J Relig Health (2013) 52:368–385
DOI 10.1007/s10943-013-9699-9

PHILOSOPHICAL EXPLORATION

Engaging the Faith Community for Public Health Advocacy: An Agenda for the Surgeon General

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Published online: 22 March 2013

Abstract This article proposes an agenda for the Surgeon General of the United States that is consonant with the traditional public health approach of "upstream" and "midstream" intervention addressing social and institutional determinants of health. Accordingly, this features a prominent role for expanded partnerships between the faith-based and public health sectors. Such an agenda would revise the current status quo for the Surgeon General, whose celebrated bully pulpit is currently focused more on encouraging "downstream" compliance with federal guidelines related to lifestyle behavior modification. A new faith-based agenda, by contrast, could more effectively advocate for core features of the traditional public health ethic, including primary prevention, the multiple determinants of population health, communitarianism and social justice, and a global perspective, supported by the historic prophetic role of the faith traditions.

Keywords Religion · Faith · Surgeon General · Public health · Prevention

Introduction

A recent article in this journal advocated an expanded role for faith-based initiatives and resources in furthering the operational mission of the U.S. Office of the Surgeon General (Levin 2012a). Religious institutions and organizations, it was shown, actually have a long history of engagement within the healthcare and public health sectors, dating back many centuries. In order to address contemporary public health issues, including many pressing concerns, the article offered five specific recommendations tied to respective domains of public health action, including community health education ("informing the public, raising risk awareness, and changing behavior"), vital statistics ("identifying public health needs and eliminating health disparities in underserved populations"), community-based primary care ("delivering preventive healthcare"), public health policy ("strengthening the national resolve to bolster the public health infrastructure"), and disease prevention and

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surveillance ("meeting the nation's global health responsibilities") (pp. 65–67). The present paper continues this discussion, with an emphasis on laying out a tangible faith-based agenda for the Surgeon General of the United States (SGUS), whether the current or a future one, and whether serving in the Obama Administration or in that of the next President. The goal of this agenda, as stated in the paper's title, is to draw a roadmap that will advocate for the nation's public health preparedness.

Note that the title of this paper does not call for "embracing" the faith community or faith-based values; that may be too much to ask for many readers, perhaps with good reason. Moreover, it is of little consequence for population health whether or not anyone working in the public health sector chooses to embrace such a perspective or not. Rather, the call here is for one agency within the federal public health infrastructure, namely the Office of the Surgeon General (OSG), to begin "engaging" partnerships with faith-based organizations and institutions for very pragmatic reasons. These include, above all, the potential for such partnerships to be directed toward positive population-health-impacting social and institutional change that can engender actions and responses that in turn serve to alleviate health disparities.

This perspective was succinctly stated in remarks by Dr. Howard K. Koh, the U.S. Assistant Secretary for Health (ASH), on the occasion of the launch of the federal government's Healthy People 2020 initiative in 2010:

> Faith-based organizations are a tremendous example of the social determinant's [sic] approach at work. Where people worship and pray is often a place where people also have strongest social networks, and often receive information that can be of value to the health of their families and their neighborhoods…. So we have viewed that partnership as a very valuable one (U.S. Department of Health and Human Services 2012c, p. 14).

The presence of such partnerships in public health, as noted, is not novel. Religious institutions have been a radix or font (perhaps *the* font) of hospital formation, establishment of physicians' guilds, and organized efforts to professionalize healing for millennia, across the major faith traditions (see Marty and Vaux 1982; Numbers and Amundsen 1986; Sullivan 1989) and especially within Christianity (Kelsey 1995), Judaism (Berger 1995), and Islam (Rahman 1987). Religious congregations in the USA have sponsored community-oriented public health interventions for the past five decades, notably within African-American communities in the urban north and rural south (see, e.g., Levin 1984; Eng et al. 1985). The idea of partnerships between the public health establishment and associated agencies, on the one hand, and religious institutions and organizations, on the other, may seem unlikely or counterintuitive. But in theory, as well as historically, public health leaders' solicitation of faith-based partnerships is consonant with both the longstanding prophetic role of religious institutions, at least ideally, and historic principles of public health practice. These include the public health field's communitarian ethos (Barry 1975), affirmation of mutual responsibility (Turoldo 2009), and reference to social justice in advocating redress of socioeconomic disparities that lead to disparities in morbidity and mortality (Callahan and Jennings 2002). Indeed, one noted public health expert has stated, "The purpose of public health is to promote social justice" (Foege 2011, pp. 186–187). Accordingly, since 1996, the American Public Health Association (APHA) has sponsored a Caucus on Public Health and the Faith Community, and a past president of the APHA has endorsed such partnerships as "one example of how we can practice public health creatively using existing relationships to advantage" (Evans 1995, p. 2).

The impetus for the present paper is the recent appearance of two important documents and a renewed federal initiative, each focused on public health, disease prevention, and health promotion. The documents are the *National Prevention Strategy*, issued by the OSG's National Prevention Council (2011), and the three-volume report entitled, *For the Public's Health*, issued by the Institute of Medicine (2011a, b, 2012). The former is a government report presenting an idealized look at how the present administration intends to address the health of the American people; the latter series is a detailed and scholarly assessment of current public health needs and the tangible and financial resources required to enable the public health infrastructure to meet those needs, along with legal and policy challenges. These two documents present distinctive and only partly overlapping perspectives on what is required to resolve the most pressing public health concerns in the USA. A detailed analysis of the political reasons for and repercussions of the disparity between these two documents is not the focus of the present paper, other than a few brief comments to follow. Rather, these important statements will be referenced, alongside the new federal Healthy People 2020 initiative (U.S. Department of Health and Human Services 2010a), in order to make the case for an expanded faith-based role in public health. Such a development would open up a large sector of personal and institutional resources for meeting the nation's public health needs.

