Opening Task Force (OTF)

Report and Recommendation to the UUCB Board of Trustees on UUCB Vaccine Policy

Introduction – Science – Policy Options

November 28, 2021

INTRODUCTION

From the beginning, the Opening Task Force (OTF) has been guided in its efforts by an overall principle of pursuing the best for the most. We want what is best for our community and what will unite, not divide us. Honoring the science and the advice of public health experts and our UU values, we have developed protocol phases to be as inclusive, welcoming, safe and accommodating as possible. With invaluable staff support, we have acted to minimize risk, maximize comfort, honor trust, manage the phases and adjust as changes with the pandemic have developed. As lifesaving vaccines have become available, we have strongly encouraged all who can be vaccinated to do so.

The pandemic is not over. When COVID numbers change significantly, so that public health experts adjust their protocol advice, and when our congregation expresses more confidence in the safety of gathering in person indoors, we will review existing policies and protocols to recommend appropriate adjustments for the continued safety and welfare of our members and friends.

Our specific guiding principles have been:

- The common good and the health and welfare of our congregants is foremost in our deliberations.
- We commit to listen deeply to congregants.
- Draft reopening plans will be shared for review and comment with key UUCB entities, e.g., Program Council, Coordinating Team, Buildings and Grounds, Family Ministry, Music, Social Justice, Pastoral Care.
- Reopening will be consistent with congregational risk levels and tolerance and based on science based health indicators set by the county, state and WHO.
- The congregation will be kept informed of reopening efforts and have the opportunity to share concerns and suggestions.

ACTIONS AND RESPONSES TO DATE

To date task force efforts have established the following safety protocols currently active in church operations.

Gathering Preparation:

Advance registration – attendance limited to 100 people
Distancing/reminder signage throughout campus
Every other pew roped off
Robust ventilation systems
Bathrooms adapted for single occupancy
Usher/Greeter training with Safety Task Force rep
Continuous communication plan
Livestream capability/Multi-platform participation (including virtual Coffee Hour)
Continued vaccination encouragement
Alternative participation spaces identified and ready
Lanyards of different colors to facilitate visual expression of individual distancing preference

Gathering

Mandatory masking at all times while on campus
No food or drink served
No congregational singing
Administrative staff and volunteers onsite to assist in registration and compliance

Our safety record since the start of the pandemic has been excellent, with only one COVID case at one of the schools. Due to COVID protocols in place for renters, contact tracing procedures satisfied the need for identifying at risk persons and responding effectively.

SCIENCE: HIGHLIGHTS OF RESEARCH

CDC guidance says that for indoor gatherings, a person who is trying to prevent becoming infected or contributing to the spread of infection should:
1) get vaccinated
2) wear a well-fitted mask
3) stay 6’ away from others not in their household

4) stick to indoor spaces that are well ventilated with outdoor air
5) wash hands frequently
6) cover coughs and sneezes
7) monitor their own health daily
https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html

The CDC states that "since vaccines are not 100% effective at preventing infection, some people who are fully vaccinated will still get COVID-19. An infection of a fully vaccinated person is called a 'vaccine breakthrough infection.'"
https://www.cdc.gov/coronavirus/2019-ncov/vaccines/effectiveness/why-measure-effectiveness/breakthrough-cases.html

From CDC guidance for older adults: "The more people you interact with, the more closely you interact with them, and the longer that interaction, the more likely you are to get or spread the virus that causes COVID-19."
https://www.cdc.gov/aging/covid19/covid19-older-adults.html

On vaccination requirements for eligible children:
The American Academy of Pediatrics and the American Academy of Family Physicians do recommend vaccinating children aged 5 to 11 years, but the FDA has only authorized the vaccine for emergency use for children in that age group, rather than granting full approval for the age group. In an article published by the American Medical Association on November 5, 2021, "Pediatric COVID-19 Vaccines - What Parents, Practitioners, and Policy Makers Need to Know," the authors emphasize the importance of "parental trust in childhood vaccinations," and argue that "It is premature to mandate COVID-19 vaccines as a condition of school entry for children given the limited size of pediatric trials and the need for ongoing safety monitoring" as the number of vaccinated children grows. They advocate instead "effective but nuanced vaccine education that encourages parents to voluntarily vaccinate their children."
https://jamanetwork.com/journals/jama/fullarticle/2786095

CONCLUSIONS BASED ON RESEARCH, OBSERVATION AND VALUES

These conclusions are based on our research into public health recommendations and scientific studies:

- All eligible for vaccination are strongly encouraged to be vaccinated.
- The COVID safety protocols currently operational at UUCB continue to be essential regardless of the vaccination status of those gathering at church.

- Although it's clear that effective masking is an important part of safety protocols, we found sometimes surprising data on effectiveness of various forms of masks. We recommend using this research to educate the congregation on effective masking.
- Based on our research into the costs and efficacy of the rapid at-home COVID tests, **particularly for asymptomatic cases**, we chose not to include use of COVID tests in our recommendations.

As you consider your options for the best vaccination policy for UUCB, we offer the following observations:

- With a high rate of vaccinations in our congregation and open discussion of vaccination status, more people are accepting the risk of gathering with family and close friends.
- At the same time, a different risk assessment is being made about gathering with larger groups of persons of unknown vaccination status and unknown public health protocol practices.
- It is vital to remember that all risk cannot be eliminated.
- Our church community includes people who are particularly vulnerable to suffering serious consequences from contagious disease.
- We continue to rely on everyone in our community to stay home when they have any symptoms of contagious disease.

We believe that our UU values support these conclusions:

- Each of us will make a personal and respected decision about our risk tolerance and our own participation in person, indoors at UUCB.
- We acknowledge the responsibility of parents and guardians to safeguard their children's wellbeing, and suggest adopting a policy that allows for their discretion in vaccinating their children during the period of emergency use authorization (before FDA **approval** of vaccines for their age group). We recommend the board consider the timeline on COVID vaccinations for children when determining the timeline for the implementation of their policy.
- We want to welcome fully but for safety reasons, we may not be able for now to welcome everyone; we continue to plan a phased reopening and encourage those who may not be able at this time to participate indoors, in person, to take

advantage of the live stream options for Sunday services and other church activities.

POLICY OPTIONS AND FEASIBILITY

Policy proposal alternative #1 (proof of vaccination)

In order to attend indoor in person church activities, on Sundays from 6:00am through 3:00pm, or indoor in person church events with over 50 attendees at any other time to protect the health and safety of all, each person:

•**must provide proof** that they are fully vaccinated* for COVID-19, if they are in an age group for whom the FDA has approved a COVID-19 vaccine, and for whom the CDC recommends COVID-19 vaccination (this does not include FDA authorization for emergency use);

•**must follow all safety protocols** while on the UUCB campus, regardless of vaccination status; AND

•**must affirm** that they are not ill, have no symptoms of contagious disease, and in the last 10 days have neither tested positive for COVID-19, nor been in contact with anyone who has tested positive for COVID-19, and furthermore that they will inform the church if they test positive for COVID-19 within the following 14 days.

Requests for medical exemptions to the vaccination requirement may be addressed to the Senior Minister, who has full approval authority. Medical exemption refers to vaccination only; all safety protocols and affirmations are still required.

*Fully vaccinated means that EITHER 2 weeks have passed since receiving the second dose of a 2-dose series (such as Pfizer or Moderna vaccines), OR 2 weeks have passed since receiving a single-dose vaccine (such as Johnson & Johnson's Janssen vaccine).

Policy proposal alternative #2 (attestation of vaccination)

In order to attend indoor in person church activities, on Sundays from 6:00am through 3:00pm, or indoor in person church events with over 50 attendees at any other time, to protect the health and safety of all, each person:

•**must attest** that they are fully vaccinated* for COVID-19, if they are in an age group for whom the FDA has approved a COVID-19 vaccine, and for whom the CDC recommends COVID-19 vaccination (this does not include FDA authorization for emergency use);

•**must follow all safety protocols** while on the UUCB campus, regardless of vaccination status; AND

•**must affirm** that they are not ill, have no symptoms of contagious disease, and in the last 10 days have neither tested positive for COVID-19, nor been in contact with anyone who has tested positive for COVID-19, and furthermore that they will inform the church if they test positive for COVID-19 within the following 14 days.

