BUILDING TRUST IN IMMUNIZATION
Partnering with Religious Leaders and Groups

For every child
Health, Education, Equality, Protection
ADVANCE HUMANITY

COVER PHOTO: © UNICEF/HQ03-0366/AMI VITALE

This publication is the first in a series. Future publications will focus on building partnerships for immunization with other groups, including the media and parliamentarians.

BUILDING TRUST IN IMMUNIZATION
Partnering with Religious Leaders and Groups

CONTENTS

1. WHY RELIGIOUS GROUPS? 5

2. FORGING ALLIANCES 9

Assess the situation 9

Make initial contact 10

Begin group work 11

Facilitate the planning process 12

Maintain motivation and commitment 15

3. BUILDING TRUST 19

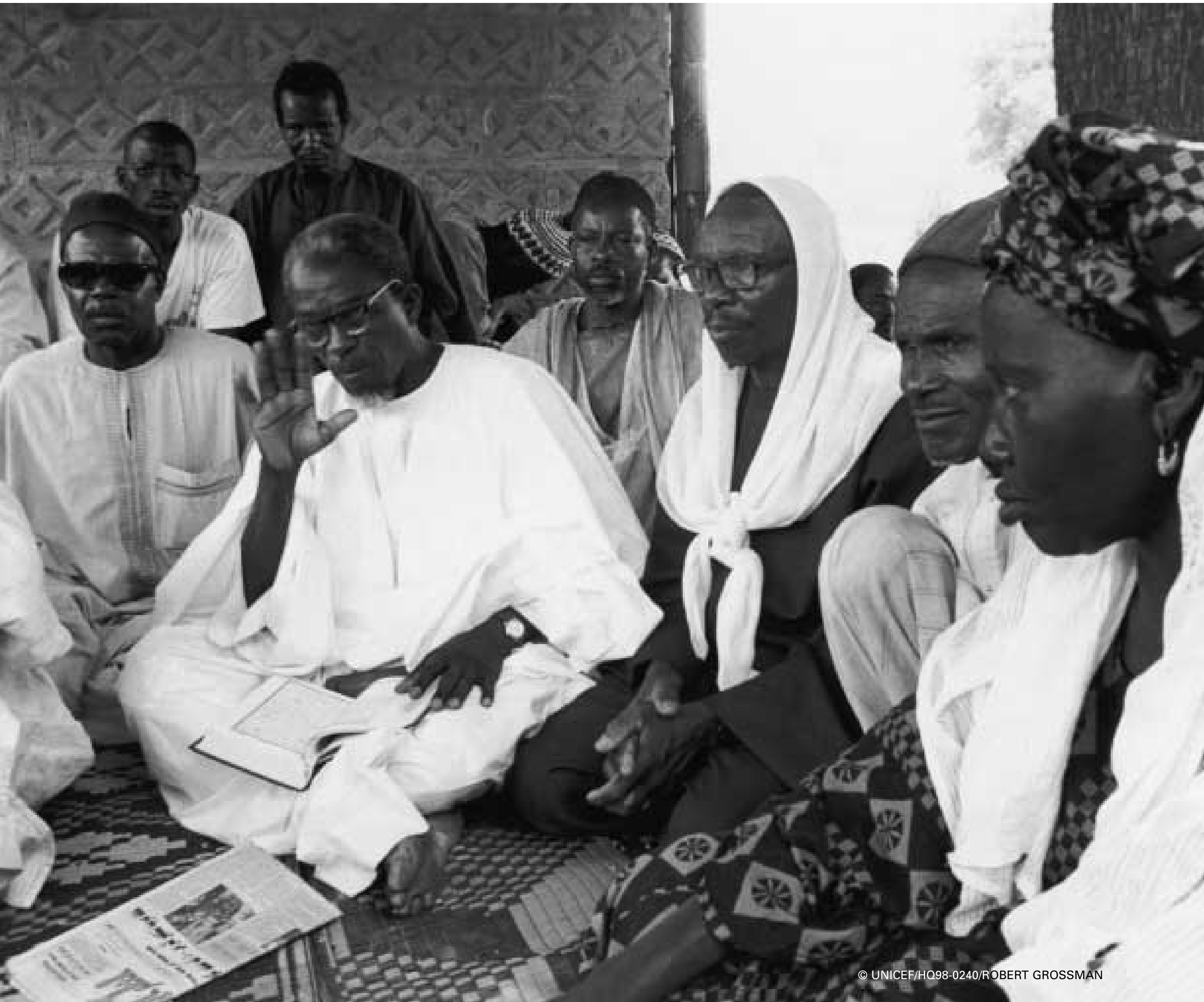
4. LEARNING FROM OTHERS 23

Case study: Religious leaders in Sierra Leone adopt immunization goals as their own 23

Case study: Churches become allies in ending polio in Angola, one household at a time 27

Case study: Muslim leaders counter resistance to polio vaccinations in India 30

5. RESOURCES 35


© UNICEF/HQ98-0240/ROBERT GROSSMAN

1. WHY RELIGIOUS GROUPS?

By approaching religious groups with an informed respect for their views, communication and health officers can often gain the trust needed to garner their support.

Whether immunizing children house-to-house or providing services at fixed sites, the support of the community is essential in achieving broad coverage. One way of eliciting such support is to gain the trust and confidence of religious leaders, who often wield tremendous authority at the grass roots. Religious leaders not only have the power to shape public opinion, they can also mobilize their constituencies and improve the links between communities and health services. By approaching religious groups with an informed respect for their views, communication and health officers can often gain the trust needed to garner their support.

