THE NEEDS OF THE SAINTS
Returning to Church 4.0

RELEASED MARCH 4, 2022

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EXECUTIVE SUMMARY

As the Omicron wave appears to subside, and in light of new guidance on "COVID-19 Community Levels" from the CDC, we feel that it is appropriate to take stock of the current situation and update the COVID-safer guidelines put forward in the Returning To Church series.

We undergird these recommendations with the Christian values of **Community**, **Hospitality**, **and Care and Concern for the Vulnerable**, giving special consideration to the often-difficult task of balancing diverse needs and opinions, while calling Christian communities to renew their commitment to the common good and to seek new life and new energy in this moment.

In response to the CDC guidelines, and in alignment with our values, we offer five key points of awareness:

1. **The COVID pandemic is not over.** Safer protocols can be adjusted, but should not be discarded altogether.
2. Individual members of communities will be at **different levels of willingness to drop risk mitigations**. Consider the needs of all, without neglecting those of disabled or vulnerable members.
3. There are likely to be more COVID waves. **Plans for risk mitigations should be adaptable** to circumstance on short notice. We offer detailed recommendations, best practices and suggested ways to structure plans starting on page 6.
4. Communities outside of the church are likely to loosen or drop safer protocols. **Seek creative, both-and solutions** rooted in joy, thanksgiving and love for those we serve, and a sense of the Holy Spirit's continued presence.
5. **The COVID pandemic has long-term implications for the church**. Now is the time to prepare for future needs.

We have replaced our previous Unsafe/Safer/Safest rubric with a new ***Levels of Concern*** scale, which can be found starting on page 6. We draw metrics from **COVIDActNow.org**. We invite churches to scale their mitigations up and down as conditions change, with our "safest" recommendations to be found in Table B on page 9.

CONTEXT

CDC Guidance

Throughout the pandemic, the Wisconsin Council of Churches has been an advocate for bridging the world of science and epidemiology and the world of the church. Public health is the field that "promotes and protects the health of people and the communities where they live, learn, work and play"...and worship.[1] We've been close partners for the past several years, trying to promote wellness and prevent illness in the church and the communities where we serve. We take the recommendations of public health officials seriously, but we also know that they sometimes need to be evaluated for their alignment with our ministry contexts and our Christian values.

The timing of the release of *Returning to Church 4.0* was very much prompted by recent CDC guidance, which attempts to respond to the ongoing volatile, uncertain, complex, and ambiguous environment we find ourselves in - exacerbated by COVID and the partisan entanglement of the pandemic response in the US. We agree that this stage of the pandemic calls for updated public health recommendations. At the same time, we feel that a more cautious approach is more appropriate to the current situation. This position is rooted in deep engagement with the scientific conversation around COVID and public health. For example, the CDC appears to model future waves on the Omicron variant—highly transmissible, but less severe compared to previous variants.[2] But outside epidemiologists warn that it is highly likely that there will be another COVID wave, and there is no guarantee that it will be as mild as Omicron.

There are other reasons for caution. Some public health experts are concerned about the CDC's reliance on hospitalizations, in addition to trends in infections. This concern derives from the fact that hospitalizations are a "lagging indicator," that is, one that follows after a surge in infections, lagging by roughly two weeks. By the time new COVID patients are admitted to hospitals, they contend, it may be too late for effective intervention to stop the wave. Moreover, risk of exposure in churches or other public spaces depends on the rate of new infections in the community, not on hospitalization rates or hospital bed usage. Accordingly, we appreciate and adopt the approach of those who emphasize other factors (such as new case rates, or test positivity) in their risk indicators.[3]

And though the CDC advice calls for "protecting people at high risk for severe illness or death by ensuring equitable access to vaccination, testing, treatment, support services, and information," particularly when community levels are high, the new guidance still places much of the burden on vulnerable people to monitor the situation and take individual protective action. This is of particular concern because many of the recommendations advise consultation with a primary health care provider, something that 10-15% of Americans lack.

We are also concerned that the average person will interpret this new guidance as an "all-clear situation" declaring the pandemic over and COVID-safer practices unnecessary. Our trusted sources remind us regularly that the pandemic is not over. Our call to community care invites us to continue "small, but important measures" we can continue to keep one another safe.[4] We want to support community leaders who maintain appropriate cautions, and encourage faith communities to practice "both-and" solutions to ongoing risks, rather than "either-or" decisions.

In short: we respect the CDC and the work of the scientists within that institution. However, the latest recommendations seem connected with values more aligned with commerce, industry and public sentiment than the values that have guided us since the beginning of the pandemic.[5] In this case, the ministry context of the church calls us not to reject the baseline recommendations of the CDC, but to move a step beyond them. This is not only a matter of theological fidelity, but justice, equity, and the long-term health of the church.

