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FAITH

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FAITH DOMAIN AS SOCIAL IMMUNE SYSTEM: RECOMMENDATIONS FOR RESPONSE AND RECOVERY

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NOTE: Figures available at the end of the Springboard document

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by Gary Gunderson and Teresa Cutts

THINKING LIKE A VIRUS

A pandemic forces us to look for our social immune system protecting life of the social body. A virus moves without emotion to exploit social weaknesses. Humans, in contrast, are emotional, guided as much by our webs of meaning as we are by cold logic. Some of the most lamentable infection hotspots have been churches. And Spirit makes us resilient, so some of the most creative community scale partnerships are animated by networks of faith.

There is a long history of research and practice linking public health and faith relevant to the recovery from COVID-19. We can see the opportunity through seven questions:

- What do we mean by "faith" as our social immune system?
- What are the strengths of the social unit of faith that pertain to public health?
- What are the "religious health assets," that have helped the Centers for Disease Control (CDC) as well as World Health Organization (WHO), USAID, Bill & Melinda Gates Foundation (Gates), and NAS-Roundtable imagine substantive, appropriate and sustained partnerships in diverse contexts across many presenting conditions?
- How has COVID-19 affected these faith assets?
- How might the CDC frame a comprehensive recovery strategy including faith-based assets in an appropriate and sustained manner to move us toward the Healthy People 2030 goals? (These recommendations focus on leadership capacity to weave from both sides.)
- What should we NOT do in a pandemic and recovery period?

FAITH AS IMMUNE SYSTEM

Long before the chaos of COVID-19, Joshua Cooper Ramo, a health economist from the Kissinger Associates, wrote a pre-sentient book, *The Age of the Unthinkable*.[1] Ramo outlined how entities as diverse as terrorist groups or public health practitioners in Durban, South Africa, were learning how to adapt to a chaotic, post-modern world in which all the traditional behaviors of the structures of economy, health, climate, church, business and more, were no longer adequate. Ramo suggested we think more like the immune system which swarms to the locus of pain to galvanize healing. Faith-based organizations are often involved in community efforts, but usually understood as free help or cheap delivery systems. What if faith communities are part of our immune system?

Once, immune cells were thought to be concentrated in the thymus, lymph nodes, and spleen, moving only when an injury or infection occurred.[2] Actually, immune system cells are in every organ system of the body, particularly the gastrointestinal tract and what is often disparagingly termed "vestigial organs" (e.g., the appendix and tonsils).[3] Faith appears vestigial, too; showing great value in crisis.

Faith communities are visible in natural disasters such as Hurricane Katrina or COVID-19 as well as unnatural ones such as mass shootings. In Katrina, faith communities (and Wal-Mart) cut through red tape, showed up with water and food within hours, swarming like immune cells

1 Ramo, Joshua Cooper. The Age of the Unthinkable: Why the New World Disorder Constantly Surprises Us and What We Can Do about It. New York: Little Brown and Company; 2009

2 Parkin, J, Cohen B. An overview of the immune system. Lancet. 2001; 357 (9270): 1777-1789.

3 oij IA, Sahami S, Meijer SL, Buskens CJ, Te Velde AA. The immunology of the vermiform appendix: a review of the literature. Clin Exp Immunol. 2016; 186(1):1.9. doi:10.1111/cei.12821.

to meet the basic needs of the body of New Orleans and the overlooked towns on the Gulf. They were ready for the unthinkable.

Often, we find that the smallest congregations are *already* where the pain is located, in places big structures aren't nimble enough to reach. In Winston Salem, NC, we found no response from big churches when a man (with no local family) was discharged from the hospital after surgery and needed meals. A 12-member church provided three meals a day to this stranger for weeks.

Faith assets, like an immune system, are interconnected in mysteriously effective ways that allow quick delivery of resources, information, and more. This is not always ideal medicine, but even a casserole keeps the social muscle connected to more specialized help.

WHAT IS THE FAITH DOMAIN?

What do we mean by the "faith domain?" Not everyone uses the terms "faith," "religion," or "spirituality" in the same way, which makes precise analysis of the role of faith frustrating, especially to scientists.[4] The literature and language of the major traditions predate democracy and germ theory. Each tradition has its distinctive differences and commonalities, all visible in the 21st century United States which remains particularly religious, as industrialized Western nations go.[5] In recent years we have seen a regression to the historic baseline of lower active participation, including the rise of "nones," who claim no religious affiliation, but sharp civic values.[6]

The faith "immune cell" is its own social structure—the faith-forming entity, usually called congregations. These 331,000 entities[7] are linked in a complex system of hundreds of formal and informal networks. Some share a common theology, as well as training and credentialing of leaders. These social nodes often create other structures pertinent to the social determinants of health as well as clinical assets. The largest portion of private health care was founded by faith entities, as were a large portion of the "human service" domain addressed elsewhere in this Springboard.

