb McFarland, who did so much work on health systems, which brought in the conversation around faith-based organizations and their involvement in health systems. There was Roger Rochat and his work in reproductive health, and Rafael Flores – it was really powerful for me to see how different people were applying these concepts across fields and

topics and in different ways. That was a really important piece of this work.

These connections were also important for being able to connect to their work, too. I did a lot of work around mapping religious health assets[9] in Zambia and Lesotho with Deb, which was really applied research that was community and practice driven. These applied experiences really shaped how I saw my role. How do I take what the scientists are saying and turn it into things that someone on Capitol Hill wants to read, or one of our partners wants to read? That thinking that emerged for me at Emory was needed in my future work, for example, during my time at the CDC Country Office in Bangladesh – where I led a research portfolio of practice-based research. So you're spot-on, Mimi, the opportunity to do really applied work was instrumental in setting up my career. I want to be doing things that are practical and applied and really make a difference. A lot of people are doing things to gain and create knowledge, which is important, but I like being able to be the bridge and have that make sense in practice.

Mimi Kiser: During that time period, there wasn't a big welcome mat to these ideas of practice-based programs and applied research in religion and health. But there was power in this translational and relational role. Through its Faith Health Consortium partnership relationships with universities in Africa, IHP was able to bring in people like Deb and Roger who had been doing relevant work, in a clear way and helped us demonstrate the different possibilities.

Stephanie Doan-Soares: I was also thinking about the time I traveled with you and Gary and the team to South Africa, as we were presenting the final version of our report on mapping religious health assets. I think one thing that was important about that trip was there were people from the World Health Organization there, along with all of these different players. Even ten years after that trip when I was in Bangladesh leading a CDC team, those partnerships and understanding the dynamics and how all of these players fit together was really important for me. I don't know how I would have navigated some of the positions I was in without understanding their context earlier on.

I remember we also had a grant from CDC around engaging faith-based organizations around pandemic preparedness and influenza.[10] Through that, I got to know Dr. Scott Santibañez, and that relationship has been important throughout my whole career at CDC.

Mimi Kiser: Something that was underlying that grant, and the whole concept that came out of the work of the IHP with key partners, was this concept of understanding the different religious health assets and how the strengths of faith-based organizations could contribute and be understood in their role in community health. You became involved in that more in some way as you developed and built your thesis. You were very creative in how you did that. Can you say more about that?

Stephanie Doan-Soares: For my MPH thesis, I focused on a book[11] that Gary Gunderson had written, describing the eight strengths that congregations have[12] for impacting the health of their community. One thing that we had talked about was that it would be helpful if there was some sort of tool for congregations to use to either assess their strengths or to think about how they could build them. I really focused my thesis on talking to congregations to understand how they might view their own strengths and whether there was some overlap between how they talked about it and how Gary had sort of theorized it based on his experiences. The strengths of congregations in building and maintaining social capital are what, in many ways, position them to contribute to health and be a health asset in the community.

In addition to his book on congregational strengths, Gary also had a book[13] on boundary leadership. That term, boundary leadership, really sticks with me as something that has always defined my career. It is a way of thinking about how you go across boundaries and figuring out

how we do cross-sector collaboration in meaningful ways.

Mimi Kiser: What's becoming clear is how in an emerging field like this, particularly an interdisciplinary one where there are lots of different kinds of ideas, it's important to have people like you bring a new way of thinking, to put ideas together and make them work. I could feel all these pieces coming together to build the substantial body of work that contributes to the health of the public.

So I know that after you graduated, Gary asked you to come to Memphis and work there,[14] so you had more time to grow and develop in a significant way. You had this learning at Emory, and then you went to Memphis, and had experiences at the Department of Health and Human Services (HHS) and in Africa, stepping into some fairly high-level roles and responsibilities.

