To the UU Cville Board of Trustees:

In thinking about reopening the church physically during the pandemic, there are several, to some extent competing, factors that the building use task force has taken into consideration:

1) The physical well-being of the congregation and visitors
2) The spiritual and emotional well-being of the congregation and visitors
3) The physical well-being of the community
4) The safety and physical, spiritual and emotional well-being of the staff

To try to meet these ends, we have endeavored to follow the data and the science regarding COVID, and use that information to guide our recommendations. And as the information about COVID has changed, so have our recommendations evolved. We started out with a pandemic characterized by a high level of uncertainty. Next, we had a virus with relatively high transmission and mortality rates, little or no immunity in the population, a shortage of appropriate protective equipment, and high anxiety. That evolved very briefly into a period with increasing immunity and low transmission, only to be followed by a virus with an even higher transmission rate. And now we have a virus with the highest transmission rate yet, but tempered by higher population immunity rates, availability of higher quality masks, increased availability of at-home testing, and relatively mild disease among those with immunity, with a precipitous downward trend in infection in our community. It's been enough to make our heads spin, and has required constant re-evaluation of our policies.

As most people now know, the omicron variant of the COVID virus is highly contagious, even for people who have been fully vaccinated against the virus. Probably most of us know, or know of, someone who was fully vaccinated and masked who contracted COVID nonetheless. However, compared to unvaccinated individuals, people who are fully vaccinated are still much less likely to become infected if exposed (about a 2/3 reduction). If infected, vaccinated people are several times less likely to become seriously ill, need hospitalization, need intensive care management, or die. It is not yet clear if people who are vaccinated are also less likely to transmit the omicron variant if infected, but that was true for earlier variants of the virus.

Here are some of the things that we have learned along the way: That the virus is spread by both large and small airborne droplets, and that small aerosol droplets may remain airborne for long periods. That the mRNA vaccines may be the safest vaccines ever developed. That given enough time and enough bodies to replicate in, the virus will mutate. That people like to sit or stand close to each other, even when it's a health risk, and often don't wear their masks properly (or at all). That N95 masks are much more effective at reducing transmission than any other readily available masks, and that cloth masks are only marginally better than no masks at all. That the vaccine may be much less effective in children than it is in adults.

It is important to keep in mind that we want to live our faith as a compassionate multi-generational community, and so we feel it is important to be thoughtful of those who are not candidates for vaccination (such as young children), others for whom vaccinations may not have optimal effectiveness (such as children and immunocompromised individuals), and those who are at risk for serious consequences of infection. And we have been determined that services and events at our church and with our congregation will not be sources of transmission within our congregation and beyond of a virus that has the potential to have serious, potentially life-threatening, short- and long-term consequences. We recognize that other institutions, including other churches, have been less careful and compassionate than we have been. But they are not responsible for our congregants, and we are not responsible for theirs.

In light of all of this, we believe that it would be possible to attend to the spiritual and emotional needs of the congregation and visitors by opening the church, while limiting the potential physical harm of being together. We are recommending that we begin opening the church to fully vaccinated individuals using the following strategy, or some version of it:

1) Announce that we are inviting congregants who are fully vaccinated to attend in-person services in the building
2) Make it clear that we will not be checking on the vaccination status of individuals entering the building
3) Make it clear that we will be relying on attendees' honesty and their compassion toward other attendees and the community (2nd UU principle) to comply with our policy

4) Make it clear that persons who are attending without being fully vaccinated are putting not only themselves at risk, but also anyone that they might come into contact with who is vulnerable, particularly other unvaccinated individuals (e.g., young children) or persons for whom vaccines may not be fully effective (e.g., people with compromised immune systems) – this may include other church members
5) Strongly discourage anyone who is not fully vaccinated from attending in-person services for the reasons above
    a. Unvaccinated persons who intend to attend church events regardless should be asked to avoid any potential COVID exposure within 5 days of the event, and should be asked to perform a rapid at-home or commercial COVID test the day of the event with a negative result; it should be emphasized to them that, while a positive at-home test is highly accurate, a negative at-home test is much less so
6) Make it clear that being fully vaccinated is by no means a guarantee of protection against infection, and that attending church events is still a risk even if vaccinated
7) Strongly discourage anyone from attending services regardless of vaccination status if they have symptoms suggestive of COVID infection such as (but not limited to) fever, chills, cough, runny nose, shortness of breath, loss of sense of taste or smell or diarrhea
    a. It would be all right for those persons to attend services if they have a negative rapid COVID test that day, and it has been at least 5 days since their last possible COVID exposure or at least 2 days since the onset of symptoms
8) Make signage available at the church doors that we are asking that attendees be vaccinated and masked
9) Implore attendees to wear effective masks in the building – N95 or approved KN95 if at all possible (we should make N95 masks available at the door); double-masking with a cloth mask over a surgical mask would be next best, but is suboptimal
    a. See graphic at the end of this document describing the typical time it takes for a COVID exposure depending on the kind of mask worn (this was pre-omicron, and times may be reduced with omicron) – consider making this graphic available to congregants to help them understand why the kind of mask worn makes such a difference

    b. Below is a link to the list of the KN95 masks that were approved by the FDA under Emergency Use Authorization early in the pandemic; this approval was revoked last year only because of the increased availability of N95 masks, and should still be considered as listing the best KN95 masks available, and should be made available to the congregants, as it is still sometimes difficult to get N95 masks: https://www.fda.gov/medical-devices/emergency-use-authorizations-medical-devices/revoked-euas-non-niosh-approved-disposable-filtering-facepiece-respirators#imported

