Distribution Agreement

In presenting this thesis or dissertation as a partial fulfillment of the requirements for an advanced degree from Emory University, I hereby grant to Emory University and its agents the non-exclusive license to archive, make accessible, and display my thesis or dissertation in whole or in part in all forms of media, now or hereafter known, including display on the world wide web. I understand that I may select some access restrictions as part of the online submission of this thesis or dissertation. I retain all ownership rights to the copyright of the thesis or dissertation. I also retain the right to use in future works (such as articles or books) all or part of this thesis or dissertation.

Signature:

_____ _____

Emma Horwath Date

"Liberation, Social Justice and Anti-Racism: How Three Health-Focused Faith-Based Organizations Communicate Their Commitment to Anti-Racism"

By

Emma Horwath
MPH

Hubert Department of Global Health

John Blevins, M. Div., Th. D.
Committee Chair

“Liberation, Social Justice and Anti-Racism: How Three Health-Focused Faith-Based Organizations Communicate Their Commitment to Anti-Racism”

By

Emma J. Horwath

Bachelor of Arts

University of Notre Dame, 2019

Thesis Committee Chair: John Blevins, M. Div., Th. D.

An abstract of
A thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
in partial fulfillment of the requirements for the degree of
Master of Public Heatlh
In Global Health
2022

Abstract

"Liberation, Social Justice and Anti-Racism: How Three Health-Focused Faith-Based Organizations Communicate Their Commitment to Anti-Racism"

By Emma J. Horwath

Increased media attention to health and racial disparities and to the impact of racism in the United States has highlighted an area of necessary development in public health. Faith-based organizations (FBOs), including Catholic FBOs, play an important part in the public health space given their reach and impact and have an opportunity to be a leader in anti-racist health-based solutions. This paper critically analyzes the religious, organizational, strategic and service dimensions of three health-based FBOs, including Catholic Health Association (St. Louis, MO), Mercy Care (Atlanta, GA) and The Center for Faith and Community Health Transformation (Chicago, IL). These case studies will also emphasize elements of social justice and anti-racism rooted in Christian theological tradition. While all three FBOs display aspects of anti-racism and social justice in their organizational approaches, programming and missions, the way and the degree vary. Catholic Health Association is the most explicit and operates at more of an institutional level, whereas Mercy Care and The Center are less explicit and more focused on individual actions. These organizations have the platform and theological backing to amplify societal change and convincingly commit to anti-racist initiatives, and must continue to be leaders in this space.

“Liberation, Social Justice and Anti-Racism: How Three Health-Focused Faith-Based Organizations Communicate Their Commitment to Anti-Racism”

By

Emma J. Horwath

Bachelor of Arts

University of Notre Dame, 2019

Thesis Committee Chair: John Blevins, M. Div., Th. D.

A thesis submitted to the Faculty of the Rollins School of Public Health at Emory University in partial fulfillment of the requirements for the degree of
Master of Public Health
in Hubert Department of Global Health
2022

Acknowledgements

I would like to extend my sincerest gratitude and appreciation to my thesis advisor, Dr. John Blevins, for his patience, commitment and support throughout this entire process. His knowledge and perspective have been critical in the development of this paper and my understanding of public health. Thank you to all of the Rollins academic support staff, especially Catherine Strate, for their understanding and support to get this project over the finish line. Additionally, thank you to Marie Donahue, without whom I would not be on this journey. Finally, to my friends and family: words can't describe how much your unwavering support and love mean to me. Thank you.

Table of Contents

Abbreviations

FBO – Faith-based organization

SES – Socio-economic status

LGBTQ+ -

The Option – Preferential option for the poor

CST – Catholic social teaching

CHA – Catholic Health Association

FQHC – Federally qualified health center

The Center – The Center for Faith and Community Health Transformation

CHOP – Community Health Outreach Program

OCEAN-HP – Office of Community Engagement and Neighborhood Health Partnerships

CHAMP – Congregational Health Asset Mapping Partnership

LAMP – Love Asset Mapping Partnership

Introduction

According to the Centers for Disease Control and Prevention, health disparities "are preventable differences in the burden of disease, injury, violence or opportunities to achieve optimal health that are experienced by socially disadvantaged populations" (2020). Across a wide range of health outcomes ranging from infant mortality, prevalence of chronic disease and general physical and mental health, people of color, including Black people, have worse health than their White counterparts (Ndugga & Artiga, 2021). Racism in the United States (U.S.) cuts across a variety of social and economic factors that ultimately impact health, including education and socio-economic status (Came & Griffith, 2018). Thus, the impact of racism and discrimination can be felt in a multitude of ways and ultimately negatively affect individual and population health. A potential solution is to be anti-racist and implement anti-racist policies, which involves actively fighting against racist policies and ideas (Kendi, 2019). It is this mentality that the healthcare and public health fields must incorporate into their work in order to address the root causes of health disparities and inequities.

Many in the United States carry strong religious and spiritual beliefs and it is important to recognize religion's ability to play a powerful role in people's lives (VanderWeele, 2017). There has been increasing research and knowledge around the influence of religion in many areas of health, not only health care, but also in a person's individual health. This suggests that religion and faith-based organizations (FBOs) have an opportunity to affect individuals and groups regarding their health. In a very direct way, the Catholic Church has been doing just that through its many avenues of providing clinical healthcare to people and health programming. Catholicism has a long tradition of caring for the sick that is grounded in the narratives of the Gospels and life of Jesus and has been carried on within many religious communities through

nursing and hospital ownership. Health-focused FBOs are uniquely situated to positively impact the health of individuals and populations, especially through the prioritization of those who are underserved.

In the wake of both the COVID-19 pandemic and the killing of George Floyd in the summer of 2021, there is a need for health-focused organizations to incorporate anti-racism into their programming. Additionally, racism has been declared a serious public health issue in the United States, making organizations reflect on their organizational and programming values. Given these circumstances and the unique position of health-based FBOs to affect health, the goal of this evaluation is to analyze the ways in which FBOs, particularly Catholic organizations, with a focus on public health and healthcare communicate a commitment to social justice and antiracism.

Background

Race, Racism and Anti-racism

The United States has a very complex relationship with race that the country struggles to address. This relationship is a critical part of understanding the history of the United States as well as the present, particularly in terms of the racial disparities and inequities that are found in various areas of life including health (Hammonds & Reverby, 2019) First, it is important to define a few terms. Before we can talk about anti-racism, it is critical to understand what racism is and how it is being conceptualized. This is important because there are a number of different definitions of racism, as understood in general vernacular as well as among academic scholars. Racism as a cultural phenomenon, a result of policies and ideas, and the normalization of

inequities are some of the ways that racism has been defined and understood by various scholars (Kendi, 2019; Massingale, 2010). However, some common components of racism are the inclusion of a power dynamic, a complicit system and institutions, and a sense of superiority/inferiority due to the color of a person's skin (race) (Came & Griffith, 2018). One broad definition is "a system of advantages for the dominant racial group (whites) in society" (O'Brien, 2018, p. 414). In their paper on anti-racism praxis in public health, Came and Griffith (2018) use this definition of racism: "an organized system, rooted in an ideology of inferiority that categorizes, ranks, and differentially allocates societal resources to human population groups." They also note that "racism is a violent system of power that can be active and explicit, passive and implicit, or between this binary" (Came & Griffith, 2018, p. 181). Thus, it is through these common elements of power, prejudice and institutions/systems that we develop a general and foundational understanding of racism. Drawing from this brief review of the definitions of racism, this paper will understand racism as an organized system of power that, based off of the color of a person's skin, confers certain advantages and disadvantages onto that individual or population group, and is manifested in different ways, including policies and culture.

Anti-racism, then, in its broadest sense is "any theory and/or practice…that seeks to challenge, reduce, or eliminate manifestations of racism in society" (O'Brien, 2018, p. 413). This means that anti-racism is active and is inherently based on action and practice. It is not just about not being racist or about neutrality, but requires active steps to fight against all forms of racism (Kendi, 2019). It can also be broken down into different types of anti-racism, which includes individual and institutional anti-racism (O'Brien, 2018). Though these two categories of anti-racism are not without overlap, this binary does provide a useful analytic for

understanding different anti-racist actions. Individual antiracism is understood as functioning "largely at the level of interpersonal and micro-level interactions", whereas the ideal type of institutional anti-racism is focused on structural and/or institutional actions, such as policy or organizational arrangements (O'Brien, 2018, p. 417).

O'Brien goes on to discuss the conditions that do and do not foster anti-racism. One of these factors is the involvement of whites: how they become aware of racism and then commit to acting against it. This is different from the experiences of people of color, largely due to the fact that racism helps normalize a culture of whiteness. In other words, it's hard to see the water when you're swimming in it. Relatedly, the concept of 'color blindness', or the denial of the structural realities of racism, is cited as a challenge to anti-racist efforts. Instead of recognizing racial differences and the consequences of those differences as systematic, they are viewed as a result of "biological, psychological, or cultural factors intrinsic to individuals" (O'Brien, 2018, p. 421). Those who hold onto the concept of color blindness refuse to acknowledge that a race issue exists, making it difficult to argue that there is any action to take. Other factors that may impact the motivation towards anti-racist action include similar experiences or perspectives of oppression, interactions with other activists (individual or organizational), and potentially interracial relationships. These elements and others all combine to influence whether an individual or organization moves towards anti-racist actions. It is also important to note that "the key difference among the various anti-racist efforts is not as much about the racial identities of who they have included, but in the goals, tactics, and strategies they have utilized to attain racial equality" (O'Brien, 2018, p. 421). Again, drawing largely from O'Brien's broad understanding of anti-racism, this paper will define it as an individual or institution's active capacity to challenge, reduce or eliminate any and all forms of racism.

Race and Health

As mentioned above, racism is an organized and institutionalized system that has real consequences on those who are most negatively affected. Racism and discrimination remain a fixture in the lived experiences of many, both around the globe and here in the United States, impacting various aspects of daily living, including health (Williams & Mohammed, 2013). This can be seen in the construction of cities and neighborhoods or residential segregation, resulting in food deserts and disrupted communities, and racial profiling of African Americans (Laurencin & Walker, 2020; O'Brien et al., 2020). These are direct examples of the ways racism and discrimination play out in society. Williams and Mohammed (2013) examine various mechanisms by which racism can affect health, emphasizing the influence of institutional and cultural racism, and its role as a root cause in health disparities. It is through these larger systems and forces that race, socio-economic status (SES), gender and age, among other social status categories, impact health. At a more micro level, individual health is affected via stigma, stereotypes, prejudice and racial discrimination, which, again, has a ripple effect on societal resources and opportunities, as well as physiological, behavioral and psychological responses in the body. As Williams (2012) succinctly explains, "Discrimination can lead to reduced access to desirable goods and services, internalized racism (acceptance of society's negative characterization) can adversely affect health, racism can trigger increased exposure to traditional stressors (e.g., unemployment), and experiences of discrimination may be a neglected psychosocial stressor" (p. 284). These pathways are complex, though not exhaustive; however, the upstream impact of racism on individual and population health is clear.

Health disparities along racial differences have been well documented in the field of public health, manifesting in higher rates of mortality, earlier onset of disease, higher level of

comorbidity and impairment, and greater severity and progression of disease (Williams & Mohammed, 2013). Disparities also extend into other elements that impact physical health, such as healthcare access, SES, and education (Murray et al., 2005). In a prospective cohort study looking at racial/ethnic health disparities in late middle age individuals, Sudano and Baker (2006) identified two predominant mediating factors: baseline health status and SES. They found that Black people were almost twice as likely to report fair/poor health, had more chronic diseases and reported more physical limitations than white people. This association also held true, though to a lesser degree, for Hispanic individuals. Sudano and Baker (2006) found "enormous differences" in certain elements that contribute to SES, such as education, income and net worth and noted that these results are consistent with the literature (p. 918). There are racial disparities in both the social determinants of health and health itself. In the end, the root cause of these health inequities is social and institutional racism.

