G20 INTERFAITH FORUM 2021
The COVID-19 emergencies: Religious engagement
September 7, 2021

Highlights: Challenges and Call to Action

Active engagement by G20 member governments of religious communities is crucial to effective responses to pandemic challenges. It can draw on the direct involvement of countless religious communities in aspects of the COVID-19 pandemic including broader economic/social crises. Vital religious community interests in and energetic mobilization to address the COVID-19 crises highlight needs for explicit, strategic, and continuing consultation and engagement mechanisms for faith actors within the G20 system.

The **most immediate priority** is to engage and organize strategic support for the **global COVID19 vaccination campaigns**, with, notably, action on global vaccine equity, logistics of rollout, positive messages to communities, and countering misinformation and vaccine hesitancy.

Experience argues for proactive **support to the majority of religious communities that follow public health measures, social protection efforts (hunger, livelihoods), and conflict resolution is needed**. Strategic attention should go to the minority of religious communities that resist public health measures, further divisions, and spread misinformation. Clear information for policy makers on lessons learned and religious engagement is essential.

Framing and delivering **public health messages** are particularly significant in the COVID-19 health crisis. International and national health authorities are engaging faith actors in delivering critical messages; WHO's appreciation for vital roles of religious leaders is reflected in outreach efforts and specific guidance directed to religious communities[1]. Public health guidelines on gatherings, for example, meet generally positive responses and compliance from religious groups, but also some opposition and resistance. Religious communities can address and combat resistance and to counter misinformation, whether or not religious actors are responsible.

Religious **delivery of health care** (integrated to varying degrees in national health systems) and spiritual care plays important roles. Broader religious roles and their potential for positive impact are frequently ignored; distinctive assets and challenges are not taken fully into account.

Shared religious focus on mobilizing **direct assistance for social and economic needs of vulnerable communities and advocacy for the voiceless** argue for G20 engagement. This applies to health, pastoral care needs, and indirect effects of economic shutdowns. Religious community efforts to protect and support vulnerable communities suffer from weak coordination with, and limited support from, the public health sector.

Social tensions linked to the COVID-19 emergency often involve religious communities, including scapegoating of specific, often minority, groups. Domestic violence and abuse of children are priority concerns as they have increased during the crisis, calling for swift action. Religious communities can play active roles. Such efforts should be combined with continuing active religious involvement in broader promotion of social cohesion through education and leadership, including addressing hate speech which has expanded with the pandemic.

Religious leaders and communities will play crucial roles in the **next phases of the COVID-19 crisis and recovery.** Priority areas are vaccination programs to address practical aspects of testing, distribution, and working with scientific and public health communities to earn local community confidence and trust. Crucial roles include addressing health disparities, fortifying primary health care systems, and identifying and supporting vulnerable communities in socio-economic crises. Potential contributions of faith communities in conflict prevention, resolution, and peacebuilding are essential to address social tensions in fragile and conflict zones and throughout societies where COVID-19 has shone a bright light on wide inequalities and injustice.

Religious engagement and the COVID19 Emergencies

Analysis of the *essential assets* and the *distinctive roles and needs* of religious communities in the global COVID-19 response underscores crucial expanded engagement with religious communities. The G20 should give urgent and priority attention to the following:

(i) Increasing the effectiveness of pandemic and epidemic responses through *primary health care delivery*; supporting *direct service provision through religious health infrastructure and personnel*, and *community engagement*, especially in Africa and with sharp attention to children.

(ii) Utilizing more proactively the significant capacity and comparative advantage of religious communities in delivering *critical public health messages*, including guidance in adapting messages to local contexts and addressing sensitive topics (burial practices, for example).

(iii) Building on active roles in addressing *misinformation,* inadvertent and deliberate, linked to religious communities;

(iv) Drawing on capacities to address emerging *issues of mental health and trauma healing;*

(v) *Bolstering capacities to bring in* and *work more effectively with rule breakers and their followers* (e.g. religious communities resisting public health guidelines)

(vi) Supporting religious communities in rapid and effective *innovations and adaptations of practices and services* that address critical new needs and reduce tensions, and offering support and insight on resilience and delivery of innovations.

