EVALUATING THE PRESENT AND FUTURE ROLE OF FAITH-BASED ORGANIZATIONS IN IMPROVING UNDERSERVED COMMUNITIES IN THE U.S.
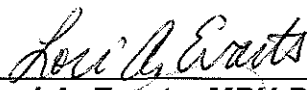
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Abstract
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Evaluating the Present and Future Role of Faith-Based Organizations in Improving Underserved Communities in the U.S.
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This paper reviews the racial and health disparities that exist in underserved communities in the United States and how faith-based organizations have affected them. Reducing health disparities remains a major public health challenge. With the persistence of these disparities, faith-based organizations will continue to play a major role in the improvement of underserved communities. In fact, these organizations are vital to the eradication of these differences. Health disparities do not have a single root cause and many factors may lead to differences in health care. To adequately address these disparities and their determinants, they must be approached at multi-levels, including individual, family, and community improvements. Faith-based organizations should be involved in this strategic effort, because they play an intricate role in the lives of those living in underserved communities.

There are three major types of faith-based organizations: congregations (e.g. the local church), denominational organizations (e.g. Catholic Charities, The Salvation Army) and national networks (e.g. YMCA, YWCA), and freestanding organizations (non-profit organizations). All three types have been involved in health initiatives and community-based interventions. Some have exhibited success and some have highlighted the inherent limitations of faith-based organizations in community development. Best practices of faith-based

organization involvement in community development are best illustrated in denominational networks such as Catholic Charities, and in non-profit Community Development Corporations (CDCs), such as the Abyssinian Development Corporation (ADC) in Central Harlem. Although there are many models of success, a closer look at this evidence reveals that despite their broad involvement in *services*, most faith-based organizations are not active in *community development*. While the social services that are offered are vital to meeting individual human needs, they do not scratch the surface of improving the community and society in underserved areas.

In order for faith-based organizations to attain capacity to engage in effective and sustaining community development, assistance from external sources is necessary. The Office of Faith-Based and Neighborhood Partnerships established by President Obama can provide the vehicle for education, resources, networking, and sharing of best practices that is necessary for these organizations to develop these abilities. This Office will train the trainers, partner with State and Local Offices, hold recipients responsible, and close the learning gap (Obama '08, 2008). Furthermore, commitment by federal and state offices to collaborate/educate these organizations is vital to the increased commitment of faith-based organizations to community development. This assistance must illuminate the shared goals of faith-based organizations and the public health field (e.g. improved community for the underserved, ministry to the "whole" person, better living conditions, better access to healthcare), which will result in progress towards eliminating the current health disparities.

Given the churches' demonstrated ability to motivate, to inspire, and to pull people together, there is great potential for faith-based interventions and models to address health disparities in the future (Kaplan et al., 2006). In fact, the past models of success, as well as failures, which can be used as lessons learned, can propel faith-based organizations to the forefront of community development that will reduce health disparities in underserved communities.

Table of Contents

List of Tables

List of Figures

List of Abbreviations

ADC	Abyssinian Development Corporation
AHRQ	Agency for Healthcare Research and Quality
AIDS	Acquired Immunodeficiency Syndrome
AME	African Methodist Episcopal
BIG	Balm in Gilead
CDC	Centers for Disease Control and Prevention
CDCs	Community Development Corporations
CDDPH	Centers for Population Health and Health Disparities
CEO	Chief Executive Officer
HHS	U.S. Department of Health and Human Services
HIV	Human Immunodeficiency Virus
HUD	U.S. Department of Housing and Urban Development
IHP	Interfaith Health Program
IOM	Institute of Medicine
ISIS	Intimate Sessions for Informed Sexuality
KC – CDC	Kansas City - Chronic Disease Coalition
NCC	New Community Corporation
NHDR	National Healthcare Disparities Report
NIH	National Institutes of Health
OLPC	One Laptop per Child
OMH	Office of Minority Health
REACH	Racial and Ethnic Approaches to Community Health
RFP	Request for Proposal
SAWSO	The Salvation Army World Service Office
VOHCDC	Vision of Hope Community Development Corporation
YMCA	Young Men's Christian Association
YWCA	Young Women's Christian Association

Introduction

Americans are a deeply religious people, with more than 71 percent reporting that they believe in God or a higher power, and faith-based organizations provide critical social services to tens of millions of Americans every year. A recent Pew report noted that a majority of Americans (66%) favor allowing churches and other faith communities to apply for government funding to provide social services (Obama '08: Partnering with Communities of Faith [Obama '08], 2008). Everyday these organizations develop innovative solutions to our nation's most worrisome problems. For example, Catholic Charities is working to ensure that homeless veterans are not sleeping on the streets of Chicago (Obama '08, 2008) and Ready4Work is a faith-based initiative devoted to ensuring that ex-offenders do not return to a life of crime in 11 cities across the country (Obama '08, 2008). A diverse coalition of religious groups have come together for causes ranging from rebuilding New Orleans to fighting for secure wages for all workers (Obama '08, 2008). Furthermore, with the persistence of health disparities in America, faith-based organizations have and will continue to play a major role in the improvement of underserved communities. In fact, these organizations are vital to the eradication of these differences.

This paper will review the racial and health disparities that exist in underserved communities in the United States and review how faith-based organizations have affected them. It will also review the various types of faith-based organizations, their best practices, failures and limitations, federal policies, and their future role. In summary, it will explore the present and future roles of faith-based organizations in underserved communities.

Discussion of Problem

Reducing health disparities remains a major public health challenge in the United States. In its broadest sense, the term "health disparities refers to preventable differences in the indicators of health of different population groups, often defined by race, ethnicity, sex, educational level, socioeconomic status, and geographic location of residence" (Mensah, Mokdad, Ford, Greenlund, & Croft, 2005, p. 1233). Health was defined as a state of "complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (Fielding, 2008, slide 4) by the World Health Organization in 1948 and in 1996 it was defined by Alvin Tarlov as an "individual's capacity in relation to aspirations and potential for living fully in the social environment" (Fielding, 2008, slide 5). On the other hand, the word "disparity" can be defined as "the condition or fact of being unequal, as in age, rank, or degree" (Agency for Healthcare Research and Quality [AHRQ], 2003). The first National Institutes of Health Working Group on Health Disparities defined disparities as including "differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions" (Mensah et al., 2005, p. 1233).

Health disparities do not have a single root cause and in fact many factors may lead to differences in health care, especially with respect to aggregate measures of use. These include different underlying rates of illness due to genetic predisposition, local environmental conditions, or lifestyle choices. As described by Fielding (2008), Figure 1 illustrates that a person's social, physical, and genetic environment, as well as other factors such as public health services, health services, and the economy affect health. There are also variations in patient care-seeking behavior, which vary due to differing cultural beliefs, linguistic barriers, degree of trust of health care providers, or differences in the predisposition to seek timely care. Moreover, the

2

availability of care is dependent upon such factors as the ability to pay for care, the location, management and delivery of health care services, clinical uncertainty, and health care practitioner beliefs. There may also be differing perspectives regarding the appropriate division of financial responsibility between the individual, the public sector, and the private sector in regard to health services. Finally, population and family characteristics (e.g. race, ethnicity, income, education, place of residence, age, etc.) may also influence access to health care, and these effects are both independent and cumulative (see Figure 2 for health, demographic, and household family characteristics) (Fielding, 2008).

Despite improvements in health care and overall health in the United States, health disparities still persist in minorities. This is important because nearly one in two Americans will be a member of a racial or ethnic minority, i.e. Black, Hispanic, Asian, or American Indian, by the year 2050 (AHRQ, 2003). In 1985, the Report of the Secretary's Task Force on Black and Minority Health documented the disparity in key indicators among certain groups of the U.S. population, investigating long-standing disparities between the health status of African-Americans, Hispanics, Asian/Pacific Islanders, and Native Americans compared to that of Whites. The key finding of this Report was that 60,000 deaths occur each year in minority populations with 80% of them accounted for by the following six causes of death: 1)Cancer, 2)Cardiovascular disease and stroke, 3)Chemical dependency, measured by deaths due to cirrhosis, 4)Diabetes, 5)Homicides and accidents (unintentional injuries), and 6)Infant mortality (Perspectives in Disease Prevention and Health Promotion Report of the Secretary's Task Force on Black and Minority Health [Secretary's Task Force], 1985). The Centers for Disease Control and Prevention (2006) found twenty-one years after this study there was little change in the leading causes of African Americans deaths, with the ten leading causes of death being 1)Heart

Disease, 2)Cancer, 3)Stroke, 4)Unintentional injuries, 5)Diabetes, 6)Homicide, 7)Nephritis, Nephrotic syndrome, and Nephrosis, 8)Chronic lower respiratory disease, 9)HIV/AIDS, and 10) Septicemia.