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[1] https://www.apha.org/what-is-public-health

[2] Because of this, the CDC uses three measurements to assess pandemic risk: new COVID-19 admissions per 100,000 population in the past 7 days, the percent of staffed inpatient beds occupied by COVID-19 patients, and total new COVID-19 cases per 100,000 population in the past 7 days. https://www.cdc.gov/coronavirus/2019-ncov/science/community-levels.html

[3] https://www.covidactnow.org/covid-risk-levels-metrics

[4] https://www.ama-assn.org/press-center/press-releases/ama-statement-cdc-covid-19-updates

[5] Dr. Greg Gonsalves, Associate Professor of Epidemiology at the Yale School of Public Health and Associate Professor of Law at the Yale Law School, summarizes this perspective (shared in much other commentary as CDC recommendations were released) in a Twitter thread here: https://twitter.com/greggonsalves/status/1497889516274606087?s=20&t=jX90Ac-kWN1nzF1es8UbNA

THEOLOGY, ETHICS & VALUES

The recommendations in *Returning to Church 4.0* are guided by the following values:

- **Community:** It is a time to renew commitment to the common good
- **Hospitality:** See God in the "stranger" (even the newly unfamiliar to us)
- **Care and Concern for the Vulnerable:** We must center equity and accommodations in our ministry

Christians are Easter people. Especially in this Lenten season pointing us toward the celebration of Christ's victory over death, we recognize the reality of pandemic exhaustion and the desire for new life. Two years of isolation, anxiety and grief are enough for anyone. We look forward to a time of new energy among God's people. As we move toward that point, we want to ground the transition in the traditional Christian values of community, hospitality, and care and concern for the vulnerable.

Community

I told them that the hand of my God had been gracious upon me .... Then they said, "Let us start building!" So they committed themselves to the common good. —Nehemiah 2:18[6]

Pandemics are by nature social, and thus require social responses. That is to say, individuals must commit themselves to building up the common good through collective action. This in turn often requires taking steps such as masking, social distancing, or physically-distanced ministry that benefit the community with little or no discernible reward for the individual. Over time, the commitment to such work may weaken as the perceived burden increases and the perceived benefits decrease.

While it may be time to reassess COVID-safe practices in faith communities, we suggest that it is also a time to renew commitment to the common good. The pandemic is not over, particularly for those who are unvaccinated, immunocompromised, or living with disabilities. There will likely be future waves of COVID, or other emergent diseases that require public health measures. Leaders will want to help their people think carefully about ongoing responsibility to the body of Christ, and what the future may require of them.

In doing so, leaders and communities should work with consideration of the mutual and equitable nature of community. This means recognizing the needs of all members while deliberately prioritizing the voices of those on the margins.

The renewal of commitment to the common good is well-rooted in the grace of God in blessing, consoling, protecting and healing the community in the midst of a terrible season. It is important to claim not just the costs of discipleship, but also its joys.

Hospitality

Contribute to the needs of the saints; extend hospitality to strangers. —Romans 12:13

The ancient Christian practice of welcoming takes many - sometimes surprising - forms in the COVID era. There is the grace of forgiveness when the congregation or its members make choices other than what one as an individual would do, the generosity of diversity in feelings about, and approaches to, COVID-safe practices, and the practices themselves.

[6] All scripture translations from the NRSV, ©1989 National Council of the Churches of Christ in the United States of America. Used by permission. All rights reserved worldwide.

Navigating the pandemic has been difficult for many, sometimes in not very obvious ways. Each person has a different tolerance for risk affected by personal circumstances, family make-up and relationships, local context, and more. Each person also has ideals and theology that pull towards certain values, yet lived reality may not correspond to this vision. It is important to avoid as much as possible causing moral injury by asking individuals to violate their sense of right and wrong for the sake of accommodating the community.[7]

Members of the community will also need to cultivate flexibility in their responses to the pandemic, and charity for those who disagree with them. God's grace and call to love their neighbor invites Christians to see them through God's eyes, even when they choose different ways to navigate the pandemic. This might mean letting go of thoughts that our neighbor is "too strict" or "reckless" in favor of seeing them and ourselves surrounded with God's grace in all of life's mess and complication.

When we find ourselves being judgmental or angry of others, it may be best to shift our stance to one of loving curiosity. We may discover that "strangers" include not just those we don't know, but familiar faces whose thoughts and commitments we have not considered deeply. Welcoming can mean making new friends, or making new room in our hearts for the ones we currently have. Jesus often asked questions when confronted with difficult situations. Non-leading questions may help individuals or the community move from a space of hurt or judgment towards a space of better understanding and grace, even if disagreement persists.

