Faith Communities as a Social Immune System: Recommendations for COVID-19 Response and Recovery

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Abstract
This article describes how faith communities often function like an organic social immune system during times of crisis, particularly our current COVID-19 pandemic. We share the strengths of faith communities pertaining to healthcare and public health, as well as name the religious health assets with which faith communities and other health partnerships have to work. These religious health assets have helped the Centers for Disease Control and Prevention (CDC), as well as World Health Organization (WHO) and the National Academies of Science (NAS), imagine substantive and sustained partnerships in diverse contexts across many presenting conditions. We share how COVID-19 has affected these faith assets and offer a case study in how the Leading Causes of Life (LCL) and Positive Deviance (PD) frameworks have been implemented in faith partnerships to impact health and racial disparities in the past and now, during the pandemic. We offer recommendations on how the CDC might frame a comprehensive recovery strategy, including faith-based assets in an appropriate and sustained manner to move us towards health and well-being, focusing on leadership capacity of both faith and health domains. Finally, we suggest what not to do as part of a COVID-19 response and recovery in these partnerships.

Keywords
Faith community, public health, health disparity, COVID-19, positive deviancy

Thinking like a Virus
A pandemic focuses the minds of public health leaders on ‘What do we have to work with?’ We grab for technology first, forgetting that humanity has survived many pandemics by means of the social immune

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system protecting the life of the social body. A virus moves without emotion to exploit social weaknesses. Humans, in contrast, are emotional, guided by our webs of meaning as much as cold logic. Some of the most lamentable infection hotspots have been places of worship of all faiths, where people gather in high trust that makes them vulnerable to contagion. However, faith practices also strengthen our capacity for resilience and adaptive behaviour. This article explores faith-based assets for population health as civic muscle, visible in creative community-scale partnerships. We examine the opportunity through these questions:

1. What do we mean by ‘faith’ as our social immune system?
2. What are the strengths of the social unit of faith that pertain to public health?
3. What are the ‘religious health assets’ that have helped the Centers for Disease Control and Prevention (CDC) as well as World Health Organization (WHO), and National Academies of Science (NAS) imagine substantive, appropriate and sustained partnerships in diverse contexts across many presenting conditions?
4. How has COVID-19 affected these faith assets?
5. How have the Leading Causes of Life (LCL) and Positive Deviancy (PD) frameworks been implemented in faith partnerships to impact health and racial disparities in the past and now, during the pandemic?
6. How might the CDC frame a comprehensive recovery strategy, including faith-based assets, in an appropriate manner to move us towards long-term health goals, focusing on leadership capacity to weave both faith and health domains? Plus, what should we not do in a pandemic and recovery period?

**Faith as Immune System**

Long before COVID-19, health economist Joshua Cooper Ramo wrote *The Age of the Unthinkable*, outlining how entities, ranging from terrorist groups to public health practitioners in South Africa, were adapting to a chaotic, post-modern world, in which the traditional tactics of politics, health, climate, church and business no longer worked (Ramo, 2009). Ramo recommended the ubiquitous immune system as a model because it swarms to the locus of injury to galvanise a response before a centralised elite can command it. Faith-based organisations work like that, which are already present on every street and responding before being directed to do so. This valuable social effect can be strategically amplified as an immune system.

Our understanding of both immune systems and faith has changed recently. Immune cells were once thought to be concentrated in the thymus, lymph nodes, spleen and moving only when an injury or infection occurred (Parkin & Cohen, 2001). Actually, immune cells are in every organ system, particularly the gastrointestinal tract, and what are often denigratingly termed ‘vestigial organs’ like the appendix and tonsils (Kooij et al., 2016). Modern society once considered faith as vestigial too, until a crisis.

Faith communities are highly visible in natural disasters like Hurricane Katrina or COVID-19, as well as unnatural ones like mass shootings. In Katrina, faith networks (and Walmart) ignored red tape, showed up with water and food within hours, swarming like immune cells to social body of New Orleans and many overlooked towns of the Gulf that never saw a TV camera (Phillips & Jenkins, 2010). Already present, they were ready for the unthinkable and not as isolated cells, but connected to broader faith networks. Acting like fibroblasts do in physical injuries, the immune response created a locally relevant connective tissue.
Often, the smallest congregations respond organically as any fibroblast. In Winston-Salem, NC, we asked a large congregation to help a man, with no local family, being discharged from the hospital after surgery, who needed meals to heal. They refused, but a 12-member church stepped in to deliver 3 meals a day to the stranger for weeks (Chris Gambill, personal communication, 20 June 2014). Likewise, a modest Baptist Church in Forsyth County partnered with the local Baptist Men’s Association and, with donations from the medical staff and a local hardware store, built a wheelchair ramp for a woman who was unable to walk after a lengthy unsuccessful surgery. The men’s group and staff escorted the woman home after discharge, prayed for her and then ‘blessed’ the ramp, too (Angela Brown, personal communication, 15 April 2016).

