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A global health expert offers tools for your congregation to respond now.



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As I write this, my heart is very heavy. I just spent the second Sunday morning of Lent in my living room with my wife, watching a livestream of the worship service from my church. The church was empty because this past Friday, the King County Public Health Department in Washington state sent a notice to faith-based organizations, recommending that they cancel all gatherings with 50 or more people. Pretty much all churches in the Seattle area have already stopped their in-person worship services along with most other church activities. Since the evangelical church that I attend has over 1,500 worshipers in four services each Sunday, we livestreamed our worship services. As this article was being prepared for publication, Gov. Jay Inslee took it further, banning gatherings larger than 250 people in three metro counties, and WHO declared COVID-19 a global pandemic.

But my heart is not heavy because I could not gather with others to worship (as much as I appreciate corporate worship). It is heavy because I can see where the COVID-19 epidemic is going to take us, while most of those in our society and churches do not. Seventeen years ago, I was working for the World Health Organization (WHO) in Beijing when the SARS coronavirus epidemic broke out in China. I was thrust into leading much of WHO's support to China and worked 24/7 for over three months to help contain that epidemic. I saw firsthand the effects of SARS on the people of China, the extraordinary social distancing efforts undertaken by the government, and the cost that the society paid to contain that epidemic.

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After working for WHO and then the Bill and Melinda Gates Foundation in China, my wife and I moved to Seattle in 2015 to lead the foundation's work to control tuberculosis in several countries. For a quarter of a century, I've answered a calling as a follower of Christ to stop the spread of diseases and work to eliminate them, and now I heed that calling to speak to my brothers and sisters in Christ to take this epidemic seriously and respond.

When COVID-19 first surfaced publicly in China in January, this was not an issue for most churches in the Seattle area. But it generated a lot of anxieties among local Chinese churches because Chinese Spring Festival was happening and their members were going to and coming from China. Church members were extremely concerned about being infected by a traveler from China, and the number of Sunday worshipers declined by half. The leadership of a large majority-ethnic Chinese evangelical church asked me to help guide their church's local response. Subsequently, the large American evangelical church I attend, which draws congregants from a wide geographic base, made the same request, along with a smaller neighborhood church deeply engaged in its local community through service programs like Scouts, childcare, and youth work.

From working with these churches, each with diverse approaches to kingdom engagement, I learned that a robust church response requires a proper understanding of how COVID-19 spreads and harms, how to protect ourselves and others from being infected, and how to properly assess the risks we face in our communities.

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CT EDITORS

Understanding how COVID-19 spreads and harms

Several factors have come together to help the COVID-19 effectively and stealthily invade our community without notice.

First, it is hard to know whether you have COVID-19 or just the common cold. Eighty percent of people with COVID-19 have mild symptoms like fever, cough, runny nose, and general tiredness, which matches the common cold. This means a person may be carrying and transmitting the virus without knowing it.

Second, you don't have to be around an infected person to get infected. Infected people can cough and generate respiratory droplets, which then land on nearby surfaces. Or people with the viruses on their hands can deposit the viruses onto a door handle when they open the door. Because these viruses can stay alive on surfaces for at least several hours, people who touch a surface with the viruses on it and then touch their nose or eyes can become infected.

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Third, about 20 percent of infected people develop a more severe illness and may need to be hospitalized; 3 percent of all those infected die. However, the virus is particularly aggressive among the elderly and those with chronic illnesses, resulting in a death rate several times higher for these vulnerable individuals.

Therefore, this virus is particularly difficult to control because it causes complacency among the vast majority of people who have the infection, which facilitates its transmission from person to person while causing the greatest harm to the most vulnerable individuals.

Adding to the difficulty is the fact that we currently do not have enough test kits to diagnose this infection. Right now in Seattle, there are barely enough tests for those admitted to the hospital with pneumonia. Though more tests should become available soon, we need to make testing so widely available in Seattle that anyone who wants the test can get it. Only then can we shine a light on the real size of this outbreak, which is what is needed to contain it.

How to protect ourselves and others from COVID-19

By now, you are probably looking for some good news. Fortunately, there is some.

First, we know it is possible to protect ourselves and others from being infected. However, the approaches are so ordinary that we underestimate how effective they can be: Wash your hands frequently, avoid touching your face, be friendly but don't shake hands, keep away from sick people, and stay home when you are sick.

You don't have to be afraid when you hear someone coughing near you. If that person is not coughing directly in your direction and is within six feet,

the viruses can't get to you because they are in large respiratory droplets that fall to the ground. The virus does not float and circulate in the air.

