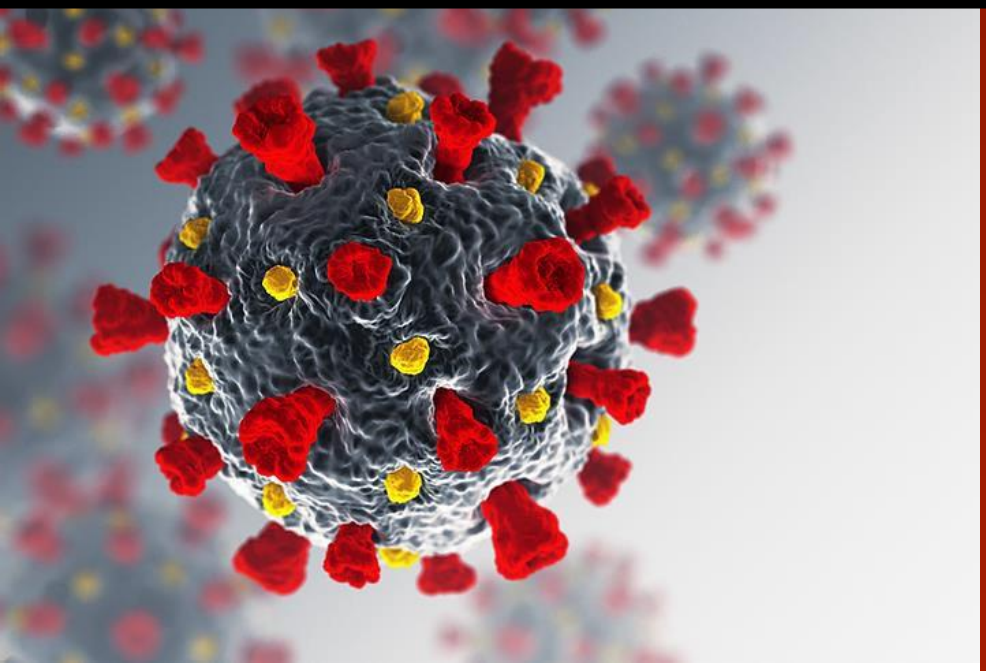
The Religious Liberty & COVID-19 Research Project

Religious freedom during public health emergencies

Lessons from the COVID-19 pandemic



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Executive summary

During public health emergencies, public authorities must recognize that access to sacred places and the practice of communal worship is essential to the spiritual, social, mental, and even physical wellbeing of many individuals and communities. At the same time, religious persons must recognize that the right to the free exercise of religious practice and worship is not absolute, and that certain restrictions, necessary to the protection of public health and safety, and proportionate to real threats in time and scope, may be justified in order to protect public health. Further, dialogue and cooperation between civil authorities and religious leaders is important to both assessing threats and implementing safeguards. Such dialogue allows religious leaders to communicate effectively to their own communities about the need, efficacy and importance of various public health response, including safeguards, preventive measures, and vaccines; it also allows for the formulation of reasonable conscientious accommodations from vaccine mandates.

Key recommendations

- Public authorities should identify and consult with appropriately designated representatives of religious communities prior, whenever reasonably possible, to the application of restrictions on freedom of religion in application of necessary health measures.

- Restrictions on religious freedom in application of necessary health measures should be strictly proportionate to, and solely justified by, the current risk to public health, and should be especially narrowly tailored when they pertain to activities which are considered by the religious community to be sacramental or related to religious worship obligations.

- Restrictions on worship and religious practice should not exceed those imposed on other social settings which present similar characteristics as places of religious worship, and no religious community should be unfairly discriminated against as a result of restrictions imposed in application of necessary health measures.

- No religious persons or religious community should be stigmatized by public authorities, or by private community actors, as scapegoats for a public health crisis, and the state may reimburse equally with private non-religious groups the financial burdens shouldered during the pandemic by closings and shutdowns

- If civil leaders are willing to be collaborative and transparent, religious leaders can play an important role in fostering a relationship of trust between their followers and the state in matters of public health.

- Religious leaders should seek information from qualified sources about the medical basis for vaccination and other preventative public health measures. They should communicate with the civil authorities to define the scope and limitations of any member's religious or conscientious objections to vaccines, and to determine what accommodations can be made consistent with the public health and safety.