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Policy proposal alternative #3 (no vaccination requirement)

In order to attend in person church activities at any time, to protect the health and safety of all, each person:

•**must follow all safety protocols** while on the UUCB campus, regardless of vaccination status; AND

•**must affirm** that they are not ill, have no symptoms of contagious disease, and in the last 10 days have neither tested positive for COVID-19, nor been in contact with anyone who has tested positive for COVID-19, and furthermore that they will inform the church if they test positive for COVID-19 within the following 14 days.

FEASIBILITY OF POLICY ALTERNATIVES

Currently our plan remains to require registration for in person Sunday activities through 3pm, and for other in person church activities with over 50 attendees. We expect that setting up the registration in Breeze for Sunday activities will require approximately 30-60 minutes of staff time each week. This task could be completed by a trained volunteer, should one appear later. (.5-1 staff hours each week)

On Sunday mornings, church staff are fully occupied making the livestream service happen, and would not be available to assist attendees with onsite registration and sign in. Training volunteers for these tasks (which will use Breeze) will require approximately two hours of staff time. We expect that volunteer coordinators will attend the training sessions and be able to train additional volunteers as time passes. Staff monitoring of

the volunteer access to Breeze, and setting up access for new volunteers for these special tasks, might take one half hour per week. (.5 staff hours each week)

We estimate these volunteer requirements on Sundays: three greeters 9:00am-11:00am, to facilitate sign in, using laptops logged into Breeze; one greeter 9:00am-2:00pm to facilitate registration for anyone who arrives without preregistering, and sign in for anyone who arrives after the service begins at 11:00am; three ushers in Atrium and Sanctuary 10:30am-12:30pm; and one or more safety volunteers to remain available for safety questions and issues throughout Sunday "prime time," 9:00am-3:00pm. Presumably some of these hours would be split into shifts. We assume that volunteers who coordinate these activities would spend an average of about three hours per week total. All activities will require backup volunteers, since anyone who has symptoms of contagious illness must cancel their participation. (26 volunteer hours total each week)

The above measures are necessitated by our safety protocols regarding contact tracing and physical distancing, regardless of vaccination policy. Policy proposal alternatives #1 and #2 will require additional measures; estimates of additional staff and volunteer hours are below.

Proposal #1, as we envision it operationally, would require staff to set up a "vaccination proof presented" check box in Breeze (one hour of staff time), and then to provide Breeze training for a small group of volunteers who would run drop in sessions to be attended by congregants who wish to have their vaccination proof recorded (two hours of staff time). We expect that three or four volunteers could run three two-hour verification sessions to check documents for the congregants who are eager to complete the process. This proposal would also require a Sunday volunteer, 9:00am-3:00pm, to check documents and set up records for visitors and any congregants who attend without providing their proof of vaccination in advance at one of the drop in sessions. (3 staff hours and 24-32 volunteer hours to start up; 6 volunteer hours per week ongoing)

Proposal #2 would require staff to set up a "vaccination attestation" check box in Breeze (one hour of staff time), and to create and disseminate communications to church members so that each person can complete their attestation in Breeze (two hours of staff time). This proposal would also require a Sunday volunteer, 9:00am-3:00pm, to facilitate onsite attestation for members and visitors. (3 staff hours to start up; 6 volunteer hours per week ongoing).

Proposal #3 does not require recording of vaccination status in Breeze, but since it does require an affirmation by each attendee, it may be desirable to devote additional time to creating prominent signage regarding these affirmations.

APPENDICES

UUCB Opening Phases

Table of UU church vaccination policies

UUA COVID Information

Nov. JAMA article on vaccines and children

Information on Mask Efficacy

Rev. Dr. Michelle Collins Essay on COVID and Vaccinations

UUCB Reopening Phases

UUCB Phase (A)	State Tier for Contra Costa County (B)	CA Indoor Capacity Allowance (C)	Safety Precautions (in brief) (D)
0 -- Closed to all but essential staff/volunteers (for facilities security/mail processing)	Purple Tier 1 Widespread	Maximum 25% capacity for each room **and** building overall	**Facemasks and physical distancing** (6 feet) required; building open for **essential business only**
1 -- Closed to all but limited staff, and authorized outdoor activity such as landscape maintenance (not gatherings)	Red Tier 2 Substantial	Maximum 25% capacity for each room **and** building overall	**Facemasks and physical distancin**g (6 feet) required; building open for **essential business only**
2 -- Open to outdoor work parties, outdoor programs/gatherings	Orange Tier 3 Moderate	Maximum 50% capacity for each room **and** building overall	**Facemasks and physical distancing** (6 feet) required; building open for **authorized business and scheduled activities only**
3 -- Open to small indoor church meetings and programs	Yellow Tier 4 Minimal	Maximum 50% capacity for each room **and** building overall	**Facemasks and physical distancing** (6 feet) required; building open for **authorized business and scheduled activities only**; **eating** prohibited at indoor gatherings
4 – See "Phases 4 and Beyond" below	"Beyond the Blueprint"	Unknown (perhaps none)	To be determined

The chart above shows our church community's current and planned progress towards reopening fully. Only church activities are listed in Column A; the schools and other rentals sometimes operate under different guidelines and protocols.

We used California state-wide Tiers (Column B) as the basis for UUCB Phases 0-3; the State moves our county to the next Tier once the operative criteria have been met for the required amount of time. UUCB determines timing for movement to a less restrictive Phase after the state announces our county's advancement to a new Tier, or discontinues stateTier system ("Beyond the Blueprint"). We study directives and guidelines from the California Department of Public Health (CDPH), Contra Costa County Health Services (CCHS), and the CDC, and keep our activities well within the more restrictive requirements. CA Indoor capacity allowances (Column C) are provided for reference. Column D provides a few of the pertinent safety precautions at each Phase. Protocols provide the full plan, in separate documents.

<u>Phase 4 and Beyond</u>

California plans to "reopen the economy" on June 15; at that time the state Tier system will be discontinued. The state will continue to monitor COVID-19 vaccination and infection rates, and provide guidelines for face masks and physical distancing. **UUCB will continue its phased reopening.** While we expect to resume some indoor, in-person small group activities this summer, our Sunday "prime time" programming (worship services and other activities) will continue **online only** throughout the summer. We expect the requirement to wear facemasks to continue at least until October 1.

Some changes to expect when we do open our church buildings for full Sunday programming: "safety zones" in Sanctuary and Social Hall for congregants and visitors who prefer to maintain physical distance from others; new guidelines for food and beverage service; livestreaming of Sunday worship services; some activities continuing to use Zoom in order to include those who do not attend in person.

