



Policy Brief

ENGAGING FAITH ACTORS TO BOOST IMMUNIZATION UPTAKE AND COMBAT VACCINE HESITANCY

Evidence and Promising Practices

INTRODUCTION

Local faith actors are generally recognized for their role in influencing health in low- and middle-income countries (LMICs), including immunization uptake, coverage, and equity. Despite this, gaps remain in understanding how faith actors influence immunization uptake and coverage and what interventions help to reduce vaccine hesitancy among local faith actors. Vaccine hesitancy among faith communities is believed to undermine immunization coverage in some LMICs. The rollout of COVID-19 vaccinations adds urgency to the need to engage religious leaders and other local faith actors in what will be the largest public health vaccination campaign in 100 years. This brief summarizes findings from a June 2021 global landscape analysis, [Effects of Faith Actor Engagement in the Uptake and Coverage of Immunization in Low- and Middle-Income Countries](#), and highlights opportunities to engage local faith actors in boosting immunization uptake and reducing vaccine hesitancy.



Vaccine Hesitancy's Impact in Nigeria

"The polio experience (in the 2000s) showed us that one word from a religious leader just upset the apple cart. You had another 10 years of fighting polio and billions of dollars spent." —Key informant

BACKGROUND

Many major religions today commonly believe that vaccination supports their shared objectives of preserving and protecting life, health, well-being, equity, and prevention of suffering.⁶¹ Some religions even call for vaccination as a moral imperative to preserve the lives of vulnerable groups within a community.^{34,103} Yet, despite the powerful positive potential, religious factors remain the third most frequently cited reason for vaccine hesitancy in global surveys.^{25,37,54,56,58,62,105} Faith-linked vaccine hesitancy concerns are especially pronounced and rising in LMICs. Prominent media coverage and academic study of widespread polio vaccine hesitancy among religious communities in Northern Nigeria and Pakistan in the 2000s has further heightened concern about vaccine hesitancy among faith actors.

Despite their powerful potential, there is still limited information on and understanding of how faith actors impact the uptake and coverage of immunizations in LMICs, as well as what interventions work to combat vaccine hesitancy among faith communities. The U.S. Agency for International Development’s (USAID’s) MOMENTUM Country and Global Leadership project conducted a global landscape analysis to explore three related questions:

1. How do religious leaders and faith-based organizations (FBOs) impact the uptake and coverage of immunization in LMICs?
2. What successful strategies exist for working with local faith actors and communities to improve immunization acceptance and reduce vaccine hesitancy?
3. What evidence gaps exist in relation to faith engagement and immunization?

METHODS

To answer these questions, MOMENTUM conducted a literature review of several online databases to identify peer-reviewed and grey literature published from 2011 to January 2021 that addressed faith engagement and immunization in LMICs. Then, a selection of 18 global faith-based and secular immunization experts (see **Acknowledgements Table 2**), drawn from MOMENTUM Country and Global Leadership’s faith engagement team networks, were interviewed.

RESULTS

Q1: HOW RELIGIOUS LEADERS AND FBOS IMPACT IMMUNIZATION UPTAKE AND COVERAGE IN LMICS

Analysis of the literature demonstrates **four main ways** that religious leaders and FBOs impact immunization uptake in LMICs:

- Influencing household vaccine decision-maker beliefs and values.^{13,23,24,74}
- Impacting access to resources that facilitate immunization uptake.²³
- Communicating immunization messages and conducting mobilization.⁷⁴
- Providing routine immunization in hard-to-reach areas or humanitarian settings and reaching underserved populations.^{72,74}

The consensus was that continued engagement of local faith actors is necessary to positively influence immunization uptake.

RELIGIOUSLY LINKED VACCINE HESITANCY

Few religions or their sacred texts explicitly reject immunization.^{34,62} This study found that vaccination hesitancy is often cloaked under the guise of religion without a theologically grounded objection. Instead, religious objections to vaccination serve as a proxy for concerns about safety, social norms, sociocultural issues, political, and economic factors.^{34,57,61,70,74}

Box 1. Common Faith-Linked Vaccine Hesitancy Beliefs Across Religions

- Humans should not attempt to override God’s will with manufactured solutions.^{34,36,55}
- God created a perfect world and a perfect immune system; humanity shouldn’t try to improve upon it.³⁶
- The human body is a temple of God—immunizations may introduce harmful substances.³⁶
- Religions prohibit the taking of life, including the use of fetal tissue from abortions.^{36,82}
- Vaccines may violate dietary laws (e.g. vaccine development materials with porcine or bovine origins).³⁴

VACCINE HESITANCY AMONG MUSLIM POPULATIONS

There is extensive documentation of vaccine hesitancy among Muslim populations in LMICs, amounting to 69% of all single-religion studies reviewed. This is likely due in part to highly visible cases of vaccine hesitancy and boycotts in the early 2000s in Northern Nigeria, Pakistan, and Afghanistan. Major drivers of vaccine hesitancy among Muslim communities included (1) the halal status of vaccines,^{4,53,80} (2) fears that immunization would impact fertility,^{2,69} and (3) beliefs that vaccinations were part of a Western conspiracy to harm their population.^{21,83} On the other hand, several information sources clarify that Islamic theology generally supports immunization,^{4,5,26} and some predominantly Muslim countries, including Bangladesh, Malaysia, Niger, and Saudi Arabia, have high rates of vaccine acceptance.