The Public Health Sector in the USA

The general public's understanding of public health—what it is, what it does, who is involved, who is in charge—much less its history and the scope and organization of current federal efforts—is probably close to nil. That judgment is not based on a statistical analysis of national opinion data, of course, but rather on over 30 years of involvement in public health. It is hard to imagine a veteran public health professional or academic who would sharply disagree. More concerning is that similar, though not as pronounced, lacunae of understanding seem to be present among our nation's legislators and policymakers and among the medical profession. These misunderstandings of the nature and contribution of public health have reinforced an ongoing undervaluing of the public health sector as, say, something vaguely health-related mainly involving sanitarians and the like, maybe essential for poor folks but not all that relevant to anyone else, and mostly a kind of homely stepchild of the medical profession. What public health is not, then, may be as important to point out as what public health is.

What public health is not, to begin, is a branch of medicine. While physicians and other clinicians, such as nurses and dentists, may obtain graduate degrees in public health and may practice in public health settings, the public health field itself constitutes a distinct profession or field with its own historical narrative and conceptual and theoretical foundations (see Holland et al. 1991; Tulchinsky and Varavikova 2009). More correctly, public health could be thought of as a meta-field, involving several distinct professions, scientific disciplines, and substantive emphases. An effective illustration of this is the list of the five core "areas of knowledge" required for accreditation of new schools of public health or graduate public health programs (see Council on Education for Public Health 2011). These include biostatistics, epidemiology, environmental health sciences, health services administration (including health planning, organization, administration, management, evaluation, and policy analysis), and the social and behavioral sciences (including community health education). Many schools and programs also have units focused on maternal and child health, parasitology, global health, community mental health, and nutrition,

among other subjects and fields. Individuals can obtain the standard professional degree (the M.P.H.) or study for a Ph.D. in a particular discipline and go onto an academic, research, or administrative career.

Another illustration of the identity and scope of the public health field can be found in the table of contents of its leading textbook, *Maxcy-Rosenau-Last Public Health and Preventive Medicine* (Wallace 2008), first published a century ago, in 1913, and currently in its fifteenth edition. Its 1,416 pages contain nearly 150 chapters organized in seven sections: public health principles and methods; communicable diseases; environmental health; behavioral factors affecting health; non-communicable and chronic disabling conditions; healthcare planning, organization, and evaluation; and injury and violence. The communicable diseases section alone contains over 65 chapters on control of communicable diseases, diseases controlled primarily by vaccination, sexually transmitted diseases, HIV/AIDS, infections spread by close personal contact, infections spread by food and water, healthcare-associated infections, viral diseases transmitted primarily by arthropod vectors, diseases transmitted primarily from animals to humans (zoonoses), opportunistic fungal infections, and other infection-related diseases of public health import.

Still another illustration of the scope of public health is a list of the established Offices that constitute the federal U.S. Public Health Service (USPHS), under direction of the ASH, who reports to the Secretary of Health and Human Services (SHHS) (see U.S. Department of Health and Human Services 2012b). The ASH oversees a sprawling enterprise that, besides the Office of the Assistant Secretary for Health (OASH), comprises nearly a dozen agencies: the OSG, the National Vaccine Program Office, the Office of Adolescent Health, the Office of Disease Prevention and Health Promotion, the Office of Healthcare Quality, the Office of HIV/AIDS and Infectious Disease Policy, the Office for Human Research Protections, the Office of Minority Health, the Office of Population Affairs, the Office of Research Integrity, and the Office on Women's Health.

Taken together, these three lists are as good a way as any to summarize the scope and breadth of public health as it exists and is practiced in the USA today. The public health sector, in turn, is a term used to encompass the various people, professions, institutions, and organizations that are involved in public health work, whether federally, in state or local agencies, in multinational non-governmental organizations (NGOs), in the private or philanthropic sector, or in academia. A key component of the public health sector is the Commissioned Corps of the U.S. Public Health Service (PHSCC), under the operational command of the SGUS and the administrative oversight of the ASH. The PHSCC is one of the nation's seven uniformed services, and its 6,500-plus commissioned officers function as deployable public health assets who "protect, promote, and advance the health and safety of the Nation" through a mission encompassing three components: "Rapid and effective response to public health needs," "Leadership and excellence in public health practices," and "Advancement of public health science" (see U.S. Department of Health and Human Services 2011). Respective officers, in both the Regular Corps and the Ready Reserve Corps, serve in one of about a dozen career paths, including physicians, nurses, dentists, veterinarians, pharmacists, public health educators and administrators, behavioral health professionals, engineers, environmental health officers, allied health practitioners, and research scientists, including biostatisticians and, most famously, a cadre of epidemiologists. This list is yet another illustration of the range of content encompassed by the phrase "public health."

