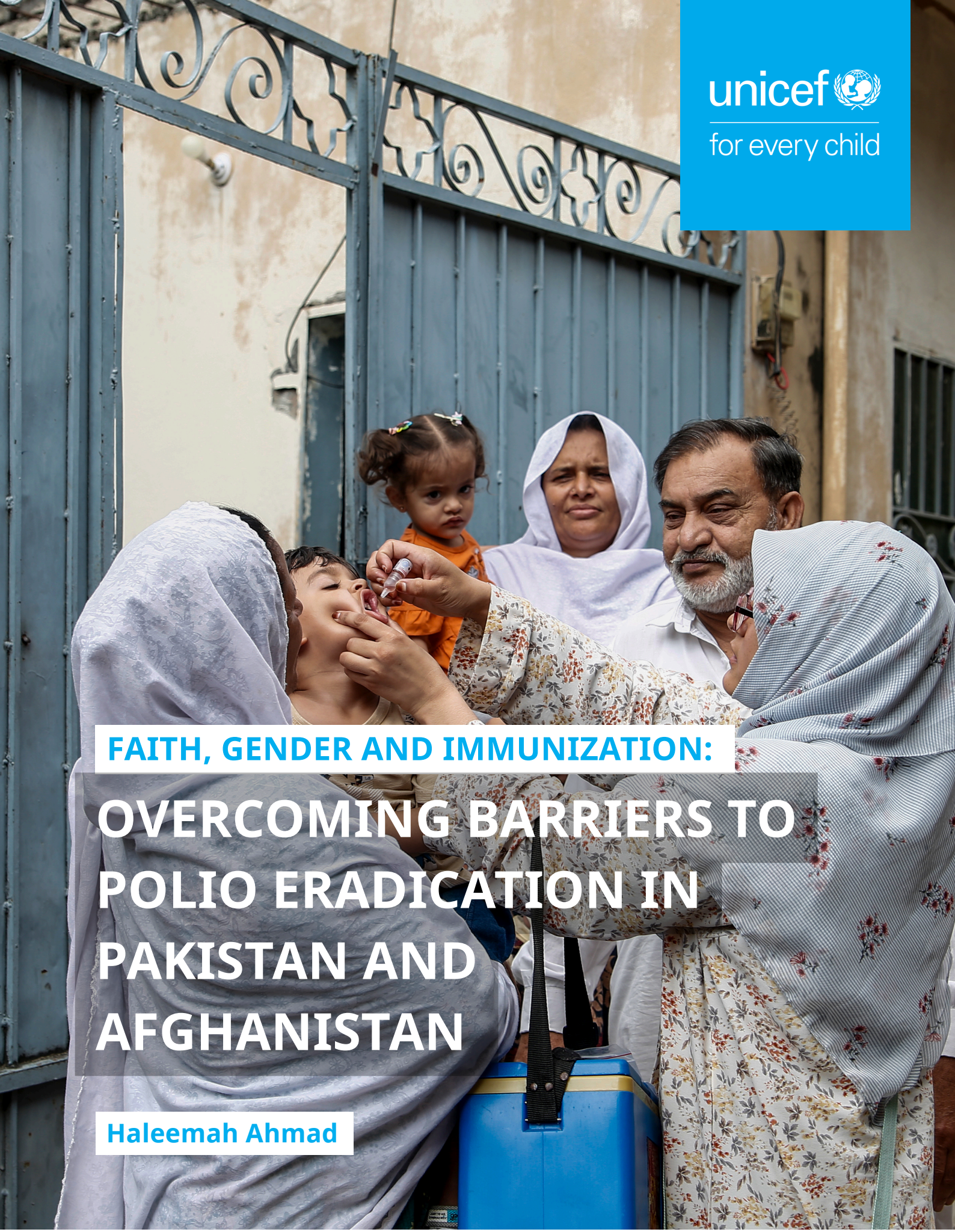

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FAITH, GENDER AND IMMUNIZATION:

OVERCOMING BARRIERS TO POLIO ERADICATION IN PAKISTAN AND AFGHANISTAN

Haleemah Ahmad

Joint Learning Initiative on Faith & Local Communities

Religions *for* Peace

FAITH AND POSITIVE CHANGE FOR CHILDREN, FAMILIES AND COMMUNITIES

The evidence brief, "*Faith, Gender and Immunization: Overcoming Barriers to Polio Eradication in Pakistan and Afghanistan*", was commissioned by the UNICEF Regional Office for South Asia (ROSA) through the Joint Learning Initiative for Faith and Local Communities (JLI), and authored by Haleemah Oladamade Ahmad, Consultant Faith and Development Specialist.

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FAITH, GENDER AND IMMUNIZATION:

Overcoming Barriers to Polio Eradication in Pakistan and Afghanistan

Haleemah Ahmad

January 2026

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Lastly, we are grateful to all frontline workers and stakeholders working diligently with dignity and perseverance to help achieve global polio eradication and strengthen routine vaccination.

ACRONYMS

CDC – Centers for Disease Control and Prevention
CHW – Community Health Worker
EPI - Expanded Programme on Immunization
FFLWs – Female Frontline workers
FLWs – Frontline workers
FPCC – Faith and Positive Change for Children, Families, and Communities
GPEI - Global Polio Eradication Initiative
IPV – Inactivated Polio Vaccine
JLI – Joint Learning Initiative on Faith and Local Communities
OPV – Oral Polio Vaccine
PBUH – Peace Be Upon Him (salutation said or written after the name of Prophet Muhammad is mentioned or written)
RA – May Allah be pleased with him (title of respect used for companions of the Prophet (PBUH)
RfP – Religions for Peace
UNICEF – United Nations Children's Fund
WHO – World Health Organization
WPV1- Wild Poliovirus Type 1

Executive Summary

Poliomyelitis, commonly known as polio, remains a critical public health challenge in Pakistan and Afghanistan, the only two countries where wild poliovirus type 1 (WPV1) continues to circulate. Despite substantial global progress since the launch of the Global Polio Eradication Initiative (GPEI) in 1988, recent epidemiological trends, including the resurgence of WPV1 cases and positive environmental samples, underscore the fragility of eradication gains in both countries. Evidence indicates that the remaining barriers to polio eradication are not primarily technical or biomedical, but are rooted in social, gendered, religious, and structural factors that influence trust, access to services and household decision-making.

This evidence brief examines how faith, gender norms, and intersecting vulnerabilities shape immunization outcomes in Pakistan and Afghanistan. Drawing on a targeted review of academic and grey literature, national consultations, and insights from a regional dissemination dialogue convened with UNICEF and partners, the analysis explores why immunization efforts continue to miss children despite repeated campaigns, extensive surveillance systems and significant investments.

Key findings from the research indicate that:

Immunization gaps are produced by intersecting inequities, not single barriers

Children are most likely to be missed where multiple disadvantages overlap, including poverty, displacement, insecurity, disability, and restrictions on women's mobility. Evidence from both countries shows that inflexible or site-based delivery approaches disproportionately exclude households facing compounded vulnerabilities, indicating that uniform campaign models are insufficient in these settings.

Women are central to childhood immunization outcomes but face layered constraints limiting their agency

Across Pakistan and Afghanistan, women carry the primary responsibility for childcare and health, yet their ability to act is often constrained by restricted mobility, limited decision-making power within households, and unequal access to trusted information. These constraints are intensified in contexts of poverty, displacement, insecurity, and disability, where caregivers face additional logistical and social barriers to access vaccination services. Hence, immunization programmes must account for women's lived realities and systematically include strategies to reach women who are otherwise excluded.

Faith is a critical system of trust, legitimacy and moral authority shaping immunization acceptance

Faith consistently emerges in the evidence as a significant determinant of immunization acceptance and access. Religious beliefs and leadership shape social norms, influence household decision-making, and mediate trust between communities and health systems, particularly in contexts marked by insecurity, political marginalization, and low confidence in state or international actors. When misinformation and mistrust go unaddressed, religious authority can reinforce resistance. Conversely, sustained engagement with locally trusted religious leaders and institutions can strengthen acceptance and legitimacy. The analysis shows that Islamic ethical principles related to the preservation of life, prevention of harm, parental responsibility, and collective duty provide a strong moral foundation for vaccination when translated into locally grounded narratives. Faith engagement in immunization efforts is most effective when it is institutionalized, relationship-based and embedded within immunization systems, rather than treated as a stand-alone communication or short-term advocacy intervention.

Female frontline health workers are indispensable to immunization delivery but remain highly exposed

Female frontline workers (FFLWs) are indispensable in reaching households, building trust with caregivers, and navigating conservative social norms. However, they face heightened security risks, inconsistent institutional support, and restrictions that undermine their safety, legitimacy and retention. Areas where FFLWs are constrained or withdrawn showed greater difficulty sustaining immunization coverage.

Immunization is more effective when framed as a shared social and moral responsibility rather than a stand-alone campaign activity

Evidence indicates that vaccination outcomes improved when immunization was integrated with broader maternal and child health services, grounded in faith-consistent narratives of care and responsibility, and delivered through trusted local systems. Approaches that reduce community fatigue and restore dignity and trust are more likely to sustain coverage in high-risk settings. Creative, future-oriented strategies include bundling polio vaccination with routine maternal and child health services, institutionalizing faith–health partnerships, elevating women's roles through culturally legitimate pathways, and redesigning delivery models to reduce community fatigue while restoring dignity and trust.

Building on evidence, consultations, and a regional dialogue, this evidence brief advances **six interlinked**, strategic recommendations to support polio eradication in Pakistan and Afghanistan:

- **Institutionalize faith engagement** by embedding sustained partnerships with locally trusted religious leaders, scholars, and faith-based networks as a core component of immunization strategies rather than as a stand-alone intervention.
- **Enable and legitimize the roles of women and girls** by addressing constraints on mobility and decision-making, protecting and professionalizing female frontline health workers, and reinforcing these roles through faith-consistent narratives of care and responsibility.
- **Strengthen and protect the female frontline workforce** as a critical bridge to households and communities, recognizing their safety, legitimacy, and retention as decisive factors in sustaining access to children for vaccination and immunization coverage.
- **Reduce community fatigue** by shifting from narrowly focused, repeated polio campaigns towards integrated, dignified delivery of polio vaccination alongside maternal, child health and basic services.
- **Rebuild trust and strengthen information ecosystems** through locally tailored, faith-sensitive communication delivered by trusted community and religious actors, supported by timely, credible information.
- **Address intersecting vulnerabilities** by designing adaptive strategies that respond to overlapping challenges related to poverty, displacement, disability, insecurity, and constrained caregiving environments.

This evidence brief is organized in eight sections to show how faith, gender, and social dynamics intersect to shape immunization outcomes in Pakistan and Afghanistan.

Following this Executive Summary,

- the **Introduction** and **Context** sections (sections 1.0 & 2.0 respectively) outline the epidemiological landscape and programme environment in Pakistan and Afghanistan.
- the **Methodology Approach** (section 3.0) describes the evidence review, national consultations, and regional dialogue underpinning the analysis.
- the subsequent chapter, **Key Barriers to Immunization** (section 4.0), examines key barriers to immunization, including structural and security constraints, social and

behavioural dynamics, gender norms, and household decision-making. This section also highlights the importance of gender transformative programming and equity to advance polio eradication (4.3 Gender Norms, Power and Household Decision-Making).

- the following chapter, **Faith, Trust and Leadership in Immunization Systems** (section 5.0), builds on section 4.0, applying a gender lens to examine the relationship between religion and vaccine hesitancy, as well as faith-based principles that support immunization, including the role of religious leadership, ethical considerations, and global declarations. This section provides important findings from the formative research on faith-based support for women and girls, and on the importance of female frontline health workers among other issues.

- sections 4.0 and 5.0 provide important, complementary religious arguments, including examples of declarations and principles to counter misconception. These sections advocate for strengthening religious leaders' continuous engagement to provide accurate information about the polio vaccine and encourage vaccine acceptance based on religious doctrines. Religious leaders and polio program officials can use the content in sections 4.0 and 5.0 during religious meetings and individual or group discussions, including to develop messages "Addressing Common Misconceptions about Vaccination" (section 5.6).