Stephanie Doan-Soares: I left the job in Memphis to start a fellowship program at CDC that included an opportunity to do three-month rotations in different offices across HHS. I had lined up a rotation at the Center for Faith-based and Neighborhood Partnerships at HHS and got there maybe a week or two before H1N1 happened. One skill that has continued to follow me in my career is how to quickly adapt. This ability to change plans really quickly had been a part of my learning with IHP, and it was really helpful when I ended up being tasked as the coordinator of a guidance document for faith-based organizations and congregations on how they could support the H1N1 response. That included collaborating between IHP and Dr. Scott Santibañez and others at CDC who were leading the H1N1 response, and the partnerships with IHP's Institute for Public Health and Faith Collaborations and the HHS Faith-based office were instrumental in activating vaccination sites. We benefited a lot from the expertise of the folks activating these sites as we were writing the guidance documents.

Then about a year later, I still had one rotation left. I was talking to Mimi and the team at IHP when Sandy Thurman, director of IHM at the time, came up with this idea that I should go to Kenya. There was a big need in the PEPFAR office to do some coordination, but also an asset mapping project that IHP was involved in that could use some help. This, yet again, helped set me up for a job I took later in Bangladesh. I credit that opportunity to Sandy and her relationships in the PEPFAR world.

Then about another two years later, Sandy called me up again and said, "Stephanie, I need you to go back to Africa and help with this meeting we're planning." Sandy organized this elaborate swap of people so my job was covered, and I went to Kenya for several months to help plan a big meeting that brought together faith leaders from four east African countries to get their insights for the reauthorization of PEPFAR. We were really trying to include country and local leadership to move the HIV response forward in East Africa — something you can't do without working with faith leaders.

Mimi Kiser: I remember that you had a significant role in coordinating the convening for East African countries, and you had this unique responsibility of connecting with religious leaders from four countries. That is not a small endeavor. I had this view into the relationships that you had built and you were kind of facilitating my connection to them. It was really extraordinary, I think, to be on the other end of what you built across the religious leaders and other faith-based and public health organizations and government entities that were there.

So, there's organizational relational and there's human relational, but there's also a cross-cultural dimension of that, which I think you naturally had. But you really blossomed with the cultural and religious pieces, which was likely developed from the engagement you had with religious leaders during your time with IHP. That was quite a moment for me to see that.

This has led me to reflect on how the religion and health idea grew at Emory before the Interfaith Health Program. But then with The Carter Center's engagement and the leadership at the level of Dr. Foege and President Jimmy Carter. Having the kind of inroads and connections and relational connections with the CDC, the HHS Faith-based Office, and other partners really helped amplify religion and public health because of those organizational relationships. There was pretty significant institutional and structural amplification of religion as a part of public health programming.

Stephanie Doan-Soares: What do you think helped build those connections from IHP to these pretty big institutions?

Mimi Kiser: My first thought is around the credibility of Dr. Foege and his position, but there was something kind of hidden and unspoken historically. The nature of a lot of faith-based work aligns pretty closely with the values of public health, this idea of doing good for the public in the social realm. Many of the important leaders in public health – Dr. Foege, Dr. Tom Droege,[15] and some of the other surgeon generals, for example – got their start in public health as missionary doctors. So there's been this commitment to serve and do good, and enough leaders had that familiarity to give some credibility to this work. When Dr. Satcher was CDC Director, he put a lot of his authority and directive towards faith-based work. Do you have thoughts about that?

Stephanie Doan-Soares: I think that's true, but also it might not be the case now. The ecosystem for this new field that's emerging is different than it was, even thinking about the healthcare sector. There used to be a lot more hospital systems run by the Methodist Church or the Catholic Church. I mean, there are still organizations with connections to these churches, but the connectedness isn't as strong as it used to be. Maybe another question for reflection might be what that means for the field of faith and health as this work moves forward, right?