Whenever faith can thrive in concert with the best scientific evidence, the combination is powerful in the service of human flourishing. People of faith create institutions intended to harness science for good. These institutions often grow to dwarf the congregations as they become woven into the government and insurance systems.

Faith networks a century ago created the politics that made public health possible. They viewed public health science as a gift to serve the mission of mercy and compassion, albeit sometimes with paternalistic overtones. It would be the rare public health department whose initial founding meeting was not opened in prayer with clergy on the Board.

RELIGIOUS HEALTH ASSETS

The modern history of public health and faith traces to the CDC's 1984 "Closing the Gap" conference, which focused on how much of the burden of premature death could be prevented with existing knowledge in the hands of civil society.[8] This resulted in the creation of the Interfaith Health Program of The Carter Center, which initiated the concept of "religious health assets" at another CDC conference, Strong Partners in 1992.[9] The language was borrowed by the WHO in 2005 responding to the HIV/AIDS pandemic.[10] They contracted with researchers of The Carter Center and the University of Cape Town to form the Africa Religious Health Assets Program (ARHAP), eventually with other funding from the CDC, Gates, and the World Bank. Practices built on

4 Koenig HG, King DE, Carson VB. Handbook of Religion and Health (Oxford Univ Press, Oxford), 2nd Ed.; 2012.
5 Eck D. A New Religious America: How a Christian Country Has Become the World's Most Religiously Diverse Nation. San Francisco: Harper San Francisco; 2001
6 Pew Research Center, Oct. 17, 2019, "In U.S., Decline of Christianity Continues at Rapid Pace." Retrieved June 4, 2020 from https://www.pewforum.org/2019/10/17/in-u-s-decline-of-christianity-continues-at-rapid-pace/
7 Hadaway CK, Marler PL. How many Americans attend worship each week? An alternative approach to measurement. Journal for the Scientific Study of Religion, Sept. 2005; 44(3): 307-322.
8 Foege W, Amler RW, White CC. Closing the Gap: Report of the Carter Center Health Policy Consultation. JAMA. 1985;254(10):1355-1358. doi:10.1001/jama.1985.03360100105023
9 Gunderson GR. Strong Partners: Realigning Religious Health Assets for Community Health. Atlanta: The Carter Center; 1997.
10 ARHAP. Appreciating assets: the contribution of religion to universal access in Africa.Report for the World Health Organization by the African Religious Health Assets Programme, Cape Town, 2006.

this foundation in Memphis are recognized by the Agency for Healthcare Research and Quality (ARHQ)[11] and CDC as validated models for Community Benefit planning. Stakeholder Health is a group of health care systems (mostly faith-founded) focused on adapting this logic to many U.S. communities including, of course, North Carolina.[12] A broad professional literature has emerged.

STRENGTHS OF CONGREGATIONS

The social structures of faith have strengths on which cross-cutting public health programs can be built.[13] The strengths are of the social unit, not just the clergy leadership.

The first strength is to *Accompany*. Even six feet apart, congregations create roles and practices of relationship beyond bonds of blood, commerce, and politics. They *Convene* people around the urgent prevention opportunity, such as wearing a mask. They *Connect* not only by talking to clergy, but many lay people of influence in business and civic life beyond their own self-interest. They develop a community *Narrative* or *Story* for new knowledge that helps people find their role. They do not have any command power, but do have the strength to *Bless*. They reverse blaming in favor of sustained recovery, be it from dependency on substances or the long slow slog to reconstruct an economy. They create *Sanctuary* for song, tears and hard conversations, and programs such as testing. They do *Pray* and help create civic rituals tapping the roots of common purpose. Finally, they have a long view based on the strength to *Endure* and lend strength to the communities that need to rebuild their life.

These strengths function within public health strategy as community assets, not just inside the religious group. The Winston-Salem Masking the City movement created masks for the whole city. They were woven, distributed, and promoted with a seamless partnership of business, health, government and, at the very center, faith networks modeling all of the eight strengths.[14]

THE LEADING CAUSES OF LIFE

Faith groups commonly use an integrative framework for health as bio-psycho-social-spiritual. This term traces to a World Council of Churches consortium on Mental Health and Faith, held in Vellore, India in December 2007. [15] The participants focused on integrating mental health into the existing faith structures and ministries. Faith communities of the United States invented the first mental health facilities, just as they did hundreds of hospitals and social service organizations. The four-fold model integrated medical and mental health providers with community-based trainers, peer supporters, community health workers, and into the congregations practice.