(vii) Consistent *support for human rights including Freedom of Religion or Belief* (FoRB), with particular attention to easing tensions involving state/religion relationships arising from public health restrictions.

(viii) Engaging with religious experience and capacity in *addressing social protection priorities,* including *critical food security and social protection needs* (e.g food banks, providing PPE supplies, support to vulnerable communities).

With successful vaccine implementation crucial to controlling the pandemic, strategic religious actor roles include advocacy for equity and bolstering vaccine production, equitable and ethics-driven distribution of vaccines, delivery, and monitoring. Religious actors should be purposefully included in *accountability mechanisms*, including assurance of priority to vulnerable communities and corruption-proofing relief funds. The *voices of the voiceless* merit top priority in actions on COVID response.

Issues and Opportunities

Within the context of widely diverse communities and situations, religious community responses to the COVID-19 emergencies take different forms. Monitoring and analysis of responses across world regions suggests broad areas where positive engagement has contributed significantly as well as areas of actual or potential conflict that demand attention.[1] These concern the leadership of global institutions, notably the G20, and religious communities themselves. Areas for reflection and action in relation to public health and related social protection imperatives include:

(a) *Engaging religious communities on health messages aimed at appropriate behavior change.*

Religious leaders have distinctive influence in public health messaging, especially in stress-filled settings requiring urgent pandemic responses and changes in traditional practices. Reviews of past faith contributions in health crisis situations identify large and distinctive potential for positive impact in critical situations. This includes notably direct support for implementing health interventions[2] and effective messaging geared to awareness raising[3], especially when sophisticated, subtle understandings and well adapted action are needed. Thus, religious communities can contribute to COVID-19 responses through fine-tuned messages that, in language and framing, reflect local contexts and set out practical options and priorities. Generic, globally designed messaging may not apply or resonate in specific contexts and cultures. Deep and continuing engagement between public health authorities and religious communities is needed to ensure that health messaging is well contextualized and enjoys authentic and deep understanding from faith communities so that they fully understand the issues and contribute

[1] See COVID-19 religious response project at https://berkleycenter.georgetown.edu/subprojects/religious-responses-to-covid-19

[2] K.J. Lancaster, Carter-Edwards, L., Grilo, S., Shen, C. and Schoenthaler, A.M. (2014), Faith-based obesity programmes in blacks. Obes Rev, 15: 159-176. doi:10.1111/obr.12207; Hou, S., Cao, X. "A Systematic Review of Promising Strategies of Faith-Based Cancer Education and Lifestyle Interventions Among Racial/Ethnic Minority Groups." J Canc Educ 33, 1161–1175 (2018). https://doi.org/10.1007/s13187-017-1277-5; Tristão Parra M, Porfírio GJM, Arredondo EM, Atallah ÁN. Physical Activity Interventions in Faith-Based Organizations: A Systematic Review. American Journal of Health Promotion. 2018;32(3):677-690. doi:10.1177/0890117116688107

[3] Elizabeth Costenbader et al., "Getting to Intent: Are Social Norms Influencing Intentions to Use Modern Contraception in the DRC?," *PLOS ONE* 14, no. 7 (July 16, 2019): e0219617, https://doi.org/10.1371/journal.pone.0219617.

actively to the design and implementation of solutions. As an example, messages that are linked to religious teachings, including stories and parables, use of music, and other creative efforts can greatly enhance national health programs.