Moreover, by 2006 HIV/AIDS had moved into the top ten leading causes of death among African-Americans. Therefore, it is not surprising that African-Americans experienced the highest rates of HIV diagnoses among adults and adolescents of all ethnic groups from 2001 - 2004 (see Figure 3). As documented by Sutton, et. al., a statistically significant decrease was observed in the diagnosis of HIV among African-American population from 2001 to 2004, however much work is still required to eliminate the vast difference in this population from other ethnic groups in the United States (Sutton, Durant, Prejean, Xiaohong, Wei, Lee, 2009). Additionally, there are tremendous disparities in HIV/AIDS cases as reported by The Balm in Gilead (n.d.). Although African Americans represent only 12 percent of the total U.S. population, they account for 46 percent of total U.S. AIDS cases (Centers for Disease Control and Prevention [CDC], 2008). It was found in 2007 that more than 50 percent of newly reported HIV infections in the United States is among African Americans (see Figure 4) (CDC, 2009). In fact, AIDS is the number one cause of death in the U.S. for Black adults aged 25 to 44, before heart disease, cancer and homicide, and Black children in the U.S. represent almost two-thirds (62 percent) of all reported pediatric AIDS cases (CDC, 2008).

Because of these glaring disparities that have existed for decades, the Secretary's Task Force (1985) made eight main recommendations:

1. Implement an outreach campaign, specifically designed for minority populations, to disseminate targeted health information, educational materials, and program strategies.

2. Increase patient education by developing materials and programs responsive to minority needs and by improving provider awareness of minority cultural and language needs.

3. Improve the access, delivery, and financing of health services to minority populations through increased efficiency and acceptability.

4. Develop strategies to improve the availability and accessibility of health professionals to minority communities through communication and coordination with nonfederal entities.

5. Promote and improve communication and coordination among federal agencies in administering existing programs for improving the health status and availability of health professionals to minorities.

6. Provide technical assistance and encourage efforts by local and community agencies to meet minority-health needs.

7. Improve the quality, availability, and use of health data pertaining to minority populations.

8. Adopt and support research to investigate factors affecting minority health, including risk-factor identification, education interventions, and prevention and treatment services.

Since 1985, many of these recommendations have been acted upon and most progress has been made through the institutionalization of minority-related health and service initiatives at the federal and state level. For instance, the federal Office of Minority Health (OMH) was

established in 1985 to serve as the federal focal point for leadership, coordination, and guidance on policies and programs aimed at improving minority health and ameliorating health disparities to specifically address Recommendation 5 (Kaiser Family Foundation, 2005). This Office advises the Secretary of the U.S. Department of Health and Human Services (HHS) and the Office of Public Health and Science on public health policy and program activities affecting minority communities. Following this approach, many states have developed their own Offices of Minority Health to address disparities within their prospective state. These offices assist in addressing Recommendations 6, 7, and 8. In 1990, the National Center for Minority Health and Health Disparities of the National Institute of Health was established, which resulted in RFPs for the first-time being released with the term "community-based participatory research" (Kaiser, 2005).

Also in 1998, President Clinton implemented a racial and ethnic health disparities initiative entitled One America (One Laptop per Child [OLPC] Internet FAQ Archives, n.d.) that changed the focus of government efforts from reducing disparities to eliminating them. After the 1999 publication of *Healthy People 2010*, the Centers for Disease Control and Prevention introduced the Racial and Ethnic Approaches to Community Health (REACH) program, which features community-based participatory research as a tool to achieve social justice in health care. These institutes and programs addressed Recommendations 1 and 2. Besides this, national, state, and local agencies have all improved their data collection methods to address Recommendation 7, which makes it possible to measure the health problems of minorities with increasing sophistication (OLPC Internet FAQ Archives, n.d.). Furthermore, when the National Center on Minority Health and Health Disparities was established as part of the Minority Health and Health Disparities Research and Education Act of 2000, all National Institutes of Health (NIH) institutes

and centers were required to develop strategic plans for modifying and eliminating health disparities. Federally funded researchers were challenged to adopt research models combining social, behavioral, clinical, and basic science. Reports published by the Institute of Medicine and the National Academy of Sciences also described new multilevel, trans-disciplinary research paradigms that integrated theories from the social and behavioral sciences with new research on genetics and molecular biology. Together, all these developments created a strong stimulus for a new approach to research by the federal government to address Recommendation 8.

In 2002, the National Institute of Environmental Health Sciences invited applications to establish Centers for Population Health and Health Disparities (CPHHDs) with eight CPHHDs launched in September 2003. At the same time, the Agency for Healthcare Research and Quality (AHRQ) initiated several programs that addressed disparities in health services. Reflecting the design of the REACH program (Collie-Akers, Schultz, Carson, Fawcett, & Ronan, 2009), each CPHHD was required to include at least one community-based participatory research project to ensure that resulting new interventions would have external validity and relevance to public health concerns and policy. Partnerships forged through local public health programs, advisory boards, and the direct participation of community members in the research process have expanded the research and service delivery infrastructure at the state and local level to again address Recommendations 1, 2, 3, and 8 (Warnecke et al., 2008).

Finally, Recommendation 4 has been addressed in many ways. A variety of programs recruit minority-group members to become physicians and encourage them to practice in underserved areas. Through the efforts of many medical schools and other organizations, the proportion of minorities in medical school has increased significantly. In addition, programs such as the National Health Service Corps recruit medical students willing to commit three years

of service as a physician in underserved areas in exchange for significant relief from student loan debts. As well, immigration rules permit thousands of foreign-trained physicians to come to the United States for specialty training and many of them join programs in underserved areas (OLPC Internet FAQ Archives, n.d.).

After the National Healthcare Disparities Report (NHDR) and an Institute of Medicine (IOM) report confirmed that disparities were pervasive and that improvements were possible, elimination of health disparities became one of the two overarching goals of the Healthy People 2010 national public health agenda. Therefore, when exploring health determinants (see Figure 1), one must look at population health, as well as community health. Community health is population health, but also includes the characteristics of the community that influence health determinants over time, such as safety of parks, civic engagement, environmental problems, and markets selling affordable fresh fruit and vegetables (Fielding, 2008). In addition, community health is influenced by the collection of family environments that exists within a community and these environments are impacted by individual family characteristics and family life-cycles (see Figure 5 for community and family pathways to health). Thus, exploring family environments will also shed insight into community health and health disparities.

Faith-based organizations are strategic vehicles, well positioned, to address not only the Secretary's Task Force recommendations previously mentioned, but to facilitate community health and development. Community development is asset building, which not only focuses on human services that directly address issues such as healthcare, but also centers around housing and community economic development, and includes developmental efforts, such as job training, to prepare residents for more productive lives (HUD, 2001). Individual, family, and community

8

improvements are essential to tackling the health determinants that have resulted in the current health disparities. Faith-based organizations should be involved in this strategic effort, because they play an intricate role in the individual, familial, and communal lives of those living in underserved communities.

Review of Faith-Based Organizations

There are three major types of faith-based organizations: congregations, denominational organizations and national networks, and freestanding organizations. Many congregations engage in activities that extend beyond worship and the National Congregations Study indicated that 57 percent of congregations engage in some type of service or community activity (HUD, 2001), and the range of activities undertaken is vast, with human services and health-related programs predominating. As reported in 2001, the most frequently offered human services were youth programs (including camps), marriage counseling, family counseling, and meal services or food kitchens. The most widespread health-related activities were found to be visitation or other supports for sick persons or shut-ins. When looking at specific activities, the most common programs addressed food, housing/shelter, and clothing provision (HUD, 2001). Only 18 percent of congregations participated in any type of housing program, the most common community development activity, and only 1 percent engaged in employment-related programs (see Table 1) (HUD, 2001).

Such a congregation that engages in community development activity is The New Hope Baptist Church in Newark, NJ, which created the Vision of Hope Community Development Corporation (VOHCDC) in 1999 to address social issues and ultimately relieve the underserved

and distressed in the surrounding community (Vision of Hope Community Development Corporation [VOHCDC], n.d.). Its overall mission is to service the needs of the Greater Essex County population by affording residents an array of programs that will empower and support them. This mission is executed by working in collaboration with other faith and community based organizations (VOHCDC, n.d.). Some of the social services that the organization offers are food and clothing services, substance abuse counseling and drug rehabilitation referrals, employment resources, senior services, health services, fathers' ministry, domestic violence counseling, and social service referrals (VOHCDC, 2008).