- section 6.0 includes comparative case studies from **India and Nigeria**, offering important lessons on social and behaviour change implementation strategies and what works. However, the approaches need to be adapted to the local context in Pakistan and Afghanistan. A three-pronged approach to contextualize, co-create, and continue engagement is included in this section for consideration.

- the discussion sections (sections 7.0 and 8.0) synthesize findings from the desk review, country consultations, and the regional webinar, including perspectives from UNICEF Pakistan and the Afghanistan Country Offices, before concluding with strategic recommendations organized around six pillars to inform policy, programming, and partnership approaches for sustained polio eradication. The two sections: **Discussion: Insights from Evidence, National and Regional Dialogue** (section 7.0) and the **Strategic Recommendations** (section 8.0) will be of particular interest to readers engaged in high-level advocacy, developing policy messages and briefing notes.

We hope you find this evidence brief titled, "***Faith, Gender and Immunization: Overcoming Barriers to Polio Eradication in Pakistan and Afghanistan***", thought provoking and its rich resources useful as you work to halt polio.

CHAPTER 1

Introduction

Poliomyelitis, or polio, is a life-threatening disease that primarily targets children under five, causing paralysis or death in severe cases. It spreads through the fecal-oral route, often via contaminated food or water. Although incurable, it is preventable through vaccination. Since the launch of the Global Polio Eradication Initiative (GPEI) in 1988, spearheaded by global organizations like WHO, UNICEF, and Rotary International, polio cases worldwide have declined by 99 per cent.[1] However, wild poliovirus type 1 (WPV1) remains endemic in Afghanistan and Pakistan.[2]

Pakistan and Afghanistan are epidemiologically linked through population movement, their shared borders, and the interconnected social and economic systems in both countries.[3] Cross-border mobility, including seasonal labour migration, displacement due to conflict or climate-related shocks, and informal travel, facilitates the transmission of viruses across their national boundaries. As a result, progress in one country is highly vulnerable to setbacks in the other. This interdependence means eradication cannot be achieved through isolated national strategies alone but requires socially coherent, regionally aligned approaches, trusted at the community level on both sides of the border.

Immunization is one of the most successful and cost-effective public health interventions, potentially saving millions of lives annually. Polio cannot be cured but can be prevented. It

requires multiple vaccination doses to achieve full immunity, and despite concerted efforts, many children remain susceptible to the virus due to them either never having received a vaccination or having received an incomplete course of the vaccination. Both Pakistan and Afghanistan are part of the 10 countries worldwide with the highest number of unvaccinated children.[4] Afghanistan and Pakistan have the second and third highest number of unvaccinated children in South Asia, with 467,000 and 396,000 zero-dose children in 2023, respectively.[5] Even if children are vaccinated in both countries, many do not complete the required number of vaccine doses, leaving them susceptible to the poliovirus. For example, about 1 million children in Pakistan missed their polio vaccinations in September 2024.[6]

While technical tools such as improved surveillance, refined microplanning, and repeated vaccination campaigns remain essential, evidence increasingly shows they are insufficient on their own to reach the last remaining pockets of transmission. Persistent immunization gaps are not primarily the result of vaccine supply constraints or lack of biomedical knowledge, but because of barriers rooted in trust, access, authority, and everyday lived realities. In communities where insecurity, political marginalization, or service fatigue are prevalent, repeated campaigns without corresponding social engagement can deepen rather than resolve resistance.

The following sections further unpack the immunization context across both Pakistan and Afghanistan, especially in section 5.0, **Faith, Trust and Leadership in Immunization Systems**.

CHAPTER 2

Context

With the launch of the Global Polio Eradication Program (GPEI) in 1988, the world has achieved tremendous progress towards overcoming poliomyelitis, successfully reducing cases by nearly 99 per cent worldwide. The goal to eradicate polio by the end of 2023, making it the second disease to be eradicated worldwide, after smallpox, has not yet been achieved, however, as the wild poliovirus (WPV1) remains endemic in Pakistan and Afghanistan.[7]

Polio Cases in Pakistan and Afghanistan

In 2024, there were a total of 99 cases of WPV1 globally, with Pakistan recording 74 and Afghanistan reporting 25 cases. The affected provinces in Pakistan were Balochistan with 27 cases, Sindh with 23 cases, Khyber Pakhtunkhwa with 22 cases, and Punjab and Islamabad with one case each. The affected provinces in Afghanistan were Kandahar with 14 cases, Hilmand with 7 cases, Uruzgan with 2 cases, and Nuristan and Kunar with one case each.[8] In 2025, there were a total of 40 WPV1 cases, with Pakistan recording 31 and Afghanistan reporting 9 cases. The affected provinces in Pakistan were Khyber Pakhtunkhwa with 20 cases, Sindh with 9 cases, and Punjab and Gilgit-Baltistan with 1 case each.[9] In Afghanistan, 1 case each was reported in Uruzgan, Badghis, Nuristan, and Farah provinces, with 2 in Paktika and 3 in Helmand provinces.[10] Notably, most of the newly infected provinces from 2024 onwards had not reported WPV1 cases in recent

years, raising concerns of an outbreak.[11] In fact, the 11th case recorded in Pakistan in 2025 originated in the Diamer district in the Gilgit-Baltistan region, which had not reported any polio cases in seven years.[12]

WPV1-positive environmental samples have continued to surge across both countries. Pakistan reported 126 detections in 2023 and 628 detections in 2024. Conversely, Afghanistan reported 62 detections in 2023 and 113 detections in 2024. In 2025, Afghanistan reported 64 positive samples, while Pakistan reported 651, totaling 715 WPV1-positive environmental samples.[13] These numbers raise concerns about the virus's persistence and spread in both countries, underscoring the need for strengthened eradication efforts in vulnerable regions. The affected provinces in Pakistan include Balochistan, Punjab, Khyber Pakhtunkhwa, Sindh and Islamabad. In Afghanistan, the affected provinces are Kandahar, Nangarhar, Kabul, Helmand and Herat.[14]

A Snapshot of Pakistan's Polio Eradication Programme Context

Since 1994, Pakistan's polio eradication programme has achieved a 99 per cent reduction in polio cases from the 20,000 reported in the early 1990s. This success stems from annual vaccination drives involving over 400,000 health workers delivering vaccines door-to-door and conducting rigorous surveillance to track and contain the virus. In 2024, the programme conducted three nationwide campaigns and eight regional rounds, vaccinating 45 million children under the age of five. Health workers have also offered vaccinations at key transit points, such as borders and highways, to curb the spread of the virus.[15] In 2025, Pakistan conducted five large-scale national week-long door-to-door vaccination campaigns successfully targeting 45 million children throughout February, April, May, October and December.[16]

PAKISTAN

CONTEXT SNAPSHOT

Polio Cases

- 2024 - 74
- 2025 (up to October 30, 2025) - 30
- Affected Areas - Khyber Pakhtunkhwa (19), Sindh (9), Punjab (1), Gilgit-Baltistan (1)
- Balochistan: 27 cases in 2024 - 0 in 2025
- Gilgit-Baltistan: First case since 2017
- WV1-positive samples: 2023 (126), 2024 (628), 2025 TD (513)
- Provinces: All major regions above, including Islamabad and Balochistan

Efforts

- Rigorous AFP + environmental surveillance
- Transit point vaccinations (borders, highways)
- Four national door-to-door campaigns in 2025 (Feb, Apr, May, Oct)

Expanded access + aggressive surveillance are stabilizing gains.

Afghanistan's Polio Eradication Programme Context

Afghanistan continues its battle against polio, overcoming significant challenges. In 2024, the country held two nationwide and four regional vaccination campaigns, reintroducing door-to-door vaccination for the first time in five years. Vaccination efforts were temporarily suspended in September 2024 due to security concerns and restrictions on women vaccinators,[17] but resumed in December 2024, targeting 4.8 million children across 11 provinces.[18] Since late 2024, the campaign modality in Afghanistan has shifted from a house-to-house vaccination strategy to a site-to-site approach, where caregivers bring their children to designated vaccination sites to receive polio drops. This change has introduced new challenges, particularly around ensuring high coverage in hard-to-reach communities. Nevertheless, the Afghanistan polio eradication programme continues to adapt and innovate to protect every child. In 2025, the country conducted three nationwide polio vaccination campaigns in April, May and December, immunizing over 11 million children under five.[19] These national efforts followed earlier subnational campaigns in January and February, which focused on high-risk areas in the eastern, southeastern, and southern regions of Afghanistan.[20] The country also organized several regional polio campaigns throughout 2025.

AFGHANISTAN — **CONTEXT SNAPSHOT**

Polio Cases

- 2024 - 25
- 2025 (up to October 30, 2025) - 9
- Affected Provinces - Helmand (3), Paktika (2), Uruzgan (1), Badghis(1), Nuristan (1), Farah (1)
- WPV1-positive samples: 2023 (62), 2024 (113), 2025 YTD (64)
- Provinces: Kandahar, Nangarhar, Kabul, Helmand, Herat

Efforts

- National, sub-national, and regional vaccination campaigns
- Door-to-door vaccination was introduced in early 2024 but stopped in September 2024
- Currently uses a site-to-site vaccination approach

Sustained gains despite the challenges

CHAPTER 3

Methodological Approach

The evidence brief adopts a mixed qualitative approach that combines evidence synthesis with consultative validation to examine how faith, social norms, and structural conditions shape immunization outcomes across Pakistan and Afghanistan. The methodology was designed to review not only what is known, but also to test, refine, and contextualize evidence through engagement with religious leaders, practitioners, and policy stakeholders operating at national and regional levels.

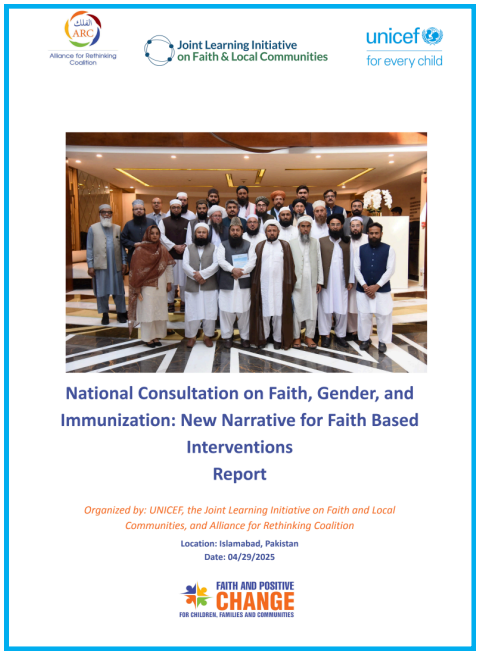
Evidence Review

The analysis draws on a targeted desk review of peer-reviewed literature, policy documents, programme evaluations, and grey literature published between 2013 and 2025. Sources were identified through academic databases, including PubMed, Scopus, and Google Scholar, as well as institutional repositories such as those of UNICEF, WHO, GPEI and faith-based development organizations. Priority was given to studies and programme documentation addressing immunization, faith engagement, women's roles in caregiving and service delivery, and social barriers to access in Pakistan, Afghanistan and comparable contexts.

In addition to country-specific evidence, the review examined documented experiences from India and Nigeria, two countries that previously faced significant resistance to polio vaccination and have since achieved eradication. These cases were selected to identify

transferable principles related to faith engagement, community trust, and service delivery, while recognizing the need for contextual adaptation rather than replication.

National Consultations



To ground the evidence in lived realities and programme experience, national consultations were conducted in Pakistan and Afghanistan. These consultations brought together religious leaders, faith-based actors, and immunization stakeholders from high-risk areas to explore how religious beliefs, social norms, and household dynamics influence vaccination behaviours.

In Pakistan, discussions focused on the role of local imams, madrasa educators, and female religious scholars in shaping community perceptions of immunization, as well as the operational challenges women caregivers and female frontline health workers face. In Afghanistan, consultations involved religious authorities and community leaders operating under constrained political and social conditions, with a particular focus on mobility restrictions, shifts in vaccination modalities, and their implications for women's access to services.

The national consultations served as both a source of qualitative insight and a mechanism for validating the findings that emerged from the literature review. They also enabled the identification of context-specific opportunities for faith-consistent messaging and engagement.