Ashley Meehan: Yeah, I had a similar question for both of you. Religion and public health, as an explicit area of focus in schools of public health, really started emerging at the same time as we were navigating HIV/AIDS, and you talked about going through influenza and H1N1, and now we have COVID-19 and monkeypox. I'm curious how you see religion and health playing out in these two concurrent pandemics right now. What do you think is going to happen? What do you think the role of religion is both structurally but also in communities and in people's daily lives? What do you think it means that religion and health are maybe a bit more settled now, and not emerging alongside these pandemics?

Mimi Kiser: So the environment has changed considerably, including the religious environment and changing church membership. I would say that religious leaders became very important during the COVID-19 pandemic in addressing vaccine hesitancy and misinformation, and I think that kept religion and health alive in a particular

Now that the pandemic is less intense, one of the questions we have is, "How do we continue all of the energy of the public health and healthcare systems working together with these faith communities in a practical way?

– Stephanie Doan-Soares

way. I'm really curious about how that stays alive in pandemic preparedness because I have never seen this many federal agencies take religion as seriously as they did during COVID-19, investing staff and programmatic resources, time, materials, strategies, and partnerships. It has been phenomenal – I've never seen it in my whole career. So, I don't have a prognosis for that. I'm really curious about where it will land.

Stephanie Doan-Soares: During the COVID-19 pandemic, I worked at a health system, the University of Massachusetts Memorial, a safety net hospital in central Massachusetts. I worked closely with a local task force that focused on the equity as part of the response to the virus. This task force came together with multiple interfaith partners, non-profits, and the city. Now that the pandemic is less intense, one of the questions we have is, "How do we continue all of the energy of the public health and healthcare systems working together with these faith communities in a practical way?" We've been having conversations about how we can transition this really effective task force to focus on the opioid epidemic or another high priority area. We want to make sure we learn from COVID-19 and maintain some of that momentum, but we're also not sure how much of that momentum is going to just fade away because everyone's really tired. I think a lot will depend on thoughtful and creative leaders who have the energy to carry this forward.

Ashley Meehan: I think that sets the stage really nicely for a call to action. How are we going to commit ourselves to this work, moving forward amidst a really overburdened public health workforce and communities that are stretched thin?

Mimi Kiser: I'm going to be curious to see how it unfolds. I will say, the Religion and Public Health Collaborative at Emory is still very active and alive at Emory, and there have been a number of leadership changes across Emory that I think are bringing in new momentum. Those leaders that are still here, Dr. Ellen Idler in Emory's College and Laney Graduate School, Dr. John Blevins in the Rollins School of Public Health, and other faculty in the Candler School of Theology have worked to create a really solid, interdisciplinary curriculum. They provide a significant amount of support to students. I like to think we were starting the platform and creating the basis for this work, particularly with Dr. Idler's work around religion as a social determinant of health. Over the last ten years, a number of doctoral graduate students from the Department of Religion have engaged in this curriculum, so I'm really curious about how they're shaping their roles and the field as a whole.

Now, I'd like to switch gears and reflect with you, Stephanie, about what you experienced in graduate school at Harvard. Can you say what may be distinctive about the work at Harvard, and any predictions you may have about its future?

Stephanie Doan-Soares: Yeah, so I came to Harvard for my DrPH for a few reasons, one of which is because Harvard's program is really incredible and focused on the leadership aspects in addition to public health science. Pretty early on in my time here, I had a meeting with Dr. Howard Koh, who I had connected with while I was at HHS when he was the Assistant Secretary for Health at HHS. Dr. Koh talks quite openly about religion as a social determinant of health and how we think about a culture of health.