However, even with strong alliances, vocal minorities have sometimes used religious arguments to dissuade parents from immunizing their children. Such resistance may be tied to a political agenda or based on a misunderstanding of the facts. Whatever the case, UNICEF, among other agencies, is often a key player in developing an appropriate response. Allies among religious organizations can be crucial collaborators in reacting in an appropriate and effective way.

The guidelines presented in this workbook were created for communication and programme officers and their immunization partners seeking to develop and maintain strong working relationships with religious leaders and groups. They also suggest what actions might be taken when a religious leader or group organizes resistance to immunization. While the guidelines provide an overall framework, they do not offer specific health messages based on religious texts. Such messages should be generated at the local level by religious groups themselves, since interpretation of doctrine can be influenced by culture and social conditions and may vary among religious sects. In fact, the very process of debate and arriving at a common position on immunization is what can ensure long-term involvement on the part of religious groups.

The guidelines also suggest ways to reinforce a group's own organizational structure so that leaders and their followers stay actively engaged in supporting immunization and other health programmes.

Three case studies illustrate how alliances were built in Sierra Leone, Angola and India to overcome resistance against routine immunization and polio eradication. The studies are intended to illustrate processes that have worked, rather than models to follow when working with religious groups.

Why religious leaders?

Because they:

- Wield considerable social and political influence
- Have an established network of people and an organizational and physical infrastructure that reaches from national to district and community levels
- Are a source of credible information for their followers
- Provide motivation to act for the wider social good
- Can sanction certain behaviours or actions
- Can become allies in dispelling rumours and reducing resistance
- Are often willing to act on their own with minimum support

What can a strong working relationship with religious groups achieve?

It can:

- Instil local 'ownership' to ensure that every child is vaccinated
- Build local capacity to organize, reach consensus on and resolve social problems
- Create long-term support for essential health services for children

What are the guiding principles for building alliances with religious groups?

- Be proactive. Don't wait for a crisis before approaching them for support
- Do your homework. Know the group's stance on child health
- Start small, and approach leaders of different religious groups and sects separately, respecting leadership hierarchy
- Take care to show respect for the beliefs and values of those with whom you are working
- Be a facilitator for dialogue

- Don’t quote doctrine. Stick to the facts and issues on which there is broad agreement, such as the importance of child health
- Don’t consolidate multiple religious groups until they request joint activities
- Don’t appear to align with any group. Try to include as many groups as possible, but let each work according to its own views
- Plan for sustainability

© UNICEF/HQ02-0290/GIACOMO PIROZZI

2. FORGING ALLIANCES

First impressions are always important, so plan ahead before approaching a religious group.

Following are descriptions of five steps required to build and maintain successful alliances with religious groups. How you carry out each step and the order in which they are taken will vary according to the specific situation. However, all of them are important.

1. Assess the situation

Before approaching a religious leader or group, become knowledgeable about the religious and traditional beliefs and practices operating in the country or a particular locale. Below is a menu of the kinds of information needed to build a strategy for engagement.

Gather enough information to make a solid start – and to avoid costly errors. For example, due to lack of information you may inadvertently exclude a small but influential group. But don't feel that your knowledge needs to be exhaustive before moving ahead.

- Identify the various religious groups in the country and subgroups among them. This could include, for example, different sects of Islam, different Christian denominations, groups ascribing to traditional belief systems and any minority religions.
- Identify the leadership and organizational structure of each group.
- Identify alliances and conflicts among different groups and within each group.
- Identify any global or regional networks associated with each group.
- What is each group's track record on local political, health and social issues?
- Which groups question the value of immunization and why? How is this scepticism manifested?

- Which groups are supportive of immunization? How do they demonstrate that support and why?
- What formal structures exist for integrating religious views in government and on issues relating to health? These could include, for example, a Ministry of Religious Affairs or representation by a religious organization on the Inter-agency Coordination Committee on immunization.
- What are each group's resources? These could include, for example, communication and transport capabilities, health facilities, the effectiveness of its internal network and the level of literacy of its leadership and followers.
- Distinguish between resistance to immunization that is rooted in religion and resistance that may be associated with an underserved population that belongs to a particular religious group. In the case of the latter, the health system may have a bias in serving a particular segment of the population or the population may be hard to reach.

2. Make initial contact

First impressions are always important, so plan ahead before approaching a religious group. This will enable you to prepare adequately, be focused and ready to respond to issues and questions that will inevitably arise. Don't underestimate the importance of showing proper respect, especially early on. The steps below will help you make these initial contacts constructive ones.

- Prepare. Before the first meeting, learn and be prepared to discuss local statistics on children, health and immunization. Find out what that religious group is already doing for child health in other parts of the country and in other countries. Know the basic facts about immunization and the history of immunization programmes in the country.
- Choose an appropriate person to make the first contact. Consider whether an individual or a delegation is appropriate for the initial visit. The factors that may influence your decision include the religious affiliation, nationality, professional position, age and gender of each person in the delegation. For example, a good emissary might be a respected doctor who is of the same religion. The UNICEF country representative may want to be part of the delegation or send a letter of introduction.
- Make contact with individual leaders in each religious group. Find out the hierarchy of the religious group to determine the order in which individual leaders should be approached. If higher-level officials are unavailable, you may want to start with middle-level leaders. Eventually, however, contact with top officials will have to be established. Where acceptable, meet with important subsets in the group, such as women's or youth groups. Also meet with leaders that represent religious views in government.
- Make your pitch. You or a delegation have come to talk to a leader about the state of children in their country or community and what their religious group can do to improve children's lives. Assume the role of facilitator (see page 11) to open the dialogue, dispel misconceptions and provide a forum for discussion on the group's position on immunization.

