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Boots on the Ground: Faith and Public Health in Action

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Editors' Note: In addition to interviews with senior scholars and other features, the PHRS Bulletin includes personal essays written by field leaders and other key contributors. Here, Dr. Scott Santibañez shares some lessons he has learned while working with community and faith-based organizations (CFBOs), along with links for additional information.[2]

My work at the intersection of religion, spirituality, and public health began over 30 years ago. In 1991, I worked at a clinic in the Times Square/Hell's Kitchen area of New York City during medical school. The clinic was staffed by volunteer health professionals who were motivated by their faith and beliefs to serve others by providing free, high-quality healthcare to those who were underserved. Our clients included people who were unhoused, struggling with addictions, or engaging in sex work to survive. In those days, medical students had limited clinical exposure prior to our third year. I could do basic things like check blood pressures and provide first aid. I also did the laundry, made copies, and just listened to people. Although HIV and other infectious diseases disproportionately affected our patients, effective treatments were not yet available. Tragically, being diagnosed with HIV caused many of our clients to be stigmatized by their families, friends, and society.

This experience had a profound effect on how I view the world. I became a primary care physician, specialized in infectious diseases, pursued a public health career that focused on preventing infections among people who were the most vulnerable, and later obtained a doctorate from seminary to better reflect on the ethical and social justice aspects of disease.

While working with community and faith-based organizations (CFBOs), one of the key lessons I learned was how social determinants, including those encountered by the patients in our clinic, impact health and the spread of infectious diseases. Addressing social determinants of health became part of my worldview[2,3] and influenced the trajectory of my career. For example, in Fischer et al., we describe how people who are stigmatized during a disease outbreak – on the basis of race/ethnicity, gender, socioeconomic status, or other factors—may be less likely to adopt healthy behaviors, making the control of infectious diseases more difficult and exacerbating inequities in outcomes.[4,5]

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CFBOs can be invaluable allies in public health—working together to address factors like disease-related stigma and other barriers and making health interventions available to people who might not otherwise have access. As was the case at our clinic in New York City, many CFBOs attract staff and volunteers from various faith traditions, as well as people without a religious background who feel a sense of calling to serve others.[6] Over the years, I have been fortunate to work alongside a variety of diverse faith-based and community partners[7,8] and experience how faith leaders can be trusted voices and sources of information who understand their communities' unique attributes, needs, and assets.

I have learned that science provides communities with the tools to fight diseases like HIV, tuberculosis, and other emerging infections. In our clinic, we were limited by the somewhat

rudimentary diagnostic tests and medications that were available in that era. Keeping the focus on public health science is an essential aspect of community partnerships. For example, in 2014 we used contact tracing— a science-based approach which involves identifying and monitoring potentially infected individuals— to prevent Ebola transmission in Dallas. Importantly, we worked with local CFBOs to implement contact tracing while respecting the community's unique cultural, linguistic, and socioeconomic differences.[9] Similarly, during the COVID-19 pandemic, many jurisdictions worked with CFBOs to provide vaccines—another tool made available by science— to those in greatest need.[10]

Lastly, I learned that obstacles can be overcome. Sustaining relationships between public health and CFBOs is challenging but necessary. The clinic where I served as a medical student has long since closed its doors. Other sites face similar obstacles with sustainability. Our paper by Peterson et al. describes how the Minnesota Immunization Networking Initiative received Eliminating Health Disparities Initiative grants from the Minnesota Department of Health Office of Minority and Multicultural Health with a cumulative total of more than $1 million as part of a multiyear legislative mandate to reduce health disparities within the state.[7] Another challenge we have seen is how the public may struggle to recognize misinformation about health topics. Building trusted relationships with those in public health may help community partners be more prepared and empowered to identify reliable sources of health information. Having public health trained providers serving with CFBOs can also help to ensure that resources are utilized in high-impact ways consistent with a CFBO's values.[8]

While much has been accomplished in the field of Public Health, Religion, and Spirituality, in terms of collaboration there is more work to be done. I hope that interested readers will take a look at the additional information using links I've provided and be encouraged to learn from and expand upon these efforts.

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[2]^ The findings and conclusions in this article are those of the author and do not necessarily represent the official position of CDC.