Second, the virus can be beat. All around the world, there are many examples of COVID-19 entering a community and then never gaining a foothold—all because people apply basic public health principles. There is nothing sexy about rapidly identifying and isolating infectious cases and their contacts. But it works. However, it needs to be applied aggressively and effectively right at the start.

Unfortunately, what we see over and over is that the response is late. By the time the virus gains a foothold in the community, beating it requires much more aggressive social distancing. I believe this virus is already firmly established in many of our communities. Even so, many churches are reluctant to act. By the time an outbreak spirals out of control—like the ones in China, South Korea, and northern Italy—extreme social distancing measures, like locking down cities or regions, become necessary. But the social cost of such extreme distancing will be high, not to mention the economic cost.



7 Lessons from Singapore's Churches for When the Coronavirus Reaches Yours

Advice from Christians in the "Antioch of Asia" on how your congregation can survive—and thrive—

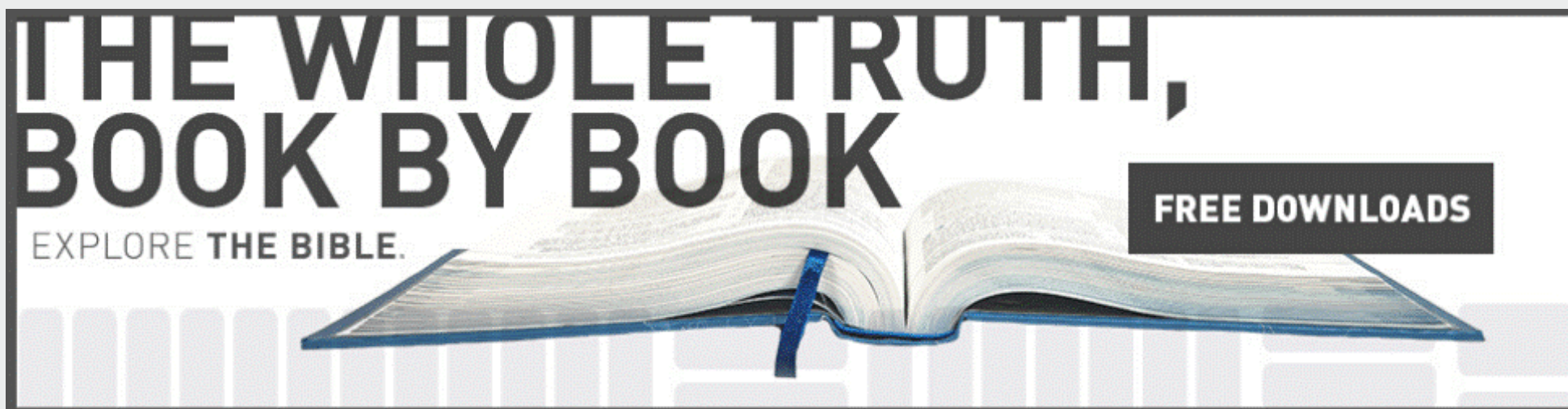
amid the COVID-19 outbreak.

EDRIC SNG

Simple tools are needed to formulate a response




As part of our mission in this world, the church can be a strong agent to prevent sickness and protect the vulnerable. We are an integral part of our community, and many social contacts run through our church. If we can recognize the early signs of a local COVID-19 outbreak, we can lead in protecting those inside and outside our churches. But I have worked with enough disease control efforts to know that it is not enough to convince people they should act. People need to be given simple tools to help them take action.