The second type of faith-based organizations is the national denominations and their social arms, such as Catholic Charities, the Salvation Army, the United Jewish Federations, and Lutheran Social Services that provide a wide variety of services, often on a much larger scale than congregations. As a denominational organization, Catholic Charities works with individuals, families and communities to help them meet their needs, address their issues, eliminate oppression, and build a just and compassionate society (Catholic Charities, n.d.). The organizational mission of Catholic Charities is "to provide service to people in need, to advocate for justice in social structures, and to call the entire church and other people of good will to do the same" (Catholic Charities, n.d.). Catholic Charities USA is the national office for over 1,700 local Catholic Charities agencies and institutions nationwide (Catholic Charities, n.d.). It provides strong leadership and support to enhance the work of local agencies in their efforts to reduce poverty, support families, and empower communities. In fact, it traces its roots back to 1727 when the French Ursuline Sisters opened an orphanage in New Orleans (Catholic Charities, n.d.). Catholic institutions were also established in major cities along the east coast, providing homes and education for children whose parents were lost to disease and tragedies common in

10

early America. With the rise of immigration in the mid-1800s, which resulted in an increase in poverty and orphans, the demand for Catholic charities increased, and by the early 20th century, a Catholic Charities network had developed to provide social work and health care, and to serve as an advocate for the poor. The National Conference of Catholic Charities was created to promote the creation of diocesan Catholic "solidarity" among those in charitable ministries, and to be the "attorney for the poor" (Catholic Charities, n.d.). People of many faiths work with Catholic Charities, but essential traits characterize the organization: such as, being rooted in the Scriptures, being an integral part of the Catholic Church, promoting the sanctity of human life and the dignity of the human person, supporting an active public-private partnership, and advocating for those in need (Catholic Charities, n.d.).

Similarly, The Salvation Army's motto is "DOING THE MOST GOOD" (Salvation Army, n.d.). The Salvation Army's eleven articles of faith reflect its determination to remain faithful to its standards and principles (see Figure 6). All members of The Salvation Army are encouraged to review these principles periodically and to reaffirm their dedication to God and to His good works. It is an international movement that is an evangelical part of the universal Christian Church. The Salvation Army's message is based on the Bible and it is motivated by the love of God, and its mission is to preach the gospel of Jesus Christ and to meet human needs in His name without discrimination (Salvation Army, n.d.). Further, it seeks to work hand in hand with communities to improve the health, education, living, economic and spiritual conditions of the poor throughout the world. It accomplishes this through thrift stores, disaster relief, The Salvation Army World Service Office (SAWSO), prisoner, drug and alcohol rehabilitation, youth camps, Kroc centers, maternal and child health services, and community development (Salvation Army, n.d.).

11

National denominations are typically large, sophisticated entities with professional staff. They tend to be much better than congregations at record-keeping, because they handle much larger sums for which they are held accountable. Their social service agencies are also much more likely than congregations to use public funding to support their work (HUD, 2001). Together with national denominations, network organizations (such as the YMCA and YWCA) provide many of the same kind of services congregations do, often with the same family focus, but their greater size and resources enable them to provide more in-depth social services. The six largest such social service providers assisted more than 60 million people in 1994 with an estimated more than $1.6 billion in private contributions (HUD, 2001).

Lastly, freestanding faith-based organizations constitute a heterogeneous group. It includes ecumenical and interfaith coalitions, large nonprofit institutions such as universities and hospitals with a current or previous religious affiliation, and a multitude of smaller nonprofits. Like congregations, small faith-based nonprofits are much more likely to provide direct services than to engage in broader community benefit activities (HUD, 2001).

Such a freestanding organization is The Balm in Gilead, which is an organization that is celebrating 20 years of service developing educational and training programs specifically designed "to meet the unique needs of African American and African congregations that strive to become community centers for health education and disease prevention" (The Balm in Gilead, n.d.). Furthermore, its mission is to prevent diseases and to improve the health status of people of the African Diaspora by "providing support to faith institutions in areas of program design, implementation and evaluation which strengthens their capacity to deliver programs and services that contribute to the elimination of health disparities" (The Balm in Gilead, n.d.). It strives to

12

develop and disseminate culturally appropriate educational materials to the African American

Christian community; provide training, organizational, and technical assistance to churches,

church groups, AIDS service organizations and health departments through its HIV/AIDS

Technical Assistance Center; assist AIDS service organizations and health departments in

deepening their understanding of the African and African American community; and provide the

media industry with information about how the church meets the HIV/AIDS educational needs

of congregations and communities (The Balm in Gilead, n.d.).

Faith-Based Organization Best Practices/Models of Success

There have been numerous successful public health initiatives nationwide to reduce

health disparities through the involvement of faith-based organizations, individually and

collaboratively.   One such initiative was the Bronx Health REACH faith-based initiative which

took place in the Bronx, New York (Kaplan et al., 2009). It used a community-based

participatory approach that was designed to educate community members about health

promotion and disease management and to mobilize church members to seek equal access to

health care services. This initiative utilized qualitative methods, including a logic model, focus

groups, interviews, analysis of program reports, and participant observation. It also examined

the three key aspects of the initiative's implementation: "1) the engagement of the church

leadership; 2) the use of church structures as venues for education and intervention; and 3)

changes in church policies" (Kaplan, Calman, Golub, Ruddock, & Billings, 2006, p.1). The key

findings included "the importance of a pre-existing relationship within the community and the

prominent agenda-setting role played by key pastors, and the strength of the Coalition's dual

focus on health behaviors and health disparities" (Kaplan et al., 2006, p.1). This intervention was highly successful and best practices can be gleaned from it.

Another successful project was the REACH 2010 initiative that was undertaken by the Kansas City - Chronic Disease Coalition (KC - CDC). Through community mobilization of neighborhood and faith organizations this initiative sought to change conditions to reduce risk for cardiovascular disease and diabetes. These changes included such activities as increasing engagement in physical activity (e.g. creating walking groups), increasing fruit and vegetable intake, and increasing the number of residents that had a primary care provider (see Table 2). As a matter of fact, nutrition and physical activity were the most frequently targeted risk factors. With partners in neighborhood and faith organizations, the KC - CDC implemented 306 community changes (Collie-Akers et al., 2009). The results achieved between October 2001 and September 2007 were the facilitation of 86% of the community changes by neighborhood organizations and 90% of the community changes by faith organizations (Collie-Akers et al., 2009). Most of the changes facilitated were ongoing (64.8% among neighborhood associations and 60% among faith organizations), as opposed to being events that occurred one or more times (Collie-Akers et al., 2009). The additional tools and strategies highlighted by this study may help health practitioners to address health disparities where people live and worship to change conditions for health and health equity in the community (Collie-Akers et al., 2009).

As was previously discussed, reducing health disparities requires that multiple and interrelated factors be addressed through change in multiple sectors in the community (Collie-Akers et al., 2009), (Fielding, 2008). In other words, faith-based organizations must address the "whole person", which translates into addressing individual, familial and communal factors

14

influencing the population, and therefore the individual (Fielding, 2008). That being said, faith-based organizations' perceived importance of dealing with the "whole person" might give them an advantage over their secular counterparts in developing communities. Specific examples illustrate that congregations can achieve significant impact when they do become involved in community development. For instance, faith-based organizations, collectively, spend between $15 and $20 billion annually in privately-raised funds on social services, in addition to millions of volunteer hours (HUD, 2001). Faith-based organizations can also provide indirect support for community development through their social investments (HUD, 2001).

Examining congregations specifically, it appears that these types of faith-based organizations have a unique vantage point from which to enter community development, since many possess the qualities that are needed to be successful, such as an organizational structure and the dedication to improving the situations of low-income people and their neighborhoods (AHRQ, 2003). Community development, as currently practiced by Community Development Corporations (CDCs) and others, is best addressed by independently incorporated organizations because this provides the greatest financial and legal security for the participating organizations. This is the reason that faith-based CDCs are the most common examples of congregational sponsorship of spin-off non-profit organizations that engage in community development (HUD, 2001). Interestingly, it was found that about 14 percent of the nation's CDCs reported that they were faith-based (HUD, 2001). In the aggregate, evidence suggests that the group of congregations most likely to become actively engaged in services includes large (>900 congregants) African American congregations that are located in lower-income communities, but that attract as members significant numbers of congregants who are not themselves poor (HUD, 2001).

A prominent model of success is the Abyssinian Development Corporation (ADC) that was established by Abyssinian Baptist Church in Central Harlem (HUD, 2001). During its early development, ADC received from its church important in-kind support, including rent-free office space, free telephone and telephone answering service, access to Xerox and fax machines, help from church volunteers, and high-quality financial management services from the individual who performed the function for the church (HUD, 2001). ADC's first project in 1992 was a 25-unit transitional housing development, with on-site services, for formerly homeless families (Vidal, 1998). By 1998, they had developed more than 400 units of housing, as well as a variety of economic development projects (Vidal, 1998). Another example includes the Greater Allen African Methodist Episcopal (AME) Cathedral of New York (formerly Allen AME Church) in Jamaica, New York (HUD, 2001). The CDC started by this church began its work in 1978 by developing a $13 million, 300-unit senior citizens center with funding from Section 8 and Section 202 programs (Decaro, 1997). It was one of the largest faith-based elderly housing developments ever constructed (Decaro, 1997).