Religion, Health and Theology

Religion occupies a powerful place in the lives of many people; approximately 84% of the world's population reports a religious affiliation and this hold true for the United States (VanderWeele, 2017). There has been increasing research and knowledge around the influence of religion and religious practices, both positive and negative, on a variety of health outcomes, including mortality, depression, suicide and well-being (VanderWeele, 2017). It is for these reasons that religion has been deemed by a growing group of researchers in the health sciences as a social determinant of health (Idler, 2014). Religion operates through a few different mechanisms including religious frameworks and systems of meaning, and can influence health through social support, social control and social capital (Idler, 2014).

Ties to social groups and feelings of connectedness oftentimes provide important material and emotional support to people, which in turn positively impacts sense of well-being. Participation in religious services or religious group membership is an oft cited example of social ties. This feeling of community can have a strong impact on health, including mental health, although the causal relationship is not completely clear. What does have more concrete evidence is the relationship between service attendance and mortality. In one study by Rogers et al. (2010), those who never attended religious services were found to be almost 50% more likely to die from any cause over the study period than those who attend services more than once per week. A dose response relationship can also be found among those who attend religious services with a statistically significant lower mortality rate (Hummer et al., 1999).

Another way in which religion impacts health is through social control. Through structures and rules, religious groups are able to control and regulate the behavior of their members. This happens both through positive and negative reinforcement by providing community and acceptance or through pressure to conform. Religious groups can have influence over many different behaviors including diet, smoking and drinking, and the degree in which this is done can vary among religious traditions. In a longitudinal study Spoerri et al. (2010) found that after adjusting for a range of characteristics, the rate of suicide was lower for Catholics than Protestants. This also held when comparing Protestants to those with no religious affiliation. Spoerri et al. discuss two of the potential mechanisms that may have factored into these results: social integration and normative integration. Social integration goes back to the importance of social ties and the sense of community. Normative integration is the concept of accepting social norms and beliefs of a faith by individuals. This would explain the differences between those

who identify as Catholic and those who do not given the degree in which the Catholic Church denounces suicide.

This form of social control can also have a harmful impact on individual and community health. Being too restrictive, controlling and/or punishing to regulate behavior by religious groups can have serious ramifications. This can manifest itself through an imbalance and misuse of power within religious structures and hierarchies. Religion can also be wielded to restrict women's rights, hurt the LGBTQ+ community and discourage beneficial public health practices. Just as strong social ties can provide a protective effect to those deemed the 'in-group', they can also justify exclusion and harm done to those in the 'out-group'. The way in which in- and out-groups are determined is also an important aspect to consider, though that is outside the scope of this literature review and analysis. Thus, religious institutions and practices can negatively impact an array of public health areas including sexual and reproductive health, maternal and child health, spread of infectious disease and clinical health decisions. These impacts can operate at both individual and community levels resulting in great harm to both. It is important to acknowledge both the positive and negative influences of religion on health.

Social capital is a third method of influence that religious institutions can wield. Social capital is composed of the relationships among a multitude of social institutions and actors including political, economic, educational, religious and social structures, as well as monetary, material and social resources. Religious communities can leverage their power to reinforce and create their own forms of social capital and increase their capacities. Some of the common ways this has been done is through the establishment of schools, hospitals and social service organizations, which are all formed to positively impact their own communities but also to fulfill their religious missions.

Role of Catholicism/Christianity, Race and Health

As mentioned above, the impacts of religion and the moral guidance it provides can both positively and negatively affect individuals and groups of people. At times, different traditions with the same religion can even be contradictory, including Protestant and Roman Catholicism, as noted by Blevins (2019). In regards to race, Bryan Massingale (2010) reflects that "the most remarkable thing to note concerning U.S. Catholic social teaching on racism is how little there is to note" (p. 43). This is true, especially in terms of official Church documents and doctrine; however, it does not mean that Christianity has not weighed in on various social issues around race with a wide range of stances. The American Catholic Church has often reflected the attitudes of the greater American society, with Robert Robinson, a former coordinator of the National Black Catholic Lay Caucus saying, "[it] is the history of the theological sin of scandal and the triumph of prejudice" (as cited in Hrier Mich, 1998, p. 134). This is exemplified in the past complicity with slavery at various levels of the church, with bishops, priests, religious orders and the laity commonly owning slaves in the 18th and 19th centuries. Additionally, up through the 1930s, there were instances of Black men being refused by seminaries. This transitioned into apathy towards developing leadership among the Black Catholic community and still persists to this day (Massingale, 2010).

In a similar way, various racially-skewed social arguments and stances have been made by religious movements, to the detriment of minority populations. One such example comes from the Social Gospel movement, led by liberal Protestants, which sought to "Christianize the social order" and influence legislation, policies and governments (Blevins, 2019). In the 1920s and 30s, there were a number of Protestant leaders in support of eugenics, often under thinly disguised racism and ideas of racial supremacy (Blevins, 2019). While not homogeneous by any

means, some of these Protestant denominations "provided the religious foundation for a racialized vision of birth control" (Blevins 2019, p. 66). This was based on the accepted idea of race suicide, which Wilde and Danielson (2014) define as "the belief that white Anglo-Saxon Protestants were being outbred by southern and eastern European immigrants", who were mainly Catholic, as well as Black and Brown people (p. 1711). In the same era as its segregated seminaries, the Roman Catholic Church was a clear critic of eugenics, opposing the racist arguments being touted (Wilde & Danielson, 2014). Wilde and Danielson note the numerous articles that made clear the Catholic Church's opposition of to the racist claims favoring of eugenics and contraceptives, which also had influence on immigration at the time. This is yet another example of the power and influence that religion can have on issues of race in the United States. Theology has the ability to provide a voice and positive moral guidance on racial issues. With a grounding in liberation theology and the preferential option for the poor, a pillar of Catholic Social Teaching (CST), there is an opportunity for Roman Catholicism to bridge the gap between the vulnerable and the powerful and to uplift marginalized populations.

Liberation Theology

Latin American liberation theology is conceptualized in the book "A Theology of Liberation", written by Peruvian Catholic priest, Gustavo Gutiérrez (1971). Gutierrez was writing in response to much of the social, political and even theological events occurring during the 1960s and 70s, such as the push for development in so called Third-World countries, the economic struggles that encompassed much of Latin America and the Second Vatican Council. Gutiérrez understands liberation as "a process" and a "search of a qualitatively different society in which [human beings] will be free from all servitude, in which [they] will be the artisan of [their] own destiny" (Gutiérrez, 1973, p. 91). Liberation theology contends that people must be

liberated from all barriers—social, political, economic and spiritual—that prevent or limit self-fulfillment and freedom. More specifically, this refers to poverty, alienation and exploitation, particularly within the Latin American context. Liberation theology is utilized to understand God's place and role in the face of injustice especially among the poor and oppressed.

In fleshing out his conceptualization of liberation theology, Gutiérrez provides a deep analysis of poverty and the poor. Latin American liberation theology recognizes two different kinds of poverty: spiritual and material poverty. Spiritual poverty can be understood in two ways. The first as a detachment from worldly goods, an indifference to material possessions. The other understanding invokes the idea of spiritual childhood, the total dependence and openness to God. Material poverty refers to the lack of necessary economic goods for a decent and dignified life. In other words, spiritual poverty is a religious virtue of openness to God, whereas material poverty is a negative consequence of structural sin. Gutiérrez elaborates, saying "to be poor means to die of hunger, to be illiterate, to be exploited by others, not to know that you are being exploited, not to know that you are a person" (Gutiérrez, 1973, p. 288). Gutiérrez argues that the cause of poverty is the injustice of the oppressed. His claim is important because it refuses to accept that poverty is a consequence of fate or determined by God. Rather, Gutiérrez argues that material poverty is contrary to human dignity and thus to the will, and Kingdom, of God. A commitment of solidarity and protest, an act of love and liberation, is necessary to dismantle poverty and its effects. Christians have an obligation to protest against poverty and to stand in solidarity with the poor, which includes the oppressed, the marginalized, the exploited at all levels, and those without rights. As liberation theology develops, this concept becomes formalized in the phrase 'the preferential option for the poor'.

The preferential option ("The Option") has its basis in Latin America and the Latin American Bishops' Conference in Medellín (1968) and Puebla (1978), where the bishops gathered to discuss the reality and signs of the times in their countries. Material poverty took center stage in Medellín. What The Option challenges Christians to do is to act against the forces that are oppressive and create structural inequities (Gutiérrez, 1973). It means to prioritize the poor and oppressed, to empower them and to stand in solidarity with them (Surmiak, 2019). As Gutiérrez says, "to be for the poor is not to accept their poverty… how [could it] be possible to be committed to the poor if we are not against poverty" (Gutiérrez, 2011, as cited in Griffin & Block, 2013, p. 29). Further, in understanding who the poor are, Leonard Boff, another liberation theologian, explains "the Church's option is a preferential option for the poor" who "are those who suffer injustice" (Boff, 1989, as cited in Griffin & Block, 2013, p. 36). This interpretation opens the door to broadening who the Church should be prioritizing when calling on The Option as an obligation, a responsibility and an essential part of the Catholic faith.

Black Liberation Theology

Black Theology was formally conceptualized in the 1960s, though it is rooted in the culture and context of the Black experience and African American history dating back to the slave trade. From this history of slavery, segregation, the civil rights movement and Black power, Black Theology sought to challenge the assumptions of White theologians and preachers, and more importantly, to challenge racism, White supremacy and oppression. Black theology was also influenced by the global emergence of colonialism and development critiques among nations in Africa, South America, and others (Blevins, 2019). American racism was seen as the root oppression in the Black experience and therefore, a theological problem. James Cone, a thought leader on Black theology claimed that "Black Power is an authentic expression of the

Gospel [affirming] his belief that the Christian faith, as the praxis liberation, was accountable to the oppressed black community" (Cummings, 1993, p. 40). This struggle for justice and righteousness is central to Black Christian tradition and was heavily incorporated in the development of Black theology, which focused on the religio-cultural and political liberation of African Americans.

Key to Black Theology is the identification by God (and Jesus) with the humanity and the oppression of Black people, an oppression that is rooted in racism that affects social and political dimensions of life in America. Black liberation theologians see God existing among Black people in the US via the Black Messiah: "Since the black community's experience in the United States has been characterized by suffering and oppression, and since its persistent witness has been to the presence of the suffering one among them, then Jesus Christ is black" (Cummings, 1993, p. 45). As such, God understands the nature of oppression as experienced by African Americans in a very distinct social and cultural context. In this context, the Black church plays a critical role, not just as a faith institution, but also as an actor for political and social change. The importance of the church has a historical background in being at the forefront of the struggle for liberation against racist structures, providing strength and community. This history of the Black church allowed Black theologians to identify a link between Christian faith and political action, which is necessary for liberation. Additionally, it provided another platform for Blacks to draw attention and push back against the growing racism in public health, resulting in health disparities and inequities (Blevins, 2019).