The movement within faith communities toward a fully integrated model of health led to the development of the Leading Causes of Life (LCL).[16]

The ideas of LCL resonate with studies of the long-term nature of the social bruising that many have in early childhood known as Adverse Childhood Experiences (ACES).[17] Long term patterns of diseases and disability reflect the damage to our human capacities to nurture and care for each other, planting weakness at our greatest strength.

Like the concept of well-being, LCL cuts across disciplines and domains. In doing so, it helps us see the most important thing: what we have to work with. The causes are:

Connection

The ways people live "a thick weave of relationships" that can build and support trust. For children experiencing

11 Agency for Healthcare Research and Quality. US Department of Health and Human Services. Church-health system partnership facilitates transitions from hospital to home for urban, low- income African Americans, reducing mortality, utilization, and costs. Agency for Healthcare and Research and Quality website. Available at: https://innovations.ahrq.gov/profiles/church-health-system-partnership-facilitates-transitions-hospital-home-urban-low-income. Accessed September 17, 2018.
12 Cutts T, Cochrane JR, eds. Stakeholder Health: Insights from New Systems of Health. Winston Salem, NC: FaithHealth Innovations; 2016.
13 Gunderson GR. Deeply Woven Roots: Improving the Quality of Life in Your Community. Minneapolis: Augsberg Fortress Press; 1997.
14 National Academies of Science Action Collaborative on Business Engagement in Building Healthy Communities. Webinar: A Conversation about Employer COVID-19 Issues and Emerging Opportunities, May 22, 2020. Available at https://www.nationalacademies.org/event/05-22-2020/collaborative-webinar-a-conversation-about-employer-covid19-issues-and-emerging-opportunities
15 World Council of Churches. Consultation on Mental Health Faith Communities. Vellore India: Christian Medical College. Available at www.arhap.uct.za.
16 Gunderson GR with Pray L. Leading Causes of Life: Five Fundamental Ways to Change the Way You Live Your Life. Nashville, Abingdon Press; 2009.
17 Burke Harris N. The Deepest Well: Healing the Long-Term Effects of Childhood Adversity. Boston: Mariner Books; 2018.

ACES, any stable relationship with a teacher, a neighbor or health provider who cares and understands the child's triggers for acting out when exposed to toxic stress can mitigate impacts of ACES in later life.[18]

Coherence

The meaning and purpose in life held narratives. Post-traumatic growth syndrome is a phenomenon in which persons grow stronger after trauma,[19] as they craft their own story of healing (coherence), claim their sense of control (agency) and embrace the challenge of illness or problems as an opportunity for growth.

Agency

The "human capacity to choose and to do." Self-efficacy is the belief that a person can make a difference in their circumstances, with a sense of control.[20] The root of resiliency, doing something, even in limits, improves depression and anxiety.

Inter-generativity or Blessing

How we sense our relationship to those who have come before, after, and those with whom we share our life journey. Psycho-neuro-immunology shows how our immune system function can be impacted by every encounter with others enhancing both physical and mental health.[21] In several studies,[22] visiting and caring for others decreased loneliness, depression and improved immune system functioning in the lonely person and the visitor.

Hope

The positive orientation toward the future, not just optimism about personal medical outcomes. Study after study shows better cancer, cardiac, and surgical treatment outcomes and improved anxiety and depression levels in those with higher levels of optimism and hope.[23] Hope enables us to continue our life, work, and relationships, even in adversity.

The Leading Causes of Life are most relevant in the context of those traumas we inappropriately call "mental" or "psychological." Like ACEs, the LCLs do not recognize the unhelpful distinction between mental and physical and social wounds. Very recent work links LCL with the toolbox of Positive Deviance to develop community-based programming perfectly tuned to the recovery phase.[24]

VITAL SIGNS OF THE FAITH DOMAIN

Faith communities in the United States make a large contribution to the well being of the communities. Many of the activities related to healthcare, education, and social services amount to $378 billion annually.[25] These include providing support groups, volunteers, food pantries, housing, health clinics, day care, after school tutoring, and more.

Many of these derivative health-related organizations manage even larger endowments and reserve funds. While the operating budgets are subject to Community Benefiting, the endowments are rarely seen as assets to be held accountable for community health. Many hospitals are just beginning to consider investing in housing voluntarily. The CDC recovery plan could bring these assets into view and thus potential alignment. Faith leadership (if not management) would welcome this.

