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_____ _____

Stephen Kim Date

Emory Religion and Health Summer Institute Needs Assessment

By

Stephen Kim

Master of Public Health

Hubert Department of Global Health

_____

Mimi Kiser, DMin, MPH

Committee Chair

Emory Religion and Health Summer Institute Needs Assessment

By

Stephen Kim

Bachelor of Science

Grove City College

2015

Mimi Kiser, DMin, MPH

Committee Chair

An abstract of
A thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
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Abstract

Emory Religion and Health Summer Institute Needs Assessment

By Stephen Kim

The Religion and Public Health Collaborative is planning a 2020 summer institute with religion as a social determinant of public health as the learning framework. A needs assessment study was conducted to understand learners' interest in religion and health. The study seeks to understand competency needs in the workforce for practice at this intersection; identify target learners and their priority issue interests; and understand competing programs offered in other organizations.

Researcher conducted a survey study. The survey was distributed using a survey software platform targeting through emailing 125 potential network distributors and 1254 individuals working in the intersection of religion and health. Additional surveys were distributed through professional association listservs and the alumni listservs of Emory theology and public health graduate schools. One hundred and ninety-six surveys were completed and used in the analysis.

Participant responses overall represent positive attitudes towards the opportunity to learn about religion and health. Respondents ranked mental health followed by social isolation and connectedness as learning priorities. Cultural awareness and building strong multisector partnerships were the top priority competencies identified by the respondents. Open ended responses provided an opportunity for respondents to describe their interests in more detail. Common themes across all topic areas were addressing stigma, recognizing vulnerable groups, and understanding religion as both an asset and a harm.

The institute at Emory will benefit the learners through an opportunity not available in other organizations. As religious leaders were underrepresented in the survey, further efforts to reach their networks are necessary. In the field of religious leader education, there are currently no standards of professional preparation competencies. A new set of competencies need to be developed for practice at the intersection of religion and health. Additional in-depth interviews or focus group discussions with educators and professionals will provide valuable information on future workforce needs for working collaboratively across these disciplines to address public health challenges.

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I. Introduction

Introduction and rationale

In light of continually advancing scientific research and knowledge, the field of public health continues to improve methods of preventing, addressing and treating diseases (Chatters, 2000). One particular framework for understanding health is the social determinants of health. Social determinants of health are "the conditions in which people are born, grow, live, work and age" (WHO,2010). Living conditions impacted by socioeconomic circumstances also affect the health outcomes of individuals and the community (Idler and Patton, 2014). The social determinants of health framework provide further insight into how these inequalities in social resources influence the health of the population.

Social determinants of health represent the complex challenges of addressing health issues and requires interventions that appropriately address the full array of the determinants and environments affecting health. Increasingly, there is greater recognition that this complexity requires new partners to tackle many public health challenges. Initiatives such as From Vision to Action, Healthy People 2020 and Public Health 3.0 (PH 3.0) highlight the importance of partnering with diverse sectors. This kind of multisector partnership occurs when sectors with common goals and vision partner together in order to combine resources and efforts to improve health.

Advances in public health thinking and practice informed by the social determinants of health framework and the need for multisector partnership require a new set of skills and competencies in the public health workforce. New competency and skill development must occur in both academia and in organizations that train the workforce. Recent efforts to update

knowledge and skill development has occurred in both the preparation of MPH graduates as well as the current public health workforce. Accreditation bodies in public health are continuously revising competencies for graduate students to ensure the competency model is relevant current public health thinking and challenges. The Beaumont Foundation with a National Consortium for Public Health Workforce Development have identified the need for strategic skills in the public health workforce in addition to discipline specific skills to engage different sectors for the mutual benefit of addressing population health (De Beaumont Foundation, 2017). Strengthening the public health infrastructure through professional development is increasingly important. Studies conducted by Gebbie and colleagues also identify the need for continuing education to address gaps in skills that exists in public health workforce (Allegrante, Moon, Auld & Gebbie, 2001; Tilson and Gebbie ,2004).

Faith communities can be valuable cross-sector collaborators in addressing the social determinants. Historically, religious organizations have been at the forefront of social justice, health promotion and access to care (Idler, 2014). While religious institutions do not always contribute positively to health of the public, religious members have knowledge of the community, trusted networks, and communicative channels that can be utilized for public health interventions and for reaching community members (Idler, 2014).

There is a need in both the faith community and the public health sector to fully understand religion and the role of the faith community in the social determinants of health. The knowledge and understanding of their contribution will lead to multisector partnership that can more effectively address the social determinants. Public health schools are addressing the importance of religion and health to better equip students with knowledge of religion and the role

of faith-based organizations. Fifty three percent of the survey respondents which included 980 graduate students from 24 public health school across United States stated their school addressed Religion /Spirituality in their education (Oman,2018).

A variety of the top schools of public health are now addressing the intersection of religion and public health in their education. These schools include Emory, Harvard, U.C Berkeley, Boston University, University of Michigan, Drexel, and University of Illinois. Opportunities for students at these institutions include research, courses, seminars, and conferences. The scope of classroom and applied learning vary ranging from a social justice approach to health, evidence-based literature review, sociological and behavioral relationships, cultural and religious beliefs, ethics and health, to role of faith in ill patients (Idler, 2014).

Emory University is known for its distinctive academic resources across the intersection of the fields of religion and public health. In this rich interdisciplinary learning and research environment, there are a number of opportunities for degree seeking students to learn from experienced faculty. These include earning a dual degree or a certificate; interdisciplinary courses cross listed with other schools; and applied contextual learning. The religion and public health interdisciplinary learning and scholarship environment at Emory is represented in the book Religion as a Social Determinant of Public Health edited by Ellen L. Idler, Director of the Religion and the Public Health Collaborative. This book is the culmination of faculty seminars held at Emory over three years with contributions by 35 scholars from different schools and disciplinary fields at the university (Idler,2014).

While academic institutions are providing knowledge and skills to address religion and public health, the workforce lacks the same opportunity in their respective fields. Workforce

competencies at the intersection between religion and public health can include: describing the health effects of religion; facilitating and communicating with religious organizations on community health needs; recognizing and addressing the diversity of individuals and populations; and supporting and collaborating with organizations to improve health in the community (Idler, 2014 ; Oman, 2018).

Problem statement

While Emory, amongst many other academic institutions has taken steps to address religion as part of their degree curricula, there is a need for working professionals to be better equipped to address religion in public health. Additionally, there is a gap in understanding what the competencies, in terms of attitude, knowledge and skills public health professionals and the religious leaders need to address public health issues in their communities.

Purpose statement

The Religion and Public Health Collaborative (RPHC) at Emory University strives to "engage scholars and practitioners in world religions and public health to understand the sometimes converging, sometimes conflicting relationships of religion and public health, through teaching and research." (RPHC, n.d.). The RPHC at Emory is planning to provide an interdisciplinary, non-degree education program on religion and public health during the summer in the near future. This non-degree education program at Emory would be a unique and optimal environment for learners to develop skills relevant to their leadership and community's needs. Understanding the potential learners and their knowledge and skill priorities is an important reference for curriculum design.

Project Objective

The objectives of this needs assessment study is to understand learners' interest in religion and health, their priority issue interests, and competency needs in the workforce for practice at this intersection. Secondly, to understand competing programs offered in other organizations. The needs assessment study will allow the Emory to develop a non-degree program considering the preferred learning environments in addition to the interest and needs that are identified by religious leaders and public health professionals. It will also allow Emory to identify learning opportunities in competitive program and distinguish Emory's program to benefit professionals in their respective work place as well as the communities they serve.

Significance Statement

Academic institutions are adept at synthesizing scholarship and evidence-based information and challenging learners to think critically and consider the application to their future work. There are not many opportunities for working professionals to learn from experts in religion and public health. First, the need assessment of the project will contribute to the curriculum development by identifying areas of competency needs and learning interest of the potential learners. The curriculum design will shape the institute can prepare interdisciplinary cohorts of professionals with religion and health knowledge and skills to address the complex health challenges in their communities. An effective faith and health curriculum design exploring multisector collaborative practices with religion and faith-based partners can encourage future religion and health frameworks, interventions and initiatives. When learners demonstrate enhanced partnership abilities with faith communities and understanding of faith and health, this will also promote, encourage and challenge other academic institutions and workforce to consider the role of religion in public health. Successful implementation of the program will

strengthen the education and training of public health and religious leaders on the role of religion in healthy communities.

Definition of terms

Competencies: Knowledge, skill and attitudes and represents the goals of the learning process (Anderson, 1994)

Multisector partnership: Include representatives and resources from various substantive issue areas and span the business, nonprofit, and governmental sectors (Woulfe; Oliver; Zahner; and Siemering, 2010).

Religion: as shared practices, beliefs, and institutions, distinct from the subjective and potentially idiosyncratic spirituality of individuals (Idler, 2014).

Social determinants of health: the conditions in which people are born, grow, live, work and age. (WHO, 2010)

II. Literature Review

Overview

The literature review provides a description of the new thinking, strategies and approaches that influence the current public health system. Social determinants of health as a framework and multisector partnerships are particularly vital elements needed for addressing challenging, complex and diverse public health issues of this time. These two elements have reshaped public health competencies in the academy and the workforce. The review also explores the trends in the theological education and the relationship between religion and public health. An assessment of theological education programs identifies examples of innovative programs suggesting a major shift in vocational interest of seminary students and the need to prepare students for real world challenges through context-based education. The review identified transferable competencies in religion and public health. The review provides examples of religion and health intersect in several settings and issues. Finally, the literature review offers more on the unique strengths of Emory and what distinctive program at Emory can offer in comparison to other religion and health non-degree education opportunities at competing organizations.

A. Public Health System: New thinking, emerging strategies and approaches

The public health system went through a major transformation at the turn of the 21st century in response to the challenging, complex, and diverse public health issues. These changes were first represented in the framework of public health efforts. *Healthy People 2020, From Vision to Action,* and *Public Health 3.0 (PH 3.0)* demonstrate the shift in the public health system and frameworks. These frameworks focused on engaging multiple sectors to address health using the social determinants of health model.

Beginning in 1980, the US Department of Health and Human Services (HSS) initiated Healthy People in order to provide more focused national public health objectives. Healthy People is released each decade after input from an advisory committee, public meetings and public comments. The current model is Healthy People 2020. The role of social determinants health and multisector partnership in achieving their four overarching goals are key features in the current national objectives (HHS,2010).

1. **Eliminate preventable disease, disability, injury, and premature death:** This is achieved through multisector partnerships. Partnership with major institutional sectors include government, business, education, religion, and families as well as with stakeholders in public health, health care, social services, municipal planners, transportation departments, food industry manufacturers and suppliers, and media companies.
2. **Achieve health equity and eliminate health disparities:** Identifying determinants in physical and social environments to address health disparities.
3. **Create social and physical environments that promote good health for all:** This objective recognizes the interaction of the individual, policies and the environment in which they live (social and physical). Efforts include interventions that address health and relationship dynamics at all levels.
4. **Promote healthy development and healthy behaviors at every stage of life:** Monitoring and intervening risks and social physical factors improve length and quality of life and reduce health disparity. Further efforts in prevention and promotion of health during critical periods help mitigate behaviors and yield long term benefits throughout the individual's life span.

From Vision to Action is a model developed by the Robert Wood Johnson Foundation (RWJF) in 2015. It provides an action framework on how communities can create a culture of health. Their primary focus is on social, economic and policy indicators to change communities with an emphasis on strong partnership and the social determinants of health (RWJF, 2015).