> "Islam's vision of child protection complements international frameworks such as the Convention on the Rights of the Child (CRC) and the Sustainable Development Goals (SDGs), which call for universal child health and protection. By vaccinating children, Muslim communities fulfill both their religious duty and their global responsibility toward justice, equity, and compassion."

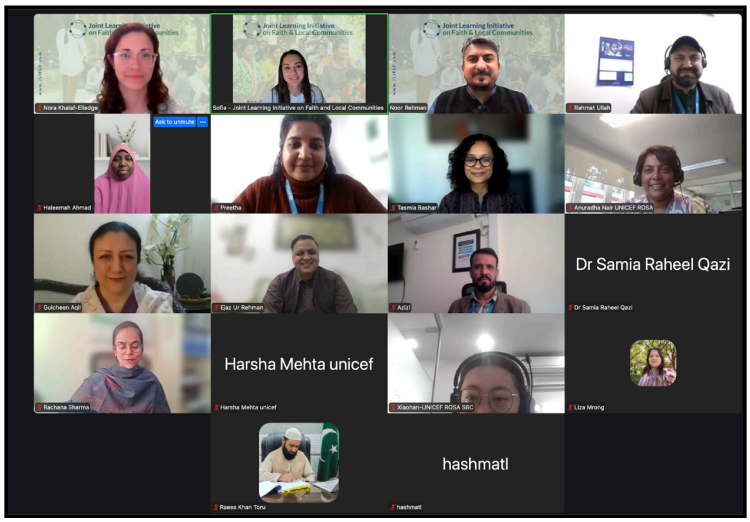
National Consultation on Faith, Gender and Immunization in Afghanistan: UNICEF, JLI, and other partners, Jalalabad, Afghanistan, 27th August 2025

> "Faith leaders in the consultation dismissed the false opposition between Islamic values and gender equity, insisting that women's participation in healthcare is founded in the religious teachings."

National Consultation on Faith, Gender and Immunization: New Narrative for Faith-Based Interventions; UNICEF, JLI, and ARC, Islamabad, Pakistan, 29th April 2025

Regional Dissemination and Multi-Stakeholder Dialogue

UNICEF, JLI and RfP convened a regional dissemination webinar, in conjunction with GPEI, WHO, faith actors, technical experts, and immunization partners, to further examine the findings from the evidence review and national consultations. The webinar created a space for cross-country learning and critical reflection, allowing stakeholders from Pakistan, Afghanistan, and the broader South Asia region to interrogate evidence, share programme experience, and highlight emerging challenges.



Discussions during the regional dialogue highlighted practical insights not always captured in written sources, including community fatigue, the operational risks female health workers face, and the importance of aligning faith engagement with visible improvements in service delivery. These insights were treated as an integral component of the analytical process, informing the interpretation of evidence and the development of strategic recommendations.

> **Insights from the Regional Dissemination Webinar on Faith, Gender & Immunization**
>
> "Participants reaffirmed the need for sustained collaboration, cross-border coordination between Pakistan and Afghanistan, and long-term investment in faith-based advocacy. The integration of gender-sensitive and faith-rooted strategies must move from pilot initiatives to formalized national frameworks."

> **Insights from the Regional Dissemination Webinar on Faith, Gender & Immunization**
>
> "Women continue to shoulder primary responsibility for child health while decision-making power may rest with male household members, who in some settings remain less engaged in immunization processes. These gender dynamics, when compounded by religious misconceptions and historical mistrust of public health initiatives, significantly undermine vaccine acceptance and access."

Limitations

While the methodology prioritizes contextual depth and relevance, the aim of the evidence brief is not to provide a comprehensive mapping of all immunization interventions in Pakistan and Afghanistan. Insights from the consultations and regional dialogue reflect the perspectives of participants and are intended to complement, not replace, quantitative surveillance data. Nevertheless, the triangulation of literature, the national consultations, and the regional dialogue provides a robust basis for the evidence brief's conclusions and recommendations.

CHAPTER 4

Key Barriers to Immunization

Evidence from Pakistan and Afghanistan indicates persistent gaps in immunization coverage are shaped by interrelated structural, social, gendered, and institutional barriers rather than isolated constraints. These barriers operate across household, community and system levels, influencing access, trust, and decision-making in ways that cannot be addressed through uniform or campaign-only approaches. Understanding how these barriers intersect is essential for designing immunization strategies that are responsive, equitable and sustainable.

4.1 Structural and Security Constraints

Geography and insecurity continue to shape who immunization services reach and who they miss. Even where vaccination services are technically available, distance, cost, and time burdens discourage caregivers from travelling to fixed sites.

4.1.1 Geographical Barriers

Geographical barriers to vaccine coverage manifest in two distinct ways. First, the physical inaccessibility of remote and hard-to-reach areas presents a significant challenge for immunization efforts. Factors such as difficult terrain, inadequate transportation infrastructure, and logistical constraints often hinder healthcare workers' ability to deliver vaccines to populations residing in these regions. These factors also exacerbate concerns about the safety of the polio vaccine, particularly in areas that are more difficult to access.

With frequent power outages, averaging eight hours of power interruptions per day owing to load-shedding, preserving the cold chain needed during vaccine storage and distribution may pose an issue, raising concerns about the quality, efficacy, and safety of polio vaccines administered in isolated rural areas and hard-to-reach communities.[21]

Second, even when immunization services are available, parental reluctance to travel long distances to health centres or vaccination sites further exacerbates low coverage rates. Their reluctance may stem from the financial and time-related burdens associated with travel, particularly in resource-limited settings where transportation options are scarce. Studies show that the caregivers of 18 per cent of children in Pakistan, whose children had less than three routine OPV doses, reported vaccination posts were too far away;[22] that children who lived further from the immunization facility were less likely to be vaccinated;[23] and the likelihood of missed vaccinations occurred among children whose mothers lack formal education, whose fathers are unemployed or are daily wage earners, and reside at a distance of more than two km from vaccination centres.[24] Similar results have been reported in Afghanistan, where health workers have implemented three main strategies to provide immunization services to children throughout the country: fixed (clients come to a health facility within 0.5–1-h walking distance), outreach (vaccinator goes to the field/village and returns on the same day), and mobile (vaccinator goes to the field and needs an overnight stay indicating a long distance). Parents reported that the factors motivating them to vaccinate their children included the convenience of proximity to a healthcare facility offering vaccines and the effective outreach efforts of vaccination programmes.[25]

4.1.2 Insecurity and Targeting of Polio Officials

Insecurity and targeted attacks on polio vaccination officials have severely undermined vaccine coverage in Pakistan and Afghanistan, preventing the consistent delivery of vaccines to at-risk populations. In conflict-affected areas, healthcare workers often face logistical challenges, movement restrictions, and security threats that impede immunization campaigns. The deliberate targeting of polio vaccinators by militant groups has further deterred both health workers and communities from participating in vaccination efforts.[26] In 2024, there were 27 attacks on polio workers in Pakistan's northwestern Khyber Pakhtunkhwa province alone. In September 2024, armed militants killed a police officer protecting a polio vaccination site in the northwest city of Bannu. In the northwest city of Bajaur, a police officer and a polio worker were killed in another shooting.[27] In October 2025, there were two attacks on polio vaccination teams, one in Upper Orakzai, Khyber Pakhtunkhwa province, that killed two policemen who were guarding vaccinators, and a bombing near a police security vehicle in Mastung, Balochistan, that killed nine people, including five children.[28] There have also been similar attacks on polio workers in Afghanistan.[29]

4.1.3 Displacement and Mobility

Another major challenge hindering vaccination efforts is population movement, as Pakistan and Afghanistan have considerable domestic and international migration.[30] Border-crossings between the two countries are often driven by medical treatment, a lack of economic opportunities, family ties, and security concerns. The scale of displacement increases the risk of cross-border poliovirus spread and spread within both countries. Both countries are currently managing and mitigating polio transmission within and across their borders through vaccination at border crossing points and updating micro-plans in the districts of origin and return.[31]

Given the current security situation in the region, increased cross-border movement, internal displacement, and refugee crises may exacerbate already heightened concerns for viral circulation. The population mobility in the region presents a key obstacle to reaching WPV1 eradication, as the dispersal of infected individuals has the potential to introduce the pathogen to many under-vaccinated communities. There is an urgent need for high-quality surveillance systems in all districts that can detect possible cases in a timely manner, as well as coordinated efforts between the two countries to enhance already existing data-sharing agreements and surveillance cooperation.[32]

4.2 Social and Community Barriers

Beyond access, community perceptions, historical experiences, and political contexts influence immunization efforts. Trust deficits also play a significant role. Scepticism towards government institutions, international actors and health authorities, often shaped by broader political marginalization, can spill over into vaccine resistance.

4.2.1 Parent/Caregiver Refusal and Community Boycotts

Parents, caregivers, and communities' acceptance or refusal of polio vaccination for their children is perhaps the most critical factor hindering full immunity against polio. Several individual, social, behavioural, and cultural factors, including gender norms, influence refusal patterns. Where people's perceptions and attitudes towards polio immunization are low, it is usually due to ignorance, a lack of confidence in healthcare authorities, including the government and international organizations, erroneous religious and cultural beliefs, misinformation and misunderstandings regarding the polio vaccination, persistent anti-vaccine rumours, and political tension. A recent study in Pakistan found that perceptions of religious conspiracies, beliefs among local people that governments used vaccinations as a tool for spying, and misconceptions about the side effects of vaccines correlated with a negative attitude towards polio vaccination efforts.[33] In some highly honour-sensitive communities throughout Pakistan, having the police appear at one's door is extremely embarrassing, and the government's use of the police to enforce polio vaccination has resulted in community backlash and recast polio vaccination as a political issue, influencing vaccine refusals and boycotts.[34]

A 2023 study evaluated the social-behavioural and cultural barriers and risk factors for polio vaccine, Routine Immunization (RI), or both in high-risk areas of poliovirus circulation in Pakistan. RI refusal was generally associated with illiteracy, fear of the vaccine's adverse effects, and the assumption that the polio vaccine caused infertility. The study found education substantially affected mothers' and families' acceptance of RI for their children under five, as a greater proportion of RI refusal cases (91.3 per cent) were identified among illiterate primary caregivers compared to the controls (76 per cent). The study also showed that some cases of vaccine refusal were due to adverse effects earlier reported, such as pain, discomfort, and fever following vaccination, misleading or incorrect information from mass media, friends or family having experienced unfavourable incidents, and a lack of knowledge regarding the role of vaccines in disease prevention. These reasons, coupled with false assumptions and doubts surrounding vaccines, caused fear and worry among parents.[35]

> "The consultation also emphasized the need for community engagement and education to dispel myths surrounding vaccines. It aimed to empower local leaders to advocate for immunization as a communal responsibility, reinforcing the idea that protecting children's health is a shared duty. By leveraging faith-based networks, the initiative sought to create a supportive environment for health interventions, ultimately striving for a healthier future for all children in Afghanistan."
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> **National Consultation on Faith, Gender and Immunization in Afghanistan: UNICEF, JLI, and other partners, Jalalabad, Afghanistan, 27th August 2025**

Several studies have highlighted misconceptions and misunderstandings about the polio vaccine as a barrier to higher vaccination rates, which is often tied to demographic, geopolitical and religious concerns. Demographic concerns were concentrated on the potential fertility effects of polio vaccines on increasing sterility; geopolitical anxieties regarding the genuine motive for vaccines, with concerns about a foreign agenda to shrink the Muslim population; as well as concerns that the polio campaign is part of a covert intelligence gathering plot.[36] Religious and societal views seemed to be the biggest obstacle to the disease's full elimination, with local religious groups condemning polio vaccine campaigns for various reasons, including the belief that vaccines contained substances forbidden by Islam and are an artificial alteration of the fate determined by God, especially when the vaccine recipient had not experienced the disease.[37]