Faith assets, like an immune system, are interconnected in unpredictably effective ways, mobilising resources, information and more. Science can travel across such connections in the form of testing, counsel, vaccines and direct access to medical care.

**What is the Faith Domain?**

The complexity and fluidity of the ‘faith domain’ can frustrate scientists finding the terms ‘faith’, ‘religion’ and ‘spirituality’ too variable in meaning and application (Koenig et al., 2012). Each tradition has its distinctives and commonalities, which express differently in modern national polities. For instance, the USA remains peculiarly religious as industrial, Western nations go (Eck, 2001), even as it has seen a regression to the historic baseline of lower active participation. This becomes more complex with the rise of ‘nones’, who claim no religious affiliation, but manifest valuable civic values (Pew Research Center, 2019).

The ‘immune cell’ of faith is its social structure—the faith-forming entity, usually called congregations. These 331,000 US entities (Hadaway & Marler, 2005) are a complex network of hundreds of formal and informal relationships. Some networks are built of common theology, training and credentialing leaders, while others focus on an activity, like providing food. Congregations are not immortal; one in five are expected to succumb to the economic stresses of COVID-19 (Gryboski, 2020).

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. Many vital social service networks, like Salvation Army or the YMCA, began as faith-based initiatives (Wolf-Branigin & Bingaman, 2016; YMCA.net, 2020).

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 (Gunderson, 1999).

**Religious Health Assets**

The modern relationship of public health and faith traces to CDC’s *Closing the Gap* conference in 1984, exploring how much of the burden of premature death could be prevented with existing knowledge in the hands of the civil society (Amler & Dull, 1987; Foege et al., 1985). 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 (Gunderson, 1997a). The language was borrowed by
the WHO in the 2005 response to the HIV/AIDS pandemic (ARHAP, 2006) as they contracted with researchers of The Carter Center and the University of Cape Town to form the Africa Religious Health Assets Programme (ARHAP). Eventually, the CDC, Gates Foundation and World Bank used the language in multiple countries. This logic and tools, adapted in Memphis, were recognised by the Agency for Healthcare Research and Quality (AHRQ, 2014) and CDC as validated models for improving health outcomes by linking faith communities with a health system. Stakeholder Health is a group of healthcare systems (mostly faith-founded) focused on adapting this logic to many US communities, including, of course, North Carolina where the authors work (Cutts & Cochrane, 2016). A broad professional literature has emerged, used in schools of public health, social work and theology.

**Strengths of Congregations**

In the same way medical researchers came to new understandings of the capacities of fibroblasts, it is helpful to have new eyes for the eight distinctive strengths of the social structures of faith on which cross-cutting public health alignments can be built (Gunderson, 1997b). The strengths are of the social unit, not just the clergy leadership. Medicine often embraces an entirely different theoretical framework for thinking about individual spirituality and its role in individual health (Koenig et al., 2012). Complexity theory (Walby, 2007) would describe these strengths as social systems, not visible or active at the level of an individual.

The first strength is to *Accompany*. Even socially distanced, congregations create roles and practices of relationship beyond bonds of blood, commerce and politics. They *Convene* people around the urgent prevention opportunity, like masking. They *Connect* not only by the actions of clergy but also activated by laypeople in civic life. They develop a community *Narrative* or *Story* for new knowledge that helps people find their role in a crisis of the social body—like COVID-19. The subtle strength *to Bless* is at the root of all recovery ministries. Clergy are often expected to be able to command moral compliance, but relevant strength offered is blessing, which is the key to sustained recovery, be it from substance dependency or the slow slog of economic reconstruction. Congregations create *Sanctuary* for song, tears and hard conversations, as well as venues for services like testing. They *Pray* and create civic rituals nurturing common purpose. Finally, they encourage a long view, reflecting the strength to *Endure* and lend resilience to rebuild civic life.