1. **Making health a shared value**: Promotes that individuals have a collective role in health of the community. Activities include increasing awareness of the importance of community physical and social health and its effect on the individual's health, health information seeking behaviors, investments in community health, and civic engagement such as voter and volunteer participation.
2. **Fostering multisector partnership:** There is an emphasis on quality and quantity in partnership within different sectors and organizations. Partnership also includes investors in their program.
3. **Creating healthier more equitable communities:** The importance of the physical (i.e., air, housing, transportation, access to healthy food options) as well as the social and economic environment (i.e., racial and socioeconomic segregation, and education) are necessary for the population to stay healthy.

Thirdly, HHS developed Public Health 3.0 (PH 3.0) in 2016. It is a third era model that was modified in order to emphasize current approaches to public health practices in engaging multiple sectors and community partners for collective impact and addressing social determinants of health (HHS, 2016). The five key components of PH 3.0 demonstrating their commitment to multisector partnership are as follows (HHS, 2016).

1. **Strong leadership and workforce:** A diverse, policy-oriented public health workforce and leaders that can adapt and communicate new initiatives is essential. Leadership includes both those in and outside of traditional health sectors and organizations. Improved incentives and professional development opportunities are used to attract and retain talent as well as strengthen collaboration and leadership skills.
2. **Strategic partnerships**: It is necessary to have a politically neutral party that can moderate partners and direct collaborators towards shared goal. Strong partnership requires structured timelines and work plans, collective goals and values, and maintaining and building new relationships.
3. **Flexible and sustainable funding**: Identification of new financial models and funders with similar goals and values reduce funding silos and duplicate work.
4. **Timely and locally relevant data, metrics, and analytics**: Utilizing new types of data and promoting partnership in data sharing and analysis can address current data gaps and access challenges.
5. **Foundational infrastructure**: Development of departmentwide collaborative infrastructure, cultural competency, and institutionalization of PH 3.0 framework allows for more sustainability.

Multisector partnership approaches

Multisector partnership models address the social determinants of health. Two central models utilized in multisector partnership are Health in All Policies (HiAP) and Collective Impact. HiAP promotes inclusion of health in policies across all sectors to make informed decisions concerning the health consequences and outcomes (Rudolph, Caplan, Ben-Moshe

and Dillon, 2013). HiAP recognizes that policy decisions outside of health sectors influence the economic, physical, and social environment which impact health and equity (Rudolph, Caplan, Ben-Moshe and Dillon, 2013). Others have suggested using the term "Well-being in All Policies" to better engage non-health sector stakeholders in health by addressing well-being (Kottke, Stiefel and Pronk, 2016). Well-being is subjective and includes living condition and life satisfaction (CDC, 2018). Well-being may more effectively help policy makers understand how policy changes can positively or negatively impact well-being outcomes beyond health.

Another model, Collective Impact (CI) engages different sectors and community members to decrease duplicity of efforts for better coordination and delegation towards a common goal (Kania and Miller, 2016). The model requires investors and partners to recognize the insufficiency of current efforts and feel an urgency for change. Initial steps include analysis of data and identifying the need for partners to have a shared understanding of the problem and objectives (Kania and Miller, 2016). Afterwards, the data will be collected, progress will be monitored to maintain accountability, and reinforcing activities will be provided to support progression towards the overarching goal (Kania and Miller, 2016).

Many Scholars have studied different types of collaborative efforts in addressing social determinants. The purpose of a study from 2014- 2015 was to identify, categorize, and describe these multisector initiatives in the United States and focus on social determinants to promote community health (Koo, O'Carrol, Harris and DeSalvo, 2016). Hundreds of multi-sector initiatives were identified and placed into six categories. The categories of the

initiatives are examples of different ways collaboratives can impact public health (Koo et.al, 2016):

1) **Community-generated initiatives to promote community health and well-being (n=133).** These public health and health care initiatives were concerned with community developing and livability. Partnership occurred among sectors in housing, transportation, social services, local government and community organizations.

Similar efforts exist in **2) federal and 3) philanthropic initiatives promoting community health and supporting multisector partnership**. Examples of federal initiatives include Community Health Improvement Navigator by US Department of Health and Human Services and PH 3.0 with the HHS and Office of the Assistant Secretary of Health (Koo et.al, 2016). Examples of foundation initiatives includes Robert Wood Johnson Foundation (Culture of Health), Kresge foundation (health equity), and Kellogg foundation (supporting children) (Koo et.al, 2016).

4) Data and metrics initiatives to set goals, measure and assess community health (n=9). These partnerships utilized data and metrics in monitoring and evaluating the health of the community.

5) Comprehensive resource with theory of change and action steps that promote multisector efforts to address health (n=6). The theory of change models, practical tools to take actions, steps to maintain partnership with other sectors, and anecdotes of successful partnerships are resources for different programs to adopt multisector initiatives.

6) Campaigns intended to encourage broad multisector approaches to health (n=11). Advocacy raises awareness of the importance of communities to engage across sectors to address health and condition of the community.

In summary, more community leaders and public health professionals are recognizing the role of the social determinants of health. This recognition stems from the understanding that greater societal impact can occur through addressing the physical and socioeconomic environment, which determine health outcomes. To accomplish this task, the public health sector needs to engage other sectors for collaboration. Different frameworks and action models are examples of these efforts and trends in current public health practice. Thus, there is a need for competencies in education and the workforce to reflect current demands, thinking and approaches in public health.

B. Public Health Professional Competencies

School of public health competencies

Accrediting bodies and educational institutions revise and update competencies to remain relevant based on current thinking, approaches, and public health challenges. Association of Schools and Program in Public Health (ASPPH) in 2013 provided advisory board perspective on what knowledge, skills, and attitude future graduates will need. Emerging trends from the interviews stressed that the public health commitment includes recognizing societal factors to health and serving disadvantaged population (ASPPH,2013). The interview emphasized opportunities in multisector partnership and professional applicability of public health skills in diverse setting and fields (ASPPH,2013). ASPPH also convened a panel to review education criteria for Master of Public Health programs in 2014. ASPPH identified growing interest in

public health in numerous sectors and subsequent need to prepare graduates for interdisciplinary and interprofessional roles and environments, and wider use of MPH degree in less traditional public health agencies (ASPPH, 2014). The ASPPH panel further identified the following critical core competencies for the 21st century: systems thinking and dynamic interaction between sectors and actors for health improvements; factors (socio-economic, behavioral, cultural, biological and environmental) that impact health and health disparities; and respectful engagement with people of different cultures and socioeconomic status (ASPPH, 2014).

Recognizing the shift in public health described above, The Council on Education for Public Health (CEPH) released an updated MPH competency in 2016. CEPH distinguished core knowledge areas along with competencies. Core knowledge includes public health specific knowledge as well as 6 factors related to human health (environmental; biological and genetic; behavioral and psychological; social, political and economic determinants of health; globalization effects on global burdens of disease; and ecological perspective on the connection among human health, animal health and ecosystem) (CEPH,2016). Relevant to multisector partnership and social determinants of health addressed in MPH competencies are the following (CEPH, 2016):

1. **Public Health & Health Care Systems:** "Discuss the means by which structural bias, social inequities and racism undermine health and create challenges to achieving health equity at organizational, community and societal levels".
2. **Planning & Management**: "Awareness of cultural values and practices to the design or implementation of public health policies or programs".
3. **Policy in Public Health: "**Propose strategies to identify stakeholders and build coalitions and partnerships for influencing public health outcomes".
4. **Policy in Public Health: "**Advocate for political, social or economic policies and programs that will improve health in diverse populations".
5. **Communication:** "Select communication strategies for different audiences and sectors".

6. **Communication:** "Describe the importance of cultural competence in communicating public health content".
7. **Interprofessional:** "Perform effectively on interprofessional teams".
8. **Systems Thinking:** "Apply systems thinking tools to a public health issue".

The ASPPH also reviewed and updated global health concentration competencies for MPH degree in 2018 assessing both ASPPH and Consortium of Universities for Global Health members model of global health competencies. These changes reflect the current thinking and approaches in public health practice. Out of the six competencies, three competencies directly and indirectly address social determinants of health and multisector partnership. These are (ASPPH, 2018):

1. "**Analyze** the roles, relationships and resources of the entities influencing global health".
2. "**Propose** sustainable and evidence-based multi-sectoral interventions, considering the social determinants of health specific to the local area"
3. "**Display** critical self-reflection, cultural humility and ongoing learning in global health"

Self-reflection and cultural humility are necessary to sustain a multi-sectoral partnership that addresses social determinants of health and other factors and relationships that influence global health.

Competencies in public health workforce

The Core Competencies for Public Health Professionals, revised in 2014, are skills that compliment public health practices and services outlined in ten essential services (monitor, diagnosis and investigate; inform, educate and empower; mobilize community partnerships; develop policies; enforce laws; ensure access to care; assure competent workforce; and evaluate) (Council on Linkage,2014). The competencies help the public health workforce identify skills necessary to effectively provide public health services. Eight core competencies are: analytical

and assessment; policy and program development; communication; cultural competency; community dimensions of practice; public health sciences; financial planning and management skills; and leadership and systems thinking (Council on Linkage,2014). Professional development is a way for professionals to strengthen their skills. Workforce competencies are similar to competencies needed to address social determinants of health and build multisector partnership such as leadership, systems thinking and cultural competency.

More recent public health workforce competencies are a set of strategic skills for the governmental public health workforce developed by The National Consortium for Public Health Workforce Development (de Beaumont Foundation, 2017). For professionals to engage essential sectors and partners in addressing complex population health improvements, strategic skills are required (de Beaumont Foundation, 2017). Eight Strategic skills to enhance multisector partnership are (de Beaumont Foundation, 2017):

1. **Systems thinking:** Ability to notice factors, trends, and relationships of problems on a systemic level and introducing interventions addressing all components of the connection.
2. **Change management:** Ability to respond to changes, and challenges.
3. **Persuasive communication:** Ability to effectively engage audience and promote response to the public health message.
4. **Data analytics:** Ability to utilize and analyze existing multiple sources of data towards use of big data.
5. **Problem solving:** Ability to identify the central problem and appropriate solution that addressing the problem.
6. **Diversity and inclusion:** Recognizing the diversity and ensuring under-represented population are included and heard in the decisions making.
7. **Resource management:** Ability to retain and manage the workforce and budget.
8. **Policy engagement:** Ability to engage and persuade policymakers to raise and prioritize public health concern and need.

Competencies in the workforce represent expected capacities for public health professionals.

Many of the competencies in workforce and in education address the social determinants and multisector partnerships directly and indirectly through skills such as factors affecting health, systems thinking (strategic analysis), capacity building, and leadership. Cultural humility, diversity, and inclusion are also competencies that are necessary to strengthen and support social determinants of health and multisector partnerships. These public health competencies prepare professionals to work in interdisciplinary settings with diverse groups and sectors.

C. Trends in Theological Education

Faith communities are unique partners that can make essential contributions to the social determinants. Strong partnerships with faith communities require understanding of recent trends and competencies in theological education. Religious education and competencies reviewed in this section are limited in focus to protestant seminaries hence it does not represent competencies from other religious traditions. Other religions such as Catholicism, Judaism, Islam, Buddhism, and Hinduism are preparing their students in distinctive ways in their institutions. A more thorough effort in understanding one particular religion is a preliminary assessment to explore the role of religion aligning with a protestant religion. Protestant religions have been extensively studied and examples from protestant religion is utilized for uniformity.

The changes in the 21st century also impact theological education. The Association of Theological School (ATS) developed the Educational Models and Practices in Theological Education Project to identify strengths and assess the current education model in order to satisfy changing demands. The ATS has undertaken several works since 2015. Efforts to further understand theological education degree programs and its objectives include a mapping survey of 200 schools that assessed the goal and effectiveness of 440 degree programs and implementing

18 peer groups that represent 110 schools (Graham,2017). The ATS also surveyed theology school alumni in their employment opportunities and vocational interest as well as competencies necessary and utilized at their work (ATS, 2017). Finally, ATS gathered input from other graduate education programs as external benchmarks in order to improve learning and overall experience at theological schools (ATS,2018). These activities have all contributed to the project to help the ATS redevelop their accreditation standards (ATS,2018).