We have heard many stories over the course of the pandemic of individuals who felt hurt and rejected by faith communities that refused to take steps to adequately protect them from the risk of COVID infection. These include people such as pregnant mothers or young families with unvaccinated children. Some of the most painful involve individuals with chronic conditions affecting their immune systems, who feel cast aside or devalued by society under the best of circumstances, only to experience it even more keenly during the pandemic.[8] Without minimizing these experiences, we also know that some who have higher risk budgets feel alienated from their more cautious siblings and struggle to understand their choices to remain apart.[9] We know that those who struggle with COVID precautions sometimes express mental health concerns arising from isolation, and experience other barriers due to geography, finances, and life circumstances.

At the same time as we hold these places of compassion, we have also heard of communities that have found new ways to flourish and even grow amid COVID. Some of these, such as a children's ministry conducted by video, involved groundwork that had been laid in person before the pandemic. Others arose directly from the circumstances of COVID. While in-person worship services were difficult for them even before the pandemic, some immunocompromised individuals have found new ways to be connected with their church through online meetings, as have some individuals with dementia. A congregation in an isolated area has used the same technology to care for homebound members; other communities are able to include members snowbirding in other states, or even individuals living on another continent. Still others have taken to streaming worship online, broadcasting it to cars in their parking lot, or over the local radio station.

This should not be taken as a commandment to remain physically distant, or to hold up Zoom church as the model for gathering. Each community will have to discern for itself the best way of gathering. Whether in-person or remotely, this should include asking what implications COVID-safer practices, or their absence, have for how welcome members of the church and its neighbors and friends feel in the community. We invite congregations to rediscover the joy of serving members who are not able to be physically present, and welcoming the wider world into the community.

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[7] "Moral injury is the social, psychological, and spiritual harm that arises from a betrayal of one's core values, such as justice, fairness, and loyalty." https://www.psychologytoday.com/us/basics/moral-injury See also Greene, T., Bloomfield, M. A. P., & Billings, J. (2020). Psychological trauma and moral injury in religious leaders during COVID-19. Psychological Trauma: Theory, Research, Practice, and Policy, 12(S1), S143-S145. https://psycnet.apa.org/fulltext/2020-41718-001.html

[8] https://www.theatlantic.com/health/archive/2022/02/covid-pandemic-immunocompromised-risk-vaccines/622094/

[9] For more on risk budgets, see https://covid-101.org/science/what-is-your-risk-budget/

Care and concern for the vulnerable

"Lord, I am not worthy to have you come under my roof;
but only speak the word, and my servant will be healed." —Matthew 8:8

Christians are often reminded, and rightfully proud of their call to minister to widows, orphans, the poor, sick, imprisoned, and other individuals needing special care. As with so many aspects of life together, this calling has taken on new dimensions in light of COVID-19.

The first and most obvious concern is to provide for the physical safety of such individuals. It is important to recognize that their needs - and sensitivity - may last long after the bulk of the community is ready to return to familiar ways of life. To the extent possible, congregations should continue to provide for those needs in ways that do not place the burden on vulnerable individuals to protect themselves. Consider ways to mitigate or offset risk, such as requiring children and adults to mask in Sunday School classrooms, by improving airflow in the sanctuary, or continuing to hold business meetings over Zoom. Again, it is best to seek both-and solutions, rather than all-or-nothing.

In the same way, it is also important to recognize and accept the perspectives of especially vulnerable people. In particular, the feelings and ideas of the disabled are often discounted in our society. The pandemic has reinforced the idea with many that their voices are not heard and their lives are not valued. The church must recover an active sense of how people living with disabilities bear the image of God, and so deserve a central place in the conversations of the faith community.

By doing so, we may discover that the umbrella of disability is much wider than expected. An estimated one-in-four Americans live with some form of disability,[10] whether physical, cognitive, or emotional, including people we may not think of. For example, individuals with compromised immune systems include those with rheumatoid arthritis, Crohn's disease, diabetes, heart, lung or kidney ailments, or who have received a transplant. Autism, mental health concerns, and other "invisible" disabilities are also considerations. Six out of ten Americans have an underlying condition that puts them at higher risk for severe illness if they contract COVID19.[11] COVID itself is now being considered a mass disabling event,[12] with many people receiving new diagnoses for chronic conditions after their initial recovery. COVID can complicate or prevent treatment for many of these conditions.

Christians may accept their own mortality, but they can never give up the responsibility to protect vulnerable individuals such as children under the age of 5, others who are unable to be vaccinated, or for whom vaccination may be less effective. There is an inescapable need to advocate for equity within faith communities and in the broader world, where many do not have equal access to vaccines, testing, or medical care to treat infections.

