



Engaging Faith Communities on Immunization: What Next?

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HIGHLIGHTS

Preventable child deaths outrage everyone. Immunization campaigns save millions of children's lives and therefore unite widely divergent communities. But the untapped potential for partnerships to extend vaccination coverage, especially involving religious actors, is large. Two critical challenges are important and offer great promise: extending newer vaccines (notably against rotavirus and pneumococcus) and reaching underserved populations ("the fifth child"). The support and cooperation of religious communities, at global and national levels, is essential for both—leaders and communities can help address challenges and prevent the grave problems that arise when religious leaders oppose vaccination (such as in Pakistan and Nigeria). In building partnerships there are four priorities: (a) informing populations and building trust; (b) focusing on underserved populations; (c) overcoming barriers to vaccination campaigns in tumultuous countries like the Democratic Republic of the Congo where faith networks are especially vital players; and (d) helping through holistic health approaches to "connect the dots" among different public health and welfare efforts to meet the needs of people and communities.

This brief draws on the 2012 WFDD report *Faith and Immunization: Past, Present and Potential Roles of Faith-Inspired Organizations*, prepared at the request of the Global Alliance for Vaccines and Immunization.

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WHAT CONNECTS CHILD VACCINATION AND RELIGIOUS COMMUNITIES?

Vaccination campaigns inspire collaboration between religious and non-religious institutions and communities. When wars wracked Central America, Catholic Church officials helped to broker ceasefires so that children could be immunized. Muslim leaders led the way to life-saving campaigns in Indonesia. Religious actors from many traditions persuade anxious parents to vaccinate their children, often by example. But where religious leaders are skeptical about the motivations of public health workers or suspicious of vaccines, campaigns flounder. Religious tensions in Nigeria and Pakistan, for example, jeopardize the global campaign to eradicate polio.

Vaccination of children is nearly universal in many world regions (over 100 million children are immunized every year before their first birthday) and estimates put annual child

deaths prevented as a result at 2.5 million. However, there are still large gaps: about 20 percent of the world's children and young people (24 million) are unvaccinated or under-vaccinated. Around two million children die each year of diseases that could be prevented by vaccination.

Religious communities have been and can be vital partners in efforts to fill these gaps, through delivery of services, providing information, mustering financial support, or advocating for immunization. But while they are engaged in global efforts, they are less involved than they could be. The question is: what can be done and what would it take to build more robust and effective new partnerships to tackle one of the world's most compelling and demanding priorities: saving children's lives?

WHAT ARE THE ISSUES?

The central challenge is to identify ways to integrate the myriad of faith actors—leaders, communities, independent institutions (termed here faith-inspired organizations or FIOs), training institutions—into global immunization efforts, both routine national immunization programs and special campaigns. This involves building on current work and partnerships and identifying new ones. An immediate opportunity is presented by the rollout of two newer vaccines against pneumonia and diarrhea. Another is to address gaps in the reach of vaccination because of poverty, weak institutions, and conflict.

Focusing on immunization is worthwhile because it is one of the most powerful health interventions of all time. Except for safe water, nothing else has such potential to reduce needless deaths. Vaccines benefit individuals, communities, and entire populations; their impact on a nation's health is rapid compared to other health interventions; and they save lives and costs. The role of vaccination in global development, already a focal point in the twentieth century, is even more central now. Extending the reach of vaccination figures prominently in the Millennium Development Goals adopted in 2000. This global focus on poverty and human development has inspired various new organizations and initiatives. The Bill and Melinda Gates Foundation called in 2010 for a “Decade of Vaccines”, and made a ten-year, \$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.

The Global Alliance for Vaccines and Immunization (GAVI) works to increase access to immunization in poor countries. Alliance members include developing country and donor governments, the World Health Organization (WHO), UNICEF, the World Bank, the vaccine industry in both industrialized and developing countries, research and technical agencies, civil society, the Bill and Melinda Gates Foundation, and other private philanthropies. Other organizations working 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.

Important new financing mechanisms are advancing the campaigns, including the International Finance Facility for Immunisation (IFFIm), which has raised \$3.6 billion since 2006 by issuing bonds in the capital markets to support GAVI's work. The Advance Market Commitment (AMC) mechanism was created as a new approach to stimulate the development and manufacture of vaccines for low income countries. 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 \$1.5 billion commitment by the Bill and Melinda Gates Foundation, Canada, Italy, Norway, Russia, and the United Kingdom, supported GAVI to finance the rollout of the pneumococcal vaccine for developing countries.

The past decade has been one of the most productive in the history of vaccine development and access. Five new vaccines have been developed, including the pneumococcal and rotavirus vaccines. 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.