There is an increased emphasis on raising awareness in faith leaders on the importance of remaining current in social issues for the generation that they serve and lead. Auburn Seminary identified a major shift in theological educational model in US seminaries (Scharen and Miller, 2016). Auburn Seminary accomplished the research through diverse case studies and report on pedagogical and programmatic findings (Scharen and Miller, 2016). Various innovations and strategies in seminaries illustrate the changing trends in theological students, and seminaries attempt to adjust to these needs in theological education and society. Examples of seminaries and program explored include The United Theological Seminary, The Underground Seminary, and The Methodist Theological School.

The United Theological Seminary in Minneapolis is leading innovative programs by adapting to the changing needs of society. They achieved this by addressing students' vast vocational interests and providing opportunities to experience real world challenges. Under the United Theology Seminary is the Twin Cities School of Theology (TwinSoT), which is a Master of Theological Studies in Integrative Theology. It is based in downtown Minneapolis in order to engage people where they "live, work and play" (Scharen and Miller, 2016). Public Theology for Social Transformation and Culture and Justice are examples of integrative and transformative

courses that bridge the social realities of life with theology (TwinSoT, n.d.). The United Theological Seminary also provides a Master in Leadership for Social Transformation as well as a certificate program and concentration through Master of Divinity from Kaleo Center for Faith, Justice and Social Transformation. This program equips students with competencies in leadership for social transformation and justice movements. The program requires students to learn through community or congregational site engagement to develop their leadership skills throughout their program. Their capstone project examines their ability to integrate learning and social transformation in their community (Kaleo Center, n.d.). The program appeals to students interested in numerous vocational tracks such as social justice advocacy; non-profit leadership; religious organizations and congregational ministries; educational institutions; civic and governmental agencies; business; and philanthropy (Kaleo Center, n.d.).

The Underground Seminary is also based in Minneapolis and it provides a Master of Divinity Degree with an emphasis on community engagement by addressing societal challenges inspired by Dietrich Bonhoeffer's Finkenwalde Seminary (Underground Seminary). The seminary challenges the modern imperial system in the U.S by providing scriptural basis for counter-imperial witness and engaging local race and economic justice movements (Scharen and Miller, 2016).

The Methodist Theological School in Ohio offers an Ecology and Social Justice specialization as a Master in Practical Theology or Master of Divinity. The school is committed to environmental justice not only in teaching but also in practice. They utilize alternative energy sources to power portions of their campuses and have their own farms from which they provide organic produce for the seminary's dining halls and for purchase in the community (Scharen and

Miller, 2016). The school partners with rural and urban congregations to provide fresh food in areas that have difficulty accessing affordable, fresh produce. There are other seminaries committed to food and ecology. Examples include Wake Forest University's School of Divinity, Drew University Theological School's Green Seminaries and Princeton Seminary's Farminary (Scharen and Miller, 2016).

All the aforementioned programs assessed by Auburn Seminary are examples of schools that are preparing students for real-world challenges. In other words, the schools are more interested in equipping students with societal, contextual experiences to lead transformational social change rather than a more traditional model of core content transfers inside congregational settings. Schools are beginning to respond and value varying vocational interests and the role of faith leaders even outside faith communities. Seminaries are attempting different models based on students' diverse vocational goals and aspirations to engage social issues with faith-based approaches and leadership.

The 2016–2017 Association of Theological School (ATS) surveyed 940 recent theological seminary alumni to understand where they were working post-graduation. From the survey, only 41% planned on doing ministry at the congregational level and 49% were interested in a wide array of ministry and other non-ministry settings (Deasy, 2017). Among those pursuing positions outside of congregational settings were in community service (8%), health care (12%), faith related (14%) and education (38%) (Deasy, 2017).

D. Competencies in Theological Education

In theological schools' educational model, competencies are not yet standardized across schools. Unlike core competencies in public health, theology schools do not have core

competencies that schools are required to teach and that students must possess at the end of their education. Each theology school has different models and objectives that provide a diverse learning experience. The ATS tried measuring competency needs in various jobs through the 2016–2017 ATS Graduating Student Questionnaire (GSQ) surveying 940 recent alumni (Gin, 2018). Alumni were asked to answer the question "In your current role, what skills/knowledge/dispositions do you rely on most heavily to do your work?" from a list of 46 different competencies. The results varied by job setting. Alumni that worked in health-care (n=64) identified competencies such as active listening (67%), pastoral care and counseling (60%), difficult conversations (50%), spiritual disciplines (48%), theology (31%), and interpersonal competency (30%) to be most helpful (Gin, 2018). Competencies in administration (49%), communications (41%), finance (29%), conflict resolution (29%) and intercultural competency (29%) were helpful for those who worked in community service (n=41) (Gin,2018).

Qualitative methods were also utilized to understand how students are learning from theological education. In 2007, Emory Candler School of Theology directors Jenkins and Rogers brought together 17 seminaries across the United States because they recognized the benefit of sharing best practices in contextual and field education in equipping students to be leaders in the postmodern era. The book *Equipping the Saints: Best Practices in Contextual Theological Education* is a culmination of this conference.

The book presents several unique methods that shape how students are prepared for upcoming challenges in their ministries. One key highlighting discipline in theological school is the ministerial reflection. Ministerial reflection is "skill building and the growth of self-understanding" (Jenkins and Roger, 2010). Ministerial reflection allows students to understand

themselves better as an individual and as a faith leader as well as providing skills needed to address different challenges (Jenkins and Roger, 2010). Several different reflecting models were identified in the contextual education setting. Contextual education provides learning through opportunities working in ministerial and community sites. Students learned to be reflective professionals through supervisor-student relationships. Supervisors helped develop self-reflection in students by providing insight to students who were processing challenges by sharing their experiences. Secondly, students learned to reflect removed from context and work while in the seminary. Through seminars they can process challenges and reflect on their response and reactions more thoroughly. Finally, the integrative reflection model integrates reflective thinking in curriculum to supplement field experiences. Regardless of the approach, theological schools promote reflection and contextualization from their field experience to learn and understand the self, individuals, congregation, and ministries (Jenkins and Roger, 2010).

Several innovative models in religion stood out that paralleled efforts in public health. Iliff School of Theology focused their efforts on battling individualism and promoting social analysis. Individualism can hinder perception of social differences and how that constitutes and impacts another's life and experiences. Social analysis focused efforts on community engagement and social context to increase social awareness of the congregation and the structural dimensions of the issue (Campbell, 2010). This approach resembled the systems thinking and social analysis competencies found in public health.

Another paralleling competency includes appreciating diversity and other cultures. New York Theological Seminary (NYTS) and Wesley Theological Seminary place their emphasis on valuing culture and diversity (Jenkins and Roger, 2010). Awareness of cultural diversity is very

crucial for the success of anyone that is looking to go into ministry and community development with diverse demographics and populations living in the United States. In the case of NYTS, they are living in a multiracial, multicultural, and multilingual environment that requires inclusivity. In this environment, students learned to live as a part of a diverse community that appreciates others' experiences and views and engages in open dialogue to understand one another (Jenkins and Roger, 2010). For Wesley Theological Seminary, they chose intercultural immersion, a participant-observer approach to learn through immersion and observation. Observation takes place in short-term trips to other countries engaging with people from different continents. It allows students to view their world with a different set of lenses than that of their own assumptions and expectations (Jenkins and Roger, 2010). These experiences helped students to be more reflexive and sensitive to others' culture (Jenkins and Roger, 2010).

Continuing education in multisector partnership

In theological education, there is a recognition of the benefits to continuing education in multisector partnership. Mark Rouch, a national staff person at the board of Higher Education and Ministry of the United Methodist stated the church should be subversive. To subvert the "limited, fragmented, and distorted views of truth and every block to human growth" (Reber and Roberts, 2009). One area of need in continuing theological education is the need for "collaborative enterprise" (Reber and Roberts, 2009). It serves as a way for the church to connect with other sectors of society for partnerships and to develop a community of moral deliberation (Reber and Roberts, 2009). There is an awareness that partnerships should go beyond religious institutions to include government agencies, social services, healthcare, nonprofits, business, and industries.

E. Religion as a Social Determinant of Public Health

Religion can impact health through social factors or social determinants of health – "the circumstances in which people are born, grow up, live, work, and age" (Idler, 2014). Religious practices occurring daily, weekly, annually, or even once in a lifetime can serve as experiences and exposure in varying degrees and frequencies that impact the person (Idler, 2014). A study by sociologist Emile Durkheim found a decrease in suicide among the religious (Durkheim, 1897). The study suggested a connection between increased rates of suicide to alienation and isolation. Durkheim conjectured that religious institutions and congregations provide social support through warmth, belonging, responsibility and purpose (Durkheim, 1897). Additionally, religion can be a social control regulating behaviors and reinforcing positive values while discouraging unhealthy habits and behaviors (Idler, 2014). On the other hand, extreme social control can be harmful when individuals are too controlling or abusive and misuse their power (Idler, 2014). Examples of this include restricting rights, promoting division and bigotry against people with different values, and advocating against certain health practices such as immunizations, contraception, and blood transfusions (Idler, 2014).

Religion can also contribute to efforts in addressing economic inequalities. Religion addresses inequalities through charitable giving, challenging moral response, promoting compassion, and physical capital (Idler, 2014). Religious institutions also have buildings and space to provide shelter in addition to events and program for the community. They can provide food to the hungry and housing for the poor. Additionally, religious institutions have social capital. Social capital is found in "communities composed of political, economic, educational, religious and social institutions" (Idler, 2014). Religious institutions themselves have social

capital and they invest in the community to build schools, hospitals, social services to provide for those with needs in the community (Idler, 2014). As individuals, religious members have knowledge of the community, networks, and communicative channels that can be utilized for public health interventions and for reaching community members.

Religion can also address perception and psychological impact of economic inequalities. Psychological impact of economic inequalities can lead to increased stress, depression, insecurity, shame and aggression which can trigger violence, drug and alcohol use, and antisocial behavior (Idler, 2014). Religion can provide a different perception and basis for comparison and worth (Idler, 2014). Often religion does not focus on material goods or worldly success. Additionally, religious experiences and awareness of others who are less fortunate around them can produce contentment and humility (Idler, 2014). Members can find opportunity and positions in the congregation that may give them an increased sense of value and worth. In contrast, religion can at times add to economic inequality. Researchers found disparities in wealth and income based on religion affiliation (Idler, 2014). Possible explanation according to Keister, particular religious activities may teach skills, knowledge and values that influence consumption, saving and investment decision making (Idler,2014). Startlingly, research from US would suggest a positive correlation between religion and health while some poorer countries have higher levels of reported religiosity and importance in their lives (Idler, 2014). This is indicative of the complex role of religion and supports the need for understanding how religion is a social determinant of health (Idler, 2014).

Religion has in the past and continues to contribute to the health of communities in various ways. There are cases for both advancements and harm as a result of religion. For

example, Reverend Henry Whitehead contributed to the cholera ghost map by collecting data going door to door and writing the initial report (Idler, 2014). Early religious leaders' efforts and religious motivation led to the social justice movement, public health reforms focused on improving economic and living conditions, promoting health, providing basic remedies and access to care while other movements promoted anti-obscenity laws restricting sex education and contraceptive practices (Blevins, 2014 ; Hogue and Hogue, 2014). Providing clinical health care, healthcare workers, and supplying medical and pharmaceutical supplies has been a big presence of faith-based organization in developing and low-income countries (Brown, 2014). Medical care has been the primary focus of many religious organizations, motivated by the desire to show mercy, heal the sick and alleviate them from their suffering. However, recent trends in faith-based organization show a shift from providing service to training locals (Brown, 2014). Local capacity building allows partnerships and empowerment with the locals, hiring locals to manage the task established by international organization.