Another cross-sectional study identified risk factors for vaccine hesitancy, including residing in rural areas, illiteracy, socioeconomic vulnerability, food insecurity, unemployment, concerns about vaccine safety, and failure to follow government guidelines. Conversely, participants who were university graduates, who believed in healthcare agencies, and who resided in urban areas were more likely to accept the polio vaccine. Young people appeared to be better informed than elderly individuals and were more likely to accept vaccines.[38] Similar factors have also been reported in Afghanistan.[39]

A study on Afghanistan reported factors such as a recognition of the crucial importance of vaccination, convenience of proximity to a healthcare facility offering vaccines, effective outreach efforts of vaccination programmes, and positive interactions with vaccinators as factors motivating parents to vaccinate their children. Parents of unvaccinated or under-vaccinated children reported unawareness, a lack of time, losing their children's vaccination cards, insecurity hampering access to health facilities for vaccination and wide time gaps between vaccinations, not having family permission (often defined as permission from fathers, grandfathers, or close family relatives), and health facility closures as factors contributing to their inability to access the vaccine or complete the vaccine dose schedule.[40] Other factors indicated to enhance vaccination rates included improved parental education and awareness, knowledge and understanding of vaccines, maternal empowerment, high socioeconomic conditions, proximity to immunization centres, and previous visits by health workers.[41] Finally, the vaccinator's status as a trusted 'insider' in the community, either through shared ethnicity, language, or community ties, can influence the decision of parents and other primary caregivers to accept or reject the vaccine. In rural settings, an insider was typically someone who was native to the area. In urban locales, however, an insider was often anyone who could speak the local language.[42]

4.2.2 Community Fatigue

A two-year study engaged frontline workers (FLWs) operating in 18 Super High-Risk Union Councils (SHRUCs) in Pakistan, utilizing a Human-Centered Design approach, to identify the most significant barriers they face conducting their work and suggest solutions to address the identified barriers. One major challenge identified was community fatigue due to numerous visits and data collection. During a single polio campaign, frontline healthcare workers visited every household multiple times, with many of these visits involving data collection but no service provision. Community members' perceived these repeated visits as an unnecessary invasion of their privacy and personal space, which increasingly led to refusals, as people grew tired of responding to numerous disruptions to their daily lives. The data healthcare workers requested during their household visits was also extensive, fuelling conspiracy theories that the polio programme was connected to police or international military operations.[43] As a consequence, parents, caregivers, and communities that had hitherto been receptive to the vaccine became resistant.

During polio campaigns, community members confronted FLWs with pleas for broader health services such as medicine, maternal health and nutrition services. FLWs referred families to government-run centres for these needs, which they could not provide. When families went to these centres, however, they encountered disrespect or received substandard treatment or no treatment at all. At times, local frustrations stemming from a lack of basic health services and systematic underinvestment in sanitation have taken the form of OPV refusals or anger towards polio FLWs.[44]

4.3 Gender Norms, Power and Household Decision-Making

Religious beliefs in Pakistan and Afghanistan significantly influence gender norms, shaping women's roles in public health and limiting their ability to serve as frontline vaccinators or make independent healthcare decisions for their children. In both countries, as is the case in most communities worldwide, mothers bear the primary responsibility for their children's health. However, sociocultural norms and religious beliefs can limit their status and decision-making authority, which can interfere with their ability to act on their own and on their children's behalf.

Beyond gender alone, intersecting factors such as socioeconomic class, ethnicity, disability, and rurality further shape access to immunization. Women in lower-income and ethnic minority communities face compounding barriers due to both patriarchal norms and systemic marginalization. Recognizing how barriers to immunization intersect helps tailor more comprehensive outreach strategies. For instance, pairing female vaccinators with local women's cooperatives in marginalized districts or integrating disability inclusion within gender-responsive messaging can ensure no child is left behind.

> **Insights from the Regional Dissemination Webinar on Faith, Gender & Immunization**
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> "This dissemination webinar reaffirmed that achieving polio eradication and equitable immunization in South Asia requires a paradigm shift that recognizes faith engagement and gender justice as central pillars of public health strategy. By aligning religious legitimacy with rights-based programming, stakeholders can foster resilient, inclusive systems that protect every child's right to health and dignity."

4.3.1 Maternal Education, Empowerment and Zero-Dose Risk

Empirical studies underscore a strong correlation between maternal empowerment and vaccination rates. A cross-national analysis of 74 countries revealed 23.5 per cent of zero-dose children are born to mothers with no formal education, decreasing to 13.1 per cent and 6.9 per cent for mothers with primary and secondary education, respectively.[45] Some mothers are not empowered to make healthcare or financial decisions because of prevalent gender norms. A 2023 UNICEF report on Afghanistan highlighted the prevalence of zero-dose children among mothers with low empowerment was 29.4 per cent, compared to 16.7 per cent among those mothers with high empowerment. In Pakistan, the figures were 22.4 per cent and 4.8 per cent, respectively.[46] Similarly, research across Pakistan, Afghanistan, and Nigeria indicates that educated, employed, and socioeconomically empowered mothers, particularly those in government or white-collar jobs, are significantly more likely to vaccinate their children. However, maternal employment correlates with increased non-vaccination in Afghanistan, suggesting complex gender dynamics.[47] It is essential for religious leaders and stakeholders to promote the education and empowerment of girls for the benefit of public health and other social advantages.

4.3.2 Male Authority and Family Permission Structures

In patriarchal societies like Afghanistan and Pakistan, sociocultural norms and religious interpretations often require women to seek permission from male and older family members (such as mothers-in-law), restricting their ability to take their children for vaccination. A 2023 study in Pakistan's high-risk polio areas found over half of mothers refusing the vaccine for their children cited the need for familial consent (from their husbands, mothers-in-law, brothers-in-law, or fathers-in-law) for their children's vaccination, reflecting the existing social and familial structures and a lack of empowerment, which hinders routine immunization in targeted regions.[48] Cross-national demographic studies confirm children of mothers with greater decision-making power exhibited higher vaccination rates. While maternal knowledge is critical, shared parental decision-making often reduces vaccine refusals.[49]

To effectively address male authority and family permission-related barriers, it is essential to design engagement strategies that specifically target male decision-makers within families and communities. Evidence from successful initiatives in comparable settings suggests male-to-male dialogue, leveraging respected male religious leaders, community elders, and local influencers to directly address fathers and male guardians, can be particularly impactful. These peer-led discussions can frame immunization as an extension of a man's duty to protect and provide for his family, reinforcing positive masculinity through religious teachings that emphasize guardianship and responsibility. Additionally, integrating pro-vaccine messaging into male-dominated spaces, such as Friday sermons, madrasa discourses, community meetings, or local markets, can foster open discussion and collective buy-in. These approaches can shift attitudes and increase male support for immunization by positioning vaccination as a key aspect of fulfilling one's religious and social obligations as a protector of family health.

4.3.4 Socioeconomic Barriers and Gender Norms

A qualitative study involving 153 in-depth interviews across Pashtun communities in Pakistan found vaccine hesitancy was concentrated in socioeconomically marginalized households. Limited female mobility is a norm in rural and some urban migrant communities, thereby limiting their exposure and access to information sources, including conventional media, social media, and mobile phones. Restrictions on female movement often hinders women from conservative communities from attending counselling and polio vaccination awareness sessions arranged for the caregivers of persistently missed children. The research also found that while men had traditionally held decision-making authority, gender norms appeared to be evolving, with some women, especially mothers-in-law, exerting increased influence within households and asserting their agency in decisions regarding childhood vaccination. Notably, while vaccine hesitancy affects both boys and girls, boys are more likely to receive medical attention in clinical settings, whereas girls are primarily treated at home with traditional remedies.[50]

Insights from the Regional Dissemination Webinar on Faith, Gender & Immunization

"During the Afghanistan and ACO segment, the discussion highlighted the profound impact of current political and gender restrictions on access to immunization. Mobility constraints for women—both vaccinators and caregivers—were described as significantly limiting service uptake, while the shift from door-to-door vaccination to site-based delivery has further reduced coverage for households with restricted movement. The session also pointed to fragile community trust in the health system, underscoring the need for sustained engagement with community elders, religious leaders, and local governance structures."

4.3.5 Female Frontline Health Workers: Access, Trust and Risk

In conservative communities in Pakistan and Afghanistan, men are rarely allowed to meet women from outside their households or immediate families, and a male health worker visiting a household is unacceptable. This prohibition can sometimes pose a challenge for polio vaccination campaigns when there are inadequate numbers of female vaccinators. Female frontline health workers are, therefore, among the most critical actors in immunization efforts in Pakistan and Afghanistan. In contexts where social norms restrict interaction between male health workers and female caregivers, female vaccinators and mobilizers often serve as the only trusted and culturally acceptable link between immunization programmes and households. Their presence enables access to children who would otherwise remain unreached, particularly in conservative, rural and high-risk settings.

The training, engagement, and deployment of female health workers and female communication engagement officers are thus crucial for enhancing vaccine acceptance and eradicating polio, especially in rural communities. Of the 905,375 health workers engaged in polio, routine immunization, maternal and child health, and COVID-19 awareness in

Afghanistan in 2024, 889,327 were women, which is more than 98 per cent.[51] Across both countries, female healthcare workers play multiple roles beyond vaccine delivery. They provide health information, address caregivers' concerns, navigate household dynamics, and build trust through repeated interpersonal engagement. Their ability to communicate in local languages, understand community norms, and establish rapport with mothers and senior women positions them as uniquely effective agents of immunization uptake. In many cases, households are more likely to accept vaccination when they are engaged by female workers who they perceive as insiders and caregivers themselves.

However, religious beliefs and sociocultural norms surrounding the role of women in public spaces pose significant challenges to vaccine coverage, particularly in conservative settings. In some regions, religious leaders and community members use interpretations of religious beliefs to discourage or prohibit women from participating in public health campaigns as vaccinators. Many women who wish to serve in such roles face systemic barriers, including the requirement to seek permission from male guardians, such as fathers or husbands, who may withhold consent. Furthermore, the women who overcome these obstacles and work as vaccinators often encounter social stigma, ostracism, or even violence within their communities.

Hundreds of polio workers, many of them women, have been killed in targeted attacks in Pakistan and Afghanistan over the last decade.[52] A bombing near a girls' school in Mastung, Balochistan, claimed nine lives, including five schoolchildren, and injured 29 others in November 2024.[53] These attacks have continued despite police escorts accompanying vaccination teams, resulting in the targeting of both security officials and vaccinators.[54] A recent report showed the provinces with the highest number of polio cases in 2024 also experienced the most frequent and severe attacks on health workers, suggesting an alarming correlation between insecurity and polio resurgence.[55] There have also been incidents of abduction, sexual harassment, and the rape of female polio workers.[56] These incidents of violence against female frontline workers not only deter them from continuing in their roles but also discourage other women from participating, thereby exacerbating the challenges to effective vaccine delivery.

> "Ejaz ur Rahman (SBCC Specialist) of UNICEF later emphasized the importance of reframing negative stereotypes about Islam through narratives based on mercy (Rahma) and wisdom (Hikmah). His Presentation, "Faith and New Narrative in Pakistan," focused on youth as key drivers of change, susceptible to ideological conflict but able to shape social change. He promoted online campaigns to recover the faith's narrative and emphasized "Mukalama (cooperative dialogue) rather than Munazara (argumentation)", calling for unity on shared values instead of sectarianism."
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> **National Consultation on Faith, Gender and Immunization: New Narrative for Faith-Based Interventions; UNICEF, JLI, and ARC, Islamabad, Pakistan, 29th April 2025**

Social and institutional barriers further weaken the effectiveness of the female workforce. Female health workers often face low remuneration, delayed payments, limited opportunities for training and advancement, and insufficient recognition within health systems. In some communities, their work may be stigmatized or viewed as inappropriate, particularly when it involves movement outside the home or interactions with male colleagues. These pressures contribute to attrition, low morale, and inconsistent participation, especially during intensified campaigns. These constraints directly undermine programme reach, particularly in settings where male workers cannot substitute for women without compromising access.

Discussions during the national consultations and regional dissemination webinar underscored a clear operational link between the presence of female frontline workers and sustained immunization coverage. Participants highlighted that areas experiencing persistent immunization gaps frequently coincided with places where female workers were restricted, threatened or insufficiently supported. Conversely, where female health workers were protected, trained, and socially legitimized, programmes were better able to maintain access even amid insecurity and resistance.