In summary, congregations bring distinctive advantages to the table that have led to success and represent possible best practices to future roles in community development with the potential to serve as incubators, the potential to provide access to volunteers and financial resources of the congregation and its affiliated organizations, and a context that engenders public trust (HUD, 2001). This was shown to be true in Bridgeport, Connecticut where Freddie Mac, the federally chartered financier of mortgage loans, joined with churches, CDCs, and lenders to initiate faith-based efforts aimed at increasing rates of minority homeownership. Surveys and focus groups conducted by Freddie Mac showed that a primary cause of the low rates within minority communities was uncertainty about whom to trust in the home buying process (Prevost,

2006). It was discovered that an emissary – that the potential minority homeowners trusted – was needed to help them make the first step, and Freddie Mac found that to be the faith community. Clergy involved in the initiatives vigorously preached "the virtues of self-sufficiency and the financial benefits of homeownership at Sunday services, an aspect of their ministry that members of the clergy say is critical to stabilizing their communities and halting generational cycles of poverty" (Prevost, 2006).

At a denominational level, Catholic Charities is a model of success celebrating 100 years of service in 2010 (Catholic Charities, n.d.). Catholic Charities agencies throughout the country are an integral part of the safety net that keeps people from utter destitution by providing a continuum of services; food, shelter, supportive housing, clothing, financial assistance, and other forms of help. Going beyond meeting peoples' daily needs, Catholic Charities also strives to strengthen families and build stronger communities by offering a variety of other programs such as counseling, immigration and refuge services, adoption, disaster response, child care, employment training, and supports for seniors (Catholic Charities, n.d.). Catholic Charities has built its reputation as a strong and trusted network through more than 280 years of compassionate work in the United States and is recognized as one of the nation's largest social service networks with more than 240,000 volunteers, staff, and board members (Catholic Charities, n.d.). Its efficient operations allow ninety cents of every dollar donated to its agencies to go directly to programs and services (Catholic Charities, n.d.). While every agency is unique, they share a common goal of providing the services and programs that their particular community needs the most. The National Office assists the individual agencies in determining their community needs and provides assistance with program development, formal training and technical assistance, financial support, and networking opportunities (Catholic Charities, n.d.).

For this reason, although each agency tailors its program, implementation, and evaluation process to fit its particular needs, there is a certain amount of consistency among the programs implemented across the U.S. One agency, Catholic Charities of the Archdiocese of Boston, determines the needs of its community by using the logic model, and its outcomes measurement system also follows the logic model (JustGive.org, n.d.). Agency-wide programs are evaluated by measuring the indicators of short and long term outcomes and using corresponding data collection tools to collect information, including indicators and influencing factors. Program types are also evaluated on an agency-wide basis and information is solicited from and shared with stakeholders, which helps to ensure that the programs are truly meeting the needs of those in the community. Furthermore, the National Office also enhances the network by serving as a national voice through federal advocacy and media efforts. In 2008, Catholic Charities across the nation provided help for 8,522,997 people regardless of their religious, social or economic backgrounds (Catholic Charities, n.d.). In all, 171 main Catholic Charities agencies, which included 1,668 branches and affiliates, provided an array of vital community-based services 13,887,583 times (Catholic Charities, n.d.). In summary, Catholic Charities USA supports local agencies through advocacy, networking, national voice, training, financial support, and leadership.

New Community Corporation (NCC) is by far the largest faith-based CDC and it is a freestanding organization (Briggs, Mueller, & Sullivan, 1997). It has developed more than 3,300 housing units and a number of economic development projects in its Central Ward neighborhood of Newark, New Jersey (Briggs et al., 1997). Through its affiliates, it also provides a variety of social services. NCC's origins lie in a coalition of urban and suburban churches formed in response to the Newark riots in 1968 (Briggs et al., 1997). Another freestanding organization

much smaller in size is The Balm In Gilead, which has mobilized The Black Church Week of Prayer for the Healing of AIDS that engages Black churches to become centers for education, compassion and care in the fight against HIV/AIDS (The Balm in Gilead, n.d.). Pernessa Seele, the founder and Chief Executive Officer (CEO) of The Balm in Gilead, organized Harlem's first Week of Prayer for the Healing of AIDS in 1989, and her efforts have led to a national movement to address public-health issues through communities of faith (The Balm in Gilead, n.d.). This approach has garnered Seele high-level recognition. In fact, she was a guest of President and Mrs. Bush's at the State of the Union address, in which the President talked about the disproportionate toll that AIDS is taking on the African-American community (Gorman, 2006). Those churches that Seele has worked with have broadened their AIDS education and ministries, an important first step toward eliminating disparities. Seele has done this through many programs such as The BIG Coffee Project, The Black Church Week of Prayer for the Healing of AIDS, the Black Church HIV/AIDS Training Institute, Our Church Lights the Way, Africa HIV/AIDS Faith Initiative, Denominational Leadership Initiative, The ISIS Project, and The Faith Based HIV/AIDS National Technical Assistance Center (The Balm in Gilead, n.d.).

Faith-Based Organization Failures and Limitations

Although there are many models of success, a closer look at this evidence reveals that despite their broad involvement in *services*, most faith-based organizations are not active in *community development*. Congregations, in particular, typically approach their service activities in a manner that appears poorly matched to current community development practice (HUD, 2001). Although Table 3 illustrates high levels of engagement that appear to imply the operation of formal programs, it is not the norm. The activities performed by congregation faith-based

programs are numerous, yet the amount of money involved is generally small. For example, Hodgkinson, et al. (as cited in HUD, 2001, p. 7) estimated that the "more than 236,000 congregations involved in human services/welfare activities devoted an impressive $4.4 billion to them" (HUD, 2001, p.7). However, Chaves and Tsitsos (as cited in HUD, 2001, p. 7) found that the "median dollar amount spent by congregations, directly in support of social service programs [by which they mean all non-worship activities], is about $1,200" not counting the value of staff or volunteer time or other donations to denominations. High rates of participation supported by small amounts of funding are the approach congregations typically use with respect to involvement in service activities. For instance, while 33 percent of congregations support food programs, they do so in differing ways (HUD, 2001). Some donate money or supply volunteers to meal-making projects or to a food bank; others distribute holiday food baskets to the poor or operate a soup kitchen. While these services are vital to meeting individual human needs, they do not scratch the surface of improving the community and society in underserved areas. They simply address the symptoms of the problems and not the root causes.

This distinctive approach, high participation with a low financial commitment, used by congregations, extends to participation in activities commonly considered part of community development (see Table 3). For example, of all of the housing programs for seniors supported by congregations, 86 percent of these programs are actually conducted by other organizations and 73 percent of affordable housing programs are also done that way. Chaves (as cited in HUD, 2001, p. 8) finds that supplying volunteers to Habitat for Humanity is by far the most common form of congregational participation in housing as exhibited in Table 3, as opposed to participation in faith-based housing programs run independently of other organizations.

Although, some CDCs have been successful, more congregational efforts to start independent community development entities have failed than have succeeded (HUD, 2001). This has occurred for a number of reasons. One is the result of the high participation with a low financial commitment approach, and another is that congregational staff and volunteers typically lack the skills, knowledge, and time required to successfully sponsor community development projects. Moreover, most congregations have not applied for government grants to sponsor community development projects, and lack the management capacity to do so. Indeed, only a fraction of organizations have the resources to successfully engage in community development activities. However, the willingness of congregations to make use of public funding is essential, since public funding is an irreplaceable part of much community development work. Unwillingness to accept such funding could severely limit congregational participation in such developments. Yet, acceptance of such funds does come with restrictions as outlined in the next section.

Issues of faith must be also considered, as they may be limiting factors in the programs faith-based organizations undertake. Many members of faith communities want their participation in urban ministry to be valued as more than money, free space and cheap labor. To that end, faith-based practitioners feel that they bring something distinctive and valuable to community development. This frame of thought affects how faith makes a difference in the character of community development work a congregation undertakes. In other words, a belief system or ties to a religious organization affects decisions about whether and how development is done. For example, faith-based organizations were important participants in the federal housing production program, Section 236 (HUD, 2001). However, anecdotal evidence suggests that congregational sponsors experience high default rates in this program. One view is that

"church groups often looked upon the projects they sponsored as a form of charity, kept rents artificially low, and were willing to overlook delinquencies" (Comptroller General of the United States, 1978). This view has had a significant impact on the failure rates since most CDC-built housing is rental housing. To that end, it is important that faith-based organizations have the willingness and ability to treat property management as a business rather than a service activity.