F. History at Emory: Public Health, Religion, and Social Determinants of Health

Emory has a long history of interdisciplinary scholarship and opportunities for students to engage in public health and religion in classrooms and other settings. Emory University's program in public health and religion is closely tied to the founding of the Interfaith Health Program (IHP) at The Carter Center (Idler and Kiser, 2018). The initiative, led by President Carter and Carter Center Executive Director William Foege, sought to involve religious communities to utilize their unique strengths in addressing health disparities. The IHP included an Atlanta Interfaith Health initiative to improve community health in inner city Atlanta using a congregational health promotion and disease prevention model (IHP, n.d.). IHP developed partnership opportunities in public health and theological schools and seminaries for research,

teaching and practice. Later in 1999, IHP became part of Rollins School of Public Health. Since then, IHP implemented the Institute for Public Health and Faith Collaborations, which trained 78 teams (400 religious and public health leaders) from various religious background to collaborate with each other to address health disparities (Idler and Kiser, 2018). Examples of other IHP projects include: efforts in reaching vulnerable populations with influenza vaccines; Faith Health Collaboration and Leadership Development Program addressing the HIV crisis in Kenya; mapping the connections between faith-based and civil society organizations that provide HIV services in Kenya; and assessment of access to faith-based HIV/AIDS services in several countries in Africa (Idler and Kiser, 2018).

Emory University's 2005-2015 initiative to expand cross-school and interdisciplinary programs gave birth to the Religion and Public Health Collaborative(RPHC) (RPHC, n.d.). The RPHC develops and supports religion and public health curriculum, research, conferences, and programs.

Emory has a plethora of courses, as well as a certificate and a dual-degree to provide opportunities for students to learn across religion and public health disciplines. Students from different disciplines and religious backgrounds explore the intersection and integrate learning on the topic of their interest through some key courses such as: Religion and Public Health and Faith and Health: Transforming Communities (Idler and Kiser, 2018). Further opportunities to develop knowledge and experiences in religion and public health include fieldwork experiences, various events such as guest lectures, conferences, films, workshops and receptions providing exposure to the ways that religion is present in public health and vice versa.

Finally, Emory University is a leader in contributing to the larger academic field on religion as the social determinant of health. Religion as a Social Determinant of Public Health is a culmination of a faculty seminar held at Emory with contributions from 35 scholars from different schools of study and disciplinary fields at the university (Idler, 2014). The book allows audiences from various disciplines and backgrounds to understand the importance of religion in public health and the well-being of the population.

Emory's distinctive strengths and pressing health issues of the time

With a long history of efforts and involvement in religion and health, Emory plans to develop a summer institute with a curriculum centered on its distinctive strengths as well as focusing on pressing health issues of our time. Topics currently under review include mental health; social isolation and connectedness; community development, housing and employment; nutrition and food systems; the opioid epidemic, reproductive health; HIV/AIDS in the U.S. (Southeast) and HIV/AIDS in Africa. The core foundation of religion as a social determinant of public health would be a conceptual anchor for understanding the role of religion in social isolation and connectedness, community development, and housing and employment.

Religion and Mental health

Dr.Ozawa-de Silva, an associate professor of anthropology at Emory, characterized Emory's strength in religion and mental health through his contribution to a chapter on religion and mental health in Religion as a Social Determinant of Public Health.

Positive psychology and religion are ways mental health is understood in a positive light, more than the absence of illness and dysfunction but to flourish and enjoy purposeful and holistic living (Ozawa-De Silva, 2014). Moral emotions and ethical values such as compassion,

gratitude, forgiveness, and generosity promote flourishing social relations as well as preventative mental and physical health (Ozawa-De Silva, 2014). Although not distinctively a religious factor, religious communities serve as protective factors in that it provides close community. Such community settings provide the benefit of a sense of belonging and social support (Ozawa-De Silva, 2014). The ways that religion aids and supports an individual's flourishing are distinctly different from secular notions. For example, religious practices such as prayer and bowing encourage positive values such as humility, respect and devotion (Ozawa-De Silva, 2014). Religion focuses on positive functioning and being in a healthy relationship with self and others which bears a clear contrast from positive and negative emotions and affects spotted in psychology (Ozawa-De Silva, 2014).

Religion and Reproductive Health

Emory's strength in religion and reproductive health is represented by Dr.Gaydos, an associate professor of Health Policy and Management at Emory. She has expertise on women's reproductive and maternal/child health issues and contributed to a chapter on religion and reproductive health in Religion as a Social Determinant of Public Health.

Religion's influence on reproductive health can be seen in a variety of issues. Religion contributes to individuals' lives such as the timing of the marriage, perceptions of premarital sex, childbearing, family size, contraception use, and routine health management (Gaydos and Page, 2014). On a community level, religion can regulate community norms and beliefs of the congregation, provide health services, and engage in policies to promote moral teachings.

The relationship between health and different religions, sects and denominations are complicated. Historically, many religions were against contraception. Over time, religion appears

to have become more permissive of contraception for family planning, while its stance and condition vary in each religion and sect (Gaydos and Page, 2014). Prenatal care in contrast, is generally well received and widely utilized (Gaydos and Page, 2014). On the contrary, abortion is primarily not supported (Gaydos and Page, 2014). It shows the way that many religions perceive life in conception. The most likely exception to the stance is only when the life of the mother was in danger. Another more common exception stance acknowledged the mother's mental and emotional health to be acceptable motivation for abortion. Religious beliefs and norms influence decision making, thus public health professionals should have greater sensitivity and awareness when navigating issues in reproductive health.

Religion and HIV/AIDS

Dr. Dalmida, an assistant professor of Nell Hodgson Woodruff School of Nursing at Emory and Ms. Thurman, faculty of the Department of Global Health at RSPH represent Emory's strength in religion and HIV/AIDS through their expertise in HIV and contributions to a chapter on religion and HIV/AIDS in Religion as a Social Determinant of Public Health.

The role of religion in HIV/AIDS is particularly complex. In the beginning of the epidemic in the 1980s, religious sectors negatively perceived HIV and AIDS because they considered it to be punishment for sins of homosexuality, adultery, or extramarital sex. Anti-gay Christians in the government during Reagan's presidency contributed to the lack of response to AIDS epidemics (Dalmida and Thurman, 2014). While many religious organizations are criticized for their apathy and negligence, other religious organizations were leading the care for those affected by HIV and AIDS (Dalmida and Thurman, 2014). In prevention, religions adopt certain messages and strategies in response to HIV/AIDS. They promote messages of abstinence

and monogamy while also insufficiently providing education on contraception use and HIV transmission modes and risks. Ministries were typically more active in raising awareness of getting tested and pastoral care with those with HIV/AIDS rather than emphasizing prevention through contraceptives (Dalmida and Thurman, 2014). Research also suggests an association between religious coping and better psychological and physical health outcomes for people with HIV (Dalmida and Thurman, 2014). Other benefits included greater optimism, less depression and suicidal ideation (Dalmida and Thurman, 2014). Religiosity was linked to slower disease progression (Dalmida and Thurman, 2014). Possible explanations of these differences are relaxation through prayer and meditation, social support, coping styles and increased adherence to medical regimen and healthy lifestyles (Dalmida and Thurman, 2014).

Religion and Nutrition and Food system

Wake Forest University's School of Divinity Drew University Theological School and the Green Seminaries and Princeton Seminary's Farminary are examples of religion's commitment to food and feeding others (Scharen and Miller, 2016). Faithful Families Thriving Communities program in partnership with the North Carolina Division of Public Health and North Carolina State University Strategies is another partnership with faith communities to help community members manage health through healthy eating and physical activities. Programs in healthy eating include nutrition, meal preparation, cooking and food safety. These programs provide resources for families to live healthier. The program promotes capacity building among faith leaders to lead health initiatives by training lay leaders to teach healthy eating lessons and provide environments for health discussions with their faith communities and outside communities. Evaluation results indicated that 78% of participants practiced better food resource

management, 93% had improved dietary intake and 67% improved food safety practices. This model is an example of partnership with faith communities to improve access to food and encourage faith communities to be active members of change in their communities.

Opioid Epidemic

Every day, more than 130 people in the U.S die from overdosing on opioids (HHS, 2019). Overdosing on opioids such as prescription pain relievers, heroin, and synthetic opioids has become a national epidemic. The HHS declared opioids a public health emergency in 2017 (HHS, 2019). In 2017 alone, there has been more than 47,000 opioid overdose deaths and 1.7 million people suffered from substance use disorder and 652,000 from heroin use disorder in the U.S. (NIH, 2019). When ATS gathered input from other graduate education programs, ATS recognized the need to converse about how different graduate schools such as law, education, medicine, social work, and theology is addressing the opioid crisis (ATS, 2018). Theology schools are thoroughly addressing the opioid crisis by teaching students. They articulate the need for interconnectedness across professions and for those entering pastoral care to refer out for addiction treatment (ATS, 2018). Emory President Clair E. Sterk, a social scientist and public health professional herself, has been actively addressing the opioid epidemic in public discussions (Parvin, 2018). In January 2018, Emory held the opioid crisis panel inviting various experts and advocates to speak about the current crisis. RSPH holds strengths related to this epidemic in expertise on social determinants of drug use, drug-related harm, and substance abuse research conducted by Hannah Cooper, RSPH Chair in Substance Use Disorders (Woodruff Health Sciences Center, 2018).

G. External benchmarks

External benchmarking was important in order to understand and identify other current religion and public health learning opportunities and ways Emory could fill any gaps with its scholarship strengths. Utilizing the provided database from Emory's non-degree educational program feasibility study from 2008 of existing faith and health as well as additional institutions, assessed continuing education opportunities for professional development in the intersection of faith and health. Criteria for inclusion are:

- Workshop or certificate program (excludes conference and symposium)
- Religion and health or public health
- Non-degree education
- On-site learning
- Minimum one full day programs

Forty-two academic institutes and 11 Healthcare related organizations were reviewed for the criteria. From these institutions and organizations, there were five academic institutions and one health care organization that met the criteria. These criteria are based on what is most comparable to programs that Emory's summer institute will offer.

Duke University, Center for Spirituality, Theology and Health – five-day research course

The Center for Spirituality, Theology and Health at Duke University has been providing a summer research course on spirituality and health since 2004 (Duke University, n.d.). Enrollment in the program averaged 50-70 participants for the past few years. Although limited to 25 people, one-on-one individual mentorship sessions with the faculty of their choosing were provided for an additional cost. The focus of the course is on conducting research on religion, spirituality and health, and is most appropriate for those interested in developing an academic career in this field. The course is taught by qualified researchers from Duke, Yale, and Emory with a variety of

expertise in epidemiology, psychiatry, theology, medicine, nursing, chaplaincy, pastoral, and behavioral. The primary target group for the workshop includes established researchers, new investigators, and graduate students from a variety of disciplines ranging from medicine, nursing, psychology, sociology, chaplaincy, theology, counseling and public health.

George Washington University, George Washington Institute for Spirituality and Health (GWish) - Interprofessional Spiritual Care Education Curriculum (ISPEC).

