

20231 Partnering with Faith-Based Organizations to Improve Public Health and Vaccination Equity

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Abstract

The COVID-19 pandemic underscored the vital role that vaccination plays in preventing the spread of infectious diseases and supporting social and economic security. At the same time, years of progress made in achieving and maintaining high vaccination coverage rates have been reversed due to a convergence of factors related to the pandemic. This coupled with rising vaccination hesitancy and politicization of public health has created an urgent need to engage across sectors to recover and build forward a stronger, more resilient vaccination ecosystem. The faith community, including faith-based organizations (FBOs), is one such example that has helped improve awareness of the value of vaccination, strengthen vaccination confidence, and improve vaccination equity. Based on strong evidence, this policy statement urges that FBOs be prioritized as critical partners in supporting vaccination efforts. This can be done by ensuring that these organizations are critical thought partners in strategy development from the local to the national and global levels, enabling funding opportunities to support FBO-led vaccination initiatives, investing in culturally appropriate strategies and messaging, implementing concrete programs targeting vaccination hesitancy through multiple outreach channels, and building the capacity of religious leaders to respond to and emphasize together with public health professionals the importance of and need for routine vaccination across the life course.

Relationship to Existing APHA Policy Statements

No APHA policy statements relate either to this specific topic or to faith community or religious involvement in health promotion and disease prevention.

Current and Active Policies Related to Vaccination

- APHA Policy Statement 7806: Improving the Immunization Status of the U.S. Population Through the Establishment of a National Compensation System for Inadvertent Vaccine-Related Injuries
- APHA Policy Statement 200023: The Need for Continued and Strengthened Support for Immunization Programs
- APHA Policy Statement 20221: Intellectual Property Protections and Profits Limit Global Vaccine Access

Relevant Archived Policy Statements:

20231 Partnering with Faith-Based Organizations to Improve Public Health and Vaccination Equity

- 34 • APHA Policy Statement 7805: Immunization against Childhood Diseases
- 35 • APHA Policy Statement 7906: Adoption of a Standard Immunization Record Format
- 36 • APHA Policy Statement 8302: An Indemnity System for Vaccine-Related Reactions
- 37 • APHA Policy Statement 8706: Universal Childhood Immunization
- 38 • APHA Policy Statement 8906: Recommendations for Adult Immunization
- 39 • APHA Policy Statement 9103: Preventing and Controlling Measle Outbreaks through Improved
- 40 Service Delivery
- 41 • APHA Policy Statement 9102: Childhood Immunizations: Easy Access versus Requirement for
- 42 Essential Services

43 Problem Statement

44 The COVID-19 pandemic has resulted in 340 million infections and more than 5 million deaths and has
45 impacted both adults and children around the globe. Unfortunately, a silent crisis emerged because of a
46 convergence of factors related to the pandemic—namely a concerning decline in routine vaccinations
47 across the life course, upending years of progress made in achieving and maintaining high vaccination
48 rates. This places our global communities at risk of vaccine-preventable diseases, outbreaks, and certain
49 cancers associated with vaccine-preventable diseases. Declines in routine vaccination rates have been
50 identified across all ages, from early childhood to older adults. According to the World Health
51 Organization (WHO) and the United Nations Children’s Fund (UNICEF), approximately 23 million
52 children did not receive routine vaccinations in 2020, and close to 17 million did not receive a single
53 vaccine.[1] In 2021, nearly 61 million measles vaccine doses in 18 countries were postponed or missed
54 due to COVID-19-related delays. This is particularly worrisome given that, since 2016, 10 countries that
55 had previously eliminated measles have experienced outbreaks and reestablished transmission.[2]

56
57 Recent data further underscore the situation, in that worldwide measles cases increased by 79% in the first
58 2 months of 2022 relative to the same period in 2021.[2] Experts have suggested that the reported measles
59 resurgence is the proverbial “canary in the coalmine,” a signal of what may come indicating that other
60 vaccine-preventable diseases, long since forgotten or controlled, may soon make a similar resurgence.[3]
61 This is best illustrated by the recent polio case observed in New York.