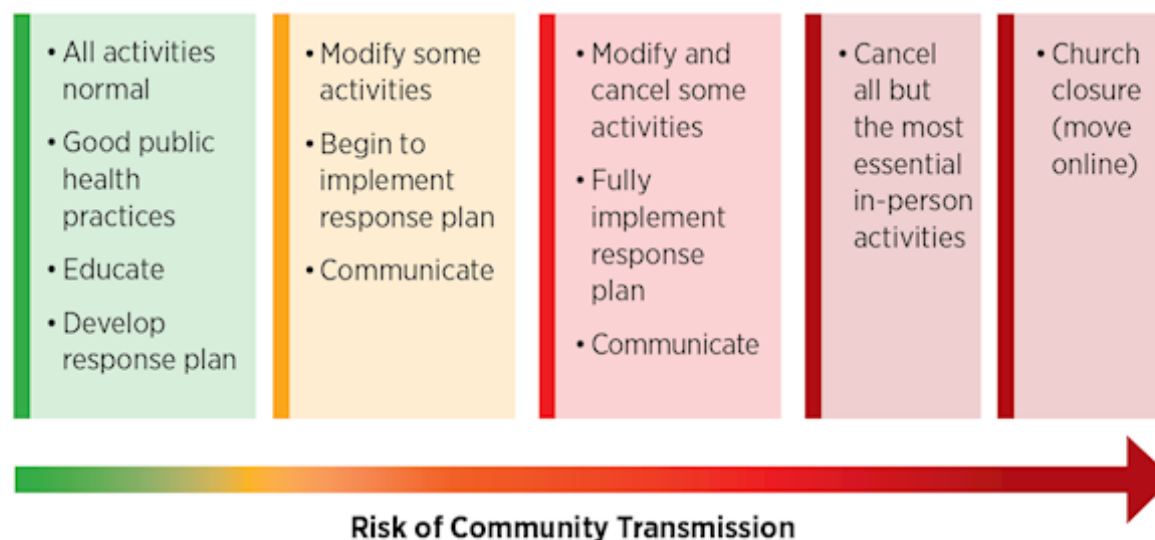
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Churches in the US are in uncharted territory regarding how to respond to the current epidemic. We will all continue to learn as this epidemic evolves. But based on my recent experience, here are two simple tools to help churches make good decisions in real time: (1) a simple way to assess what kind of actions a church should take based on the local risk of transmission, and (2) a framework that can help churches develop a specific plan to prevent infection and increase social distancing that can be implemented as soon as it is necessary.

What's My Church's Level of Risk?

-  There are no cases in my community.
-  There are cases in my community, but:
Cases are all imported from another area or are contacts to an imported case.
-  There are one or more cases, and they do not have contact to a known case.
Multiple generations of transmission.



- Educate your church about the COVID-19—its symptoms, how it spreads, how it affects the elderly and those with chronic illnesses, and what they can do to protect themselves from being infected.
- Carry out discussions within the church and make concrete plans to modify, cancel, or replace church activities as needed. The church leadership should be engaged in this process. Now is the time lay a good foundation in preparation for what the church might face next.

Because of the huge mobility of people and ease of travel, many communities have started to see COVID-19 cases imported into their community. As soon as a case from another community enters your community, your church is in the “yellow light” zone. If no one who came into contact with this case is infected, this indicates there was no further transmission of COVID-19. When one or more of the contacts are infected, but no one else in the community is infected, this means transmission has not spread to the broader community. The church is still in the yellow zone. At this point, what should your church be doing?

- If your church hasn’t completed a concrete response plan, do it now.
- Begin implementing this plan, modifying some activities to reduce risk and inform the entire church about this.
- Establish a system to rapidly communicate any changes in church activities to the entire congregation.

- Be hypervigilant, and check regularly with your local public health department about additional cases that could move your community and church into the “red light” zone.

Your church moves into the “red light” zone as soon as a resident of your community becomes infected but has not traveled recently to another area with cases and cannot be linked to any other case. This raises alarm because it means transmission in the community was previously undetected.

Epidemiologists call this *community transmission*. A community is also in the red zone when multiple generations of transmission in the community are linked to an imported case. As soon as you are in the red zone, your church should do the following:

- Implement various social distancing measures and protect the vulnerable groups.
- As more community transmission takes place, temporarily discontinue more and more activities, including corporate worship, and move if possible to livestreaming or to small group worship.

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- Watch for recommendations or mandates from your local public health department; you may be asked to limit social gatherings.

How to make decisions on your church's activities

In my work with the three churches in Seattle, I found that they all initially struggled with diverse opinions about what activities to cancel or modify when planning their response to COVID-19. I developed a framework to help them. Using a spreadsheet, we listed church activities, thought of possible transmission of the virus during each activity, rated risks, provided modifications or substitutes, and then made decisions for each (see figure for an example).

The key is to work out the how transmission, whether direct or indirect, can occur through each activity. Keep in mind the ways COVID-19 is

transmitted. When assessing the risk of direct transmission, ask: How likely are people to cough, sneeze, or generate respiratory droplets toward others? How likely is direct hand contact? Activities like singing, talking at very close quarters, giving handshakes, and hugging will have increased risk. To decrease risk, consider increasing distance between people, preferably to more than six feet.

When assessing the risk of indirect transmission, ask: How likely will people touch surfaces that could be infected? Activities that involve touching surfaces, such as offering plates, Communion plates, Bibles, and coffee dispensers will increase risk. To decrease risk, implement frequent hand-washing and use of hand sanitizers.

Consider the age groups involved when planning what activities to modify or cancel. The much higher risk of severe illness among the elderly and those with chronic illnesses means we need to protect this group from infection.