Faith and community norms play an important role in shaping the acceptance of female frontline workers. Where religious leaders and community elders publicly affirmed the legitimacy of women's participation in health service delivery and drew on faith-consistent narratives of care related to the protection of life and service to the community, female workers reported greater acceptance and cooperation. In contrast, the absence of such endorsements can leave women workers vulnerable to suspicion or backlash.

Strengthening immunization outcomes, therefore, depends on not only increasing the number of female frontline health workers but on institutionally protecting, socially legitimizing, and operationally supporting them. This includes ensuring safe working conditions, predictable compensation, access to training, and engagement with religious and community leaders to reinforce women's role as trusted caregivers and public servants.

CHAPTER 5

Faith, Trust and Religious Leadership in Immunization Systems

Faith plays a central role in shaping health behaviours, moral reasoning, and community trust in Pakistan and Afghanistan. Religious beliefs and leadership influence how illness, prevention, and responsibility are understood at household and community levels, often carrying greater legitimacy than formal state actors or external stakeholders. As such, faith is not a peripheral consideration in immunization efforts, but rather a governing social system that can either reinforce resistance or facilitate acceptance.

5.1 Religious Narratives and Vaccine Hesitancy

Religious beliefs have been identified as a significant barrier to vaccine acceptance, and they are notably distinct in that they are generally linked to core values, making it more challenging to persuade individuals to change their views on immunization.[57] A review of published studies on childhood vaccine hesitancy and refusal in Islamic countries or Muslim-majority countries from 2011 to 2021 revealed that religious factors influencing parental decisions on childhood immunization remained significant in these countries, although the magnitude of their influence varied.[58] Similarly, studies in Pakistan and Afghanistan found that 50 per cent of vaccine-hesitant parents quoted religious reasons, with parental religious misconceptions associated with being “uncommitted” to polio vaccination.[59] Results from a recent qualitative study, which included Pakistan, showed

that religious beliefs and interpretations of religious teachings from sacred texts influenced people's understanding of vaccination. On one hand, anti-vaccine sentiment was justified through religious reasoning, particularly in religious communities that strictly interpreted sacred texts. Anti-vaccine sentiments were also led by religious leaders who lacked in-depth information and training, especially on medical matters. On the other hand, religious teachings aided vaccine uptake. Teachings emphasizing the importance of caring for oneself (as a divinely created being) and caring for the community (loving one's neighbour), as core concepts, encouraged religious people to accept vaccinations and get their children vaccinated.[60]

Religious objections to vaccines are often intertwined with gender norms limiting women's roles in public health initiatives. In some conservative communities, opposition to female vaccinators is justified through religious interpretations discouraging women's participation in the workforce. This results in a critical shortage of female health workers, making it difficult to access households where male vaccinators are not permitted.

Reasons for vaccine hesitancy or refusal tied to religious beliefs include claims that the vaccine contains traces of pork and alcohol, which are forbidden in Islam; the polio vaccine affects fertility; only God can protect people, not vaccines; and that immunization is tantamount to artificially circumventing predestination.[61] These claims are frequently amplified through informal networks, rumours, and the absence of clear guidance from trusted religious figures. These claims rarely operate in isolation as they also intersect with other factors such as fatigue from repeated campaigns, perceptions of external control, and dissatisfaction with wider health-related service delivery.

5.2 The Role of Religious Leaders in Immunization Efforts

Results from numerous studies have shown that religious leaders can influence community health, with their ability to affect change either positively or negatively, depending on the stance these leaders adopt.[62] Religious leaders are often trusted community figures who local people look to for information and guidance. Local religious leaders are so influential within many Muslim communities that any misconception or lack of support for vaccination from them correspondingly influences vaccine hesitancy and refusal.[63] In Pakistan, 20 per cent of caregivers expressing disinterest in the polio vaccine had quoted their religious leaders' belief that the childhood polio vaccine was "not a very good idea." Similarly, there were reports of religious leaders opposing vaccination programmes, and religious institutions (madrasas) heavily influencing parents' opinions.[64]

While there have been many positive examples of religious leaders openly advocating for and encouraging vaccination, there have also been many instances of other religious leaders miscommunicating, refusing to communicate, or actively choosing to communicate misinformation on vaccinations. There have also been cases of 'silent refusal' where some religious leaders do not openly oppose immunization but refuse it for their families, non-verbally communicating their disapproval of vaccines to those around them.

There is a need, therefore, to continually engage and empower religious leaders, who are already trusted community voices, to provide accurate information about the polio vaccine, and encourage vaccine acceptance based on religious teachings supporting immunization and the general maintenance of good health. In doing so, it is essential to adopt a more nuanced approach that considers the diversity of religious opinions and local contexts. A blanket assertion that all religious scepticism stems from misinformation risks alienating communities rather than engaging them constructively. Polio programs should actively involve faith leaders in tailored community dialogues, addressing specific theological concerns with clear, compassionate and evidence-based responses. Drawing on Islamic jurisprudence (fiqh) principles prioritizing the common good (maslaha) and harm prevention (darar), religious leaders and institutions should articulate how immunization aligns with Shari'ah principles. Similarly, other religious traditions in the region should mobilize to provide faith-based justifications for vaccinations within their communities.

While global religious endorsements and fatwas provide important theological clarity, their impact at the community level depends on translation through trusted local voices. Local imams, madrasa teachers, female religious scholars, and respected community figures play a critical role in shaping norms and influencing household decisions, often more directly than national or international institutions, which may be unfamiliar to community members.

5.3 Global Religious Declarations and their Local Relevance

Over the past two decades, major Islamic institutions and transnational religious bodies have issued declarations and legal opinions affirming the permissibility and importance of vaccination, including polio immunization. These global religious statements draw on well-established Islamic ethical principles, such as the preservation of life, prevention of harm, parental responsibility, and collective welfare, to clarify that immunization is consistent with religious obligations and moral responsibility. These endorsements have played a crucial role in addressing vaccine hesitancy and mobilizing communities towards immunization initiatives. In 2009, the International Islamic Fiqh Academy (IIFA), a subsidiary of the Organization of Islamic Cooperation (OIC), issued a statement urging parents to vaccinate their children against polio. The IIFA emphasized that vaccination is a preventive measure aligned with Islamic principles, countering misconceptions that vaccines are harmful or un-Islamic. This declaration was pivotal in garnering support from Muslim communities worldwide.[65]

Building on this progress, the Islamic Advisory Group (IAG) for Polio Eradication was established in 2013, comprising esteemed institutions such as Al-Azhar, the IIFA, the OIC, and the Islamic Development Bank. In its inaugural meeting in 2014, the IAG adopted the 'Jeddah Declaration', which reaffirmed the safety and necessity of polio vaccination under Islamic law. The declaration condemned attacks on health workers and called for unimpeded access to children for vaccination purposes.[66] The IAG has consistently reiterated its commitment to polio eradication and broader public health priorities. In its

eighth annual meeting in 2021, the group emphasized the alignment of routine childhood vaccinations with Islamic teachings and commended religious scholars for their efforts to promote immunization. The IAG also emphasized the importance of dispelling misinformation and encouraged communities to follow preventive health measures.[67] At the national level, Pakistan has a National Islamic Advisory Group (NIAG), which continues to collaborate with religious leaders and communities to increase polio vaccine coverage.[68]

Similarly, several networks of Muslim scholars and faith-based organizations have publicly endorsed vaccination as a legitimate and necessary public health intervention. These declarations and fatwas explicitly reject claims that vaccines violate religious teachings, harm fertility, or constitute prohibited substances. They instead frame immunization as an act of care, prevention, and protection of the vulnerable. In addition, there have been numerous efforts geared towards encouraging parents to devote the same attention to the education, healthcare, and overall well-being of their daughters as they devote to their sons. Most recently, several notable organizations and religious leaders, including the Muslim World League and the Organization of Muslim Scholars, in collaboration with the government of Pakistan and other stakeholders, issued the 'Islamabad Declaration for Girls' Education' in January 2025, emphasizing and affirming the fundamental right of girls to education, and calling for unified efforts to ensure this right is upheld.

> "In Islam, gender equity and women's empowerment teachings are not societal ideals but sacred injunctions that are well entrenched in the religion's ethical paradigm. The consultation highlighted how such teachings constitute a common moral call to improve access to healthcare, maternal autonomy, and immunization equity."
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> **National Consultation on Faith, Gender and Immunization in Afghanistan: UNICEF, JLI, and other partners, Jalalabad, Afghanistan, 27th August 2025**

Evidence from Pakistan and Afghanistan demonstrates, however, that global declarations alone do not automatically translate into community-level behaviour change. While such declarations establish theological clarity and counter misinformation at a conceptual level, their influence depends on how local religious leaders interpret, communicate, and embody them. Communities are more likely to respond to guidance delivered by imams, madrasa teachers, female religious scholars, and other locally respected figures who can effectively contextualize global principles within the lived realities and local moral frameworks of their communities.

Global religious declarations are therefore most effective when understood as enabling instruments rather than stand-alone solutions. They provide a shared ethical foundation that can empower national programmes, support faith engagement strategies, and legitimize local advocacy, particularly for the protection of women and girls and the acceptance of immunization. When coupled with sustained local dialogue, responsive service delivery, and visible support for female caregivers and frontline workers, these global endorsements can reinforce trust and contribute meaningfully to closing remaining immunization gaps.

5.4 Islamic Ethical Principles Supporting Immunization

Islamic tradition offers a robust ethical foundation for immunization, rooted in principles prioritizing life, prevention, and collective responsibility. Rather than relying on isolated textual references, these principles provide a coherent moral framework that supports vaccination as a protective and responsible measure.

5.4.1 Sanctity of Life and the Objectives of Islamic Law (Maqasid al-Shari'ah)

Islam considers human life sacred and must be maintained and kept safe. A summary of the higher intents of Islamic Law (Maqasid al-Shari'ah) includes the promotion and preservation of the common good and benefit (jalb al-masalih) and to avoid and protect from harm (dar al-mafasid). The five core objectives of Shari'ah (Maqasid al-Shari'ah) include the preservation of religion (hifz al-deen), the preservation of life (hifz al-nafs), the preservation of progeny (hifz al-nasb), the preservation of intellect (hifz al-aql), and the preservation of wealth (hifz al-mal). For the preservation of religion, Muslims vaccinated against vaccine-preventable diseases will be better positioned to uphold and practice all the obligatory acts of Islamic worship. With regards to the preservation of life, vaccination becomes a religious obligation when refusing a vaccine may lead to infection or death to oneself or others, as is the case when there is a lack of polio immunization. Additionally, parents who opt to have their children vaccinated fulfil their responsibility to preserve progeny by safeguarding their children from succumbing to vaccine-preventable diseases. Vaccination also contributes to preserving wealth, as disease prevention is more economical than treatment and treating disease-related complications.

Islam also teaches there are remedies for all diseases humanity faces, and Allah created the remedy for every disease first. Abu Hurayrah (RA) narrated that the Prophet (PBUH) said, "*Allah did not send down a disease without having sent down its cure*".[69] Usamah Bin Shareek (RA) also narrated: I was with the Prophet, and some Arabs came asking, "O Messenger of Allah, should we take medicine for any disease"? He said, "*Yes, O You servants of Allah, take medicine as Allah has not created a disease without creating a cure except for one (old age)*".[70] Immunization is a form of medication helping to prevent diseases in accordance with the Shari'ah and is thus permissible based on this prophetic injunction.

Complications from poliovirus not only cause paralysis but sometimes lead to death. The Qur'an states, "…. *And do not kill yourselves (or one another). Indeed, Allah is to you ever merciful*".[71] The Qur'an also notes, "…*And whosoever saves a life, it is as if he had saved mankind entirely…*".[72] One of the principles in Islamic jurisprudence states that "whatever is a prerequisite for an obligation is in itself an obligation" *(malaa yatimmu al-wajib illa bihi fahuwa wajib)*.[73] Given saving lives is compulsory and vaccines are a prerequisite to prevent life limiting conditions or death, vaccines are mandatory, and all parents and caregivers should ensure every child under their care is fully vaccinated.