Besides serving as operational commander of the PHSCC, the SGUS has no other statutory responsibilities (see Commissioned Officers Association 2009) and few other formal roles, mostly related to serving an advisory function to the President and on federal

panels (see Wright 1998). Indeed, the position has a complex and varied history, its formal job description and its location in the federal public health organizational chart having changed significantly more than once over its century-plus existence (see Levin 2012a). Precisely who is eligible to serve as SGUS and what the job is about are not widely understood, even by members of Congress and, it must be said, by prospective nominees for the office (see Mullan 2004, p. 181). Legislation is occasionally proposed to reboot the job's responsibilities and prerequisites, yet again, but the most recent efforts failed (U.S. House of Representatives 2007; U.S. Senate 2007). A common public misperception is that the SGUS must be a physician (see, e.g., Gutner 2003). This has been proposed, but at present, the statute simply requires eligibility to serve in the PHSCC Regular Corps, regardless of profession, and to have "specialized training or significant experience in public health programs" (U.S. House of Representatives Office of the Law Revision Counsel 2011).

At present, the SGUS directs the OSG, but answers to the ASH and does not lead the entire USPHS, something else commonly misperceived. Besides various formal and informal advisory functions, the position's major role—and most publicly visible—is as "the nation's health educator," a not quite accurate professional description but one that does depict the bully pulpit that provides the SGUS with a ready-made platform to speak out on important public health issues. Each SGUS typically has been identified with a particular issue that has come to define his or her tenure, such as smoking, AIDS, immunization, and childhood obesity.

The newest role for the SGUS is as Chair of the new National Prevention, Health Promotion, and Public Health Council (a.k.a. National Prevention Council, or NPC). Established by a presidential Executive Order in 2010, the NPC consists of over a dozen cabinet secretaries and executive department or agency heads and, along with a national Advisory Board, is charged with overseeing federal efforts at health promotion, disease prevention, public health, and integrative healthcare, including administrative, scientific, and policymaking roles (see Obama 2010). The NPC's underlying perspective is laid out clearly in the Executive Order: its recommendations will be "lifestyle-based" (p. 33984) and concomitant national priorities will entail "lifestyle behavior modification" (p. 33985). This represents a departure from the historic perspective of public health policy and programming that emphasizes socioeconomic, environmental, and other structural determinants of population health, consonant with the field's communitarian and social-justice orientations, as described earlier.

The NPC has its origins, in part, in the famous Malone-Heckler Report (see Heckler 1985), issued by the Department of Health and Human Services in 1985. A product of the Reagan Administration, the report "emphasized the importance of health education, research, and … lifestyle changes" for minority populations in poor health (Dell and Whitman 2011, p. 18). According to critics, "the report blamed the victim's lack of knowledge about health, instead of questioning whether the nation really had the will to address the systemic issues that limit health equity, such as unequal access, limited economic opportunity, racial discrimination, and cultural incompetency" (Dell and Whitman 2011, p. 18).

Current National Agenda Statements for Public Health

Two recent reports issued by the federal government and a current federal initiative, noted above, together offer a look at what different constituencies see as a national agenda for the

public health sector. These are the NPC's *National Prevention Strategy*; the three-volume Institute of Medicine (IOM) proceedings on the future of public health entitled, *For the Public's Health*; and the most recent version of the Healthy People program of the Department of Health and Human Services (DHHS), an every-decade initiative first rolled out in 1979.

The NPC report comprehensively does what its title promises: it lays out a detailed national prevention policy focused on four "strategic directions" and seven "priorities" (National Prevention Council 2011). The strategic directions serve as "the foundation for all prevention efforts and form the basis for a prevention-oriented society" (p. 11). Accordingly, they entail collective action and reflect traditional public health values: Healthy and Safe Community Environments, Clinical and Community Preventive Services, Empowered People, and Elimination of Health Disparities. The priorities, by contrast, which are "designed to improve health and wellness for the entire U.S. population" (p. 12), are mostly about changing discrete behaviors of individuals in several categories: Tobacco Free Living, Preventing Drug Abuse and Excessive Alcohol Use, Healthy Eating, Active Living, Injury and Violence Free Living, Reproductive and Sexual Health, and Mental and Emotional Well-Being. Each is a pressing health concern, for sure, but the individual level of focus of these priorities, in keeping with the intention to craft national public health priorities around "lifestyle behavior modification," seems at odds with the report's more visionary strategic recognition of the importance of structural determinants of health disparities, unsafe communities and environments, and political disempowerment. The *National Prevention Strategy* thus reads like two separate reports: one effectively identifying societal sources of population-wide health disparities and another targeting discrete personal lifestyle behaviors for modification. To be fair, in both categories, the report does an outstanding job of proposing substantive actions to be taken by the federal government and by various partners, including state and local governments and the business, healthcare, educational, and non-profit sectors, as well as by individuals and families, so the multilevel approach characteristic of public health intervention is apparent.

Still, the NPC report is a mixed bag: in one sense, a prodigious, commendable, and unprecedented effort to tackle an enormous topic; in another sense, a bit of a disappointment for the public health community, both supporters of the Obama Administration and those who while not initially supporters were at least optimistic that public health issues would be well taken care of under this administration. While the report's strategic directions are on-target, the prioritization of individual behavior change as a primary strategy to address the nation's health disparities seems somewhat regressive. It would appear to fit more with the stereotyped depiction of an ultra-conservative political agenda—pulling oneself up by one's bootstraps, glossing over structural injustices or inequalities, blaming the victim, and so on. Yet the NPC report is the product of a politically progressive administration, which makes some of its content, notably its identified priorities, appear counterintuitive.