These strengths are *community* assets, not just for those inside the religious group. The Winston-Salem, NC, Masking the City movement aimed at masks for the *whole* city. They were woven, distributed and promoted with a seamless partnership of business, health, government and, at the very centre, faith networks, modelling all the eight strengths (National Academies of Sciences, Engineering, and Medicine, 2020, May 22).

**Leading Causes of Life and Positive Deviancy Approaches**

Faith groups work out of an integrative framework for health described as a Bio-psycho-social-*spiritual* framework (World Council of Churches [WCC], 2007). Participants of a WCC faith and mental health consortium held in Vellore, India, in 2007, focused on *integrating* mental health into the faith structures and ministries. US faith groups invented the first mental health facilities just as they did for hundreds of hospitals and social service organisations. The WCC’s fourfold model envisioned integrating medical
and mental health providers with community-based trainers, peer supporters and community health workers into congregational practice (WCC, 2007).

The movement of faith groups towards an integrated model of health led to the development of the LCL (Gunderson & Pray, 2009). This is a non-sectarian language embracing the complexity of the fourfold model of health that helps enable dialogue with and among faith groups and non-faith partners. In the same way, LCL resonates with studies of positive deviancy, or focusing on using community wisdom to find solutions (Singhal, 2010). What could be more positively deviant than the lives of the great spiritual icons, Mahatma Gandhi, Martin Luther King, Jr., John Lewis and the countless millions who model their lives after them?

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:

1. **Connection**: the ways people live ‘a thick weave of relationships’ that can support trust.
2. **Coherence**: the meaning and purpose in life narratives so crucial to prevention. This is reflected in post-traumatic growth syndrome, a phenomenon in which persons grow stronger after trauma (Tedeschi et al., 2018), 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 development or growth.
3. **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 (Bandura, 1982). The root of resiliency, doing something, even in limits, improves depression and anxiety.
4. **Blessing or inter-generativity**: how we sense our relationship to those who have come before, after and those with whom we share our life work. Psychoneuroimmunology shows how our immune system functions can be impacted by every encounter with others, enhancing both physical and mental health (Kiecolt-Glaser, 2009). In several studies (Uchino et al., 1996), visiting and caring for others decreased loneliness, depression and improved immune system functioning in the lonely person and the visitor.
5. **Hope**: the positive orientation towards 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 (Schiavon et al., 2017). Hope enables us to continue our life, work and relationships, even in adversity.

LCLs are most relevant to the social traumas we inappropriately call ‘mental’ or ‘psychological’ like many are experiencing during the pandemic. Recent work links LCL with Positive Deviance (PD) to develop community-based tools perfectly tuned to the recovery phase (Leading Cause of Life Initiative & Positive Deviancy, 2020).

A PD approach enables communities to discover the wisdom they already have and finds a way to amplify it (Pascale & Sternin, 2005; Singhal, 2010; Singhal & Dura, 2009; Singhal & Svenkerud, 2019). Instead of focusing on problems, it identifies and shines a light on solutions already embedded in a given healthcare organisation, community, condition, etc., and has been used in numerous settings, ranging from improving infection rates in hospitals (Singhal & Greiner, 2008) to decreasing sex trafficking (Singhal & Dura, 2009). As mentioned earlier (Leading Causes of Life Initiative & Positive Deviancy, 2020), the blending of these two bodies of work has been highly complementary and is well-tuned to the work of coping with COVID-19 in terms of recovery. Next, we offer a brief case study to illustrate how both PD and LCL approaches were utilised in Memphis, TN, in a health system and faith community partnership to decrease racial disparity in sudden cardiac death.
Memphis Model Congregational Health Network Disparity Study

This study has been briefly profiled before (Cutts et al., 2016, p. 90):

As part of the Aligning Forces for Quality (AF4Q) work on race and ethnic disparity, Paula Jacobs’ team at Methodist Le Bonheur Healthcare, North was charged with establishing an ideal clinical practice for cardiac disease. Although the hospital achieved this goal in treating Congestive Heart Failure (96%) and Acute Myocardial Infarction (100%)—rates which were the highest of 8 sites—the work also unearthed the fact that African-Americans were dying at twice the rate of Whites in its Emergency Department. Congregational Health Network (CHN) leaders then engaged the CHN Liaison Advisory Council (a self-organizing group of women who serve as ‘gatekeepers’ of CHN’s interaction with researchers and other community agents and organizations) and CHN members to tap into community wisdom about why these death rates were so high. Findings from CHN members were then used to improve both community and medical staff education, led to simplification of discharge materials for cardiac patients, and to co-branding and teaching of those modules in CHN Chronic Disease sessions. These combined efforts helped Methodist Le Bonheur Healthcare (MLH) decrease its disparity in sudden cardiac death among African-American (AA) persons at its Methodist North hospital by 15 % between 2010 to 2012 (Cutts et al., 2013).