Challenges remain. 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 and key players often lack the required resources. Relatively high average national immunization coverage rates in many less-developed countries obscure low rates in individual districts. New vaccines commonly available in industrialized countries are not in poor ones: the pneumococcal vaccine is part of routine vaccinations in only 17 percent of WHO's 193 member states, and the comparable share for the rotavirus vaccine is even lower, at 12 percent. UNICEF estimates that if these two vaccines and others now available against childhood diseases were given with a global average coverage rate of 90 percent, a further two million deaths per year could be prevented.

Financing immunization in poor countries is a major challenge, notwithstanding the exceptional cost-benefit ratio. Sustainable immunization financing remains a distant goal. Immunization programs in the 72 poorest countries of the

world will on average cost about \$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 from 2006 to 2015 are estimated at \$35 billion, of which \$16.2 billion represents incremental costs for delivering new vaccines and \$19.3 billion the cost of maintaining immunization programs at 2005 levels. Some 30 to 40 percent of the overall resource needs to achieve vaccination goals in poor countries were so far unmet.

Many poor countries provide only a tiny fraction of the costs of their immunization programs: total government spending on health in poor countries averages about \$25 per capita, while fully immunizing a child with the four basic vaccines costs around \$20. A goal is that each country finances or at least co-finances its own immunization program.

Immunization generates significant economic benefits. In the United States, every dollar spent on immunization saves \$6.30 in direct medical costs and \$12.10 in indirect costs to society (for example, costs due to missed work and disability). In poorer countries, immunizing all children would 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.

Introducing such vaccines is primarily a top-down exercise: both financing and a government's agreement are essential. Immunization services provided by FIOs can come into play when funding and government agreement are in place.

FOCUS ON THE NEW VACCINES TO COMBAT PNEUMONIA AND DIARRHEA

Pneumonia kills more children under five years of age than any other illness, in every world region: 1.6 million young children, the vast majority in low income countries, die each year from pneumonia—more than from malaria, HIV/AIDS, and measles combined, with 14.5 million annual serious cases of pneumococcal infection globally. A vaccine against pneumococcal disease has been widely used in Europe and the United States since 2000, but vaccines suitable for the strains of the disease prevalent in poorer countries were introduced quite recently.

The pneumococcal vaccine had been rolled out (as of December 2011) in 16 countries including Benin, Cameroon, the Central African Republic, the Democratic Republic of Congo, Guyana, Honduras, Kenya, Mali, Nicaragua, and Yemen. GAVI hopes to be able to support introduction of the vaccine in more than 40 low income countries by 2015. Although the price of the pneumococcal vaccine in poor countries is relatively low, there are major financial challenges to its wider introduction. The pneumococcal vaccine, which requires three doses for adequate protection, has a ceiling price of around \$10 per course in low income countries, reflecting in part the impact of the AMC, compared to a cost in the United States of around \$100 per dose. Few countries can afford it.

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, the WHO recommended that every country include rotavirus vaccines in its national immunization program.

As of September 2011, the rotavirus vaccine had been rolled out in five low income countries: Bolivia, Guyana, Honduras, Nicaragua, and Sudan. The GAVI goal is 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 \$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 AND IMMUNIZATION

Historical associations between faiths and vaccination are both positive and negative. Some faith leaders were out in front promoting vaccination while others took considerable convincing to accept and tolerate this approach. To-

day 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 cases points to motivations that are not wholly or even mostly religious, but rather concern other cultural, social, or political factors.

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

Thus 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 vaccines that target specific diseases in major campaigns.

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. Objections and fears generally have non-religious origins. The most famous case is the opposition by Muslim clergy in Northern Nigeria to a polio vaccination campaign. 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 gained traction, and governors of three Northern Nigeria states refused to allow the vaccination campaign to proceed. UNICEF and other involved partners responded by engaging important Muslim leaders, and the campaign went ahead. More extreme objections to vaccination have occurred in Pakistan and Afghanistan. The Taliban have kidnapped, beaten, and assassinated vaccination officials. These experiences highlight the importance of working with religious communities.

The complete report *Faith and Immunization: Past, Present, and Potential Roles of Faith-Inspired Organizations* is available at: <http://berkeleycenter.georgetown.edu/wfdd/publications/faith-immunization-past-present-and-potential-roles-of-faith-inspired-organizations>.

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ABOUT THE WORLD FAITHS DEVELOPMENT DIALOGUE

The World Faiths Development Dialogue works to build bridges between the worlds of faith and secular development. Established at the initiative of James D. Wolfensohn, then president of the World Bank, and Lord Carey of Clifton, then archbishop of Canterbury, WFDD responds to the opportunities and concerns of many faith leaders who have seen untapped potential for partnerships.