5.4.2 Parents' Responsibility to Protect their Children from Harm

Children are a blessing from God, "*Wealth and children are the adornments of the life of this (dunya) world*",[74] but they are also the responsibility (*amanah*) of parents for which they will be questioned by God on the Last Day. The Qur'an says, "*Your wealth and children are only a test, and Allah has with Him a great reward*".[75] The Prophet (PBUH) also said, "*Every one of you is a shepherd and is responsible for his flock. The leader of people is a guardian and is responsible for his subjects. A man is the guardian of his family, and he is responsible for them. A woman is the guardian of her husband's home and his children, and she is responsible for them*".[76]

Parents have a responsibility to protect their children from every form of possible harm, including illness and disease. Vaccination has been scientifically proven to be the most effective method to protect children, including girls, from preventable infectious diseases. Ensuring all children are vaccinated aligns with Islamic teachings on guardianship and care. It is a religious obligation (wajib) for parents or guardians, therefore, to protect their children against illnesses using vaccines. Vaccination is also included in the category of exerting 'human efforts to avoid harm,' as one of the universal maxims of Islamic jurisprudence states: "Harm must be eliminated" ("*Ad-dararu yuzal*").[77] We can liken vaccination to wearing a life jacket to avoid unforeseen calamities when at sea. Just as human efforts are intended to prevent harm, vaccination is a means of exerting human effort to prevent disease.

5.4.3 Immunization as part of Social Responsibility

Social responsibility, the understanding that people and organizations should act in ways that benefit society and the environment, is another important reason why parents should vaccinate their children, and religious leaders should encourage their congregants and followers to accept vaccination. The Prophet (PBUH) linked the principle of social responsibility to preventing and guarding against the spread of epidemics. For instance, when a man from an Arab tribe visited Medina to convert to Islam while he was suffering from leprosy, the Prophet (PBUH) accepted his conversion to Islam but forbade him entering Medina so as not to put at risk the health of Medinan people.[78]

Vaccination not only protects the immunized child but also the children around them, through herd immunity. Muslims are expected to protect their health and the health of others, as Allah has clearly prohibited humankind from putting themselves in danger or engaging in self-destruction.[79] Thus, it is essential for religious leaders to collaborate with credible stakeholders to ensure the most effective modality for immunization access for all children, including providing support for female vaccinators and social mobilizers, as well as facilitating access to immunization services for female caregivers to protect their children. Religious leaders should discourage husbands and fathers from preventing their wives taking children to health centres for immunization but should rather support them in doing so.

The Sunna also provides strong evidence for preventative health and maternal responsibility. The Prophet Muhammad (PBUH) said: “There should be neither harming nor reciprocating harm”.[80] This principle (lā ḍarar wa lā ḍirār) obliges the community to eliminate practices that cause harm, which includes preventing women from accessing healthcare or denying children essential vaccines. Moreover, the compassion of the Prophet (PBUH) toward children and his encouragement of maternal care demonstrate the importance of empowering mothers to fulfil their duty to protect their children’s well-being.

As the Prophet (PBUH) said: “The believers are like a building, they support and strengthen each other”[81] and ‘“The believers in their mutual mercy, love and compassion are like a body, when one limb is in pain the rest of the body joins in insomnia, fever and restlessness”.[82] In line with these prophetic injunctions, as long as even a single child in Pakistan or Afghanistan remains incompletely immunized against polio, the responsibility lies with every scholar, healthcare professional, parent, caregiver, influencer, and community member to persevere relentlessly. The collective effort must continue unabated until full immunity is ensured for every child, leaving no one behind in the fight against this preventable disease.

5.5 Faith-Based Support for Women and Girls

Religious teachings also affirm the dignity, worth, and well-being of women and girls, providing a basis for addressing inequalities that affect immunization outcomes. Faith-based narratives emphasize equal care for all children and reject differential treatment based on gender.

5.5.1 Dignity of Women and Girls

Immunizing and educating girls, empowering women, and ensuring the overall well-being of women are deeply rooted in Islamic values prioritizing the preservation of life, fulfilling parental responsibilities, and promoting equality and justice. Islamic teachings uphold the inherent dignity and personhood of every human being, irrespective of gender. The Qur'an states, "*We have bestowed dignity on the children of Adam… and conferred upon them special favors above the greater part of Our creation*".[83] The dignity and favours referred to in this verse apply to all children of Adam, including girls and women. The Qur'an also explicitly emphasizes the equality of men and women in terms of spiritual worth, "*Whoever does good, whether male or female, and is a believer, will enter Paradise*".[84]

Islam also teaches there is no inherent superiority of one gender or race over the other, except by piety. "*O mankind! We have created you from a male and a female and made you into nations and tribes so that you may know one another. Verily, the most honoured of you in the sight of Allah is (he who is) the most righteous of you. Verily, Allah is All-Knowing, All-Aware*".[85] The societal bias against girls in pre-Islamic Arabia facilitated the practice of female infanticide, but Islam categorically prohibited the practice, condemning the devaluation of girls, affirming their equal worth, and emphasizing the responsibility to provide for and protect girls, countering any societal biases devaluing their lives.[86] These sacred teachings establish that girls and boys deserve equal care and attention, including access to health, education, socio-economic empowerment, and protection from harm.

5.5.2 Gender Inclusion and Equity

Considering gender inclusion as 'Western' or foreign to Islam overlooks Islam's history of female scholarship and public service. It is thus essential for religious leaders and institutions to draw on Islamic scriptures, rather than external models, in developing the case for women's participation in immunization efforts. Islamic history is replete with examples of Muslim women making significant societal contributions while adhering to the principles of Islam, from Khadijah bint Khuwaylid (the wife of the Prophet Muhammad (PBUH)) to Fatimah Al-Fihri, who founded the world's first university.

Narratives that highlight and emphasize women's work on education and healthcare, preserving girls' health, empowering mothers, and supporting female vaccinators are not concessions to modernity but remain loyal to Islam's enduring principles and practices. As the Prophet (PBUH) taught, "*The best of you is the one who is best to his womenfolk, and I am the best of you to my womenfolk*".[87] This is a call to action that continues to ring out in the struggle for equal healthcare and a polio-free future.

5.5.3 Education for Girls and Women

Education is a fundamental right in Islam for both boys and girls, and the Prophet Muhammad (PBUH) emphasized the importance of knowledge, making no distinction based on gender. He (PBUH) said, "*Seeking knowledge is an obligation upon every Muslim*".[88] Women and girls are not exempt from the obligation to seek formal, beneficial knowledge. By ensuring girls receive education, communities fulfil a core Islamic value of empowerment and prepare girls to contribute positively to society. A community that deprives its girls and women of access to quality formal education disempowers them from contributing their quota to community development. Several notable scholars, including Imam al-Bukhari and Ahmad ibn Hanbal, learned a great deal from their well-educated mothers, and history is a testament to the benefits they have brought to the Ummah. An educated Muslim woman stands a better chance of raising children well-equipped to tackle the challenges of the 21st century, and thus more beneficial to the Ummah. Denying or limiting their education has the opposite effect. Religious leaders should encourage parents to allow and support their daughters, sisters, and wives to attend school and pursue a good education, thereby contributing to the betterment of society as a whole.[89]

> "Religious leaders play a pivotal role in shaping social norms, guiding communities, and providing moral legitimacy to collective actions. In the Afghan context, where religion profoundly influences daily life, their involvement is central to promoting child health and equity. By advocating for immunization, maternal care, and equitable treatment of boys and girls, religious leaders can champion child rights in a manner that resonates with Islamic teachings and strengthens community trust."
>
> **National Consultation on Faith, Gender and Immunization in Afghanistan: UNICEF, JLI, and other partners, Jalalabad, Afghanistan, 27th August 2025**

5.5.4 Equal and Fair Treatment of Female Children

Parents must be just to their children, and it is a sin in itself for parents to treat one child better than another. The Prophet (PBUH) said, "*Fear Allah and be just with regards to your children*"[90] and "*act equally between your children*".[91] Islam promotes equal rights and opportunities for both males and females, from childhood onwards. Islam promotes justice (adl) and condemns any form of injustice, including discrimination against girls. Ensuring the care of girls is an act of justice and aligns with Islamic principles.[92]

The Prophet Muhammad (PBUH) explicitly praised those who cared for and nurtured their daughters, speaking highly of the reward for doing so. He (PBUH) said, "*If anyone has a female child, and does not bury her alive, or slight her, or prefer his male children to her, Allah will bring him into Paradise*"[93] and "*Whoever has three daughters, and he remains patient with them, provides for them, and clothes them, they will be a shield for him from the Fire*".[94]

These religious teachings emphasize the religious and moral obligation to ensure the well-being and care of girls, viewing it as an act of worship and compassion. Caring for girls is thus not only a moral duty but also a means of attaining spiritual reward. Providing equal care for girls reflects the divine mandate to uphold justice and fairness in all aspects of life. Immunization protects children from diseases that could lead to long-term illnesses, disability, or death. Immunizing girls is, therefore, an act of ensuring their right to health and aligns with the Islamic obligation to nurture girls and protect them from harm.

5.5.5 Empowerment of Wives and Mothers

Islamic teachings similarly encourage the empowerment of women, including in their roles as wives and mothers. Islam respects mothers as primary care providers and promotes their role in protecting children's health. The Qur'an commands husbands to live honourably with their wives and treat them with kindness. The Prophet Muhammad (PBUH) himself demonstrated an exemplary model of mutual consultation with his wives, respecting their opinions, and valuing their contributions to decision-making. Aisha, the wife of the Prophet (PBUH), reported that he (PBUH) said, "*Verily, women are the counterparts of men*".[95] Islam recognizes wives and husbands as partners who should support each other in running the affairs of the home and wives' opinions on their children's welfare matters significantly.

Islam particularly encourages consultation between spouses, especially on significant decisions that affect the family, fostering a sense of partnership and mutual respect. God says, "*...and live with them honourably...*".[96] Similarly, the Prophet (PBUH) said, "*And treat women with kindness, and treat women with kindness*"[97] and "*The best of you is the one who is best to his womenfolk, and I am the best of you to my womenfolk*".[98] There are also several examples of wives and daughters giving their opinion on matters, such as when Prophet Shuayb's daughters asked him to hire Prophet Musa, and when, Umm Salamah, the wife of Prophet Muhammad (PBUH), told him to shave his hair during the treaty of Hudaybiyyah.[99] The fact that even Prophets of God listened to their wives, accepting their opinions, emphasizes the agency of women in Islamic history. Empowered mothers are more likely to immunize their children.

Furthermore, the Qur'an emphasizes the equal dignity and responsibility of both men and women: "And their Lord responded to them, '*Never will I allow to be lost the work of [any] worker among you, whether male or female; you are of one another*'."[100] This verse reinforces the idea that women's roles, including as health workers and decision-makers, are valued and divinely recognized. Religious leaders should encourage parents and families to educate and empower their female children, emphasizing their critical role in making health-related decisions for their own families.


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5.5.6 Religious Legitimacy for Female Frontline Health Workers

Female frontline health workers occupy a critical position at the intersection of faith, caregiving, and service delivery. Public endorsements by religious leaders play a vital role in protecting and legitimizing female health workers, particularly in conservative or insecure settings. When religious authority affirms women's participation as a form of service and communal responsibility, communities are more likely to cooperate and provide protection. Conversely, the absence of such endorsements can leave women workers exposed to stigma, resistance or harm.

Historical precedents within Islamic tradition affirm the participation of women in healthcare and caregiving roles, establishing religious legitimacy for their work. Female vaccinators follow in the footsteps of esteemed female companions of the Prophet Muhammad (PBUH), such as Umm Sulaym, Nusaybah bint Ka'ab, and Aisha bint Abubakr, who played critical roles in the Prophet's expeditions by nursing the injured, providing water, and tending to the wounded soldiers. Anas Ibn Malik said: "*The Prophet (PBUH) used to go out to the battles taking Umm Sulaym and some other women of the Ansaar with him; when he fights in the battle, they [i.e. the women] would give water to the soldiers and treat the injured*".[101]

Most notably, the first professional Muslim nurse in Islamic history was a female companion of Prophet Muhammad (PBUH), Rufaida bint Sa'ad Al-Aslamiyah, whom the Prophet (PBUH) allowed to erect a tent inside his mosque (Al-Masjid An-Nabawi) in Madinah, serving as a clinic where she provided nursing care and trained Muslim women

as nurses. When the eminent companion Sa'd Ibn Mu'adh was injured in the Battle of the Trench (*Khandaq*), the Prophet (PBUH) ordered she treat him in her makeshift clinic. Today, female health workers and their service align with the maqasid al-Shari'ah principles of safeguarding life (hifz al-nafs) and faith (hifz al-deen), demonstrating the integral role of women in advancing both health and Islamic values.