Womanist theologians have also provided significant contributions to the understanding of God and theology, highlighting the fact that race can never be experienced separate from gender and class (Prevot, 2008). They explore, not only the intersecting oppressions that women

of color experience, but also uplift stories of survival and triumph, resistance and creativity. While they do draw on Black male theology, including the work of Cone and his conception of the Black Christ, womanist theologians offer their own distinct and varied conceptions of God and religion (Prevot, 2008). Much of their work is grounded in personal narrative and lived experiences that validate and empower women of color. Additionally, Catholic theology has not been untouched by these womanist perspectives. Theologians such as Diana Hayes and M. Shawn Copeland similarly provide their own contributions in emphasizing stories of Black women while attending to a specifically Catholic hermeneutic, such as reinterpreting the role and presence of Mary (Hrier Mich, 1998). As Prevot (2008) points out, "They also provide a path along which Catholic theology may move forward in solidarity with poor, despised women of color without abandoning its essential faith commitments and, indeed, while more authentically, credibly, and coherently holding such commitments." (p. 64) Womanist theologians show the power, possibility and necessity of making space for the perspectives of women of color.

Both Latin American liberation theology and Black liberation theology were conceptualized to address the relevancy of Christianity and the Gospel in light of the suffering and oppression of certain peoples. There are similarities between the two, despite emerging from different contexts and there are elements of each that can inform the other. Some of these similarities include the belief that the central focus of the Gospel is liberation, and the linkage of God's Kingdom with the human struggle on earth. They also both have components of the preferential option for the poor, and though 'the poor' are not clearly defined, it has been interpreted as referring to all those oppressed: the economically poor, Blacks, women, indigenous people and others. The primary differences between Latin American liberation theology and Black theology lie in the contexts in which they were developed. Latin American

liberation theology was developed in response to Euro-American/European domination, neoliberalism and international development of so-called Third World Countries. Thus, it developed a socio-economic based argument, where one's economic status was the determinative element in defining oppression. Black theology, on the other hand, was rooted in the religio-cultural context of the African American experience. As such, race was the primary context and all analysis was based on the historical reality of racism and the affirmation of the worth of Black humanity. By sharing and incorporating these two primary bases of analysis (economic and racial), both theologies can broaden their perspectives and widen their relevancy to other peoples.

Catholic Social Teaching (CST)

Catholic Social Teaching (CST), which may also be referred to as Catholic Social Tradition or Catholic Social Thought, is Church doctrine that is based on the Corporal Works of Mercy, where Jesus says "just as you did it to one of the least of these…, you did it to me" and a commitment to the poor (Mt. 25:40). CST has a rich history that is rooted in the Gospel, is an "essential part of the Catholic faith" and informs the actions and decisions of the church in the face of everchanging social issues, dating back to the 1850s (Hrier Mich, 1998; United States Conference of Catholic Bishops [USCCB], 1998). There are seven pillars of CST: call to family, community, and participation; rights and responsibilities; preferential option for the poor and vulnerable; dignity of work and the rights of workers; solidarity; and care for God's creation. These represent common themes that are highlighted throughout key CST documents and shape the Church's response to issues ranging from the American labor movement to climate change to racism.

CST is not just a stagnant church doctrine, but an adaptable one that is rooted in papal, clerical and biblical sources. Further, "the non-magisterial contribution to the development of the Church's social teaching must be actively embraced. For in truth of fact, Catholic social teachings are not shaped by the magisterium alone" (Hrier Mich, 1998, p. 3). In other words, CST is not composed of just "official" teaching from Church encyclicals and pastoral letters, but part of its power also comes from living out those teachings through individual movements and actions. This can be seen in the work of Dorothy Day and Peter Maurin and their Catholic Worker movement and in the efforts of Black Catholics, laity and clergy alike, to make their voices heard in an overwhelmingly white, and often discriminatory, institution. As Cahill (2007) claims, "[CST] demands participatory and democratic political action aimed at improving the conditions of social life on which the common good depends… Such action includes empowering people in marginalized communities to become advocates on their own behalf." (para. 5). It is through these actions, through the embodiment of solidarity and the preferential option, through the defending of human dignity and the common good that Catholics can be anti-racist. Just as anti-racism is predicated on action as opposed to neutrality, CST offers that challenge and call to action.

Catholic Healthcare in the United States

Healthcare in the United States is rooted in the development and growth of hospitals, both public and private. It is impossible for the influence of religion in healthcare to be ignored, and the Catholic Church has played a significant role in this history. Many women religious communities, including the Daughters of Charity and the Sisters of Mercy have long been involved in healthcare, particularly through nursing. These sisters have brought a unique

perspective of ministry and religious motivation to the bedside. St. Vincent de Paul, co-founder of the Daughters of Charity reflected on the mindset that they brought to their work, "the poorest and the most abandoned are our Lords and Masters" (Kauffman, 1995, p. 22). The belief that caring for and being of service to others is derived from the Gospel led to two religious understandings: minister and serve those suffering; and see Christ in the sick and vulnerable. As Christopher Kauffman says, "the sacred position of the sick man… became the preferential position which has been his ever since." (Kauffman, 1995, p. 13)

As these religious communities of men and women began migrating to the United States from Europe, they maintained their ministry of caring for the sick; however, the American ideal of separation between church state forced them to balance religious pluralism with the freedom to convey their religious commitment. Following the cholera epidemic in 1849 and under the increasing health burden resulting from immigration, industrialization and urbanization, hospitals proliferated. This included a rise in denominational hospitals from various religious traditions, such as Episcopalian, Protestantism and Catholicism. Often founded by philanthropists, benevolent associations, or leading clergy men, these commonly private voluntary hospitals primarily depended on paying patients due to lack of funding. Nativism and anti-Catholic sentiment also pushed the development of Catholic hospitals. Morris Vogel explained (as cited in Kauffman, 1995, p.70) "the major function of such institutions…was to…serve quite specific needs within their communities. … hospitals were agencies of identification for uprooted immigrants, promoting group cohesion", further emphasizing the impact of religion on health.

Catholic Health Association

In the spring of 1915, the Catholic Hospital Association, now Catholic Health Association (CHA), was established. Acknowledging the importance of medical, religious and

ethical components in healthcare catalyzed the formation of the CHA as it filled a need for national medical, religious and social education. It helped communities of women religious involved in healthcare, particularly sister-administrators, to keep pace with hospital and medical modernization and reform. One of the priorities for CHA was standardization across Catholic hospitals, especially in terms of education and accreditation. Within five years, CHA had established a high level of authority and credibility among Catholic hospitals and institutions, while also having a strong impact at the local level. Years later, in the wake of the Second Vatican Council, CHA revised its governance, opening up more leadership to laity and placing a specific emphasis on public health policy and advocacy. It has continued to be a leader in Catholic healthcare, lending its voice to a variety of health issues including disparities, ethics, global health, and immigration. CHA has continued to grow and change throughout the years in response to emerging concerns and competing priorities.

Catholic Healthcare for African Americans

Racism and discrimination of African Americans has not been uncommon throughout the history of the Catholic Church. There is documentation of several bishops and religious communities having owned slaves prior to the Civil War. And it was not until after World War I that a Black Catholic hospital was built. The American Catholic bishops did nothing to foster inclusion of Black Catholics within the church following the Emancipation Proclamation due to, according to Kauffman, concerns over anti-Catholic sentiments. Additionally, since many Catholic hospitals were founded as private voluntary institutions, they depended on paying patients as their primary source of funding, which has become a continual challenge. Even today, with ballooning healthcare costs, hospitals must walk a fine line between their mission of caring for the underserved and maintaining financial viability.

Summary

Drawing from a variety of sources, this paper developed working definitions for racism and anti-racism, respectively. The complex relationships between race, health, and religion were discussed, highlighting the institutional nature of racism, its impact on public health and the social determinants of health, resulting in racial health disparities. The influence of religion, both positive and negative, on individual and community health was also explored. Additionally, given that the make-up of the organizations chosen for analysis, this literature review paid particular attention to the role of Christianity in the United States as it pertains to race, racism and public health. Key Christian theological traditions are laid out, including Latin American Liberation Theology, Black Theology, Womanist Theology and Catholic Social Teaching. Finally, there is a brief overview of Catholic healthcare in the United States to set the scene for the FBOs that will be analyzed in the following pages. This literature review sets the stage for an organizational analysis of three health-focused faith-based organizations emphasizing anti-racism. It seeks to provide a foundation for key background knowledge in anti-racism, religion, especially the Christian tradition, and public health, in addition to an argument as to why these are compelling issues to study and understand.

Methodology

This thesis will employ a case study analysis of three FBOs: Catholic Health Association (CHA), Mercy Care and The Center for Faith and Community Health Transformation ("The Center"). The analysis of these organizations will revolve around their front facing materials, including their website, reports and other publicly available documents. As such, IRB approval

and data use approval are not needed. The organizational analysis will focus on four dimensions: religious; organizational; strategic; and service. A lens of CST and liberation theology will be utilized in the analysis while also emphasizing the elements of social justice and anti-racism.

The Catholic Health Association was chosen because it has been a leader in Catholic healthcare since the early 1900s and has considerable reach among Catholic healthcare facilities: it is a national organization and is comprised of more than 600 hospitals (CHA, 2022). The CHA is also directly affiliated with the Catholic Church, providing a perspective that is dependent on the religious structure of the Church. Finally, CHA has a wide range of focus areas in which to analyze and to incorporate anti-racist values. Mercy Care is another Catholic organization. This federally qualified health center (FQHC) was founded in the tradition of the Sisters of Mercy and is based in Atlanta, GA. It is primarily focused on providing direct medical care to its patients and provides a perspective from an organization that is involved in direct service in a field where the involvement of Catholic religious communities is rich. The Center for Faith and Community Health Transformation, based in Chicago, IL and founded in 2009 with the goal of impacting community health through the development of collaboration and partnership, provides a contrast to the previous two organizations. Though it embraces the values and practices of religion, The Center does not have an affiliation with any particular faith tradition. It is also more community and public health focused with a wide variety of programming that includes nutrition, maternal health and the convening of partners. These three organizations provide a glimpse at a spectrum of faith-based health organizations and the ways in which they understand and operationalize social justice and anti-racism.

Organizational Analysis

Catholic Health Association

Religious Dimensions

The Catholic Health Association (CHA) is a non-profit national membership organization that is primarily informed by the Roman Catholic faith tradition. The organization is first and foremost defined by its religious identity and that is visible across much, if not all, of its public and front-facing material. This includes its mission and vision statements, which are as follows: "CHA advances the Catholic health ministry of the United States in caring for people and communities" while the vision states that "CHA is a passionate voice for Jesus' mission of love and healing. A valuable resource for information, services and programs. A vibrant community of members joined in a shared mission" (CHA, 2020 & CHA, n.d.). Further, the bylaws of CHA explain that its purpose is "…to advance the mission of the Catholic Church through the ministry of providing optimal health services and programs to the people and communities they serve" (CHA, 2021). These statements show not only how deeply rooted its Catholic nature is but also that the organization is committed to furthering and bettering Catholic health care in the United States. CHA, explicitly and implicitly, expresses motivation and guidance through the principles of CST, which include human dignity, the preferential option for the poor, stewardship of creation and the call to the common good. This is implied through the association's variety of focus areas, and is stated outright in its brochure and membership eligibility document.

Organizational Dimensions

Secondarily, CHA is defined by its commitment to the provision of and access to healthcare for all. The association is comprised of more than 600 hospitals, and more than 1,600 long term care and other health facilities in all 50 states (CHA, 2022). Of the hospitals, 73% are

located in urban settings while 27% are rural (CHA, 2022). While the members themselves are predominantly other organizations and institutions, it is the individual healthcare providers, patient caregivers and organizational leadership that benefit from the variety of resources, publications and networking opportunities offered by CHA.