After I finished my first year at Harvard, Dr. Koh asked me to join a project for a few hours a week – writing this systematic review about religion and health. It ended up turning into a much bigger project than we expected. Our team of incredible research assistants reviewed all of the literature from 2000 to 2020. Our team looked at the impact of religion and spirituality on health outcomes from a public health perspective, both for the general population and among patients with more serious illnesses. We presented our findings to a group of experts, including Dr. Idler and Gary Gunderson, and many others, including what our recommendations were for the future. And the manuscript was published this summer in *JAMA*.[16]

I think the approach at Harvard focuses a bit more on understanding the causality of religion on health, or how religion is a contributor to well-being and purpose and what that means for our health, as well as the role of spirituality among patients with serious illnesses. These themes are really central to the work led by Dr. Tyler VanderWeele, Dr. Tracy Balboni, and Dr. Koh. To me, that feels a little bit different from the approach at Emory, which might be more applied and focused on the social environment of communities, and also different from approaches at schools like Duke and Berkeley. All of these play an integral part in understanding religion and health, but they have slightly different angles.

Ashley Meehan: So, we are almost to the end of our time together. Are there any last-minute things you want to make sure are included? Any words of wisdom for new leaders or people considering this intersection?

Mimi Kiser: I am really glad that we are able to share about my and Stephanie's journeys, and that we got to see how Stephanie has really come alive in her work and in her leadership. But there is one more thing I want to make sure is captured in this conversation. In a new field, we have really great scholars, academics, and researchers, but I don't want us to miss out on the piece related to teaching and mentoring and supporting the creation of new students in this field. Investing in course development, supporting students in fieldwork, and advising students through this interdisciplinary study is critical to ensure the expansion and success of the field.

Stephanie Doan-Soares: Such a good point. That makes me think of one additional thing – I think another big piece of my learning at IHP was walking alongside you, Mimi, as I was going through all these experiences. I still vividly remember a conversation we had at Panera Bread about listening to myself and having more confidence in who I was. And that's just one example. I'm curious about what it was like for you as a faculty member, not only mentoring me but mentoring all of the students that you were able to mentor. What was the intentional work that went into creating a space where new leaders could grow and flourish in this new interdisciplinary field?

Mimi Kiser: What a great question! I cared a lot about the field and realized that I could make a great contribution to the field by supporting the next generation of leaders. I have a natural tendency towards a supporting and developing role, and it's rewarding for me to engage in reflective conversations with people who have this commitment and who want to develop themselves in a way to make a difference. It's really inspiring for me to think about how people are becoming while the field is being created – it's not just the field, but co-creating possibilities for what this field can do. There's a need for this integrative thinking that can bring about change and create environments for people to thrive, and thrive equally.

This conversation with Mimi Kiser and Stephanie Doan-Soares took place over Zoom on August 16, 2022. The transcript has been edited for clarity and brevity.

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[1]^Ashley Meehan, MPH, received her MPH in Global Health with a Certificate in Religion and Health from Emory University in May 2019, and worked at Emory's Interfaith Health Program (IHP) during the 2-year graduate program. She is currently a PhD student at Johns Hopkins Bloomberg School of Public Health (Ashleymeehan20@gmail.com).

[2]^Angela Monahan, MPH, is a contractor at the Department of Human and Health Services, and a graduate from the Infectious Diseases and Vaccinology master's program and the Public Health, Religion, and Spirituality Traineeship at the University of California Berkeley (angela.grace.monahan@gmail.com).

[3]^Emory University: Interfaith Health Program

[4]^Emory University: Religion and Public Health Collaborative

[5]^Foege, W. H., Amler, R. W., & White, C. C. (1985). Closing the Gap: Report of The Carter Center for Health Policy Consultation. *JAMA*, *254*(10),

1355–1358. https://doi.org/10.1001/jama.1985.03360100105023

[6]^McGinnis, J. M. & Foege, W. H. (1993). Actual Causes of Death in the United States. *JAMA*, *270*(18), 2207–2212. https://doi.org/10.1001/jama.1993.03510180077038

[7]^Interfaith Health Program: IHP History and Milestones

[8]^See, for example, "A Movement Toward Wholeness", by Gary Gunderson and the IHP in The Carter Center's Fall 1998 Issue of *Faith & Health*, highlighting the early energy around this work: faithanfhealth-10011998.pdf (cartercenter.org)

[9]^Stakeholder Health: Religious Health Assets Mapping

[10]^Santibañez, S., Davis, M., & Avchen, R. N. (2019). CDC Engagement With Community and Faith-Based Organizations in Public Health Emergencies. *American Journal of Public Health*, *109*(S4), S274-S276. https://doi.org/10.2105/AJPH.2019.305275 PMID: 31505142; PMCID: PMC6737812.