LEADING THROUGH FACILITATION

In trying to mobilize support for immunization programmes, you are often faced with a difficult dilemma: how to reconcile the need to bring religious groups on board quickly, and the need to create an environment of trust and cooperation, which often takes time. Yet without dialogue and active listening, an alliance with religious groups is likely to be weak or temporary at best. That is why assuming the role of facilitator, rather than that of an expert or teacher, is so important when approaching religious leaders or working with a core group.

- A facilitator has a commitment to honour various points of view. A facilitator gives up control and listens to others as they express their opinions, relate their experiences and form their own ideas and plans.
- A facilitator does not claim to have the answers. He or she has no preconceptions about what changes are needed and must remain receptive to the ideas that emerge from the group.
- A facilitator values the participation of group members and believes that the group has the capacity to collaborate and to take appropriate action.
- A facilitator acts to empower those who are vulnerable, marginalized or otherwise disadvantaged. A facilitator strives to ensure meaningful participation of all those present.

- Work to establish an open and trusting relationship with leaders. Once this is established, move on to group planning and action.

3. Begin group work

- Agree on the composition of the first group meetings. From individual meetings and other assessments, decide with religious leaders who should be included in the initial working group. Within each group, decide what levels of the organization should be represented – national leaders, subnational leaders or heads of local congregations.
- At these first group meetings, facilitate discussion on the role of the religious groups in regard to children. Act as a resource for facts relating to child health, education, immunization programmes and other issues. Leave the religious debate to members of the group. The purpose of these meetings is to generate a consensus on the problem and to gain the group's commitment to seek a

solution. It is not appropriate to talk about an action plan at this stage. Encourage informality and the building of relationships. Serve tea.

- Encourage participants to form a core working group of leaders from each religious group. This core group might be formed specifically for work on immunization activities, or it might be an existing social action group that adds immunization to its agenda. Unless they request it, don't try to consolidate several religions or sects into one working group. Eventually, they may choose to work together, but this is not essential.
- Help the group to arrive at a clear position on immunization. You may need several meetings before the group is comfortable with their position. There may not be an action agenda right away. Be patient. That is for the group to develop when it is ready.
- Take the core working group to health centres to see children being vaccinated, talk to health workers and visit clinics where children are suffering from vaccine-preventable diseases. This will build the group's knowledge base and strengthen their interest and commitment to immunization programmes.

4. Facilitate the planning process

- Organize a series of workshops (at the appropriate level – national, provincial, state, district) in which participants develop a simple action plan. Advise the group not to be overly ambitious. Help them identify which aspect of the problem their congregations can best address. Focus on one target group. Identify what resources they are willing to contribute. Articulate what they see as opportunities and obstacles to action. And determine what kind of external support they will need (see page 13 for a suggested workshop plan).
- Include, as appropriate, national and district level programme staff at action planning workshops. This could include health and nutrition as well as immunization officers along with local service providers. Having broad representation will ensure that these activities are integrated into overall health programming.
- Name the group that will manage the activity. Have the group find a name for itself that captures its identity and purpose. Try to make it short and catchy. The group's composition may be the same as the initial core group or modified according to the wishes of the planning workshop. The action group's responsibility is to supervise activities with minimal external support. This is particularly important as activities reach down to congregations at the village level (see page 15 for an example of a well designed management structure).
- Facilitate a workshop to develop messages. Message development is a specific task that will help members to master and commit to the facts about immunization. Training will also be needed to develop the skills of those who are designated responsible for contacting community members, appearing in the media, mobilizing local groups or liaising with health workers.

ORGANIZING AN ACTION-PLANNING WORKSHOP

Participants in the workshop should be of the same religious group. For this reason, you may have to hold similar workshops for different religious groups active in the country. An effort should also be made to give the workshops an 'in-house' feel. The atmosphere should be casual enough so that participants feel secure in expressing their views, even when they may contradict popular opinion or official interpretations of religious doctrines.

If possible, consider dividing the workshop into two half-days with a religious observance in between. For Christian groups, the workshop could be held on Saturday and Sunday afternoons, with all participants attending a church service on Sunday morning. For Muslim groups, the workshop could be held on Friday and Saturday mornings, with all participants attending the mosque on Friday afternoon.

Design the workshops so that information will cascade out to local levels. Build the capacity of core working group members so that they can facilitate consensus-building in their own congregations or train others to do so. Take advantage of the religious group's internal organization to reach community levels effectively.

National level workshop outline

Suggested participants:

- Ministry of Health officials, preferably from the religious group represented at the workshop
- Selected health workers (such as vaccinators and facility administrators)
- Representatives from UNICEF and the World Health Organization
- Key NGO representatives, especially any religious-based NGOs active in health
- Representative from an international affiliate of the religious group concerned
- Respected local leaders of that religion
- Subnational leaders of that religion
- Representatives from any respected traditional structure in the country, for example, paramount chiefs, emirs and governors
- Representatives from the media

Suggested agenda: Day one

Open the workshop with addresses by one or more of the following:

- The highest ranking political leader of the same religion
- National or international religious leaders, including those that represent different sects and women's and youth groups
- Ministry of Health official
- Other health sector officials

Provide an overview. In explaining the situation of child health and immunization in the country, be simple, clear and accurate. Tailor your presentation by using local sayings and proverbs. Below are some possible themes:

- Emphasize the number of children who can be saved through high immunization coverage.
- Use smallpox eradication as an example of what can be achieved (adults will remember days when people died of smallpox and measles).

Continued on next page

- Discuss the costs of the programme. While immunization costs parents nothing, governments and international donors, who see healthy children as important to the development of the country, spend $20 to $30 per child to supply and deliver quality vaccines.
- Explain how the cold chain works.
- Explain routine immunization schedules, the required number of visits, the age of children vaccinated and other issues.
- Discuss the loss to the nation when children are sick or disabled. Appeal to the emotions of parents.