The governing structure of CHA includes the president, Board of Trustees, specialized committees and the membership assembly. The Board of Trustees, which includes the President, is the body that manages and controls the operation of CHA and whose responsibilities include administrative appointments, purchasing power and establishing or dissolving conferences, councils and committees, among others. The Board also has the responsibility to set the strategic agenda of the organization (CHA, n.d.). While the Membership Assembly has the power to vote, the matters reserved for voting are limited and primarily involve election/removal of leadership and amendments to organizational bylaws. Additionally, the Catholic Church looms large in its influence over CHA. However, CHA is not directly part of the official hierarchy of the Church, its administrative regulations stating, "The Board affirms the importance and value of an effective working relationship and spirit of mutual support between the Association and the Roman Catholic Church as represented by the [United States Conference of Catholic Bishops]" (CHA, 2020). The association agrees to collaborate in the "identification, definition and articulation of positions relative to public policy of concern to the Catholic Church" (CHA, 2021). This is a critical relationship to define and understand given some of the important religious teachings related to health including sexual and reproductive health and end-of-life care.

Strategic Dimensions

As discussed earlier, the nature and social teachings of the Catholic Church are the primary motivators at CHA. This is most obviously exemplified in the association's mission and vision statements but it is also visible in CHA's Strategic Plan 2021-2023, its focus areas and even the way its website is displayed, which highlights prayers, a webinar on the health needs of vulnerable populations and a meeting on theology and ethics. In its Strategic Plan 2021-2023, it states "The plan focuses on four areas where CHA can have the most impact to ensure Catholic health care continues to thrive and fulfills its *mission to care for all, with special attention to those who are poor and vulnerable*" (CHA, n.d.)[*]. This second half of the sentence is directly in line with CST, which emphasizes the preferential option for the poor and vulnerable as well as the life and dignity of the human person. The strategic plan further describes how CHA expects to prioritize its resources to achieve its mission. As such it describes four primary focus areas, emphasizing access to healthcare, community health, organizational identity and members' ability to thrive (CHA, n.d.). Commitment to CST and social justice is visible as the plan elaborates on each of the four focus areas. In explanation of its strategy to promote access to healthcare, the plan states an emphasis on "those who are poor and vulnerable" and "rural and underserved communities" (CHA, n.d.). CHA describes "[Promoting] a culture of human dignity that serves as a foundation for eliminating racial disparities through improved health and confronting racism" while also "[Enhancing] Catholic health ministries and community relationships" as justification for its strategic direction in addressing community health (CHA, n.d.). CHA also leverages its catalog of four different publications to promote the Catholic

[*] Author's emphasis

health ministry, including the journal, Health Progress, and the newspaper, *Catholic Health World*.

Service Dimensions

The majority of what CHA does include advocacy, networking and resource provision. It also sponsors educational opportunities, conferences and the sharing of best practices. CHA's publications provide one method of sharing these various resources which cover a wide range of topics. The environment, ethics, global health, immigration and palliative care are just a few of the focus areas that CHA develops resources for. The resources that CHA has curated on the topic of the environment, for example, are varied, covering issues such as climate change, Earth Day programming, and *Laudato Si*, Pope Francis' 2015 encyclical highlighting the importance of care for the earth. At the top of the webpage for climate change, it declares:

> As Catholic health care providers, climate change is a moral concern and our faith demands prudent action to reduce our carbon footprint, care for 'the least of these' (Mt 25) and raise our voice on behalf of Creation and the poor (CHA, n.d.).

This statement again highlights elements of CST and is rooted in Scripture. The rest of the webpage consists of educational modules on climate change and healthcare, climate resources such as brochures, video reflections, past webinar recordings and two related reports published by CHA. Describing the webpage for CHA's focus area on the environment provides a sample of resources that CHA offers to both its members and the public in regards to topics relevant to Catholic healthcare.

Anti-racist and Social Justice Dimensions

The final focus of this organizational analysis of CHA is the way that social justice and anti-racism show up in CHA's motivation and programming. One of the most direct ways CHA

is incorporating ideas and activities of anti-racism is with their 'We Are Called' Initiative, which implores its members and anyone in Catholic health ministry to take immediate action to achieve health equity. It was adopted by the Board of Trustees in July of 2020, in the wake of the start of the COVID-19 pandemic and the murder of George Floyd (CHA, n.d.). The ministry commitment, titled Confronting Racism by Achieving Health Equity, declares that "Racism within any context is an afront to the core values of Catholic social teaching" and that "We must be actively anti-racist" (CHA, 2020). This is a strongly written statement in acknowledgement of the structural inequities that still exist in the United States, and that Catholics and those in healthcare have a responsibility to address these issues. The mission makes two primary commitments: COVID-19-related immediate action and systemic change for health equity. The latter consists of examining business operations including clinical care, human resource practices, leadership and governance; developing relationships with the community by listening and understanding their needs; establishing sustainable change and sufficient monitoring and evaluation mechanisms; and advocacy for the elimination of health disparities and systemic racism through increased healthcare access, promotion of culturally competent care, workforce diversity, the social determinants of health and an emphasis on policy change. CHA has developed a separate website for this initiative (https://www.chausa.org/cha-we-are-called), which provides success stories, examples of best practices and other educational resources to support members in acting upon this commitment.

A desire to be anti-racist also shows up in other aspects of CHA's work. Another example of this is CHA's Advocacy Agenda 2021-2022, which highlights healthcare access, coverage and affordability for everyone, "paying special attention to low-income and vulnerable individuals, disadvantaged communities and those in rural areas", and eliminating disparities

(CHA, 2021). In reference to the latter policy priority, it's stated that CHA and its members will support policies and efforts that "end racial and ethnic disparities in health outcomes" and "achieve economic and social equity and address health disparities and systemic racism" (CHA, 2021). Structural racism is explicitly identified as one of the roots of health inequity and is cited as a reason for community health and a focus on the social determinants of health (CHA, n.d.). CHA also points to a partnership with the Institute for Diversity and Health Equity's Equity of Care initiative, which is a part of the American Hospital Association. The focus of the initiative includes disaggregation of data based on race, ethnicity and language preferences; cultural competency training; and diversity in leadership and governance.

It is in predominantly explicit ways that CHA displays program priorities and an organizational culture that reflects CST and liberation theology. In many of the organization's strategy documents, including its Strategic Plan 2021-2023, Brochure and its strategy document to community health, there are references to "special attention" or a "preferential option" for the poor, care for the environment and human dignity. An even more direct influence of CST is shown in CHA's Shared Statement of Identity, which commits "the Church's ministry of health care" to promote and defend human dignity; attend to the whole person; care for the poor and vulnerable persons; promote the common good; act on behalf of justice; steward resources; and serve as a ministry of the Church (CHA, n.d.). At least four of those seven commitments are drawn from the pillars of CST in human dignity, attending to the whole person, the preferential option, and the common good. This Shared Statement of Identity appears to be a foundational component of CHA's organizational culture and mission due to its inclusion on several strategy documents, and other visible, promotional opportunities. Finally, CHA's focus areas are also a determined reflection of CST themes. Primary areas of resource development such as individual

well-being, community benefit, and Medicaid display a commitment to the Church's social teaching through a holistic focus on both individual and community as well as those who are more vulnerable.

Mercy Care

Religious Dimensions

Mercy Care is a Catholic FQHC based in Atlanta, GA, specifically focused on those experiencing homelessness. It is a member of Saint Joseph's Health System, which was founded by the Sisters of Mercy and also based in Atlanta, as well as Trinity Health, a national Catholic health care system. Within Trinity Health, Mercy Care operates as part of their Community Health and Community Benefit programming, which seeks to impact a variety of the social determinants of health, with a focus "on preventative care and public health for those who are poor and vulnerable" (Trinity Health, n.d.). Within Mercy Care itself, the organization lists a number of values that correlate with the principles of CST, including commitment to the poor, reverence for the dignity of each person, justice and stewardship (Mercy Care, n.d.). The organization's mission and vision statements also reflect these ideals while also drawing from their founding by the Sisters of Mercy, saying:

> Furthering the healing ministry of the Sisters of Mercy, Mercy Care gives tangible expression to Christ's merciful love by providing compassionate, clinically excellent healthcare in the spirit of loving service to those in need, with special attention to the poor and vulnerable (Mercy Care, n.d.).

Human dignity and the preferential option for the poor are the most explicitly stated CST principles among Mercy Care's publicly available materials.

Organizational Dimensions

Mercy Care operates in metro Atlanta, with seven brick and mortar locations and four mobile medical coach sites, and Rome, GA, where it has a single location. At its Atlanta locations, where it receives the federal funding to be designated an FQHC, Mercy Care primarily serves people experiencing homelessness and those who are un- or underinsured. In 2018, 75% of the organization's patients lived at or below the federal poverty level (Mercy Care, 2018). Mercy Care Rome has a slightly different focus: the needs of older adults and their families. However, they are both under the same organizational leadership, which consists of the high-level leadership of the president, vice president, CEO and four other ranking positions; department heads; and Boards of Directors and Trustees. These entities are responsible for the oversight and managing the affairs of Mercy Care (Mercy Care, n.d.). Leadership positions include Sisters of Mercy, people from Saint Joseph's, Mercy Care itself and Mercy Care Foundation, which is the fundraising arm of the organization.

In terms of Mercy Care's relationship with Trinity Health, it is unclear what obligations, if any, Mercy Care may have as a community resource, such as reporting, needs assessments or financials. Mercy Care may be able to take advantage of Trinity Health's community benefit initiatives, such as their Community Investing Program and other funding opportunities (Trinity Health, n.d.). Also of note is Trinity Health's association with the Catholic Church. The sponsor of the health system, Catholic Health Ministries, oversees its "healing ministry and Catholic identity" through ownership, management, governance and programming, and was established by the Church (Trinity Health, n.d.). The members of the Catholic Health Ministries are public juridic persons, meaning they represent the Catholic Church, similar to a diocese or religious congregation (Morrisey, 2001). These are important governing aspects of both Mercy Care and

Trinity Health, particularly regarding their relationship with the Catholic Church; however, the parameters of this relationship are unclear and there appears to be minimal direct leadership from Trinity Health for Mercy Care.

Strategic Dimensions

The work and mission of Mercy Care are deeply rooted in its legacy and founding by the Sisters of Mercy. The Sisters of Mercy, who themselves were founded by Catherine McAuley in the 1830s, sought to serve the poor by meeting them where they were, whether in their homes or on the streets (Mercy Care, n.d.). Similarly, Mercy Care believes "the spirit of mercy is tangible in countless ways we care for those experiencing homelessness, poverty, mental illness or linguistic isolation" and that "faith and community are at the heart of this mission that is lived out today on the streets and in clinics across Atlanta" (Mercy Care, n.d.). This background is important to the organization not only as history but as an orientation for the present and the future. Religious sisters have had a hand in the ministry of Mercy Care from the beginning, from the opening of Saint Joseph's hospital through the eventual incorporation of Mercy Care Services in 1985, to the present as Mercy Care continues to grow. While Sisters do not control the organization, there are still a handful who are part of its leadership, including as Chief Mission Officer. In striving to achieve its mission of "providing compassionate, clinically excellent healthcare…with special attention to the poor and vulnerable", Mercy Care focuses primarily on the provision of clinical care with an emphasis on the social determinants of health (Mercy Care, n.d.). Mercy Care determines its priorities through community health needs assessments, with the last one conducted in 2018 and published January 2019.

Service Dimensions

As an FQHC, Mercy Care primarily provides clinical healthcare to its patients. As an FQHC that is dedicated to serving those experiencing homelessness, Mercy Care seeks to cater to these individuals, while serving all those in need. Mercy Care offers comprehensive services, ranging from primary care for adults and pediatrics to dental and vision, to behavioral health and HIV testing and treatment (Mercy Care, n.d.). Health education is also offered at Mercy Care through community classes, group classes and individual appointments. There are four courses that are typically offered, all centered around health behaviors, chronic disease and wellness, including smoking cessation, peer support and diabetes care. Pastoral Care is another service "central to [Mercy Care's] core values in compassion and reverence for the dignity of every person" in which the organization strives to make patients "feel seen and heard before, during, and after their appointments" (Mercy Care, n.d.). One of the programs that is highlighted the most is Street Medicine, which is a part of the Community Health Outreach Program (CHOP). The Street Medicine program encourages staff to literally meet patients where they are at by seeking to bring healthcare and resources to people experiencing chronic homelessness on the streets, under bridges, in parks and in shelters. Given that the clientele is older adults, Mercy Care Rome focuses on elder services including adult day health, and support groups from caregivers and older guardians of children.