Digging deeper into this case, one can see both PD and LCL principles at work. Hospital CEO Gary Shorb exemplified PD when he transparently allowed the local newspaper to share both the good clinical news and racial disparities made visible in the data. Many C-Suite leaders would have buried the negative. With continued PD foci, Congregational Health Network (CHN) staff, including the second author of this article, then shared these ‘ugly’ disparity data with the all African American CHN members. In a memorable participatory dialogue with over 75 persons, staff sought answers from that community, instead of clinical staff, on how to decrease these disparities. That process surfaced how some cardiac medications impacted males’ ‘manhood’ (i.e., virility), decreasing medication compliance, also underlining reasons why African Americans historically feared hospitals. These community members were educated about frequent prodromal signs of an impending myocardial infarction (MI) in both African American and Hispanic women: extreme fatigue.

LCL principles were also implemented in this case, in terms of both agency and coherence. Along with CEO Shorb, CHN leaders did not allow the racial disparities to be eclipsed by the ideal clinical practice data and a ‘success story’ for the hospital, but they demanded answers from clinical and other C-Suite leaders at Methodist Le Bonheur Healthcare (Cutts et al., 2016). Instead, they told their own story versus that of the research projects’ findings. Agency and hope were evident, when staff, armed with what came out of the CHN ‘focus group’ of 75 persons, decreased the amount of educational paperwork given at discharge for MI and congestive heart failure (CHF), changed the discharge materials to have more photos, less text, a fifth grade reading level and a more easily understood stop-light framework for when to seek follow-up medical attention. Staff also incorporated these new materials into our 8-week Chronic Disease classes for the CHN members. Connection was clearly seen as staff worked both within Methodist Le Bonheur Healthcare staff and in the community to address disparities, integrating community wisdom to create educational opportunities and materials (Cutts et al., 2016). Finally, Intergenerativity/Blessing was evident when we shared with CHN members that extreme fatigue was the most common prodromal sign that an MI was pending in both African American and Hispanic women. Staff asked that they be aware of extraordinary reports of fatigue in themselves, mothers, aunts and other loved ones and, if this occurred, to seek medical attention (Cutts et al., 2016). This simple intervention may have saved lives, as shared anecdotally from CHN members whose awareness helped navigate African American women more quickly to medical attention. After 18 months of these efforts, the disparity rates in sudden cardiac death in African Americans at our Methodist North site decreased by 15%.
**Vital Signs of the Domain**

Faith networks in the USA contribute significantly to the well-being of communities. The activities related to healthcare, education and social services amount to US$378 billion annually (Grim & Grim, 2016). These include providing support groups, volunteers, food pantries, housing, health clinics, day care, after school tutoring and more.

Many of these faith-initiated health organisations have large endowments and reserve funds. While the operating budgets are legally accountable to provide community benefit, the endowments are not currently 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) might welcome their greater relevance.

Harder to quantify, but as valuable, are the ways faith assets weave and maintain the relational webs within community. Members not only worship but also run businesses, teach in schools, work in the health and healthcare sector, provide civic service and hold office. Faith communities are one of the few places left where community members spend significant time with people outside their families and their work sites. 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 have fewer viable congregations, sharply accelerating a 30-year decline that has seen gifts to religious charities, including churches and synagogues, decrease as much as 50% since 1990 (Grim & Grim, 2016). Many were already close to the financial brink, and the reduction in revenues that most congregations are experiencing will accelerate their demise with greatest loss in rural and urban areas versus suburbs. (Alternet.org, 2020).

Two types of congregations may be more resilient. Smaller congregations without high overhead build on social relationships. Very large churches have economic strength and greater embrace of technology (essential during this pandemic) at the core of their ministries. Most vulnerable are the mid-range of churches, usually 150–500 in regular attendance (Pew Research Center, 2019). Public health partnerships should focus on these.