Use drama, songs or poetry. Express immunization issues creatively by way of interactive communication techniques. Note that, though entertaining, such activities may not be appropriate for some religious groups.

Begin group work:

- Divide into working groups.
- Select members of the group carefully. For example, it may be appropriate to separate women from men.
- Have the group answer the following questions: Do you think all the children in your community are getting vaccinated? Why not?
- List problems associated with vaccinations.
- List group resources by answering the following question: What can we as religious leaders do to get children vaccinated? List possible actions.
- Report from the groups. Make a consolidated list of issues and possible actions.

Suggested agenda: Day two

- Re-cap the results from the previous day.
- Divide again into groups for action planning.
- Provide groups with an action plan format that is geared to their level of literacy and sophistication. Keep the plan focused on:
  - the problem
  - action (who's doing what)
  - desired outcomes
  - resources available
  - resources needed
  - time-frame
- Plenary session to consolidate or refine action plans

Form a coordinating body. Give it a name. Discuss roles and responsibilities.

Discuss next steps. Upon returning home, subnational religious leaders should brief the local health team on the workshop. They should also plan a local-level workshop to continue joint action planning between the health sector and the religious group. The national level coordination team can help plan and facilitate local workshops.

Close the workshop.

The following day: Work with the coordinating body to develop a press release on the outcome of the workshop.

5. Maintain motivation and commitment

- Help develop and maintain links among the religious group, government, the media and other partners. Organize team field visits and promote regular information-sharing at all levels.
- Encourage a forum for regular problem-solving to handle changes that will invariably develop in working relationships. Each group will have its own agenda that will influence how it will work with UNICEF, the government and other partners (see page 16 for tips on how to maintain motivation during implementation).
- Ensure that groups get positive feedback on how their activities have affected children. Encourage them to track their efforts and share their experiences with other congregations and religious groups. Have members of community A visit community B to observe what is being done for children.
- Organize recognition of the group's efforts. Get the media involved. Ask government leaders to provide recognition for good work. Produce a documentary video that congregations can keep and view.

WORKING THROUGH AN EXISTING MANAGEMENT STRUCTURE

When attempting to mobilize religious groups, it is essential that the management of activities they sponsor is handled through their own organizational structures. It is helpful to offer encouragement and technical guidance, but day-to-day management should emanate from the group itself.

Following is an example of a management structure that reinforces the interaction between the health system and the religious group at every level.

National level: Ministry of Health (and possibly the Health Education Unit) and Religious Coordinating Committee

District level: District health team and district hospital administrators, Religious Coordinating Committee and district leader

Local government level: Health care centre staff and religious leader

Village level: Congregation members and leader

MAINTAINING MOTIVATION

Management of activities resulting from the workshops should be left to the religious group. However, UNICEF and other partners can support the process by helping to solve logistical problems, maintain enthusiasm, encourage coordination, sustain the interest of the media, and foster continuous, open dialogue.

Arrange for field visits of national-level religious leaders together with Ministry of Health representatives, other partners, the media, politicians, and current or potential donors. Later on, facilitate exchange visits between districts or even between one religious group and another.

Involve the media

- Bring religious leaders into television or radio studios for interviews
- Take reporters on field trips to document activities
- Develop tape cassettes about a religious group's grass-roots support for immunization. Distribute them to radio stations

Link up with politicians, including parliamentarians, mayors, local representatives

- Take them on field trips
- Ensure media coverage showing their involvement

Provide written updates to participating groups. Print a newsletter with reports from a district or chiefdom. Keep it informal – "How are we doing?" – and use it to give groups feedback and encouragement. The newsletter can also be distributed to politicians and the media.

Produce a video cassette that documents the group's activities and distribute it to each congregation.

- Always work with sustainability as a priority. Emphasize capacity-building. Encourage activities that are readily integrated into the agenda of the religious group. Reinforce efforts that rely primarily on locally available resources, and gradually reduce any external material support, while continuing to provide recognition and feedback. Make sure there is commitment within development organizations and government to maintain newly formed relationships with religious groups.
- Respond to the group's desire to expand to other areas of development, such as nutrition, promotion of breastfeeding, hygiene, and diarrhoea prevention. Communities have multiple health needs and religious groups can address these in an integrated and sustainable way. For other areas of development, such as clean water supply, help the group connect with the relevant authorities.

© UNICEF/HQ93-1559/ ROGER LEMOYNE

3. BUILDING TRUST

In responding to resistance, the first reaction is to develop messages to counter the resistance and disseminate them immediately. Experience shows that a more measured approach is often more effective.

Despite your best efforts, resistance to immunization can and does arise. Sometimes the resistance is along religious lines. In other cases, a religious spokesperson may simply be circulating unfounded rumours. In any event, a rapid response is required, which UNICEF, the government and other partners may be called upon to develop.

Often, the first reaction is to develop messages to counter the resistance and to disseminate them immediately. Experience shows, however, that a more measured approach is often more effective. Such an approach will involve an assessment of the situation and consultation with immunization partners. Most importantly, it will mean calling upon allies within the religious community to help devise a strategy and direct the response.

Before taking any action, work with government and religious allies and other partners to answer the questions on page 20 of the table that follows. Doing so will help you to correctly assess a situation.

Depending on your answers, one or a combination of options can be included in your response. Others may be added as they are developed. A description of possible response options begins on page 21. They do not appear in any particular order.