Based on an analysis of CDCs in 23 states, Walker and Weinheimer (as cited in HUD, 2001, p. 16) identified five factors important for successful, sustained CDC performance. CDCs must have the ability and capacity to:

> Plan effectively – This includes developing an understanding of community assets and needs that inform a strategic vision for change, and internal planning to match its programs, resources, etc. to the requirements of implementing that vision.

> Secure resources – This includes acquiring grants, loans, contracts, fee or earnings, and technical assistance.

> Develop strong internal management and governance – This includes establishing good working relationships between board and staff and representation of the community on the board.

> Deliver programs – This includes erecting systems to deliver the full range of programs undertaken.

> Network – This includes building relationships with other entities, both public and private, inside and outside the community.

In order for faith-based organizations to attain the ability to perform the above tasks, assistance from external sources will be necessary. The Office of Faith-Based and

Neighborhood Partnerships discussed in the next section can provide the vehicle for education, resources, networking, and sharing of best practices that is necessary for these organizations to develop these capacities. As they develop experience with programs that result from these factors, they will have a better understanding of how their work connects to community development. This will lead to more programs that are specifically directed toward community development, which will result in a reduction of health disparities. Along the same lines, more programs specifically directed toward the reduction of health disparities will result in improved communities.

In summary, congregations are encumbered with some disadvantages that have led to failures and represent possible limitations to future roles in community development that include the potential for projects to be viewed as church rather than neighborhood objectives, congregational staff may have too many demands on their time, congregational staff may lack necessary skills, and potential for conflicts between religious values and the demands of the marketplace (HUD, 2001). However, previous research and findings provide both lessons learned and a roadmap for possible future success.

Federal Policy: Office of Faith-Based and Neighborhood Partnerships

The Office of Faith-Based and Community Initiatives was originally established by President George W. Bush with a promise to "rally the armies of compassion." (Obama '08, 2008, p.1). In spite of this, the promise of the Office of Faith-Based and Community Initiatives was never fully realized due to a number of factors. First, support for social services to the poor and the needy were consistently underfunded. For instance, the Bush administration proposed

elimination of the Commodity Supplemental Food Program, which benefited an average of

433,000 low-income seniors every month and was administered in part by local non-profits,

including faith-based groups (Obama '08, 2008). Second, former key officials in this Office

described how the Office was often used to promote partisan interests (Obama '08, 2008).

Finally, as a result of a lack of funding, robust training, and technical assistance, smaller

congregations and community groups that were supposed to be empowered by this initiative

were short-changed.

Nonetheless, with the election of President Barack Obama, there is the potential for this

Office to have a greater impact on the nation, especially in underserved communities. Obama

stated that:

> We know that faith and values can be a source of strength in our lives. That's what it's
> been to me. And that's what it is to so many Americans. But it can also be something
> more. It can be the foundation of a new project of American renewal. And that's the
> kind of effort I intend to lead as president of the United States (Obama '08, 2008, p. 1).

Obama has established a new President's Council for Faith-Based and Neighborhood

Partnerships that will train the trainers, partner with State and Local Offices, hold recipients

responsible, and close the learning gap (Obama '08, 2008).

However, there will be some guiding principles which some faith-based organizations

may view as limitations or restrictions to their activities. Organizations receiving grants to fund

their community initiatives:

> ➢ Cannot use federal funds to proselytize or provide religious sectarian instruction.
> ➢ Cannot discriminate against nonmembers in providing services. They must
> remain open to all and cannot practice religious discrimination against the
> populations they serve.
> ➢ Must comply with federal anti-discrimination laws, including Title VII and the
> Civil Rights Act of 1964. Religious organizations that receive federal dollars
> cannot discriminate with regard to hiring for government-funded social service
> programs.

- ➢ Can only use taxpayer dollars on secular programs and initiatives.
- ➢ Must prove their efficacy and be judged based on program effectiveness. They will be expected to demonstrate proven program outcomes to continue to receive funding. Obama will fund programs that work and end funding for programs that do not – whether they are large or small, well-established or new, faith-based or otherwise (Obama '08, 2008, p. 2).

Previous federal assistance and collaborations with faith-based organizations have proved to be successful. In fact, in 2001, with financial support from the Centers for Disease Control and Prevention (CDC), the Interfaith Health Program (IHP) at Emory University's Rollins School of Public Health launched the Institute for Public Health and Faith Collaborations to address health disparities (Kegler, Kiser, & Hall, 2007). The Institute's mission is to cultivate boundary leadership needed to assure effective collaboration across religious and health sectors, and to train teams of health and religious leaders to address community-level conditions associated with health disparities. The logic underlying the Institute curriculum is depicted visually in Figure 7 (Kegler et al., 2007). The logic model shows that for individuals, participation in the Institute should result in: strengthened awareness and development of boundary leadership, increased understanding of health disparities, increased appreciation and understanding of each field/discipline, and strengthened understanding of systems, systems change, and community transformation. These short-term outcomes should have informed a team's vision for community change and a plan for community action that should have resulted in community and systems change (if well implemented). These systems changes, should have contributed to the long-term outcomes of improved community health, wholeness, and justice, as well as, widespread behavior change.

Detailed results from the retrospective pretest and posttest of the Institute's curriculum comparisons by discipline are shown in Table 4 (Kegler et al., 2007). Among participants from

the health and faith community fields, the largest increases were observed in describing the four organizational frames, understanding the role of boundary leaders in community systems change, and understanding why reframing is necessary in creating successful community change strategies. A key attribute of "boundary leaders" as defined by Gary Gunderson is that they "think, lead, and hope at the level of the whole system" (as cited in Kiser, 2009, p. 2). Contrarily, health representatives reported the least change in describing major health disparities in their communities and in identifying the potential contributions of the health community in eliminating health disparities. On the other hand, faith representatives reported learning a great deal about health disparities. Thus, there is considerable opportunity to increase the overall effectiveness of faith-based organizations in community development and therefore produce a reduction in health disparities, through the leadership of federal institutes and/or offices.

Future Role of Faith-Based Organizations

Given the churches' demonstrated ability to motivate, to inspire, and to pull people together, there is great potential for faith-based interventions and models to address health disparities in the future (Kaplan et al., 2006). Faith organizations can be effective implementers of new or modified programs, policies, and community changes related to reducing health disparities. They can implement community changes that use a mixture of sustainable strategies. They should also capitalize on their ability to diversify beyond housing because of their orientation toward assisting "the whole person" and the conviction that the person reaches full potential only in connection to community. Consequently, faith-based development groups do a better job than secular groups of keeping residents engaged in the organization's work and this is

essential to community improvement (HUD, 2001). Moreover, leadership stability can be increased and organizational capacity and production enhanced, because community development practitioners are sustained by their faith in the face of burnout and poor compensation.

In conclusion, optimism about the potential of faith-based organizations to engage in community development is based in part on the active role many of them play in providing social services and in part on the direction the newly established Office of Faith-Based and Neighborhood Partnerships has taken. Given the tenor of current policy discussions and the establishment of the federal office in which congregations are looked upon to assume new roles; determining how best to help faith-based organizations move into community development on their own is an obvious priority (HUD, 2001). Some of the groundwork toward this priority has already been laid by the past and current initiatives and by the projects that faith-based organizations have shown to be highly successful (HUD, 2001). These models of success, as well as failures, which can be used as lessons learned, can propel faith-based organizations to the forefront of community development that will reduce health disparities in underserved communities. This increased community involvement by faith-based organizations must be nurtured by the federal Office of Faith-Based and Neighborhood Partnerships, as well as state and local offices. Commitment by these offices to collaborate and educate these organizations will be vital to the increased commitment of these organizations' community development efforts. This assistance can and must illuminate the shared goals of faith-based organizations and the public health field (e.g. improved community for the underserved, ministry to the "whole" person, better living conditions, better access to healthcare for the congregation and/or community), which will result in progress toward eliminating the current health disparities.

Table 1. Congregations / Social Service Activities
(Number of Congregations = 1,236)

Program Type	Participating Congregations (%)	Congregants in Participating Congregations (%)[1]
Food	33	50
Housing/Shelter	18	32
Clothing	11	18
Homelessness	8	16
Health	4	10
Education (not religious education)	6	10
Domestic Violence	4	7
Tutoring/mentoring	3	4
Substance abuse	2	4
Employment	1	2
All projects	57	75

[1] These figures are larger because large congregations are more likely than smaller ones to offer services.

Source: U.S. Department of Housing and Urban Development, Office of Policy Development and Research. (2001). *Faith-Based Organizations In Community Development* [PDF file]. Retrieved October 1, 2009 from www.huduser.org.