62
63 While there have been observable declines across all ages, there has been a disparate impact and a slower
64 recovery for the most vulnerable and underserved populations, widening the disparities that existed and
65 persisted long before the pandemic.[4] In the United States, significant disparities in COVID-19
66 vaccination have emerged along geographical, socioeconomic, racial/ethnic, educational, and political
67 lines, leading to reduced vaccination rates in specific population groups. These disparities underscore the

20231 Partnering with Faith-Based Organizations to Improve Public Health and Vaccination Equity

68 imperative for tailored interventions and educational initiatives aimed at mitigating vaccine hesitancy and
69 advancing equity in immunization.[5–8]

70
71 As such, the COVID-19 pandemic has compelled us as a public health community to generate creative yet
72 sustainable solutions to strengthen and build more resilient vaccination programs to not only address this
73 growing concern but ultimately achieve and maintain national and global vaccination targets. For
74 example, from a local perspective, there are solutions that are deeply embedded in faith-based
75 organizations (FBOs), including congregations and national denominations. FBOs differ from other
76 charitable nongovernmental organizations (NGOs) or community-based organizations in their support of
77 childhood immunizations primarily through their religious or faith-based mission. FBOs often integrate
78 their religious beliefs and values into health care initiatives, including immunization programs. This
79 distinguishes them from secular NGOs and community-based organizations, which typically operate
80 without a religious or faith-based orientation when providing health care services. FBOs and faith-based
81 engagement strategies have been the foundation of many previous collective efforts targeting other
82 infectious diseases and public health initiatives.[9,10] This policy statement, based on a strong evidence
83 base and the worldwide challenges to recover and achieve high rates of vaccine uptake, is the first to
84 focus on the importance of the role of FBOs and faith-based engagement strategies in vaccination efforts,
85 filling a timely public health gap.

86
87 It will take years to recover from the severe declines experienced globally in routine vaccinations across
88 the life course. Projections based on 2020 and early 2021 declines estimate that for adolescents in the
89 United States alone, if every provider saw 15% more patients each month, it would take 3–7 years to
90 recover what has been missed during the pandemic.[11]

91
92 The public health imperative of going hyperlocal by engaging FBOs and leveraging faith-based
93 engagement is critical as (1) the pandemic has worsened long-standing vaccination disparities, (2) low-
94 and middle-income countries and regions share a disproportionate burden of low childhood vaccine
95 uptake, and (3) there are public health challenges to global routine vaccination uptake.[12]

96
97 The COVID-19 lessons learned support alertness to new emerging preventable infections.
98 Access to health care and vaccinations as prevention tools is essential for human health, but not all
99 people, particularly our most vulnerable populations, are afforded access. Historically, health care
100 disparities have contributed to low vaccination rates in children.[1] While vaccination rates were
101 impacted across the life course, the most available, complete, and reported data largely focus on

20231 Partnering with Faith-Based Organizations to Improve Public Health and Vaccination Equity

102 childhood vaccination.[13] Globally, many of the vaccination disparities among children occur in regions
103 of conflict. A United Nations High Commissioner for Refugees report shows that 82.4 billion people were
104 estimated to be forcibly displaced in 2020, and children are estimated to account for 42% of all displaced
105 people.[14]

106
107 According to UNICEF, 23 countries across the world had to postpone their measles vaccination
108 campaigns due to the ongoing COVID-19 pandemic, leaving approximately 93 million people at risk.
109 More than 1.3 million additional children have missed their first DTP-1 (diphtheria, tetanus, and
110 pertussis) dose. Similarly, an estimated 1.6 million more girls missed out on human papillomavirus
111 (HPV) vaccination in 2020. Also, global rates of HPV vaccination declined to 13% in 2020 from 15% in
112 2019, risking a lost generation of individuals vulnerable to certain HPV-associated cancers and diseases.
113 Declines in other routine vaccinations were observed globally, including poliovirus, hepatitis A, and
114 pneumococcal vaccines. A total of 170 countries and territories showed declines in DTP and MCV1
115 (measles-containing vaccine) in the first half of 2020.[15] Missed immunizations threaten to reverse hard-
116 won progress on vaccination-preventable diseases. Each year immunization programs prevent 2.7 million
117 cases of measles, 2 million cases of neonatal tetanus, 1 million pertussis cases, 600,000 cases of
118 poliomyelitis, and 300,000 diphtheria cases. Catch-up campaigns in low- and middle-income countries
119 increase the burden on already-overwhelmed local community health services needing to vaccinate both
120 missed and recently born neonates and children.[16]