VACCINE HESITANCY AMONG CHRISTIAN POPULATIONS

Christian faiths accounted for 23% of all studies reviewed, many of which were focused on Apostolic faiths in Zimbabwe.⁹ Multiple studies showed lower immunization uptake and completion in Zimbabwe among Apostolic communities, with varying degrees of refusal toward immunization, indicating a need for interventions to address this growing population in Southern Africa.^{31,37,38,54,58} Despite anecdotal reports and media stories that some Christian leaders are concerned about the use of cells from aborted fetuses to develop vaccines (Catholic leaders in particular), no research studies specifically addressed this concern. Two studies identified Catholic leaders’ concerns in Kenya about the fertility effects of maternal tetanus toxoid and safety of childhood polio vaccines.⁷¹

VACCINES OF CONCERN TO FAITH ACTORS

In general, local faith actors did not have explicit objections to most childhood routine vaccines. The polio vaccine was cited most as a vaccine with objections within the literature, with examples of religiously linked hesitancy from Pakistan,^{7,14,52,53,69} Nigeria,^{2,10,16,28,32,68,70,85} and Kenya.⁷¹ Human papillomavirus (HPV) vaccine was the second most frequently cited vaccine with religious objections, due to its perceived links to sexual activity, especially among Catholic²⁵ and Muslim⁴¹ communities.

⁹ Originating from the Protestant Pentecostal church, Apostolic churches reflect a desire to emulate first-century Christianity in its faith, practices, and government and have historically objected to most medical interventions in lieu of prayer for healing.

Q2: EVIDENCE-BASED APPROACHES FOR WORKING WITH LOCAL FAITH ACTORS ON IMMUNIZATION

Few rigorous studies tested approaches for engaging local faith actors to strengthen immunization uptake. In general, most past immunization interventions involved engaging religious leaders and the local community in dialogue-based interventions⁴⁹ and engaging religious leaders and church structures in social mobilization and advocacy to promote vaccination.^{11,19,23,41,74,78,97} Promising practices identified during the review are featured in **Table 1**.

TABLE 1. EVIDENCE-BASED APPROACHES TO ENGAGE LOCAL FAITH ACTORS IN IMMUNIZATION

<p>Improving immunization uptake and coverage</p>
<ul style="list-style-type: none"> • Ensure immunization promotion with local faith actors is included as part of a multipronged—not standalone—strategy. This includes increasing vaccine availability concurrently among priority populations.⁴⁹ • Use religious infrastructure and places of worship, faith-based health facilities, and religious rituals—such as baptism—for vaccine messaging and service delivery points.^{55,64,72} • Engage with male decision-makers through male religious groups and Friday prayer meetings to promote vaccination messaging and services. • Tap health workers to speak about immunizations to congregations, building on their trust in the community. • Capitalize on the pre-existing structures and networks among hierarchically organized religions to more efficiently cascade immunization interventions and messaging (Cambodia’s Buddhist pagoda system, for example). To kickstart this process, engage in dialogue with high-level religious leaders, who can encourage decentralized local faith actors to adopt interventions via their roles as trusted and influential leaders.
<ul style="list-style-type: none"> • Engage FBOs and faith communities early in the rollout of new vaccines to increase acceptability, improve coordination in messaging and delivery, and prevent potential hesitancy.^{17,30,104} • Address faith-linked concerns to vaccines through theological analyses of sacred text, dialogue with faith leaders, and sensitivity, as well as understanding alternatives among available vaccines.^{14,17,79} • Communicate effectively with Muslim religious leaders on the halal status of vaccines in countries where there is concern that vaccines were manufactured with <i>haram</i> (forbidden) materials.^{4,51} • Provide clear scientific information on the safety and efficacy of vaccines, breaking down complex science into digestible pieces for the audience (faith leaders, families). Be transparent when vaccine science is evolving. • Tap into umbrella interreligious councils when appropriate to create a clear and unified message of vaccine acceptance for new immunizations (or where there are vaccine hesitancy concerns). • Work with global faith governance structures to ensure accountability in vaccine messaging among clergy.