6/3/2021

for special Board meeting 10/25/21

Policies of UU churches regarding vaccination status, from their websites

Church	Policies regarding vaccination status	Worship
Mt Diablo UUC (Walnut Creek)	**no vaccination requirements**	Worship Four Ways: •in sanctuary, registration, limited seating, ages 12 and up only (distanced but not 6', not safe for younger children) •livestream on patio, location for Time for All Ages, families/children encouraged •livestream in social hall, registration, 6' distance •online
UU Marin	**no vaccination requirements** publicized	all (including children) gather in Fellowship Hall (aka sanctuary), with patio for overflow; worship also online
UUC Santa Rosa	**vaccination required** for all age 12 and over, to enter indoor spaces; **OR** **negative COVID test** within 72 hours (proof of either must be shown on request)	worship online and in person in sanctuary
UU SF	**proof of full vaccination required** for all age 12 and over, to be on premises	worship online and in person in sanctuary, vaccination required (no children under 12); some areas designated for RE activities (only children/ youth, parents, RE staff/volunteers allowed in those areas)
UU Live Oak (Alameda)	**prefer vaccinated** (apparently no proof required); those not vaccinated asked to attend online	worship in person indoors; online worship option
UUC Palo Alto	**no vaccination requirements** publicized, though those who attend small group meetings in person are **expected** to be vaccinated	worship in person outdoors at 9:30; online worship offered at 11:00
UU San Mateo	agreement, waiver & **vaccination confirmation** via online form	worship in person outdoors twice monthly through October; online worship also

UU Davis	protocols include **expectation** that those eligible will get vaccinated (apparently no proof required)	occasional in person worship appears to be outdoors; online worship also
UU Oakland	**pending Board approval: vaccination or negative COVID test** (to be considered at Board meeting 10/26/21)	worship currently online; may return to in person worship mid November
UU East Brunswick* (NJ)	**vaccination required** for: •staff •volunteers working directly with children and youth	worship currently online only
UU Nashua* (NH)	**vaccination proof required** for: •staff •anyone working with children/youth •anyone leading worship or running tech from sanctuary •anyone singing in the building •anyone making in person pastoral care visits •anyone engaging with vulnerable populations in church role	worship currently online; multiplatform may return when COVIDActNow status is Green (low risk)
UU Petaluma	**vaccination proof required** for staff who work with unvaccinated youth/children **vaccination strongly encouraged** for those eligible	worship currently online only
Berkeley Fellowship	**no vaccination requirements** publicized	worship currently online only
San Jose UU	**no vaccination requirements** publicized	worship appears to be online only
UU Petaluma	**no vaccination requirements** publicized	worship currently online only

*offered as example in the UUA web article on vaccination

prepared by Lisa Maynard, Opening Task Force
v.2 (changed order of list)

COVID-19 Vaccination for Volunteers, Members, and Visitors

By UUA Congregational Life Staff Group

September 1, 2021

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We know vaccination is how we end this pandemic and care for each other. Many congregations are wondering how they should approach tracking COVID vaccination with members, volunteers and visitors. The UUA encourages congregations to consider how to sensitively encourage vaccination even if vaccination isn't required.

Please remember every congregation is different. Some congregations know they have a high rate of vaccination because people have been volunteering this information. Some congregations have a significant number of vaccine-hesitant members. Some congregations include many children under 12, some have none. Some congregations have many immunocompromised adults who are not as well protected by vaccination. Following the guidance of science while centering inclusion, consent, and flexibility will look different in different congregations.

Some congregations are considering asking staff to be vaccinated. Please see our LeaderLab article on staff vaccination if you are considering this.

Can We Legally Require Vaccination for Participation?

One legal concern that comes up about this relates to HIPAA, a US law that protects patients from having their health-related information shared without their permission. HIPAA does not prevent your congregation from asking about vaccination status. However, some states may have

laws restricting your ability to ask specifically about COVID vaccination status. Make sure you are familiar with any relevant laws in your state or locality.

Why Would We Ask Participants About Vaccination?

- Your congregation's locality's government may require vaccination for public indoor spaces. If this is the case, your visitors and members may expect to be attending events where all are vaccinated.
- Having a high level of vaccination at in-person events reduces the chance of someone attending with an infectious case of COVID-19.
- Combined with universal masking, vaccination substantially increases the safety of an event.
- Widespread vaccination is the most important way to protect our world from COVID-19 in the long term.

Why Wouldn't We Ask Participants About Vaccination?

There are a few concerns about asking for vaccination:

- Asking for or requiring vaccination can put pressure on people who cannot be vaccinated or are vaccine hesitant that make it difficult to build trust
- Not all people can be vaccinated, including those under 12. Requiring vaccination can reinforce ableism for those who have medical reasons they cannot get vaccinated. Guidance on supporting those with medical concerns.
- Some people are still at risk, even with vaccination, as their immune systems do not mount a strong protective response and they are at risk of severe illness if infected
- Some vaccine-hesitant people need more encouragement and support, including concrete help accessing vaccination, and a vaccine requirement that doesn't include support may be challenged.

What Should We Tell People?

Members, friends, and visitors are likely to want to know, even if they don't ask, what the level of vaccination is in your congregation and your approach to vaccination. Being transparent allows people to make more informed safety decisions for themselves. Examples:

"We do not ask the vaccination status of those attending our services; however we require vaccination of those supervising children under 12."

“We know from personal sharing that more than 90% of our congregation is vaccinated. We hope visitors are also vaccinated, unless medical conditions prevent this. We are continuing to require masks for all people in order to slow the virus’s spread and to protect our children and more vulnerable members of our congregation.”

“Because our city is asking for vaccination for adults attending restaurants and gyms, we are asking the same of those attending in person events. Please contact the senior minister to discuss a medical exemption.”

“We do not ask the vaccination status for those attending our in-person services. Because we have some differences among our membership on vaccination we are planning our safety standards as if all are unvaccinated and at high risk.”

Sample Vaccination Policies

The **UU Church of Nashua, NH** has a policy (PDF) that requires COVID vaccinations and proof of vaccination for all staff, anyone working with children and youth, anyone leading worship or running tech from the sanctuary, anyone singing in the building, pastoral associates doing in person visits, and anyone engaging with vulnerable populations due to their role in church.

The **UU Congregation in East Brunswick, NJ** has written a policy requiring staff and volunteers with children (PDF) to be vaccinated and includes policy on handling medical exemptions.

Considerations for Asking Participants About Vaccination Status

If you are considering asking volunteers, members, friends, or visitors about their vaccination status, here are some questions to consider:

For All

- What exemptions or additional protections should we have in place knowing that some people cannot be vaccinated for medical reasons or even with a vaccine may not be well protected?
- While HIPAA doesn’t apply to congregations, everyone deserves to have their medical information kept confidential. How can our congregation honor people’s privacy, especially the privacy of those with medical exemptions?
- Would we ask for proof of vaccination and/or compile documentation? Who would do that?
- If we are going to trust people’s word, do we trust that our participants will be honest?

For Volunteers

- Are there volunteer roles where volunteers should be vaccinated for the near term? (For instance, volunteer choir directors or people who spend time with elders or younger children.)
- Will our safety standards still take into account that even though the number of transmissible cases in vaccinated individuals is substantially lower, it is still possible for vaccinated individuals to infect others?

For Members and Friends

- What is the local expectation for vaccination in public spaces?
- If vaccination is controversial in our community, can we find a covenantal approach to helping members and friends consider the impacts of their vaccination choices on the safety of their fellow congregants?
- Do we worry that any in our congregation might lie in order to participate? How could we handle this?
- Understanding a small number of people cannot vaccinated or will mount a strongly protective antibody response, how can we work against ableism and have an inclusive community? In what ways will we include people who cannot attend safely in person?
- Can we create a medical exemption process just as we would for staff?

For Visitors

- What are our local city and state standards around vaccination? If asking about vaccination is common or required in our city, will visitors be expected to be asked about their vaccination status and expect to be attending only with others who are vaccinated?
- If we asked about vaccination for members and friends, how would we be inclusive of visitors? Would we ask them at the door?
- If we choose to require vaccinations of visitors, how will we help visitors be aware of this?

Covenantal and Creative Ways Forward

- Consider having covenantal conversations about how we protect each other.
- Celebrate vaccination within the congregation and encourage people to share their vaccination pictures and emotions.
- Keep track of what percentage of the congregation has voluntarily shared their vaccination story and point out to the congregation how this is creating a safer congregation for all.

- Recognize there is a difference between policies for the whole congregation's public Sunday morning gathering and choices of smaller groups who have built trust and know each other's vaccination status.
- Remind people that vaccination is not available to all yet and does not protect all.
- Consider following the UUA recommendation to continue indoor masking regardless of vaccination status as vaccinated individuals can spread COVID-19 and can spread its Delta variant even more readily.