121
122 Authorized vaccines, along with effective mitigation strategies, are critical for reducing rates of infection
123 and slowing the spread of infectious diseases. With the continued circulation of SARS-CoV-2 and its
124 emerging variants, we have seen the profound impact on children in terms of number of acute infections
125 as well as postinfection sequelae. The United States experienced a record of more than 1.1 million
126 pediatric COVID-19 cases over one week in January 2022, bringing the count to more than 10.6 million
127 children since the beginning of the pandemic. According to the COVERAGE database, which includes data
128 from 106 countries and accounts for 134 million COVID-19 cases, children and adolescents account for
129 33% of the population and 17% of COVID-19 cases.[17] Globally, one in 20 children are estimated to
130 suffer from post-COVID conditions, and in the United States more than 6,000 children have been
131 diagnosed with multisystem inflammatory syndrome in children. Beyond COVID-19 illness, there is
132 strong scientific evidence of morbidity and mortality risk reduction due to routine childhood vaccinations.

133
134 Lower resource regions and countries share a disproportionate burden of low immunization uptake.

20231 Partnering with Faith-Based Organizations to Improve Public Health and Vaccination Equity

135 Recent WHO-UNICEF estimates of national immunization coverage revealed that 60% of children who
136 missed their first immunization doses were primarily from 10 countries. Three countries, India, Pakistan,
137 and Indonesia, had the highest decreases in immunization coverage from 2019 to 2020. Other countries
138 with large reductions were Argentina, Venezuela, Mexico, Mozambique, Angola, Tanzania, and Mali.[1]
139 People in both low- and middle-income countries suffer disproportionate immunization impacts. GAVI,
140 the Vaccine Alliance was established to help low-income countries, but unfortunately poverty exists
141 outside low-income countries as well.[3] People residing in heavily populated middle-income countries
142 can suffer from vaccination and health inequities due to a myriad of reasons, including lack of access to
143 vaccines, inadequate supplies, high cost, and challenges in deploying successful immunization
144 campaigns. Many countries lack the infrastructure needed to run successful vaccination campaigns. The
145 problem is multifaceted due to challenges such as lack of trained support staff needed to provide vaccine
146 education and administration and the complexity of building vaccine confidence using culturally
147 competent methods in diverse communities.

148
149 Public health challenges to childhood routine immunization uptake: While there is a strong evidence base
150 to support the benefits of receiving routine and on-time vaccinations, there is an equally strong evidence
151 base documenting disparities in acceptance and uptake of vaccines. Vaccine hesitancy was amplified
152 further during the COVID-19 pandemic; in the United States, widely documented disparities in vaccine
153 distribution and access are compounded by issues such as health literacy and political challenges.[6–8]
154 Vaccine hesitancy is multifaceted and is intricately linked to specific circumstances evolving over time
155 and differing based on location and the types of vaccines in question. One study showed that political
156 partisanship and COVID-19 vaccine willingness were correlated, while the proliferation of
157 misinformation on social media platforms further complicates efforts to promote accurate vaccine
158 information.[5] A 2022 vaccine survey conducted by the Kaiser Family Foundation showed that 71% of
159 respondents expressed support for MMR (measles, mumps, and rubella) vaccination requirements in U.S.
160 public schools, a decline from 82% in a 2019 Pew Research Center poll. In addition, there was an
161 approximate increase from 16% to 28% of respondents who said that parents should be able to decide not
162 to vaccinate their school-age children even if this creates health risks for others.[18]

163
164 The reasons for vaccination hesitancy are varied and can be community and context dependent; however,
165 some reported contributors to vaccination hesitancy include but are not limited to concerns about
166 perceived vaccine safety, skepticism about the source(s) of vaccination recommendations, cost, and
167 personal, cultural, or religious beliefs discouraging vaccination. Religion has also been recognized as a
168 potential influence on vaccine decision making, leading to delays or refusals. The rationales behind these