The concern voiced here is not explicitly political or ideological. Rather, the NPC report's priorities represent a limited vision of what public health is about, an incomplete approach according to other contemporary vision statements that identify the determinants of population health and how we might go about addressing them. For example, the highly admired Dr. David Satcher, a former SGUS under President Clinton, has called for a national public health strategy that increases our investment in preventive efforts targeting three levels of action: *upstream*, focused on "policies that support prevention"; *midstream*, focused on "community and institutions within communities"; and *downstream*, focused on "the individual and his or her lifestyle or behavior" (Satcher 2006, pp. 1009–1010).

This strategy maps nicely onto the multilevel empowerment process entailing "individual involvement, organizational development, and community change" familiar to community organizers (see Checkoway 1995, p. 4). A comprehensive, population-wide preventive strategy that omits or deemphasizes one or two of these foci will necessarily be compromising its effectiveness. Moreover, the determinants of population health themselves encompass various such levels or categories, including biological, psychological, and behavioral characteristics of individuals, on the one hand, and physical, biological, social, cultural-ideological (including political) dimensions of the environment, on the other, any or all of which may impact on the natural history of disease in people and populations (see Jenkins 1985). Accordingly, a national public health vision that does not prioritize addressing environmental and population-wide determinants of health, such as socioeconomic disparities and the unmet needs of underserved and less advantaged populations, is "unlikely to improve public health" (Goldberg 2009, p. 70). A focus on proximal or downstream factors "may temporarily reduce disparities, but differences will likely reemerge as new mechanisms emerge. Breaking the cycle requires affecting the metamechanism itself" (Diez Roux 2012, p. 48).

While the NPC report thus advances a mostly, but not entirely, "downstream" vision of public health and prevention, the IOM report, by contrast, is a strongly "upstream" document. In the three reports issued by the specially convened IOM Committee on Public Health Strategies to Improve Health, the members have

> made the case for increased accountability of all sectors that affect health—including the clinical care delivery system, the business sector, academe, nongovernment organizations, communities, the mass media, and various government agencies—with coordination, wherever possible, by the governmental public health agency that is leading or coordinating activities and sectors (Institute of Medicine 2012, p. xv).

In support of their work, the committee's members developed a couple of conceptual models that lay out their perspective on maximizing the capacity of the public health infrastructure to achieve its mission and meet public health needs. Their model of "the health system" includes the governmental public health infrastructure at the federal, state, and local levels in relationship with the educational, media, and business sectors, the clinical care delivery system, non-public-health government agencies, and the community. The public health infrastructure, they note, is an integral though "relatively small" part of this overall system (Institute of Medicine 2012, p. 154).

The committee also proposed a logic model in order to identify the steps required to link inputs and resources to population-health outcomes. Their model identifies and defines public health resources; capacities; processes, interventions, and policies; and intermediate and health outcomes explicitly and solely in the context of the social and environmental determinants of health. Further, it emphasizes "the broader systemic context" that exists "[a]cross different geographic levels and including public health agencies and stakeholders" and calls for "attention to equity and disparities among population groups" (Institute of Medicine 2012, p. 155).

Improvements in population health, according to the IOM report, will require a "determinants-of-health perspective" characterized by a "multiple-determinants approach" that it describes as "a broader view of how population health is created (including but going well beyond clinical care)" (Institute of Medicine 2011b, p. 38). This "ecologic-multiple-determinants perspective" thus contrasts with the traditional clinical approach. These two approaches differ dramatically in their respective determinants/domains, measures, and stakeholders, and the report exemplifies this in great detail for

infant mortality, a key marker of population health. While the clinical (and, associated with it, lifestyle behavior change) approach focuses primarily on access to prenatal care, the population-health approach acknowledges a plethora of putative determinant factors (behavior, clinical care, education, nutrition, income, social support, and environment) along with respective measured indicators (e.g., teen pregnancy data, quality of care information, presence of early intervention programs in the schools, school nutrition standards and policies, income and unemployment statistics, community programs, presence of public transportation) and institutional stakeholders (e.g., public health agencies, medical care providers, school boards, retailers, employers, community organizations, environmental planners) (p. 39). Clearly, this is a broader perspective and implementation agenda than is highlighted in the NPC report, although features of this type of approach can be discerned in places in the latter document.

Nonetheless, the IOM report, too, is a limited statement in that its focus is primarily upstream and focused on fiscal and structural issues. It represents a mirror image, in a sense, of the NPC report. To be clear, neither report is "wrong" or in error; both are exceptional efforts and they do what they set out to do: the NPC report, to lay out a behavioral agenda for disease prevention and health promotion; the IOM report, to identify the financial and organizational resources required to secure the nation's public health future. But each report sees the solution to public health problems through a particular lens, and the respective lenses focus on different domains of the public health sector.