Harder to quantify, but just as valuable, are the ways faith communities weave and maintain the relational webs within every community. Members worship, but also run businesses, teach in schools, work in the health and health care sector, serve in the civic service, and hold office. Faith communities are one of the few places left where

18 Burke Harris N. The Deepest Well: Healing the Long-Term Effects of Childhood Adversity. Boston: Mariner Books; 2018.
19 Tedeschi RG, Shakespeare-Finch J, Taku K, Calhoun LG. Posttraumatic Growth: Theory, Research and Applications. New York, NY: Routledge; 2018.
20 Bandura A. Self-efficacy mechanism in human agency. American Psychologist. 1982; 37 (2): 122–147.
21 Kiecolt-Glaser JK. Psychoneuroimmunology: Psychology's Gateway to the Biomedical Future. Perspect Psychol Sci. 2009;4(4):367- 369. doi:10.11 11/j.1745-6924.2009.01139.
22 Uchino BN, Cacioppo JT, Kiecolt-Glaser JK. The relationship between social support and physiological processes: A Review with Emphasis on Underlying Mechanisms and Implications for Health. Psychological Bulletin, 1996; 119(3): 488-531.
23 Schiavon CC, Marchetti E, Gurgel LG, Busnello FM, Reppold CT. Optimism and Hope in Chronic Disease: A Systematic Review. Front Psychol. 2017;7:2022. Published 2017 Jan 4. doi:10.3389/fpsyg.2016.02022
24 Leading Causes of Life Initiative and Positive Deviancy. Leading Causes of Life/Positive Deviance UnConference, Zoom meeting, April 16, 2020.
25 Grim BJ, Grim ME. The Socio-Economic Contribution of Religion to American Society: An Empirical Analysis. Interdisciplinary Journal of Research on Religion, 2016; Vol. 12, Article 3, p. 31.

community members spend significant time with people outside their families or their work mates. Congregations' still stratify along lines of race, geography, or economics, but they also provide a safe place for people to explore and extend the boundaries of relationships in their community.

The post-pandemic world will likely see fewer viable congregations overall, sharply accelerating a 30-year decline that has seen gifts to religious charities, including churches and synagogues, decrease as much as 50 percent since 1990.[26] Many were already close to the financial brink for many reasons, and the reduction in revenue most congregations are experiencing will accelerate their demise. Church closures, previously taking place at 1 percent annually, are projected to increase to 5 percent annually.[27] While 30 percent of pastors and church leaders reported that giving was close to the same, over 60 percent have seen their giving go down.[28] This includes 25 percent saying that giving was down at least 10 percent, and another 24 percent saying giving was down at least 25 percent. Most concerning is the 11 percent of pastors and church leaders who replied that giving was down by at least 50 percent. Lastly, churches reporting a decline of at least 25 percent are 41 percent rural and 44 percent urban, notably higher than the 31 percent of suburban churches.[29]

Two groups may be more resilient: smaller congregations without the burdens of overhead, instead built on social relationships; and very large churches that have economic strength and a greater use of technology (essential during this pandemic) at the core of their ministries. Most vulnerable are the mid-range of churches (150-500 in regular attendance).[30] They often struggled with expensive aging facilities and declining attendance and giving before COVID-19.

Black churches were the only faith group in the US not suffering declining membership before COVID-19, their high relevance even more visible now. They are front-line as trusted liaisons, providing information and advocating to hospitals and government for services to protect their members and neighbors, and to lead People of Color to earlier screening and interventions. A recent paper outlined how COVID-19 is "failing" yet another test of how America deals with health disparities.[31] These authors shined a light on the disproportionate COVID-19 mortality rate among People of Color, citing a mortality rate of almost 81 percent for Black people in Milwaukee, when only 26 percent of the residents are Black.

RECOMMENDATIONS FOR ACTIVATING THE FAITH IMMUNE SYSTEM

Activating the "immune system" of faith is less about faith-based programs and more about linking the generative leaders in faith, public health, and health care. It is as important to train leaders of public organizations how to engage faith as it is to train faith leaders how to engage public health. Research in North Carolina tested the assumptions underneath the Memphis Model to find more generalizable principles for expanding FaithHealth at public scale.[32] Summarizing these for an NAS Roundtable, it found it critical to focus on:

- Community-scale networks and capacity building in a broader population health management strategy are necessary, not just individual care reflected in the traditional biomedical model.
- Trust building among community members must shape every program design decision.
- Raising up humble leaders who value community intelligence.
- An asset based focus, not gap or deficits focused. Use ARHAP model of mapping, aligning, and leveraging them.
- Community-based participatory research principles; co-creation of model design, transparency, and ongoing participatory analysis of data, program, and outcomes; shared risks and benefits.