20231 Partnering with Faith-Based Organizations to Improve Public Health and Vaccination Equity

169 decisions may fall into diverse categories of religious vaccine skepticism or stem from entirely
170 nonreligious considerations.[19]

171
172 According to the results of a 2019 national survey conducted by the American Academy of Pediatrics,
173 more than one quarter of parents reported hesitancy about influenza vaccinations. Only one in four
174 parents believed that the influenza vaccine was effective, and one in eight had concerns about the safety
175 of both influenza and other childhood vaccines.[20] A March 2021 survey conducted by the Public
176 Religion Research Institute revealed that 36% of Black Protestants and 33% of Hispanic Americans who
177 are vaccine hesitant say one or more faith-based approaches would make them more likely to get
178 vaccinated.[21] In the context of COVID-19 vaccines, religious leaders and congregants were recognized
179 as influential figures capable of swaying the vaccination choices of individuals who had previously been
180 hesitant.[22]

181
182 Evidence-Based Strategies to Address the Problem

183 The intersection of the faith-based and public health sectors encompasses recent initiatives and long-
184 standing intersectoral relationships. “Around the world, faith-based organizations...engage in a wide
185 variety of activities related to development, ranging from health and educational services, disaster relief
186 and financial aid to conflict resolution, social justice activism, human rights advocacy and women’s
187 empowerment. They contribute—both indirectly and directly—to the promotion and implementation of
188 the Sustainable Development Goals. Some of the world’s largest development and humanitarian NGOs
189 are faith-based. In many parts of the world, FBOs make up a substantial part of civil society. FBOs act
190 both as service providers and actors of governance in their own right, participating in dialogue processes
191 with bilateral and multilateral actors.”[23] Studies have demonstrated the broad opportunities for faith-
192 based organizations and communities to drive public health policy and action to promote public
193 health.[24] This is achievable because FBOs have established their values and demonstrated their worth
194 in secular practice while adapting to market forces.[25] Despite the recognized value of faith-based
195 organizations, they remain largely underutilized across the public health spectrum, resulting in limited
196 systematic reviews of effectiveness for areas of public health concern such as vaccine uptake. A
197 systematic review of articles examining faith-based activities revealed that while only approximately 7%
198 of these articles reported specific outcomes linked to interventions, the comprehensive data set indicated
199 that faith-based activities had beneficial impacts on health outcomes. These impacts included
200 improvements in screening and behavioral changes, reductions in risk factors associated with diseases,
201 and a substantial increase in knowledge about various diseases.[26]

202

20231 Partnering with Faith-Based Organizations to Improve Public Health and Vaccination Equity

203 Below is an overview of literature and strategies being leveraged to support COVID-19 vaccination that
204 can and should be maximized and sustained to support routine vaccination. Engaging with FBOs is
205 particularly critical in addressing traditionally underserved, marginalized, and difficult-to-reach
206 populations.

207
208 Demonstrated evidence of the role of FBOs and faith-based engagement in improving vaccine uptake: It
209 is important to note that evidence-based strategies for faith-based intervention should be culturally
210 sensitive and informed by nuances in underlying beliefs and reasons for vaccine hesitancy, which vary
211 among and within communities and religious affiliations. Many contexts, faith groups, and geographical
212 areas have been understudied (e.g., Latin America, Asia-Pacific, Eastern Europe).[4] Specifically, on-site
213 vaccination efforts have been found most effective. Another effective strategy is providing education to
214 increase awareness and cross-sector collaboration with other entities, including the government.[4]

215
216 One study demonstrated the value of partnering with FBOs to increase influenza vaccination uptake in
217 difficult-to-reach populations. This study examined the impact of a national collaboration including the
218 Interfaith Health Program at Emory University, the Department of Health and Human Services
219 Partnership Center, the Centers for Disease Control and Prevention (CDC), and the Association of State
220 and Territorial Health Officials to bring together capabilities of local public health, health care, and faith-
221 based organizations in 10 communities around the country. It found that such collaborations were able to
222 more effectively communicate both vertically and horizontally across key partners and community
223 members and were able to build demand for vaccinations.[27] Although national collaboration with FBOs
224 was strong during the H1N1 pandemic, resulting in high vaccine demand, challenges remained with
225 respect to vaccine supplies, access, and delivery.