GWish partnered with City of Hope and the Fetzer Institute to develop an interprofessional spiritual care training program (GWish, n.d.). It was first launched in the summer of 2018. One hundred participants from healthcare organizations from 23 US states, one US territory, and 12 different counties attended the program. In 2018, the program was held in Washington, D.C. but will be held in Honolulu, Hawaii in 2019. The three-day ISPEC program addresses the competency and training gap of healthcare providers in engaging patients' spirituality. The program seeks to build capacity through training and building leaders and clinicians that can guide other healthcare professionals in spiritual care. The program is taught by several faculties with backgrounds in medicine, public health, social work, nursing, counseling, and theology. Primary target groups are clinicians such as physicians, nurses, social workers, psychologist, and chaplains. The training is highly selective and requires the organization's team to include one clinician and one chaplain.

Wesley Theological Seminary, Heal the Sick, Health Minister Certificate

The health minister certificate through Wesley Theological Seminary addresses whole person health through a 22-hour course (Wesley Theological Seminary n.d.). It is offered in-person in Washington D.C. over two weekends (Friday and Saturday) and can also be taken

online (10 modules). The participants are limited to 30 people. Health ministers assist the congregation with creating an organized, healthy ministry and explore ways to help faith community members find the resources and services they need. Health ministers will learn personal and community asset mapping, active listening, theological reflection, and basic health education and networking skills. The curriculum is based on guidelines published in 2011 by Health Ministries Association's "The Health Minister Role: Guidelines and Foundational Curriculum Elements". Instructors for this certificate are Wesley Seminary faculty, professionals from hospitals and public health that serve as faith community leaders, faith community nurses and health ministry coordinators. The primary target group for this program can be anyone that is interested in faith and health and are looking to serve as health navigators, wellness coaches, health educators, health promoters, and outreach workers. The health minister certificate will allow them to be part of health and wellness ministry to organize, plan, and evaluate health ministry activities. The certificate serves as an introductory program and through the Heal the Sick, participants will have opportunities to connect with program alumni, have a supportive network, advanced leadership training to support growth and sustainment of their health ministry capacity.

The University of Chicago (Program on Medicine and Religion)

The program on medicine and religion is a collaboration between the School of Medicine and the Divinity School. It offers various opportunities for discourse in the intersection of medicine and religion (The University of Chicago n.d.). While they do not have recurring workshop curriculum, they offer workshop events that address different topics and issues to train and inform clinicians, chaplains and community members on the medicine and religion. One

workshop that was held in September 2018, addressed the issue of Islam and Biomedicine. The two-day and half event consisted of a networking dinner, symposium and workshop. The symposium addressed the relationship between Islam, metaphysics and biomedicine. Workshops addressed the ethical consideration for organ donation from Muslim context and Islamic perspective. The speakers who presented at the event were from academia, healthcare, and the Islamic seminary. The target population for the event was allied health professionals, Muslim leaders, Islamic scholars, social scientists, Islamic studies students, and anyone interested in biomedicine and religion.

Another initiative includes multidisciplinary workshop. It will be a two-day workshop on the "religious dimensions of healthcare delivery". The purpose of the workshop is to improve understanding of religious dimensions for health professionals to address patient's religious orientation and perspectives as well as resources available in the hospital for spiritual care. Target population is clinicians, chaplains, and health professionals. The workshop consists of panel presentation, discussions and skill building activities. Speakers range from hospital administrators, health professionals, and professors from theology schools.

Pittsburgh Mercy Hospital Foundations of Faith Community Nursing Course

Foundations of Faith Community Nursing course is 34-hour long course that is a four-day hybrid of in-person and online learning (Pittsburgh Mercy, n.d.). The primary target group for this program are registered nurses, health professionals, or anyone that is interested in faith and health and are looking to promote health, wellness, and spirituality in their faith communities, be involved in visitation ministry, and coordinating volunteers. The course covers roles of faith community nurse such as coordinating volunteers, developing support groups, health advocation,

health education, health counseling, and integration of faith. Instructors are qualified faith community nurses, and experts in the field. At the end of the course, registered nurses received a certificate of faith community nurse and layperson received a certificate of health minister.

Gaps in external benchmarks in relation to Emory's distinctive strengths

Two external benchmark programs addressed the faith of patients in the hospital setting, two programs promoted health through education and resources in community settings and one program focused on conducting research in religion and health. Four out of the five opportunities targeted two sectors: hospitals and faith communities. Four out of the five opportunities relied heavily on individual role or direct services. Emory provides learning that fosters partnerships with faith communities that extend beyond direct services. Networking opportunities with various sectors are a huge advantage of the program. The program is also beneficial to people in a variety of sectors including social work, faith, non-faith, hospitals, academia, government agencies, and public health. The social determinants of health framework provides an understanding of physical and social factors not addressed in other programs. Emory also provides various observational learning in local community organizations.

Summary of current problem and study relevance

The literature review of current frameworks, trends in public health and religion, and other competing programs provides support for religion as a promising model to address the social determinants of public health and a multisector partnerships. Healthy People 2020, From Vision to Action and PH 3.0 demonstrate efforts that address the social determinants of health also require multisector partnership. Multisector partnerships such as CI and HiAP are important to reduce silos, duplicate work and address health in all policy discussion and decisions. Public

health schools and workforce development organizations revised their competencies to address social determinants and multisector partnerships. A successful multisector partnership has the ability to engage with diverse sectors and populations. Diverse sectors and populations likely have cultural differences that require cultural humility and awareness. Systems thinking is a way to recognize different factors and relationships that impact health. Addressing social determinants of health to achieve health equity requires systems thinking skills to understand the complexity of these relationships and addressing the issues. This requires multiple sectors that can promote structural and policy interventions. Theology schools are also noticing the shift in vocational interests of students. Although theology schools do not yet have standardized competencies, various theology schools have found ways to address student needs through innovative programs to prepare their students with real-life experiences, cultural awareness, and social analysis. This literature review explores ways religion is a social determinant of public health, and ways Emory is leading this model. Emory's program and efforts highlight Emory's distinctive strength. Development of the Religion and Health program for professionals at this intersection is in process at Emory. The researcher explored external benchmarks to understand current gaps in non-degree program opportunities. It is important to ensure that what Emory has to offer addresses those gaps while also being coherent with current thinking in public health and faith communities. A needs assessment will guide the development of a more sought after and effective curriculum.

III. Methodology

The following section describes the population and sample, survey design, data collection, and analysis steps used to understand preferred learning structure, methods, competency needs, and topic interests for the religion and public health continuing education program planning.

Population and sample

The population sampled for the survey are professionals in the field of religion, community-based health programs, and public health. Target organizations in the field of religion, health, and public health were categorized into three groups: religious groups, health groups and a religion and health group. The religious or health groups are potential learners and leaders that can recognize the benefits of the knowledge to enhance their current work. The religion and health group was identified by the presence of religion and health programming and activities or an interest in the intersection of religion and health. This group represents a population that is already knowledgeable and committed to religion and health. These groups collectively were targeted to understand learning and capacity needs in their leadership practices informed by Emory's distinctive knowledge sources of *religion as a social determinant of public health*. Examples of these organizations include professional associations, membership organizations, foundations, government agencies, hospitals, educational institutions, humanitarian agencies, alumni listservs, and non-profit organizations. Twenty-three religious institutions, 30 religion and health organizations, 22 health organizations, five educational institutions, six humanitarian organizations, and one foundation were identified as target organizations.

Research design and procedures

A non-degree educational program's feasibility study was conducted in 2008 on interest in the religion and health intersection based on Emory's distinctive strengths and competencies in reproductive health and end of life issues. Since then, Emory's strengths and scholarship capacities continue to grow and can be applied to emerging contexts, trends, and priority issues using the new framework; *religion as a social determinant of public health*. A new needs assessment study considers Emory's current strengths, competencies, and framework as well as the trends, model and approaches in the present society outlined in literature review.

Dr. Mimi Kiser, the committee chair, provided guidance on organizations with relevant work in addition to connections to individuals with influence in organizations with networks. The researcher identified organization leaders as survey distributors, who then identified individuals as direct survey respondents. Utilizing the target database, the researcher created a contact list database of names and emails to invite participation in and distribution of surveys. The researcher organized email campaigns to deliver surveys to organization distributors and direct individuals utilizing SurveyGizmo and the contact list database. The researcher created distributor and direct respondent email campaigns separately in order to tailor content to the recipients. Email campaigns attempted to contact 125 distributors and 1,254 individuals. The number of surveys distributed through the distributors or whether distributors had distributed the survey is unknown. The researcher sent a direct reminder email a week following the initial survey invitation on March 8th to address limitations of the reach of SurveyGizmo due to spam filters and all addresses were blind copied. Additionally, the researcher contacted Interfaith Health Program site partners as direct respondents and snowball sampling was utilized to reach

respondents through a professional association listserv, School of Theology and School of Public Health Emory Alumni listservs, and public health workforce connections maintained by the Region IV Public Health Training Center. From the Candler school of Theology and Rollins School of Public Health, 11,157 alumni were identified. The alumni coordinator successfully delivered the survey invitation to 6,143 public health alums on March 16th, 2019. Records showed that 34% of the recipients opened the email of which 196 clicked the survey link. There were technical errors that delayed survey delivery to 4,741 alums from the school of theology. School of theology alumni were not included in the analysis because they did not receive the survey in time. Only the survey responses received from February 28th, 2019 to March 19th, 2019 were analyzed. Through Region IV Public Health Training Center, the survey was posted on the SOPHE national House of Delegates Community of Practice Forum which has around 50 people. The survey was also shared with Region IV American Public Health Association Chapter Affiliate contacts. On both postings, contacts were encouraged to share with their networks which includes state membership listservs. Whether or not contacts distributed the survey is unknown.

The researcher conducted the survey online, anonymously, through SurveyGizmo. The researcher developed an original 18 question survey to understand knowledge and leadership capacity needs and the desired environment for learning. The survey questionnaire is located in Appendix A. Respondents were asked about profession, factors contributing to motivation in non-degree education, desired learning environment, topics of interest, and desired competencies. Respondents had opportunities to elaborate on their answers and provide additional comments.

Data Analysis Plan

Researcher analyzed only the responses received between February 28th, 2019 and March 19th, 2019 in the report. Researcher analyzed quantitative data from the Survey Gizmo exported report and analysis tool. Researcher collected qualitative data through open responses. Quantitative data analysis included cross-tabulation analysis using excel pivot tables and frequency analysis. Qualitative open responses were thematically coded and analyzed using descriptive and comparative analysis. The researcher recognizes the limitation of analysis and possible implications from short open responses.

Ethical considerations

The researcher collected data using a secure, encrypted electronic platform, SurveyGizmo, with which Emory University has established a business associate agreement to ensure HIPAA (Health Insurance Portability and Accountability Act) compliance. For the purpose of this project, the researcher received permission from the Emory Center for AIDS Research (P30AI050409) to use their SurveyGizmo account. Study data collected through SurveyGizmo is maintained on a dedicated secure server, with no co-mingling of study data with other SurveyGizmo data, or between Emory University projects administered by SurveyGizmo. Because the program is intended only for internal program use and has no potentially harmful identifiable information, the IRB Review board determined that the project does not meet the definition of research with human subjects or clinical investigation.

Limitations and delimitations

The number of questions in a survey are constrained during survey design. The researcher identifies the questions and objectives when constructing the survey. As a result, respondents

may not be able to address questions that are important to them. Respondents cannot provide data in areas which the researcher does not address. There are limitations in analyzing open-ended responses due to variation in detail and scope. A brief response can simplify the complexity of the issues and context is then lost in translation. The researcher cannot control the respondents. While the relevant parties received the survey, survey completion is voluntary. Survey invitations shared by the distributors were not possible to track. Thus, the distributor's willingness and willingness of the individuals to complete the survey influenced respondent rate, which is beyond the control of the researcher. The technical error in delivering email to School of Theology alumni is a factor of the lower representation of religious leaders in the survey.