RESPONDING TO RESISTANCE: ISSUES AND OPTIONS

ISSUES

What is the source of the resistance? Which individual or group is involved? Do they represent mainstream thinking or are they outcasts or radical elements of a religious group? How credible is the leader of the resistance to other members of the religious group? **If the resistance represents mainstream thinking, consider options 2, 4 and 6. If it represents the views of outcasts or radical elements of a religious group, consider options 1, 2 and 5.**

What are the issues underlying the resistance? Sometimes an individual affiliated with a particular group uses religious doctrine to support his or her views on immunization. Alternatively, an organized religion may have political motives and use opposition to a government-sanctioned health programme to further its own agenda. **If the agenda is broader than an objection to immunization, consider options 1, 3 and 5.**

What impact does the resistance have on a community's use of immunization services? Despite the objections voiced by a religious group, the community's behaviour might not be significantly affected. Study trends in local coverage rates to determine the actual impact of rumours or resistance. **If coverage is minimally affected, consider options 1 and 5.**

Are people reacting to real or perceived dangers of immunization? News of a child contracting polio from a vaccination or getting a severe infection from an unclean syringe must be dealt with differently from resistance due to perceived government plots or unfounded statements about immunization. **If resistance is due to an actual negative event, consider options 3, 5 and 7. If due to perceived or rumoured dangers, consider options 5 and 6.**

Is this active resistance on the part of a religious group? Or is it the voice of an underserved population that happens to be of one religion? A religious group is sometimes labelled as 'resistant' when, in fact, the health system is not effectively reaching out to families in this group. Sometimes their cultural practices and social norms are so different from those who work in the health system that biases and misunderstandings occur. Addressing an underserved religious group will require a different strategy to one in which the group is actively resisting immunization. **If you are dealing with an underserved population, consider options 2, 3 and 7.**

OPTIONS

Option 1: Avoid drawing attention to the source of the resistance. Resistance is usually localized, so don't give credence to the movement by publicizing it. Take indirect action to reduce resistance by increasing the flow of accurate information on immunization. Avoid 'fanning the fire'.

Option 2: Draw support from allies. Approach leaders of the same religious group who are not resistant to immunization. They may offer suggestions or volunteer to speak to the resistant leaders themselves. Avoid giving the impression that you are driving a wedge between these groups. Keep the emphasis on child health and survival.

Option 3: Visit the affected area. Go to the site of the resistance (or delegate someone to go) to assess the situation. Talk to community members, local government officials, health professionals and religious and traditional leaders to separate fact from rumour and determine the scope of the problem.

Option 4: Approach the leader(s) of the resistance. It is best to deal with resistance face to face. Sometimes leaders themselves are misinformed about immunization. Or, for various political, personal or economic reasons, they use religious arguments to vocalize their views. Many crises have been diffused when opposing parties have sat down and had frank and informed discussions. Consider carefully who should make this contact. In the discussion, explain the possible consequences of resistance to the welfare of children. Help the group separate its personal or political agendas from the issue of immunization.

Option 5: Increase communication on immunization at all levels. Revitalize communication channels already in use through community groups, health workers, vaccination outreach teams, radio and television broadcasts. Make sure all information disseminated is accurate and responds to the specific issues raised by the resistant voice or group. Mentioning the resistance itself may be counterproductive. Concentrate on reaching as many people as possible with accurate information about immunization.

Option 6: Use the media. While there might be a call for a direct response on the national media – especially if the resistant movement has received similar coverage – use national media primarily to increase dissemination of information about immunization. The messages can be shaped to appeal to the resistant group and respond to its arguments (see also option 2), while bypassing mention of actual incidents.

Option 7: Tackle service-delivery problems. Before taking action, make sure the group is reacting to actual service-delivery problems, rather than perceived dangers. If such problems are real, find constructive ways to bring the group's views to local service providers. Often the group is objecting less to immunization than to a shortage in vaccines, poor treatment from health workers or lack of other health services. Assess the relationship between the health workers that provide immunization and the members of the religious group. If the attitudes of health workers are affecting the quality of service, find ways to improve the relationship by offering training in interpersonal communication skills. Advocate with immunization partners to improve the quality of service in affected areas.

© UNICEF/HQ95-0326/FRANCK CHARTON

4. LEARNING FROM OTHERS

CASE STUDY: RELIGIOUS LEADERS IN SIERRA LEONE ADOPT IMMUNIZATION GOALS AS THEIR OWN

Although Sierra Leone began an 'Expanded Programme on Immunization' in the late 1970s, it ground to a halt in just a few years. High levels of illiteracy, the lack of mass media and religious-based resistance among Muslims were cited as barriers to its success. By 1986, when a new, more comprehensive immunization programme began, only 6 per cent of children under the age of one had been fully immunized. The goal of the new programme – called *Marklate* or 'vaccinate' in the local language – was at least 75 per cent coverage of all children with six antigens by 1990.

Progress was slow. By 1988, less than a quarter of all children under one had been vaccinated. A 'Knowledge, Attitude and Practice' study showed that messages were simply not getting through to target audiences. The study found that although the general benefits of vaccination were beginning to be understood, almost 90 per cent of respondents had no knowledge, or the wrong knowledge about when and where to vaccinate their children.

Shifting focus to social mobilization

The strategy of the Marklate programme shifted as a result of the study's findings. Its new focus was on training health workers, expanding the number of vaccination sites and encouraging outreach services. In a radical move, 25 per cent of programme resources were dedicated to social mobilization and training, and new broad-based strategies were devised to involve all sectors and levels of society.

The UNICEF national social mobilization team, working in close collaboration with the Ministry of Health, began to form action groups to promote Marklate among political bodies, farmers associations, market women and many other groups.

Suitable messages and materials for Marklate were selected from UNICEF's *Facts for Life* handbook and translated into local languages. The social mobilization

team then turned to established social networks, such as traditional entertainers, women's associations, schools and religious groups to spread the messages among the general population.

In an initial attempt to involve religious leaders in Marklate, the social mobilization team invited representatives from all religions in Sierra Leone to a leadership workshop. This proved unproductive because participants were more interested in debating the differences in their beliefs than in finding common ground on how to promote immunization.