This is also a matter of self-concern, as recent evidence suggests that it is not just our own neighborhoods that determine COVID outcomes, but the communities those neighborhoods are connected to. Because pandemics take place in communities, caring for the vulnerable protects all. Rev. Dr. Martin Luther King Jr. wrote, "of all the forms of inequality, injustice in healthcare is the most shocking and inhumane."[13] We remember also Dr. King's cry of interdependence in *Letter from a Birmingham Jail:* "We are caught in an inescapable network of mutuality, tied in a single garment of destiny. Whatever affects on directly affects all indirectly."[14]

As the church seeks new life in a time beyond the COVID crisis, it will need to do so with a sense of the grace and goodness of Jesus Christ, who took initiative for the healing of all humanity.

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[10] https://www.cdc.gov/media/releases/2018/p0816-disability.html
[11] https://www.healthline.com/health-news/60-percent-of-americans-have-underlying-condition-that-increases-covid19-risk
[12] https://dcp.ucla.edu/covid-19-mass-disabling-event
[13] Speech to the Medical Committee for Human Rights, 1966
[14] https://www.africa.upenn.edu/Articles_Gen/Letter_Birmingham.html

CORE RECOMMENDATIONS & BEST PRACTICES

Returning to Church 4.0 includes the most significant updates we have made to our core guidelines for churches gathering in the COVID era. As earlier sections of this document illustrate, the science of mitigations and interventions has advanced a great deal since 2020. Nevertheless, there are still those among us who are vulnerable and there is no zero-risk approach to gathering. In light of our identities as love-focused communities offering alternatives to economic and power-driven ethics, a sliding scale of conditions can help us make more nuanced decisions than "all open" or "all closed", inviting us into a both/and approach to solutions to risk.

Table A, below, offers a range of conditions on a scale from Low Concern to Extreme Concern, within which our recommendations are framed. The three key metrics used to identify each condition are:

- **Daily New Cases / 100,000 population**
- **Infection Rate - also known as Rt**
- **Test Positivity Rate**

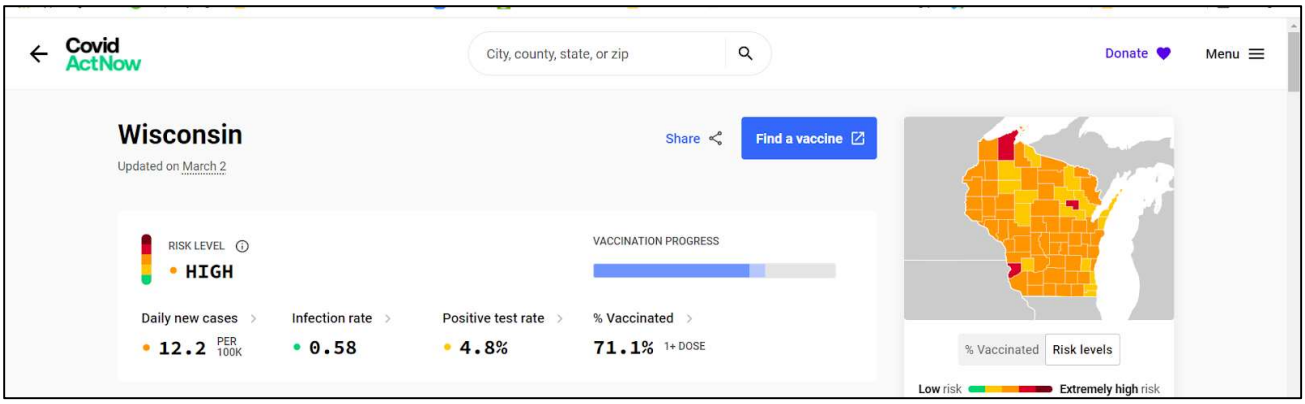
If you have been following previous versions of *Returning to Church,* you'll notice that we have dropped vaccination as a key metric, as vaccinations are now widely available. However, we do strongly urge vaccination and consider the availability of vaccines for all ages a critical factor for considering when to go mask optional. Definitions for statistical measures can be found in the final section of this document. These rates are all easily found on most COVID tracking sites. The Council will be reporting statewide rates from the well-regarded site CovidActNow.org. We encourage you to track your county-wide rates or metropolitan area, using the site that works best for you.

Table A. Levels of Concern[15]

Conditions	Daily New Cases/100K (7 day average)	Infection Rate R(t)	Test Positivity Rate
LOW Concern	<1 daily new case /100K	<1 new infections for each new case	<3% of tests positive
MEDIUM Concern	1 to <10 daily new cases /100K	1-1.09 new infections for each new case	3-9.9% of tests positive
HIGH Concern	10-24.9 daily new cases /100K	1.10-1.39 new infections for each new case	10-19.9% of tests positive
CRITICAL Concern	25-74.9 daily new cases /100K	1.4-2.09 new infections for each new case	20-35.9% of tests positive
EXTREME Concern	75+ daily new cases /100K	2.1+ new infections for each new case	36%+ of tests positive

[15] Adapted from *COVID Mitigation Plan, The Church of the Holy Trinity, Rittenhouse Square* in consultation with WCC medical advisers.