Anti-racist and Social Justice Dimensions

Throughout its publicly available resources, Mercy Care makes clear that it not only recognizes the social determinants of health but prioritizes them in its programming and services. One way that this emphasis is made explicit is through Mercy Care's 2019 Community Health Needs Assessment. The final report frames the justification for the assessment as "The first step

in understanding how social factors impact health is to collect robust data on the situation in which people live and relate it to their health status" (Mercy Care, 2019). Utilized client data was drawn from a new screening tool for the social determinants that was integrated with the clinic's electronic medical record system (Mercy Care, 2019). However, explicit reference to race as a social determinant or a motivating factor for the organization's work is minimal. There are few connections made between race and other components impacting health, such as transportation and housing. There are two associations that are noted: the tie between racism and chronic stress and the association between race and socio-economic status (Mercy Care, 2019).

On the other hand, it does not appear that any publicly available clientele data, such as responses for the community needs assessment, program participants or even general patient demographics, was disaggregated by race. Disaggregating data by race can be a tricky undertaking due to misinterpretation of results and especially the challenges in consistent racial and ethnic perception and self-identification, which also includes terminology and categorization (Kader et al., 2022). Both race and ethnicity are nuanced and complex, but it is important in understanding the different ways that certain groups of people interact with and are impacted by their environment, which includes racism (Kauh et al., 2021). The lived experience of Black people is different from those who identify as White, which is important to keep in mind. By disaggregating data from a community needs assessment, for example, it might be revealed that certain patient populations have varying needs determined by various social-demographic factors that should be considered when developing programs and services. It is possible that disaggregation is only an internal practice at Mercy Care, though there is a case to be made that this information should be public. However, whether data is being disaggregated or not is unclear from Mercy Care's front-facing materials.

Though there are minimal explicit references to anti-racism, or even CST, the services that Mercy Care offers reflects its religious motivation and principles of CST. Mercy Care embraces the tenet of The Option by focusing its services on individuals and families who are underserved, under-resourced and uninsured. It offers dedicated social support to assist clients in applying for health insurance or Medicaid and housing as well as offering case management. Additionally, through CHOP and its Street Medicine program, Mercy Care directly cares for and pays special attention to the poor, while also upholding human dignity for all people. Mercy Care actively and visibly lives out the calling of CST and liberation theology. In conclusion, as it relates to the anti-racism and social justice dimensions of Mercy Care, the primary focuses appear to be the social determinants of health and living out the principles of CST, particularly the preferential option for the poor. The FQHC prioritizes the care and well-being of people experiencing poverty, especially elderly adults (Mercy Care Rome) and those experiencing homelessness.

The Center for Faith and Community Health Transformation

Religious Dimensions

The Center for Faith and Community Health Transformation ("The Center"), is a "collaborative entity" that works with neighborhoods and religious communities to develop faith-based health initiatives (The Center for Faith and Community Health Transformation [TCFCHT], n.d.). It is formally a joint project between Advocate Health Care and the Office of Community Engagement and Neighborhood Health Partnerships (OCEAN-HP) at University of Illinois at Chicago. The Center is not informed by any single religious tradition; rather, it seeks to embrace communities and practices of all faiths. Through its work, The Center tries to

"integrate the language, symbols, and frameworks of all those who live out a faith practice or spiritual commitment" (TCFCHT, n.d.). The Center is rooted in the power of faith, love and the strength of the various faith communities that it partners with. These values are stated clearly in the vision statement, which proclaims "We envision Loving Communities of hope, justice and wholeness in which all people are healthy – able to live out their deepest calling and potential" (TCFCHT, n.d.). The mission, likewise, states "The Center promotes health equity through community building, nurturing leaders and connecting with the unique spirit power of people of faith to promote social justice and abundant life for families, neighborhoods and communities" (TCFCHT, n.d.). References to general religious beliefs and concepts, such as 'a calling', 'spirit power' and 'loving community' are common throughout the website and associated materials, clearly showing a commitment to The Center's faith-based roots, while also conveying a welcoming presence for people of all religious traditions.

Organizational Dimensions

As mentioned before, The Center primarily operates through partnerships and collaboration with neighborhoods, faith communities and other leaders seeking to enact faith-based health activities. These partnerships are typically based in and around metro Chicago. In this way, The Center helps build community capacity via a strengths-based approach though the different organizations and communities that it works with.

The Center operates through joint staffing from its parent organizations, Advocate Health Care and OCEAN-HP at University of Illinois Chicago. As such, it does not have a formal board. Instead, the organization utilizes a variety of accountability bodies, which includes its staff and representatives from the two partner organizations. The Center's co-directors are from Advocate Health and OCEAN-HP, and they help carry out the organization's day-to-day

operations. The Faith and Health Community of Practice also operates as another accountability body. This group consists of community partners – anyone who's working on faith-rooted approaches to promoting health equity. The Community of Practice meets regularly to receive and respond to updates on various programs, and its members contribute to the designing of opportunities for projects and areas of growth for The Center. The third governing body of The Center is The Wisdom Circle which "functions as a body that helps us reflect on our work and consult with a broad range of stakeholders" (TCFCHT, n.d.). A diverse 15–25-person membership makes up The Wisdom Circle, which meets regularly to discuss various ongoing projects and developing ideas. The Wisdom Circle also allows members to share their own work, collaborate and get consultations from the group.

Strategic Dimensions

The Center is deeply motivated by faith teachings and practices of all kinds and seeks to embody this through both its organizational culture and programming. The Center believes "that there are two unique and transformational gifts that people of faith bring to the work of creating health equity": moral imagination and spiritual power (TCFCHT, n.d.). These are the two primary guiding principles of The Center. Moral imagination provides a different, more holistic view of what it means to be whole and healthy. In other words, the organization "does not settle for just the absence of disease, but that embraces abundance, justice and the opportunity for everyone to live out their highest spiritual capacity" (TCFCHT, n.d.). This conceptualization of health allows The Center to expand its perspective on health beyond just the physical and to also include the mental, emotional and spiritual components of wellbeing. The other guiding principal of The Center, spiritual power, is what it understands as "the sense of calling and conviction that comes from faith that drives us toward and through work that seems beyond us"

(TCFCHT, n.d.). This truly is where its motivation for action is rooted, in conviction, love and healing. With these three values, individuals and communities are empowered to act and achieve more than would be possible alone.

The Center employs four primary strategies in order to achieve its mission of "fostering Loving Communities" with a particular emphasis on health. First and foremost, The Center operates through collaborative partnerships and by supporting groups and communities in growing their organizational capacities. Furthermore, the organization "works under the expectation that there is a shared investment in the goal of eliminating health disparities…and that all partners will bring forward their strongest assets and share them as freely as they are able" (TCFCHT, n.d.). Collaboration is a foundational organizational principle for The Center, and through it The Center works to build 'Loving Communities', nurture leaders and connect the Faith and Health Community of Practice. By building loving community, The Center draws on the concept of social cohesion, seeking to develop and strengthen positive social relationships in the name of health. The Center also works to develop a different kind of leader, one capable of transformational change in health equity, one who is "willing and able to pay attention to their 'interior condition' – their own core, Source, capacity, gifts, anxieties, trip-wires" (TCFCHT, n.d.). The Center achieves this through various development initiatives and by creating "spaces where people who are leading in many different ways can pause, reflect, connect and learn" (TCFCHT, n.d.). Finally, The Center can connect and collaborate with its partners through its Community of Practice.

Service Dimensions

Much of the work that The Center does is intended to build up community and organizational capacity in various ways throughout the greater metropolitan Chicago region.

This includes in-depth engagement strategies, workshops, educational programs and, of course, long-term partnerships. The organization also conducts conferences and summits, offers internships and facilitates dialogue around faith and health. Some of the specific programming that The Center carries out includes workshops focused on healthy eating, infant mortality, racism, and preventative medicine, such as receiving flu shots. The Center is a partner with the Chicagoland Trauma Informed Congregations Network, which "brings together faith-rooted organizations and others that are interested in using our collective wisdom to respond to the call to facilitate and deepen the role of faith communities" by serving as "a vehicle for education, skills transfer and connection" (TCFCHT, n.d.). Another key partnering initiative in which The Center is involved is the Congregational Health Asset Mapping Partnership (CHAMP), which is an asset-based process, and now operates under the initiative name of Love Asset Mapping Partnership (LAMP). The asset-based process seeks to engage a diverse slice of the community and identify strengths, needs and action steps to achieve a common goal. The Center offers a series of workshops that focus on four key components of LAMP: community members, service providers, faith leaders and reporting, consensus and action. The Center is also a leader in health ministry development and, as such, is devoted to working with congregations on setting up new health ministries and initiatives through workshops, consultation, and other programming.

Anti-Racist and Social Justice Dimensions

At the heart of The Center's purpose and motivation is the act of putting faith into action to impact the health of individuals and communities. It commonly cites health (in)equity and social justice as the reasoning behind The Center's work, saying "We work to create health equity… to promote social justice and abundant life for all" (TCFCHT, n.d.). The references, both explicit and implicit, to social justice are common throughout The Center's publicly

available materials and documents, and show that social justice is a deeply held organizational value. Much of the writing style The Center utilizes is positivist, emphasizing the power of faith, the fullness of community and right relationships. For example, instead of stating that health *inequity* is the reason for varying levels of health among populations, it talks about the "creation of health *equity*".[*] Instead of focusing on the needs or deficiencies that might impact poor health in a community, The Center highlights positive approaches such as the creation of social relationship or the nurturing of leaders. All this to say, the front-facing materials of The Center rarely utilizes negative language and sentence structure; thus, there are few instances of explicit references to racism or even anti-racism. The one notable exception is in regards to certain programs that are centered around the effects of racism and discrimination. The Center's Courage to Love program, which highlights the health disparities in Black pregnant women and Black infant mortality, references the cause of this as "institutional racism and discrimination" (TCFCHT, n.d.). While The Center openly expresses its commitment to social justice, it does not visibly make anti-racism, as an organizational value or an objective, a point of emphasis.

However, in the way that The Center expresses its commitment to social justice it also displays an affinity for the values of CST, despite not claiming any one religious tradition. The Center's focus on the community, or the common good, its holistic perspective on health and the individual, and solidarity through partnership reflect some of the key ideas of CST. These ideas are most exemplified in this statement about the organization's goal and purpose: "If our social environment affects our bodies, then let's work for positive, connected, loving communities so that all people can be healthy!" (TCFCHT, n.d.). It is The Center's approach of collaboration and community that is the powerful driving force behind its work, and sets it apart from other

[*] Author's emphasis

organizations in the healthcare/public health sphere. While The Center draws on the teachings and practices of all faith traditions, there are real resonances of CST in its mission and approach to health equity.

Discussion:

What does Anti-Racism Look Like?

Since racism has different forms, anti-racism, too, can be varied from individual to individual and organization to organization. A single organization can even operationalize a variety of different forms of anti-racist strategies (Scott 2000). It can be individualized, for example, with a single individual commitment or project goal. Anti-racism can also be institutionalized within the culture of an organization, via the mission and vision of the organization or its programming priorities. Both of these anti-racist approaches can occur separately or simultaneously within an organization. Even under these two broad conceptions of anti-racism, there can be a lot of variation depending on the purpose of the organization, its commitment and its structure (Scott 2000). Each of the three faith-based health organizations discussed here, CHA, Mercy Care and The Center for Faith and Community Health Transformation, signal a commitment to social justice and anti-racist action. However, each organization has a layered and varied understanding of anti-racism, which affects the strength of their commitments and thus how the priorities, strategies and obligations of the organizations tangibly convey anti-racist action.