Six months later, the social mobilization team tried a different tactic. Reasoning that Muslims were the largest segment of the population (60 per cent), and that vaccination coverage rates were the lowest in Muslim children, the team organized a leadership workshop specifically for Islamic leaders.

© UNICEF/HQ01-0223/ROGER LEMOYNE

A local health worker promotes immunization in the town of Makeni, Sierra Leone.

During the three-day workshop, the team helped the attending religious leaders, Islamic scholars and prominent Muslims from government and business to form a new NGO – the Islamic Action Group – which became an important vehicle for disseminating the messages. Quotations from the Koran were also identified to support child survival and other development initiatives.

The Islamic Action Group encouraged different Islamic organizations around the country to use their networks to spread these messages and inspire local leaders. Smaller action groups were established in each of Sierra Leone's 12 districts.

At that time, a new generation of Islamic scholars was rising to prominence. Many had studied overseas, were open to the ideas of modern medicine and welcomed working with the UNICEF team.

Nevertheless, some religious leaders remained resistant to the idea of vaccination. They considered the practice anti-Islamic or were wary of UNICEF's motives. Some even suspected a secret family planning agenda. In response, the social mobilization team organized a series of national and district-level workshops to win over these leaders.

It didn't take long before the leaders that attended the workshops had adopted the Marklate campaign as their own. They explained to their congregations that parents held a duty to secure their children's well-being. Imams included messages promoting child survival and development in their sermons and announced the times and locations of immunization sessions. Sometimes they allowed their mosques to be used as vaccination sites.

Christians, inspired by the work of the Muslim groups, also wanted to get involved.

A poster in Arabic showing a child polio survivor and suggesting that immunization could have prevented his disability was a particularly effective communication tool. Even though few people could understand Arabic, the language was associated with Islam and displayed in mosques, which provided additional credibility among the Muslim population. The poster proved so popular, in fact, that the social mobilization team used the number of posters displayed in mosques as an indicator of campaign reach.

Women as change agents

Islamic women were also important agents for change. The National Council of Muslim Women – an umbrella organization of 96 different women's groups – attended leadership workshops and conferences. Some of the leaders then organized their own meetings and special events to further promote Marklate and enlist the support of their members.

The women soon became familiar figures at vaccination sites, preparing food for vaccination workers, assisting in registration and providing entertainment by singing about Marklate. They also went door-to-door to find children not being brought for immunization. The women, mostly mothers themselves, were particularly credible as advocates, winning over reluctant families with arguments in favour of vaccination.

Christians, inspired by the work of the Muslim groups, also wanted to get involved. They approached UNICEF, asking how they could help.

The UNICEF social mobilization team, again in close cooperation with the Ministry of Health, organized a national leadership conference with the Christian Council of

Sierra Leone. Participants formed an NGO similar to the Muslim group, called the Christian Action Group, to help organize district-level activities. They selected biblical passages supporting childcare and community development to use as messages.

Pastors and priests shared information on immunization with their parishioners and organized workshops and special events, such as 'crusades' in sports stadiums featuring preaching, testimonials, gospel singing and talks by health providers. Other awareness-building activities included an evening candlelight parade and a thanksgiving parade with floats built by community organizations to promote child survival and other development themes.

After just two years of activity, the immunization programme reached its goal, moving from 6 per cent to 75 per cent coverage of Sierra Leone's children under one year of age.

Mothers' Unions, a long-established women's network in local churches, played a role similar to the Islamic women's groups, going directly to communities to promote and support vaccination. Initially, Christian and Muslim women and men went separately to the communities. They were so keen to help that soon fierce competition arose for places on the UNICEF bus that took the Marklate campaign into the districts. Eventually, the group leaders saw the advantages of making field visits together, and a bus schedule was organized to accommodate both Christians and Muslims on the same trip. By arriving together in a community with the same objectives and activities, but targeting their own congregations, they sent a powerful message to the community, thus increasing the impact of their work.

The relationship built up between Christian and Muslim women persisted long after the immunization campaign was successfully concluded.

Working collaboratively for results

This collaborative effort, led by Muslim and Christian leaders, was highly successful in increasing community involvement and demand for vaccination. In 1990, after just two years of activity, the immunization programme reached its goal, moving from 6 per cent to 75 per cent coverage of Sierra Leone's 135,000 children under one year of age.

Churches and mosques – along with village meeting places – became forums for debate, not only on immunization, but for other ongoing development issues.

CASE STUDY: CHURCHES BECOME ALLIES IN ENDING POLIO IN ANGOLA, ONE HOUSEHOLD AT A TIME

By 1998 Angola had suffered almost continuous civil war for more than two decades. Despite the devastation caused to infrastructure and the economy, the country had managed to hold national immunization days for the previous three years.

It therefore came as a surprise when a polio epidemic – the largest recorded in sub-Saharan Africa – erupted. Two major cities, Benguela and Luanda, were affected and 1,103 cases and 60 deaths were recorded.

As efforts to increase vaccination coverage intensified, there was a new and deeply troubling development. Some of the country's Catholic clergy, including bishops and archbishops, were preaching against polio vaccination saying that the vaccine being used had been altered to cause sterilization.

Colonial religious restrictions had left Angola a predominantly Christian country (38 per cent Roman Catholic, 15 per cent Protestant and 47 per cent practising indigenous beliefs). So when UNICEF set out to assist the Inter-agency Coordinating Committee, it was decided to not only work to stop the rumours, but also to recruit the churches as active allies in polio elimination.