Additional Resources

- How to Talk to Someone Fearful of Getting the Vaccine, from the *New York Times*
- Houses of Worship Grapple with the Vaxxed and Un-Vaxxed Divide, from NPR
- The Unseen Covid Risk for Unvaccinated People, from the *Washington Post*
- They Haven't Gotten a Covid Vaccine Yet. But They Aren't 'Hesitant' Either, from the *New York Times*

About the Author

UUA Congregational Life Staff Group
The regional Congregational Life staff are congregations' local connection to the UUA. All of the program Congregational Life staff have expertise in most aspects of congregational life and each also has a few program areas of expertise.

For more information contact **conglife@uua.org**.

November 5, 2021

Pediatric COVID-19 Vaccines What Parents, Practitioners, and Policy Makers Need to Know

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The US Food and Drug Administration (FDA) granted Emergency Use Authorization for Pfizer-BioNTech's mRNA COVID-19 vaccine (BNT162b2) for children 5 to 11 years of age on October 29, 2021. The Centers for Disease Control and Prevention recommended use of the vaccine among children in this age group on November 2, 2021. Approximately 28 million children are now eligible for vaccination, with only those younger than 5 years remaining excluded from vaccine eligibility. The benefits of pediatric COVID-19 vaccines are clear. Vaccinations protect children, decrease spread to families and communities, and ensure educational continuity. What do parents, practitioners, and policy makers need to know about pediatric COVID-19 vaccines?

Safety and Effectiveness of Pediatric COVID-19 Vaccines

Clinical trials of BNT162b2 induced a robust immune response in children but had far fewer participants than in adult COVID-19 vaccine trials. The trial of the BNT162b2 vaccine was initially limited to 2268 children 5 to 11 years of age, 1518 of whom received 2 vaccine doses of 10 µg of mRNA (one-third the amount used in adult vaccines) spaced 3 weeks apart.[1] The other 750 children received a placebo vaccine. The study assessed safety, levels of neutralizing antibodies, and vaccine efficacy for at least 2 months after the second dose. At the FDA's request, an additional 1591 vaccinated children were followed up for 2.5 weeks after their second dose to expand surveillance for adverse events.

Pfizer-BioNTech reported an efficacy rate of 91% against symptomatic COVID-19 (a total of 19 COVID-19 cases, 16 cases among children in the placebo group [100.6 cases per 1000 person-years] and 3 cases among children who received the BNT162b2 vaccine [9.3 cases per 1000 person-years]).[1] The trial reported no cases of severe COVID-19, hospitalization, or death. Of the children who developed COVID-19, symptoms were milder in vaccine recipients, underscoring the vaccine protection conferred.

Adverse effects were similar to those reported among older children and adults in frequency and severity, including pain at the injection site (71%), fatigue (39.4%), and headache (28%).[1] The study, however, was insufficiently large to assess risks of rare adverse events such as myocarditis and pericarditis that have been observed in young men 18 to 25 years of age after receiving mRNA vaccines. In these young men, cardiac risks were highest within the first week following the second mRNA dose, and most cases were clinically mild and resolved quickly. The cardiac risk in teenaged individuals varies but is estimated to be 180 cases per 1 million fully vaccinated males 12 to 15 years of age and 200 cases per 1 million for fully vaccinated males 16 to 17 years of age.[1]

Given the lower risk of severe COVID-19 in young children, vaccine safety is paramount. The Centers for Disease Control and Prevention will monitor vaccine safety in children through multiple mechanisms, including the Vaccine Adverse Event Reporting System and the Vaccine Safety Datalink.

Where and When Can Children Get Vaccinated?

The rollout of vaccines for the 28 million children aged 5 to 11 years will differ from adolescent and adult vaccine campaigns. Instead of large vaccination sites, the Biden administration plans to focus vaccine delivery at pediatrician, family medicine physician, general practitioner, and nurse practitioner offices, as well as pharmacies and school health clinics.[2] Vaccines will be packaged in smaller vials that can be stored in refrigerators in clinicians' offices.

Benefits of Vaccinating Young Children

Severe illness has been uncommon among the more than 6 million children who have tested positive for SARS-CoV-2. Depending on the state, 0.1% to 2.0% and 0.00% to 0.03% of pediatric COVID-19 cases resulted in hospitalization and death, respectively.[3] As of October 4, 2021, a total of 5217 cases of multisystem inflammatory syndrome in children (MIS-C) and 46 MIS-C deaths have been reported.[4] The risk of severe illness and death is greater for children older than 10 years. Although the percentage of severe illness among pediatric cases is small, as infections increase, so too will the number of children who become seriously ill. At least 1.9 million children aged 5 to 11 years have been infected with SARS-CoV-2 and more than 8300 of them have been hospitalized, a third of whom needed intensive care.[5] Nearly 100 children aged 5 to 11 years have died, making COVID-19 among the leading causes of death in this age group. Hospitalization rates among children aged 5 to 11 years are 3 times higher for Black, Hispanic, or Native American children than for White children, with rates of 45 to 50 per 100 000 children vs 15 per 100 000 children, respectively.[5] Data from adolescents suggest that BNT162b2 vaccinations for children 5 to 11 years old will likely prevent most hospitalizations and deaths.[6]

Although pediatric studies did not examine whether vaccines reduce SARS-CoV-2 transmission, data from vaccinated adults suggest that vaccinated children will be likely to shed lower amounts of virus and be contagious for a shorter time. Thus, vaccinating children 5 to 11 years of age may lower transmission in families, schools, and communities.

Will COVID-19 Vaccines Keep Children and Schools Safe?

The effects of the pandemic on childhood education have been profound, with more than 2000 schools closed and 1 million students affected between August 2 and October 8, 2021.[6] Remote learning has been associated with exacerbation of racial and socioeconomic disparities in educational achievement and increased rates of depression and anxiety.[7] Vaccinating students could help ensure educational continuity along with other layers of protection, including higher community vaccination coverage, masking of students and staff, school ventilation, and testing unvaccinated students. These risk-mitigation measures should help reassure families who are concerned about their children contracting SARS-CoV-2 at school or in after-school activities, as well as transmitting the virus to siblings, parents, grandparents, or other family members. Pediatric vaccines may also reduce the time children spend in quarantine after exposure to a person with SARS-CoV-2 infection, which may help reduce disruptions to children's education.

COVID-19 Vaccine School Mandates

Currently, all states require a series of childhood vaccines as a condition of school entry, but only the Los Angeles Unified School District requires COVID-19 vaccination for students aged 12 years and older. California announced a COVID-19 mandate for children in kindergarten through 12th grade once the vaccine is authorized. Other school districts are likely to consider COVID-19 school mandates.

There are good reasons, however, to delay school mandates until the FDA fully licenses pediatric vaccines based on longer-term safety data. A Kaiser Family Foundation nationally representative survey of 219 parents found that only 59 parents (27%) reported they would vaccinate their 5- to 11-year-old child immediately, 72 (33%) would "wait and see," and 66 (30%) would definitely not get their child vaccinated.[8] Although children and adolescents 12 to 15 years of age have been eligible for vaccination since May 2021, less than half (47%) are fully vaccinated.[4] Low uptake among adolescents may suggest similarly low coverage among younger children. Premature issuance of school mandates could create a backlash not only for COVID-19 vaccines, but also for other childhood vaccines such as measles, mumps, and rubella. Maintaining public and parental trust in childhood vaccinations is essential.

What Remains Unknown About Pediatric COVID-19 Vaccines?

Several questions remain unanswered about COVID-19 vaccines in children, including how long protection will last and whether young children will need booster doses, especially because of their lower risk of severe disease. Because the vaccine trials in children were not powered to fully assess the risk of rare events, such as myocarditis and pericarditis, there remains the possibility safety signals could emerge as the vaccines are administered to larger numbers of children. Clinical studies on the safety and efficacy of COVID-19 vaccines are ongoing for children 2 to 5 years of age and those 6 months to 2 years of age. Moderna is also likely to request authorization for its pediatric mRNA vaccine in the coming months.

