# LOCAL FAITH COMMUNITIES AND IMMUNIZATION FOR SYSTEMS STRENGTHENING

Brief of Hub Activities and Preliminary Research Agenda from Scoping and Systematic Reviews

JOINT LEARNING INITIATIVE ON LOCAL FAITH COMMUNITIES

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## About the JLI F&LC

The Joint Learning Initiative on Faith and Local Communities (JLI F&LC)'s has instituted several Learning Hubs on different topics. At this time, four main Hubs have been formed: HIV/AIDS and Maternal Health, Resilience in Humanitarian Contexts, Strengthening Capacity and Engagement at the Local Level, as well as Immunization and Systems Strengthening.

Each hub is conducting a process of consultations with multi-sectoral partners and scoping reviews of available evidence in order to assess the value of further engagement on these topics, as well as identify evidence gaps which would most usefully be filled by targeted research engagement. The goals of the JLI F&LC are as follows:

1. To build an *improved evidence base* providing insight into the impact of Local Faith Communities in addressing the health and well-being of their communities;
2. To provide *actionable recommendations* for potential partners, including governments, donors and practitioners, who work with faith assets and Local Faith Communities (LFCs) for improved partnership at local levels, as well as broader national and international level strategies;
3. To develop the *capacity* of researchers, practitioners and community members and their affiliated networks and institutions through shared language tools, knowledge-resources and network building.

***Internal brief for JLI discussion – not for broader publication at this time***

## About the Immunization and Systems Strengthening Hub

Immunization (including 'vaccination' concerns) is a core component of achieving Millenium Development Goals, and immunization interventions are often seen as one of the key public health strategies in the developing world.

However, there is very little evidence of how religion or faith intersects with immunization concerns. In the public media there are occasional stories of local faith communities (LFCs) and religious leaders acting as 'obstacles to the advances of science' or denouncing vaccines based on religious ideologies. On the other hand, faith leaders and communities are also sometimes described as key facilitators of immunization information or intervention.

There has also been a significantly increased interest in the contribution of faith-inspired health institutions - and suggestions that these provide essential access to primary health services or facilitate the distribution of vaccines into areas where there are otherwise none.

However, there is little evidence on the particular role of local faith communities in relation to immunization—and current accounts are not sufficient to inform policy or best practice.

### Immunization Hub

*2011-2012: Immunization identified by JLI F&LC committee as an area of key interest. Consultations begun with various stakeholders (academic and practitioner)*

*Nov2012-March2013: scoping and systematic review process, including further consultation*

*Mid-2013: Decision taken on continuation of immunization hub and future potential joint learning*

## Phased Approach

In the initial JLI F&LC consultation (2011-2012) it was decided that immunization was a key area of interest and that a Hub should be formed to explore the potential for further joint learning in this area. A two-phase approach was undertaken:

*Phase One: Mapping Existing Knowledge and Evidence* - systematic and scoping reviews of available evidence – inclusive of consultation with academics, researchers and practitioners to enhance review quality and establish relationships for future collaboration.

*Phase Two: Agenda Setting, Resource Allocation, Primary Research and Joint Learning* - the preceding review work will provide guidance on the value and nature of further research-engagement, and provide justification for the allocation of key resources to further primary research and joint learning.

## Review Findings: Status of the Evidence

Scoping and systematic review strategies have different findings as a result of the significantly different materials available on this particular issue. Some key observations about the status of evidence on faith and immunization:

- The bulk of materials are 'grey' literature—and mainly news reports
- A number of peer reviewed articles have recently emerged—in the period 2010-2012. The majority of these articles represent application of 'religious affiliation' or 'religious reasoning' as an econometric criteria for immunization/vaccine update or refusal
- The available peer-reviewed materials have a limited geographic representivity—mostly focused on those countries which experienced public vaccine rejections. (The countries most frequently covered are: Nigeria, Pakistan, India, Afghanistan and Ghana)
- The HIV/AIDS epidemic has resulted in increasing literature—as can be see in in emerging literature on the influencers (such as religion) on potential HIV vaccines.

## Preliminary Lessons for Agenda-Setting

As with all issues on religion and health, there is an inherent tension between religion as an individual characteristic that influences behaviours and religion as a public force (with social institutions). This tension is enhanced in relation to immunization which also holds a dialectic between concerns at the individual level (e.g. belief, rights, uptake, refusals) and the health of the public (e.g. public good, herd immunization, health systems and global forces).

**Individual religious belief and immunization/vaccine uptake or refusal:** The available literature mainly focuses on religion and immunization at the individual level. For example, religion is presented as an explanation for vaccine refusals—such as orthodox traditions which refuse because of a belief that they contain animal products (or in the case of Islamic tradition, are non-halaal). Some have attempted to measure which religious tradition contains more 'non-acceptors'—however the interrogation of these findings are usually poor. The literature from the USA has a particular focus on so-called 'religious exemptions'—although it is emerging that those who take up religious exemptions, do not always do so on religious grounds.

**Religious leadership as barriers to immunization campaigns:** One of the most common observations is the role of religious leadership in influencing individual behaviours or decision-making. There are numerous examples of literature where the explanation for poliomyelitis campaign failure is ascribed to 'Muslim clerics' who influenced community belief and resulted in rejection and resistance to the immunization campaign. These statements usually demonstrate a complex weaving of religious, cultural and political beliefs – for example that religious leaders supported the belief that a particular vaccine was a US plot to depopulate Muslim lands by causing sterility and spreading AIDS.

**Religious leadership as facilitators and influencers for social mobilization:** As a result of such resistance—most particularly since the poliomyelitis campaign boycotts in Nigeria and Pakistan from around 2000—there has been a visible increase in the literature of mention of religious leadership as important influencers and facilitators for immunization campaigns.