Simply "using" religious leaders to pass on public health messages is insufficient and potentially counterproductive. Thus broader, strategic engagement is important. Oversimplification and insensitive communication about COVID-19 risks and ways to address them can result in distorted information about critical topics that can also foment tensions. This applies with particular force during the COVID-19 pandemic, where adaptations to public health advice are essential as knowledge expands. Messaging is one important link among others in the complex causal chain through which people change attitudes and adopt altered practices. An overemphasis on messaging or exclusive focus on this dimension often fails to achieve the behavior changes crucial to protecting lives. Reliance solely on religious leaders' sermons and other public statements (radio, TV, social media), for example, will fail to achieve the full potential benefits of religious engagement. This speaks to strategic and broad-based approaches to religious engagement that include attention to messaging capacities but also look to broader opportunities that include taking advantage of peer-to-peer influence among members of a faith community. Linking religious outreach with efforts to expand women's and youth leadership, especially in traditionally patriarchal religious structures, can yield important benefits.

(b) *Defining, adapting, and tempering public health restrictions*.

Active dialogue between public health and religious authorities can identify and implement appropriate adaptations to religious practice that assure safety and prevent transmission but also reflect the needs of communities for pastoral care. Public health restrictions and guidance need to take into account the overall welfare of religious communities and their essential social roles. A concrete example is public health guidance on funeral and burial services during pandemic emergencies,[4] where the response of communities that grieve and disrupt traditional and religious handling of death has particular importance. Restrictions on funeral gatherings and regulated handling of bodies have caused suffering in different countries and aggravated sorrow and stress for surviving families and communities. Rushed burials prompted by fears linked to the COVID-19 can erode trust in public health services, including causing people to hide ill and dying people for fear of being denied proper burial. The COVID-19 infodemics plus poorly adapted messaging can accentuate intra and interreligious prejudices (an example is the case of Sri Lanka and Muslim burial regulation).[5]

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[4] The WHO faith guidance includes a safe burials section: https://www.who.int/publications/i/item/practical-considerations-and-recommendations-for-religious-leaders-and-faith-based-communities-in-the-context-of-covid-19?gclid=CjwKCAjwwab7BRBAEiwAapqpTO8DFaoO0t2CATSiaWMECAbVxoH7YeZ3PZTv5HGoNXaZbfL1yX04PRoC0BYQAvD_BwE

[5] "Anguish as Sri Lanka forces Muslims to cremate COVID-19 victims", AlJazeera, Aprio 2020.

https://www.aljazeera.com/news/2020/04/anguish-sri-lanka-forces-muslims-cremate-covid-19-victims-20040305376048.html

More broadly, public health guidance and regulations on mass gatherings and other religious practices are followed by most religious communities and actors who share general concerns for the safety of their communities. However, some communities contest regulations, sparking tensions. In many instances in very different societies, standards and approaches applied to different types of gatherings and open facilities (shopping malls, liquor stores, sporting events, religious facilities) are not transparent or open to dialogue. This can contribute to frayed relationships between government authorities and religious communities. Appreciation for distinctive religious roles and assets, including pastoral care and community support, and transparency and consultation in the process of developing guidelines are vital needs.

(c) *Roles played by religious communities in addressing social tensions and violence linked to the COVID-19 pandemic and response, with special attention to misinformation.*

Spread of (mis)information is of significant concern in the COVID-19 and other pandemics. This includes misinterpretation of health messaging, the purposeful spread of rumors, and support for practices contrary to public health advice. Religious leaders have capabilities and responsibilities to support corrections of misinformation and to deal with outliers in communities that spread such misinformation, especially when it is dangerous. Of special concern is rising discrimination towards certain groups, including some religious communities that are identified with practices perceived as linked to spread of disease. Positive religious leadership can address the so-called "infodemic" in significant ways, even as neglect or hostilities can make the situation worse.

(d) *Applying and expanding innovations in communication approaches in many faith communities propelled by the pandemic shutdowns*; *need to address digital divides*.

Technological adaptations needed to reorient the life of faith communities away from meeting in person have spurred remarkable changes, notably with shifts to online worship and pastoral care. However, large technological divides in access to information tools (internet and equipment as well as knowledge) reflect and accentuate patterns of exclusion. Many cannot access technology for remote worship, and clerics cannot attend to the urgent needs of most followers. Working with young people can support faith community adaptations and overcome some digital divides.

(e) *Addressing wide disparities within and among communities in health care access and outcomes, with special attention needed to racial, religious, and class distinctions*.