Here's what these statistics looked like on CovidActNow as of March 3, 2022 on a statewide level:



Daily New Cases/100K were at 12.2, R(t) was at 0.58 and Positive Tests at 4.8%. On a statewide basis, this puts us in a HIGH category, although several indicators have been moving in a promising direction. Try searching for your own county or metro area and assessing it based on the metrics in Table A.

Below we offer suggestions for best practices at each level of concern. You may wish to adapt them according to the characteristics of your own faith community.

BEST PRACTICES: MASKING and DISTANCING

As described in prior recommendations from the Council, the best mask is generally the one that fits individuals the best and that they will wear regularly. Even so, we have learned that fabric masks are not protective enough against some COVID variants. When transmission is higher, it is necessary to increase the quality of mask material and check for fit to protect self and neighbor.[16] It is also wise to re-check your sense of social distance; the safer distance of 6 feet easily creeps to 3 feet or less with familiarity.

- **We invite you to consider *maintaining your masking expectations* until:**
  - 4-8 weeks after all ages are eligible to be vaccinated.
  - All metrics are in the LOW concern category

- **When you shift to *Masks Optional*, consider the following to maximize your welcome** to those who are most cautious:
  - Use language indicating that you are a *Mask Affirming* environment. Anyone may decide that wearing a mask is the right decision for them, regardless of Community Level.
  - Maintain a *Masks Required* and physically distanced area of the gathering space
  - Consider whether there will be other *Masks Required* areas of your building, such as child care spaces

- **When to resume mask expectations:**
  - We urge you to *resume* mask and distance expectations whenever any conditions reach MEDIUM level.
  - We urge you to resume *high quality* mask requirements (medical grade, N95, KN95, KF94) and physical distancing whenever any conditions reach HIGH level.
  - Consider scaling mask expectations up more quickly for those who are singing, speaking, and in close proximity to the most vulnerable.

[16] The Public Health Collaborative offers a shareable guide to selecting an appropriate mask: https://publichealthcollaborative.org/resources/shareable-graphic-what-mask-should-i-wear/

BEST PRACTICES: VACCINATION

- **Consider *strongly encouraging* being up-to-date on vaccinations** to attend church in physical place.
- **There *are* churches in the US which require vaccination for physical attendance.** If this is a direction you choose, be pastoral in your language and ensure you continue to offer the choice to attend a full, vibrant hybrid or online option as an alternative.
- **Consider *requiring* all church staff, paid & volunteer singers and worship leaders, paid & volunteer child care workers, and food service volunteers to be up to date on vaccination, including boosters.**
- **Consider vaccination requirements for other settings and activities**, such as rental groups that present higher risk; volunteers with public-facing duties; youth groups; to receive childcare; or retreats.

BEST PRACTICES: COMMUNICATIONS

As we will be dealing with COVID and other diseases for some time, it is good to establish practices that help us normalize our range of individual and communal responses that help us stay safe. Here are two best practices that will improve communication and reduce points of potential conflict:

- **Best Practice:** Have a way for people to let you know their comfort level with interpersonal interactions. Some churches have implemented wristband systems or adapted their nametags. People will have varying risk tolerance and needs, and Christian welcome includes a sensitivity to these needs.
- **Best Practice:** Use language that normalizes the up-and-down flow of mitigations as needed. Make it clear when you reduce mitigations that there may come a time when they may need to return, out of care for the community and as part of the church's established practice. (Be aware that those who study epidemics anticipate another surge within the next 6-12 months.)

BEST PRACTICES: ADAPTING MITIGATIONS

For every level of concern indicated in Table A, we recommend a stance toward community-wide activities and a baseline set of mitigations. Please note: While our best practice is that when *any* metric moves into a higher category you move to that level of mitigation, you know what is best for your community. Your COVID task force or leadership group may choose to wait until more metrics change.[17]

- **Best Practice:** Shift UP a level in Table B when any metric in Table A increases a level (when COVID conditions worsen in community). Shift DOWN a level in Table B when ALL metrics meet the lower level
- **Best Practice:** YOU know your community best. Establish your local mitigations policy with your COVID task force and communicate it to your congregation.

The list of recommended mitigations for each level of concern can be found on the next page.

[17] Prior editions of *Returning to Church* have used a framework of Unsafe / Safer / Safest. You might consider shifting at 1 increased metric our "safest" threshold, and waiting until 2 or 3 metrics have shifted our "safer" threshold. Having no framework established would fall in our "unsafe" category.