Introduction – The risk of conflict between public health measures and religious beliefs and practices

In response to the COVID-19 pandemic, governments across the globe have implemented unprecedented restrictions on public religious gatherings, communal religious practices, and access to religious spaces. Whilst all state curtailments of rights and liberties merit critical scrutiny as to their legality and their legitimacy, even in response to important governmental interests such as protecting public health, restrictions imposed upon religious freedoms raise (at least) three specific concerns.

First, many people believe that access to sacred places (sites which are of special meaning to the followers of a religion) or worship assemblies constitutes a sacred moral obligation.[i] Further, religion has been shown to play a uniquely powerful role in individuals' sense of self due to the compelling affective experiences and the moral reinforcement associated with collective religious practices.[ii] Thus, total prohibition or excessive limitations on individuals' access to sacred places or worship assemblies likely violates their moral autonomy, conscience, and dignity, which are foundational to religious freedom.

Second, religion virtually always has a communal dimension, which may be predicated upon gathering for community worship, the teaching of doctrine, and/or public manifestations of belief and ritual. In order for individuals to truly have religious freedom, it is necessary that the religious organizations to which they belong have a right of autonomy to organize their internal affairs, both those which are clearly religious in nature, as well as those which may seem less so.[iii] Therefore, such restrictions that forcibly close or place excessive limitations on the internal organization of sacred places or worship assemblies are likely to violate the right to autonomy of religious groups.[iv]

Third, the World Health Organization defines health as a state of complete physical, mental, and social well-being; and not merely the absence of disease or infirmity.[v] Unfortunately, State responses to the pandemic have often focused on physical well-being and economic considerations, without also adequately considering the importance of mental, emotional, social, and spiritual dimensions of health and well-being. In the absence of such consideration, state policy can undermine these important health factors, exposing people to unintended risks, including depression, despair, and even suicide. Such responses may thus violate the spirit of the WHO definition of health.

Religious persons must recognize that the right to the free exercise of religious practice and worship is not absolute.[vi] At the same time, it is also imperative for states to recognize that access to sacred places and the practice of communal worship is fundamental for the moral autonomy, conscience, dignity, and wellbeing of many individuals, as well as the autonomy of religious groups. Moreover, international human rights law also guarantees the right of persons belonging to religious minorities to participate equally and effectively in cultural, religious, social, economic and public life.[vii] In times of pandemic, the rights of religious minorities are especially susceptible to being overlooked.[viii]

Furthermore, the protection of freedom of religion or conscience can enhance the protection of public health and the promotion of civic peace. When the state uses force to prohibit what religion prescribes, these two spheres of authority can come into collision, raising the political risk of civic disaffection, disorder, and conflict. However, when public authorities demonstrate respect for religious persons and communities, this can foster civic trust between religious communities and the state, leading to greater levels of cooperation with religious leaders in communicating effectively regarding public health guidelines, vaccine education, and other public health actions.

Dialogue between the state and religious communities

In order to respect the rights of religious persons and to better encourage their sense of social responsibility, public authorities should actively involve representatives of a wide range of religions in any procedure that would seek to restrict freedom of worship in application of necessary health measures. Public authorities should also acknowledge that, as public health interests intensify in times of crisis, the significance of religion in people's lives also intensifies. A public health approach based on dialogue and inclusiveness with religious communities will help to foster a relationship of trust and cooperation between those communities and the state. In turn, this will lead to greater levels of cooperation with public health guidelines and participation in programs such as vaccination campaigns.

The inclusion of a wide range of religions in such an approach will also prevent the undue prioritization of popular and widespread religious practices over those of minority religious belief. This will orient restrictive measures so as to take into account the convictions and practices of larger as well as lesser-known religions, thus safe-guarding against the implementation of discriminatory policies.

Challenges for religious freedom

The hierarchization of the essential

Beyond the practical restrictions which social distancing measures impose on religious practices, in cases where such restrictions burden the fulfilment of religious obligations, they also risk undermining the social legitimacy of religious normative authority by subordinating it to the political authority of the state. This subordination is manifest when states create hierarchies of social activities by grouping them into essential (permitted) and non-essential (prohibited) categories.

Over the course of 2020, many governments initially attempted to unilaterally define collective religious practices as non-essential activities. These actions generally assumed a skewed analysis of what is essential to different groups and failed to demonstrate understanding with regards to the range of religious issues thereby created. Such moves precipitated opposition from the courts, as well as popular dissent from religious groups, thereby damaging public trust in the state's response to the COVID-19 pandemic.

