May 22, 2020

Dear Friends –

We pray that this correspondence finds you well and healthy amidst this unprecedented pandemic, quarantine, and heartbreaking loss in an ever narrowing circle of connection.

Our presbytery leaders, Warren McNeill and Barbara Smith, have been in touch with congregations and clergy since the beginning of this pandemic. They have shared recommendations on church building closures based on the directives of the CDC, and the States of New Jersey and New York, and compiled helpful articles from reputable sources on the Newark Presbytery website.

At its May 12 meeting, the Vision Accountability Board voted unanimously to create a task force to expand the conversations around reopening our church buildings. That task force is now comprised of Rev. Dr. Barbara Smith, Elder Warren McNeill, Rev. Maria Crompton (Elmwood), Rev. Dan Martian (Livingston), Elder Carlos Monteagudo, MD, MPH (Bloomfield Church on the Green) and Elder Tia Goss Sawhney, DrPH, FSA, MAAA (First Newark). On Thursday, May 21 the task force met via Zoom for in depth, thorough conversation, the basis of which we write to you today.

We know that some of our congregations are anxious to return to in-person worship in your church buildings. Others have taken official steps to continue only virtual worship into September and October. Others have said they don't feel comfortable returning to in-person worship until a vaccine is created. We have crafted today's letter from both theological and scientific positions – ***which lead us to recommend that our church buildings remain closed and worship remain virtual until at least September 12.*** Why?

THE THEOLOGY

When the Israelites were exiled in Babylon for 70 years, by necessity – and opportunity – they found new ways to live. They did not travel to their usual wells to dip water, or to their local temple to pray. But they still dipped water and they still prayed. And when it was time to begin their long journey back to their homeland, they knew that their new reality would be far different from their past. It was in the context of that journey to a new normal that Jeremiah shared the word of the Lord, which we find in Jeremiah 29:11 – *"For surely I know the plans I have for you…plans for your welfare and not for harm, to give you a future with hope."* And the Israelites did have a new normal. From the descendants of that wandering, questioning, searching crowd, we have a Savior: Jesus.

Jesus, our Lord and our Savior, told us – as recorded in Matthew 22 – the greatest commandment is to "…love the Lord your God with all your heart, and with all your soul, and with all your mind…And a second is like it: You shall love your neighbor as yourself." By continuing our quarantine long after our patience wears thin, by continuing our virtual and building-less worship, by recognizing the unintended consequences of inadvertently spreading a deadly virus that is not going away anytime soon, we are loving our neighbor. We are – as Jesus did before us – caring for the other.

Quite honestly, this pandemic is one of the greatest evangelism opportunities we've had in forever. The Gospel message is being heard by greater numbers of people tuning in to our virtual services who were not in the habit of stopping by to sit in our pews. Yes, we are sad that we can't hear the strains of "Holy, Holy, Holy" in our usual pew. Yes, we are sad that we can't pass the peace of Christ with our friends. But yes, we are being morally and ethically responsible. And we are also being morally and ethically responsible to the cultural diversity that is Newark Presbytery as some communities in our midst are part of a demographic that is more greatly impacted than others.

God is present whether we are in our buildings or not. We know that. This pandemic has given us great opportunity to be the hands and feet of Jesus as we provide food to people whose pantries are bare. This pandemic has given us great opportunity to reach people we haven't seen in years or ever – online. This pandemic

has given us great opportunity to connect with colleagues and brothers and sisters across the Presbytery we might never have met – online. How will we be different after this pandemic ends?

But when will that be?

As with everything with this novel corona virus, much is not known for certain and scientific guidance is made based on prior knowledge of other known and similar viruses and infectious diseases in general. It is not unusual for public health guidance to change based on emerging or additional scientific facts and observations on the ground. Any decisions to open up our churches and houses of worship will need to be informed by the best science that God has made possible for us to know. The following is a science primer.

THE SCIENCE

From a public health standpoint, the numbers tell the story. Let's start with what we do know from the global experience of COVID-19 thus far.