Table B. Recommended Mitigations[18]

Conditions	STANCE	Church Recommendations	Congregational Expectations
LOW Concern	**Wide Open Community** Hybrid Availability	Vaccination Recommended Full Activities Offered	Indicate your risk tolerance so we can be welcoming
MEDIUM Concern	**Open Community** Hybrid Availability Basic Mitigations	In-person events if outdoors Or if indoors and masked Sign in for case tracking Reduced congregational singing	Please wear masks, expect physical distancing + outdoor fellowship We will be singing less
HIGH Concern	**Community Care** Hybrid Encouraged Better Mitigations	Avoid food-oriented activities[19] Online alternatives encouraged Event registration expected Singing by worship leaders only Adapt Communion for safety Leaders/caregivers test Increase ventilation as possible	Please wear High-Quality Masks, Expect physical distancing, Maintain Layered Mitigations Only worship leaders will sing Many of our activities will be online
CRITICAL Concern	**Community Caution** Online Worship Strong Mitigations Limited Persons Onsite	All mitigations in HIGH concern, PLUS Provide high-quality masks to those who will be in building Pause on in-person activities other than worship	Worship Leaders in Sanctuary Assembly at home OR Worship in physical space will be open to vaccinated persons only with high quality masks
EXTREME Concern	**Extreme Caution** Online Worship Maximal Mitigations Minimal Persons On Site	Provide high-quality masks to those who will be in building No food-oriented activities Pause on in-person activities other than worship Limit building use	Worship Leaders in Sanctuary or Offsite + High Quality Masks + Testing

[18] Adapted from *COVID Mitigation Plan, The Church of the Holy Trinity, Rittenhouse Square* in consultation with WCC medical advisers.
[19] We avoid food-oriented activities at higher levels of concern not because the food is inherently a problem, but because of the inability to eat and be masked. You might switch to take-away or delivery options if you want to offer a food-oriented ministry at these levels.

Here are two illustrations of how this might work in a local worshiping community. Example number one is a situation in which COVID numbers are worsening. Example number two is a situation in which COVID numbers are improving.

Example #1 - Should we increase mitigations?

Your community is at a level of LOW concern with less than 1 new case per day/100K population on average, 0.7 new infections for each new case, and a 1% test positivity rate. Just before your COVID task force meeting, CO*VIDActNow* updates, showing 2 new cases per day/100K population, a rate of 1.25 infections for each new case, and a 2% test positivity rate. Two factors have moved beyond the LOW concern level. You agree that the trend is not good and agree to move to MEDIUM concern according to your protocol.

Example #2 - Should we decrease mitigations?

Your community has been at a level of HIGH concern with 15 daily new cases per day/100K population, 1.25 new infections per new case, and a 12% test positivity rate according to CO*VIDActNow*. When you check for an update, you're happy to see that the numbers have updated to 10 daily new cases/day per 100K population, 1.09 new infections per new case, and 10% test positivity. One factor has gone down to the MEDIUM level! Your team agrees that the trend is good, but you're not quite there yet and agree to check again in another week before shifting your stance.

WHAT TO DO WHEN THE COMMUNITY MAKES OTHER CHOICES

Are any among you suffering? They should pray. Are any cheerful? They should sing songs of praise.
Are any among you sick? They should call for the elders of the church and have them pray over them,
anointing them with oil in the name of the Lord. The prayer of faith will save the sick, and the Lord will raise them up.
—James 5:13-15

The church is meant to be set apart. Christians care for the most vulnerable even, and especially when the world as a whole does not. That being said, we know how difficult it is to maintain COVID-safer disciplines when schools, business, athletic teams, and some other churches are operating without them. CDC guidance advising that most of the nation can relax its standards is cold comfort when trying to protect vulnerable members of the community from COVID risks. We also recognize the difficulty of balancing many different perspectives and needs within faith communities. Sometime groups make decisions that are not what any one individual would choose.

The pandemic continues to place large burdens on leaders who often sideline their own feelings in order to make space for others in community. They must make and stand behind decisions that they know will never satisfy everyone. They regularly experience anger and unkindness from people who are not getting their way. We ask members of all faith communities to respect and overtly appreciate their leaders, open themselves to curiosity that can lead to understanding, and remember that circumstances change. We can all weather seasons of disappointment or minor discomforts for the sake of building up the body of Christ.

The epistle of James suggests that Christians care for the sick and suffering not because they have been explicitly commanded to do so, but because it is a mark of their character. Tending the sick is simply what Christians do because they are Christians. It is possible to look at the work of COVID-safer protocols from other ethical perspectives: we do it because it's the right thing to do, or because it's the best thing for the greatest number of people, or because it advances the goal of a world in which COVID is more predictable, rather than regularly disruptive of daily life.