26 IBID 6.
27 Alternet.org. "Why American Churches Are Struggling to Get by during the Pandemic." 29 Apr. 2020. www.alternet.org, https://www.alternet.org/2020/04/why-american-churches-are-struggling-to-get-by-during-the-pandemic/.
28 IBID 27.
29 IBID 27.
30 IBID 6.
31 Owen WF Jr, Carmona R, Pomeroy C. Failing Another National Stress Test on Health Disparities [published online ahead of print, 2020 Apr 15]. JAMA. 2020;10.1001/jama.2020.6547. doi:10.1001/jama.2020.6547.
32 Cutts T, Gunderson G. The North Carolina Way: Emerging healthcare system and faith community partnerships, Development in Practice. 2017; 27:5, 719-732.

- Person-centric, not hospital-centric focus needs, based on "a person's journey of health."
- Integrative strategy, which blends community caregiving with traditional clinical medical care.
- Shared data protocol across stakeholders to show proof of concept in a mixed model design, relying on both qualitative data captured from community mapping and congregational caregiving, as well as quantitative metrics captured from hospitals.[33]

It is now much easier to act on these assumptions at large scale because of wide interdisciplinary and trans-partisan streams of work that bridge a number of federal administrations and a wide range of academic and research institutions with a long relationship to the CDC. The faith aspect has grown up with the healthy communities movement that, itself, is borrowed from the embrace of the social determinants and then the concepts of well being and vital conditions and Leading Causes of Life. We are finishing the alignment, not starting it.

SO MUCH ALREADY EXISTS

Much valuable structure and curricula noted above rests "on the shelves" and should be taken off, but we recommend the light spreadable model of FaithHealth Fellows as the quickest way to support COVID-19 recovery.

The long history of the CDC engaging interfaith, trans-partisan, and racially diverse faith networks has resulted in:

- The Interfaith Health Program (IHP) at The Carter Center
- The CDC Institute for Public Health and Faith
- The FaithHealth Consortium (pairing numerous schools of public health and seminaries)
- The Religious Health Assets Program (Emory/ University of Cape Town and Wake Forest)
- Stakeholder Health and the faith-based health care systems
- Community Health Assets Mapping Partnership and other community assessment tools
- The Strong Partners Cooperative Agreement, which created a web of local conversion foundations that matched federal funding and flows to FBO/CBO aided by technical assistance from IHP
- Two large implementation sites (Memphis and NC) and dozens of other smaller ones

One of the surprisingly durable assets is the HHS Office for Faith-based and Neighborhood Partnerships which was established by President Bush and continued through the administrations since. It has extensive experience navigating the sometimes challenging waters of religious conflict and politicization. For 20 years, the HHS Office of Faith and Community Partnerships has been a facilitating partner through this evolution and remains a point of collaboration to this day. We expect it will play a key role in continuing to gain collaboration across the broad faith networks in this crisis and recovery too. Given the always-present wariness of inappropriate entanglement, it is best for this office to not be positioned as the hub, but a point of coordination within government as a crucial catalyst.

FaithHealth Fellows

In North Carolina, we have found a very light touch of training with a focus on connecting several roles, including Connectors, Supporters of Health, and FaithHealth Fellows.[34] Fellows are individuals already working for organizations near the intersection of faith, public health, and health care. They work locally to build the web of trust among generous and generative relationships, and among the leaders that make all public health efforts thrive. The Fellows are not just trained as individuals, but given the funds to hire two part-time Connectors (described below) that invite the Fellow to learn the arts and crafts of institutional engagement and influence for the purpose of locally relevant conditions and needs ("social determinants"). The Fellows usually gain institutional support during the Fellowship, including the funding for the Connectors. Most Fellows stay involved in mentoring the next class of Fellows, which is crucial because they need each other more than they do a didactic curriculum.

The Fellows are identified as FaithHealth leaders working with healthcare or public health. Their local role is the

33 National Research Council. Faith–Health collaboration to improve population health: Proceedings of a workshop—in brief. Washington, DC: The National Academies Press; 2018. https://doi.org/10.17226/25169

34 Cutts TF, Gunderson GR. Impact of Faith-Based and Community Partnerships on Costs in an Urban Academic Medical Center. Am J Med. 2020;133(4):409-411. doi:10.1016/j.amjmed.2019.08.041

same as the national vision of the Springboard: to make visible and align all the relevant assets of faith for the purpose of recovery and thriving. The Fellows develop cross-cutting competencies where health, public health, social factors, and faith find their powerful effect for well being. It adapts the model of transformational leadership competencies developed by a team of public health leaders led by Kate Wright[35] and augments the map with "transformational competencies" for engaging highly diverse faith networks and integrating their broad strengths for community well-being. See Figure 1 attached at the end of the Springboard document.

