Faith & Immunization: PAST, PRESENT AND POTENTIAL ROLES OF FAITH-INSPIRED ORGANIZATIONS

World Faiths Development Dialogue
Some of the most compelling stories about active collaboration between religious and non-religious bodies turn around vaccination campaigns. During the terrible wars that wracked Central America, it was Catholic Church officials who helped to broker cease fires so that children could be immunized. Muslim leaders led the way to life saving campaigns in Indonesia. Religious leaders from many traditions in far corners of the world have persuaded anxious parents that they should vaccinate their children, often by example. But where religious leaders are skeptical about the motivations of public health workers or suspicious of the vaccines, campaigns founder.

In many world regions vaccination of children is near universal but there are still large gaps and new vaccines are being developed that need to be explained and promoted. The stakes are high. Vaccines prevent an estimated 2.5 million child deaths a year; over 100 million children are immunized every year before their first birthday; and, though their capacities vary, all countries have national immunization programs. However, some 20 percent of the world’s children and young people, 24 million, are unvaccinated or under-vaccinated. And with new vaccines coming available new challenges constantly appear. Explaining needs, benefits, and risks well and honestly are critical success factors, and religious communities are vital partners, both here and in delivery of services.

This report focuses on the important remaining gaps in coverage, with an eye also to new opportunities. The starting hypothesis is that faith communities are engaged but far less than they could be. Thus it sets out to answer the question: what more can be done and what would it take to build robust and effective new partnerships in one of the world’s most compelling and demanding global campaigns.

The answers are both straightforward and complex. For a start, gathering information on what is being done is essential, and this report represents a beginning. Building trust, in governments and in their actual and potential faith partners is equally important, though harder to translate into practice. The report recommends a sharp focus on rolling out the relatively new pneumococcal and rotavirus vaccines, which offer such potential against the cruel child killers, pneumonia and diarrhea. Education and information will likely be the main focus in the short term as introducing such vaccines is primarily a top-down exercise: both financing and a government’s agreement are essential. Immunization services provided by faith-inspired organizations (FIOs) will come into play once the funding and government agreement are in place.

The report points to three areas where faith-inspired actors can play critical roles. The first is equity, as faith communities can both point to underserved populations and, given their presence there, help focus support to immunization campaigns there. Second, many of the least vaccinated populations are in complex, tumultuous countries like the Democratic Republic of the Congo (DRC) where faith networks are especially vital players. They can help overcome the barriers. And finally faith communities with their focus on holistic visions of health care can help “connect the dots” among different public health and welfare efforts so that they truly meet the needs of those people and communities most in need.

In short, the potential to contribute in tangible ways to the common good through cooperation on vaccine efforts is enormous.

The report was written by Lynn Aylward, WFDD Senior Fellow, with input from Hahna Kimbrough (WFDD) and the generous help of several external reviewers. WFDD undertook the review at the urging of GAVI, which is seeking opportunities to collaborate more actively and creatively with faith partners.

Katherine Marshall, Executive Director, WFDD
THE PAST, PRESENT AND POTENTIAL ROLES OF FAITH-INSPIRED ORGANIZATIONS

ACRONYMS

AMC. Advance Market Commitment
ARHAP. African Religious Health Assets Programme
CDC. US Centers for Disease Control and Prevention
CHAs. Christian Health Associations
CIFA. Center for Interfaith Action on Global Poverty
DPT. Diphtheria, tetanus and pertussis
FIOs. Faith-inspired organizations
GAVI Alliance. Global Alliances for Vaccines and Immunisation
GIVS. Global Immunization Vision and Strategy
HIV and AIDS

IFFIm. International Finance Facility for Immunisation
MDGs. Millennium Development Goals
NGOs. Non-governmental organizations
UNF. United Nations Foundation
UNICEF. United Nations Children’s Fund
WFDD. World Faiths Development Dialogue
WHO. World Health Organisation

COVER: A mother, holding her baby and children’s patient cards, waits for the monthly mobile clinic in Bairro Mecedzele, Mozambique, March 2012. The GAVI Alliance is a public-private partnership that brings together developing country and donor governments, WHO, UNICEF; the World Bank, the vaccine industry in both industrialised and developing countries, research and technical agencies, civil society, the Bill & Melinda Gates Foundation and other private philanthropists. Set up in 2000 as the Global Alliance for Vaccines and Immunisation, GAVI’s mission is to save children’s lives and protect people’s health by increasing access to immunisation in the world’s poorest countries. GAVI/2012/Eva-Lisa Jansson INSIDE FRONT COVER: Ghana: 27 April 2012, A woman holds her son as she waits to have him vaccinated at the Nkynoa health outreach point in the village of Nkynoa. GAVI/2012/Olivier Asselin
1. INTRODUCTION

Progress in recent years to reduce child mortality worldwide has been remarkable and sharply increased access to childhood vaccines has been an important contributing factor. However, almost 20 percent of the world’s children still do not have access to lifesaving vaccines. Recent efforts to close this gap include the Decade of Vaccines Collaboration; a major push by the Global Alliances for Vaccines and Immunisation (the GAVI Alliance) to introduce new vaccines to prevent pneumonia and diarrhea (the two leading killers of children worldwide) in low-income countries; and a new campaign spearheaded by the United Nations Foundation, Shot@Life, whose mission is to educate, connect, and empower Americans to champion global vaccines. The effort, resources, and persistence required to fight vaccine-preventable disease killers, which claim the lives of almost 2 million children each year, have inspired the GAVI Alliance and the United Nations Foundation (UN Foundation) to engage as many partners as possible. In that spirit they have embarked on this effort to explore the actual and potential roles of faith-inspired organizations (FIOs).

This paper examines the links between faith and immunization. A goal is to stimulate brainstorming as to how FIOs, many of which are already very much involved with immunization in poor countries, could help to introduce the new vaccines. It represents a joint effort of the GAVI Alliance; the UN Foundation’s Shot@Life campaign; and the World Faiths Development Dialogue (WFDD). The paper reviews how FIOs are involved in direct immunization services in low-income countries and in advocacy and financing.

The study drew on desk research and interviews with experts. Desk research focused on FIOs that work in vaccination and on the countries with the heaviest disease burden from pneumonia and diarrhea (Table 1). A list of experts interviewed in person, by telephone, or via e-mail appears in Table 2.

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1 There are numerous different causes of pneumonia and diarrhea. However, since pneumococcal disease is the leading cause of pneumonia and rotavirus is the most common cause of severe diarrheal disease in children, this paper will generally not distinguish between pneumonia caused by pneumococcal disease and other causes, and between diarrhea caused by rotavirus and other causes, except where the distinction is material.
2. IMMUNIZATION AND INTERNATIONAL DEVELOPMENT

Immunization is one of the most powerful health interventions of all time. A UNICEF/WHO publication highlights that, “With the exception of safe water, no other modality, not even antibiotics, has had such a major effect on mortality reduction.” Vaccines are powerful because, among other things, they benefit individuals, communities, and entire populations; their impact on a nation’s health is rapid compared to other health interventions; and they are both life- and cost-saving. Vaccines prevent more than 2.5 million child deaths a year; over 100 million children are immunized every year before their first birthday; and, though their capacities vary, all countries have national immunization programs.