Out of the three organizations, CHA uses the most explicit language to convey its prioritization of anti-racism; however, it is also the most institutional in terms of its methods. As

an association, CHA primarily sets priorities and provides resources for other hospitals and health systems. As such, it operates at a high, big-picture level as opposed to on-the-ground with individuals. This places a greater burden of work and responsibility for change on individual member organizations. CHA can develop itself as an example by highlighting anti-racism and doing its own internal anti-racist work but that does not guarantee that all 600 Catholic hospitals in its system will do the same. CHA appears to be starting the organizational work of opposing and challenging racism in its various manifestations with its 'We are Called' initiative by promoting it on their home webpage, creating its own website for the initiative and by continuing to develop it through social media and recent stories on success and best practices.

The one drawback of this particular approach and its challenge at CHA is minimal accountability within CHA itself or its members to conduct the individual or tangible work of anti-racism. This is in part due the size of CHA, its institutional nature, and its scope of work; however, in March 2022, two senior directors of CHA wrote and published an article to the 'We are Called' webpage that noted some of the successes that have resulted from this initiative. They write that more than 87% of members have committed to the pledge for health equity and that CHA's board and leadership have made 'We are Called' a centerpiece of their strategic plan (Curran and Gonzales, 2022). The two authors then provide a brief description of some of the health equity and anti-racist activities that have been accomplished in the past one and a half years since the initiative was launched. CHA is highlighting that anti-racist work can be creative and different, offering suggestions such as writing a "racial autobiography", detailing the organization's history, both positive and negative, with race, and including anti-racism as a part of the organization's strategic plan. These initiatives can have tangible impacts that can

reverberate throughout the organization. Overall, CHA is looking to support and advocate for anti-racism via health equity from a high level, institutional perspective.

Both Mercy Care and The Center provide a contrast to CHA in the different ways they appear to convey their commitments to anti-racism and social justice. Neither organization appeared to explicitly utilize the term anti-racist or anti-racism in their front-facing materials, mission or vision statements, history/background pages, or programming. Clearly and visibly stating a commitment to anti-racism can be a basic and powerful way to begin including this value into the greater culture and mission of an organization (Hassen et al. 2021). For Mercy Care, though, the clients/patient population served along with the organization's programming (especially the community outreach) best exemplifies anti-racism in the work that it performs. Both Mercy Care's community outreach and street medicine program give special attention to the poor and vulnerable and prioritizes them when institutional barriers so often prevent these individuals from flourishing. These two programs actively oppose those societal barriers that influence wealth (or lack thereof), education and health by providing support and access to healthcare. Perhaps even more importantly, the community outreach provides an opportunity to humanize people who have been made invisible through caring and creating relationships with them. It is through these interactions that Mercy Care attempts to challenge the status quo by caring for those made invisible. At the same time, developing relationships is only one, single individual action that neglects the institutional nature of racism, and as O'Brien (2018) notes, becoming anti-racist is not contingent on having actual relationships with people of color or other oppressed peoples. Though Mercy Care prioritizes underserved individuals and highlights health disparities, the lack of explicit institutional support and programming for anti-racism makes it challenging to determine the extent of Mercy Care's anti-racist commitment.

Similarly, The Center operationalizes its understanding of anti-racism in a less explicit way than CHA. The Center does it through its approach to its work, through collaboration and partnership, as well as some of its programming. Health equity and social justice are two key organizational values that are emphasized whenever possible, including in the mission statement and the organizational goal. The Center's belief in the dignity of every human being and their dedication to a holistic understanding of health stands in opposition to racism. This comes out in the organization's efforts to center relationships in everything that it does, from consultations to health ministry development and efforts to address infant mortality. Through this open and respectful approach to partnerships, The Center offers an alternative to the unequal power dynamic that characterizes racism and racist structures. However, like Mercy Care, The Center does not make explicit references to racism or anti-racism, diluting its effectiveness in this area and calls into question what The Center is doing to actively dismantle the structures of racism.

Influence of CST

Throughout the documents analyzed for all three healthcare organizations there were clear and explicit, as well as subtle, influences of CST on the organizational missions, approaches and programming. Some of the most common values of CHA, Mercy Care and The Center were pillars of CST: human dignity, social justice and the common good. The preferential option for the poor was another critical value that will be discussed in the next section relating it to the influence of liberation theology throughout the organizations.

Human Dignity

The protection and sacredness of the whole person, along with human dignity, is a central theme and value among CHA, Mercy Care and The Center. It is viewed as a cultural value at

CHA and The Center; it is an implicit motivation for certain programs at CHA and Mercy Care; and it is a programming approach at all three. As an organizational value, the prioritization of human dignity seeks to become part of the culture by influencing the way that people interact with each other both within and outside of the organization. It also attempts to permeate the motivation and purpose for the work being done at the organization. The Center, for example, is built around the importance of collaboration and partnerships, but without the organizational value of human dignity this approach could be seen as hollow and may not be taken as seriously if it was not enforced in numerous spaces. CHA, likewise, reinforces its healthcare mission by stating a care and prioritization for human dignity, taking into account the patient experience, not just the experience of medical professionals. At Mercy Care, as an organization that prides itself on providing quality healthcare to individuals, especially those who are underserved, an individual's human dignity is central to their work. More specifically, Mercy Care's community outreach and Street Medicine programs highlight exactly how it is emphasizing human dignity by providing it to those experiencing homelessness and poverty. People experiencing homelessness are often ignored and have minimal support systems; in this instance, human dignity becomes an inherent motivator for this kind of work and to provide those exact things that society fails to provide.

Social Justice and the Common Good

The pillar of social justice and the common good was also commonly found among the documents and materials of the three organizations. These are clearly stated values, mottos and desires for all three faith-based organizations and are often expressed as such, mentioning social justice and community on their 'About' pages. But social justice also comes up in a variety of

other ways that serve to show its prevalence and pervasiveness, though with slightly different degrees, within CHA, Mercy Care and The Center.

At CHA, justice and the common good are not just stated as organizational values but are also key elements of CHA's vision for U.S healthcare. In their focus on advocacy, CHA has formulated a clear vision founded on six principles, including the common good and justice, and explain the reasoning for including those values. In terms of justice, for instance, CHA refers to the fact that health care is a human right and is necessary for individuals to flourish and thrive in society. In expressing the importance of valuing the common good, CHA states "The health and well-being of each person is intertwined with the health and well-being of the broader community. Access to health care is an essential element contributing to the common good alongside others such as education, employment and a safe environment" (CHA, n.d.). Again, this shows that social justice and the common good are not just organizational values but also concepts that are being incorporated into programming and the advocacy agenda in the hopes of affecting the larger society.

The primary way Mercy Care communicates its values, priorities and culture is through the services and programs that it provides to its patients. While the vast majority of these services are individual i.e., providing primary medical care or health education, there is still a sense of greater purpose that comes from working at Mercy Care. That feeling is cited in blog posts and videos that Mercy Care has uploaded to its cite. In the video, "Taking healthcare where it's needed most", which takes a closer look at the Street Medicine program, multiple individuals refer to "the greater good," breaking the cycle of poverty and homelessness, and the idea of vocation in serving the poor and vulnerable (Mercy Care, 2019). There is an understanding that the experience of homelessness is often a result of structural inequities and

other underlying issues that culminate in a person living on the streets. Though highly individualized, Mercy Care acknowledges that the root causes of racial discrimination and homelessness go much deeper. However, Mercy Care does not have the structure nor the capacity to address these issues at an institutional and societal level. This limits their impact but it does not dilute it.

The Center for Faith and Community Health Transformation reflects that social justice and health equity is what it wants to achieve, but it is through an appreciation and understanding of the common good that forms its approach. The Center is "driven by community" and is "committed to being a humble, authentic and learning partner with communities" (TCFCHT, n.d.). It is in this way that The Center emphasizes the common good, explaining how it measures and assesses health through the strength of community (TCFCHT, n.d.). The Center seeks to conduct its work via a holistic, strengths-based, and justice-oriented approach, which highlights the importance of these values and their pervasiveness throughout the organizational culture. Overall, social justice as a way to achieve quality healthcare and health equity is frequently cited as a motivator for the work that CHA, Mercy Care and The Center carry out. This was done explicitly by all three organizations, a rare display of unanimity, and emphasizes social justice and the common good as a mutual value upon which a prioritization for anti-racism can be built.

Influence of Liberation Theology

Another notable influence within all three of the organizations was liberation theology, and particularly the concept of the preferential option for the poor. Similar to how the themes of human dignity and social justice were portrayed, there was variety in the significance and

prevalence in which the preferential option was communicated. At the same time, it was commonly identified as an organizational value, an idea that provided purpose for the organization and motivated their programming. However, liberation theology, particularly Black liberation theology and Womanist theology can also provide insight into areas where CHA, Mercy Care and The Center may be able to grow, develop and better articulate their commitment to anti-racism.

As with the other themes and values already noted, CHA is the most explicit in its uplifting of the poor and the preferential option for the poor. It is not just a stated organizational value but something that CHA is trying to communicate as an explanation for their priorities, such as diversity and inclusion, health disparities, community benefit, and the social determinants of health. CHA does not just state that paying 'special attention' to the poor is important, but also supplies its argument and evidence for doing so. The association cites a 1986 U.S Catholic Bishops pastoral letter, "Economic Justice for All" and *Ethical and Religious Directives for Catholic Health Care Services*, both of which note that the preferential option is a responsibility and obligation for Catholics to uphold (CHA, n.d.). The association goes on to state that "Poverty is not just the absence of wealth. It feeds prejudice, discrimination, and injustice. Additionally, although 'uninsured' and 'poor' are not synonyms…there are distinct relationships between being uninsured and poverty" (CHA, n.d.).

While there is plenty of reference to this idea of the preferential option, there is less reference to another aspect of liberation theology: liberation as led by those who are oppressed. This idea, related to solidarity, is not as prevalent in CHA's program focus areas. It is referenced more in CHA's "We Are Called" initiative, particularly in its pledge which calls on members to "[seek] justice through solidarity", to '[lean] in' to listen, and to "[work] with partners who share

these convictions" (CHA, 2020). However, this shift in power dynamics is not championed as consistently and thoroughly in CHA's front-facing materials. Further, a well-articulated component of Black theology is the belief that God's identification with the struggle of the oppressed is always made real in historical contexts in which God is actively allied with those struggling against oppression. James Cone, an influential Black liberation theologian, argues that this theological principle requires American Christians to worship a Black Jesus. Cone (1970) claims that "Revelation is God's self-disclosure to man *in a situation of liberation*. To know God is to know of his activity of liberation on behalf of the oppressed." (p. 91). Thus, by seeing Jesus as Black and understanding God's opposition to oppression and the misuse of power, Black theology provides another argument for standing in solidarity with Black people and Black communities to actively oppose racist institutions and policies. CHA demonstrates some strong influences of liberation theology on its programming, priorities and values. In order to more directly address the power dynamic integral to racism, clearer language towards solidarity and the empowerment of oppressed populations could communicate a stronger anti-racist stance that is rooted in liberation theology.