IV. Results

Respondents Demographics

The demographics of the survey participants summarized in Table 1 and 2 indicate that survey participants are representative of the targeted fields and settings. One hundred ninety-six participants completed the survey and of these professionals, 35% were public health professional, 18% were administrator or manager, 17% were educator or academic professional, 14% health professional and 5% were religious leader or chaplain. Most were working in educational institutions (21%) followed by hospitals (20%), government agencies (18%), non-profit organizations (14%), faith-based organizations (10%), and religious institutions (1%).

Table 1 - Frequency of survey participant's current profession

Positions	**Frequency (Percent)**
Chaplain	3 (2%)
Religious Leader	6 (3%)
Other	11 (6%)
Retired Professional	11 (6%)
Health Professional	27 (14%)
Educator or Academic Professional	34 (17%)
Administrator or Manager	36 (18%)
Public Health Professional	68 (35%)
Totals	**196 (100%)**

Table 2 – Frequency of survey participants' work settings

Work Setting	**Frequency (Percent)**
Religious Institution	2 (1%)
Retired Professional	10 (5%)
Other	18 (9%)
Faith-Based Organization	20 (10%)
Non-Profit Organization	28 (14%)
Government Agency	36 (18%)
Hospital/Health Care Facility	40 (20%)
Educational Institution	42 (21%)
Totals	**196 (100%)**

The respondents typically had some graduate work level education or higher (97%) with either a completed master's degree (57%) or doctorate (34%). Forty-seven percent of professionals have been working in their field for 11 or more years, 26% for four years and 21% less than four years. Eighty-one percent of the workforce focused their work in the U.S.

A variety of combinations of fields and work settings were identified (Table 3). Chaplain and religious leaders with a religious discipline background were working in faith-based organizations (56%), hospitals (22%) and religious institutions (22%). Public health and health professionals were working in government agencies (34%), hospitals (23%), and non-profit organizations (18%). Most academic professionals were in educational institutions (68%) and in hospitals (24%). Administrators or managers were in hospitals (33%), non-profit organizations (25%), and faith-based organizations (17%).

Table 3 – Distribution of professions by work setting

Positions	**Frequency (Percent)**
Chaplain and Religious Leaders	**9**
Faith Based Organization	5 (56%)
Hospital/Health Care	2 (22%)
Religious Institution	2 (22%)
Public Health and Health Professional	**95**
Government Agency	32 (34%)
Hospital/Health Care Facility	22 (23%)
Non-Profit Organization	17 (18%)
Educational Institute	11 (12%)
Faith-Based Organization	7 (7%)
*Other	6 (6%)
Education or Academic Professional	**34**
Educational Institution	23 (68%)
Hospital/Health Care Facility	8 (24%)
Faith-Based Organization	1 (3%)
Non-Profit Organization	1 (3%)
Other-Professional Association	1 (3%)

Administrator or Manager	**36**
Hospital/Health Care Facility	12 (33%)
Non-Profit Organization	9 (25%)
Faith Based Organization	6 (17%)
Educational Institution	5 (14%)
Government Agency	3 (8%)
Other - Consulting	1 (3%)
Totals	**174**

* Insurance (2), Undefined (2), Technology (1) and Unemployed (1)

Survey Results

The survey asked professionals to identify their learning preferences and motivation for attending a non-degree religion and public health program. Participants reported the following: expanding knowledge of the intersection of religion and public health (88%); developing skills for themselves (53%); and developing educational programs or curricula in educational institutions (39%) to be their primary motivations for attending the program. Table 4 provides further detail on their primary motivation.

Table 4 – Primary motivations for attending religion and public health educational programs

Primary Motivations	**Frequency (%)**
To expand my knowledge of the intersection of religion and public health	165 (88%)
To develop the skills for myself	100 (53%)
To develop educational programs or curricula in educational institutions	73 (39%)
To conduct research in this field	55 (29%)
To develop the skills of the staff I supervise	54 (29%)
To earn continuing education units (CEUs)	50 (27%)

The cost of participation (89%), presenters reputation and qualification (82%), located in the U.S (68%), and sponsored by an academic institution (71%) were very important or

important factors contributing to their attendance of non-degree religion as a social determinants of public health education programs (Table 5).

Table 5 -Factors contributing when considering non-degree religion as a social determinant of public health educational programs. (n=194)

Factors	**Very Important (n)**	**Important (n)**	**Very Important & Important (%)**
Cost of participation in the program (registration fees, lodging, travel and meals)	100	66	89%
Presenters and/or instructors are nationally (U.S.) or internationally-recognized experts in their fields	86	66	82%
Programs offered are located in the U.S.	82	44	68%
Sponsoring organization is an academic institution or center	58	71	71%
Sponsoring organization is a health-affiliated institution or center (e.g. hospital, CDC)	47	70	64%
Programs are offered online	51	60	59%
Programs are offered in one-day formats (In-Person)	37	63	54%
Programs are offered in multi-day formats (In-Person)	24	47	39%

A program that provides practical skills and tools that can be applied to their profession (94.3%), academic or intellectual stimulation (94.3%), opportunities for dialogues with presenters (92.2%), and dialogue with learners from other disciplines (90.2%) were very important and important factors to the participants (Table 6).

Table 6 -Factors contributing when considering non-degree religion as a social determinant of public health educational programs. (n=194)

Factors	**Very Important (n)**	**Important (n)**	**Very Important &**

			Important (%)
Programs offered provide practical skills and tools that can be applied in my profession	131	52	94.3%
Programs offered provide academic or intellectual stimulation	116	67	94.3%
Programs offered provide opportunities for dialogue and exchange with presenters and/or instructors	100	79	92.2%
Programs offered provide opportunities for dialogue and exchange with learners from other disciplines and/or religions	101	74	90.2%
Programs offered provide practical skills and tools that can be applied in my daily living	57	60	60.3%

The researcher asked the participants to rank topics based on their priority learning interests. The topic list includes Emory's distinctive strengths as well as relevant pressing issues in public health. Scores were weighted and ranked. Results indicate that participants were most interested in learning about mental health followed by social isolation and connectedness; community development, housing and employment; and nutrition and food systems. Detailed score distribution and ranking order is shown in Figure below (Figure 1).

Topic	Overall Rank	Rank Distribution	Score	No. of Rankings
Mental Health	1		1,070	175
Social Isolation and Connectedness	2		1,065	182
Community Development, Housing, Employment	3		879	171
Nutrition and Food Systems	4		805	169
Reproductive Health	5		796	171
Opioid Epidemic	6		703	173
HIV/AIDS in the U.S. Southeast	7		600	171
HIV/AIDS in Africa	8		486	171

Lowest Rank Highest Rank

Figure 1 – Priority learning interest topics ranked using weighted score calculation. Rank distribution shows distribution of topics ranked indicated with different color hues.

Researcher asked the participants to rank competencies that would be most valuable to them. Results indicate participants are most interested in competencies in diversity and culture awareness and identifying own bias followed by multisector partnership, systems thinking, and application of knowledge to leadership and professional practice. Figure 2 provides a detailed ranking and rank distribution of competencies (Figure 2).

Competencies	Overall Rank	Rank Distribution	Score	No. of Rankings
Develop awareness and ability to interact with both diverse individuals and communities and understanding of own cultural and religious biases and effects of those	1		764	185
Successfully build multi-sector partnership relationships based on a shared vision and commitments to community well-being	2		758	180
Develop systems thinking and social analysis skills: recognizing system level properties that result from dynamic interactions among human and social systems and understand how they affect the relationships	3		729	179
Integrate a more comprehensive understanding of religion as a social determinant of public health into my leadership and professional practice	4		710	179
Include a more comprehensive knowledge base of religion as a social determinant of public health into my teaching in an educational institution	5		430	168
Include a more comprehensive understanding of religion as a social determinant of public health in my research proposals or grant making	6		422	171

Lowest Rank Highest Rank

Figure 2 – Priority competencies ranking using weighted score calculation. Rank distribution shows distribution of topics ranked indicated with different color hues.

Competencies and topics stratified by profession and setting help understand the priority topic interest and competencies in each category. Five broad categories of profession are: religious leaders (Nμ =23) if they were chaplain or religious leader or worked in faith-based organization and religious institution; public health professionals (Nμ=62); public health administrators (Nμ=16) if they were administrator and worked in faith-based organization, non-

profit organization, or government agency; health care professionals (Nμ=45) if they were health care professionals or worked in hospital/health care facilities; and educators (Nμ=45) if they were educators or academic professionals or worked in academic institution. When they were stratified in these professions, mental health, social isolation and connectedness and community development, housing and employment consistently ranked high in each category. Public health professionals ranked reproductive health higher than many other issues while the others listed nutrition and food system to be of greater interest. In competency needs, building multisector partnerships and developing cultural awareness consistently ranked high in all five categories. Public health professionals and educators understood a greater need for developing systems thinking while religious leaders, health care professionals, and administrators placed greater importance on integrating religion as a social determinants of public health model in leadership and professional practice. Appendix B provides further details of the rankings (Appendix B).

The researcher asked the respondents to provide open responses to "How can an institute on religion as a social determinant of public health help you achieve your priority knowledge and skills goals?". From the 76 responses received, 47 expressed the benefit of gaining knowledge. Respondents identified knowledge as perspectives (18), different strategies to address challenges (17) and evidence-based information (10). In addition, other responses described other benefits to the program, namely networking opportunities (11), skill development (9), teaching or curriculum building (8), program development (7), advocacy skills (6), and research (5)

Priority Topics: Specific Learning Interests

In addition to ranking the specific topics, researcher asked the participants to provide an open-ended response describing specific learning interests related to the each of the eight topics

listed above. These priority topics and themes in each topic are presented below in rank order from most to least (Figure 1).

Respondents addressed stigma and contribution of personal faith and religion most frequently in the open-ended responses to mental health. Specific interests surrounding this topic were vulnerable groups, education, treatment, social support, prevention, the black church's role, access to resources and current strategies.

Specific interests related to social isolation and connectedness were community programs, strategies and support, role of religious institution, health impacts, mental health, individualism and role of social media, and stigma surrounding certain groups and individuals such as LGBTQ community, people living with HIV/AIDS, disabled and elderly.

For community development, housing and employment, many were interested in addressing disparity in neighborhoods and the need for equity. Examples of these issues are access to affordable housing, transportation, safe environment, and enhanced community facilities for those in low-income neighborhoods. Respondents reported special attention to the role of religious institutions, outcomes linked to health, and vulnerable populations such as minority communities, immigrants, low-income class, high risk for mental issues, and people living with HIV/AIDS. They also mentioned issues of discriminatory employment and developing employment opportunities and providing resources to address persons' own needs. Participants were also interested in current strategies, partnership opportunities, providing resource, and policy engagement.

In nutrition and food systems, participants expressed food insecurity and access to food to be a great concern. Respondents also mentioned learning interest in nutrition's impact on health;

role of religious institutions; current strategies; education; malnutrition; policy; general healthy diet; for specific health conditions; and prepping food at home.

In reproductive health, the themes included controversial issues of women's rights, religious norms, raising awareness, family planning, addressing stigma, policy engagement, ethics, and role of churches

Issues respondents were interested in learning around opioids are role of religious institutions, vulnerable groups, education, addressing stigma, current context, mental health, access to care, addressing health care system, problems with pharmacies and analogue drugs, and 12 step strategies.

Specific topic interests in HIV in Africa from the open-ended responses include current context about HIV in the world and Africa; strategies to address HIV; role of religious institutions; partnerships; awareness, education, prevention and treatment; stigma; and access to care. Respondents were curious about ways to support and contribute indirectly in Africa from the US. The researcher observed similar themes for HIV in the US (Southeast). Respondents frequently expressed interest in vulnerable groups; stigma; and patient support for people living with HIV in the US (Southeast).