Another reason for working with the churches was that the ongoing civil war made it imperative to enlist the help of committed, reliable, social mobilizers who were respected by their communities and by authorities from both sides of the conflict. It was also important that they could work within social structures – such as churches – that extended from national to municipal and community levels and that could be mobilized rapidly enough to contribute to an emergency vaccination operation.

UNICEF Angola's programme communication team then began a two-step process: to dispel the growing misconceptions and rumours, and to get church organizations to participate in social mobilization training and other activities.

Getting the message to isolated populations

With the high level of illiteracy and poor media coverage in Angola it was evident that interpersonal communication channels would have to be used to take messages to hard-to-reach areas and isolated populations.

UNICEF had to strengthen its polio eradication team by recruiting on a temporary basis a senior member of the Catholic Church who had previously worked for UNICEF as a social mobilization consultant. Using his contacts, a series of meetings was held with bishops from the Episcopal Conference of Angola and Sao Tome and with members of the Executive Board of the Council of Christian Churches of Angola (one of the two largest confederations of Protestant churches).

The meetings gradually worked towards a common understanding:

- Demonstrating that the rumours around sterilization were unfounded and that the vaccines were safe
- Linking the goal of saving lives through vaccination to the basic values of Christianity, including the curative dimension of Christ's life, his love for children and the social responsibility of the modern church
- Exploring ways of working together to promote these two main points.

As a first step towards dispelling rumours, a poster showing Mother Teresa administering the oral polio vaccine to a child in India and a pamphlet entitled 'What you do to these little ones, to Me you do' were developed and distributed in Catholic parishes throughout the country.

Next, the churches were enlisted as social mobilizers. The church leaders were asked to nominate organizations within their respective churches that could work with the urgency that eradicating polio demanded. The organizations were to provide activists who were motivated, willing to make sacrifices, and able to commit strongly to the goals of polio eradication. UNICEF would provide the training, travel costs and small fees for the coordination body.

Another reason for working with the churches was that the ongoing civil war made it imperative to enlist the help of social mobilizers who were respected by their communities and by authorities from both sides of the conflict.

The Catholic bishops first nominated the local branch of the Legion of Mary, which specializes in house visits for the sick and destitute, and later added the female branch of the Catholic Church called Promotion of the Catholic Women. Between them, these two organizations covered the most remote and difficult to access provinces of the country, including the north-east and eastern regions. The Council of Christian Churches of Angola nominated its Medical Council, an association of doctors and nurses from their congregations.

Having reached this point, the following steps were taken:

- UNICEF and the respective church groups worked together to develop a joint project representing their shared vision of a polio free world.
- A training and travel plan was also developed and 60 trainers (30 for each denomination) attended a series of sessions on training trainers. UNICEF hired a Brazilian international consultant with experience in non-formal training to organize the sessions.

© UNICEF/HQ99-0967/ JEREMY HORNER

For this polio survivor in Lobito, Angola, who must now rely on crutches, a national campaign against the disease came too late.

- The trainers then travelled to 10 of the country's 18 provinces and conducted their own training seminars for over 20,000 mobilizers within their respective churches. Their outreach to individual families contributed significantly to the polio eradication campaign.
- It was also necessary to advocate for the religious volunteers within the Ministry of Health so that they would be fully accepted by health workers, who tended to regard the volunteers and mobilizers as intruders.

Although the project cooperation agreements expired in May 2003, the activists did not stop working for polio eradication. A review of their activities has just been finalized and a new agenda is due to be signed to allow their joint activities to continue.

In the new agreement, each of the nominated religious organizations is pledging to engage five managers at the national level, 25 trainers at the provincial level, and 1,000 activists at the district and community levels to the partnership. The new recruits are expected to visit about 10,000 families (around 70,000 people) each month.

CASE STUDY: MUSLIM LEADERS COUNTER RESISTANCE TO POLIO VACCINATIONS IN INDIA

In 2003, the northern India state of Bihar and its neighbour, Uttar Pradesh, had the highest concentration of remaining polio cases in Asia.

Bihar is predominately Hindu with a small Sunni Muslim population. Many of its families have relatives in the more heavily Muslim Uttar Pradesh. This meant that rumours and concerns about the government – including its vaccination programme – spread easily from family to family across the state border.

A couple of years earlier, studies in Bihar revealed that coverage rates for polio vaccination in predominately Muslim areas were lower than the state average. During an Inter-agency Coordination Committee meeting, this issue was discussed with social mobilization coordinators and district health officials working in Muslim blocks. They agreed that lack of information about polio vaccines for children and misconceptions about their safety were the main reasons that participation in campaigns was low.

Studies in Bihar revealed that coverage rates for polio vaccination in predominantly Muslim areas were lower than the state average.

The UNICEF health officer took the lead in approaching local Muslim leaders for help. A Christian himself, he first sought information from key informants to develop a strategy that would be sensitive to the Muslim culture in Bihar. He also sought the help of a consultant who was Muslim and a medical doctor. Together they approached the four leading imams in Bihar. Over the course of the next three weeks, the consultant and health officer visited each imam individually, beginning with lower ranking leaders, who in turn advised them on how UNICEF could position itself to meet with the highest imam in the state. At the same time, they met with the state secretary of health and the minister of health to demonstrate transparency and to gain their support. Both officials were Muslim – the minister of health was also a medical doctor – so their active support was crucial to initiating and maintaining a successful alliance.

The individual meetings took place in the imam's office next to the mosque. The UNICEF officer and consultant brought materials on polio eradication and made the following points to alleviate common concerns:

- Other countries in Asia, Africa and Latin America have eradicated polio, so India can do the same.
- Smallpox was successfully eradicated, and the elimination of polio is within reach.
- There is no cure for polio. Though it rarely kills, polio can permanently disable people, making them dependent for life. This can be especially difficult for girls.