A Lancet Health Commission drew attention to the need to grapple with data gaps as well as with the realities behind wide differences among communities: "Urgent surveying should be undertaken to identify humanitarian needs and hunger hotspots, especially among the poor, older people, people living with disabilities, Indigenous peoples, women who are vulnerable, young children, refugees, people who are incarcerated, people working in high-risk jobs (eg,

meatpacking plants or guest workers), and other minority populations (including ethnic, racial, and religious minorities).[6]

(f) Potential roles in refocusing on non-COVID primary health care; religious roles in universal health coverage (UHC).

The COVID-19 crisis highlights wide health disparities and the need for robust action at national and international levels to advance universal health coverage objectives, with a particular focus on primary health care. Further, primary health care, even for essential services like maternal health, child vaccination, and HIV/AIDS, TB, and malaria programs, is disrupted both by lockdowns linked to the COVID-19 pandemic and people's fear of visiting health facilities. Diverse faith community roles include direct service delivery, advocacy for national priority attention to developing health systems, and encouraging community adherence to basic health care. Two urgent needs are to support health facilities owned and run by religious bodies in their COVID-19 response and to redress tendencies for people to avoid health care so that urgent needs are not met. Attention to priority issues, including child vaccination, maternal health care, and sustaining HIV/AIDS, malaria, tuberculosis, and other programs is urgent, and religious organizations are directly involved and can provide support. With wide disparities capturing attention (critical shortages of ventilators in most African countries, and lack of basic medical supplies), assuring adequate funding of health care during the crisis and far broader attention to equitable health development in the aftermath is of critical importance.

(f) *Benefitting from this timely opportunity to reflect on future pandemic preparedness with active efforts to absorb and act on specific lessons learned from Ebola and HIV/AIDS experience and from the COVID-19 crisis.*

Many years of health expert warnings about likely pandemics and how they can most effectively be dealt with went largely unheeded.[7] This included failures to learn from faith community experiences in dealing with epidemics such as Ebola and HIV/AIDS. The need for better-coordinated interactions between governments and private health providers (including faith communities) stands out. Faith actors need to sit at tables where decisions are made (notably seen in the case of adapted burial practices for Ebola), with proper attention to sensitivities. Especially important is strategic and thoughtful engagement where health perspectives and faith perspectives seem incompatible or even in intractable direct conflict, but may not necessarily be [section (k) below]. Faith actors are among those who have reflected seriously on failures to learn from past lessons. Deliberate attention to this effort could yield major benefits.

(g) *Defining essential services and social functions, including essential spiritual services.*

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[6] The Lancet COVID-19 Commission, https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31927-9/fulltext

[7] *A World at Risk: Annual report on global preparedness for health emergencies*. Global Preparedness Monitoring Board. WHO, 2019. https://apps.who.int/gpmb/assets/annual_report/GPMB_annualreport_2019.pdf

New designations of “essential workers" are a COVID-19 crisis feature. From nursing staff to grocery store employees, redefinitions of “essential” demonstrate how much is owed to people in certain jobs and their vital importance for societies. These designations have rarely been applied to religious leaders and others with roles in religious communities, but this needs explicit consideration given vital needs in many communities for spiritual care. Limiting religious gatherings is open to politicization and can be divisive; other forms of religious services need to be part of the dialogue. Material welfare services (food banks and distributions that meet basic needs, counselling and spiritual support) deserve priority as essential services, including where religious actors provide services that are indeed essential.

(h) *Social protection support at community levels.*

Faith communities often step into gaps where governments fail or cannot reach communities. The economic and social effects of the pandemic have isolated and financially disempowered many in faith and broader communities, interrupting their roles or making them more demanding. Faith actors are among those who have stepped in and overcome barriers to fill social protection gaps, with child care, food distribution, homeless shelters, care of the elderly and the disabled, and other mechanisms of social support. They have both continued and ramped up these efforts in the face of the pandemic. Faith actors, and other grassroots and community-based actors are often the first and last responders – providing for communities before outside and more systemic responses arrive, and also sustaining support long after others have left. The COVID-19 pandemic highlights the need for robust reviews of social protection mechanisms in many countries, that should include and build on faith community experience.