Table 2. Types of Community Changes by Strategy and Group

Community Change Clusters	Microgrant Strategy		Resource Distribution Strategy	
	Neighborhood	Faith	Neighborhood	Faith
Created walking groups	X	X		
Replaced soda with water drinks at events	X	X		
Provided health information in Welcome Wagon Baskets	X			
Improved nutrition at group meetings	X	X		
Health sections in newsletter	X			
Offered health workshop/campaign	X	X		
Developed a walking path	X			
Give cooking classes/demonstrations	X	X		
Distributed health information	X	X		
Created a place for physical activity (e.g., gym)	X	X		X
Provided physical activity classes		X	X	
Provided screenings		X		
Created new collaborative relationship			X	X

Source: Collie-Akers, V., Schultz, J.A., Carson, V., Fawcett, S.B., & Ronan, M. (2009). REACH 2010: Kansas City, Missouri: Evaluating Mobilization Strategies With Neighborhood and Faith Organizations to Reduce Risk for Health Disparities. *Health Promotion Practice, Vol. 10, No. 2 Suppl, 118S-127S (2009).*

Table 3. Percentage of Congregations
Engaged in Activity Areas by Program Types
(Number of Congregations: 257,648)

Areas of Activity	All Congregations	All Programs	Program Run within Congregation	Program Separately Incorporated	Participates in, Supports, or is Affiliated with Programs in Other Organizations or in Denomination
Housing/shelter programs for homeless people	38.7	43.6	9.9	6.9	83.3
Affordable housing development or programs	19.7	22.5	13.8	12.9	73.3
Housing programs for seniors	19.2	20.8	3.4	10.6	86.1
Programs in community, including economic development, job training, etc.	20.2	24.0	16.7	11.3	72.1

Note: Congregations could give multiple responses

Source: U.S. Department of Housing and Urban Development, Office of Policy Development and Research. (2001). *Faith-Based Organizations In Community Development* [PDF file]. Retrieved October 1, 2009 from www.huduser.org

## Table 4. Pre/Post Assessments of Knowledge & Skills Gained

Knowledge and skill items[1]	All participants[a] (n=220)			Health participants (n=117)			Faith participants (n=69)		
	Pre	Post	Diff[a]	Pre	Post	Diff[a]	Pre	Post	Diff[a]
Describe the major health disparities in your community.	3.89	4.55	0.66	4.22	4.62	.40	3.19	4.43	1.24
Describe how historical, organizational, cultural, and environmental issues contribute to health disparities.	3.54	4.53	0.98	3.70	4.58	.89	3.31	4.52	1.21
Identify the potential contribution of the faith community in eliminating health disparities.	3.50	4.50	1.00	3.59	4.54	.95	3.44	4.54	1.10
Identify the potential contribution of the health community in eliminating health disparities.	3.70	4.43	0.72	4.05	4.53	.47	3.15	4.31	1.16
Understand your own personal leadership tendencies.	3.38	4.57	1.19	3.32	4.54	1.22	3.46	4.69	1.24
Understand the contribution and impact of leadership tendencies of others.	3.13	4.51	1.38	3.06	4.53	1.47	3.35	4.54	1.19
Understand the role of boundary leaders in community systems change.	2.70	4.44	1.75	2.64	4.43	1.79	2.68	4.50	1.82
Discuss how tension is both a reality and an asset.	2.94	4.42	1.49	2.88	4.38	1.50	3.00	4.59	1.59
Describe the four organizational frames.	2.13	4.27	2.15	2.18	4.32	2.14	2.06	4.31	2.25
Understand the nature of organizational systems.	2.82	4.21	1.39	2.82	4.11	1.29	2.84	4.36	1.52
Use a feedback circle for understanding organizational, cultural, political, and community systems.	2.61	4.00	1.39	2.66	4.04	1.38	2.51	4.05	1.54
Understand why "reframing" is necessary for creating successful community change strategies.	2.67	4.41	1.74	2.73	4.42	1.69	2.57	4.45	1.88
Identify and restructure community resources to accomplish a vision.	3.10	4.38	1.29	3.16	4.36	1.20	2.99	4.51	1.52
Create and implement a shared vision for a healthy community.	3.30	4.40	1.10	3.42	4.36	0.94	3.14	4.52	1.39
Identify community strengths, weaknesses, challenges, threats, and opportunities related to reducing health disparities.	3.50	4.51	1.01	3.64	4.53	0.89	3.21	4.56	1.35

Note: Participants rated their confidence in their ability to perform each skill prior to the Institute and then again on the last day of the Institute using response options ranging from 1 = not at all confident to 5 = completely confident.

Source: Kegler, M.C., Kiser, M., & Hall, S.M. (2007, Nov.-Dec.). Evaluation Findings from the Institute for Public Health and Faith Collaborations. *Public Health Reports 122*(6), 793–802.

Figure 1. Determinants of Health
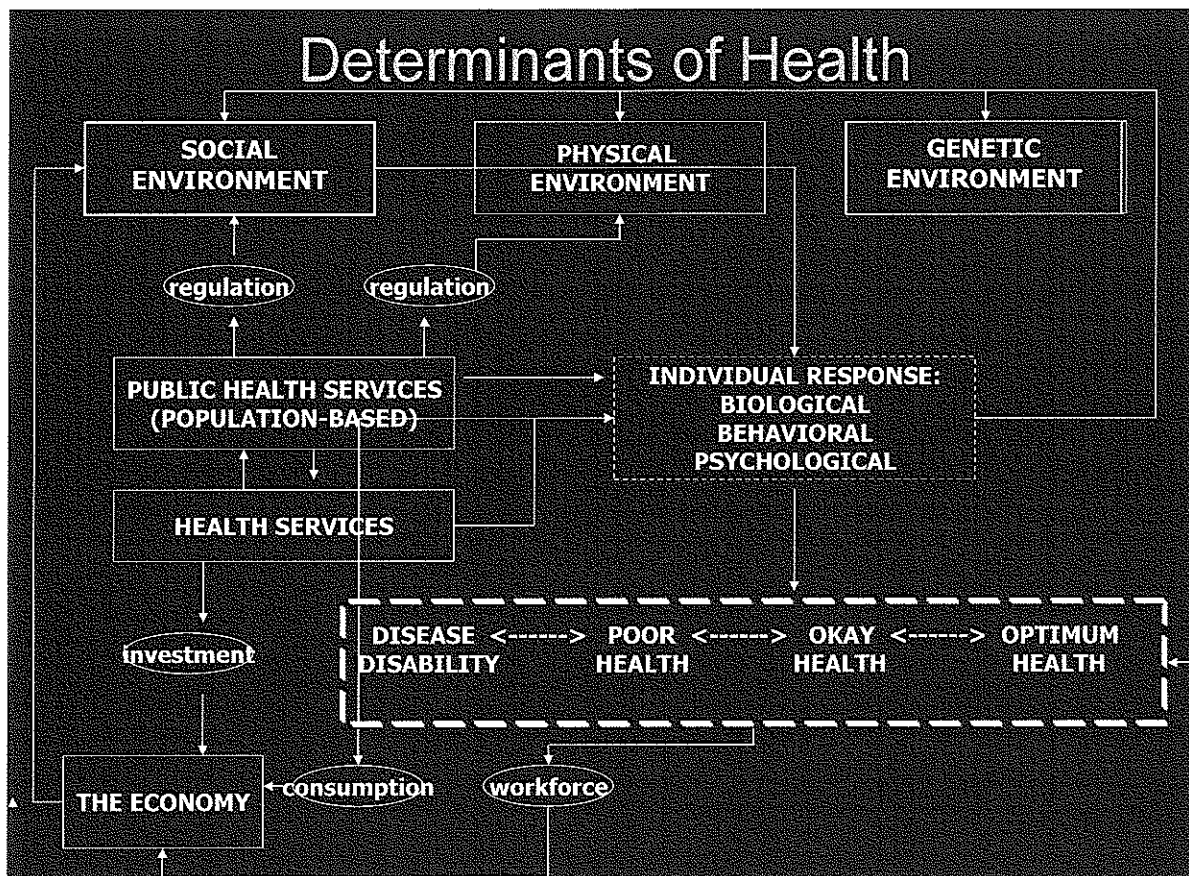
Source: Fielding, J. (2008) Determinants of Health [PowerPoint slides]. Retrieved October 15, 2010 from http://www.ph.ucla.edu/epi/faculty/detels/PH150/Fielding_deterhlth.ppt

Figure 2. Familial Influences

Family's Characteristics

<u>Health</u>	<u>Demographic</u>	<u>Household</u>
Biological	**Income**	**Marital Status**
Psychological	**Education**	**Composition**
Health Behaviors	**Occupation**	**Relation**
	Race	
	Ethnicity	
	Housing	
	Residence	
	Employment	
	Religion	
	Language	