The Prophet's practice of mercy (rahma) and justice (adl) applies to support for female healthcare providers, who are important in conservative societies where male vaccinators encounter cultural barriers. Empowering mothers and female vaccinators guarantee culturally appropriate immunization outreach, especially in gender-segregated societies. Their work aligns with the Qur'anic concept of cooperation in righteousness (ta'awun) and the Prophetic emphasis on community welfare. Stigmatization or attacks on female health workers contradict Islamic teachings, and religious leaders should actively support and protect them, ensuring their safety and legitimacy within their communities. They should advocate for and facilitate women's mobility in the context of immunization and public health, serving the greater public good (maslaha). In doing so, cultural sensitivities must be carefully navigated to boost buy-in and acceptance within communities. For example, it is recommended that male counterparts or trusted community figures accompany female vaccinators to gain broader acceptance. Additionally, religious leaders should directly address male guardians, emphasizing their responsibility in ensuring their families receive proper medical care.

5.6 Addressing Common Religious Misconceptions

Religious concerns related to immunization tend to cluster around a limited set of themes, including permissibility, fertility, trust in vaccine origins, and fear of side effects. Addressing these concerns effectively requires consistent and respectful engagement, rather than reactive rebuttals. Faith-informed approaches that provide clear guidance, acknowledge concerns, and link vaccination to ethical principles of care and protection are more effective than technical messaging alone. These approaches are most successful when delivered by trusted religious and community figures and reinforced through dialogue rather than confrontation.

Below are responses to some of the specific faith-based misconceptions about vaccination:

5.6.1 "The vaccine ingredients are haram (forbidden) or contain prohibited substances".

A Muslim's decision must be guided by evidence and proof, not by unfounded speculation and superstitions, and Muslims are enjoined to avoid harbouring unfounded prejudiced suspicion as Allah says, "*O you who believe! Avoid suspicion, for surely, suspicion in some cases is a sin*....".[102] There is no evidence that the polio vaccine contains any forbidden (haram) ingredients. The polio vaccine does not contain pork, pork gelatin or derivatives, alcohol, or other prohibited substances. Both the OPV and IPV are halal (permissible). To declare a

product halal or haram (permissible or forbidden) is a call for the Islamic scholars and fatwa councils who have also studied the vaccine and its ingredients. Allah says, "...*So, ask the people of Knowledge if you do not know*".[103] In the Islamic Guidance section of the Polio Free Pakistan FAQs, it states that the Grand Sheik Tantawi of Al-Azhar University, the Grand Mufti of Saudi Arabia, the Majelis Council of Ulemmas in Indonesia, Dar-ul-Uloom Haqqania, Pakistan; Dar al Uloom Deo-Band, India; the Organization of the Islamic Conference; the International Union for Muslim Scholars; Imam of Masjid Al Aqsa (Bait ul Muqades), and other prominent scholars and muftis from all sects across all provinces of Pakistan have declared the polio vaccine halal and encouraged.[104] In Pakistan, all major Islamic clerics and madrassas have issued fatwas in favour of the polio vaccine, including Mufti E Azaam Pakistan, Mufti Rafi Usmani, Mufti Muneeb Ur Rehman, Mufti Naeem, and Maulana Sami Ul Haq, among others.[105] A test conducted in 2015 by the National Control Laboratory for Biologicals, which is controlled by the Drug Regulatory Authority of Pakistan (DRAP), also confirmed the polio vaccine used in Pakistan is halal.

Globally, fatwa councils that regard vaccines as halal include the Federation of Islamic Medical Association (FIMA), Islamic Medical Association & Network of Indonesia (IMANI), Islamic Medical Association of Malaysia (IMAM), Islamic Medical Association of South Africa (IMASA), among many others.[106] Similarly, the Islamic Advisory Group for Polio Eradication (IAG), which includes religious leaders from across the Muslim world, including Pakistan and Afghanistan, as well as Al-Azhar Al-Sharif, the International Islamic Fiqh Academy (IIFA), and many others, has endorsed the polio vaccine as halal and encouraged all Muslims to get their children vaccinated. Notably, for any Muslim wishing to perform pilgrimage (hajj), the government of Saudi Arabia mandates them to have taken the polio vaccine irrespective of age and previous vaccination status.

5.6.2 "Muslims are encouraged to have many children, but the polio vaccine causes infertility".

There are established procedures for medicine and vaccine development. Vaccine use in humans can only proceed after several laboratory and clinical trials have established the vaccines' relative safety, and approval systems and checks have been conducted. There is currently no biological evidence that antibodies from the polio vaccine or other vaccine ingredients could cause problems with reproductive organs or fertility.

A conclusion based on assumptions and rumours with no evidence is not regarded as evidence scientifically or Islamically, as Allah says: "...*and surely conjecture can be no substitute for truth*".[107] This is against one of Islam's significant teachings and maxims, that "certainty is not overruled by doubt" ("*al yaqinu la yazulu bi al shakk*").[108] The opinion of trusted experts such as the numerous muftis and fatwa councils that have endorsed the polio vaccine should always be considered and prioritized based on the Qur'anic teaching, "...*So, ask the people of Knowledge if you do not know*".[109] Many Muslim-majority countries in the world, including Saudi Arabia, Indonesia, and others, have eradicated the polio virus without any record of infertility issues linked to the vaccine.

5.6.3 "Allah is the only protector, so a vaccine cannot protect anyone".

The fact that Allah is the protector and ultimate cause of life and death does not remove or reduce the responsibility of humans to protect human life and prevent harm. Moreover, people already take measures to protect themselves every day from harm. In fact, Prophet Muhammad (PBUH) taught that people are responsible for defending and protecting themselves and others from harm first before expecting Allah's help. The Prophet (PBUH) asked a man why he had left his camel untied, and when the man responded that it was because he trusted Allah to protect it, the Prophet (PBUH) replied, "*Tie your camel first, and then put your trust in Allah*".[110] Similarly, parents and caregivers should vaccinate their children first, and then trust Allah to protect the child from the polio virus.

5.6.4 "Muslims are required to believe in predestination (qadr). Taking vaccines is trying to circumvent the fate determined by God, especially when the vaccine recipient has not experienced the disease".

Taking vaccines to prevent disease or medicine to cure illnesses is not against the Islamic principle of predestination (qadr). Rather, doing so is in line with the Islamic obligation to preserve life. Allah says: "…. *And do not kill yourselves (or one another). Indeed, Allah is to you ever merciful*".[111] Since the Shari'ah is concerned about the promotion and preservation of life (hifz al-nafs), Muslims are expected to take advantage of all opportunities to save their lives and the lives of others. Preserving life involves taking care of one's physical health and protecting it from threats, such as disease. The Islamic principle of "*al-wikayah khayrun min al-ilaj*" (prevention is better than cure) is also in line with the preservation of life. Polio harms children by putting at risk their health, future and life. Islam teaches that harm must be eliminated ("*ad-darar yuzaal*"). Taking the polio vaccine, therefore, is also consistent with the principle of the avoidance of harm in Islam.

There are also prophetic reports on pandemic control, quarantine, and prevention policies to safeguard the Muslim community from debilitating illnesses that are preventable. Teaching the principle of quarantine, the Prophet (PBUH) said, "If you get wind of the outbreak of plague in a land, do not enter it; and if it breaks out in a land in which you are, do not leave it".[112] He also instructed a man whose camel was diseased not to mix the sick and mangy camels with the healthy animals.[113] Based on this prophetic teaching, when the third Caliph of Islam, Umar bn Al-Khattab, was traveling to Syria and learned the plague of *Amwās* (634–644 C.E.) had broken out there, he returned to the city of Medina. When he was asked, "*Are you running away from what Allah had ordained*"? Umar answered, "*Yes, I am fleeing from the decree of Allah to the decree of Allah*", and added, "*Don't you agree that if you had camels that went down a valley having two places, one green and the other dry, you would graze them on the green one only if Allah had ordained that, and you would graze them on the dry one only if Allah had ordained that?*".[114] The Caliph Umar's comment is a superb illustration of how to strike a balance between trusting in Allah, exercising adequate care, and taking measures to prevent disease.[115] Thus, taking precautions to avoid the spread of diseases such as polio is part of prophetic practice (sunna) and does not negate the Islamic understanding of predestination.

5.6.5 "Vaccines are not always 100 per cent effective at preventing diseases, so why take them at all if there is no guarantee"?

Scholars believe the provisions in Shari'ah regarding permissibility and prohibition are based on the majority; thus, if benefits prevail, the ruling is permissible, and when harm prevails, the rule forbids it. Accordingly, when vaccines are most likely to limit the harmful effects of infectious diseases and facilitate swift recovery, then the legal ruling is based on the majority. It is permissible, therefore, to take the vaccine even when there is no guarantee of its 100 per cent effectiveness.[114] In the case of polio, however, vaccines have successfully eradicated the disease in 99 per cent of the world. There is a guarantee that if 95 per cent of all children under 5 across Pakistan and Afghanistan are fully immunized against polio, transmission of the disease can be stopped in both countries.

Ensuring children are fully vaccinated significantly reduces the rate of infection to almost zero. Cases where vaccinated children still contract polio are often due to under-vaccination, where the child did not complete the recommended vaccination schedule. Children require multiple doses of the polio vaccine, sometimes more than ten, to be fully protected. The current routine immunization schedule recommends one dose of IPV and multiple doses of OPV for full protection against polio. To ensure all children are protected against polio, no child should miss a round of the vaccination.

5.6.6 "The vaccine causes side effects such as fever in children".

All medications have side effects and affect people differently. Some children may experience mild reactions to the vaccine, such as fever or swelling at the injection site. These side effects do not occur frequently and, when they do, are often temporary. Serious adverse effects due to vaccination are rare, as the oral polio vaccine is one of the safest vaccines ever developed. It is so safe it can be given to sick children and newborns.

One of the maxims of Islamic jurisprudence is the principle of "*al-akhdh bi akhaff al-dararayn*" (choosing the lesser of two harms). When there is a clash of two harmful situations, and Muslims have to choose one of the two, they must choose the less harmful situation, in line with the practice (sunna) of the Prophet (PBUH). Another related maxim is the principle of "*yuzal ad-darar al-ashaddu bid-darar al-akhaff*" (a greater harm may be eliminated by a lesser penalty), meaning that when Muslims must choose between evil alternatives, they should choose the lesser evil.[118]

In a vaccination context, even though the polio vaccine may cause some side effects in some children, it must still be administered due to the consequences of not receiving any vaccination. The harm that befalls children, such as a temporary fever, is far less serious than harm resulting from non-vaccination, including paralysis or death. It is thus Islamically better to take the polio vaccine and be mildly ill than not take the vaccine and risk paralysis or death.

5.6.7 "The polio vaccine comes from the West, and we cannot trust them".

The polio vaccine administered in Pakistan and Afghanistan comes from Indonesia, which has the highest Muslim population in the world.[119] However, the polio eradication programme in both countries is a collective effort involving numerous stakeholders, including their respective governments and many others, such as WHO, UNICEF and the Global Polio Eradication Initiative. Such collective cooperation is in line with Allah's injunction, "*Cooperate in righteousness and piety, but do not cooperate in sin and aggression, and fear God. Indeed, God is severe in punishment*".[120] Muslims are enjoined to cooperate with others in good deeds that bring public benefit to the Ummah and all of humanity.