(i) *Focusing on mental health.*

Mental health issues are increasingly recognized as a crucial aspect of the COVID-19 crisis, and faith traditions provide some of humanity’s most important resources in dealing effectively with them. Already often stretched, COVID-19 imposes large additional burdens on communities; many volunteers and religious leaders are facing burnout. Caregivers have not been well cared for. Some older members of congregations are particularly at risk for COVID-19 and older religious leaders are themselves dying from the disease. Rising domestic violence and child abuse are related issues where faith communities have responsibilities and, in some instances, quite well developed response mechanisms.

(j) *Recognizing and addressing inequalities*.

While faith actors step into social protection gaps in different ways, efforts are often disparate and poorly coordinated. This can accentuate inequalities and tensions among religious communities. Faith communities fall along a full continuum of wealth and associated advantages or disadvantages, as well as intersecting inequalities connected to race, gender, ethnicity, age, and class. Different faith responses can depend on where religious communities are located, with some serving their own communities, others acting as service providers for outside communities, and some choosing to distance themselves from social services provision altogether. This area

calls for thoughtful engagement as well as reinforcing interreligious and intrareligious approaches and mechanisms that can be helpful.

(k) *Dealing with outliers; religious freedom issues*.

Most faith communities follow public health measures carefully, but significant minorities do not. Religious groups are embedded in their culture and the politics surrounding them, influenced by these forces and influencing society in turn. The problematic politicization of public health issues has sometimes been exacerbated by religious dimensions, including closures of religious buildings (for example in Niger, sparking protests and demands to re-open them[8]), and mandates for wearing masks (as seen in the United States[9]). Engaging religious partners effectively before conflicts reach dangerous levels is crucial.

The spread of inadvertent but also malicious misinformation demands attention both in measures focused on messaging around the COVID-19 pandemic and more broadly linked to public health (family planning, for example).

Issues linked to religious freedom (Freedom of Religion or Belief – FoRB) have arisen in relation to the COVID-19 emergency, linked to the authority of governments to restrict religious practice in the interests of public health. Some religious groups have invoked FoRB rights to contest or reject public health restrictions. Both religious and secular scholars argue that it is possible to reaffirm the rights of freedom of religion for all without undermining public health restrictions. Rather, governments need to implement measures judiciously and with appropriate consultation that "accommodate as far as possible the wishes of individuals to exercise their rights to communal religious expression," (UN Special Rapporteur on Freedom of Religion or Belief)[10]. Religious groups need to understand that "the prohibition of assemblies is not meant as religious discrimination and persecution. At present this measure is intended to safeguard human lives, both of the believers and of other members of society" (World Council of Churches).[11] Governments and religious leaders need to work together so that each group understands both aspects of religious freedom and public health measures, appreciating the intricacies of framing this around religious freedom and seeing possibilities to protect public health while simultaneously re-affirming the rights of freedom of religion for all.

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[8] "Locked-down Niger braces for violence as Ramadan approaches", April 2020. https://www.pulse.com.gh/news/world/locked-down-niger-braces-for-violence-as-ramadan-approaches/7wvsvf1; https://www.crisisgroup.org/africa/sahel/niger/covid-19-au-niger-reduire-les-tensions-entre-etat-et-croyants-pour-mieux-contenir-le-virus

[9] John E. Finn, "Freedom of religion doesn't mean freedom from mask mandates", August 11, 2020 https://theconversation.com/freedom-of-religion-doesnt-mean-freedom-from-mask-mandates-144190

[10] "A Conversation with UN Special Rapporteur Ahmed Shaheed: COVID-19 and Freedom of Belief." https://www.justsecurity.org/70843/a-conversation-with-u-n-special-rapporteur-ahmed-shaheed-covid-19-and-freedom-of-belief/