The grouping of social activities into a hierarchy of essential and non-essential categories by the state is not value neutral. In all countries, it is expected that state policy will be guided by science, embodied in committees of researchers and health professionals. It would be a category error, however, to see scientific analysis, even with economic input, as a full and complete transposition of all values to be considered for the community. The definition of essential and non-essential activities is a political decision, which is both value-laden and normative in scope, and needs to consider values outside the scientific and economic enterprises, especially those values embodied in religious communities.[ix]

Fair treatment for all religious traditions

Restrictions on public religious practices and access to sites of worship risk being more detrimental to certain religious communities than to others. Countries with a Protestant background or majority may have a focus on rights of individual practice and expression that can more easily be handled through distanced worship methods than, for example, Catholic, Orthodox, or Jewish traditions. The impact of in-person worship restrictions is more consequential for those communities which consider collective worship, sacramental practices, or physical contact to be essential from a theological perspective.

Catholics and Eastern Orthodox hold that the presence of Christ is manifested in the highest degree under the Eucharistic species and the work of salvation continued by the Church is realized in the liturgy of the Mass.[x] Orthodox Jewish groups believe that an in-person gathering of 10 adult men (a minyan) is required for liturgical purposes of worship. In Islam, the ritual washing and shrouding of the body of a deceased person is considered a religious obligation. Such cases raise the issue of whether policies requiring virtual worship or prohibiting physical contact have a disparate impact on, or constitute indirect discrimination against, certain religious groups and persons.

Financial impact

International human rights law guarantees the freedoms to worship or assemble in connection with a religion or belief, to establish and maintain places for these purposes, to establish and maintain appropriate charitable or humanitarian institutions, as well as to solicit and receive voluntary financial and other contributions from individuals and institutions.[xi] Attendance at places of worship and the activities that take place there constitute an important source of revenue for religious institutions and their members. Such financial resources may support the upkeep of religious buildings, fund the salary of the clergy and lay employees, and defray other routine costs incurred by religious institutions. Additionally, such resources also often are critical to funding of charitable activities run by religious actors such as food banks, homeless shelters, and educational establishments.

Just as many commercial establishments have suffered unprecedented financial losses as a result of social distancing and lockdown policies, many religious institutions are unable to recuperate lost revenue through total or partial reliance online sources of funding. Subject to constitutional limitations, when government aid programs, whether loans or grants, are implemented, religious institutions and programs should be supported on an equal basis with other entities. In cooperating with the state and locking down, they equally sacrificed their operations and finances for the public good. While constitutional and legal standards will differ from country to country, it is generally not unfair state-advancement of religion for the public to treat similarly both secular and religious entities that have sacrificed on behalf of the public good, as long as the funds are distributed equally to all religious and non-religious groups, based on size and actual financial impact.

Recommendations for creating religion-informed health guidelines

1. The importance of dialogue and consultation

As stated above, public authorities should identify and consult with appropriately designated representatives of religious communities prior, whenever reasonably possible, to the application of restrictions on freedom of religion in application of necessary health measures. Where urgent health circumstances require the enactment of restrictions prior to full consultations, such consultations shall be made with all due speed afterwards. Such consultations should include representatives from minority faith communities. Additionally, where appropriate, public authorities may wish to hold public hearings, which provide a forum for under-represented group to voice concerns.

2. Non-discrimination: secular versus religious activities

Restrictions on religious freedom in application of necessary health measures should be strictly proportionate to, and solely justified by, the current risk to public health. Further, given the central importance of religious practice to people's expression of conscience and belief, restrictions on religious freedom should only be imposed in a narrowly tailored way, maximizing the opportunity for worship and practice.

Absolute bans on religious gatherings or bans based on fixed numbers are typically not narrowly tailored to an actual threat. Where possible, restrictions on gatherings should be based on a percentage or proportion of attendance capacity relative to the location of gathering, rather than bans on absolute numbers, irrespective of the size of the facility.

Where in those rare instances the extremity of the health threat has been sufficiently demonstrated to justify full bans on religious gatherings and in-person worship, allowance should be made for alternative arrangements. These might include socially distanced outdoor gatherings, "drive-in" gatherings, and online streamed/virtual services held by a small number of socially-distanced and masked worship leaders.

Such restrictions should be temporary in scope. Public authorities should modulate restrictions in favor of rights as experience and understanding of the disease and health risks matures. Restrictions should be lifted for all religious groups within a reasonable timeframe when the health threat has diminished.