Q3: CURRENT EVIDENCE GAPS IN RELATION TO FAITH ENGAGEMENT AND IMMUNIZATION

Existing evidence strongly supports the value of religious engagement in immunization promotion and acceptance in LMICs across faiths. Despite this, evidence remains scant on effective strategies to reduce vaccine hesitancy among faith actors. Most studies treat religion as a confounding variable, without a detailed examination of the nuanced impact or interrelated social, political, or economic factors that impact immunization uptake.^{23,74} Knowledge gaps exist because:



There is disparity in the amount of literature available on vaccine hesitancy and faith engagement in LMICs compared to high-income countries.²²



Of the current LMIC literature, 35% of all reviewed sources focused on Nigeria (19.5%) and Pakistan (14.6%), with little to no information on Latin America and the Caribbean, North Africa, Asia Pacific, and Eastern European regions.



Most studies reviewed examined only large-scale organized monotheistic faiths—predominantly Islam (40%) and Christianity (15%)—limiting their potential applicability to differently organized and traditional/folk religions.



Most studies explored vaccine hesitancy among campaign-based, new, or so-called “hot button” vaccines such as polio and HPV, especially when compared to childhood immunizations.



Most of the evidence on the impact of faith engagement on immunization uptake and coverage is observational and reflected in grey literature or discussion papers. More rigorous studies are needed.^{22,74,108} Most practice-based knowledge generally resides with local experts and typically is not published or shared globally. Only three intervention studies were found that evaluated approaches for engaging faith leaders on immunization or vaccine hesitancy.



Few tools have been developed to measure vaccine hesitancy, and of those that do exist, none have been validated within Africa.²²

CONCLUSION

Engaged local faith actors have long contributed to achieving full immunization coverage within their communities, and today offer great potential to help combat growing vaccine hesitancy in some LMICs. This landscape analysis supports the following recommendations and future action steps:

- **Listening, understanding, and diagnosing** some of the complex and interrelated sociocultural factors that contribute to religiously linked vaccine hesitancy before starting an intervention is essential. In cases where vaccine hesitancy is identified, the review suggests listening and dialogue with faith leaders is critical to finding theologically acceptable solutions.
- More work is needed to **foster global and national-level dialogue** to engage faith leaders in addressing vaccine hesitancy. Country-level strategies to stimulate research and dialogue with religious structures, interfaith networks, and theological institutions may help identify some of the underlying concerns related to immunization and develop more effective solutions.
- Though there are limited documented examples, it will be critical to **adapt previous evidence-based approaches** for engaging faith leaders in immunization promotion efforts to successfully promote uptake of COVID-19 vaccination. Many religious leaders are at the forefront of calls for global vaccine equity and are already leading the charge to promote COVID-19 immunization in their countries, offering a promising opportunity for continued success.
- At the same time, **more investigation and evidence are needed** to discover which interventions with local faith actors work most effectively in which contexts to promote vaccine uptake. The current peer-reviewed and grey literature does not provide an adaptable, concise road map for tackling these issues in different geographic, cultural, linguistic, and other contexts. Further study is needed on faith leaders promoting routine immunization; the impact of local faith actors on vaccine uptake among growing Pentecostal, Charismatic, and so-called “un-networked” faiths; and on vaccine hesitancy among Buddhist and Hindu faiths in Asia.

Acknowledgements

MOMENTUM Country and Global Leadership is part of a suite of innovative USAID-funded awards that aims to holistically improve voluntary family planning and maternal and child health in partner countries around the world. The project focuses on technical and capacity development assistance to ministries of health and other country partners to improve outcomes. MOMENTUM acknowledges the generous insights that the 18 key informants provided to this global evidence summary:

Anglican Alliance (UK); Berkley Center for Religion, Peace & World Affairs (USA); Catholic Health Association (USA); Centers for Disease Control and Prevention (USA); Core Group: Global Health Security Agenda Project (Kenya), Polio Project (Ethiopia & India); Faith to Action Network (Kenya); GAVI CSO Steering Committee (Switzerland); International Vaccine Access Center (USA); Joint Learning Initiative on Faith and Local Communities (USA); Le Cadre des Religieux pour la Santé et le Développement (Senegal), UNICEF (USA); USAID MOMENTUM (USA); World Council of Churches (Switzerland); World Health Organization (Switzerland); and World Vision (USA).

References

Complete citations for references 1–110 can be found in the online report bibliography (**Annex 6**):

Melillo, S., Fountain, D., Bormet, M., and O'Brien, C. June 2021. *Effects of Faith Actor Engagement in the Uptake and Coverage of Immunization in Low- and Middle-Income Countries*. Prepared under USAID MOMENTUM Country and Global Leadership (<https://usaidmomentum.org/resource/vaccine-hesitancy-report/>) Washington, DC: USAID.

MOMENTUM

USAIDMomentum.org

TWITTER: @USAIDMomentum

FACEBOOK: USAID Momentum



USAID
FROM THE AMERICAN PEOPLE



This brief is made possible by the generous support of the American people through the U.S. Agency for International Development (USAID) under the terms of the Cooperative Agreement #7200AA20CA00002, led by Jhpiego and partners. The contents are the responsibility of MOMENTUM Country and Global Leadership and do not necessarily reflect the views of USAID or the United States Government.