Masks and Christian Communities: Guidance from the Salem Presbytery COVID-19 Re-Entry Task Force

Americans have come a great distance in a few months.

We have three highly effective and low risk vaccines widely available to everyone 12 and older!

Mandates requiring occupancy limits, physical distancing and mask wearing in many situations are lifted. Fully vaccinated* people are safe without a mask in most situations.

Vaccine rollout is a principal reason we have reached these milestones. The other is the use of public health measures of which the 3 W's (Wear a Face Covering/Mask, Wait Six Feet Apart, and Wash Hands Often) have been critical to getting to this point.

BUT, we are not beyond the pandemic yet. The Governor's declared State of Emergency in NC persists. We continue to have disparate levels of cases, hospitalizations, deaths and rates of vaccination among NC's 100 counties.

Within Salem Presbytery, counties are continuing to experience higher population case incidence than desired. Case transmission rates in the 17 counties of Salem Presbytery are currently characterized in the higher classifications (meaning more community spread). Seven counties are at the high level, ten are at the substantial level and 2 are at the moderate level. None are low.**

As for vaccinations, statewide, about 41.4% of the total population is partially vaccinated (about 37.1% of the state's total population is fully vaccinated). By comparison, in Salem Presbytery, county level total population percentages of full vaccination range from 21.7% to 37.5%. (Note: percentages reported in the media may be higher depending upon the denominator (e.g., population 12 and above or population 18 and above). Total population figures are presented here as the goal of herd immunity is 70% of the total population vaccinated).

The danger from COVID-19 remains present and very real in much of our state and in our presbytery. And while it is wonderful to find a returning path to in-person, indoor worship and church activity, all of our opening up could have to be walked back should case numbers rise precipitously.

<u>So we are still in the woods…What is the path forward</u>?

First, let us embrace the better angels of our nature and extend grace upon grace to our Christian communities (composed of both vaccinated and unvaccinated people). We should proceed from a position of a covenant — the idea of promises and commitments between members of a community. This is the actionable essence of loving God and caring for our neighbors.

We know the 3 W's work in mitigating risk of viral transmission. And in general, it makes sense to continue to embrace the strategies we know have worked to date in keeping people safe while the pandemic persists.

Realistically, the risk of significant morbidity or death from COVID-19 infection now shifts to the unvaccinated — some of whom fall into this category through no action of their own making — principally, these are children younger than 12 years of age or people who are medically ineligible for vaccination. As inclusive and gracious communities of faith, one of our immediate concerns should be for these two groups.

Moreover, data remains inconclusive on whether or not the fully vaccinated may transmit the virus in the context of asymptomatic infection, putting those who are unvaccinated at risk. Further, while rare, there are breakthrough cases of COVID-19 among the fully vaccinated. So while having completed a vaccine series confers tremendous protection against severe and fatal illness, it does not eliminate all risk for the vaccinated.

Thus we should maintain masking requirements for indoor church activities as a part of a covenant amongst members and as an embodiment of neighborly love. Wearing a mask extends grace to those who remain unvaccinated. It also avoids the risk of judgmental or discriminatory behavior. And for families who have young children who may not yet be eligible for vaccination, it is an act of solidarity in keeping the youngest of our community safe and well. It is the welcoming and right thing to do. Further, wearing masks can afford a return to singing by containing a substantial portion of the droplets and aerosolized particles exhaled.

Physical distancing still has merits as well. Evidence continues to suggest that air movement (turnover), management of the length of time in an indoor setting (particularly with large numbers of people of mixed vaccination status) combined with limiting the number of people in a space are critical factors in preventing viral spread. Physical distance (whether 6 feet or 3 feet) still helps to keep larger respiratory particles at bay (as well as eliminates or limits the physical touching possibility of particle transfer).

As a corollary to physical distancing, reducing the time of indoor exposure (shortening services and meetings) as well as increasing the interval between reading/singing components of services may allow air handling systems a chance to filter out some circulating aerosolized particles.

And finally, making certain people have access to hand sanitizer or restrooms for hand cleansing makes good sense whether you are concerned about COVID-19 or the common cold.

Some specific steps — with county metrics (*not congregation metrics*):

1) Encourage everyone to get vaccinated against COVID-19. If people are hesitant to do so, encourage them to seek the advice of physicians or other health care providers about what is prudent. The vaccines are highly effective, the risks of side effects from the vaccines are low, and opportunities to be vaccinated are readily available in our communities.
2) Continue to require mask wearing at all indoor church activities until the proportion of your county's total population fully vaccinated* reaches the desired 70% *(a less conservative metric would be 70% is partially vaccinated).*
3) Continue to maintain physical distancing indoors at 6 feet in counties where there is a orange (substantial) or red (high) level of community transmission**; consider reducing it to 3 feet once community transmission rates drop to yellow (moderate) or blue (low) risk levels.
4) Masking and physical distancing can both be eliminated when both the vaccinated proportion of the population reaches the desired level and the rates of community transmission are moderate or low.
5) Staff should continue to wear masks when visiting healthcare facilities or any location where masks are continued to be required as well as when visiting homes where the vaccination status of the household may be unknown.
6) Prior to participating in church activities, continue to ask participants to evaluate their own recent history of possible COVID-19 exposure as well as their personal/household risk for adverse outcomes from contracting COVID-19 (e.g., their age, underlying health conditions, presence of an immunocompromised or non-vaccinated person in their household, etc.).

7) Continue to provide hand sanitizer and restroom access to address the need for hand sanitation.

Parting Observations:

Compared to how we have been, living in a state in which many decisions were directed by government mandate and made by the few to keep the many safe, we are now at a point where the locus of control decidedly rests more with local communities than with a collective making the recommendations for the state as a whole.

Church leaders can use this local focus to guide risk management in their own settings. Hence, the metric driven guidance we suggest above. At this point, local experiences should be driving responses. The metrics suggested in the steps above can be readily accessed through the CDC website (CDC's COVID Data Tracker) and can help provide a path forward.

In parallel, individual risk assessment plays a greater role in how people navigate the pandemic with the removal of mandates. Everyone of us has been making and will continue to make calculated decisions about what event/activities to attend, where to go (what places are safe) and what risks we can tolerate. This calculus is the way through our current reality. What we're encouraging you to do is to take more responsibility for managing your own risks and their mitigation and in so doing, reflect upon your capacity for neighborly love by respecting the policies implemented by your church.

And at some point, our faith has to enter into the picture.

By invoking a covenant of care for one another, we are placing trust in one another to act in our own best interest in concert with that of our Christian community and to extend grace to those at greater risk by considering more than personal comfort when joining together.

May God grant you guidance and peace in this continued time of uncertainty,

Kathy Beach
Kyle Goodman
Beth Hooten
Paul Sink
Barbara Smith

*Definition of fully vaccinated — 2 full weeks after second doses of Pfizer-BioNTech or Moderna vaccines or after the single dose of Johnson & Johnson vaccine.

**For a longer exploration of these ideas including suggested policy language along with greater detail on what and where to find county level metrics (to use in guiding transitions from masking and physical distance guidelines in place to their complete removal), please follow this link.

LINK TO THE COVENANT PDF