Faith-Based Assets and Multi-Sector Community Teams:
Tapping into Deeply Woven Roots

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We know that health is the result of actions that take place across different sectors of society, from education to health care, from community organizations to employers. Therefore, improving population health and health equity requires cross-sector partnerships—in other words, team-based approaches that go well beyond the efforts and capabilities of health departments, hospitals, or clinics [1].

Health care entities have learned that health-related social needs such as housing and food security must be met in order to achieve better health. Since hospitals and health centers frequently lack capabilities to meet those needs, they rely on a variety of community partners. More broadly, areas around the country have become sites of cross-sector collaboration among different sectors and community residents to help create the conditions for health and well-being. Religious congregations and related faith-based organizations often bring social, logistical, and even financial resources to support these efforts in partnership with health departments, hospitals, and others.

What are unique assets that faith-based organizations bring to teams for improving the health and well-being of communities in North Carolina and across the country? In *Deeply Woven Roots*, 8 strengths of religious organizations are discussed: Strength to Accompany, Strength to Convene, Strength to Connect, Strength to Tell Stories, Strength to Give Sanctuary, Strength to Bless, Strength to Pray, and Strength to Endure [2].

How do public and private health sector organizations engage with these assets in their communities, and what are the principles for engagement? Rich, instructive examples can be found around the country, and from work being done abroad (eg, the World Health Organization's framing of "religious health assets"). The WHO triggered one of the richest streams of research in this area through its work with the African Religious Health Assets Programme based at the University of Cape Town in South Africa [3].

On March 22, 2018, the Roundtable on Population Health Improvement, an activity of the Health and Medicine Division of the National Academies of Sciences, Engineering, and Medicine, held a workshop in Raleigh to explore examples of faith–health collaboration. Significantly, Shaw University hosted the workshop in Boyd Chapel across from the School of Divinity, which occupies the former home of the historically black university's Leonard Medical School, shuttered in 1919. Shaw is itself a profound faith-based health asset which has educated generations of leaders tuned to care about the fundamental determinants of health, and it also embodies the often-fraught relationship between government, health elites, and African-American institutions. As part of the day's events, North Carolina Secretary of Health and Human Services Mandy Cohen joined those assembled for a "fireside chat" to outline a vision for the state's health, including the cross-sector partnerships necessary to help achieve it. Through the day's presentations, discussions, and reflections from participants, 3 key themes emerged for how the health sector can partner with faith assets (congregations, networks, programs) in their respective communities to constitute the kind of teams necessary to tackle the multi-faceted root causes of poor health. Those themes are:

Building authentic partnership through nurturing trust, demonstrating respect and humility, listening to the community talk about its needs, and letting the community lead;

Building common ground using the unique strengths of faith community partners (eg, when they are viewed as most trusted, willing and able to speak truth to power), engaging everyone together from the beginning, and using the bridge-building approaches of faith partners to surface and overcome painful history (eg, of racism); and,

Building the power of community by tapping into the human spirit and the spiritual depth that congregations and programs affiliated with them can bring to bear on important health challenges, including in the policy arena.

The examples featured during the workshop explored

the work of faith–health partnerships at 3 different scales outlined below.

Local Community

Foundry Ministries and its partnerships in Bessemer, AL, address substance use, homelessness, and other issues; UMMA Community Clinic and its partnerships in South Los Angeles, CA, provide health care services, a community garden and farmers' market, school partnerships, and care coordination.

City/County/Region

The Memphis Model in Tennessee and the Advocate Health/University of Illinois at Chicago Center for Faith and Community Health Transformation are 2 different faith community/health care organization partnerships that strategically address health and health equity issues in their respective areas.

State

The Greater Cleveland Congregations and its statewide mobilization, organizing, and policy advocacy effort have enabled Medicaid expansion in Ohio.

Scholars of the faith-health relationship have cautioned that faith-based entities should not be granted privilege in a conversation about the factors and partnerships that shape health and outcomes, in part because there are ambiguities on both the faith and health sides of the relationship (ie, both fields can cause harm) [4]. One critical component in this work is to go beyond the practical and tangible to the intangible of what it means to be a human being—what is sometimes referred to as "the mind AND the heart." What are the values, the purpose, and the "moral imagination" that drive partners from both the faith and health fields to engage in this work in the first place [5]?

Conclusion

The examples explored on March 22, 2018, hold lessons for other communities and partnerships [6]. Just as coordinated teams come together to care for and partner with patients in the clinical setting, multi-disciplinary and cross-sector teams are needed at the community level to identify and implement interventions for health and health-related social needs, and to help both individuals and communities move toward health and well-being. Faith-based and related organizations can bring strengths to shape the conditions for health and health equity. Both clinical and community teams benefit when we tap into the strengths of these "deeply woven roots" for the well-being of all. NCMJ

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