TREATMENT
Currently, there is NO cure and there is NO treatment for anyone becoming infected with COVID-19. There are only supportive therapies which aim at helping those infected survive their complications while their own bodies mount a defense against the illness.

There are dozens of potential cures and treatments in the pipeline, including vaccines, antibody harvesting and infusion, and medications. But NONE of these potential treatments have been shown to be effective or safe.

There is consensus that the best cure will likely come in the form of a vaccine. However, a cautionary note: traditionally vaccines can be very hard to develop and manufacture, and there are examples of many viruses that have proven difficult to create vaccines for, including viruses that produce the common cold and even for the virus that causes HIV.

MORBIDITY AND MORTALITY
- 70% of all individuals that get infected with COVID-19 will have a "mild case" and eventually recover.
- 30% of all individual that get infected with COVID-19 will develop serious complications and require life-saving supportive treatment in a hospital. These complications include viral pneumonia, blood clots, renal failure, encephalitis.
- 1-3% of those that get infected with COVID-19 will die from their complications.
- 30-40% of those in high risks group (pre-existing conditions such as obesity, Hypertension, Diabetes, age >60) who become infected with COVID-19 will die.
- Populations of color and those in low socio-economic groups have disproportionately high mortality and morbidity rates approximating those in high risk groups.
- In spite of previous guidance, COVID-19 can infect ALL age groups. More serious manifestations of the virus besides the lung findings are being reported in these populations. And even individuals who end up having only mild cases are still very contagious during their illness and can readily transmit the disease, especially amongst their close contacts, to others who are at high risk of becoming seriously ill.

Multiple organ systems are now known to be affected by the virus, most notably the lungs, the heart, the kidneys, the brain and the circulatory system, each producing a host of serious short and long-term effects.

TRANSMISSION
The mode of transmission of COVID-19 is believed to be primarily though contact with the bodily fluids (carrying virus) of infected individuals (saliva, mucus, urine, feces) and the air the individuals exhale. Specifically, this means:

1) **Aerosol:** Aerosol are very tiny liquid particles (from saliva, mucus, toilet water) that can carry the virus and can become suspended in the air for hours. This becomes a problem in enclosed spaces where the aerosol is produced but cannot be dispersed. High concentrations of aerosol are found in ICU settings where infected individuals are intubated and need to be suctioned routinely, a process that is known to produce aerosolized particles. It is also possible to produce aerosol when a person sneezes, coughs, sings, talks or flushes the toilet.

2) **Droplets:** Droplets are much bigger particles compared to aerosol and are also produced in high quantities when sneezing, coughing, singing and talking. They can travel long distances in high velocity during these activities. The droplets don't "hang" in the air like aerosols, but instead quickly drop to the ground and surrounding surfaces within a few seconds to minutes. Viral particles at high concentrations can be detected in these droplets for hours to days (cardboard/ paper – 24 hours, steel/hard plastic – 3 days, moist foods – 5 days).

PREVENTION

Until there is a cure or effective treatment, the best treatment is prevention.

It is known that the virus can be "shed" in large quantities by infected individuals who are NOT showing any signs or symptoms of the illness (i.e., **asymptomatic carriers**) for as many as five days prior to their becoming ill. Those individuals who do become ill and develop symptoms (most commonly fever, shortness of breath, coughing) are known to be highly infectious while they have active symptoms. Recent studies suggest that the individuals who fully recover from COVID are no longer infectious as early as one week after full recovery (even if they still show traces of virus in their bodies and still test "positive" for the virus).

The goal of prevention is not eliminating ALL contact with the virus, that is virtually impossible. The non-immunocompromised body CAN probably handle and effectively eliminate a few dozen (or even hundreds) of viral particles that it is exposed to at once through activation of its regular immune system. But the typical body CANNOT handle exposure to thousands or even millions of viral particles at once. It is this intense "viral load" exposure that likely leads to illness.