Building Trust

COVID-19 vaccines are the most important intervention to contain SARS-CoV-2. The American Academy of Pediatrics and the American Academy of Family Physicians recommend vaccinating children aged 5 to 11 years.[9,10] Yet, there are large divides in public trust, especially for pediatric COVID-19 vaccines. Public health officials must build trust, providing reassurance that pediatric COVID-19 vaccines will protect children and their classmates, families, and communities. This will require effective but nuanced vaccine education that encourages parents to voluntarily vaccinate their children. It is premature to mandate COVID-19 vaccines as a condition of school entry for children given the limited size of pediatric trials and the need for ongoing safety monitoring. Following longer-term safety surveillance and full FDA licensure, cities and states will likely include COVID-19 vaccines in their list of required childhood vaccines.

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Article Information

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Comparing a Variety of Different Face Masks

FFE = fitted filtration efficiency; how well a material filters out aerosol particles

Type of Mask	FFE	Source
3M 1860 N95 - regular	***98/93%***	1
3M 8210 N95 - one size	***99/98%***	1
Duckbill style N95 masks (composite)	***93%***	1
Two-layer nylon mask with ear loops, without aluminum nose bridge	45%	2
Two-layer nylon mask with ear loops, with aluminum nose bridge	56%	2
Two-layer nylon mask with ear loops, with aluminum nose bridge and one insert	74%	2
Cotton bandana folded surgeon general style or "bandit" style	50/49%	2
Single layer polyester neck gaiter	***38%***	2
Polypropylene mask with fixed ear loops	***29%***	2
Three-layer cotton mask with ear loops	***27%***	2
Procedure mask with ear loops	***39%***	2
Procedure mask with ear loops tied and corners tucked in	60%	2
Procedure mask with ear guard, with claw hair clip	62/65%	2
Procedure mask with mask fitter (worn over the mask, ex: www.fixthemask.com)	***78%***	2
N95 mask with beard 9-11mm/16mm/30mm in length	97/85/99%	3
Procedure mask with ear loops with beards	31%	3
Face shields alone	23%	4
Doubled procedure masks (composite)	66%	5
Doubled cotton ear loop masks	57%	5
Cotton ear loop mask with procedure mask underneath	***66%***	5
Cotton bandana with procedure mask worn underneath	77%	5
Polyester gaiter with procedure mask worn underneath	81%	5

Difference between N95 and KN95 masks: the primary difference is that the KN95 masks do not follow the same set of standards as the N95 ones do. Now if that were the only difference, they would be fairly equivalent, but the reality is that there are a great number of counterfeit KN95 masks on the market that are certainly not as effective, and as with any high degree filtration mask, the main factor effecting their filtration rates is how well they fit the face of the wearer of the mask.

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Prepared by UUCB's Opening Task Force, November 2021

From: **Connections UUCB** connectionsuucb@gmail.com
Subject: [uucb_discuss] From Rev. Michelle for Tonight's Board Meeting
Date: October 25, 2021 at 5:25 PM
To: uucb_discuss@googlegroups.com

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On Covid and Vaccinations and Their Ramifications for Our Communities
An opinion paper by Rev. Dr. Michelle Collins, October 17, 2021

We have truly had a difficult past year and a half. I don't think anyone would dispute that statement. It's not only been due to the global Covid-19 pandemic, but also many other dynamics in our country and social structure as well as the mounting influences of global climate change and the ever growing divides in our country. I know that I'm not alone in wishing that it could all be behind us and that life could get back to "normal." And of course seeking out the ways that we might be able to get back to that "normal," whatever that may mean. Thus it is easy to get attached to particular solutions as the way to make that happen, especially if they are not ones that invade many parts of our daily lives. But it is far more complex than that, and we have to both delve into many of the complexities as well as hold onto our values and commitments for our communities as we go forward.

Before starting, I should state a little of my background and my hope for this essay. While I am not trained in medicine or public health, I have taken an interest in both for many years as well as sociology and how communities work. My interest in the former is part of what led me to seek out training in medical herbalism. I have paid close attention to many aspects of the pandemic and of other health and human events prior to this past year and a half. While not an expert by any means, I consider myself to be fairly informed on these things. My hope for this essay is that it can serve to support the conversations going on in our congregation concerning Covid, protocols, vaccinations, vaccination mandates, and how we are moving forward.

First, we need to start out by taking a step back to consider what public health measures and epidemiology (the studies of infectious diseases) are intended for and the purpose of vaccinations. Largely, the public health perspective is a very large scale one, on the scale of entire populations and millions of people. It is concerned with the way that diseases move around in a population and how it impacts the overall healthcare and healthcare facilities and efforts. Some examples of this kind of large scale work include work on tuberculosis with advertising campaigns, contact tracing of exposures, and city public health departments' delivery of treatment to those affected and monitoring of their compliance with the treatment regimen. Another example is studies on condom use in countries with high rates of HIV and what kinds of condoms and distribution methods will best change disease trends.

Vaccinations, a key means of disease control in terms of public health, are about changing the trends of a disease in the overall population. Smallpox was eradicated globally through widespread (as in near total) vaccination of the population. Distribution of the flu shot each year to enough of the population helps to change the flu trends, and we

can see this based on whether or not the shot is close to the strains that end up being more rampant in any given year. A significant thing that vaccinations are intended for is reducing the risk of significant infection by the target disease and thus reducing both the burden on the healthcare system and the mortality rates from that particular disease. A vaccination helps one's body learn how to better fight off the disease so that when you are exposed to it, your immune system will recognize the disease cells and have a head start in knowing how to combat them. It does not mean that you will not “catch” the disease but instead that your body will do a better job of fighting it off if you are exposed.

That is what vaccinations are. Given that, there are a number of things that vaccinations are not. First of all, vaccinations do not prevent you from catching a disease. They have nothing to do with whether or not the viral cells are introduced into your body. Their sole purpose is to train your immune system to better combat those viral cells and fight off the disease. Even if vaccinated, you are not protected from exposure to the disease at all. Vaccinations are also not “invincibility cloaks,” as I like to say it. There are many so-called breakthrough cases of serious disease and even death in those who are vaccinated from a disease. Remember, public health is about large scale numbers, and what vaccinations do is reduce the number of serious cases and deaths from a disease. Both human bodies and diseases are far too complex to make universal and absolute statements about.

There is also the issue of variants. By way of definition for its current use, these are evolutions of the genetic structure of a disease. Sometimes, these evolutions change the way a disease behaves in some way. Diseases evolve all of the time, with the tiny genetic changes that happen as they replicate. When we are talking about variants, it is usually a sum of many much smaller genetic changes in the disease and now manifests in some different way. A key example of this is the delta variant, the current dominant variant of Covid globally. It differed from the original disease strain in that it is far more transmissible among other things. A vaccination is developed based on a particular disease strain, as was the Covid vaccination, which was based on the original strain. You have probably heard of plenty of studies and data about how each vaccination tends to hold up to a variant, meaning how well the immune systems of vaccinated individuals react to the evolved disease strain.

Now the scientific and medical communities remind us that widespread vaccination is the way to stem the pandemic, and they are absolutely correct about that. Widespread vaccinations throughout an entire community and geographic region will reduce the disease transmission levels and dramatically reduce the number of people who get significantly ill. What it will take to truly turn this pandemic around is for every eligible person to get vaccinated, AND to be attentive to following other recommended daily safety practices that have been successful in bringing some degree of health safety during the past year and a half.

As with many questions, the question of requiring vaccinations is a complicated one.

One thing that is important to remember is that the purpose of vaccine requirements from the standpoint of public health is to encourage and ensure that the greatest percentage of the population as possible will get vaccinated. This is a motivating factor behind public school vaccine requirements, because that impacts a very large group. Another setting where vaccine requirements make sense is in medical settings, where staff members are working directly with extremely vulnerable people on a regular basis, folks whose immune systems may be significantly compromised. When I served as a hospital chaplain, onboarding employees were required to get an updated pertussis vaccination (unless exempted for medical reasons) due to recent outbreaks in the area and at the hospital. Hospital employees were also required to get a flu shot, although an alternative was provided of wearing a mask when within 10 feet of any hospital patient. I recall there was about a 90% compliance rate for the flu shot the year that I was there.