Black churches are the only faith group in the USA not suffering declining membership before COVID-19, which makes them even more relevant now as their members are experiencing sharp disparities. They serve on the front-line as trusted liaisons, providing information and advocating to hospitals and government for services to protect their members and neighbours and lead people of colour to earlier screening and interventions. A recent paper outlined how COVID-19 is ‘failing’ yet another test of how America deals with health disparities (Owen et al., 2020). These authors reported on the earliest disproportionate COVID-19 mortalities among people of colour, up to a high of almost 81% mortalities for the Black in Milwaukee, when only 26% of the residents were Black. However, exceptions abound. An LCL and PD exemplary, nimble and proactive community, faith-based and clinical response in Buffalo, New York (National Academies of Sciences, Engineering, and Medicine, 2020, July 15, Roundtable on Population Health), was able to keep the proportion of the underserved Black deaths in that county to the same proportion as the number of total Blacks. Also of note in addressing racial equity during the pandemic was Bill Foege’s co-chairing of the CDC-led and NAS-supported ‘Framework for the Equitable Allocation of COVID-19’ held in October 2020 (National Academies of Sciences, Engineering, and Medicine, 2020). In this work, Foege and team directly addressed how persons of colour should have earlier access to the vaccine. Dr. Foege led the CDC in the 1980s and was the architect of the Interfaith Health Program at the Carter Center.
Recommendations for Activating the Immune System

Activating the ‘immune system’ of faith is less about replicating specific programmes than it is sparking the practical imagination of generative leaders in faith, public health and healthcare. It is as important to build the capacity of those leading public organisations 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 generalisable principles for expanding FaithHealth at public scale (Cutts & Gunderson, 2017). Summarising these for an NAS Roundtable, we recommended a focus on the following:

- **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 must shape every programme design decision.
- Raising up *humble leaders* who value community intelligence.
- Be *Asset based*, not gap or deficits. 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, programme and outcomes; and shared risks and benefits.
- **Person-centric, not hospital-centric** focus needed, based on ‘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). (Source: Cutts presentation, 22 March 2018, National Research Council, 2018).

New and Adapted Roles Accelerating in COVID-19

While faith networks are famous for their volunteer muscles, the large institutional ecology carrying the work include many formal jobs, most of which are likely to evolve quickly in the recovery of COVID-19. These roles typically rest on some credentials from faith networks as well as from some other discipline (often social work, psychotherapy or health science).

Many community roles have adapted quickly even without formal PD research, but the same adaptive spread is occurring as community roles developed for one category of health (diabetes or elder care) pivots amid COVID-19 to support for families touched by the pandemic, drawn to and then validated by the positive examples. In North Carolina, dozens of part-time *Connectors* are trusted liaisons who work 8–10 h per week, embedded in a denominational network, housing complex or neighbourhood (Cutts & Gunderson, 2017). They provide capacity building through networking, train volunteers or provide direct navigation to resources and, on occasion, provide direct caregiving in the community. FaithHealth *Connectors* are people already in the neighbourhoods, including those rich in undocumented families most vulnerable to viral spread. They include formal contact tracer, limited to phone outreach. We quickly adapted, so that our FaithHealth *Connectors* could be trained to meet the credentialling requirements, but we funded separately so that they could go find the families, earn their trust and provide services. This behavioural adaptation is not limited to the role of the *Connector*, but demonstrate how that role is being woven into the operational procedures linking public, faith and private efforts.
Crises of different kinds often force positive adaptations, some of which prove durable. *Supporters of Health*, more full-time community health worker roles, resulted when the hospital realised that its lowest wage workers could be effective health promoters in the neighbourhoods they knew well. In 2012, Wake Forest Health was considering outsourcing 267 jobs of environmental service workers. Instead, leadership was promised that, via training some of these staff as community health workers, it would recoup at least US$1 million that consultants were predicting could be saved by outsourcing these jobs, and that promise was fulfilled (Barnett et al., 2016). *Supporters of Health* are persons with lived experience, serving as hybrid community health workers and navigators as well as triagers for community-based care.

Other deviations from the expected norm are found at the national level. One of the surprisingly durable assets is the *Health and Human Services (HHS) Office for Faith-based and Neighbourhood Partnerships*, which was established by President Bush and continued through all administrations since. It has extensive experience, navigating the sometimes challenging waters of religious conflict and politicisation. For 20 years, the *Health and Human Services Office of Faith and Community Partnerships* has been a facilitating partner through this evolution and remains a point of collaboration to this day (Cutts & Cochrane, 2016). 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, as a point of coordination within government, a crucial catalyst. Amid COVID-19, the office has pivoted towards the non-controversial but crucial priorities of mental health and the riot of anxiety and stresses. This practice of finding valuable work amid a virus of political polarisation is itself a positive deviation likely to outlast both contagions.

