Public Health, Religion & Spirituality Bulletin®

http://publichealthrs.org/bulletin/

Spring/Summer 2022
Issue 6

ISSN 2689-7024 © 2022

Public Health, Religion & Spirituality Network

Editorial

2 Editors' Introduction: Spring/Summer 2022 Issue #6
Kate Long, Angela Monahan, Ashley Meehan, and *Doug Oman*

Articles

3 Interview with Barbara Baylor
Angela Monahan and *Jessie Washington*

12 How Religion Motivated Smallpox Eradication
Doug Oman

Resources

18 Resources & Updates: Spring/Summer 2022
PHRS Staff

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.

Public Health, Religion, and Spirituality Bulletin
Spring/Summer 2022, Issue 6, p. 2
[Online 24 Jun. 2022, Article A035 • ISSN 2689-7024]
https://publichealthrs.org/a035/

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,

The PHRS Editorial Team
Kate Long, Angela Monahan, Ashley Meehan, and Doug Oman

Katelyn Long, DrPH
knlong@hsph.harvard.edu
Coeditor

Angela Monahan, MPH
angela_monahan@berkeley.edu
angela.grace.monahan@gmail.com
Assistant Editor

Ashley Meehan, MPH
ashleymeehan20@gmail.com
Assistant Editor

Doug Oman, PhD
dougoman@berkeley.edu
Coeditor

Public Health, Religion, and Spirituality Bulletin
Spring/Summer 2022, Issue 6, pp. 3–11
[Online 22 Jun. 2022, Article A033 • ISSN 2689-7024]
https://publichealthrs.org/a033/

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.

---

[1]^Angela Monahan, MPH, is an ASPPH/CDC fellow 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).

[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

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

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

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

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

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

Public Health, Religion, and Spirituality Bulletin
Fall 2022, Issue 6, pp. 12–17
[Online 6 Jun. 2022, Article A032 • ISSN 2689-7024]
https://publichealthrs.org/a032/

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.

References

Bandura, A. (2003). On the psychosocial impact and mechanisms of spiritual modeling. *The International Journal for the Psychology of Religion, 13*(3), 167-173. https://doi.org/10.1207/S15327582IJPR1303_02

Brilliant, L. B. (1985). *The management of smallpox eradication in India*. Ann Arbor: University of Michigan Press.

Brilliant, L. B. (2016). *Sometimes brilliant : The impossible adventure of a spiritual seeker and visionary physician who helped conquer the worst disease in history*. New York: HarperOne.

Butel, J., & Braun, K. L. (2019). The role of collective efficacy in reducing health disparities: A systematic review. *Family & Community Health, 42*(1), 8-19. https://doi.org/10.1097/FCH.0000000000000206

Dik, B. J., Duffy, R. D., & Eldridge, B. M. (2009). Calling and vocation in career counseling: Recommendations for promoting meaningful work. *Professional Psychology: Research and Practice, 40*(6), 625-632. https://doi.org/10.1037/a0015547

Foege, W. H. (2011). *House on fire: The fight to eradicate smallpox*. Berkeley: University of California Press. https://doi.org/10.1525/9780520948891

Henderson, D. A. (1980). Smallpox eradication. *Public Health Reports, 95*(5), 422-426.

Henderson, D. A. (2011). The eradication of smallpox – an overview of the past, present, and future. *Vaccine, 29*, D7-D9. https://doi.org/10.1016/j.vaccine.2011.06.080

Holman, S. R. (2015). *Beholden: Religion, global health, and human rights*. New York: Oxford University Press. https://doi.org/10.1093/acprof:oso/9780199827763.001.0001

Idler, E., Levin, J., VanderWeele, T. J., & Khan, A. (2019). Partnerships between public health agencies and faith communities. *American Journal of Public Health, 109*(3), 346-347. https://doi.org/10.2105/ajph.2018.304941

Kegler, M. C., Kiser, M., & Hall, S. M. (2007). Evaluation findings from the institute for public health and faith collaborations. *Public Health Reports, 122*(November-December), 793-802.

Oman, D. (Ed.). (2018). *Why religion and spirituality matter for public health: Evidence, implications, and resources*. Cham, Switzerland: Springer International. https://doi.org/10.1007/978-3-319-73966-3

Oman, D., & Syme, S. L. (2018). Weighing the evidence: What is revealed by 100+ meta-analyses and systematic reviews of religion/spirituality and health? In D. Oman (Ed.), *Why religion and spirituality matter for public health: Evidence, implications, and resources* (pp. 261-281). Cham, Switzerland: Springer International. https://doi.org/10.1007/978-3-319-73966-3_15

Oman, D., Thoresen, C. E., Park, C. L., Shaver, P. R., Hood, R. W., & Plante, T. G. (2012). Spiritual modeling self-efficacy. *Psychology of Religion and Spirituality, 4*(4), 278-297. https://doi.org/10.1037/a0027941

Pargament, K. I., Kennell, J., Hathaway, W., Grevengoed, N., Newman, J., & Jones, W. (1988). Religion and the problem-solving process: Three styles of coping. *Journal for the Scientific Study of Religion, 27*(1), 90-104. https://doi.org/10.2307/1387404

Porter, D. (2005). *Health, civilization and the state: A history of public health from ancient to modern times*: Taylor and Francis. https://doi.org/10.4324/9780203980576

Ram Dass (1979). *Miracle of love: Stories about Neem Karoli Baba*. New York: Dutton.

Tower, C., Van Nostrand, E., Misra, R., & Barnett, D. J. (2021). Building collective efficacy to support public health workforce development. *Journal of public health management and practice, 27*(1), 55-61. https://doi.org/10.1097/phh.0000000000000987

Whyle, E., & Olivier, J. (2017). Models of engagement between the state and the faith sector in sub-Saharan Africa – a systematic review. *Development in Practice, 27*(5), 684-697. https://doi.org/10.1080/09614524.2017.1327030

World Health Organization (1980). *The global eradication of smallpox: Final report of the Global Commission for the Certification of Smallpox Eradication, Geneva, December 1979*. Geneva: World Health Organization.

Apart from images obtained from Wikimedia Commons, this article is copyright © 2022 Doug Oman.

[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).

Public Health, Religion, and Spirituality Bulletin
Fall 2022, Issue 6, p. 18
[Online 15 Jun. 2022, Article A034 • ISSN 2689-7024]
https://publichealthrs.org/a034/

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.