Mercy Care maintains a consistent, implicit approach to the way that these theological concepts are integrated into the organization, including the preferential option and liberation theology more generally. Given its hands-on, clinical medicine approach, Mercy Care embodies solidarity and the preferential option through the care for its patients and clients. Mercy Care prioritizes care for individuals experiencing homelessness, poverty, mental illness and/or linguistic isolation while also offering them opportunities to gain skills and information. Perhaps even more importantly, there is an understanding and a respect for meeting the patients where they are at, physically, mentally and emotionally, which is demonstrated in two videos

highlighting Mercy Care's Street Medicine and Recuperative Care programs (Mercy Care, 2019 and Mercy Care, 2019). Mercy Care has created a patient-centered culture that is rooted in the preferential option and liberation theology.

Finally, The Center also suggests being influenced by aspects of liberation theology. Reflections of liberation theology are most clear in The Center's community-centered approach, allowing neighborhoods, congregations and other community groups to initiate change. Some of The Center's programming also focuses on a preferential option for the poor, including its pre-term birth and infant mortality program and its involvement in the Healthy HotSpot initiative. Additionally, The Center's Community of Practice, whose purpose is to "Learn, Connect and Renew", prioritizes relationships and partnerships. This evokes similarities to base ecclesial communities, which were a significant aspect of Latin American liberation theology led by laypeople that brought individuals together for prayer, worship and communal reflection on both their religious and secular lives (Movements 1998). The Community of Practice puts individuals and communities in control, because they are the ones who know what they need, and allows them to seek the initiative to achieve their goals. Though The Center does not claim any one faith tradition, it subtly reflects concepts that are rooted in liberation theology.

Significance

Overall, CHA, Mercy Care and The Center for Faith and Community Health Transformation showed that there are anti-racist communications, actions and programming occurring at all three organizations. Further, in these commitments to anti-racism, the faith-based organizations all displayed influences of CST and liberation theology to explain and justify prioritizing anti-racism. However, each organization did these two things in different

ways and to varying degrees. Whereas CHA was much more explicit and forthright about its commitment to anti-racist change, and did so with an emphasis at the institutional level, Mercy Care and The Center focused on more subtle, implicit and individual actions that attempt to convey a sense of anti-racism within the organizations. Additionally, the purpose, structure and capacity of each FBO appeared to affect some of the ways in which the organizations communicated and then carried out a commitment to anti-racist action. The Center, for example, displayed its commitment to anti-racism through its community and individual-level programming, while CHA operated at the organizational and policy levels. Each intervention level allows for different impacts and effects, with some having greater potential to dismantle larger racist systems, institutions and cultures (Hassen et al. 2021).

CHA is much more intentional about its anti-racist initiatives; in comparison, Mercy Care and The Center only hint at their commitments to human dignity and the preferential option. A deeper consideration of the perspectives from Black and Womanist theologies show that organizations may have a greater responsibility for action and to challenge oppression. In both schools of thought, Black and Womanist theologians primarily center their analyses on the Black experience and the consequential societal oppressions that come with being Black in America, including racism, sexism and classism. It is equally critical to both groups of thinkers to be able to see and conceptualize a Black Jesus, since it is through His death and resurrection that Jesus fully takes "upon himself the totality of human oppression" and its institutions (Cone, 1970, p. 210). As Jacquelyn Grant (1989), a Womanist scholar, states, "Jesus is a political messiah" (p. 215). Further, these articulations about liberation and the nature of God call Christians and the Church to additional responsibilities, including proclaiming God's liberation for all, to actively be a part of the struggle for liberation, and to truthfully be a manifestation of the gospel and this

liberation (Cone, 1970). As such, Christians, both individuals and organizations, are obligated to participate in anti-racist efforts.

More and more attention is being paid to how organizations, for-profit and non-profit alike, in a variety of sectors, are addressing and implementing anti-racist interventions. These interventions are being done at various levels, from individual-focused to policy, with some of them addressing multiple levels at once (Hassen et al. 2021). A scoping review of anti-racist interventions in healthcare settings by Hassen et al (2021) identified around 40 studies that fit their criteria, primarily focusing on outpatient healthcare settings, but ultimately concluded that there was a minimal number of examples in the literature. Especially these days, there is a demand for growth in the anti-racist literature, including analyses of anti-racism in FBOs. This project has analyzed the way in which three FBOs attempt to communicate a commitment to anti-racist change, with a particular emphasis on organizations identifying with the Roman Catholic faith tradition. Change, especially organizational change, as we know from both personal experience and from the literature, is not easy, and there are both advantages and disadvantages to the various strategies that CHA, Mercy Care and The Center have employed. Given the importance of the mission statement in communicating organizational values, especially within Catholic organizations, it is important to note that this was used by each of the three FBOs (O'Rourke 2001). In the end, however, all three health-focused organizations identified the importance of the preferential option for the poor and acknowledged movement towards anti-racism. Health-focused FBOs are uniquely situated to positively impact the health of individuals and populations, especially through the prioritization of those who are underserved, and it is through the mentality of anti-racism that these organization can successfully address the root causes of health disparities and inequities.

Conclusion

This analysis has demonstrated that Catholic Health Association, Mercy Care, and The Center for Community Health Transformation all showcase elements of anti-racism in their organizational approaches, programming and missions. The three FBOs also carry influences of CST and liberation theology throughout their work and public-facing materials. However, the way and the degree these elements are reflected at each organization varies. CHA is the most explicit in its incorporation of anti-racism, CST and liberation theology while operating at more of an institutional level. Mercy Care and The Center are less explicit and more focused on individual actions, which limits their intentionality and effectiveness. The threat of racism in our society and the potential solution in anti-racist policies and interventions make this an area of extreme importance, especially among organizations in high-impact sectors such as healthcare and public health. With the history and influence of FBOs, and especially Catholic FBOs, in healthcare, these organizations have the platform, and theological backing, to amplify social change and uplift poor and underserved communities through anti-racist initiatives. This project shares examples of how some FBOs are doing just that.

Limitations

While this paper presents a unique perspective in terms of analyzing the way that FBOs, with an emphasis on Catholic FBOs, communicate a commitment to social justice and anti-racism, there are a few limitations. First, only public-facing materials were utilized in the analysis. Though CHA had an abundance of source material, including multiple websites, dozens of webpages and organizational documents, the other two organizations were less prolific in what was publicly available. This limits some of the depth of analysis available to only what the FBOs have determined to be sharable with the public, which also may have been shared with

a different purpose than that of this project. Additionally, most of the conclusions from the analysis presented here are not generalizable given that it is largely organization-specific. Each organization and FBO discussed here and otherwise has a different purpose, target population and relationship with outside institutions. This makes it difficult to determine the need and effectiveness of certain methods or interventions, which depends on the initiating organization.

Given the aforementioned limitations of this project, there are a couple of primary areas for future research. A similar analysis could be conducted with additional and more sophisticated data collection methods, such as in-depth interviews and key informant interviews at the target organizations. A specific analysis of the organizational culture and purpose/motivation of programming at the institutions studied could provide additional insight into how much of the organization's work and communication styles are intentional or potentially coincidental. Another area for further research is to expand the type of organization being studied and include FBOs outside of the Christian and Catholic tradition. These different data collection and analysis methods could provide a deeper and more complex understanding of the way the FBOs communicate their commitment to anti-racism and social justice.

Recommendations

The outcomes and conclusions from this project have prompted two primary recommendations for health-based FBOs looking to be more intentional in the anti-racism space: explicitly reference racism and anti-racism, and track evaluation and impact of key programs. More explicit efforts to prioritize anti-racism is a priority for FBOs such as CHA, Mercy Care and even The Center because they have an obligation to oppose structures and institutions that denigrate other human beings, i.e., racism. In other words, these organizations are rooted in a certain religious tradition, for example, Roman Catholicism, that preaches doctrine such as CST

and liberation theology, which emphasizes the protection of human dignity and the right to human flourishing. CST and liberation theology also highlight solidarity with others, the preferential option for the poor and other rights and responsibilities that followers of these doctrines must uphold, including organizations.

FBOs similar to those discussed in this paper also occupy a unique space to affect change, and to do so at various levels of society. CHA, for example, can have an impact at the organizational and institutional levels through its memberships. It also has the potential to influence the Catholic Church given its relationship with the Church. Mercy Care and The Center, on the other hand, are deeply rooted in the communities in which they operate, allowing their greatest impact to be on individuals, patients/clients and staff alike. Additionally, the ability to positively impact health disparities and inequities is a significant step in addressing institutional and societal racism, and is a space in which health-based FBOs are uniquely situated. Last but not least, there is a societal necessity for more organizations to be anti-racist and to more explicitly enact anti-racist policies. Given the national climate and the reckoning brought about by the COVID-19 pandemic and the police killings of Black people, including George Floyd and Breonna Taylor in 2020, there is an increased pressure for change and the dismantling of systemic racism. As previously mentioned, health-based FBOs have the opportunity to be at the forefront of this movement and to take advantage of the grassroots momentum that has generated.

As important as explicit reference to racism and anti-racism is, arguably, it is even more critical that there is transparent evaluations and follow-up on targeted programming. Organizations should be transparent in the work that they are conducting and have a plan in place to show reasonable progress and effectiveness. Publicly sharing data such as the disaggregation

by race, tracking participants in anti-racist initiatives and providing outcome and progress reports are some examples of specific efforts organizations can put into place to ensure accountability. It would also be useful to specify which programs are designed to challenge racist structures or other racial disparities, since different programs may have different purposes, and would provide increased clarity into the success of the program. As this paper lays out, health-based FBOs, especially Catholic FBOs, have a responsibility to support and develop anti-racist initiatives, due to the teachings of CST and liberation theology. There are a number of methods with varying degrees of effectiveness in which health-based FBOs can communicate a commitment to anti-racism and social justice, and it is important that organizations continue to prioritize these values.

References

Blevins, J. (2019). *Christianity's role in United States global health and development policy: to transfer the empire of the world.* New York, NY: [Routledge].

Came, H., & Griffith, D. (2018). Tackling racism as a "wicked" public health problem: Enabling allies in anti-racism praxis. *Social Science & Medicine, 199,* 181-188. doi:https://doi.org/10.1016/j.socscimed.2017.03.028

Cahill, L. S. (2007). Thinking Globally - Global Health and Catholic Social Commitment. *Health Progress*, *88*(3). Retrieved from https://www.chausa.org/publications/health-progress/archives/issues/may-june-2007/thinking-globally---global-health-and-catholic-social-commitment

Catholic Health Association. (2020). *Administrative Regulations.* https://www.chausa.org/docs/default-source/about/cha-administrative-regulations---24-sept-2020.pdf?sfvrsn=2

Catholic Health Association. *Advocacy Agenda 2021-2022.* https://www.chausa.org/docs/default-source/advocacy/2021-advocacy-agenda.pdf?sfvrsn=7ef3cef2_0

Catholic Health Association. *Advocacy Agenda 2021-2022.* https://www.chausa.org/advocacy/advocacy-agenda

Catholic Health Association. (n.d.). *Board Responsibilities.* https://www.chausa.org/about/leadership/board-responsibilities

Catholic Health Association. (2021). Bylaws of the Catholic Health Association of the United States. https://www.chausa.org/docs/default-source/about/cha-bylaws-(v2021)---clean.pdf?sfvrsn=40b5fcf2_6

Catholic Health Association. (n.d.). *Catholic Health Association of the United States: A Passionate Voice for Compassionate Care.* https://www.chausa.org/docs/default-source/default-document-library/cha-brochure.pdf?sfvrsn=c646fdf2_9

Catholic Health Association. (n.d.). *Care of the Poor*. https://www.chausa.org/disparities/disparity-resources/care-of-the-poor

Catholic Health Association. (n.d.). *CHA Resources.* https://www.chausa.org/communitybenefit/social-determinants-of-health/cha-resources

Catholic Health Association. (n.d.). *Care of the Poor*. https://www.chausa.org/disparities/disparity-resources/care-of-the-poor