The Fellows are already leaders, but usually without all of the competencies and experience necessary for this task. The faculty provide some framing and tools when appropriate; the balance comes from their peer Fellows, including the alumni. There is nothing distinctive about it's pedagogy, except perhaps its humility. Their training highlights the more distinctive component of transformational leadership: the undergirding "spirit competencies." See Figure 2 attached at the end of the *Springboard* document.

This model could work at a national scale using distance tools for the faculty with local groups of Fellows organized by Stakeholder Health partners and other "mainsail" institutions aligned with Springboard values. Community leaders already mobilized by Well-being and Equity (WE) in the World, Well-being in the Nation (WIN) Network, and other Community Initiatives groups might resonate with the Faith framework of the fellowship added to their toolkit. The FaithHealth accent might draw in other elements of new communities not already involved in broad movements so far.

Connectors

Many varieties of community health workers have been adapted to the FaithHealth logic and are evolving this work. In North Carolina, dozens of part time Connectors are trusted liaisons who work 8-10 hours per week, embedded in a denominational network, housing complex, or neighborhood. They can provide capacity building through networking, train volunteers, or provide direct navigation to resources and, on occasion, provide direct caregiving in the community. Their work is designed for ameliorating the chronic conditions of poverty and exclusion. These skills are highly relevant for the social demands of COVID-19 and the very sensitive work of helping those that tested positive find their way. Connectors often train, nurture, and deploy their own volunteer teams in the community to meet needs.

Supporters of Health

The position of Supporters of Health, a full-time community health worker role, came about in 2012 when Wake Forest Health considered the outsourcing of jobs of 267 environmental service workers. Instead, leadership was told that, through training some of these staff as community health workers, it would recoup at least $1million of the "savings" that consultants predicted could be saved by outsourcing the jobs.[36] Supporters of Health are persons with lived experience, serving as hybrid community health workers and navigators as well as triage for community-based care. These roles require Certificates of different levels, not degrees. A new FaithHealth Consortium could provide a trellis for this work.

All three roles—Connectors, Supporters, and FaithHealth Fellows—focus on competencies that include familiarity with the local health systems, community based organizations, and safety net resources, as well as being trusted members of their social and faith networks. Their work leverages hospital, safety net, and health care resources to build capacity within congregations and social networks that serve the needs of clients referred to collaborating health institutions. This kind of cross-cutting thinking now pervades the training of traditional roles such as Chaplains and counselors.

It would take another whole paper of recommendations to explore all the new roles emerging in the complex web of organizations noted above. While faith networks are famous for their volunteer muscles, the large institutional ecology carrying the work includes daytime career jobs likely to evolve quickly in the recovery of COVID-19. These roles typically rest on some credentials from the faith network as well as from some other discipline, such as social work, psychotherapy, or health science. We are not suggesting starting new degree programs, but aligning and inviting those emerging into the broad work of the

35 Wright K, Rowitz L, Merkle A, et al. Competency development in public health leadership. Am J Public Health. 2000;90(8):1202-1207. doi:10.2105/ajph.90.8.1202

36 Barnett K, Cutts T, Moseley J. Financial Accounting that Produces Health. In Stakeholder Health: Insights from New Systems of Health, edited by Teresa Cutts and James R. Cochrane, 124-147. USA: Stakeholder Health; 2016.

Springboard.

Many clergy will desire bi-vocational work and would be attracted to cross-training that aligned with their mission and values just as health and public health institutions are trying to move into the social spaces where health is built and recovered.

The Unpaid and Unpayable

Even in a time when most families have both parents working, faith networks are a dependable place to look for people willing to give their time and sweat for the health of their community. It is rare for that energy to restrict itself to the members of their own congregation. Volunteer roles vary from site to site and reflect a wide spectrum of formality of training. However, frequent volunteer tasks include providing transportation (both medical and non-medical), food, support, helping complete paperwork, and helping secure other resources (e.g., furniture, clothing, household supplies, utility or rent assistance, housing.) In more rural settings, volunteers tend to provide more transportation and hands-on caregiving (e.g., helping with light housekeeping, putting medications in pill boxes for the elderly). Across the statewide version of FaithHealth, "The NC Way" we have trained and deployed 995 unique volunteers since March 2015.