The role of vaccination in global development, already a focal point in the last century, is even more central now. The Millennium Development Goals (MDGs), adopted in 2000, focused attention on improving life in poor countries, and vaccination is a key component of achieving MDG 4, the reduction of the number of deaths of children under age 5 by two-thirds by 2015. The MDGs and other developments supported the creation of organizations and initiatives addressing vaccination in poor countries. In 2010, the Bill and Melinda Gates Foundation called for a “Decade of Vaccines”, citing the potential of vaccines to save 8 million lives by 2020. The Foundation made a 10-year, US$10 billion commitment to research, develop and deliver vaccines for the world’s poorest countries, supplementing the extensive financial support it has already provided for vaccine initiatives, including through co-founding GAVI.

Numerous organizations help promote global immunization programs. GAVI’s mission is to increase access to immunization in poor countries, and its alliance members include developing country and donor governments, the World Health Organization, UNICEF, the World Bank, the vaccine industry in both industrialized and developing countries, research and technical agencies, civil society, the Bill & Melinda Gates Foundation, and other private philanthropies. Among other organizations that are helping to make vaccines a global public health success story are the International AIDS Vaccine Initiative, the International Vaccine Access Center, PATH, the Sabin Vaccine Institute, Rotary International, American Red Cross, Lions Clubs International, the American Academy of Pediatrics, Save the Children, RESULTS, the ONE Campaign, the UN Foundation, and the US Centers for Disease Control and Prevention (CDC).

New financing mechanisms are also important. Since its creation in 2006, the International Finance Facility for Immunisation (IFFIm) has raised US$3.6 billion by issuing bonds in the capital markets to support the work of GAVI. The Advance Market Commitment (AMC) mechanism was created as a new approach to stimulate the development and manufacture of vaccines for low-income countries. Through the AMC, donors commit funds to guarantee the price of vaccines once they have been developed, thus creating the potential for a viable future market. The first AMC, a US$1.5 billion commitment by the Bill & Melinda Gates Foundation, Canada, Italy, Norway, Russia, and the United Kingdom, supported GAVI financing of the rollout of the pneumococcal vaccine for developing countries.

The past decade has also been one of the most productive in the history of vaccine development and access. Five new vaccines have been developed in the new millennium, including the pneumococcal and rotavirus vaccines, and the vaccine industry has been flourishing and evolving. These developments have led to a sense of promise and potential surrounding vaccines and vaccination. The global standard of routine immunization coverage—vaccines against DTP (diphtheria, tetanus and pertussis), measles, tuberculosis, and polio—has been augmented in recent years with recommendations from WHO to include immunization against Hepatitis B, Hib, mumps, pneumococcal disease, rotavirus, rubella and, where needed, yellow fever and Japanese encephalitis.

Many challenges, however, stand in the way to saving lives and achieving health equity by reaching more children with a wider range of vaccines. The chain from vaccine development, regulation, supply, procurement, social mobilization, delivery, and monitoring and surveillance is long, complex, and demanding. Low-income countries’ national health systems are key, and many lack the required resources.

Almost 20 percent of the world’s children born each year — approximately 24 million young people — are unvaccinated or under-vaccinated. Equity demands that these children, many of them located in difficult-to-reach rural areas, fragile states, or conflict zones, also get immunized. Relatively high average national immunization coverage rates in many less-developed countries obscure low rates in individual districts.
New vaccines that are commonly available in industrialized countries are not being utilized in poor ones. For example, in only 17 percent of WHO’s 193 member states is the pneumococcal vaccine part of the routine schedule of vaccinations for the whole country, and the comparable share for the rotavirus vaccine is even lower, at 12 percent. UNICEF estimates that if these two vaccines and the other ones now available against childhood diseases were widely given with a global average coverage rate of 90 percent, an additional two million deaths per year could be prevented. There is also a divergence between the vaccines that are needed in industrialized versus low-income countries.

Achieving success in developing vaccines against malaria, tuberculosis, and HIV and AIDS is another challenge. Development of such vaccines would advance global public health in vital ways, but their production, roll-out, and delivery will add to the already-tight constraints on resources for immunization.

Financing immunization in poor countries is also a major challenge, the exceptional cost-benefit ratio notwithstanding, as sustainable immunization financing remains a distant goal. A 2007 analysis estimated that immunization programs in the 72 poorest countries of the world will on average cost about US$4.0 billion in 2015, with vaccine purchase representing about one-third of immunization program price tag, and health system costs accounting for the balance. Total immunization costs for these countries for the period 2006–2015 are estimated at US$35 billion, of which US$16.2 billion represents incremental costs for delivering new vaccines and US$19.3 billion, the cost of maintaining immunization programs at 2005 levels. The analysis also found that 30 to 40 percent of the overall resource needs to achieve the Global Immunization Vision and Strategy (GIVS) goals in poor countries were so far unmet.

At present, many poor countries provide only a tiny fraction of the costs of their immunization programs. This is not surprising given that total government spending on health in poor countries averages about US$25 per capita, while fully immunizing a child with the four basic vaccines costs around US$20. Some observers question low-income countries’ fiscal choices and charge that they have come to view vaccines as a donor-supplied commodity, while others point out that the high cost of vaccines is a major factor in these countries’ poor level of vaccine self-sufficiency. That each country finance or at least co-finance its own immunization program is a goal of the international community—for example, GAVI-eligible countries pledge to increase their national vaccine budgets as a condition of certain grants—but a distant one.

A bright spot in these daunting numbers is that in addition to saving and improving lives, immunization generates significant economic benefits. In the US, every dollar spent on immunization saves US$6.30 in direct medical costs and US$12.10 in indirect costs to society (e.g., costs due to missed work and disability). In poorer countries, immunizing all children will yield powerful dividends including a larger and healthier labor force and smaller birth cohorts, as parents gain confidence that their children will survive childhood, allowing greater investment in each individual child and increasing overall human capital. It is estimated that eradicating polio will save governments US$2 in medical costs for every US$1 spent on vaccination, and that the internal rate of return on vaccination in low-income countries will be almost 18 percent by 2020.

2 The existing tuberculosis (TB) vaccine is not effective in preventing pulmonary TB in young adults nor is it safe for HIV-infected newborns.
3 US CDC
4 http://www.sabin.org/advocacy-education/sustainable-immunization-financing/economics
3. NEW VACCINES TO COMBAT PNEUMONIA AND DIARRHEA, TWO LEADING KILLERS OF CHILDREN

Pneumonia kills more children under five years of age than any other illness, in every region of the world, and pneumococcal disease is its leading cause. WHO estimates that 1.6 million young children, the vast majority of whom live in low-income countries, die each year from pneumonia—more than from malaria, HIV/AIDS, and measles combined. There are 14.5 million serious cases of pneumococcal infection globally each year, and these cause, in addition to the human suffering, a serious burden on the already-stressed health systems of low-income countries.

While a vaccine against pneumococcal disease has been widely used in Europe and the United States since 2000, vaccines suitable for the strains of the disease prevalent in poorer countries were introduced quite recently. Vaccination is the most effective way to prevent deaths from pneumococcal diseases, and, in 2007, WHO recommended that pneumococcal vaccines be introduced into all national immunization programs.