226
227 A 2019 study examined how collaboration of the CDC with FBOs played a key role in the response to
228 pandemic influenza (2009), Ebola (2014), and Zika (2016). In this study, the Minnesota Immunization
229 Networking Initiative (MINI) conducted vaccination clinics at various places of worship, including
230 churches, a Hindu temple, mosques, and a Buddhist monastery, and provided free influenza vaccinations.
231 The results showed that the collaboration of MINI with various FBOs to provide underserved
232 communities with influenza vaccinations helped address barriers to vaccination such as access, hesitancy,
233 and transportation.[10] Similarly, a 2006 study revealed that use of faith-based health centers was
234 effective in increasing rates of influenza vaccination among high-risk children living in the inner city.[28]

235

20231 Partnering with Faith-Based Organizations to Improve Public Health and Vaccination Equity

236 Engaging FBOs and leveraging faith-based engagement has also proven to be a successful strategy in
237 improving community education and building awareness of the value of vaccines and vaccination uptake
238 from the individual to the community and societal levels.[4] For example, a 2007 study examined the
239 effectiveness of an FBO adult vaccination program in minority communities. In the study, 15 churches
240 were randomized to intervention with on-site adult vaccinations or to comparison with no vaccinations.
241 Eligible participants were previously unvaccinated and 65 years or older and had a clinical indication for
242 vaccination. Baseline and follow-up surveys were conducted to assess vaccination status. The study
243 showed higher vaccination rates when on-site vaccinations were offered in FBOs than when education-
244 only vaccination promotion programs took place.[29]

245
246 Similarly, a 2021 study examined beliefs and perceptions around HPV vaccination with leaders and
247 members of an African Methodist Episcopal church in metropolitan Atlanta, Georgia, from April to July
248 2018. This study uncovered deeply rooted mistrust in the health care system as well as a low perceived
249 risk of HPV due to the expectation of abstinence among adolescents. Furthermore, the study discussed
250 that because church leaders hold the trust of their congregation, implementation of a church-based
251 intervention utilizing the social and behavior change communication conceptual framework strategies had
252 considerable potential to transform perceptions of the HPV vaccine and increase vaccine uptake.[30]

253
254 Documented promising practices involving FBOs and faith-based engagement to promote COVID-19
255 vaccine uptake that can be leveraged to support routine vaccination efforts: The COVID-19 pandemic
256 accelerated the inclusion and further illustrated the vital role of faith and community organizations in
257 helping to champion COVID-19 vaccination efforts.

258
259 For example, during the COVID-19 pandemic, a synagogue in North Carolina proactively reached out to
260 local provider and county health authorities to explore the possibility of using its building and
261 congregational resources to operate a neighborhood-based vaccination site.[31] Similarly, a large health
262 system in Miami, Jackson Memorial Health System, partnered with a number of churches, synagogues,
263 and mosques in Miami-Dade County to vaccinate individuals 65 years and older. This partnership enabled
264 addressing the unmet need of reaching underserved populations and doubled the local vaccination rate
265 among Black older adults within just a week.

266
267 In addition, the Compassion Care Network vaccinated more than 200 people in 4 hours in a Chicago
268 mosque, drawing from interfaith and various underserved communities throughout Chicago.[32] Along
269 with hosting vaccination sites, faith-based organizations can also enable access by assisting their members

20231 Partnering with Faith-Based Organizations to Improve Public Health and Vaccination Equity

270 in navigating what can be a complex process to secure vaccination appointments and services. For
271 example, one town in Greenburgh, New York, developed a COVID volunteer program where the
272 volunteer “angels” were trained to reach out to seniors and help them through the vaccination process.[33]
273 Another study in the United States involved academic hospitals engaging FBOs through meetings to
274 communicate information about the COVID-19 pandemic and the role FBOs can play in mitigating the
275 impact of the pandemic on communities. The study showed that medical-religious partnerships are
276 practical and valuable in minimizing the impact of COVID-19-related disparities.[34]