Seminaries and Religious Schools of Higher Education

Hundreds of faith-based higher educational institutions train leaders and laypeople in the crafts of mission. Some of the best and least known schools are of faith, forming a very rich leadership training ecology. Less than half of the alumni serve in pulpits anymore, instead working in the broad array of social service. These institutions are familiar with federal scholarship protocols and thus the "church-state" issues. They should be invited to mediate structures to help their alumni build the civic muscle detailed in the Springboard. Their extensive alumni might trust their continuing education—now commonly converted to distance technology. The longer 2030 goals may benefit from curricula for new students or degree programs.

The FaithHealth Consortium

The CDC/Robert Wood Johnson Foundation collaboration created a network of schools of public health and seminaries called the FaithHealth Consortium. These schools offered interdisciplinary courses with field immersion in community health networks such as described here. With no small part of the robust literature from both Memphis and the North Carolina Way, the FaithHealth work has emerged from these consortiums and has continued for many years after the seed funding and as faculty have dispersed to other institutions. The recent books edited by Drs. Doug Oman[37] and Ellen Idler[38] are only the latest among many. This Consortia could stand back up to humbly undergird the faith aspect of the work of the Springboard in solid science and evaluation. Given the global nature of the pandemic and the social immune system of faith, it would be most valuable for a Consortia to be global.

WHAT NOT TO DO

The most important of the operational assumptions undergirding the spread of FaithHealth as a cross-cutting asset is humility. Faith networks do not need to be invited into the work of recovery, mercy, justice and well being. They are already present in the places of greatest pain and creativity. It is very important that the Springboard does no harm to the very assets that might help it succeed. A few specific recommendations about what not to do.

DON'T SEE LIKE A STATE

The Springboard is emerging from philanthropy linked to and for the CDC, our most noble of government institutions. A key insight of the work of AHRAP was an appreciation of all civic structure and the tendencies of governments and para-governmental organizations such as philanthropies to "see like States".[39] Civil recovery depends on activating the positive social determinants for a sustained response and recovery process. One must see them to do that and pause before their vitality and resilience. It is as important to not step on the flowers as it is to plant new ones. The Community Health Assets Mapping Partnership (CHAMP) approach is a systematic participatory model making visible networks of trust and resources for action as well as historical traumas so that

37 Oman, D. (Ed.). Why Religion and Spirituality Matter for Public Health: Evidence, Implications, and Resources. Springer; 2018
38 Idler EL, Ed. Religion as a Social Determinant of Public Health (Oxford Univ Press, New York); 2014.
39 Scott JC. Seeing like a state: how certain schemes to improve the human condition have failed. New Haven & London: Yale University Press; 1998.

programs are not naïve.[40]

DON'T MICROMANAGE FAITH BASED ENTITIES

When health care organizations first come into relationship with faith groups, they often think they could be run more efficiently. They can look ragged, but deserve some respect for having survived a number of millenia of pandemics before *they* invented medical science. There is no need for off-putting micro-design of congregational best practice for all houses of worship of every faith. The key assumption of the Memphis Model was that it did not prescribe specific program structure and priorities for the hundreds of diverse partners. Collaboratively analyzing the data with faith partners, we came to understand what was working: the congregations were helping patients come a bit more likely to the *right door* (not so much ER) at the *right time* (depending on the condition) *ready for treatment* (mainly not expecting to be disrespected) and most important, *not alone*.[41] These are qualities the hospital cannot even know how to affect, entirely produced by those that love the patient: ideally their family, or often their congregation. This leads to the next thing to not to do.

INVITE, DON'T PRESCRIBE

Point faith based entities toward the science, but trust them to direct their activities. Faith networks play their role with greatest effect if the health experts lend expertise without trying to run their church or mosque, do their theology or design mercy and care. The key is the invitation preserves room for creative adaptation. This "limited domain" of collaboration[42] extends the invitation to more broad partnership of community scale. Make it all invitational, with care not to presume on the formality of relationship. In Memphis the partnership was named in broad outline with a "covenant"; in North Carolina the social/political context made explicit agreements less acceptable, so we found a less restrictive partnership based on almost pure invitation.

Avoid sinking millions of dollars of resources into creating new programs, training and infrastructure and send those funds directly to those in need as possible

Use what already exists and focus on funneling more funds, jobs, roles, and opportunities to the "boots and brains" on the ground already. Many of our most underserved persons of color could step into the roles outlined above, fulfilling the cries for justice that are resounding in the wake of both COVID-19 and the tragic death of George Floyd.

BE BOLD, NOT BOSSY

Lead with science because it illuminates opportunities for bold missions that may not have been possible at earlier stages of institutional development. After the last great pandemic a hundred years ago many faith groups took the best science of the time and created the hospitals that are now at the core of our trillion dollar health economy as well as the human service and educational complex. The Board members of all of those institutions would be open to a serious discussion about the best and highest role of all those faith-based health assets. What would science suggest faith leaders should invent—or reinvent—now?