The pneumococcal vaccine had been rolled out in sixteen countries as of December 2011 and has had its official global launch. The roll-outs of the vaccine have been in Benin, Cameroon, the Central African Republic, the Democratic Republic of Congo (DRC), Guyana, Honduras, Kenya (site of the official global launch), Mali, Nicaragua and Yemen. GAVI hopes to be able to support introduction of the vaccine in more than 40 low-income countries by 2015.

While the price of the pneumococcal vaccine in poor countries is relatively low, there are major financial challenges to its wider introduction. GAVI reports that the pneumococcal vaccine, which requires three doses for adequate protection, will have a ceiling price of around US$10 per course in low-income countries, reflecting in part the impact of the AMC, compared to a cost in the US of around US$100 per dose. The governments of low-income countries presently contribute around 15-30 cents per dose, and GAVI provides the remainder. Though the plan is for the governments’ contribution to increase over time, few countries are in a position to contribute significant amounts at this time.

Diarrhea is the second-leading killer of children, after pneumonia, and rotavirus is the leading cause of severe childhood diarrheal disease in both developed and developing countries. Rotavirus causes 111 million cases of the disease and over half a million deaths each year.

Two rotavirus vaccines have been widely available in industrialized countries beginning in 2006, and vaccines for virus strains prevalent in the developing world are even newer. GAVI support for the rotavirus vaccine became available in 2007, and in 2009, WHO recommended that every country include rotavirus vaccines in its national immunization program.

The rotavirus vaccine had been rolled out in five countries as of September 2011. GAVI hopes to be able to support introduction of the vaccine, already introduced in Bolivia, Guyana, Honduras, Nicaragua and Sudan, in at least 44 low-income countries by 2015.

Manufacturer commitments will help GAVI immunize millions of children in developing countries. As a demonstration of GAVI’s purchasing power, commitments were recently secured from rotavirus vaccine manufacturers at US$5 per course. This offer is a 67 percent reduction in the current lowest available public price. Vaccine manufacturers in middle and low income countries are also developing a rotavirus vaccine, which will further reduce the cost in years to come.
Faith-inspired organizations and individuals are intensively involved in global health and development initiatives. Unfortunately, incomplete information about their work hampers understanding of their potential and practical ways to enhance their contributions. Because of FIOs’ fragmented nature—there are literally tens of thousands of FIOs spread across different places and faiths, of very different sizes and types—it is only relatively recently that their role in development is being systematically studied.

Health is a key area for FIOs, and there is an increasing awareness of their importance in the global public health landscape. While comprehensive and systematic data are lacking, WFDD studies highlight that all the major faiths are involved in health work in low-income countries and that health FIOs are present virtually everywhere. For example, in some countries in Africa, especially those with active conflicts, FIOs may provide as much as one-third or one-half of healthcare, depending on what indicator is being measured (e.g., number of hospital beds versus share of maternal and child health services), and the World Bank (2011) reports that FIOs are the dominant non-profit, non-governmental health providers in many African countries.

FIOs’ contributions to health are complex and rich. They range from large international NGOs at one end of the spectrum to small community-based efforts at the other and involve many different types of health facilities and relationships between congregations in rich and poor countries and among international, national, and local actors of the same faith or the same values, via interfaith initiatives. Traditional healers are also part of the mix.

Table 3 summarizes selected studies that provide quantitative information on the contribution of FIOs to health in low-income countries. Much of the data that do exist concern the Christian

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**Box 1. Comparative Advantages of Faith-Inspired Organizations in Health Work**

- FIOs share fundamental values that motivate and guide engagement in health and development: such as compassion and respect for the individual and families.
- Faiths and FIOs generally have active support of a highly committed constituency.
- Faiths and FIOs often exhibit continuity and permanence in social landscapes. Because of their longevity and history, FIOs have amassed considerable health and other assets.
- FIOs can mobilize large numbers of people and large amounts of financing, through the congregations associated with their particular faith.
- FIOs are present virtually everywhere, active in every country, and often active in the poorest, socially marginalized, most remote, and unstable regions.
- Faiths are networks that can unite people and communities across different regions, countries, political stances, and levels of development.
- FIOs are among the most trusted and credible of organizations, more trusted than government and many other local institutions.
- Faith leaders often have the stature to advocate and negotiate with the most senior international decision-makers.
Health Associations (CHA) of Africa that provide important shares of national health care. For example, the membership of the Christian Health Association of Kenya totals 456 health care providers, including 25 hospitals, 50 health centers, 58 churches and church health programs, 322 dispensaries and nine nursing training colleges, affiliated to 33 Protestant denominations. The Christian Social Services Commission of Tanzania (CSSC) mapped 932 member health facilities in the country. The Christian Health Association of Mozambique reports that it trains 77 percent of national nursing personnel. Analysts Chand and Patterson point out that, although they are less reported, non-Christian health networks also exist; prominent examples are the Aga Khan network, the Uganda Muslim Medical Board, Bakawata, Hindu Mandal, and Ahamadiya.

Work on HIV and AIDS also illustrates FIO contributions in health. The human crisis and the large amount of funding that HIV and AIDS occasioned resulted in a rapid increase in the number of FIOs working on health, including the creation of new FIOs and the entry of existing ones into the health sector. The Overseas Development Institute (ODI) estimates that one out of every five organizations working on HIV/AIDS programs is faith-based.

FIOs are purported to have numerous attributes that enhance their work in the health sector. Box 1 lists these features, which have been well-covered elsewhere. The reader is reminded that secular organizations and individuals also demonstrate attributes such as commitment in their international development work. The next section takes up those purported attributes of FIOs that are particularly relevant for immunization.

The implications of these attributes are confirmed by experience and evaluations that indicate that FIOs deliver excellent health work. FIOs consistently rank among top recipients of funding by national aid agencies such as USAID to carry out overseas programs and numerous studies have tested or reviewed the efficacy of faith-linked health programs. A systematic literature review by DeHaven et al found that US faith-based programs evidenced improved health outcomes in primary prevention and general health maintenance. In a low-income country setting, Reinkka and Svensson found a higher quality of service associated with religious providers in Uganda. In a project of the Tony Blair Faith Foundation and the WFDD, Aylward reviews the evidence on the effectiveness of FIOs in health work.

However, FIOs also tend to exhibit some common weaknesses in their health work. They tend to be less integrated than secular private organizations with the public health sector and with large, international donors or institutions. They are reported to have fewer quality, financial, and other controls on their operations, and to be weak at data management.

And, there are reasons other than organizational ones why the effects of FIOs in health work could be negative. Some faith actors stigmatized HIV/AIDS, more so in the earlier days of the disease, and religious beliefs continue to influence interventions and education on HIV/AIDS. Anti-vaccination campaigns tied to religion will be discussed next.

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5 The reader is referred to the websites of WFDD, the African Religious Health Assets Programme (ARHAP), and the Center for Interfaith Action on Global Poverty (CIFA) for a wealth of information on the intersection of faith and health in low-income countries; see for example the WFDD reports "Malaria: Scoping New Partnerships," "Experiences and Issues at the Intersection of Faith and Tuberculosis," and the WFDD series on global mapping of FIOs.

6 FIOs are sometimes defined as private sector (versus public/governmental) health providers, and sometimes as civil society or nongovernmental organizations (CSOs/NGOs), which can further complicate tracking their work.