Source: Fielding, J. (2008) *Determinants of Health* [PowerPoint slides]. Retrieved October 15, 2010 from http://www.ph.ucla.edu/epi/faculty/detels/PH150/Fielding_deterhlth.ppt

Figure 3. HIV/AIDS Diagnoses among Adults and Adolescents by Race/Ethnicity
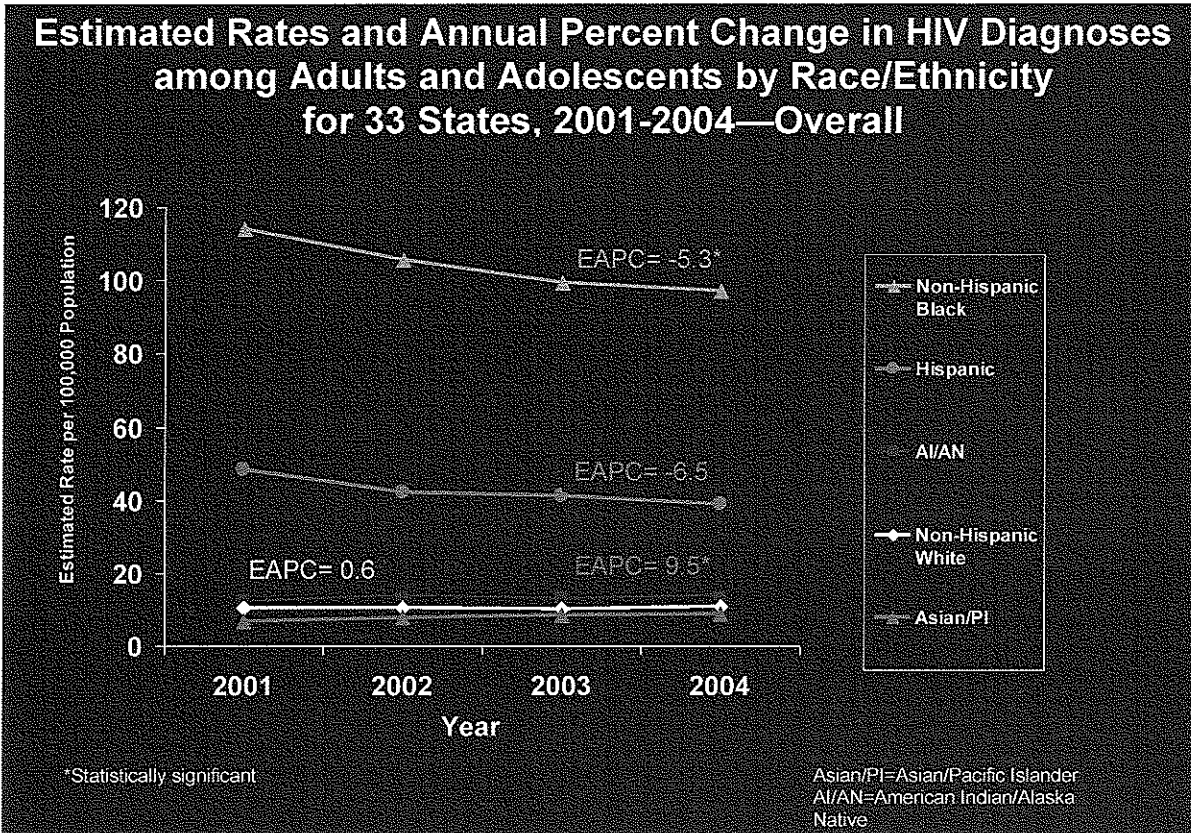
Source: Sutton, M., Durant, T., Prejean, J., Xiaohong, H., Wei, X., & Lee, L. (2009). The HIV/AIDS Epidemic and African Americans [Slide 21]. Centers for Disease Control and Prevention Retrieved September 15, 2009 from http://www.cdc.gov/hiv/topics/aa/resources/slidesets/ppt/HIV_Epidemiology.ppt

### *Figure 4. HIV/AIDS Disparities*

Race/ethnicity of persons (including children) with HIV/AIDS diagnosed during 2007

N = 42,495
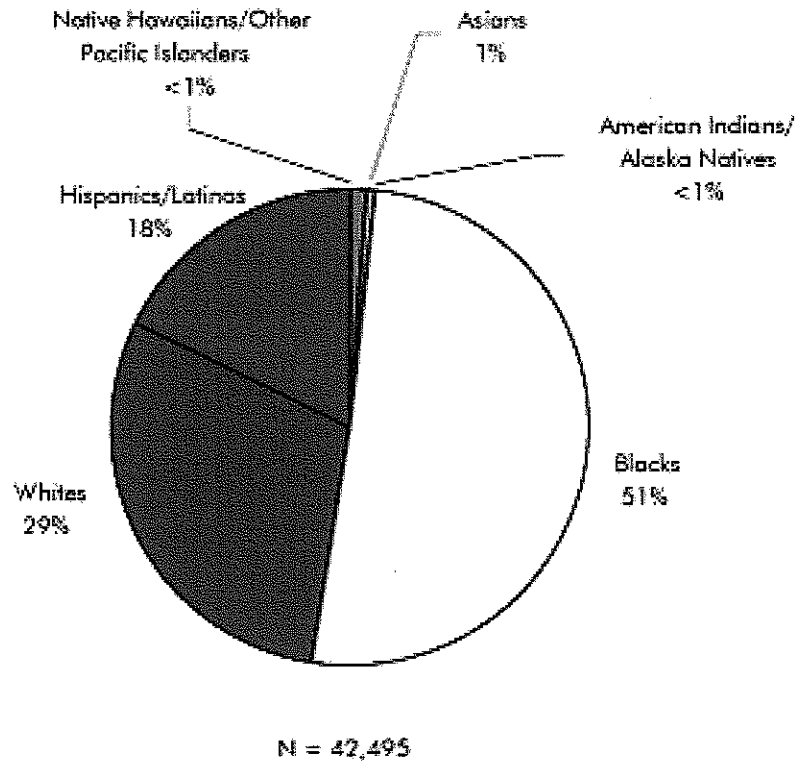
Note. Based on data from 34 states with long-term, confidential name-based HIV reporting.

Source: Centers for Disease Control and Prevention. *(2009). HIV/AIDS among African Americans.*   Retrieved September 15, 2009 from http://www.cdc.gov/hiv/topics/aa/resources/factsheets/aa.htm.

Figure 5. Pathways to Health
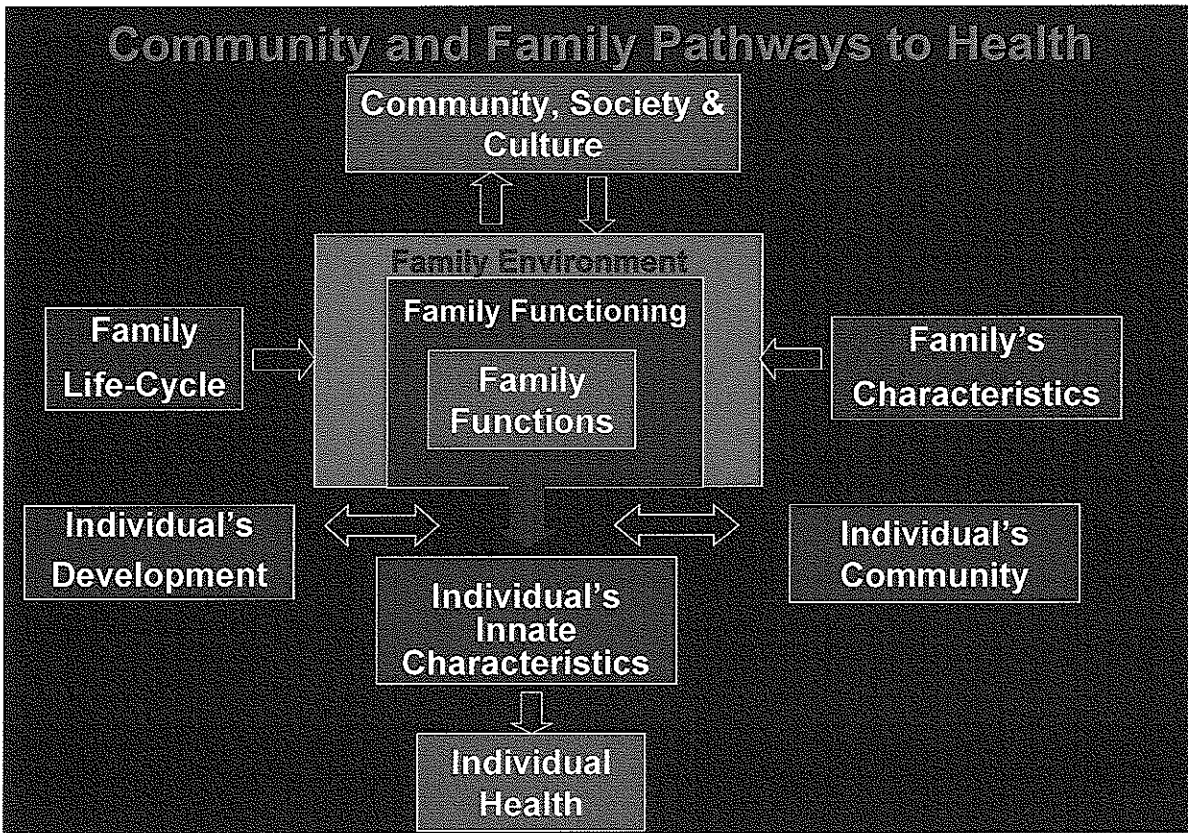
Source: Fielding, J. (2008) *Determinants of Health* [PowerPoint slides]. Retrieved October 15, 2010 from http://www.ph.ucla.edu/epi/faculty/detels/PH150/Fielding_deterhlth.ppt