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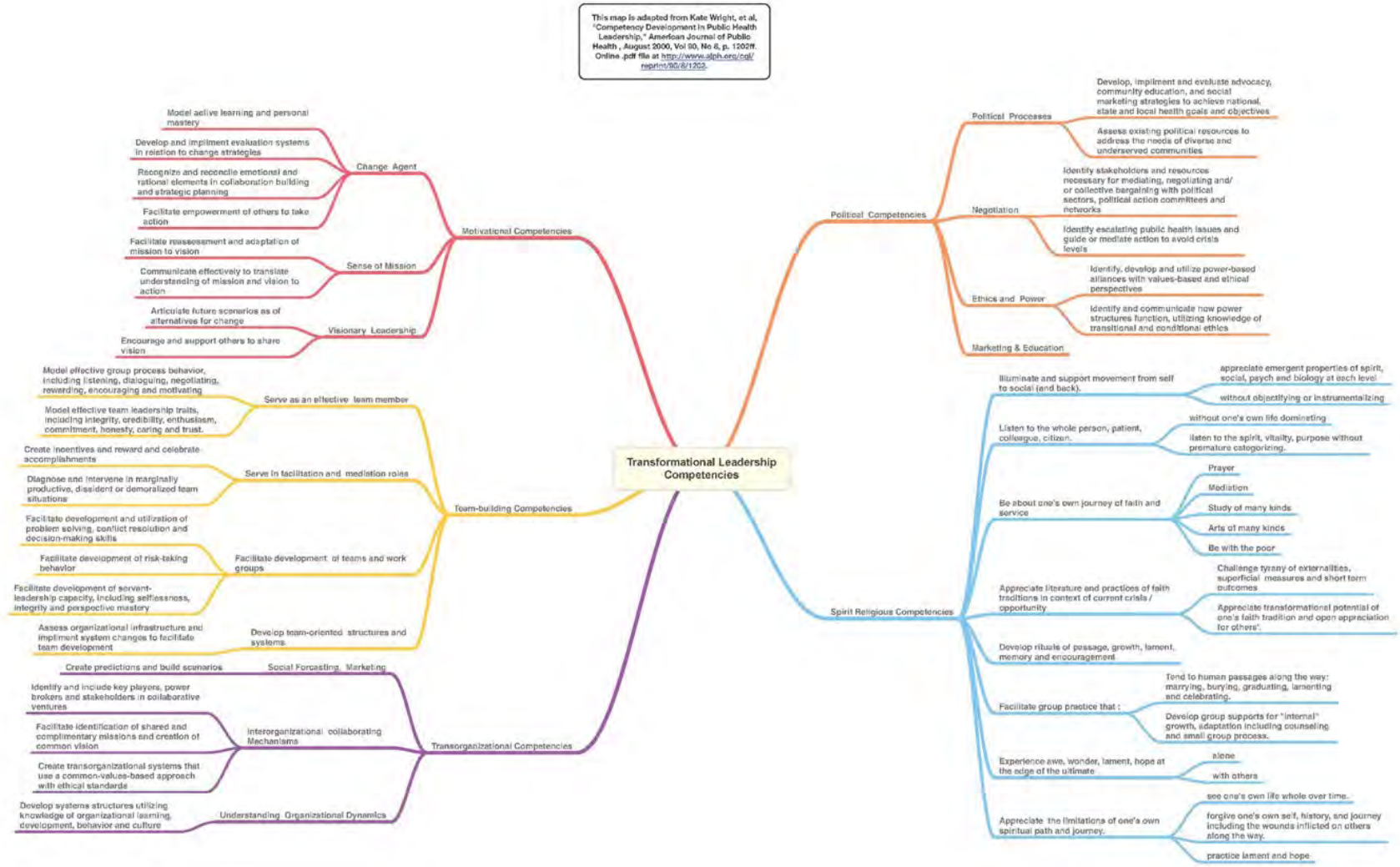
ATTACHMENTS

Figure 1: See the end of this document

Figure 2: See the end of this document

40 Cutts T, King R, Kersmarki M, Peachey K, Hodges J, Kramer S, Lazarus S. Community Asset Mapping: Integrating and Engaging Community and Health Systems. In Cutts, Teresa and James R. Cochrane (Eds.), Stakeholder Health: Insights from New Systems of Health (pp. 73-95). USA: Stakeholder Health; 2016.
41 IBID 34.
42 IBID 13.

FAITH: FIGURE 1



FAITH: FIGURE 2