7 See, for example, CIFA (2010).
5. FAITH, FIOs, AND IMMUNIZATION

This section examines in more detail FIOs’ role in public health to their involvement with vaccination. It covers links between faith and vaccination; attributes of FIOs that are particularly relevant in immunization work; and FIOs’ existing efforts in the two broad areas of immunization services and financing and advocacy.

LINKS BETWEEN FAITH AND VACCINATION

Historically associations between faiths and vaccination have been both positive and negative. Some faith leaders were out in front promoting vaccination while others took considerable convincing to accept and tolerate this approach. Today theology is rarely, if ever, the sole driver of anti-vaccination voices tied to religion. A strong positive link running from faith to immunization is the shared value major faiths place on life, health, well-being, equity, and the prevention of suffering, particularly for children and other innocents. Many faith leaders call vaccination a moral imperative. While there are numerous cases of religious objections to vaccines, and recent ones in low-income countries have been very powerful, an exploration of most, though not all, of such recent cases points to motivations that are not wholly or even mostly religious, but rather concern other cultural, social, or political factors.

Early religious reactions to immunization were mixed but mostly positive, with negative reactions usually outside the religious mainstream. In Iceland and Sweden, clergy were made responsible for smallpox vaccination and keeping vaccination records for their parishes. Catholic and Anglican missionaries vaccinated Northwest Coast Indians during an 1862 smallpox epidemic. The Aga Khan III allayed the fears of thousands of people about vaccination when he had himself publicity inoculated in 1897 during a bubonic plague epidemic. Religious objections to immunization were mainly concerned that it thwarted the will of God; these were raised by small groups of individual clergy or believers and were not adopted by church leaders.

In modern times, no major faith has expressed a blanket theological objection to immunization, and immunization exemptions in developed countries are as much tied to health and political concerns as to theology. In the US, the number of people who take advantage of religious exemptions to childhood immunization requirements is very small (a few thousand relative to the 3.7 million children who entered kindergarten in 2005), and the vast majority of these are because of parents’ health concerns or objections to government control, rather than religion.

Indeed, the mainstream religious or ethical stance at present is pro-immunization. Heads of the world’s main faiths purchased the first IFFIm bonds; Muslim leaders quote the Hadith to support the morality of vaccination; and faith institutions and communities have “adopted” specific diseases and the vaccines that target them in major campaigns.
However, cases of objections to immunization in low-income countries tied to religion, while relatively infrequent, have been very influential. As a result, today virtually no vaccine campaign is launched without considering religious and other cultural factors.

In many of these cases, objections and fears were raised by religious leaders but in retrospect many were not purely motivated by religious concerns. The most famous case is the opposition beginning in 2003 by Muslim clergy in Northern Nigeria to a polio vaccination campaign. Some Muslims there heard rumors that the vaccine and related campaign were a ploy by Western countries to reduce fertility, spread HIV and AIDS, or otherwise harm Muslims and reduce their population. The rumors gained traction and eventually governors of three Northern Nigeria states refused to allow the vaccination campaign to proceed in their jurisdictions. The fall-out of the global polio eradication effort was serious. UNICEF and other involved partners responded proactively to the situation, engaging important Muslim leaders, notably the highly-respected Sultan of Sokoto. In retrospect, the partners in charge of the polio campaign faulted themselves for insufficient engagement and not anticipating potential problems. Subsequent analysis indicates that while the rumors emanated from religious actors, the entrenchment of the rumors had more to do with political-cultural factors: Northern Nigerians tend to feel isolated from and neglected by the power centers in Lagos and Abuja, and they were suspicious about why so much emphasis was being placed on the polio campaign when they faced a long list of other health and development problems.

More extreme objections to vaccination have occurred in Pakistan and Afghanistan. In these countries, the Taliban have issued fatwas opposing vaccination as an attempt to avert Allah’s will and as an American plot to sterilize Muslims. The Taliban have kidnapped, beaten, and assassinated vaccination officials.

While most recent anti-vaccination campaigns seem associated with Muslim actors, others have originated with Christian religious leaders or adherents. Two well-documented examples are described in Box 2.

**BOX 2. ANTI-VACCINATION RUMORS ASSOCIATED WITH CHRISTIAN FAITH ACTORS**

**In Kenya in 1997**, a Catholic bishop and priests in the Central Province region, acting on their own and not with the sanction of Kenya’s Catholic Church, spoke out against government-run polio National Immunization Days (NIDs). There was nominally a religious basis, in that it was rumored that the polio vaccine was laced with contraceptives. However, in retrospect, the clergy’s warnings seemed fed by the fact that Central Province was the heartland of the political opposition and the timing of some of the NIDs was in the run-up to a presidential election. Later it was observed that the bishop was not acting on theological concerns per se, but rather out of a sense of protecting his flock. Notably, the rumors had no perceptible effect on the routine immunization program; generally vaccination opposition tends to emerge more around campaigns or NIDs, rather than around routine programs. The Kenyan government and partners took action, and by 2001, a prominent opposition politician appeared with government staff, administering the polio vaccine on camera, at a Catholic church in the Central District.

**In the Philippines in 1995**, an international pro-life organization spread rumors via the internet that the tetanus toxoid vaccine (TT) intentionally contained a contraceptive hormone so that “millions of women in Mexico and the Philippines have unknowingly received anti- fertility vaccinations under the guise of being inoculated against tetanus.” With support from WHO, six independent laboratories in five countries ran tests on TT and determined that it did not contain the suspected substance. However, that same rumor about TT re-emerged in Tanzania several years later, when a Catholic nun there who had read about the Philippines incident raised concerns, leading to strong localized vaccination opposition. The opposition was eventually resolved through dialogue.
Faith can be understood as one of the inter-related cultural factors that have an impact on “vaccine demand”; it can help or hinder immunization objectives. An Institute of Development Studies policy briefing stresses that “vaccination is an area where highly globalized technology meets the deeply personal, social and cultural worlds on infant care.” Whether people seek vaccines or not depends on cultural context, and for sustainable and successful immunization programs, it is important to foster an active demand for vaccines.

ATTRIBUTES OF FIOs RELEVANT IN IMMUNIZATION

It is noteworthy that three of the four major barriers to achieving the world’s vaccination goals identified by UNICEF/WHO concern areas where FIOs have comparative advantages. Box 3 lists them.

A UNICEF senior staff member observed that “it is incredible how much can be done with the participation of religious leaders of all faiths.” UNICEF reports that most religious groups have been strongly supportive of immunizations efforts.

FIOs’ WORK ON IMMUNIZATION SERVICES

Though systematic data are lacking, it is well appreciated that FIOs make significant contributions to immunization in many through not all countries—including the United States—within a framework that emphasizes the government’s leadership and coordination roles. Global health policy maintains that immunization is primarily the province and responsibility of the national government since cradle-to-grave vaccine provision is a complex business. Thus, FIOs do not, and arguably should not, engage in administering vaccines to patients unless in conjunction with the government, except in specific circumstances such as fragile states or emergencies. As a USAID official said, “The days when FBOs operate apart from and unknown to the Ministry of Health and with their own vaccination schedule have passed.”

That FIOs are active in immunization should come as no surprise given their role in industrialized countries such as the United States. Islamic Relief USA and the Salvation Army are just two examples of the many FIOs that help run immunization clinics throughout the US.