[11] https://www.oikoumene.org/en/press-centre/news/conference-of-european-churches-reflects-on-freedom-of-religion-during-covid-19-pandemic

(l) *Longer term challenges, including rebuilding trust and reinforcing democratic values and rapid progress towards equitable and universal health coverage*

Attention must go now to addressing longer term issues emerging through the COVID-19 crises. Especially important are religion/government relations, conscious efforts to rebuild trust in institutions, and reinforcing democratic values with respect for human rights. Respective governments should bring faith actors into reflection and planning processes. Some governments, and even departments within governments do this better than others, so mutual learning is recommended. Some governments have involved faith communities especially well (e.g. monthly meetings in New Zealand, notable trust in government in Canada). Past experience highlights the risk that a rush to engage faith communities is often followed by waning interest which can accentuate tensions and aggravate difficult or unequal relationships with different faiths. The calls for purposeful attention both to process and strategic engagement.

To achieve the SDGs, WHO, and national goals for equitable and universal health coverage that reaches the most vulnerable populations, it is vital to work with organizations that are closest to these populations. That often involves religious communities that, in a wide variety of forms, play essential roles, with expertise, competence, knowledge, and well adapted models, and organizational capacity to reach vulnerable communities. Making vaccinations and health products (tests, drugs) accessible requires such assess and skills, as well as will and determination. Today some 80% of technological innovations do not have access to the market.[12] Engagement of religious communities can play important roles in achieving the product adaptations and market savvy to reach large volumes at the best possible prices. Faith communities can play roles as central purchasing agencies (procurement agencies).

Religious Roles Linked to COVID-19 Emergencies – Examples of Effective Approaches[13]

Several deliberate efforts highlight both potential for productive collaboration and the need for faith engagement in pandemic responses and in the broader inequality and social cohesion crises it reveals.

(a) The WHO EPI-WIN department has actively reached out to faith communities both through direct inputs in drafting guidance on messaging directed to faith communities, establishing a continuing advisory group, and organizing information webinars to address coordination and collaboration efforts at national levels

(b) UNICEF has adapted a planned faith engagement strategy and program to the immediate needs of the COVID-19 emergency with specific regional information and outreach sessions. UNHCR has established a faith advisory committee with an initial focus on the COVID-19 crisis impact on refugees and IDPs.

[12] Personal communication, Jean-François de Lavison, Ahimsa

[13] For extensive information on faith responses see the Berkley Center/WFDD/JLI religious responses to COVID-19 project, including an extensive resource repository:
https://berkleycenter.georgetown.edu/subprojects/religious-responses-to-covid-19

(c) Religions for Peace has organized webinars and mobilized a special fund to support Interreligious Councils in building capacity to respond.[14] Different URI Cooperation Circles are working at community level to respond to urgent needs of vulnerable communities.

(d) KAICIID (an intergovernmental interreligious body) has provided 110 mini grants around the world to support religious institutions and leaders in their work on COVID-19 related issues. It has organized 38 different webinars on wide-ranging topics that have engaged policy makers and religious leaders.[15]

(e) Pope Francis established a working group with five task forces to address the COVID-19 crisis, including specifically a focus on primary health care as a priority and long-term pandemic readiness.[16]

(f) Countless faith communities are mobilizing at the local level, with measures adapted to local norms and needs.

(g) Ahimsa Foundation supports a network of "mobile health initiatives" that includes many inspired by religious faith, that are responding to COVID-19 needs. These include ships, trains, and mobile clinics equipped to reach those without access to health facilities where they are.[17]

(h) Faith communities are building on existing frameworks such as the Rabat Plan of Action [18] to link ongoing efforts to address hate speech and interreligious and interethnic tensions to specific issues arising in the COVID-19 context.

(i) The Catholic Church is among religious organizations pressing for action to address the fiscal crises affecting lower- and middle-income countries as a result of the COVID-19 crisis, including an expanded debt repayment standstill, external debt restructuring, mobilization of extraordinary financing, and expanded social protection measures including cash transfer programs adapted to each country's circumstances. Religious communities are advocating for well adapted and transparent accountability mechanisms.