277
278 Similar strategies have emerged globally. A 2022 case study examining the strengths of Indonesia’s two
279 largest Islamic FBOs and the challenges faced while conducting activities to mitigate the impact of
280 COVID-19 in Indonesia revealed that the collaboration of FBOs with the government aids in the
281 mobilization of resources to help reduce the impact of COVID-19.[35] Also, the Catholic Sisters COVID-
282 19 Vaccine Ambassadors Campaign was launched by the Association of Religious in Uganda in
283 November 2021.[36] The overall aim of this campaign was to encourage vaccine uptake by dispelling
284 myths surrounding the effects of the COVID-19 vaccine. The campaign used methods such as a radio
285 show, in-person interactions, and flyers to engage individuals across the country. Prior to the launch of
286 the campaign, a mere 5% of Ugandans had received the COVID-19 vaccine. Within 6 months of the
287 launch of the campaign, the proportion of individuals vaccinated with at least one dose rose to 38%, and
288 30% had received both doses.

289
290 Similarly, a Pew Research Center report published in October 2021 showed that 39% of U.S. adults
291 attending religious services in person at least once a month reported that religious leaders at their places
292 of worship emphasized the importance of getting the COVID-19 vaccine, while only 5% reported their
293 religious leaders discouraged getting the vaccine.[37] It should be noted that 54% of survey respondents
294 reported that their religious leaders did not take a stance on the vaccine. According to another survey
295 conducted by the Pew Research Center in September 2021, 61% of U.S. adults who attend religious
296 services monthly reported having at least a fair amount of confidence in religious leaders’ guidance on
297 getting the COVID-19 vaccine. This percentage was the second highest after the guidance of adults’
298 primary care doctors (84%). The most encouraging aspect is that this report was not limited to one
299 religion.[37]

300
301 The Jerusalem Impact Vaccination Initiative (JIVI), composed of public health professionals and religious
302 leaders, seeks to encourage immunization via use of tailored messages to mitigate the impact of future
303 pandemics. JIVI’s efforts in increasing COVID-19 vaccination uptake at the intersection of faith and

20231 Partnering with Faith-Based Organizations to Improve Public Health and Vaccination Equity

304 medicine have been met with success and have even been recognized by the current president of Israel,
305 Isaac Herzog. Furthermore, JIVI is working globally; for example, in sub-Saharan Africa, the initiative is
306 supporting public health and religious collaborations at the city level to increase vaccination uptake.[38]

307
308 Advocacy to improve COVID-19 vaccine uptake has been at the highest levels of religious leadership
309 globally: Pope Francis stated that getting vaccinated against the coronavirus was a “moral obligation” and
310 denounced how people had been swayed by “baseless information” to refuse one of the most effective
311 measures to save lives.[39] The Chief Rabbis of Israel advocated repeatedly for vaccine uptake and also
312 proactively suspended a rabbinical judge for refusing the COVID-19 vaccine. The National Spiritual
313 Assembly of the Bahá’í in the United States assured followers that “Bahá’í writings would not provide
314 any justification for refusing to comply with such a legal requirement [as vaccination].”[40] The president
315 of the Universal Society of Hinduism advocated that “[we] do all we can possibly do to curb COVID-
316 19.”[41] According to the archbishop of Canterbury, “Go and get vaccinated; it’s how we love our
317 neighbor”.[42] Finally, an interfaith joint call of all religious leaders in Jerusalem on vaccination and
318 resilience serves as an example of unity in advocacy and action of faith leadership in promoting
319 vaccination globally.[43]

320
321 During the COVID-19 pandemic, FBOs continued to play a critical role as trusted messengers in
322 supporting education and outreach within communities to address hesitancy. There was also demonstrated
323 success with faith-based communities inviting local health care professionals to speak to their community
324 to address concerns, myths, and misconceptions related to vaccines and vaccination. For example, BAPS
325 Charities recorded “North America - COVID-19 Vaccine Myths, Facts, FAQs,” a webinar featuring three
326 infectious disease and vaccine experts from its faith community.[44]