BOX 3. MAJOR BARRIERS TO ACHIEVING GLOBAL IMMUNIZATION GOALS IDENTIFIED BY UNICEF/WHO AND THE COMPARATIVE ADVANTAGE OF FAITH-INSPIRED ORGANIZATIONS

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<tr>
<th>BARRIER</th>
<th>FIOs advantage</th>
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<td>Weak health systems, and in particular, the high degree of variability in the coverage of underserved populations.</td>
<td>FIOs often focus on reaching the poorest of the poor, people who live in rural or remote areas, the socially marginalized, and people living in fragile states or areas of conflict and violence.</td>
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<td>Lack of information about vaccines and their importance, especially among the poorest populations, and the need to create active demand.</td>
<td>FIOs have extensive networks for communicating that reach even the smallest and poorest communities, and faith leaders and actors are considered highly credible and trusted by these communities.</td>
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<tr>
<td>Fear of immunization.</td>
<td>Again, FIOs have extensive networks and a high degree of credibility that they can deploy in addressing fear of immunization.</td>
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GAVI reports that CSOs provide up to 60 percent of immunization services across the 56 GAVI-eligible countries. While the activity of FIOs is not broken out, given the large place of FIOs within civil society, the statistic suggests a significant role for FIOs in immunization. GAVI further reports the country-specific information that CSOs provide 8 to 12 percent of routine immunization in Bangladesh, 30 to 50 percent in Cambodia, and up to 40 percent in Ghana.

Furthermore, a 2009 WHO analysis states that it is a misconception that government is providing most immunization services. The study found that many governments are unable to finance countrywide service delivery and to provide newer or more expensive vaccines. The private sector, comprising both for-profit and not-for-profit entities, is taking up some of the slack.

The WHO analysis reported data from the few studies that the authors identified on private sector immunization in middle- and low-income countries. The authors found that not-for-profit private sector organizations (NFPs), which would include FIOs, tend to provide the same vaccines as national programs, but reach areas where access to government health services is low. They thus increase access to basic vaccines, serve the under-served and marginalized, and reduce disparities in vaccine coverage. The study found that when NFPs administer vaccines, governments generally provide the vaccines and related supplies, and that governments and/or donor agencies sometimes contract out or contract in with NGOs for service provision. The survey of the literature conducted in the WHO analysis found that, for the time periods covered in the different studies, NFPs accounted for 22 percent of immunization in Bangladesh and 30 to 40 percent in Cambodia. No data on immunization by NFPS was found for Latin America. For Africa, the identified data were for percentage of facilities providing immunization services, and indicated that the share of NFP facilities that provide vaccinations is 70 percent or higher in Ghana, Kenya, Rwanda and Uganda; for Kenya, it was reported that 97 percent of the country’s NFP health facilities provide immunization.

Desk research and interviews also demonstrated that FIOs are administering vaccines in numerous countries and frequently provide immunization support services. One can distinguish between direct immunization services, whereby a FIO actually administers vaccines to patients, and a set of broader immunization services that includes services such as education and information about vaccines and immunization programs; providing transportation, supplies, or a cold chain for the vaccines; and training government and other workers in vaccine administration and record-keeping. It is not always easy to find detailed information on FIOs’ immunization activities, which may be buried in webpages or reports that are country- or program-specific.

FIOs are also heavily involved in health subsectors with strong ties to immunization such as maternal and new born child health, child survival, and primary and preventative care. This means that FIOs have established networks that can be leveraged in various ways for immunization activities. Vaccine delivery or support can utilize chains established for distributing anti-malarial nets or tie into holistic or comprehensive child health programs that may comprise Vitamin A and oral rehydration salts delivery or initiatives such as MAP International’s Total Health Village strategy.

FIOs are involved in both routine immunizations (EPI) and special campaigns. Adventist Development and Relief Agency, the Aga Khan Foundation, Caritas, Tearfund, World Vision and many other FIOs refer to their participation in routine immunization programs, which are also known as EPI, for Expanded Program on Immunization. Some international FIOs’ websites offer visitors the opportunity to purchase medical supply packages for recipients in low-income countries, which include vaccines among their contents.8

However, the extent to which NGOs and FIOs provide immunization services varies from country to country. A case study of four countries found in only one a significant role for NGOs in immunization. Kaddar et al looked at immunization in Bangladesh, Colombia, Cote d’Ivoire, and Morocco, and found that only in the first country did NGOs play a significant role. The study reported that NGOs provided direct and support immunization services in poor, urban areas of Bangladesh; that they receive the vaccines and related supplies from the government; and that hence their contribution to the immunization programs was mainly through the provision of personnel time and operational costs such as transport.

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8 Note that FIOs’ involvement in special immunization campaigns sometimes merges with advocacy and financing work and is also covered in a later section.
GAVI found that in case studies on Pakistan and Ethiopia, even though CSOs play a large role in the provision of health care, the EPI programs are almost exclusively provided by the public sector. That said, in selected areas of Pakistan, NGOs coordinate with the Ministry of Health in provision of EPI services. In Ethiopia, GAVI grantees such as the Christian Relief Development Association (CRDA), a network of faith-based and secular NGOs and members of the government, provide support but not direct immunization services.

Interviewed experts confirmed that FIOs’ involvement in immunization varies from country to country and in terms of the service provided. All reported experience of FIOs being involved in immunization support services, especially communication and education. With regard to FIOs providing direct immunization services, some reported experience of this, but others reported campaigns where government health workers administered all vaccines. A representative of Catholic health services in South Africa reported that their facilities do not administer vaccines; a UNICEF representative spoke to the important support role of FIOs in polio campaigns in India but said they were not active in vaccine administration during the campaigns. Similarly, an expert from PATH said that while FIOs were involved in communication and education in the recent African meningitis belt vaccination campaigns, they did not provide direct immunization services.

FIOs take a lead role in immunization in fragile states, notably DRC. Not only are some 40 to 50 percent of DRC’s health centers owned and operated by FIOs, but 40 percent of Congo’s 515 governmental health zones are co-managed by FIOs. It is not just large international FIOs that are playing this role, but in many cases, also small and local ones, including church groups. Among other activities, the health centers provide and report vaccinations for their catchment areas. IMA World Health, an international FIO, leads a large USAID-funded health program in Congo with local implementing partners including the Protestant Church of Congo and the SANRU rural health project. Other examples where FIOs provide immunization in fragile, conflict, or underserved areas are in Box 4.

FIOs work on immunization support services, notably education and communication, is arguably as important and powerful as actual administration of vaccines to patients, and perhaps even more so. There are many examples of FIOs’ working on community engagement and behavioral change communication around immunization, and UNICEF in particular documents their importance in these areas. Young Mormon missionaries went door to door in Guatemala, in coordination with the Ministry of Health and the Pan American Health Organization (PAHO), providing information about the benefits of measles vaccination, and the church organized the production of a jingle in Spanish, English, and native languages that advertised the measles vaccination campaign. A similar jingle was developed for Madagascar, and Church members have volunteered in measles vaccination campaigns in over ten African countries. Catholic Relief Services trains community workers to go door-to-door with preachers and evangelists of different faiths to educate people about immunization and other health interventions. For the polio campaign in Tajikistan in June 2010, UNICEF’s communication and social mobilization effort included distributing leaflets and posters to mosques. In India, Muslim leaders allowed mosques to be blanketed with posters advertising the polio vaccination campaign and preached sermons encouraging people to have their children vaccinated. Buddhists have participated in national immunization days in Cambodia, and through collaboration between Buddhist monks and UNICEF in the Mekong region, thousands of monks and nuns have educated people about HIV/AIDS, avian influenza, and other diseases.
Interfaith modalities can contribute powerfully to health education and communication. “Together Against Malaria” (TAM) is a CIFA initiative that united national leaders from the top ten faith communities in Mozambique, including the Christian, Muslim, Hindu and Baha’i faiths. TAM has mounted a national campaign to train faith leaders with key malaria prevention and control messages which they convey to their faith communities.