- Regardless of where UNICEF purchases vaccines, the vaccines must pass international standards for quality before they are distributed in India and other countries.
- They emphasized that polio knows no borders nor religion and that, in this sense, all people are of one community. They concluded by showing the imams an actual vial of oral polio vaccine.

© UNICEF/WING SIE-CHENG

An official at a local Muslim university administers oral polio vaccine to an infant in Aligarh, Uttar Pradesh.

Imams as immunization advocates

The four imams talked among themselves. Later, the head imam called UNICEF and asked for a second meeting to discuss how they might support polio vaccinations. He specifically asked what he and fellow imams could do. One suggestion was the drafting of an appeal to their community. Working with UNICEF, the imams produced a pamphlet with key messages, calling on Muslims to get their children vaccinated. They also agreed to discuss polio eradication in their sermons.

The pamphlet was translated into both Hindi and Urdu since many Muslims regard Urdu as their common language. The cover featured a photograph of a mosque and the back showed two female Muslim vaccinators. The slogan 'We are one community' was emphasized. All imams signed the text, carefully considering

the positioning of each signature according to the leadership hierarchy. The draft was then reviewed by the Inter-agency Coordination Committee, the minister of health and the health secretary. Copies of the final version were printed by UNICEF and delivered to the Ministry of Health for distribution to all districts.

> The imams promoted vaccination during their sermons and in informal discussions with congregation members.

Social mobilization coordinators and NGOs also distributed the pamphlet. After consultation with the imams, UNICEF approached a Muslim NGO to distribute the pamphlet inside mosques and to discuss it after prayer time.

The imams also promoted vaccination during their sermons and in informal discussions with congregation members. One imam launched a polio campaign in his area during a national immunization day. The minister of health and health secretary got personally involved in the mobilization effort. When they went to the mosque, for example, they made it a point to talk to their fellow worshipers about the importance of protecting their children from polio.

© UNICEF/WING S E-CHENG

Muslim mothers line up for routine immunization in Aligarh, Uttar Pradesh.

A possible crisis averted

After some months, one of the imams learned that, in parts of Bihar, the pamphlet was being indiscriminately discarded after being read by the general population. This was considered a sacrilege by Muslims since the pamphlet had a photograph of a mosque on the cover. According to their beliefs, the photo of the mosque should be accorded the same respect as the Koran. The incident could have exacerbated tensions between Hindu and Muslim communities had not a strong alliance existed between the Muslim leadership and the polio eradication partners. Also important was the fact that the leaders had been actively involved in developing the pamphlet. As a result, the imams worked together with the health officer and consultant to revise the pamphlet, eliminating the photo of the mosque and using instead photos of Muslim children being vaccinated.

Since the alliance began in 2001, more Muslim families have participated in vaccination campaigns and coverage for polio vaccination has increased in Muslim areas. The pamphlet, in particular, has turned into an effective communication tool in Bihar.

© UNICEF/HQ92-1644/ROGER LEMOYNE

5. RESOURCES

Publications

Advocacy for Immunization: How to generate and maintain support for vaccination programmes
Published by the Global Alliance for Vaccines and Immunization (GAVI), 2000 (Available in English, French, Spanish and Russian).
To download in English: http://childrensvaccine.org/files/GAVI-AdvocacyHandbook.pdf

Facts for Life
Updated information on major causes of childhood illness and death. Authoritative information on practical, effective and low-cost ways to protect children's lives and health. Published by UNICEF, WHO, UNESCO, UNFPA, UNDP, UNAIDS, World Food Programme and World Bank. Available in English, French and Spanish.
To order or download: www.unicef.org/ffl/

Supplementary information on vaccine safety. Part 1: Field issues
Published by WHO. Ordering code: WHO/V&B/00.24
To download: http://www.who.int/vaccines-documents/docsPDF00/www522.pdf

Supplementary information on vaccine safety. Part 2: Background rates of adverse events following immunization
Published by WHO. Ordering code: WHO/V&B/00.36
To download: http://www.who.int/vaccines-documents/DocsPDF00/www562.pdf

Surveillance of adverse events following immunization: Field guide for managers of immunization programmes
Published by WHO. Ordering code: WHO/EPI/TRAM/93.02 REV 1 (available in English, French, Russian)
To download: http://whqlibdoc.who.int/hq/2000/WHO_V&B_00.36.pdf

Websites

UNICEF. http://www.unicef.org/immunization/index.html
Link to statistics, 'real lives', 'UNICEF in action', publications, technical and policy documents

WHO: http://www.who.int/vaccines
Link to information on the cold chain, logistics, emergency situations, financing, vaccine quality and safety, vaccine supply, systems approach and global surveillance

Allied Vaccine Group: http://www.vaccine.org
A partnership of seven independent websites providing science-based information about immunization

Children's Vaccine Program at PATH (Program for Appropriate Technology in Health): http://www.childrensvaccine.org
The Resource Center contains an extensive library of immunization materials

The Communication Initiative: http://www.comminit.com
This website provides information and resources for communication staff working in public health in developing countries

Safe Injection Global Network (SIGN): http://www.who.int/injection_safety/sign/en/
SIGN is a voluntary coalition of stakeholders aiming to achieve safe and appropriate injection practices worldwide

Institute for Vaccine Safety: http://www.vaccinesafety.edu
An independent assessment of vaccines and vaccine safety to help guide decision makers and educate physicians, the public and the media on key issues

Polio Eradication Initiative: http://www.polioeradication.org
Information about polio and global efforts to eradicate it

United Nations Children's Fund
Division of Communication
3 UN Plaza
New York, NY 10017 USA

pubdoc@unicef.org
www.unicef.org

© The United Nations
Children's Fund (UNICEF)
May 2004