327
328 Recognizing the public health imperative of increasing COVID-19 vaccine uptake to help end the
329 pandemic, the Muslim community formed the National Muslim Task Force for COVID-19. This task
330 force held intersectoral discussions with Muslim medical, religious, and public health leaders to better
331 understand the need for vaccines and religious obligations under these circumstances. One such action the
332 task force undertook was hosting a conversation on COVID-19 with Anthony Fauci and experts from the
333 Muslim community to help build COVID-19 vaccination confidence.[45]

334
335 Opposing Arguments/Evidence

336 In reference to the value of FBOs and faith-based engagement to support vaccination uptake, limited
337 evidence exists to refute their value, and of that evidence is mainstream media and opinion based as

20231 Partnering with Faith-Based Organizations to Improve Public Health and Vaccination Equity

338 opposed to deriving from the peer-reviewed literature. One-off opposition has been quoted to suggest that
339 religious leaders could be disruptive to COVID-19 vaccination efforts; some faith leaders have opposed
340 COVID-19 vaccination, arguing that there is no need to prevent what God will fix.[46,47] One study from
341 the Netherlands did reveal that use of FBOs to promote vaccination efforts in that country might not be
342 the most effective strategy for two reasons: Protestant religious leaders are not willing to promote
343 vaccination, and overall there is a low level of religiosity in the general population.[48] In addition, in a
344 recent poll assessing the faith of Americans in the country's societal institutions, organized religion was
345 among the top-rated institutions but with a low confidence rating of 32%.[49] These factors could
346 potentially decrease the uptake of services provided by faith-based organizations and have a negative
347 impact on anticipated health outcomes. This, however, does not negate the value of engaging FBOs and
348 religious leaders who are willing to support vaccination efforts and enabling them to engage in informed
349 discussions with their communities.

350

351 Action Steps

352 For decades, religious institutions and faith-based organizations have been integral to the success of many
353 health promotion and disease prevention programs, and they have been known for their capacity to reach
354 underserved and low-income populations. Recently, faith-based engagement has been regarded as critical
355 in improving vaccine uptake, improving vaccination confidence, and reducing vaccination disparities. On
356 this basis, APHA:

- 357 • Urges government bodies from the local to federal levels to engage proactively with FBOs as
358 critical thought partners in supporting routine vaccination efforts to enhance people's trust in
359 public health and vaccination, better prepare for the next pandemic, and enable FBOs' capacity to
360 deliver health programming and routine vaccinations.
- 361 • Urges government bodies such as the Centers for Disease Control and Prevention to expand
362 eligibility of grant and funding opportunities to FBOs to support routine vaccination efforts
363 through their outreach channels.
- 364 • Calls on the broader vaccination community, including but not limited to local, state, national,
365 and global organizations and immunization coalitions and partnerships, to inform strategic
366 decision-making and implementation efforts to support vaccination using FBOs.
- 367 • Calls on the Centers for Disease Control and Prevention to gather evidence and incorporate
368 engagement with FBOs within the CDC Community Guide as a strategy to support routine
369 vaccination efforts.
- 370 • Calls on the Centers for Disease Control and Prevention to release a routine vaccination "Call to
371 Action" that encourages, in part, state and local partnership with FBOs and other community-

20231 Partnering with Faith-Based Organizations to Improve Public Health and Vaccination Equity

372 based organizations as convenient and trusted vaccination sites and messengers as a strategy to
373 support routine vaccination recovery.

- 374 • Calls on state and local governments to partner with FBOs to lead vaccination education
375 campaigns and back-to-school vaccination efforts.
- 376 • Calls on U.S. government leaders and international government leaders to establish training
377 opportunities, as they relate to vaccination, to capacitate FBOs to engage with their communities
378 effectively.
- 379 • Urges the United States to host a roundtable forum of FBO key partners to commit to and elevate
380 best practices that support cancer prevention through vaccination as part of the Biden Cancer
381 Moonshot initiative.
- 382 • Urges national and international governmental leaders, including the World Health Organization,
383 to host public roundtables with FBO leaders to elevate best practices that supported COVID-19
384 vaccination and discuss paths forward for extending these or similar efforts to routine vaccination
385 across the life course.

386 Finally, APHA promotes a call to action for continued FBO collaboration with governments in terms of
387 not only vaccinations but broader public health, education, human rights, and social justice initiatives.

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