Faith-linked medical supply networks, though they do not handle vaccines, are another relevant modality. In-country faith-linked medical supply networks such as the African Ecumenical Pharmaceutical Network (EPN) or Kenya’s Mission for Essential Drugs and Supplies (MEDS) are faith-based, not-for-profit, independent organizations committed to the provision of quality pharmaceutical services and supplies in low-income countries. While they do not source vaccines, networks such as EPN are recognized for their strong organization and good practices, and could play a role in providing vaccination supplies other than the vaccines themselves. Many international FIOs provide medical supplies to low-income countries; for example, MAP International provides US$250 million of medicines per year, including contributions from global pharmaceutical and health supply manufacturers.

The nature of a government’s relationship with religious organizations, one determinant of how openly involved FIOs can be in health work, can explain country differences in FIOs’ role in immunization services. Kenya is cited as an example of strong cooperation on immunization between FIOs and the government, and it is a country with a well-established Memoranda of Understanding (MOU) between the CHA and the government. In Kenya, the government inspects FIO vaccination facilities and incorporates their vaccine demand in the number of doses the government orders. Then, when the vaccines are received by the MOH, FIOs facilities receive their allotment. MOUs between government and FIOs networks also exist in Angola, Uganda, and Tanzania.

In countries with less or no coordination between government and FIOs, FIOs may have difficulties obtaining vaccines. Weak cooperation between FIOs and the government can lead to poor data on required doses in areas serviced by FIOs and other NGOs. In many countries in Africa, FIOs report that even when they can obtain vaccines, necessary supplies such as injection equipment are problematic, as are cold chain maintenance and waste management. This problem occurs even in Kenya where government-FIOs cooperation is strong.

But even countries with apparently poor relationships with FIOs may turn to them for help with immunization in times of need. In 2010, Caritas worked with North Korea’s Health Ministry to immunize one million children against Hepatitis B.

FIOs’ Work on Advocacy and Financing

This section briefly reviews the contribution of US-based FIOs to advocacy and financing around immunization. It considers only US-based institutions because the financial flows of faith-inspired organizations was beyond the scope of this review. However, by considering US FIOs, a good share of total FIOs’ financial and advocacy support for global health is captured.

9 The UNICEF official noted that since many poor mothers in India rely on faith-run hospitals, they could be missed in campaigns that do not go door-to-door, as the polio campaigns do.

**BOX 4. FIOs Providing Immunization in Fragile, Conflict, or Underserved Areas**

- Catholic Relief Services and a Muslim NGO, Kaatuntaya Foundation, have provided EPI and pneumonia and diarrhea care in Maguindanao, a conflict region in the Philippines.
- Tearfund provides EPI in parts of Sudan where the vaccination coverage rate is as low as 6 percent, coordinating with the government, UNICEF, and other partners.
- Episcopal Relief and Development (ERD) partners with the Episcopal Church of Bangladesh and the Anglican Diocese and its Mothers’ Union in Liberia and Angola to support immunization clinics in these three countries.
- In Afghanistan, all health services are contracted out by the government, and hence all immunization is being done by CSOs. FIOs are among these, though they operate under constraints due to the political situation.
This is because, as scholars McCleary and Barro report, what they define as US-based private and voluntary organizations (PVOs) stand out for the large role they play in international relief and development, even though the role is shifting among denominations (Box 5), and fully one-third of these PVOs are characterized as religious in nature. In the US, 41 percent of overseas development funds are channeled through PVOs, while the comparable figure is 12 percent for the UK and 2 percent for Japan. Princeton scholar Robert Wuthnow reports that US churches spend around US$4 billion annually on overseas ministries, that FIOs are major advocates for increased US overseas aid, and that a majority of US congregations engage in overseas ministry in some fashion.

Large international FIOs have contributed to or led many advocacy and financing efforts targeting specific diseases and/or immunization, using different modalities. Some general observations apply. Several Protestant initiatives stand out in terms of advocacy and financing campaigns for public health. Concerning evangelical churches, individual, large churches are important components of the evangelical sphere and it requires deep digging to obtain detailed information about this more individualistic sector’s global public health work. However, evangelical churches are heavily involved in overseas ministries. Willow Creek Church has a Global Connections program that provides support to partner churches in Latin American and Africa, and Wuthnow reports that the church collected US$2 million when it took up its first special offering for international ministries in the 1990s. Regarding the Catholic Church, CRS has a deservedly large profile in international development work and does have its own albeit relatively small malaria initiative, “Nets for Nets.” However, other than for HIV/AIDS, CRS has generally steered away from large, disease-specific campaigns. This reflects the organization’s strategic view that international development requires a comprehensive, integrated approach. So, while it has mounted large advocacy campaigns for, among other things, securing US funding and re-authorization for HIV/AIDS programs and for financial support of low-income countries more broadly, it has not emphasized disease-specific campaigns.

Another observation concerns how a FIO might secure the financial resources it directs to a given cause. An institution may fundraise a certain amount, or it may budget an amount from its existing resources. One approach that has been used allows a FIO or similar entity partnering with an international organization focused on a given disease to fundraise a set amount. Then, the FIO would give a certain share of the total raised to the international organization, while retaining a share to use on its own work on fighting the disease. Another option for a FIO coordinating with an international organization is that the latter sometimes provides a third-party fundraiser to help the FIO raise money.

BOX 5. THE EVOLVING COMPOSITION OF US FIOS

The distribution and revenue shares of religious PVOs exhibit dramatic shifts. While identifying the exact relationship between “FIOs” and “religious PVOs” as defined by McCleary and Barro is beyond the scope of this paper, the landscape of PVOs’ composition and size that they present is relevant for consideration of how FIOs are or could be involved in supporting the new vaccines. Since 2002, there has been a large increase in the number and size of religious PVOs, so that they represent about one-third of US PVOs and roughly half of PVO revenues. Moreover, evangelical PVOs have come to dominate other types of religious PVOs. In 1940, in terms of number, 38 percent of religious PVOs were Catholic and 25 percent were Jewish. In 2004, the latest year in the McCleary-Barro data set, 45 percent were Evangelical; 13 percent, “faith-founded;” 11 percent, Mainline Protestant; 7 percent, Catholic; 5 percent, Jewish; and 2 percent, Muslim. The revenue shares are fairly similar to the breakdown by number of institutions.
The United Methodist Church has created its own anti-malaria initiative, Imagine No Malaria. It is in the process of raising a planned US$75 million through this campaign, and its announcement that it will provide US$28 million of these funds to the Global Fund make it the first faith-based organization to work in direct financial partnership with the Global Fund. In addition to fundraising, the church emphasizes that it brings to its anti-malaria campaign trusted networks in remote parts of the world.