Whatever the approach, the fact remains that those taking precautions such as masking, social distancing and hand-washing may be increasingly out of step with a society that seems to be determined to move on from COVID. It is critical, therefore, to root these practices not in burden and obligation, but in joy, thanksgiving and love for those they serve. Center the conversation on God's acting and loving initiative to protect and sustain the community and the voices of those who benefit from the practices.

It is also helpful to avoid making all-or-nothing choices. Try to think of ways to keep the practices that you can—and to offset the ones that you can't. We urge you to remember that the Holy Spirit is with us in every struggle. Let the winds of creativity and holy imagination inspire you to stretch in new ways when mitigations grow tedious:

- Instead of simply mandating distancing at a church event, find a way to make it invitational. Example: a community is holding a prayer service for peace. It might be possible to post names of various cities around the room and invite people to spread out and pray specifically for the residents of each city, while making sure that the congregation was spread out across stations.

- Implementing mitigations might offer a good opportunity to reimagine a longstanding event. Example: turn a community meal that typically takes place in the church basement into an outdoors community block party.

- Instead of leaping straight from in-person events to no physical presence, or from fully remote ministry straight to fully in-person ministry, be mindful of offering a sliding scale of opportunities to gather. Small vaccinated groups can gather more safely than a large assembly when COVID conditions in the community intensify. Similarly - groups will be able to sing outdoors more safely than indoors at a time when conditions are improving but you're at "not yet." Parish care visits outdoors offer a caring outreach to those who miss community life. Seek out ministry opportunities for extroverts that give them a chance to engage in COVID-safer ways. We invoke holy imagination: think in terms of "Yes, and this is how" instead of "No."

PREPARING FOR THE FUTURE & LONG TERM IMPACTS

Even if another major COVID variant of concern does not appear, most experts believe it is only a matter of time before the world faces another significant disease outbreak. Neither "natural immunity" from infection nor vaccine-induced immunity appear to be long-lasting against COVID. Churches should invest time and resources to plan for the near-term likelihood of another COVID wave. Keep supplies readily accessible and as mentioned above, have a plan for what to do and how to make decisions quickly.

Preparing for the Future
- Have a plan & process for how to make decisions quickly
- Think about necessary projects whose costs you can spread out over time
- Consider practices/habits you want to continue to encourage
- Continue to develop staff & volunteer skills in online/hybrid worship
- Support pastors & lay leaders well
- Be prepared to deal with grief & trauma
- Find a source of hope in your ongoing work

This may be a good time to think about significant projects such as HVAC upgrades, investment in sound and video technology, social media training, or other big-ticket items related to COVID-safer practices whose costs you may want to spread out over time. We have heard from several congregations how rewarding it is to finally make investments that should have been done previously when prompted by pandemic concerns.

Consider practices and habits that you may want to continue. For example, it is good general health practice to encourage regular hand-washing or sanitizing, masking if potentially exposed to illness, and staying home when feeling ill. Public health authorities report much lower cases of influenza over the past two years, in large part due to precautions taken due to COVID.

Churches should also think about ways to support volunteers and staff leading online worship, if keeping it as an alternative to in-person services, or if it will be revived in a new surge of the virus. Do they have the training and equipment they need to be effective? Are there enough participants to allow team members to take a vacation or other break? Are there ways you can continue to develop hybrid worship skills to make that a more robust part of your ministry?

Think as well about ways to support pastors and lay leaders, each of whom were stretched during the pandemic. Do they need time away from their duties to rest and recover? Are there ways to relieve the burden on them? To insulate them from the inevitable controversy that will arise if mitigations must return or continue? To offer them thanks, blessing, and prayer for their ministry?

Be prepared to deal with grief and trauma, in individuals, the congregation, and in the community. Don't be surprised if the grieving process for ordinary changes or transitions, such as the departure of a long-time pastor or the death of a church friend, take longer or prove more difficult than in the past.

Last, find a source of hope in your ongoing work. Ask yourself:

- Who has your community been able to reach that you haven't previously?
- What has been strengthened in your community?
- What learning, and what love, can you carry forward together?

The future is inherently unpredictable. But leaning into it can also unlock tremendous energy, even from communities that feel half-dead. As Christians, we believe in resurrection. We still have a long journey ahead before COVID can be properly considered endemic—occurring at more or less stable and predictable rates. We have come this far by faith, and affirm that faith in the living God and one another will take us the rest of the way.