One ongoing initiative has managed to attain a balance of recognizing individual, social, and environmental determinants of health and of advocating a full plate of actions and interventions, from self-improvement to policy change and all points in between, in order to improve the nation's health. Healthy People 2020, under direction of the USPHS's Office of Disease Prevention and Health Promotion (ODPHP), is more consonant with the vision of Dr. Satcher and the historic public health ethic, described earlier. Whereas the NPC is mostly about advancing a downstream mission, reflecting its status as a public document prepared with political considerations in mind, and the IOM report is mostly an upstream-focused document, prepared by academics and targeting policymakers and legislators, Healthy People 2020 is a practical action-oriented initiative prepared by public health professionals for public health professionals and consumers. Accordingly, it includes both upstream and downstream foci, along with a healthy dose of midstream content, strongly emphasizing and advocating the involvement of community organizations and other public and private institutions. The other reports do, too, but only in Healthy People 2020 is this midstream component consistently fleshed out. In addition, among the over 40 substantive Topic Areas of the report are not only major causes of disease at the top of the nation's mortality statistics (e.g., cancer, heart disease and stroke, HIV, diabetes, accidents), but decidedly upstream and societally constructed issues such as social determinants of health, preparedness, public health infrastructure, global health, environmental health, and access to health services. Healthy People 2020 recognizes, along with experts on health equity, that a focus on "health behavioral change" is ideally a component part of a broader community-based educational approach targeting population-health disparities (Campbell and Wallace 2008, p. 498).

The stated aim of the Healthy People program is to provide "science-based, 10-year national objectives for improving the health of all Americans." Its four Overarching Goals include among them, "Achieve health equity, eliminate disparities, and improve the health of all groups," and "Create social and physical environments that promote good health for all." Its monitored benchmarks are intended both to "[e]mpower individuals toward making informed health decisions" and to "[e]ncourage collaborations across communities

and sectors" (U.S. Department of Health and Human Services 2012a). Early in its official Framework statement, there is a section entitled, "The Importance of an Ecological and Determinants Approach to Health Promotion and Disease Prevention," which states:

> Health and health behaviors are determined by influences at multiple levels, including personal (i.e., biological, psychological), organizational/institutional, environmental (i.e., both social and physical), and policy levels. Because significant and dynamic inter-relationships exist among these different levels of health determinants, interventions are most likely to be effective when they address determinants at all levels. Historically, many health fields have focused on individual-level health determinants and interventions. Healthy People 2020 should therefore expand its focus to emphasize health-enhancing social and physical environments. Integrating prevention into the continuum of education—from the earliest ages on—is an integral part of this ecological and determinants approach (U.S. Department of Health and Human Services 2010b, p. 2).

Healthy People 2020 thus comes closest to being an integrated and holistic mission statement for the next decade of work among the public health sector in the USA. The other two reports are exemplary in their own right, but more limited in scope. Only Healthy People 2020 appears to check all the boxes, as far as Dr. Satcher's vision of public health in action, and is most consistent with the traditional perspective that guides the public health sector. But there is one element that is mostly missing from this initiative and its supporting documents: a delineated role for faith-based resources in achieving national health goals and objectives.

Engaging the Faith Community

The SGUS is the most publicly visible star in the public health firmament, and the OSG provides a ready-made platform and audience for public health communication. The Surgeon General thus is the best person to advance a new and more focused public health agenda grounded in a multiple-determinants approach to population health that emphasizes upstream efforts and midstream partnerships with voluntary sector institutions including faith-based organizations. The SGUS is best positioned, among USPHS leadership, to give voice to such an agenda and to advocate for it to the general public and the media, to Congress, and within the DHHS and Executive Branch. Despite the consonance of such an agenda with traditional public health thinking and with public health practice, this may require a bit of a vision adjustment for the OSG, as what is being proposed diverges from its longstanding orientation.

A helpful indicator of this orientation may be gleaned from the content of the "Surgeon General's Perspectives" column featured in *Public Health Reports*, the official peer-reviewed journal of the USPHS. The subject matter of the column is a good marker of the ongoing foci of the OSG in recent years, of what is currently on the radar of the SGUS, if you will, and thus presumably of most pressing national public health import. These are the communiques that define the celebrated bully pulpit of the Surgeon General, and they reveal the values and perspective of the Office. Since 2008, the content of these "Perspectives" has included the following, in chronological order: childhood obesity, deep vein thrombosis and pulmonary embolism, preterm birth, HIV testing, underage drinking, mental health, breastfeeding, healthy aging, physical activity, oral health, osteoporosis, multiple chronic conditions, health literacy, preventive services, tobacco smoke, dietary

guidelines, breastfeeding (again), medical adherence/compliance, oral health in AIDS, viral hepatitis testing, adolescent tobacco use, and heart attacks and strokes. To be clear, these are all vitally important issues which unresolved are responsible for suffering and morbidity and, thus, are appropriate concerns of the OSG and USPHS. But note how most of these topics concern a respective disease entity or clinical medical care issue or are meant to be resolved by lifestyle behavior modification.

Less evident, if at all, is a communal or societal perspective on issues requiring collective action and social, institutional, or policy-related change to address deficits of justice or equality that are at the root of so many observed population-health disparities. The solution, as typically given in these "Perspectives," is instead for individual people to comply with their physician or with federal edicts or expert recommendations, with little reference to the contextual barriers, especially socioeconomic, that may constrain their behavior. Such a hierarchical top-down vision is antithetical to the longstanding historic ethos of public health. Again, it is not that this approach is not a significant element of an idealized public health strategy—it is and should be—but rather that it threatens to become the overwhelming focus of such a strategy, reinforcing status quo structural realities, including poverty and disempowerment, that contribute to disease and suffering throughout segments of the population (see, e.g., Farmer 2005). That this approach has continued and was enlarged upon in the Obama Administration is disheartening, and points to an apparent disconnect between progressive rhetoric and regressive policy. It also constitutes a squandering of the OSG's national platform. With some refocusing, the Surgeon General could become a voice for social justice and a spokesperson for upstream and midstream efforts to address socioeconomic and environmental determinants of morbidity and mortality in order to combat population-health disparities.