Lutheran World Relief and the Lutheran Church—Missouri Synod also partner to work on malaria. The two organizations coordinate on the Lutheran Malaria Initiative, which aims to mobilize $45 million toward the global goal of eliminating malaria deaths in Africa by 2015. As with the Methodist malaria campaign, the Lutheran initiative involves educational activities as well as fundraising, and leverages the church’s and Lutheran World Relief’s on-the-ground activities in low-income countries. Up to US$12 million of the funds raised will flow through the Global Fund to support malaria programs in Africa.

Other examples include but are not limited to malaria. Other anti-malaria campaigns include Islamic World Relief USA’s Bite the Bug campaign and World Jewish Relief’s partnership with the Tony Blair Faith Foundation. As noted earlier, the Church of the Latter-day Saints has focused on measles eradication, partnering through the Measles Initiative with UNICEF, WHO, the UN Foundation, and the US CDC. The church contributes some US$1 million per annum for measles eradication, and some 62,000 church members have volunteered in 35 low-income countries toward the objective.

FIOs advocacy and financing campaigns can be especially powerful when tied to in- and out-of-country networks and downstream implementation, in the manner of Rotary International’s PolioPlus program. Rotary International’s work on polio eradication is a gold standard of what is possible when strong advocacy and financing capability is combined with a far-flung network of members both in a headquarters country (the US) and throughout the world who support a cause with money, voice, and actual on-the-ground implementation through both foreign and local volunteers. PolioPlus has been running for over twenty years, raised over US$500 million, and involved hundreds of thousands of volunteer hours by Rotary members. Rotary has advocated for polio eradication with other public and private sector partners and obtained large challenge grants from the Bill & Melinda Gates Foundation. It has been such a major player in polio eradication that it has been able to influence the decisions of low-income country governments on immunization spending. Both FIOs and bodies such as UNICEF and GAVI confirm that when a FIO supplies not just money but also engages its congregations and affiliated health facilities, programs, or staff in both industrialized and developing countries, campaigns can be more sustained and fruitful.
Since FIOs play a significant role in immunization and have extensive networks and millions of members in both developing and developed countries, every effort should be made to engage them in the roll-outs of the pneumococcal and rotavirus vaccines. FIOs have a good track record of substantial involvement in health initiatives in low-income countries using a variety of modalities.

Engaging FIOs headquarters in advocacy and financing for the new vaccines may be the priority for now. This report’s recommendations for engaging FIOs take as given that introducing the vaccines is primarily a top-down exercise at present. Financing and a government’s agreement are necessary conditions. The significant amount of immunization services provided in-country by FIOs would come into play but only once the funding and government agreement are in place.

As financing and government agreement are secured, FIOs’ in-country contribution to the introduction of the new vaccines will be as much through communication and education as through direct service provision. Rumors or other campaigns against vaccination can quickly derail an immunization initiative; are more likely to occur around vaccine campaigns as opposed to routine immunization programs, and especially for new programs; and have often been both caused and cured by the involvement of faith leaders. FIOs are also well-placed to help in this regard.

There are three other specific, important ways that FIOs’ in-country work on immunization can contribute to the introduction of the new vaccines. These three ways involve equity; fragile states; and FIOs’ “inter-connectedness.”

Since there is evidence that FIOs serve otherwise underserved populations, engaging them in the roll-out of the new vaccines will help address concerns about equity. Immunization equity—the goal that vaccines reach every child in every district—is an important component of global immunization policy. Inequity in the introduction of these new vaccines could be actual or perceived, either as only some populations in a country receiving the new vaccines, or as very low coverage for existing routine immunizations persisting in certain communities while resources are directed to adding new vaccines elsewhere. Vaccine inequity could compromise a concerted global campaign for the new vaccines, and FIOs could help address this risk.

FIOs do play large and/or leadership roles in immunization in some fragile states with large pneumococcal and rotavirus disease burdens. DRC has the world’s third-largest disease burden for both pneumococcal and rotavirus disease. Given the role of FIOs in immunization there, they could play a lead role as roll-out of the new vaccines continues. Afghanistan and Pakistan are countries with heavy burdens from the two diseases where it is known that CSOs, including FIOs, play important roles in immunization, including in reaching underserved populations, though in both of these countries there are pronounced tensions around religion. Bangladesh, though not a fragile or conflict state, is another country with a high pneumonia burden, where FIOs have been important in increasing immunization equity.

Finally, the inter-connectedness that is a comparative advantage of FIOs could be very useful in introducing the new vaccines. As the United Methodist Church’s malaria and the Mormons’ measles campaigns, among others, indicate, synergy occurs through many FIOs’ combination of an industrial-country-headquartered church and vibrant grassroots networks. These networks often comprise congregants in both the rich and poor countries, affiliated international development organizations or activities, and in-country health facilities and related assets. A powerful aspect of this interconnectedness is the dedicated existing networks that many FIOs
have for specific endeavors such as child health or disease case management that could be leveraged in rolling out the new vaccines. For example ERD has expressed interest in using its NetsforLife® distribution system in immunization activities. The Mormons have a special campaign on clean water and well provision that could be linked with the rotavirus vaccine.

FIOs are likely to be highly receptive to a call to action on pneumonia and diarrhea. These humble diseases strongly associated with dire poverty receive far less attention and funding than higher-profile or better-branded ones, and yet they are the number one killers of young children. The call to action on these diseases is likely to resonate with FIOs.

There are additional potential benefits from engagement of FIOs in the new vaccines. As noted in section 4, an area in which FIOs may be disadvantaged is that they are often less integrated with large donors and international institutions than are secular NGOs and CSOs of comparable size, and may be weaker in terms of quality and financial controls and data management. FIOs working with GAVI could provide an opportunity to address such weaknesses, whether perceived or actual.

GAVI has already explored demonstration projects for the new vaccines with FIOs, leveraging their inter-connectedness. GAVI’s model for these demonstration projects is that a developed-country FIO with strong leadership and communications and a large membership base provides financing and organizational buy-in while a local and/or volunteer network works in-country to mobilize the community and support the immunization campaign, ideally in coordination with the Ministry of Health.

Engaging FIOs in certain countries does involve some risks and hence, a case-by-case determination is best. In some cases, overt links between FIOs and the new vaccines could be counter-productive, or at best, require careful management, since rumors about and resistance to immunization can be fed by religious factors. For example, identification of the new vaccines with a particular denomination, while not desirable anywhere, would be particularly risky in Nigeria. Happily, the Nigerian Inter-faith Action Association, created to bring leaders of the two faiths together to fight poverty and disease and the largest Muslim-Christian alliance in Africa, has already mobilized against malaria and could be enlisted in supporting the new vaccines.

The inter-connection model and the involvement of FIOs could work especially well in some countries with the largest pneumococcal and/or rotavirus disease burdens. For example, Kenya and Uganda have strong faith-inspired health networks that hold MOUs with the government, and active and well-organized churches of denominations with large US faith communities.

Various touchstones or modalities might energize FIOs engagement. Financing the new vaccines, perhaps linking to Save the Children’s “No Child Born to Die” initiative, could become a new “Jubilee 2000.” GAVI might be able to offer a common platform through which FIOs or churches can support the introduction of the new vaccines, so that organizational arrangements are less burdensome. FIOs that have seen their share in US-sourced international relief and development work decline over time might consider supporting the new vaccines as a way to “get back in the game.” A dedicated campaign linked to the new vaccines might allow an evangelical church to receive greater recognition of the contribution it is making to overseas development, including through congregants’ missionary work. A FIO that has been hesitant, holding that disease-specific campaigns belie a holistic approach to international development, might explore whether support for the new vaccines would directly achieve broad objectives such as MDG 4, thus indeed forming part of broader comprehensive health initiatives.