Catholic Health Association (n.d.). *CHA Commitment.* https://www.chausa.org/disparities/cha-commitment

Catholic Health Association. (n.d.). *Climate Change.* https://www.chausa.org/environment/climate-change

Catholic Health Association. (2020). *Confronting Racism by Achieving Health Equity: The Catholic Health Ministry Commitment.* https://www.chausa.org/docs/default-source/health-equity/cha_wearecalled_pledge_09112020.pdf?sfvrsn=5afaf1f2_2

Catholic Health Association. (2019). *Our Vision for U.S. Health Care.* https://www.chausa.org/docs/default-source/advocacy/cha_2019_visionforushealthcare_print.pdf?sfvrsn=2

Catholic Health Association. (n.d.). *A Shared Statement of Identity.* https://www.chausa.org/mission/a-shared-statement-of-identity

Catholic Health Association. (n.d.). *Strategic Plan 2021-2023.* https://www.chausa.org/docs/default-source/default-document-library/cha-2021-2023-strategic-plan-framework.pdf?sfvrsn=a142f2f2_3

Catholic Health Association. (2022). *U.S. Catholic Health Care.* https://www.chausa.org/docs/default-source/default-document-library/the-strategic-profile.pdf

Catholic Health Association. (n.d.) *We Are Called Overview.* https://www.chausa.org/we-are-called/overview

Centers for Disease Control and Prevention. (2020, November 24). *Health Disparities.* https://www.cdc.gov/healthyyouth/disparities/index.htm

The Center for Faith and Community Health Transformation. (n.d.). *The Chicagoland Trauma Informed Congregations Network.* https://www.faithhealthtransformation.org/trauma-informed-congregations-network/

The Center for Faith and Community Health Transformation. (n.d.). *Nurturing Leaders.* https://www.faithhealthtransformation.org/what-we-do/nurturing-leaders/

The Center for Faith and Community Health Transformation. (n.d.). *Our Guiding Principles.* https://www.faithhealthtransformation.org/who-we-are/our-vision-and-mission/our-guiding-principles/

The Center for Faith and Community Health Transformation. (n.d.). *Our Governance.* https://www.faithhealthtransformation.org/who-we-are/our-governance-structure/

The Center for Faith and Community Health Transformation. (n.d.). *Programs and Partnerships.* https://www.faithhealthtransformation.org/services-and-partnerships/

The Center for Faith and Community Health Transformation. (n.d.). *Vision and Mission.* https://www.faithhealthtransformation.org/who-we-are/our-vision-and-mission/

The Center for Faith and Community Health Transformation. (n.d.). *Who We Are.* https://www.faithhealthtransformation.org/who-we-are/

Cone, J. H. (1970). *A Black theology of liberation.* (1st ed.). Philadelphia: [Lippincott].

Cummings, G. C. L. (1993). *A Common Journey: Black Theology (USA) and Latin American Liberation Theology (Vol. VI).* Maryknoll, NY. Orbis Books

Curran, K., Gonzales, D. (2022, March 22). *Health Equity – Catholic health Care Systems Confront Racism Through 'We Are Called'*. We Are Called. https://www.chausa.org/cha-we-are-called/stories/detail/health-equity---catholic-health-care-systems-confront-racism-through-'we-are-called'

Grant, J. (1989). *White women's Christ and Black women's Jesus : feminist christology and womanist response.* Atlanta Ga.: [Scholars Press].

Greene, M. P., & LCSW-R, A. E. (2007). Beyond diversity and multiculturalism: Towards the development of anti-racist institutions and leaders. *Journal for Nonprofit Management, 11*(1), 9-17.

Griffin, M., & Block, J. W. (Eds.). (2013). *In the Company of the Poor: Conversations Between Dr. Paul Farmer and Fr. Gustavo Gutiérrez.* Orbis Books.

Gutiérrez, G. (1973). *A theology of liberation: history, politics, and salvation.* Maryknoll, N.Y.: [Orbis Books].

Hammonds, E. M., & Reverby, S. M. (2019). Toward a Historically Informed Analysis of Racial Health Disparities Since 1619. *American Journal of Public Health, 109*(10), 1348-1349. doi:10.2105/AJPH.2019.305262

Handbook of the Sociology of Racial and Ethnic Relations. (2018). In P. Batur & J. R. Feagin (Eds.), (Second edition. ed., pp. 413-425). Cham, Switzerland: [Springer].

Hassen, N., Lofters, A., Michael, S., Mall, A., Pinto, A. D., & Rackal, J. (2021). Implementing Anti-Racism Interventions in Healthcare Settings: A Scoping Review. *International Journal of Environmental Research and Public Health, 18*(6), 2993. Retrieved from https://www.mdpi.com/1660-4601/18/6/2993

Kader, F. Doan, L. N., Lee, M., Chin, M. K., Kwon, S. C., & Yi, S. S. (2022). Disaggregating Race/Ethnicity Data Categories: Criticisms, Dangers, And Opposing Viewpoints. *Health Affairs Forefront.* https://www.healthaffairs.org/do/10.1377/forefront.20220323.555023/

Kauffman, C. J. (1995). *Ministry and meaning : a religious history of Catholic health care in the United States.* New York: [Crossroad].

Kauh, T. J., Read, J. n. G., & Scheitler, A. J. (2021). The Critical Role of Racial/Ethnic Data Disaggregation for Health Equity. *Population Research and Policy Review*, *40*(1), 1-7. doi:10.1007/s11113-020-09631-6

Kendi, I. X. (2019). How to Be an antiracist. One World.

Laurencin, C. T., & Walker, J. M. (2020). Racial Profiling Is a Public Health and Health Disparities Issue. *Journal of Racial and Ethnic Health Disparities*, *7*(3), 393-397. doi:10.1007/s40615-020-00738-2

Massingale, B. N. (2010). *Racial Justice and the Catholic Church*. Maryknoll, NY. Orbis Books.

Mercy Care. (n.d.). *About Us.* https://mercyatlanta.org/about/

Mercy Care. (2019). *Community Health Needs Assessment.* https://mercyatlanta.org/wp-content/uploads/2020/02/CHNA-final-1.17.19.pdf

Mercy Care. (2018). *2018 Community Report.* https://indd.adobe.com/view/5d726265-a388-4a39-8758-4a915603aabf

Mercy Care. (n.d.). *Leadership and Boards.* https://mercyatlanta.org/leadership/

Mercy Care. (n.d.). *Legacy.* https://mercyatlanta.org/legacy/

Mercy Care. (2019, October 30). *Recuperative Care for women* [Video]. Vimeo. https://vimeo.com/369908927?embedded=true&source=video_title&owner=62964966

Mercy Care. (n.d.). *Services and Programs.* https://mercyatlanta.org/services/

Mercy Care. (2019, July 1). *Taking healthcare where it's needed most* [Video]. Vimeo. https://vimeo.com/345527113?embedded=true&source=video_title&owner=62964966

Mich, M. L. H. (1998). *Catholic Social Teaching And Movements.* Mystic, CT: Twenty-Third Publications.

Morrisey, F. (2001). Toward Juridic Personality. *Health Progress.* https://www.chausa.org/publications/health-progress/article/july-august-2001/toward-juridic-personality

Murray, C. J. L., Kulkarni, S., & Ezzati, M. (2005). Eight Americas: New Perspectives on U.S. Health Disparities. *American Journal of Preventive Medicine, 29*(5, Supplement 1), 4-10. doi:https://doi.org/10.1016/j.amepre.2005.07.031

Ndugga, N., & Artiga, S. (2021, May 11). *Disparities in Health and Health Care: Questions and Answers.* Kaiser Family Foundation. https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/

O'Brien, E. (2018). Antiracism. In P. Batur & J. R. Feagin (Eds.), Handbook of the Sociology of Racial and Ethnic Relations (pp. 413-425). Springer International Publishing.

O'Brien, R., Neman, T., Seltzer, N., Evans, L., & Venkataramani, A. (2020). Structural racism, economic opportunity and racial health disparities: Evidence from U.S. counties. *SSM - Population Health, 11,* 100564. doi:https://doi.org/10.1016/j.ssmph.2020.100564

O'Rourke, K., O.P. (2001). Catholic Hospitals and Catholic Identity. *Christian bioethics: Non-Ecumenical Studies in Medical Morality, 7*(1), 15-28. doi:10.1093/chbi.7.1.15.3762

Prevot, A. (2008). *Theology and Race: Black and Womanist Traditions in the United States* Leiden, The Netherlands Brill.

Religion as a social determinant of public health. (2014). In E. L. Idler (Ed.). New York, NY: [Oxford University Press].

Rogers, R. G., Krueger, P. M., & Hummer, R. A. (2010). Religious Attendance and Cause-Specific Mortality in the United States. In Ellison, C. G., & Hummer, R. A. (Eds.), *Religion, Families, and Health: Population-Based Research in the United States* (pp. 292-320). Rutgers University Press.

Scott, E. K. (2000). Everyone against Racism: Agency and the Production of Meaning in the Anti-Racism Practices of Two Feminist Organizations. *Theory and Society, 29*(6), 785-818. Retrieved from http://www.jstor.org/stable/3108529

Spoerri, A., Zwahlen, M., Bopp, M., Gutzwiller, F., Egger, M., & Study, f. t. S. N. C. (2010). Religion and assisted and non-assisted suicide in Switzerland: National Cohort Study. *International Journal of Epidemiology, 39*(6), 1486-1494. doi:10.1093/ije/dyq141

Sudano, J. J., & Baker, D. W. (2006). Explaining US racial/ethnic disparities in health declines and mortality in late middle age: The roles of socioeconomic status, health behaviors, and

health insurance. *Social Science & Medicine, 62*(4), 909-922. doi:https://doi.org/10.1016/j.socscimed.2005.06.041

Surmiak, W. (2019). The Preferential Option for the Poor as an Expression of Social Love. *Studia Pastoralne 15*, 242-253. Retrieved from https://www.ceeol.com/search/article-detail?id=815466

Trinity Health. (n.d.). *Community Health & Well-Being*. https://www.trinity-health.org/our-impact/community-health-and-well-being/

Trinity Health. (n.d.). *Investing in our Communities.* https://www.trinity-health.org/our-impact/community-health-and-well-being/investing-in-our-communities

Trinity Health. (n.d.). *Our Sponsor Catholic Health Ministries. https://www.trinity-health.org/about-us/our-sponsor-catholic-health-ministries/*

United States Catholic, C. (1998). *Sharing Catholic social teaching : challenges and directions : reflections of the U.S. Catholic bishops.* Washington, D.C.: United States Catholic Conference.

VanderWeele, T. J. (2017). Religion and Health: A Synthesis In M. J. Balboni & J. R. Peteet (Eds.), Spirituality and religion within the culture of medicine: from evidence to practice (pp. 357-401). New York, NY, Oxford University Press].

VanderWeele, T. J., & Chen, Y. (2019). VanderWeele and Chen Respond to "Religion as a Social Determinant of Health". *American Journal of Epidemiology, 189*(12), 1464-1466. doi:10.1093/aje/kwz206

Wilde, M. J., & Danielsen, S. (2014). Fewer and Better Children: Race, Class, Religion, and Birth Control Reform in America. *American Journal of Sociology, 119*(6), 1710-1760. doi:10.1086/674007

Williams, D. R. (2012). Miles to go before we sleep: racial inequities in health. *Journal of health and social behavior, 53*(3), 279-295. doi:10.1177/0022146512455804

Williams, D. R., & Mohammed, S. A. (2013). Racism and Health I: Pathways and Scientific Evidence. *American Behavioral Scientist, 57*(8), 1152-1173. doi:10.1177/0002764213487340