These realities underscore how challenging it may be to promote a faith-based agenda—or a more midstream or upstream agenda in general—within the culture of the OSG. That this broader agenda has already found acceptance within the larger USPHS culture, including the ODPHP, as indicated by Healthy People 2020, is encouraging, as is the presence of a Center for Faith-based and Neighborhood Partnerships (CFBNP) within DHHS. The "fit" between the faith-based sector and the public health sector "appears to be a natural one" (Rowland and Chappel-Aiken 2012), for historical and theoretical reasons elaborated earlier, and this is at least acknowledged within DHHS and the USPHS. But, still, this partnership is mostly constructed to achieve downstream objectives. For example, in *Partnerships for the Common Good*, a recent report from the White House Office of Faith-Based and Neighborhood Partnerships (2011), in conjunction with CFBNP, the entirety of the report's health content was illustrated by a pitch for the Affordable Care Act and how to file for benefits, a similar pitch to enroll children in Medicaid, an advert for the First Lady's initiative to combat childhood obesity through lifestyle change, and mentions of a free texting service for pregnant moms and newborns and the National HIV/AIDS Strategy. All worthy efforts, for sure, but not a particularly ambitious agenda for a putative partnership between these two large sectors of society.

A "healthy" corrective is available. Healthy People 2020 could serve as a template to help delineate and organize a full range of public health activities that involve faith-based resources, both people and institutions, in various types of partnerships across the determinants of population health (i.e., social, environmental, behavioral), across the levels of public health action (i.e., upstream, midstream, downstream), and across particular public health issues. Faith-based resources may contribute to needs assessment, program planning, health education, evaluation, community development and organization, political action, and engagement in the policy-making process, whether locally, nationally, or

globally. It would be foolish to ignore such resources, especially in a time of federal resource scarcity. The SGUS could be a significant player in making this case and could make such linkages a centerpiece of his or her bully pulpit. This would be in keeping with the statutory functions of the office, with Dr. Satcher's vision for public health, and with the longstanding contributions of the faith community to public health and healthcare.

For example, let us consider one particular Topic Area: "Older Adults," a new focus for Healthy People with the 2020 initiative. Epidemiologic studies have identified numerous dimensions and indicators of religious participation and spirituality among older adults as a significant salutary factor in relation to health and illness outcomes, related to both physical health (e.g., functional health, disability, self-rated health, physical symptoms, cancer prevalence, cardiovascular disease, smoking and drinking behavior, mortality/longevity) and mental health and well-being (e.g., depressive symptoms, chronic anxiety, other diagnosed psychiatric disorders, life satisfaction, positive affect, self-esteem, suicide) (see Levin and Chatters 2008). That is, greater levels of religiousness, spirituality, or faith, broadly defined, are associated with lower population rates of morbidity or mortality due to respective disease entities and illness behaviors (a protective or preventive effect) and with higher rates of well-being, physical and psychosocial, according to various indicators (a health-promotive effect). Within gerontology and geriatrics, by now hundreds of empirical studies have investigated these associations in older adults and/or across the life course, and most have identified positive and significant effects (see Koenig et al. 2012).

Likewise, health services research studies, published program evaluations, and public- and private-sector and academic documents have reported on organized congregational and denominational interventions and other efforts to address the health and well-being needs of older Americans, work that has been ongoing for many decades. A pioneering summary of "Aging, Religion, and the Church," in the original *Handbook of Social Gerontology*, published over 50 years ago, identified numerous programs in the USA dating to the 1940s, across denominations, and many operating in co-operation with secular agencies (Maves 1960). The seminal *Religion & Aging: An Annotated Bibliography*, published over 30 years ago, contained more than 500 entries, mostly under the categories "Organized Religion in the Service of the Elderly" and "Spiritual Ministration to the Elderly" (Fecher 1982). Community health education efforts targeting the health-related needs of older adults have existed throughout communities in the USA for decades. These programs, such as the Partnerships for Healthy Aging Project in Houston over 20 years ago (Falck and Steele 1994), are oftentimes interfaith efforts involving partnerships among congregations, health agencies, local government, community health centers, and the academic sector. Moreover, state and national religious denominations have gotten involved, as well, exemplified by the pioneering Health and Human Services Project of the General Baptist State Convention of North Carolina, which began in the 1970s (Hatch and Jackson 1981), and by contributions to the ongoing healthcare reform debate on the part of organizations from across the Jewish denominational spectrum (Levin 2012b).

This exercise could be duplicated with many of the other Topic Areas included within Healthy People 2020. Indeed, an especially helpful effort would be a comprehensive review of evidence—from epidemiology, health services research, community health education, health policy, etc.—that summarizes the impact of faith-based variables, interventions, and organizations on the occurrence, prevention, and amelioration of each of the diseases and other pressing public health concerns identified in Healthy People 2020. Such a companion document, fully referenced for researchers and policymakers, along with an associated website for the public and for public health agencies, would be a tremendous contribution to the nation's public health effort. Aside from being a practical

summary document, it would provide for the first time, by documenting faith-based efforts and resources and any evaluative evidence, a complete catalog of historical and ongoing public health programs and initiatives with significant faith-based content. It would also provide a useful baseline for the development of detailed goals, objectives, and implementation plans for federal faith-based efforts related to each Topic Area over the course of the Healthy People 2020 implementation period and beyond.