**Interventions through local faith communities:** As a result, there is increasing mention of immunization campaigns being strategically (and successfully) conducted through local faith communities—in particular through religious schools and endorsement through religious communication methods (such as announcement from mosque or in congregations). For example, in India and Pakistan, several immunization strategies deliberately engaged with religious leadership—especially in underserved and hard-to-reach population areas—and programs were set up in Madarsas (religious schools) in several areas.

*We recognize the important contribution of the **WFDD/ Georgetown-Berkley Center** who undertook a scoping review on faith and immunization in 2012 in collaboration with the Luce Foundation*
*http://repository.berkleycenter.georgetown.edu/Faith_and_Immunization-revised-DRAFT.pdf*

### Planned Phase1 Outputs

⇒ *Endnote Database*
⇒ *Annotated Bibliography*
⇒ *Scoping Review Report*
⇒ *Article based on scoping review findings*
⇒ *Article reporting on systematic review*
⇒ *Working document on research agenda-setting for JLI-Immunization*
⇒ *Targeted research proposals as output*

### Review Delimiters

⇒*Main focus on 2000-2013*
⇒*English literature*
⇒*LMIC countries prioritized*
⇒*Religion (& variations e.g. faith, mission, church, orthodox, muslim, cleric)*
⇒*Immunization (& variations)*
⇒*Vaccine (& disease-specific variations e.g. poliomyelitis)*
⇒*Related terms: e.g. exemption, non-acceptors, risk perceptions, social mobilization, community influencers, noncompliance*

## Agenda-Stetting: LFCs and Immunization for Systems Strengthening

One of the key areas for further research emerging from the review process is consideration of LFCs and immunization in relation to health and community systems strengthening.

Although local faith communities often have strong ties to religious institutions, such as faith-inspired health providers—there is little consideration of this in the available literature. Some key areas for consideration might be:

- *The contribution of faith-inspired nonprofit health providers to immunization campaigns*—in particular the characteristic and innovative strategies for improving immunization at a local level
- *The particular community participation strategies* for engagement with (particular) local faith communities
- *The role of faith-inspired providers and LFCs at the primary care level.* This is a particularly under-developed area of investigation—although anecdotally many LFCs and faith-inspired providers are involved with the provision of essential care (including immunization) in remote, under-served areas
- *The flow of vaccines and essential medicines through non-profit mechanisms* (several of which are faith-inspired in Africa)
- *Strategies and mechanisms for provision of vaccines and immunization services in conflict and post-conflict settings:* in many of these settings, religio-cultural conflict might inhibit immunization strategies, and faith-inspired providers also often dominate health care provision, and LFCs are often the only stable social institution
- *The effect and management of vertical immunization campaigns* on faith-inspired non-profit providers and health systems
- *The human resource constraints to immunization:* in particular, the lack of evidence on the religious beliefs of 'immunization staff' which might influence uptake
- *Religious factors influencing access to immunization services*—in particular access relating to affordability, availability and acceptability
- *The influence of historical factors influencing current immunization*—for example, post-colonial and religious-historical factors influencing access to immunization
- *Health systems strengthening in relation to governance of immunization campaigns*: this relates to a number of issues such as leveraging immunization campaigns for systems strengthening, or working against corruption in health service provision
- *Immunization as a community systems strengthening (CSS) strategy:* more is needed across all CSS issues—including a better understanding of effective community participation strategies which support genuine social mobilization
- *Better understanding of the role and potentials of religious leadership as community influencers:* e.g. there is little evidence on how they influence LFCs irt immunization, and what the best practice for engagement might be
- *The role of LFCs and faith-inspired health providers in public-private partnership for immunization:* including local and global partnerships
- *Trust and immunization* appears to be one of the key issues around which a number of these other concerns circulate. For example, trust of a particular vaccine, trust in the health system providing that service, trust between patient and individual provider, trust of religious leaders as influencers of beliefs and behaviour change (or knowledge brokers), trust between community partners, and trust between local and global partners

### Phase 1: Leadership

*The initial review work and consultation is being guided by Dr Jill Olivier of the University of Cape Town and the International Religious Health Assets Programme (also a member of the JLI F&LC steering committee)*

*Jean Duff (Full Circle Partnership) and Katherine Marshall (WFDD, Berkley Center) are also centrally involved in the JLI F&LC Immunization Hub*

### Hub Partners

*We do not list here all the key partners that have been consulted as part of the review process (or that are part of the broader JLI F&LC Collaboration)*

*These partners include academics and practitioners from several different countries*

*Input from new partners is welcomed as part of the ongoing joint–learning process*

## Agenda-Stetting: LFCs and Immunization for Systems cont.

There are a few key lessons for further research that are emerging from the review process:

- **The need for intentional interdisciplinary and multisectoral research engagement**—for example intentional blending of highly technical strengths of epidemiology and immunization specialists, with the local context knowledge of the social sciences and especially theological perspectives. Further stakeholder analysis (on different agenda issues) would be useful
- **Targeted theological engagement is needed**—inclusive of different religious traditions and their 'policy influences' on individual behaviour (e.g. influencing rejection or uptake of specific vaccines in specific contexts), but also theological influences on faith-inspired institutional response to immunization
- **The critical need for more case studies:** one of the most significant contributions might be a series of case studies on intersection points between LFCs and immunization in different settings—which could be utilized for program improvement and policy examples
- **The need for strategic national scoping:** The evidence on LFCs and immunization is widely dispersed—different forms of data need to be collected and synthesized, and more attention is needed on those countries where there was not a visible public boycott, so that lessons can be learnt from these (less dramatic) contexts.
- **A focus on health communication through different faith-related mechanisms** would appear to be of particular relevance

Joint Learning Initiative on Faith and Local Communities

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