The goal of prevention then is to decrease the viral load to individuals as much as possible. With this in mind, the pillars of prevention become:

Social Distancing and Mask Wearing: This will greatly decrease the chance of viral transmission through airborne contact. Old laboratory studies from the 1930's revealed that the majority of droplets travel no more than 3 feet, so the standard guidance adopted by the CDC since then for droplet-born illnesses has been based on doubling this distance to 6 feet. Much more sophisticated studies recently reveal the particle can travel much further than six feet, up to 20 feet if one introduces a small amount of wind speed effects to these experiments.

Contact Tracing and Testing: Because of the presence of asymptomatic carriers and the ubiquity of this virus, very little in the form of mass safe re-entry can be accomplished without testing and contact tracing so that new infection outbreaks can be quickly identified and contained. Until then, re-opening may be possible only with small gatherings using clearly delineated and strict guidelines designed to decrease the spread of the virus in the general population and especially to high risk groups. And remember: contact tracing brings into question issues of privacy and a very real concern of protection for those among us who are undocumented.

Proper Hygiene and Food Handling: Since food is to be ingested, proper food handling practices are essential to prevent the spread of the disease.

The virus is known to require three types of molecules to be infectious: RNA, proteins, lipids. High heat or alcohol can denature (destroy) proteins and RNA. Cooking foods at temperatures above 160 degrees can effectively deactivate the virus. So can using sanitizers with at least 60% alcohol for surfaces that cannot be heated or washed. Lipid molecules are essentially "fat" molecules that can be effectively destroyed or contained using grease cutting soapy water. Washing objects with soapy water ends up being a very effective and readily available method to deactivate the virus.

Proper Hygiene and Cross Contamination: The CDC guidance continues to be to wash hands thoroughly and frequently for 20 seconds with soap and water, or when this is not available, sanitizers with at least 60% alcohol. This is intended to decrease the viral load that an individual may introduce into their bodies without knowing when they touch surfaces containing droplets with the virus and then inadvertently touch their mouths, eyes or nose – common entry points for the virus.

Very recently, new guidance from the CDC based on new scientific evidence suggest that the virus may not be as infectious from surface contact as previously believed. This data is evolving, and the CDC still says it is possible to contract the disease through cross contamination and are therefore still advising frequent hand washing.

Until the science is clear, we must be meticulous about avoiding cross contamination. That will mean disinfecting or washing high touch surfaces or objects frequently, so that "contact" doesn't happen inadvertently over time (example: once every four hours in work places). Importantly, glove wearing is ONLY effective as long as the gloves remain uncontaminated. Once a glove touches an infected surface, it too will become the cause of cross contamination and should be discarded.

CURRENT STATUS

Based on the facts above, prior to the lockdown the US was on track to experience between 1-3 million deaths from COVID-19 as the pandemic swept unhindered across the country. This unspeakable tragedy has been largely averted (or perhaps only delayed) by the sacrifice and efforts of everyone staying at home and keeping social distance. But in spite of these measures, we are rapidly approaching 100,000 confirmed deaths from COVID-19 (the number is likely much higher) and that number will unquestionably climb and accelerate again as we remove the only effective barrier - the lockdown - that we have at our disposal to slow down the spread of this disease. (As a point of comparison, the influenza virus causes 30-60,000 deaths per year - a large number yes- but WITHOUT having to institute a lockdown).

When we as a society begin to open up, it is clear that the death rates will again mount and our healthcare and economic systems will be additionally strained. There is nothing that has fundamentally changed in our society and communities, from a medical and public health perspective, compared to when COVID-19 first entered our community. Our bodies are still as vulnerable. The disease is still as highly infectious and lethal.

We are more aware and informed, yes. And that is a good thing. But we are also showing signs as a society of becoming emotionally fatigued and depleted, and possibly reckless because of it. There will be unquestionable short- and long-term consequences of the social isolation, social distancing, and economic hardships that we are still only beginning to understand and grapple with. No question. But Jesus commands that we address basic life and death issues ahead of all else.

CONCLUDING RECOMMENDATIONS AND SUMMARY STATEMENTS

We cannot open in the short-term. Why?