10) Limit the number of people in the church, with 6 feet of separation between pods (groups of people who ordinarily spend a great deal of time together) at any one time
    a. At this time, we are recommending a limit of 75 in the sanctuary while we are in orange, 100 while we are in yellow, and no limit while we are green
    b. We recommend blocking off every other row of pews to facilitate distancing
    c. Consider using the social hall as spillover space, with the service available on the TV screen in the social hall, should the sanctuary exceed recommended capacity
11) Service leaders may be allowed to remove masks while they are speaking as long as they are distanced from the congregation
12) Stagger events in the church so that there is at least a 2 hour gap between the end of one event and the beginning of the next if different groups will be involved
13) Weather permitting, keep doors and windows open while people are in the building

We recommend posting this document on the church website, and alerting the congregation to its existence. We also recommend sending a short email to all on the church's email list with specific guidelines for attending church services and events.

It is most definitely true that in-person services means that someone may be exposed to COVID in church, and may become infected. However, limiting services to fully vaccinated persons reduces both the likelihood that that will happen, as well as the consequences of such an event. We can't control our congregants' behavior or their health, but we hope that we can rely on

them to act in accordance with our faith's principles. If not, we have bigger problems than a virus.

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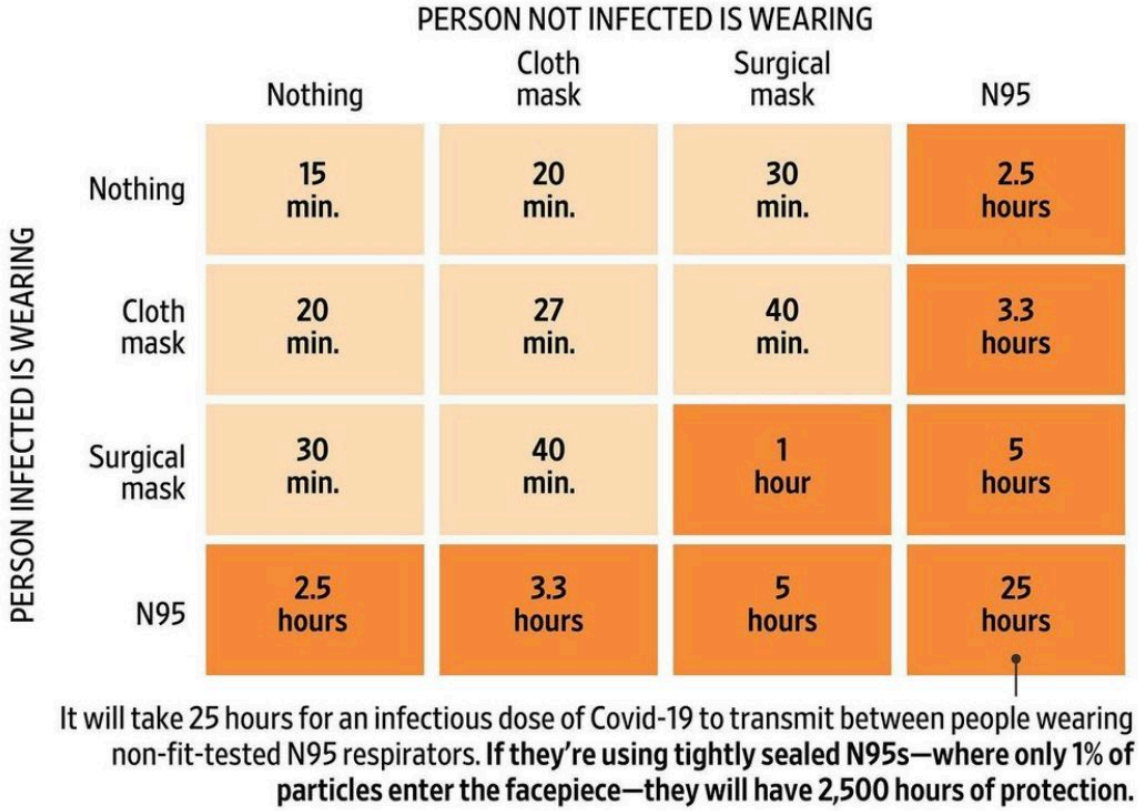
Why Cloth Masks Might Not Be Enough as Omicron Spreads

Time it takes to transmit an infectious dose of Covid-19



It will take 25 hours for an infectious dose of Covid-19 to transmit between people wearing non-fit-tested N95 respirators. **If they're using tightly sealed N95s—where only 1% of particles enter the facepiece—they will have 2,500 hours of protection.**

Note: Results published in Spring 2021. The CDC expects the Omicron variant to spread more easily.
Source: ACGIH's Pandemic Response Task Force