Summary

In summary, represented in the survey results are a diverse array of professionals working in public health and religion. Primary motivations for participants to attend a continuing education program and preferred learning environment factors were identified. Motivations identified included: programs offering practical skills and tools that are applicable in their profession; programs offering academic or intellectual stimulation; programs offering

opportunities for dialogue and exchange with presenters and/or instructors; and programs offering opportunities for dialogue and exchange with learners from other disciplines and/or religions.

Mental health, social connectedness, and community development, housing, and employment consistently ranked most important regardless of stratified categories. Cultural awareness and building multisector partnership competencies were consistently ranked as most valuable across all participant professional categories.

The open-ended responses also provided context and an opportunity to elaborate their responses. Participants when asked "How can an institute on religion as a social determinant of public health help you achieve your priority knowledge and skills goals?" expressed the program would provide religion and health knowledge and perspectives, strategies and approaches, networking opportunities, and skill development. Religion and health knowledge and perspectives desired by the participants include evidence-based information between religion and health; interdisciplinary concepts; case studies of partnerships with faith communities; religion as a social determinant of health; impact of religion to behavioral changes; how religion can address health disparities, policy engagement efforts by faith community members; and religion and reproductive health. Strategies and approach interests included efforts in addressing religion and health in faith-based institutions, non-faith institutions, communities, congregations, hospitals, schools and corporate settings. Networking opportunities anticipated include engagement with professionals, educators, researchers from various social, religious, educational, discipline background that have common interests. Skill development identified were systems thinking, multisector partnerships, and monitoring and evaluating impact.

V- Discussion

A needs assessment study assessed what competencies the current workforce needed to engage religion and health sectors. The survey aimed to understand the most valuable competencies and priority topics of interest to the participants. Additionally, the survey sought to understand participants' preferred learning environments and motivations for attending a non-degree summer institute. Open-ended questions provided opportunities to elaborate on their responses to assist the RPHC development team in designing a summer institute and enhance program participant's experience

The methodology was undertaken to ensure representativeness of the survey respondents. Responses from religious leaders are considerably lower than the health leaders. However, other measures such as faith-based organizations alternatively suggest the presence of faith leaders among the respondents. Stratification by professional identity and setting demonstrate a somewhat larger representation of religious leaders and context in the survey.

Our survey revealed a high level of interest in gaining knowledge at the intersection of religion and health in the non-degree program. Knowledge of the intersection can include, current context, strategies, new perspectives, and evidence-supported facts. Respondents were also interested in networking opportunities with presenters and professionals, researchers across disciplines for partnerships. They hoped to apply their learning in developing their skills in partnerships, cultural awareness, measuring impact, teaching, advocacy, research, program development and curriculum development. Respondents were able to recognize and identify benefits and application of the program to their context.

Competencies in cultural awareness are necessary to build strong partnerships across sectors. The results showed considerably higher rankings of these two skills. Application of knowledge of religion as a social determinant of public health in teaching, conducting research, and policy engagement were significantly lower, suggesting other competencies were neither more valuable or practical to respondents. Yet, 39% of the responders were interested in educational programing and curriculum development suggesting that religion as a social determinant of public health model is an intriguing learning model. It is also evident that teaching, and policy engagement would appeal to specific subsets of professions that would be utilizing the skills. Respondents frequently mentioned education, awareness and prevention as well as policy engagement to be crucial content for topics indicating the importance and benefit of addressing these issues in the program. The researcher should identify ways to appeal to educators and policy activists as they play a crucial role in public health impact.

Eliminating stigma around mental health, opioid epidemic, HIV and reproductive health was a common theme. Discrimination and stigma are barriers to care. It is a multifaceted issue that requires unique interventions for diverse target groups and the general public at local, regional, and state levels. Public health professionals should spend adequate time in addressing stigma, particularly in religion or religious community context.

Another common theme articulated the importance of identifying vulnerable groups and those largely impacted by the issue. Often public health and religious groups are voices that advocate and care for the marginalized. Vulnerable groups identified include minorities, immigrants, refugees, people of color, elderly, LGBTQ, youth, women, disabled, mentally ill, poor, and people living with HIV or AIDS. Identification of vulnerable groups further provide

basis for cultural competencies, inclusion and diversity as well as the partnership. There is also greater appreciation for addressing social determinants of health and health equity considering what it could mean for those marginalized.

Thirdly, complex relationships surround religious norms and recognition of religion as both a health asset and barrier across topics. Respondents have identified the positive impacts as well as the harm done in the name of religion. Thus, the institute can facilitate a balanced view of the role of religion in health. It might be easy to see only the negative side of religion and dismiss or overlook the potential partnership. It can be equally problematic to understand only the positive contributions of religion while not addressing areas of concern. Reproductive health is an example that represents controversy and tension surrounding woman's rights, religious belief and norms, ethics, and family planning. There is recognition of religion in this context but a considerable lack of focused efforts to address other pressing reproductive health concerns beyond prolife and prochoice. This suggests both the importance of the topic but also the possibility that the dispute and heated discussion could potentially distract and hinder respondents from identifying and addressing other important reproductive health concerns.

Great interest in mental health, and social connectedness and isolation indicate the apparent need in addressing mental health in communities through social connectedness and recognition that personal belief, religion and the role of religious institutions play a significant role in mental health and social connectedness. At times mental health has a larger impact on a person's life than physical health. The respondents were able to identify the invisible yet prevalent condition in our society. Respondents identified the black church as having a significant role and awareness of their role and potential in community impact. The interest in

the role of black churches align with current trends. A recent publication recognized the role of black churches and partnership opportunities in public health (Brewster and Williams, 2019). Research also reveals that African Americans were more likely to turn to clergy than to formal mental health services in times of emotional distress (Brewster and Williams, 2018). While many faith leaders lack formal training and are less equipped to appropriately address such services, some African American religious services "embody the therapeutic elements that are present in psychiatric therapy" (Brewster and Williams, 2019).

Equity and health disparity can be seen in Community Development, Housing and Employment. Nutrition and Food Systems perhaps is an example of this health disparity in the community indicated by food insecurity and food deserts. There were implications for inequity based on socioeconomic conditions. Community development then must entail movement towards equity through addressing social determinants of health. The World Health Organization Global Commission on the Social Determinants of Health supports with evidence that addressing social determinants of health is a way to achieve health equity (WHO, 2010).

The opioid epidemic and HIV fell behind other topics in priority by the respondents. Professionals not engaged in these issues in their workplace may not have as strong of an application or did not find benefit in attending an institute on topics distant from their focal work. Conversely, other priority topics have encompassed issues surrounding opioid use and HIV. There is an overlap with opioid use and community development, mental health and health equity. There are opportunities to explore HIV in the context of mental health, social connectedness and reproductive health. This should not dissuade the program from addressing these crucial issues in the summer institute. The rise of the opioid epidemic and HIV in the

southeast US and Africa are very critical and relevant issues in current society. In 2016, 66.4% of 63,632 drug overdoses were due to opioid use (Scholl, Seth, Karissa and Wilson,2018). In 2017, overdose deaths have increased across age and race. Age-adjusted overdose deaths increased by 9.6% from 2016 in the US (Scholl et.al., 2018). According to the CDC report in 2016, 44% of all people living with an HIV diagnosis in the US were from southern states (Scholl et.al. ,2018). In 2014 African Americans account for 54% of new HIV diagnoses in the southern states, of which 59% were black men who have sex with men (Scholl et.al, 2018). As HIV and the opioid crisis are prevalent in the society, innovative ways of approach the pressing issue can attract professionals in the intersect.

VI- Recommendations

There are clear benefits for Emory to implement a summer institute addressing religion as a social determinant of public health. Addressing social determinants of health is increasingly emphasized in public health. Successful interventions that address social determinants of health require partnership with multi-sectors. Engaging the faith community is an area that has been overlooked in the past. Student interest in theological backgrounds has shifted from local pastoral ministries to broader ranges of leadership in justice and social issues. Theological schools are providing innovative programs to tailor to student interest and in preparation of real-world challenges. Considering this, a curriculum centered on religion as a social determinant of public health provides a unique learning opportunity that other academic institutions do not provide. Emory has distinctive strengths in interdisciplinary knowledge in religion and health with expert faculty. The future program will address gaps in collaborative leadership skills among religion and health professions to effectively address challenging health inequities found in the social environment.

Overall the respondents were very positive about the program and acknowledged the importance of the program to their professional development. Based on the findings from the needs assessments, the following are recommendations for further information gathering and to be considered for institute design and planning:

Representation in Needs Assessment Data

One-hundred ninety-six respondents have completed the survey. The researcher was successful in identifying organizations and individuals to complete the survey. A significant number of professionals from hospital, public health, educators, and administrators responded to

the survey. There was, however, a lack of representation from the religious leaders. Based on these findings, recommendation are as follows:

- Focused effort in coordinating distributing surveys to religious leaders.
- Collecting more surveys from religious leaders to ensure representativeness of the survey sample
- Analyzing and comparing current data with new data comprising more responses from religious leaders

Optimum Learning Environment

In decision making, the learner's perception is but one point of reference and is inadequate to provide the whole context. Even among learner's interest, there exists competing factors that shape the learning environment. Based on these findings, recommendations are as follows:

- While many of the learners would prefer online learning, there are a limitation to online learning.
- In online learning, the cost of the program may be satisfactory to the learners, but it may not be cost efficient. Learners will have less of an opportunity to engage with presenters and other professionals from different sectors.
- Emory should offer the program on campus considering that a majority of respondents hoping to have dialogue and network with others. After an initial on campus institute, hosting them through distance learning in the future could be considered.
- Learners also placed importance on presenters and institutions. Credible scholars should be recruited to present at the institute.

- The institute should target learners in the US considering the cost of attending the program outside the US and availability of funding.
- Networking opportunities with professionals, educators, researchers in various fields with common interest should be included in the summer institute

Competency Priorities

In curriculum design, the summer institute should consider respondent competency interests and needs. Based on the literature review, there was not any standardized competency model for religious leader education. There is also not a competency model for the intersection of religion and public health. Needs assessment provides potential learners competency priorities and needs. Based on these findings, recommendations are as follows:

- Examining different comparable models and surveying potential learners revealed that cultural competencies, system thinking, measuring impact, context-based learning, multisector partnership, knowledge and perspectives are important skills.
- Case studies and strategies for ways faith-based institution, non-faith institution, congregations, and communities can engage religion and health should be included in the curriculum.
- In-depth interviews and focus group discussions will provide a deeper understanding of competencies needed considering the lack of competency model in theological discipline.
- There is a lack of representation from the religious leaders that can be informative of what competencies they would like to learn from the program.

Priority Content Topics

Emory's distinctive strength and position to address topics and current pressing issues influence the topic explored in the curriculum. Topic interests of potential learners should also be accounted for during curriculum design. Respondents have identified in this order mental health, social isolation and connectedness; and community development, housing and employment to be their top three priority topics. Open-ended responses provide content interest for each topic. Recommendations based on these findings are:

1. **Mental health**

- The curriculum should include stigma as a barrier to mental health care and ways to destigmatize people with mental health issues.
- The curriculum should explore the relationship between personal faith and religion to mental health.
- The curriculum should recognize mental health issues in different vulnerable groups such as: women, youth, people living with HIV/AIDS, black, youth, incarcerated, homeless and clergy.

2. **Social isolation and connectedness**

- The curriculum should address programs and strategies that support community integration and connection.
- The curriculum should explore the role of religious institutions.
- The curriculum should recognize the physical health impact and outcome of social isolation as well as mental health.
- Further understanding and exploring the role of social media and individualism to community disintegration.