- Large gatherings and faith-based services are not yet allowed -- it's the law of New Jersey and Newark

- Even the small gatherings that will soon be permitted under eased restrictions may be rescinded if COVID cases increase due to the eased restrictions.

If eased restrictions go well and COVID cases don't increase large gatherings and faith-based services might be allowed July 1 or thereafter. But we should not open then. Why?

- COVID cases "not increasing" is not the same as COVID not being in our community -- COVID is in our community and will continue to be in our community for the foreseeable future.
- Many of our members, including our elderly members, are particularly vulnerable to COVID
- Our worship traditions (e.g. passing the peace, singing) and worship spaces (e.g. poorly ventilated bathrooms, less than rigorous cleaning) are conducive to virus transmission. To sing a joyful noise could literally kill someone.
- It only takes one person to make many people sick -- a person who may not have any symptoms him/herself.
- Churches should preserve and not endanger health and life.

We will need time beyond July -

- To ascertain that COVID cases are not only not increasing, but continuing to decline in our community, hopefully to near zero -- this requires that we wait at least 30 days after large group gatherings are allowed.
- To make changes to our worship traditions, cleaning processes, and even physical buildings to reduce the chance of virus transmission.
- For our congregants to gain faith that they can join us for worship without fearing for their lives.
- The time and care that will be involved for church leaders to develop policies, communicate those policies, and develop action plans to enforce those policies.

JUST BECAUSE WE CAN DOESN'T MEAN THAT WE SHOULD

While we are likely to have insurance coverage should we open sooner rather than later and someone dies, we don't want either the moral responsibility or potential years of litigation. Barbara has been in touch with our insurance agent – Brown and Brown. Richard Rhinehart, Vice President Religious Organization Team, writes - *"In the event the church reopens & someone comes down with COVID-19, suit could possibly be brought by that individual. The church board, ultimately, is the decision making body of the church & therefore, the ones making the decision to reopen in the first place. The Directors, Officers & Trustees liability portion of the package policy will respond to this particular suit since the claim would be viewed as a "wrongful act" on the part of the board. The policy will respond for both defense as well as any judgement rendered up to the policy limit."*

SO WHAT CAN WE DO? LOTS!

We already are building virtual communities as we gather with our local congregational communities for Sunday coffee hour. The presbytery offers a weekly Zoom happy hour on Wednesdays at 5:00 p.m. One congregation watched a movie together. Others are doing their prayer meetings and Bible Studies via zoom – and having a higher turnout! Another church has a sacred music hour on Sunday evenings – you can sing along at home! Just because you can't gather in the same space doesn't mean you can't be face to face! The leadership of another church regularly reaches out to every member to ask if they need assistance, to give encouragement, and to pray. And when needs are identified, they literally deliver.

You are already doing a great job with virtual worship! How about teaming up with worship and give your pastors a bit of a break? For instance, Central Montclair and Bloomfield already have a relationship with Holy Week services. One week David Noble preaches and the Bloomfield congregation tunes in. The next week Ruth Boling

preaches and the Central congregation tunes in. What if 12 different congregations worked together for the summer and each took a week?

Camp Johnsonburg has put together Camp in a Box. What if a group of churches got together virtually and shared VBS?

If nothing else, this pandemic has made real the fact that our virtual presence must continue. Take this time to upgrade your technology – audio and video.

Start thinking about Stewardship and your 2021 budget.

Make plans for the Fall/Winter that don't require you to be in person. Since this situation is always in flux, the chances are very real that we may be away from our buildings much longer than we currently anticipate, or may reopen only to have to close again.

We leave you with the words of the Apostle Paul in his letter to the Philippians [2-3b-4] – "Rather, in humility value others above yourselves, not looking to your own interests but each of you to the interests of the others."

Faithfully,

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Transitional Director of Presbytery Ministries

Rev. Maria Crompton
Elmwood United Presbyterian Church

Rev. Dan Martian
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Elder Warren C. McNeill
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