It becomes a more complicated matter when considered alongside other factors and when small businesses and organizations begin to take up the matter. Let's start by considering the other factors, and how our own church community has reported these other behaviors. First, remember that the covid vaccination has not promised to prevent catching the illness, either symptomatic or asymptomatic. Other safe practices are vital to prevent contracting the illness yourself and thus being a vector to pass it along to others. We are all no doubt familiar with these practices by now - masking, distancing, avoiding crowds, limiting risky behavior, etc. But these are not an invincibility cloak either, as evidenced by an extremely cautious UUCB member who recently posted onto the discuss list that despite all of her precautions, that she had contracted covid at some point in the past as shown in an antibody test.

Aside from personal behavior and choices, close interaction with unvaccinated folks is also a risk factor. On these two matters, behavior and interaction with unvaccinated folks, the Opening Task Force asked about these in our poll in August. Of the respondents (who represented a significant percentage of UUCB's membership), 97% reported that they were fully vaccinated. But remember, it's complicated. Of the respondents, 25% reported that there were folks who were not yet vaccinated in their households, and less than half of those represent our families with children. Regarding behavior and choices, a full 33% of respondents reported that they were not careful as they went out their daily lives in public. (please see the Opening Task Force poll report for charts and analysis) Now, I don't believe that they are doing what one comedian joked about when the vaccination was being rolled out, of going around and licking doorknobs. But it is true that we can see cautious behaviors change when folks are vaccinated, making them more vulnerable to contracting covid which may very well be asymptomatic, making them more likely vectors of the disease. I have experienced this lack of caution multiple times at UUCB, for instance, when I have greeted someone from a distance and they have rushed over to try and give me a hug and I have stopped them requesting distancing. Their response was, "But I'm vaccinated." Yes, I received the vaccination later due to some other existing medical conditions, but I have remained

cautious despite that and believe that we all should for the foreseeable future.

There are ethical and justice related issues that complicate things further, and being a justice-oriented faith, we should be considering these as well. When the vaccines were first rolled out in this country, and for many months thereafter, their distribution was uneven. Once released to the general population, it was largely wealthier and whiter communities that gained access first, and even when they were specifically brought to communities of color, many white people were in line first to receive them before those neighborhood's residents. I remember a clear example of this for vaccination sites in Oakland, where the sites were set up in communities of color and lower socioeconomic means and yet the news showed many folks who didn't live in the area showing up in line first and using up the supply. I believe there were even notices about these sites that went out on our discuss list encouraging people to go there to get their vaccination. There are also other cultural based hesitations to receiving medical interventions, for instance from undocumented individuals. It is also true that vaccine availability globally has privileged wealthier countries. With the introduction of discussions about boosters, this disparity has been raised to the forefront since there are many countries whose populations have yet to receive their first dose. Yes it is true that global distribution is a complicated matter, but that should not be an excuse to use the insulation of our privilege to avoid considering these matters.

As we consider many of these factors, it is also important to consider the difference between precautions with actual impact as opposed to what is known as security theater. The term security theater refers to practices that make us feel safer but in reality do not change the risk level. There are many examples of this which can be easily found online (and there is a fabulous *Adam Ruins Everything* episode on them too), including things like the seal on the top of over-the-counter medicine bottles and credit card security. The bottle seals were implemented because of a false story about medicine contamination and have not actually prevented anything, and our credit card numbers are all regularly stolen online.

As vaccination mandates have been implemented in many areas, I've wondered how much is actual health safety and how much is security theater. In fact, I've wondered that about other precautions too, especially as I see folks wearing what are known as neck gaiters instead of proper masks (tubes of very thin cloth that cover the mouth and nose but allow for easy breathing). There was a study done comparing the various options for masks and the neck gaiters were shown to actually aerosolize breathed particulates thus putting smaller particles into the air that will float for longer, making them more dangerous than wearing nothing at all.

One feature distinguishing safety from theater is how the mandates are implemented. Some places simply have up a sign saying that you have to be vaccinated to enter, but cards are never examined. In others, the cards are examined, but there is no attempt to

verify if that card or card copy matches the person who is producing it. In others, both vaccination cards and photo id's are asked for and they are carefully checked. I've seen this at a local movie theater, where entrance happens only at a single door, and there are barriers on the other side of the door forcing folks to queue there while staff members check their photo ID and vaccination card, although with masks, I wonder how accurate the ID check is.

However, as we have been discussing, being vaccinated is only one of many factors affecting whether someone could be carrying and spreading covid. Personal practices and behaviors affect it, as do interaction with unvaccinated individuals. Which vaccination someone received is a significant factor. How long it has been since an individual was vaccinated makes a tremendous difference, as studies published a couple weeks ago by the New England Journal of Medicine demonstrate. Given that boosters and 3rd shots are still in their earlier stages of rollout, it will be a while before proper studies report on their efficacy, although it is generally agreed that they improve immunity and are a good idea to receive. A recent negative covid test is only good up to the moment that the sample is taken for the test, as someone could contract covid minutes after taking the test and have a negative test. The tests have varying degrees of accuracy, with the at-home tests being disappointingly low, with a reported approximately 30% efficacy for detection of asymptomatic infection. Yes, it's complicated because that number has to take into account how well folks follow the instructions on the test, but it is still disappointingly low nonetheless.

There are many questions that need to be considered as well as the congregation considers the question of mandating vaccinations. They include many of the following: what about justice and ethical issues? How about which vaccination someone received, and how long ago they received it? Are they immunocompromised in some way, which as studies have now shown decreases their immunity conveyed from the vaccination? Do they have unvaccinated individuals in their household? Children? Is anyone around them sick, thus potentially compromising their immune system making their own immunity less effective? How do they behave in public health safety wise? Have they flown recently? Have they visited another area recently that may have lower vaccination rates than our area? How much do we trust what folks self report? How likely are folks to report if they are feeling slightly sick, maybe just a sore throat? Will we require proof of boosters? What about the flu vaccination? What about folks with medical conditions that may prevent them from being vaccinated? What about producing negative covid test results from the past three days (which some places accept in lieu of proof of vaccination)?

And that's just the medical and science related questions. What about whether we want the aesthetic of folks being funneled through one door of the church into a queue where their photo ID and vaccination card are checked? And even more, turning people away who cannot provide that? Turning visitors away? How do we do our welcoming? What

does welcoming and acceptance of diversity look like? And what about folks who cannot be vaccinated, most notably anyone under the age of twelve?

Also, how long would a requirement be in place? What about future variants? What about when the county and state related requirements change, like the mask mandate that is set to go out of effect in the next couple of months?

Currently, Contra Costa county requires “high risk” business to verify vaccination or a negative covid test. These include places where folks eat (restaurants, movie theaters) and gyms where there is a greater degree of heavy breathing due to exercising. And according to the Covid Act Now data and analysis site (the data source currently in use by many UU congregations and by our Opening Task Force - https://www.covidactnow.org), Contra Costa county is now down to the medium risk category, lower than the state of California which reads as high. However both of these categories are lower than the very high and severe categories and have been going down over time.

These matters are unbelievably complex, as are the solutions that will help to bring progress for our entire population as we move through this pandemic. And as we have discovered many times over, there are also unexpected things that come up along the way (coin shortage anyone?). There are many factors to consider, including feelings of personal safety and personal needs but also the needs and perspectives of others. And of course the identity and commitments of the congregation and what we want to be saying by what we do.