3. Non-discrimination: secular versus religious activities

Restrictions on worship and religious practice should not exceed those imposed on other social settings which present similar characteristics as places of religious worship, such as sporting events, performing arts, public transportation (buses, subways, and airplanes), and other recreational or social gatherings. Public health concerns should never be invoked to justify what are, in truth, politically, ideologically, or religiously motivated restrictions on freedom of religion or conscience.

No religious community should be unfairly discriminated against as a result of restrictions imposed in application of necessary health measures. Where public authorities have determined, in consultation with representative bodies of religious denominations, that restrictions on freedom of religion or conscience are required in application of necessary health measures, such restrictions should be formulated in such a way that they do not discriminate against certain religious communities.

Thus, such formulations should be especially narrowly tailored when they pertain to activities which are considered by the religious community to be sacramental or moral in nature. Further, such formulations should not explicitly single out activities specific to certain religions. For example, in times of pandemic, there are legitimate public health concerns regarding the use of a shared spoon for the distribution of the communion amongst Eastern Orthodox communities. This is best addressed through formulations targeting acts demonstrated to encourage salivary transfer between individuals (which is the proper aim of the public health measure), rather than formulations which explicitly target specific liturgical practices.

Such restrictions should also be formulated so as to avoid unintentional targeting of certain religious practices. For example, the imposition of curfews and lockdowns should be sensitive to the hours of regular religious worship and the calendar of major religious holidays, ideally providing safeguards that will protect the public health, but allow the central elements of the worship to occur.

4. Avoiding Stigmatization and Scapegoating

Further, no religious persons or religious community should be stigmatized by public authorities as scapegoats for a public health crisis. In the event that religious persons or communities should be exposed to threats or harassment from members of the public, they should be afforded protection by the state. States must not tolerate, even in situations of emergency, the advocacy of national, racial, or religious hatred that would constitute incitement to discrimination, hostility or violence.[xii] They should take steps to ensure that public discourse in connection with the pandemic does not constitute advocacy and incitement against specific marginalized or vulnerable groups, including (but not limited to) religious minorities.[xiii].

As vaccines become more widely available, such scapegoating can extend to either groups that are willing to take the vaccine, or more often, those that refuse to take it. Respect should be extended to both groups, although those refusing the vaccine may be subject to more stringent public health restricts and limitations; but these restrictions should not be punitive or coercive, but rather protective and care-focused, as justified by scientific public health risk assessment.

Additionally, religious leaders have a crucial role to play in speaking out firmly and promptly against intolerance, discriminatory stereotyping, and scapegoating.[xiv] Their actions or inactions can have lasting impacts on overall efforts at ensuring that a public health crisis does not deepen inequalities and discrimination, notably against minorities.[xv] By drawing on language within their own faith tradition, religious leaders can promote positive messages that affirm the dignity of all people, the need to protect and care for the vulnerable, and inspire hope and resilience in those affected by, or vulnerable to, public health crises.[xvi]

5. The importance of vaccinations and the right to refuse treatment

The wide-spread distribution of vaccines has become essential to combatting the infectious diseases such as COVID-19, and will will very likely also be necessary in future public health crises. At the same time, the principle of informed consent is a corner stone of medical ethics and international human rights law, and competent patients have the right to refuse treatment, including vaccines. In addition, some individuals may have medical, religious and/or conscientious objections to receiving vaccines.

Such refusals, however, may come at the legitimate expense of limitation of certain social involvements that can reasonably expose others to harm. These losses may include the ability to travel on public transport or airlines, to attend mass gatherings such as concerts or sporting events, to work in jobs engaging or interacting with the public, or to participate with in-person attendance at school or university.

The state, however, should tailor these restrictions as narrowly as practically possible, so as to honor the autonomy and dignity of dissenters. It should seek to maximize the opportunity for on-line or remote participation in schooling and public gatherings, and to encourage the creation of work-at-home options for state and private employees. In many instances, the public health may be adequately protected by the accommodation of mask wearing and frequent (weekly covid testing) by the unvaccinated. Again, these limiting measures should be protective and proportionate to the risk involved; not punitive or coercive attempts to force compliance with the vaccine regimen.

6. Cooperation and dialogue between civil authorities and religious leaders regarding public health measures and vaccination.