REFERENCES & LINKS

WCC Status Updates

We update our key metrics approximately weekly at https://bit.ly/returningtochurch

Statistical Trackers offering state and countywide data

- COVID Act Now https://covidactnow.org/
- GlobalEpidemics https://globalepidemics.org/key-metrics-for-covid-suppression/
- DHS-WI COVID Summary Data https://www.dhs.wisconsin.gov/covid-19/data.htm
- New York Times: https://www.nytimes.com/interactive/2021/us/wisconsin-covid-cases.html
- Wisconsin Hospital Assoc. https://www.whainfocenter.com/Covid-19Update

Definitions

- **Endemic Disease:** Occurs at a more or less stable and predictable rate in a particular area. Endemic diseases such as the flu, malaria or tuberculosis can still be quite severe, and health officials monitor them carefully to make sure they don't spread or mutate into dangerous variants.
- **Epidemic Disease:** An unstable, unpredictable outbreak of disease in a particular area.[20]
- **Pandemic Disease:** Worldwide epidemic; a disease that breaks out of its area of origin to spread across the world. Pandemics are less predictable and involve greater waves of disease than endemic conditions. Most experts believe COVID will eventually become endemic, but expect one or more additional waves to come before the disease settles into a predictable pattern.
- **Case Rate:** The number of new cases of COVID-19 per 100,000 people during a specified period of time. If the specified period of time is one day, then this is called the "daily case rate" or "new cases per day" and is often reported as an average over time, e.g., a 7-day moving average. It's useful in comparing the spread of COVID in communities of different sizes, and in discerning whether transmission is increasing, decreasing, or staying the same over time. This is different from the infection rate.
- **Positivity Rate:** The percentage of tests that confirm a case of COVID-19.
- **Vaccination Rate:** Generally, percent of total population vaccinated. Some sources exclude those too young to be vaccinated, but the WCC's recommendations are based on *total* population.
- **Infection Rate (also called the Reproductive Ratio) - R(t):** the estimated number of new people each COVID-positive person will infect. An R(t) of 1.0 means that the daily new cases of COVID are stable, while an R(t) greater than 1.0 means that daily new cases are growing. We need to drive R(t) below 1.0 in order to stop community spread. Side note: You'll sometimes see Infection Rate indicated as R(t) or R_t– we use R(t) here because that's what COVIDActNow uses.

WCC Information Channels

- **WCC Website** http://wichurches.org
- **WCC Twitter and Instagram** @wichurches
- **WCC Facebook** https://www.facebook.com/WisconsinCouncilofChurches
- **WCC COVID Vaccine Outreach Project weekly newsletter** https://www.wichurches.org/2021/04/21/covid-19-vaccine-outreach/
- **WCC Community Health Program** https://www.facebook.com/WCCcommunityhealth/ has informational updates, resources to address misinformation, and support for those wishing to provide COVID resources, education and vaccine clinics to parishioners and their community.
- **WCC Programa de Salud Comunitaria** (Spanish language resources) https://www.facebook.com/WCC.Programa.de.Salud.Comunitaria
- **WCC Youtube** https://www.youtube.com/wisconsincouncilofchurches

[20] Definitions and illustrations of Epidemic, Pandemic, and Endemic can be found at https://www.publichealth.columbia.edu/public-health-now/news/epidemic-endemic-pandemic-what-are-differences

Other Reliable COVID Resources & Information Sources

- CDC COVID Information
- Center for Infectious Disease Research & Policy (CIDRAP)
- Osterholm Update
- World Health Organization
- Social Media Handles for Government Information – WHO, CDC, FDA, HHS, NIH
- Ecumenical Protocols for Worship, Fellowship and Sacramental Practices https://www.facebook.com/worshipsafely/ and https://sites.google.com/view/worshipsafely
- Dear Pandemic http://dearpandemic.org and Facebook.
- In Spanish at: https://www.facebook.com/QueridaPandemia
- Public Health Madison & Dane County blog: https://publichealthmdc.com/blog
- Your Local Epidemiologist https://yourlocalepidemiologist.substack.com/ and Facebook
- Jessica Malaty Rivera, MS @jessicamalatyrivera on Instagram
- Answers to Tough Questions about Public Health, including trust in public health guidance and pandemic fatigue
- Building Bridges: A Practical Communications Tool for Answering Tough Questions and Building Trust

This document was developed by Wisconsin Council of Churches staff with input from religious leaders, local church pastors, public health experts and emergency management officials. We are particularly grateful for the insights of Dr. Geof Swain, MD, MPH, Emeritus Professor UW School of Medicine and Public Health, founding director of the WI Center for Health Equity and President of the WI Public Health Association; and Dr. Malia Jones, PhD, MPH, co-founder and editor-in-chief of *Dear Pandemic* and Associate Scientist in Health Geography at the UW-Madison Applied Population Laboratory. This is not a formal policy statement of the Council. We are neither attorneys nor physicians. This document is based on the most recent science available to us as of the date of publication. We recommend that you consult your ecclesiastical authorities for final guidance. Released March 4, 2022.