I truly hope that everyone who is eligible will get a vaccination and will continue to engage in healthy personal practices and choices. I also hope that we can all pause to consider the perspectives and needs of folks other than ourselves, particularly before one becomes too entrenched in only their own preferences. There are no easy answers, and I do not think there is a “win-win” solution available as we consider vaccination mandates in our (comparably) small community. But hopefully we will consider the decisions that need to be made from a place of compassion and empathy as well as from a place of welcoming and inclusion.

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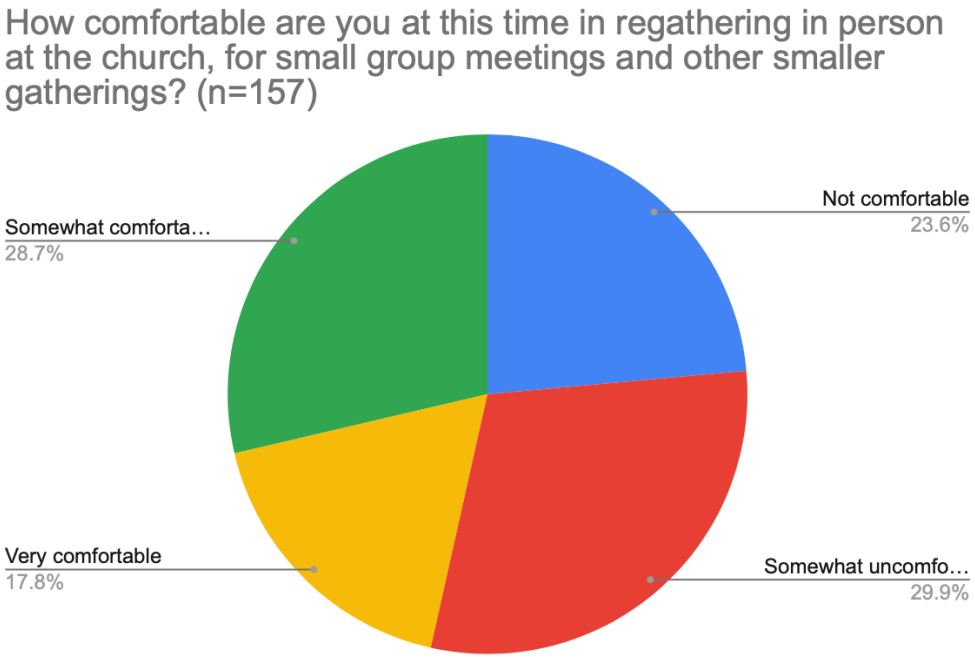
Selected results from poll.pdf

Selected results from the Opening Task Force's August 2021 Poll

We asked a number of questions in the poll, about personal comfort levels and feelings about risk, vaccination status, and personal practices. Overall, our congregation seems to be more cautious and prefers waiting on regathering for now due to the Delta variant and other factors. Selected questions and results are below, with some analysis. Some of the results were as expected, while others were more surprising.

How comfortable are you at this time in regathering in person at the church, for small group meetings and other smaller gatherings?

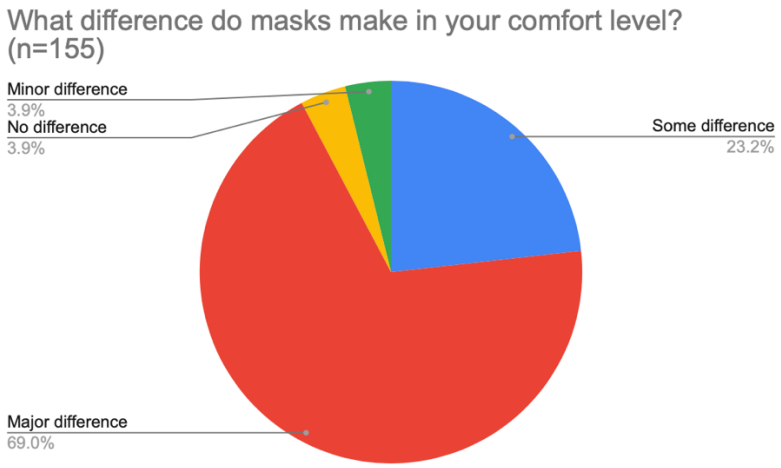
- ○ Very comfortable
- ○ Somewhat comfortable
- ○ Somewhat uncomfortable
- ○ Not comfortable

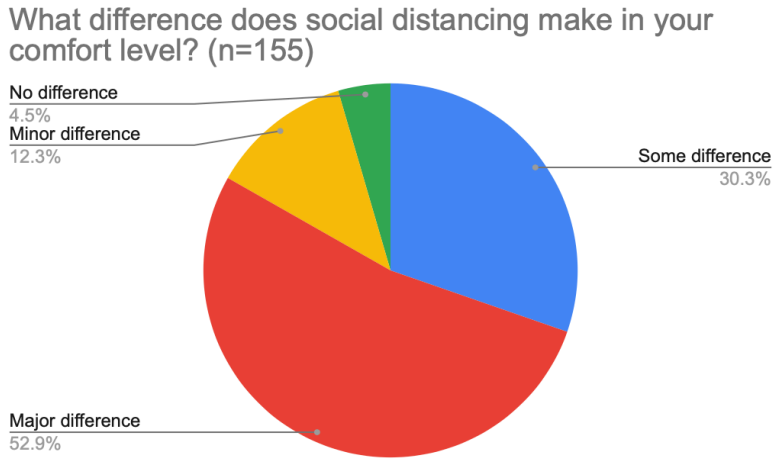


The church has been focusing for some time on ensuring that small groups can begin meeting, both indoors and outdoors. This particular result was surprising because it shows that a significant percentage of our folks – more than half – are still not comfortable with even that.

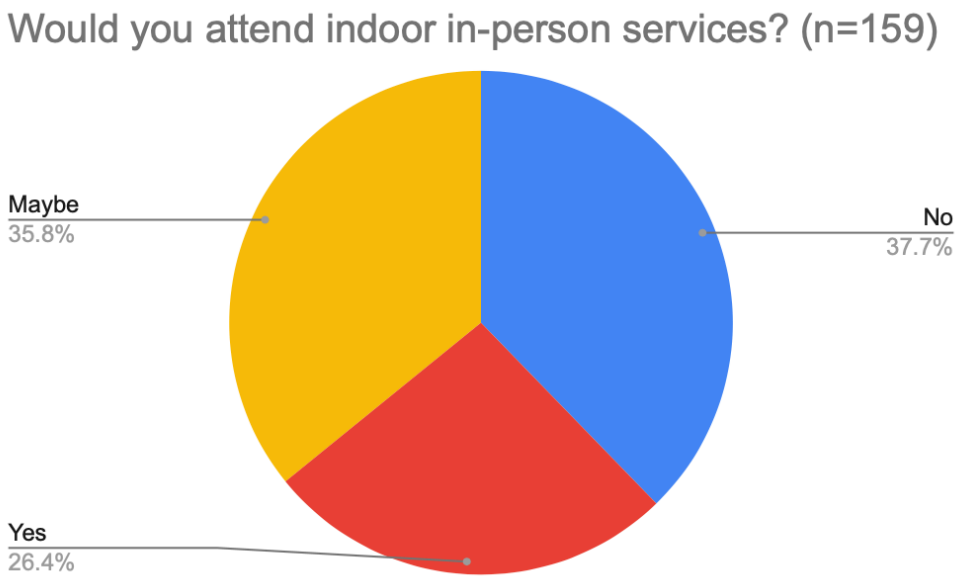
What difference do the following actions make in your comfort level for regathering in person?