The Faith-Based and Public Health Sectors: Toward Partnership

As is evident, the faith-based sector can be a significant ally for the public health sector and already has proven such on a regional and local scale, over and over again. There are multiple reasons for this: (a) these sectors share mutual concerns, (b) the tenets of many religions favor healthy living, (c) congregations provide tangible and emotional resources for health, and (d) religious organizations are able to foster participation among people otherwise hard to reach (Goldmon and Roberson 2004). Within African-American communities, especially, churches are already engaged in primary prevention, preventive health programming, and delivery of social services to at-risk populations (Sutherland et al. 1995). Such efforts are consistent with the long history of religious advocacy in policymaking, in general, with its emphasis on coalition-building across sectors (den Dulk and Hertzke 2006).

Still, despite the promise of alliances between the faith-based and public health sectors, there are barriers to expanding this relationship. For one, compared to the burgeoning literature of thousands of studies on faith-based impacts on population health (see Koenig et al. 2012), "relatively little" published literature exists on public health and faith partnerships (Kegler et al. 2010, p. 666). It has been noted that "evidence-based health promotion interventions in churches remain sporadically implemented" (Peterson et al. 2002, p. 408), as do program evaluations and evaluative research of faith-based programs (Johnson 2002) and empirical validation of factors associated with effective or efficacious such interventions (Bopp and Fallon 2013; Markens et al. 2002). This is not to say that such literature is sparse in absolute terms: more has been done and published than most public health leaders may be aware, and mounting evidence does exist for these programs' effectiveness (see DeHaven et al. 2004), particularly in African-American churches (Campbell et al. 2007). By now, enough of these interventions have been mounted that there is accumulating evidence for successful behavior change and morbidity reduction in relation to particular disease outcomes within specific populations, such as diabetes among African Americans (Newlin et al. 2012).

This work's continued failure to thrive across the board, however, may be due in part to the complexities of these partnerships and concomitant barriers among both the public health and faith-based sectors: limited resources, competition/turf protection, racism, internal team conflict, discomfort with faith-based organizations, distrust of health agencies, diversity within faith traditions, fear/distrust of faith communities, different agendas, finding a common language, and concerns over separation of church and state (Kegler et al. 2010). There is also the significant problem of widespread lack of awareness of the scope and breadth of existing work, something that a faith-based companion piece to Healthy People 2020 would rectify. With such barriers, it is a wonder that these partnerships have moved forward at all, and have flourished, a testament to the passion and commitment of the major stakeholders.

Yet, to revisit a familiar theme, even where such collaborations are present, the general focus has been more midstream or downstream and less "about harnessing the potential of

faith/health collaborations in tackling broader, systemic determinants of health" (Kegler et al. 2007, p. 794). This is a shame and a loss. As Gunderson (2000) lucidly notes,

> Something is sacred when it is the locus of ultimate value. For public health, epidemiological data confer ultimate value on community-scale determinants of health. For most religious groups, it is scripture affirmed by worship and expressed in the social relationships in family and community that is sacred. The common ground between public health and religious groups is regarded as sacred by both (p. 257).

An important contributor to expanding such efforts is recognizing the diversity of partnership strategies and resources that are possible and available for faith-based organizations and public health agencies. The conceptual model of Barnes and Curtis (2009) helpfully depicts a continuum of such strategies, from low-level to high-level partnerships: from networking to coordination to cooperation to collaboration. While, they report, most local health departments in the USA "have independent (decentralized) system relationships between state health departments," this is not necessarily a detriment, as it thus provides "more opportunities to determine priorities on the basis of community need" (p. 255). Depending upon the size and demographics of respective communities, the religious resources available may be much broader and deeper than public health leaders realize. These include congregations, connectional systems such as denominations, interfaith and ecumenical systems, structures owned directly and indirectly by religious groups, structures influenced by religious values, and the membership itself (Gunderson 2000). With the creative and prudent utilization of these resources and relationships, the conclusion is plain: "Faith-based programs can improve health outcomes" (DeHaven et al. 2004, p. 1030).

An unspoken cornerstone of these efforts, current and idealized, is the identity of population health as a religious value. Notwithstanding the reservations of some in public health who view potential faith–health partnerships as intrinsically adversarial (see Chatters et al. 1998, p. 692), the faith-based and public health sectors share a set of "[d]istinctive values and orientations" (Chatters 2000, p. 352), such as service to others, community empowerment, and social responsibility. More specifically, the consonance of the public health ethic and the communal and social-justice ethos of the major faith traditions, as noted earlier, supports the ideas proposed here and resonates with core elements of the public heath worldview. These include (a) primary prevention, (b) the multiple determinants of population health, (c) communitarianism and social justice, and (d) a global perspective. Faith traditions most exemplify their prophetic role when they call people (and governments) out of their complacency and neglect, especially regarding disadvantaged or disempowered populations. They are thus potentially vital partners in advocating to the American people, its political representatives, and the federal government for the value in realigning national public health priorities. Such realignment, according to Gunderson and Cochrane (2012), may require something of a paradigm shift; accordingly they speak of "religious health assets (pp. 41–58) and their impact on the "leading causes of life" (pp. 59–80). Taken up by the Surgeon General, an agenda focused on these four core elements of the public health perspective and highlighting faith-based and other midstream and upstream partnerships and initiatives might especially resonate with constituencies that could work together to improve the nation's health, including potential faith-based assets. This could define, in large part, his or her proverbial bully pulpit.