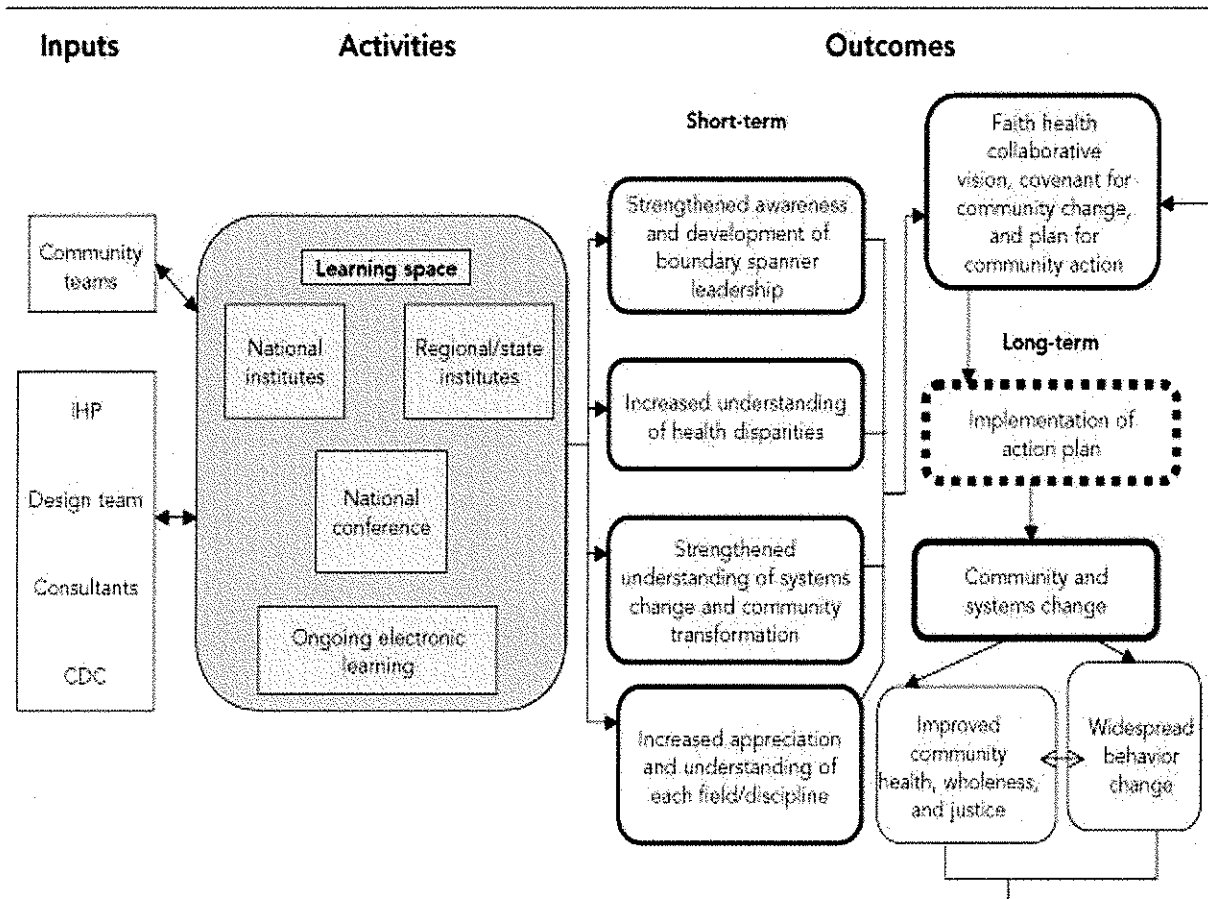*Figure 6. The Salvation Army Articles of Faith*

ABOUT: WHAT WE BELIEVE
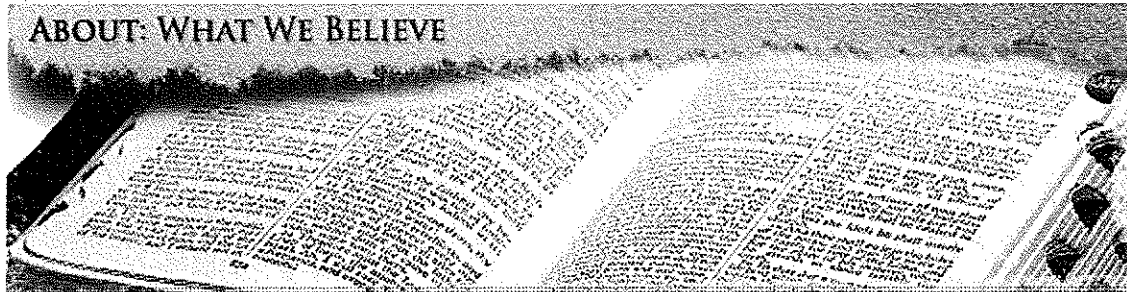
The Salvation Army's eleven articles of faith reflect our determination to remain faithful to our standards and principles. All members of The Salvation Army are encouraged to review these principles from time to time and to reaffirm before God their dedication to Him and to His good works.

1 We believe that the Scriptures of the Old and New Testaments were given by inspiration of God, and that they only constitute the Divine rule of Christian faith and practice.

2 We believe that there is only one God, who is infinitely perfect, the Creator, Preserver, and Governor of all things, and who is the only proper object of religious worship.

3 We believe that there are three persons in the Godhead – the Father, the Son, and the Holy Ghost, undivided in essence and co-equal in power and glory.

4 We believe that in the person of Jesus Christ the Divine and human natures are united, so that He is truly and properly God and truly and properly man.

5 We believe that our first parents were created in a state of innocence, but by their disobedience, they lost their purity and happiness, and that in consequence of their fall, all men have become sinners, totally depraved, and as such are justly exposed to the wrath of God.

6 We believe that the Lord Jesus Christ has by His suffering and death made an atonement for the whole world so that whosoever will may be saved.

7 We believe that repentance toward God, faith in our Lord Jesus Christ and regeneration by the Holy Spirit are necessary to salvation.

8 We believe that we are justified by grace through faith in our Lord Jesus Christ and that he that believeth hath the witness in himself.

9 We believe that continuance in a state of salvation depends upon continued obedient faith in Christ.

10 We believe that it is the privilege of all believers to be wholly sanctified, and that their whole spirit and soul and body may be preserved blameless unto the coming of our Lord Jesus Christ.

11 We believe in the immortality of the soul, the resurrection of the body, in the general judgment at the end of the world, in the eternal happiness of the righteous, and in the endless punishment of the wicked.

Source: Salvation Army. (n.d.), Retrieved September 15, 2009 from
http://www.salvationarmyusa.org/usn/www_usn_2.nsf

Figure 7. Logic Model for the Institute for Public Health and Faith Collaborations

Inputs	Activities	Outcomes

Community teams

IHP

Design team

Consultants

CDC

Learning space

National institutes

Regional/state institutes

National conference

Ongoing electronic learning

Short-term

Strengthened awareness and development of boundary spanner leadership

Increased understanding of health disparities

Strengthened understanding of systems change and community transformation

Increased appreciation and understanding of each field/discipline

Faith health collaborative vision, covenant for community change, and plan for community action

Long-term

Implementation of action plan

Community and systems change

Improved community health, wholeness, and justice

Widespread behavior change

Source: Kegler, M.C., Kiser, M., & Hall, S.M. (2007, Nov.-Dec.). Evaluation Findings from the Institute for Public Health and Faith Collaborations. *Public Health Reports 122*(6), 793–802.

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