- Recognize the particularly vulnerable groups and stigma surrounding groups such as LGBTQ, people living with HIV/AIDS, disabled and elderly.

3. Community development, housing, and employment

- The curriculum should address disparities (housing, transportation, safe environment, employment, community facilities, access to healthy food) that exist in communities based on their neighborhoods and strategies to address disparity.
- The curriculum should explore how these disparities (housing, transportation, safe environment, employment, community facilities, access to healthy food) that exist in communities impact the health of individuals living in these communities.
- The curriculum should explore the role of religious institution in addressing these disparities and needs in communities.

General remarks

- The curriculum should address religious norms and stigma that potentially hinder public health.
- The curriculum should provide a balanced view of the role of religion and impact that includes the understanding of complex relationships surrounding religious norms and recognition of religion as both a health asset and barrier across topics.
- Pressing issues such as opioid use and HIV are topics that can still appeal to specific populations and groups despite lower response. These topics are viable options to address pressing issues of our time.
- Emory's plan to invite partner organizations, provide a panel and reflection-learning site visits are ways learners can experience real world challenges. Panel and reflection

learning site incorporates theological education models such as ministerial reflection, culture immersion in and context-based learning.

- The survey actually began a marketing campaign. Thus respondents reached through the needs assessment should be the priority targets in the initial program marketing efforts.

Other Considerations

Other factors to consider in initiating and maintaining the program relevant for the summer institute are marketing strategies, identification of community partners and expert faculty, and evaluation of the curriculum and institute revision post-program.

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Appendix A: Religion and Public Health Summer Institute Interest Survey

Religion and Public Health Summer Institute

Religion and Public Health Summer Institute Interest Survey

The Religion and Public Health Collaborative at Emory University is planning a continuing education program for practitioners in the fields of religion and public health. We want to learn what kinds of new knowledge and practices would be most useful to you. For leaders like you, committed to the health and well-being of communities, we are seeing an increasing need for capacities that require new understanding and skills for collaborating in the public square. Building on Emory's distinctive strengths in *religion as a social determinant of public health*, we anticipate holding summer institutes that are constructed around this framework with each institute focusing on a singular priority issue.

Please take some time to share with us your preferences and needs on learning this framework and applying it to address issues of importance to you, your leadership, and your community. The survey will take approximately 15 minutes.

Your responses are voluntary and will be confidential. Responses will not be identified by individual. All responses will be compiled together and analyzed as a group.

If you have any questions, please contact Stephen Kim, project coordinator, at stephen.seungkwon.kim@emory.edu

Thank you very much for contributing to this work.

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1) Which of the following best describes your current professional status? Please select the ONE that fits best. *

( ) Administrator or Manager

( ) Chaplain

( ) Educator or Academic Professional

( ) Healthcare Professional

( ) Public Health Professional

( ) Religious Leader

( ) Retired Professional: _____

( ) Other: _____

2) Number of years in your current profession. *

( ) Less than 4

( ) 4 to 10

( ) 11 or more

( ) Retired

3) Which of the following best describes your place of work? Please select the ONE that fits best. *

( ) Educational Institution

( ) Faith Based Organization

( ) Government Agency

( ) Hospital/Health Care Facility

( ) Non-Profit Organization (Non-faith)

( ) Religious Institution

( ) Retired Professional: _____

( ) Other: _____

4) Please indicate the geographic focus of your work. *

( ) Primarily in the U.S.

( ) Primarily outside the U.S.

5) Please indicate your highest completed level of education. Please select only ONE. *

( ) High School Diploma(Secondary Equivalent)

( ) Associate (Two-year post-secondary) degree

( ) Undergraduate (Four-year post-secondary) degree

( ) Some Graduate level work

( ) Masters degree

( ) Doctorate degree

6) What would be your primary motivation(s) for attending religion and public health educational programs? Select ALL that apply.

[ ] To earn continuing education units (CEUs)

[ ] To expand my knowledge of the intersection of religion and public health

[ ] To develop the skills for myself

[ ] To develop the skills of the staff I supervise

[ ] To conduct research in this field

[ ] To develop educational programs or curricula in educational institutions

[ ] Other: _____

7) When considering non-degree *religion as a social determinant of public health* educational programs, how important are the following to you?

	Very Important	**Important**	**Neutral**	**Slightly Important**	**Not Important**
Programs offered provide practical skills and tools that can be applied in my profession	( )	( )	( )	( )	( )
Programs offered provide practical skills and tools that can be applied in my daily living	( )	( )	( )	( )	( )
Programs offered provide academic or intellectual stimulation	( )	( )	( )	( )	( )
Programs offered provide opportunities for dialogue and exchange with presenters and/or instructors	( )	( )	( )	( )	( )
Programs offered provide opportunities for dialogue and exchange with learners from other disciplines and/or religions	( )	( )	( )	( )	( )

8) When considering non-degree *religion as a social determinant of public health* educational programs, how important are the following to you?

	Very Important	**Important**	**Neutral**	**Slightly Important**	**Not Important**
Sponsoring organization is an academic institution or center	( )	( )	( )	( )	( )
Sponsoring organization is a health-affiliated institution or center (e.g. hospital, CDC)	( )	( )	( )	( )	( )
Presenters and/or instructors are nationally (U.S.) or internationally-recognized experts in their fields	( )	( )	( )	( )	( )
Cost of participation in the program (registration fees, lodging, travel and meals)	( )	( )	( )	( )	( )
Programs are offered in one-day formats (In-Person)	( )	( )	( )	( )	( )

Programs are offered in multi-day formats (In-Person)	( )	( )	( )	( )	( )
Programs are offered online	( )	( )	( )	( )	( )
Programs offered are located in the U.S.	( )	( )	( )	( )	( )

9) The conceptual foundation of the curriculum will be centered on *religion as a social determinant of public health* to achieve health equity. We believe that understanding religion as a social determinant of public health provides a useful framework to fully examine how religion is present in organizations, leadership, and communities. This further understanding can inform how public health can effectively align its efforts to address priority issues listed below.

There will be multiple institutes. Each institute will focus on a different topic using the *religion as a social determinant of health* framework. Please RANK the following topics based on your priority learning interests, "1" being the most important to you.

_____Community Development, Housing, Employment

_____HIV/AIDS in Africa

_____HIV/AIDS in the U.S. Southeast

_____Mental Health

_____Nutrition and Food Systems

_____Opioid Epidemic

_____Reproductive Health

_____Social Isolation and Connectedness

10) Please provide more details about your specific learning interests related to each of the topics listed.

Community Development, Housing and Employment: _____

HIV/AIDS in Africa: _____

HIV/AIDS in the U.S. Southeast: _____

Mental Health: _____

Nutrition and Food System: _____

Opioid Epidemic: _____

Reproductive Health: _____

Social Isolation and Connectedness: _____

11) Of the following competencies below, please RANK them in order of what would be most valuable to you as a participant. "1" being the most important to you.

_____Integrate a more comprehensive understanding of religion as a social determinant of public health into my **leadership and professional practice**

_____Include a more comprehensive knowledge base of religion as a social determinant of public health into my **teaching in an educational institution**

_____Include a more comprehensive understanding of religion as a social determinant of public health in my **research proposals or grant making**

_____Successfully build multisector partnership **relationships based on a shared vision and commitments to community well-being**

_____Develop **systems thinking and social analysis skills**: recognizing system level properties that result from dynamic interactions among human and social systems and understand how they affect the relationships

_____Develop awareness and ability to **interact with both diverse individuals and communities** and **understanding of own cultural and religious biases** and effects of those

12) In what context(s) or setting(s) do you hope to apply knowledge and skills gained from institutes on *religion as a social determinant of public health*?

_____

_____

_____

_____

13) What other topics would you like to see addressed in an institute that focuses on *religion as a social determinant of public health*?

_____
_____
_____
_____

14) How can institutes on *religion as social determinant of public health* help you achieve your priority knowledge and skills goals?

_____
_____
_____
_____

15) How do you prefer to learn about educational program opportunities?

( ) Email

( ) Direct mail

( ) Advertisement in professional publications

( ) Other: _____

16) How did you receive this survey?

( ) Sent to me directly by Emory University contact

( ) Forwarded to me by a non-Emory University colleague

17) Do you have any additional comments you would like to share?

_____

18) Please provide contact information (optional) if you would like to be contacted about future programs.

Name: _____

Email Address: _____

Organization: _____

Position Title: _____

Thank You

Thank you very much for taking the time to complete this survey. Your participation is very important to us and will contribute to our analysis and curricula design so that we can best address the needs of professionals like you in our summer institute.

If you have any further questions, please contact Stephen Kim, project coordinator, at stephen.seungkwon.kim@emory.edu.

Many thanks,
Religion and Public Health Collaborative Institute Planning Team

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Appendix B. Competencies and Priority Interest Topic ranked and stratified		
Category	**Competencies Rank**	**Topic Rank**
Religious Leaders (Nμ=23) **IF:** ○ Chaplain ○ Religious Leaders **OR work in:** ○ Faith-based organization ○ Religious institution.	1) Integrate more comprehensive understanding of religion as a social determinant of public health into leadership and professional practice 2) Develop awareness and ability to interact with both diverse individuals and communities and understanding of own cultural and religious biases and effects of those 3) Successfully build multisector partnership relationships based on shared vision and commitments to community well-being	1) Mental Health 2) Social Isolation and Connectedness 3) Nutrition and Food System 4) Community Development, housing and employment.
Public Health Professionals (Nμ=62) **IF:** ○ Public Health Professional	1) Successfully build multisector partnership relationships based on shared vision and commitments to community well-being 2) Develop systems thinking and social analysis skills: recognizing system level properties that result from dynamic interaction among human and social systems and understand how they affect the relationships 3) Develop awareness and ability to interact with both diverse individuals and communities and understanding of own cultural and religious biases and effects of those	1) Mental Health 2) Reproductive Health 3) Community Development, housing and employment. 4) Social Isolation and Connectedness

Health Care Professionals (Nμ =45) **IF:** ○ Health Care professional **OR work in:** ○ Hospital /Health Care facilities	1) Integrate more comprehensive understanding of religion as a social determinant of public health into leadership and professional practice 2) Develop awareness and ability to interact with both diverse individuals and communities and understanding of own cultural and religious biases and effects of those 3) Successfully build multisector partnership relationships based on shared vision and commitments to community well-being	1) Mental Health 2) Social Isolation and Connectedness 3) Community Development, housing and employment. 4) Nutrition and Food System
Educator (Nμ = 45) **IF:** ○ Educator or Academic Professional **OR work in:** ○ Academic Institution	1) Successfully build multisector partnership relationships based on shared vision and commitments to community well-being 2) Develop awareness and ability to interact with both diverse individuals and communities and understanding of own cultural and religious biases and effects of those 3) Develop systems thinking and social analysis skills: recognizing system level properties that result from dynamic interaction among human and social systems and understand how they affect the relationships	1) Social Isolation and Connectedness 2) Mental Health 3) Community Development, housing and employment. 4) Nutrition and Food System

Public Health Administrator (Nμ= 16) **IF:** ○ Administrator **OR work in:** ○ Faith-Based Organization ○ Non-Profit Organization (Non-faith) ○ Government Agency	1) Integrate more comprehensive understanding of religion as a social determinant of public health into leadership and professional practice 2) Successfully build multisector partnership relationships based on shared vision and commitments to community well-being 3) Develop awareness and ability to interact with both diverse individuals and communities and understanding of own cultural and religious biases and effects of those	1) Social Isolation and Connectedness 2) Mental Health 3) Community Development, housing and employment. 4) Reproductive Health