In the context of this perspective, as just described, one could envision substantive starting points for such an agenda. The SGUS might get considerable traction and do a lot of good with an agenda grounded in the following points:

1. *Primary prevention*. Advocating a substantial redistribution of biomedical research resources more toward preventing morbidity and promoting population health makes good public health sense, as in the old maxim that an ounce (or penny's-worth) of prevention is worth a pound (or dollar's-worth) of cure. The SGUS's advocacy role ought to extend beyond urging individual people to comply with the behavioral prescriptions and proscriptions of physicians and governmental panels. He or she could have a lot of influence in redirecting national priorities and in raising awareness of the social-structural influences on health, including systemic poverty, socioeconomic disadvantage, and environmental degradation.

2. *The multiple determinants of population heath*. The health of human populations is impacted by myriad variables and higher-order systems, from the biochemical to the psychosocial to the political-economic. Besides poverty, these include the organization of the healthcare system and access to healthcare and health-promoting resources—things that when dysfunctional or limited, respectively, may impede the ability of certain population groups to maintain their health. While not in a federal-policy-determining role regarding such issues, the SGUS does have a seat at the table, so to speak, and could be a powerful advocate for the health needs of the underserved and underclasses.

3. *Communitarianism and social justice*. Emphasizing both primary prevention and a multiple-determinants perspective requires consideration of matters related to justice, individual and social, and reminds us that population health is a collectively defined status and thus a mutual responsibility that requires political decisions regarding allocation of communal resources. This is a larger issue of political philosophy that extends beyond public health and has deep religious roots; thus, it may be outside the comfort zone of the SGUS and his or her superiors in the chain of command (i.e., the ASH and the SHHS). But if this value were consonant with the worldview of the current (or next) administration, the SGUS could give voice to such a perspective in a powerful way that would be much more "applied" than theoretical.

4. *A global perspective*. Our nation's public health responsibilities do not end at our borders, as communicable pathogens, for example, and other public health risks know no national boundaries. The ease and rapidity of global transportation and our increased connectivity make this not an ideological position but a statement of fact and public health prudence: all public health is global. The mission of the SGUS would benefit from an expanded collaborative role with other USPHS and federal agencies (e.g., the Office of Global Health, the State Department, the military surgeons general) and with international NGOs (e.g., WHO, PAHO, UNESCO), and the scope of these organizations' impact on population health would benefit in turn.

In summary, not only would the faith-based and public health sectors make good partners, but the driving values of public health would seem to resonate with faith-based values. Accordingly, the SGUS could advocate for a rebooting of national public health priorities that (a) focuses on issues like poverty, injustice, nativism, and misallocation of public resources as fundamental determinants of population ill health and (b) seeks upstream and midstream solutions in partnership with faith-based and other voluntary-sector organizations. Such an agenda might include items such as systematic anti-poverty initiatives and policies, greater investment in public education focused on improving public health, more coordinated efforts at public health preparedness across governmental and private-sector entities, promotion of risk reduction targeting structural disadvantages that create health disparities, and enlargement of the public health infrastructure, such as substantially expanding the PHSCC and the Medical Reserve Corps, in order to meet the requirements of a renewed national commitment to prevention and preparedness. The

combination of promoting a broader view of what public health can be about and offering a wider take on the potential stakeholders, major players, and partners in public health efforts here and throughout the world would be a powerful vision for "the nation's health educator" to communicate and may begin to create some positive momentum.

Because we are living in a time of scarce federal resources and economic challenge, as well as severe political polarization, this agenda may not be an easy sell. It is probably much easier, and politically more expedient, for the SGUS to maintain the status quo and focus on lifestyle behavior modification. The perceived cost, for one, and the perceived expansion of government, for another, may present political barriers that the USPHS is not willing to breech. This deduction may be correct, but it is unfortunate: in the end, as public health professionals and scientists recognize, it is often less expensive to prevent morbidity than to try to treat it, after the fact (see, e.g., Messonnier et al. 1999).

A new agenda for the SGUS, as described here, should not be perceived as a partisan political agenda. All sides and philosophies along the political-economic continuum recognize that poverty and its concomitants are a social problem of the first magnitude; they differ only on solutions. Beltway think-tanks across the political spectrum—e.g., the Center for American Progress (progressive-socialist), the Brookings Institution (neoliberal), the Heritage Foundation (movement conservative), the American Enterprise Institute (neoconservative), the Cato Institute (libertarian)—have sponsored antipoverty initiatives, projects, or events in recent years. Recognition of the importance of this issue apparently bridges otherwise divergent ideologies.

It thus may not be a difficult leap to communicate that (a) these same social disadvantages also create health disparities through elevated risk of morbidity and mortality and (b) the situation therefore demands creative efforts at identifying fruitful new partnerships to extend and enhance the government's and society's efforts to ameliorate these disadvantages and disparities. This would be the burden of the SGUS and would require someone with strong communication skills and formal training in public health, with special expertise in the social determinants of population health and, ideally, in the scope and promise of public–private partnerships, such as with the faith-based sector, which could be utilized to address this serious national issue. As the tenure of each SGUS has come to be identified with a single health-related problem or issue, this present topic is an ideal candidate to serve as the focus of the next Surgeon General.

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