Recommendations for G20 Action; A Call to Action to Religious Communities

- *Vaccine development, testing, and distribution*.

[14] Religions for Peace launches a Multi-religious Fund in Response to COVID-19. August 2020. https://rfp.org/rfp-launches-the-multi-religious-humanitarian-fund-in-response-to-covid-19/
[15] See for example https://www.kaiciid.org/dialogue-knowledge-hub/webinars/covid-19-and-religion
[16] "Augusto Zampini explains how the Pope's coronavirus Task Force will work." https://www.romereports.com/en/2020/04/17/augusto-zampini-explains-how-popes-coronavirus-task-force-works/
[17] Ahimsa Mobile Health Initiative, https://www.ahimsa-fund.com/wp-content/uploads/Concept-Note-Mobile-Health-Alliance.pdf
[18] "Freedom of Expression vs. Incitement to Hatred: OHCHR and the Rabat Plan of Action", https://www.ohchr.org/en/issues/freedomopinion/articles19-20/pages/index.aspx Rabat plan of action

    - Leaders of pertinent networks must act to establish a systematic and ongoing platforms for engaging religious actors on national levels for better communication
    - G20 members must act at national levels to include religious communities in all communications about vaccine roll out in their country and listen to religious communities' input on the best way to ensure vaccine acceptance.
    - Religious leaders and communities must work to provide correct information on vaccinations, dispel rumors and misinformation, and advocate for equality in vaccination distribution.
    - Religious institutions can acknowledge and direct attention and resources to southern hemisphere regions or marginalized and vulnerable communities.
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There is wide recognition that successful near-universal deployment of an effective vaccine is the only way to end the pandemic. Religious communities have important capabilities to contribute to this success, but only if they are actively engaged in both designing and implementing ways to address the ethical and practical issues involved: who gets it, when, how, and at what cost? How can appropriate confidence in vaccines be assured, and widespread participation of individuals and communities in vaccine programs be achieved? This will require addressing concerns about inequities in vaccine testing and distribution, fears and misinformation leading to anti-vaccination sentiments, and broader distrust of science and public health authorities. Religious communities are both affected by these issues in distinctive ways, and uniquely capable of helping ensure these issues are successfully addressed. The responsibility for leadership and collaboration falls equally to religious leaders and institutions.

- *Addressing issues related to broad public health programs disrupted and challenged by the COVID-19 pandemic, including giving a voice to the voiceless and marginalized*.
    - G20 actors should work to address health inequities and affected health programs in their countries that have inequitable impact on specific communities over others, including those communities representing racial, ethnic, and religious minorities.
    - Religious communities should examine and map health inequities in their own communities and work to address those issues, through delivery of services and advocacy for change.

Religious communities and leaders can play critical roles in addressing immediate and urgent health care needs, with, generally, a sharp focus on vulnerable communities, including children and refugees. Several strong networks link these health delivery networks. Priority should go to information sharing about good practice in overcoming hurdles standing in the way of developing health care systems. Both religious communities and the G20 leaders should emphasize sharp, action-focused attention to redressing acute health disparities with particular attention to those related to race and religious identity. Giving a voice to the voiceless, listening to people about the health issues they are facing, and acting to make change should be the priority.

- Assuring adequate international and national financing of basic health care is a pandemic priority that the G20 should highlight as a topic of critical importance.

- Religious, national, and multinational engagement on health, both COVID-19 related, should look to positive action steps towards achieving Universal health coverage. This can include platforms to highlight positive actions. The health disparities unveiled by the impact of COVID-19 on different communities and incapacities to meet specific COVID-19 needs highlight the importance of systematic and sustained religious engagement in global health governance, including participation in health ministerials and think tank support for the G20 process.

- The vital religious community investment in an energetic mobilization to address the COVID-19 crises highlights the continued need for explicit, systematic consultation and engagement mechanisms for religious communities within the G20 system.

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