GAVI stands ready to explore with interested FIOs how communication technology could be used to support initiatives around the new vaccines. Possibilities include software to allow easy online or text message donations, perhaps to allow a donor to choose to provide doses of either vaccine and/or to receive text message dispatches from the frontlines of vaccine roll-out, conceivably even from someone from the donor’s own denomination.

In the future, there are other ways that FIOs could be involved. FIOs could help ensure in-country accountability of governments in terms of meeting their financial and other commitments to immunization, as well as accountability around the Abuja Declaration on health spending. FIOs could also support sustainable businesses that offer products and services for pneumonia and diarrhea case management priced for poor people, along the lines of an SC Johnson initiative in Ghana for malaria prevention. Faith-inspired pharmaceutical networks are well-poised to furnish vaccination supplies that are often in short supply even when the vaccine itself is available.

The most important next step is for FIOs to provide their ideas or questions about how they might likely become involved in the new vaccines.
### TABLE 1. COUNTRIES WITH THE GREATEST DISEASE BURDENS FROM DIARRHEA AND PNEUMONIA

<table>
<thead>
<tr>
<th>Country</th>
<th>Annual Deaths from Diarrhea</th>
<th>Annual Deaths from Pneumonia</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>237,482</td>
<td>371,605</td>
</tr>
<tr>
<td>Nigeria</td>
<td>201,368</td>
<td>177,212</td>
</tr>
<tr>
<td>DR Congo</td>
<td>102,679</td>
<td>112,655</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>89,709</td>
<td>84,210</td>
</tr>
<tr>
<td>Pakistan</td>
<td>74,209</td>
<td>80,694</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>73,341</td>
<td>48,892</td>
</tr>
<tr>
<td>Angola</td>
<td>41,403</td>
<td>38,331</td>
</tr>
<tr>
<td>Kenya</td>
<td>38,802</td>
<td>33,078</td>
</tr>
<tr>
<td>Uganda</td>
<td>30,391</td>
<td>30,406</td>
</tr>
<tr>
<td>Indonesia</td>
<td>26,120</td>
<td>25,978</td>
</tr>
<tr>
<td>Niger</td>
<td>24,575</td>
<td></td>
</tr>
</tbody>
</table>

### TABLE 2. INTERVIEWED EXPERTS

<table>
<thead>
<tr>
<th>NAME</th>
<th>TITLE</th>
<th>ORGANIZATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Ayo Ajayi</td>
<td>VP, Field Programs</td>
<td>PATH</td>
</tr>
<tr>
<td>Frank Baer</td>
<td>Senior Advisor to IMA World Health and Advisor to the Ministry of Health of Liberia</td>
<td>IMA World Health and Independent Consultant</td>
</tr>
<tr>
<td>Fred Riley</td>
<td>Project Manager</td>
<td>Latter Day Saints Charities</td>
</tr>
<tr>
<td>Stephen Hanmer</td>
<td>Partnership Manager</td>
<td>UNICEF</td>
</tr>
<tr>
<td>Ray Martin</td>
<td>Director</td>
<td>Christian Connections for International Health</td>
</tr>
<tr>
<td>Dr. Mike McQuestion</td>
<td>Director, Sustainable Immunization Financing</td>
<td>Sabin Vaccine Institute</td>
</tr>
<tr>
<td>Dr. Samuel Mwenda</td>
<td>Chief Executive Officer</td>
<td>Christian Health Association of Kenya</td>
</tr>
<tr>
<td>Bill O'Keefe</td>
<td>Senior Director for Advocacy</td>
<td>Catholic Relief Services</td>
</tr>
<tr>
<td>Jill Olivier</td>
<td>Consultant</td>
<td>Development Dialogue on Values and Ethics, World Bank, African Religious Health Assets Programme</td>
</tr>
<tr>
<td>Christopher Thomas</td>
<td>Program officer</td>
<td>USAID</td>
</tr>
<tr>
<td>Peg Willingham</td>
<td>Executive Director, Shot@Life Campaign</td>
<td>UN Foundation</td>
</tr>
<tr>
<td>STUDY</td>
<td>SAMPLING OF QUANTITATIVE INFORMATION</td>
<td></td>
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<tr>
<td>WHO-CIFA Consultation, presentation of the Christian Health Association of Kenya</td>
<td>CHAK has 431 members including 23 hospitals, 45 health centers, 310 dispensaries, and 55 churches/church health programs, and is fully integrated in the national health plan.</td>
<td></td>
</tr>
<tr>
<td>WHO-CIFA Consultation, presentation on the Ramakrishna Mission</td>
<td>The Mission has 15 hospitals, 124 dispensaries, 53 mobile medical units and 7 nurses’ training institutes, with 164 branches in India and 42 centers outside India.</td>
<td></td>
</tr>
<tr>
<td>Health facilities and human resources geographic information system for the Christian Social service Commission of Tanzania (CSSC)</td>
<td>932 CSSC member health facilities have been mapped.</td>
<td></td>
</tr>
<tr>
<td>The contribution of religious entities to health in sub-Saharan Africa, ARHAP</td>
<td>Case studies of Mali, Uganda and Zambia find contribution of FIO health facilities to total country health care varies from 2 percent in Mali to about 30 percent in both Uganda and Zambia, with an even higher percentage in rural areas.</td>
<td></td>
</tr>
<tr>
<td>Report of the involvement of faith-based organizations in the Global Fund (TGF)</td>
<td>In 2006, nine FBOs were primary recipients of TGF funds and 488 were sub-recipients (SR). 94 out of 120 country coordinating mechanisms have at least one FBO. One FBO SR, the Christian Health Association of Zambia, disburses TGF money to 411 local FBOs to fight HIV and AIDS. However, some 50 countries report no disbursements of TGF funds to FBOs.</td>
<td></td>
</tr>
<tr>
<td>FBO health networks and renewing primary health care</td>
<td>In DR Congo, FBO networks provide 50 percent of health services and co-manage around 40 percent of the country’s health zones.</td>
<td></td>
</tr>
<tr>
<td>Christian religious entities and collaborative stakeholders responding to HIV and AIDS</td>
<td>Case studies of Kenya, Malawi, and the DR Congo found FBOs in these countries provide substantial shares of HIV and AIDS care.</td>
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<tr>
<td>Collaboration between faith-based communities and humanitarian actors when responding to HIV and AIDS in emergencies</td>
<td>One out of every five organizations working on HIV and AIDS programs is faith-based.</td>
<td></td>
</tr>
<tr>
<td>Faith-based models for improving maternal and newborn health</td>
<td>Contribution of Christian health networks to total country health care in 11 African countries ranges from not less than 30 percent to as high as 50 percent.</td>
<td></td>
</tr>
<tr>
<td>Role of private sector in provision of immunization services in low to middle income countries</td>
<td>Not-for-profit private providers account for 22 percent of immunization in Bangladesh and 30 to 40 percent in Cambodia.</td>
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</tr>
</tbody>
</table>
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