[11]^Gunderson, G. & Cochrane, J. (2012). *Religion and the Health of the Public: Shifting the Paradigm*. New York: Palgrave MacMillan.

[12]^Gunderson, G. (2022, May 2). *8 Strengths found in any congregation*. FaithHealth. https://faithhealth.org/8-strengths/

[13]^Gunderson, G. (2004). *Boundary Leaders: Leadership Skills for People of Faith*. Minneapolis, MN: Fortress Press.

[14]^Bobby Baker and Gary Gunderson. "Strengthening and Aligning Religious Health Assets in Memphis: A Conversation with Gary Gunderson and Bobby Baker." *Practical Matters Journal* (March 1, 2011). http://practicalmattersjournal.org/?p=1581.

[15]^Assorted Writings and Presentation of Thomas A. Droege (ihpemory.org)

[16]^Balboni, T. A., VanderWeele, T. J., Doan-Soares, S. D., Long, K. N. G., Ferrell, B. R., Fitchett, G., Koenig, H. G., Bain, P. A., Puchalski, C., Steinhauser, K. E., Sulmasy, D. P., & Koh, H. K. (2022). Spirituality in serious illness and health. *Journal of the American Medical Association*, *328*(2), 184-197. https://doi.org/10.1001/jama.2022.11086

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Resources & Updates: Fall 2022

PHRS Staff

Editors' Note: This section emphasizes resources at the intersection of religion/spirituality and public health, as well as major organizations that at times address these intersections. Please see the "Resources" tab on the PHRS website for more content, and please send new potential content to this section to: phrsadm1@publichealthrs.org and phrsadmin0@publichealthrs.org

New Research

- Rapid Review: March 2022: Spirituality in the Health Curricula in Canada. (Pilato et al.)
- Systematic Review: July 2022: Spirituality in Serious Illness and Health. (Balboni et al.)
- Systematic Review: August 2022: U.S. Federal Investment in Religiousness/Spirituality and Health Research: A Systematic Review (Park et al.)

Articles, Books, Commentaries, Interviews, and Webinars

- Vieten, C., & Lukoff, D. (2022). Spiritual and religious competencies in psychology. American Psychologist, 77(1), 26–38. http://dx.doi.org/10.1037/amp0000821
- **Recent Webinar:** September 1, 2022: Faith Leaders During Pandemics: Interfaith Collaboration Inspired by Jerusalem Impact Vaccination
- **Recent Webinar:** October 18, 2022. The WHO Faith Network, The Importance of Language: Faith partner resources for health emergencies.
- **Book:** The spirit of global health: The World Health Organization and the 'spiritual dimension' of health, 1946-2021. (Peng-Keller et al., 2022, Oxford)
- **Past Online Event:** October 6, 2022, 4-5:30pm Central Time. Valparaiso University, How Do We Live Well in a Wounded World?

Upcoming Conferences and Calls for Papers (newest first)

- **Upcoming:** Conference on Religion and Medicine, Conference theme: "At the Limits of Medicine: Caring for Body and Soul". Conference Date: March 12-14, Columbus, Ohio.
- **Upcoming:** American Public Health Association Conference, 150th Anniversary, November 6-9, 2022. More information about the below special events can be found in Barbara Baylor's article in this Fall 2022 Issue.

  Celebration: *United to Heal: An Interfaith Celebration of Holistic Healing and Peace, November 6, 2022, 6-7 p.m. in the Boston Convention Center*

  Special Invited Session: *Faithful Dancing with the Bears of Inequity: Past, Present, Future, November 7, 2022, 10:30 a.m.-12:00 p.m. in the Boston Convention Center*