Civic leaders should see that their decisions to act transparently and cooperatively will allow religious leaders to play a vital role in fostering a relationship of trust between their followers and the state in matters of public health.[xvii] In countries where civic engagement is low and/or where public authorities are in conflict with segments of the population, religious leaders can act as mediators and educators to promote the common good. Such public roles, however, should be the result of voluntary cooperation, rather than the instrumentalization of religion by the state.

Religious leaders should seek information from qualified sources about the medical basis for vaccination and other preventative public health measures. They should communicate these empirical facts to their followers. The state could appropriately seek to support religious leaders in the dissemination of accurate information about vaccine safety and efficacy in order to encourage vaccination within religious communities.

For the vast majority of religious traditions, there exists no prohibition against vaccinations, nor against most other preventative public health measures. In such cases, religious leaders should reassure their followers that they may legitimately receive vaccinations and that they should follow the recommendations of public health authorities. Furthermore, many religious ethical frameworks emphasize the importance of co-dependency and individuals' positive moral obligations towards others. In such cases, religious leaders are well positioned to encourage their followers to receive vaccinations and to promote public health on ethical grounds that will help protect the health of the wider community. In those instances where members persist in vaccine hesitancy or refusal, religious leaders can also play an important role in working out the scope and definition of accommodations to protect both the moral integrity of those persons, as well as their health and that of the general public.

Contact details

This document was produced as part of the *Religious Liberty and COVID-19 Research Project*, a collaboration between the Andrews University International Religious Liberty Institute, Brigham Young University Law School Center for Law and Religion Studies, and the University of Portsmouth.

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Notes and references

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[iii] Brady, K. A. (2004). Religious Organizations and Free Exercise: The Surprising Lessons of Smith. Brigham Young University Law Review, 2004, 1633-1714.

[iv] https://classic.iclrs.org/content/blurb/files/Chapter%2033.%20Durham.pdf

[v] https://www.who.int/governance/eb/who_constitution_en.pdf

[vi] Cf. limitation clauses of UDHR, Art. 18(3); ICCPR, Art 18(3); 1981 UN Declaration, Art. 1(3); Article 9(2) ECHR, Art. 9(2); American Convention of Human Rights, Art. 12(3).

[vii] See 1992 Declaration on the Rights of Persons Belonging to National or Ethnic, Religious and Linguistic Minorities (UN Doc. A/RES/47/135, annex, article 2(2)) as well as 2017 Beirut Declaration and its 18 commitments on "Faith for Rights" (UN Doc. A/HRC/40/58, annex II, commitment VI).

[viii] Art. 4(2) of the ICCPR specifies that no derogation from art. 18 may be made by State Parties.

[ix] Moreover, whilst public policy should be informed by empirical science, the language of empirical science should not be employed beyond its appropriate domain to justify the normative and value-laden dimensions of political decision-making.

[x] Constitution sur la sainte liturgie, sacrosanctum concilium, 1963, 1.6-7.

[xi] See 1981 Declaration on the Elimination of All Forms of Intolerance and of Discrimination Based on Religion or Belief (UN Doc. A/RES/36/55, article 6 (a), (b) and (f)).

[xii] Cf. ICCPR Art. 20(2).

[xiii] United Nations Human Rights Committee, Statement on derogations from the Covenant in connection with the COVID-19 pandemic, April 2020 (UN Doc. CCPR/C/128/2, para. 2 (e)).

[xiv] 2012 Rabat Plan of Action on the prohibition of advocacy of national, racial or religious hatred that constitutes incitement to discrimination, hostility or violence (A/HRC/22/17/Add.4, appendix, para. 36); 2017 Beirut Declaration on "Faith for Rights" (A/HRC/40/58, annex I, para. 22).

[xv] https://www.ohchr.org/Documents/Issues/Minorities/UN_Network_Racial_Discrimination_Minorities_COVID.pdf

[xvi] World Health Organization, Practical considerations and recommendations for religious leaders and faith-based communities in the context of COVID-19 – Interim guidance (7 April 2020), https://www.who.int/publications/i/item/practical-considerations-and-recommendations-for-religious-leaders-and-faith-based-communities-in-the-context-of-covid-19

[xvii] Lack off mutual trust and understanding between health officials and affected communities was identified as a major challenge during Western African Ebola virus epidemic (2013–2016). Cf. Manguvo, A., & Mafuvadze, B. (2015). The impact of traditional and religious practices on the spread of Ebola in West Africa: time for a strategic shift. The Pan African medical journal, 22 Suppl 1(Suppl 1), 9.