	Major difference	Some difference	Minor difference	No difference
Masks required	○	○	○	○
Social distancing rules in effect	○	○	○	○



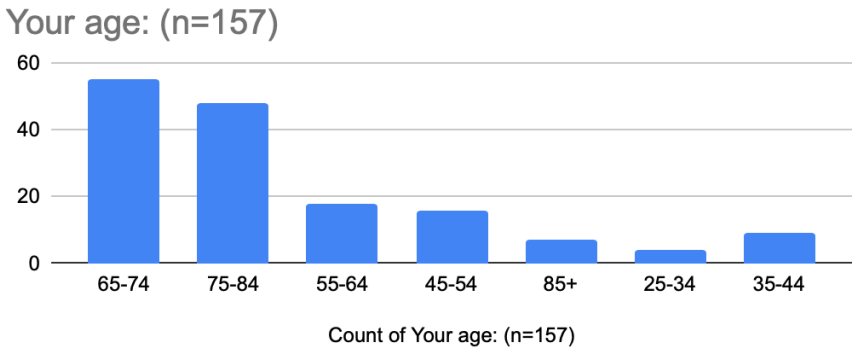


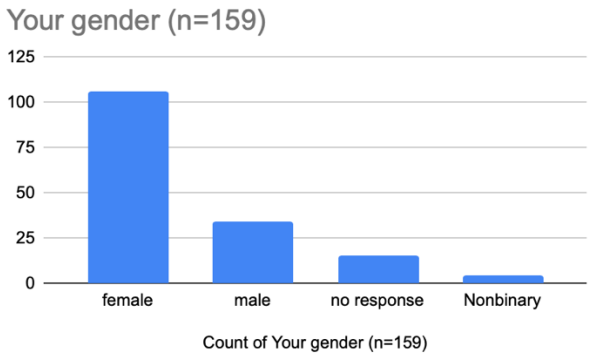
Not surprising, a majority of our folks reported that wearing masks and requiring distancing were significant factors in their comfort levels regarding any sort of in-person gatherings.

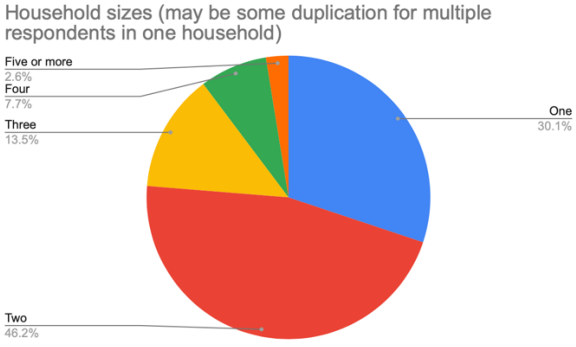


Larger indoor gatherings are still not happening in many areas, and due to Delta and other factors, are being rolled back in others. Even with our upgraded ventilation in the sanctuary and with masking and distancing in effect, just over a quarter of our folks reported being comfortable with re-gathering for indoor in-person worship services.

Some demographics from poll respondents before getting to some really interesting results.







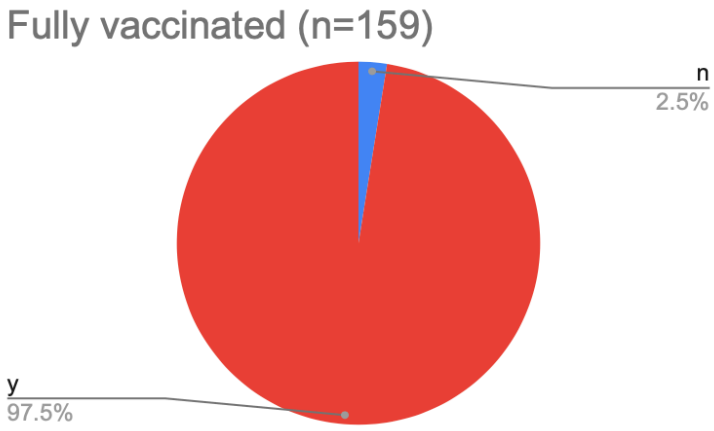
The congregation and the Opening Task force remain committed to welcoming and acceptance of all regardless of their vaccination status and other medical conditions. That being said, we still encourage all eligible folks to get the vaccination and to get boosters when those are indicated as well. Vaccinations are an important way to help protect the public health and to best protect our community, including those who are more vulnerable.

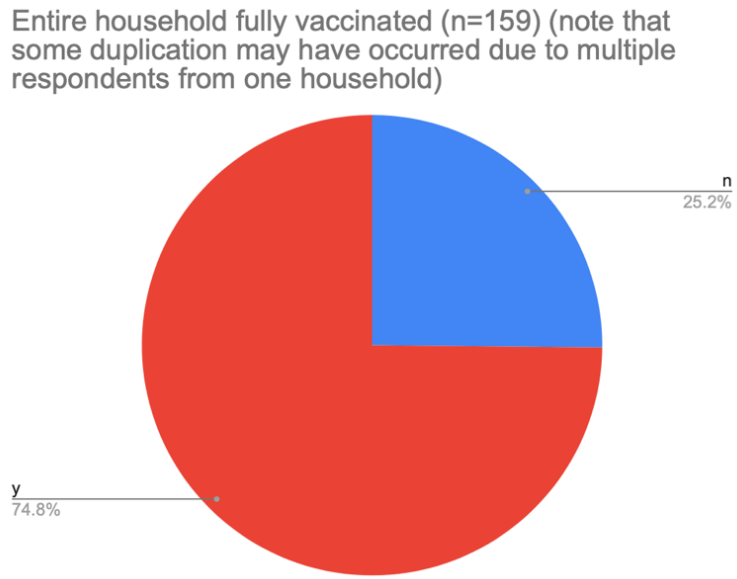
Another thing the congregation remains committed to is not requiring disclosure of personal medical information in order to be a part of our religious community. This includes vaccination status, dates of vaccinations, and other underlying or complicating medical conditions. These are personal and private information, and we welcome and accept all regardless of their private medical information and will never ask for that information.

Given that this poll was conducted anonymously, it provided a good opportunity to be able to ask about some of these factors without infringing on personal privacy to better learn about the dynamics in our church community. Of the 159 respondents to the poll, all of them answered the question regarding vaccination status of themselves, their household, and their personal practices. The question and data follow.

Tell us about your Covid vaccination status: (please choose all options that apply)

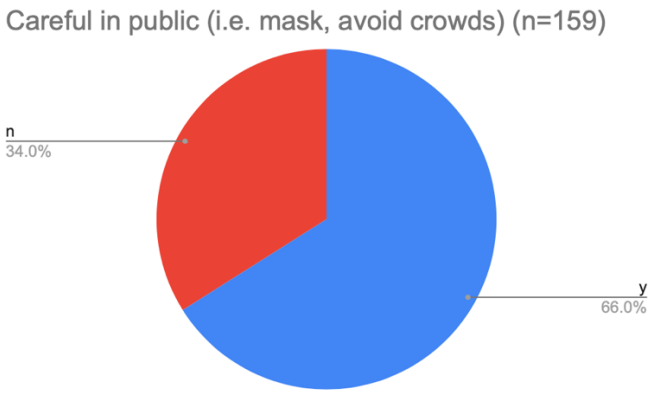
- ☐ I am fully vaccinated.
- ☐ Everyone in my household is fully vaccinated.
- ☐ I am careful as I go about my daily life in public places. (e.g., masking, distancing, avoiding crowds)
- ☐ I regularly interact with people who are not vaccinated.
- ☐ I prefer not to answer.





Of the respondents, 97.5% reported having received the Covid-19 vaccination. We did not think to include a question about when they received their vaccination, although we do know from a variety of anecdotal data that many of our members were among the earlier ones to receive it meaning that was six to eight months ago which brings them now into the larger question of when boosters are needed, a conversation currently happening in the medical community.

Considering entire households though, a full quarter of respondents reported that their entire household was not vaccinated. There was another question regarding households with children 12 or under in the survey which indicated that only 7% of respondents were in that category, so this does not account for the entire 25%. This percentage may be even higher given the significant proportion of our households of two, where it is likely that both members of the household responded to the poll.



The personal practice portion of this question was surprising. A third of respondents self-reported NOT being careful as they went about their daily lives in public places. In many ways, this is as much a transmission risk factor as the vaccination question and should be considered as we make our plans for going forward from here.