**Volunteers**

Even in a time when there are rare families without 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, often extending beyond caring for members of their own congregation. Volunteer roles vary from site to site and by county, and reflect a wide spectrum of formality of training. However, frequent 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, etc.). In more rural settings, volunteers tend to provide more transportation and hands-on caregiving (e.g., helping with light housekeeping, putting medications in pillboxes for the elderly). Across the state-wide version of FaithHealth, ‘The NC Way’, we have trained and deployed 963 unique volunteers since March 2015 (Cutts & Gunderson, 2020).

**Research, Curriculum Development and Evaluation**

Many FaithHealth innovations emerged in the complex and ambiguous boundary zone where public, private, faith and hybrid organisations and networks find themselves sharing social space. The relationships there are themselves positive deviations from the more structured, protocol-laden professional models of ‘intervention’. Just as natural systems in contested boundaries are rich, these intersections are rich intellectually. The CDC/Robert Wood Johnson Foundation collaboration created a network of schools of public health and seminaries called the FaithHealth Consortium. The schools offered interdisciplinary courses with field immersion in community health networks such as described
here. No small part of the robust literature from both Memphis and the North Carolina Way, FaithHealth work has emerged from these consortia, which continued for many years after the seed funding and as faculty have dispersed to other institutions. Recent books edited by Dr Doug Oman (2018) and Dr Ellen Idler (2014) are only the latest among many. Although this article focuses on innovations within the US context, all of the underlying drivers of deviation are global. Both the global nature of pandemic and the social immune system of faith can best be understood as local adaptations to common global phenomenon.

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. We ask that practitioners do no harm to the very assets that might promote success and offer a few practices to avoid, also seen through the lens of PD and LCL.

1. Do not see like a state. The COVID-19 response has emerged from philanthropy linked to and for the CDC, our most noble government institution. A key insight of the work of AHRAP was an appreciation of all civic structures and the tendencies of governments and para-governmental organisations like philanthropies to ‘see like States’ (Scott, 1998). 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 programmes are not naïve (Cutts et al., 2016).

2. Do not micromanage faith-based entities. When healthcare organisations first come into relationship with faith groups, they often think they could be run more efficiently. Faith communities can look ragged, but they deserve some respect for having survived a number of pandemics before they invented medical science. There is no need for off-putting micro-design of congregational best practice for all of houses of worship of every faith. The key assumption of the Memphis Model was that it did not prescribe specific programme structure and priorities for the hundreds of diverse partners. Collaboratively analysing 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 Emergency Room (ER)) at the right time (depending on the condition) ready for treatment (mainly not expecting to be disrespected) and, most important, not alone (Cutts & Gunderson, 2020). These are qualities the hospital cannot even know how to affect, entirely produced by those who love the patient: ideally their family or often their congregation.

3. Invite, do not prescribe. Point faith-based entities towards 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. Key is that the invitation preserves room for creative adaptation. This ‘limited domain’ of collaboration (Gunderson, 1997b) extends the invitation to more broad partnerships 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 binding agreements less acceptable, so we formed less restrictive bonds of voluntary shared activity.
4. **Avoid sinking millions of dollars of resources into creating new programmes, training and infrastructure and send those funds directly to those in need as much as possible.** A critical tenet of PD is to use what already exists and focus on funnelling more funds, jobs, roles and opportunities to the ‘boots and brains’ on the ground. Many of our underemployed persons of colour could step into the roles outlined earlier, fulfilling the cries for justice, that are resounding in the wake of both COVID-19 and the death of George Floyd.

5. **Be bold, not bossy.** Lead with science because it illuminates opportunities for a bold mission 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 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?

**Summary**

In normal times, professionals might imagine the future emerging as an expression of steadily evolving rational science. Pandemics, of which humans have experienced many, remind us that our species responds to novel threats with the full array of adaptive tools, blending science, government, communications and the enduring communities of meaning-making. It is worth thinking with a fresh mind of appreciation for the complex manner in which those traditional networks express their strengths in concert with the newest findings of science. Not one or the other, but together in creative tension against the most recent viral threat.

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Figure 1. Decrease in Percentage of Blacks Dying of Sudden Cardiac Death at MLH North from Baseline, 2009–2012

Source: Paula Jacobs, used with permission.

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