A Framework for Planning Church Activities during the COVID-19 Pandemic

ACTIVITIES	HOW TRANSMISSION COULD BE FACILITATED		MODIFICATIONS TO REDUCE RISK	OPTIONS TO SUBSTITUTE	SPECIFIC CONSIDERATIONS
Worship service		Moderate to High	Disinfect high-contact areas before worship.	Livestream online service.	May recommend that the elderly and those with chronic illness do not attend because of greater severity of

					illness if infected.
Singing during worship	A person singing generates respiratory droplets, which land on people close by.	Moderate	Space out worshipers to six feet, keeping families or friends together; use every other row of seating.		
Greeting time	Hand-shaking or hugging directly passes viruses from person to person.	High	Don't shake hands or hug but still greet each other.		
Offering	A person touching an offering plate with virus on it can get the virus on their hands.	Moderate	Use offering box; have usher bring offering plate to congregation or collect offering when people leave.	Use mobile or online payment.	
Communion	A person touching a communion plate with virus on it can get the virus on their hands.	Moderate	Set up stations for people to receive and collect communion element. Disinfect offering trays.		
Sunday school (elementary school/ kindergarden)	Young children may have activities with frequent touching of same objects and have lots of contact with each other.	Moderate to High	Modify activities to minimize touching of same objects. Disinfect room between use.		Need to educate parents not to bring kids with even minor symptoms. Children may have mild illness but could transmit to adults.
Fellowship groups meeting in homes (primarily adults, with or without children)	A person generates respiratory droplets or participants infected through direct or indirect touching of objects, such as dishes.	Moderate	Plan to sit around tables or lecture style, which lowers risk. Avoid huddling. Eliminate high-touch interaction. Skip meals. Keep children home. Reduce size of group by splitting into more home groups.	Use online platform for small group interaction and prayer.	Groups in home settings tend to be smaller and people know each other so they are more able to keep sick people away. Groups with children pose greater risk. Elderly participants or those with chronic illness have greater risk.
Retreats (with overnight camp)	Groups of people together for extended period including	Very High			It's difficult to reduce risk because of the length and closeness of interaction.

	<p>practices, including singing, talking, eating, and living together, all in close proximity to each other, is risky.</p>				
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Remember, the decision of what church activities to modify, cancel, or substitute largely depends on the level of community transmission (see figure). If the level is low, you may just modify some activities but not cancel any. But as the level of community transmission increases, canceling activities becomes a better idea because it is increasingly likely that an infected person will enter the church unknowingly. Finally, follow public health recommendations.

When using this approach, a pastor said, “We determined that children’s ministry was high risk because kids are constantly touching each other and we can’t control it. If they spread infection among themselves, they can bring it home to their parents and grandparents. Besides, many of our teachers are elderly, and we don’t want them to get infected. So, we quickly decided to close children Sunday school.”

An elder said, “Our choir had people of all ages participating. But with singing during rehearsals or when standing in rows and singing during worship, there was a medium-to-high risk of transmission. So, we decided to

substitute the choir with a quartet, especially since some choir members were elderly.”

An executive pastor said, “I was getting calls and emails from individual ministry leaders about what to do with their activities. It was really helpful to list all the activities and review their risk of transmission all in one go because we could compare the risk of one activity to that of another. This helped us to be consistent when making decisions about individual activities, and we were able to clearly communicate why we made these decisions. That was so helpful to our team.”

When developing your church’s response plan, communicate with church members. Some members’ anxiety will decrease when they know that your church is making a plan. They can better understand the rationale behind the church’s decision process and take comfort knowing it is based on good science. Develop a communication process because decisions often have to be made in real time and then clearly and effectively communicated to the congregation.

Article continues below



Your church needs to have a plan to respond now

Reflecting on our experience in Seattle over the past weeks, I am struck by how fast this outbreak took off. COVID-19 is going to hit many communities hard and fast. There is no time to waste. Because our church activities can facilitate the transmission of this virus, our churches should “first do no harm,” a dictum I learned in medical school. Using the tools described above, which are based on our current understanding about this virus, our churches can have a response plan in place to quickly protect ourselves and the most vulnerable among us. By implementing such a plan, our churches can play a major role in stemming the tide of this epidemic and reduce its harm on society.

The approach discussed here is admittedly heavy on good public health and epidemiological approaches for decision making but light on empathetic response and engagement around those who have the virus and are suffering from its more potent effects. I hope that, having understood how the virus spreads and harms, this response plan can also include ways to serve with

compassion those who are sick, care for the most vulnerable, and become a congregation more sensitized to and engaged with the needs of the world.

Daniel Chin is a physician trained in pulmonary and critical care medicine and epidemiology with 25 years of global public health experience. In 2003, he led much of WHO's support to China to contain the SARS epidemic.



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