Establishing and maintaining beneficial partnerships with non-Muslims was a practice during the time of the Prophet (PBUH) and is thus not just permissible but part of his tradition (sunna). This is, of course, provided that relationships do not endanger or compromise Islamic values and principles. For example, the Prophet (PBUH) employed Abdullah bin Uraiqit, a polytheist, as his guide during his migration (Hijra) from Mecca to Medina. The Prophet (PBUH) also joined a group known as the *Hilf al-Fudul* (League of the Virtuous), a group of upstanding individuals from various clans who took it upon themselves to protect the rights of any victim of oppression in Mecca, even though they were not Muslims. Even after Islam was well-established, the Prophet (PBUH) recounted his involvement with the Hilf al-Fudul, and according to Talha ibn Abdullah (RA), he (PBUH) said that "*if he were to be invited again to join such a group now in the time of Islam, he would respond and join them*".[121] Having the governments of Afghanistan and Pakistan working with different health agencies to eradicate polio is in line with Shari'ah guidelines, and all religious leaders should support these efforts, using all channels and platforms available to them to advocate for polio vaccine acceptance among parents and broader communities.

Given the religious justifications outlined in this section, it is essential for religious leaders to actively promote vaccination within their communities. They should incorporate pro-vaccine messages into Friday sermons, Qur'anic school curricula, and mosque-based awareness campaigns. Additionally, they should publicly support female health workers, legitimizing their roles by drawing on historical examples of Muslim women contributing to healthcare. It is important to note that Islamic teachings supporting immunization apply equally to boys and girls. The Prophet (PBUH) said: "*Whoever supports two daughters until they reach maturity will be with me in Paradise like this*" *(and he joined his fingers)*.[122] Parents and caregivers must ensure they vaccinate their male and female children equally against polio. By leveraging faith-based advocacy, communities can overcome vaccine hesitancy and work towards eradicating preventable diseases, such as polio.

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CHAPTER 6

Global Case Studies and Lessons Learnt on What Works for Shifting Norms

As of 2006, India, Pakistan, Afghanistan and Nigeria remained the only polio-endemic countries globally.[123] While Pakistan and Afghanistan continue to face challenges, India and Nigeria have successfully halted the spread of the virus, demonstrating the pivotal role of religious leaders in vaccine advocacy. Experiences from India and Nigeria provide important insights around how faith-informed strategies can contribute to successful polio eradication when integrated into broader public health systems. Both countries previously faced entrenched resistance to polio vaccination, rooted in mistrust, misinformation, and social marginalization. Yet, they ultimately succeeded in interrupting transmission through approaches that combined technical excellence with sustained community and religious engagement. However, direct replication of these models without considering the unique socio-political and tribal structures in Pakistan and Afghanistan may not yield the same results. It is crucial to tailor faith-based advocacy to the distinct sectarian and ethnic landscapes of Pakistan and Afghanistan. Furthermore, beyond religious leaders, collaboration with influential community figures such as tribal elders, educators and local NGOs will ensure a more holistic approach.

6.1 India Institutionalized Faith Engagement and Community Trust

India was once the epicentre of polio, accounting for more than 50 per cent of global cases in 1988. By 2002, there were 1,600 recorded cases, with 1,242 concentrated in the state of Uttar Pradesh, where vaccine hesitancy was particularly high among marginalized Muslim communities.[124] Reluctance stemmed from deep-seated mistrust, concerns over vaccine safety, and the perception that polio immunization was a lesser priority than other pressing health and socio-economic issues such as access to clean water and nutrition. The polio eradication campaign in India recognized the barriers related to religious beliefs and misconceptions, and prioritized faith-based engagement with religious leaders and institutions using a combination of strategies:

- **Engagement with Prominent Religious Institutions and Leaders:** Recognizing the influence of religious leaders, the polio eradication programme collaborated with renowned local religious scholars, institutions and prominent Muslim universities. These included Aligarh Muslim University (AMU), Jamia Milia Islamia University (JMI), Hamdard University, Shibli Inter College, Faiz-e-Aam Inter College, Darul Uloom Deoband, Miftiaul Uloom, Nadwatul Ulema, and the All India Milli Council, among others.[125] In 2004, AMU conducted tests on the Oral Polio Vaccine (OPV) to address safety concerns and subsequently issued appeals to the Muslim community, clarifying misconceptions about the vaccine. Similarly, using references from the Qur'an and Islamic literature, JMI created a 'Green Book' that compiled the religious reasoning underpinning the duty to protect children. The book was translated into Hindi and Urdu and used as a communication tool to help educate and promote polio vaccination.[126]

- **Formation of the Rotary Muslim Ulema Committee:** In 2007, the India National PolioPlus Committee (INPPC) established the Rotary Muslim Ulema Committee in Uttar Pradesh. The committee comprised senior Muslim scholars and religious leaders who addressed vaccine resistance by organizing events with district imams to discuss religious concerns and emphasize the importance of immunization.[127]

- **Utilization of the Social Mobilization Network (SMNet):** Managed by UNICEF, the SMNet deployed over 7,000 frontline social mobilizers to engage underserved and resistant communities. Mobilizers collaborated with local religious leaders to promote vaccination, often involving imams in community meetings and encouraging mosque announcements during Friday prayers to endorse polio immunization.[128]

- **Addressing Myths and Misconceptions:** Persistent myths about the OPV, such as beliefs it causes infertility or contained religiously prohibited substances, fuelled resistance. Medical professionals sensitized religious leaders, providing them with accurate information to counter misconceptions, which enabled religious leaders to reassure their communities and dispel falsehoods.[129]

- **Integration of Religious Events and Platforms:** Religious leaders utilized various platforms, including Friday sermons (Khutbahs), Eid-ul-Fitr celebrations, and other religious gatherings, to reinforce the religious obligation of disease prevention and frame polio immunization as a moral duty to protect children's well-being. They also facilitated the establishment of vaccination booths within the premises of mosques and madrasas, making immunization more accessible to the community.[130] To further strengthen these efforts, the polio eradication program also enlisted influential local imams and madrasa teachers as vaccinators and community advocates. Their presence at vaccination booths and their direct engagement with hesitant families helped dismantle misinformation and reassure caregivers. In parallel, the government bundled polio vaccine campaigns with other basic healthcare services such as routine check-ups and essential medications, making it more acceptable for families to participate in immunization drives.[131]

The combination of faith leader advocacy, religious endorsements, and integrated healthcare service provision proved highly effective, leading to a drastic reduction in polio cases. By 2014, the WHO certified India as polio-free and recognized religious engagement as a crucial factor in achieving this milestone.

Discussions during the regional dissemination webinar reinforced that India's success was driven less by the volume of religious messaging and more by the consistency of relationships and visible improvements in service delivery. Participants emphasized that trust was rebuilt when communities experienced respect, responsiveness, and tangible benefits alongside vaccination efforts.

6.1 Nigeria Religious and Traditional Leadership and Local Ownership

Nigeria's experience highlights the importance of religious legitimacy and local ownership in addressing vaccine resistance. In the early 2000s, polio vaccination in northern Nigeria was severely disrupted by boycotts linked to religious and political mistrust. By 2006, over 1,100 children were paralyzed by wild polio across the country, and OPV coverage had plummeted to 36.7 per cent.[132] Conspiracy theories about the vaccine's alleged links to infertility and Western interference fuelled misinformation, triggering a widespread boycott.[133] The country then implemented several strategies to eradicate polio, particularly in the northern regions, by actively collaborating with religious leaders. The strategies included:

- **Engagement of Traditionally Recognized Religious Authorities:** Recognizing the influence of religious leaders in northern Nigeria, health authorities engaged religious scholars and institutions to promote polio vaccination. One of the most significant turning points in Nigeria's polio eradication campaign came when polio officials successfully engaged and achieved the buy-in of the Sultan of Sokoto, the highest Islamic authority in Nigeria.[134] His endorsement of polio vaccination provided religious legitimacy and was a critical catalyst for overcoming resistance among local imams and traditional rulers. With his backing, the polio eradication program in Nigeria mobilized a structured faith-based network, leveraging Nigeria's existing hierarchical traditional leadership system at the state, local government, and village levels. Medical personnel educated imams about the safety and importance of the vaccine, enabling them to address misconceptions within their communities. This educational approach transformed initial resistance into advocacy, significantly improving vaccination acceptance. Faith leaders became central figures in polio vaccine advocacy, integrating pro-vaccine messages into sermons, community meetings and Qur'anic school discussions. In many instances, local imams participated in vaccination campaigns, administering polio drops to children in highly visible public settings, thereby normalizing the practice and mitigating fears.[135]

- ***Majigi* Campaign (Roadside Film Shows):** Initiated in 2008, the *Majigi* campaign was a mobile film outreach programme using visual storytelling to debunk vaccine myths and educate communities about polio. The roadshow featured informational films in Hausa, Nigeria's dominant northern language, explaining the safety and benefits of immunization. Due to the campaign's innovativeness, it attracted thousands of community members across different states. These sessions, often introduced by local leaders, provided visual and narrative explanations of the disease and the benefits of vaccination, reaching illiterate populations and addressing cultural beliefs. The *Majigi* approach proved remarkably effective, leading to a 310 per cent increase in polio vaccination uptake and a net 29 per cent reduction in never-vaccinated children.[136]

- **Formation of the Northern Traditional Leaders Committee for Primary Health Care and Polio Eradication:** In 2009, the Sultan of Sokoto launched this committee to involve traditional and religious leaders in health initiatives. The committee facilitated the mobilization of communities, leveraging the authority of leaders to endorse vaccination campaigns and dispel myths about the polio vaccines.[137]

- **Addressing Vaccine Hesitancy through Religious Endorsements:** To combat misinformation, health teams partnered with local religious leaders, including imams and Islamic scholars, to reassure communities about the safety and necessity of polio vaccines. Religious endorsements were crucial in reducing vaccine refusals and increasing immunization rates. The collaboration between health workers and local religious leaders not only supported polio eradication but also promoted other health services, such as antenatal care, by aligning health messages with religious teachings.[138]

Through sustained faith-driven efforts, Nigeria eradicated wild poliovirus in 2020, marking the African continent's official removal from the list of polio-endemic regions.

6.3 Lessons Learned and Adaptation Considerations

There is no doubt Pakistan and Afghanistan differ from India and Nigeria. Lessons from the case studies need to be contextualized to suit the unique needs of both Pakistan and Afghanistan. Nonetheless, lessons from India and Nigeria demonstrate that a multi-tiered, faith-based approach is essential for overcoming vaccine hesitancy in deeply religious contexts. For Pakistan and Afghanistan, this means engaging influential religious scholars from madrasas, mosque councils, and Islamic advisory bodies to issue formal endorsements for the polio vaccine as was the case in India where health workers partnered with Darul Uloom Deoband and in Nigeria with the mobilization of the Sultan of Sokoto. Local religious leaders can draw upon the endorsements of high-level, influential religious scholars, integrating them directly into Friday sermons, Qur'anic school curricula, mosque-based awareness campaigns, and everyday community conversations, amplifying the legitimacy and reach of the messaging.

A three-pronged approach in Pakistan and Afghanistan to improve polio vaccination rates will involve:

Contextualization

Begin by mapping the religious and social landscape at provincial and community levels. Identify key local clerics, mosque leaders, and religious institutions that can serve as credible champions. As seen in India's 'Green Book' and with Pakistan's National Islamic Advisory Group, involving local ulema councils in the drafting of faith-based guidance for polio vaccination ensures theological justifications align with community realities.

Co-creation

Develop culturally resonant communication materials in partnership with these religious authorities. Utilize local languages (Pashto, Urdu, Dari) in media outreach, including educational films, social media reels, and radio jingles, to dispel misinformation, particularly in low-literacy areas. Drawing on Nigeria's Social Mobilization Network (SMNet), train community mobilizers, especially female health workers, to collaborate with clerics in door-to-door advocacy and mosque courtyard Q&A sessions, ensuring pro-vaccine messages are both accurate and locally meaningful.

Continuous Engagement

Sustain these partnerships through regular training, dialogue, and public recognition of religious leaders as 'health champions.' Encourage clerics to share their own positive experiences with vaccination, quickly address emerging rumours, and embed immunization advocacy within broader health and social service campaigns, such as bundling polio vaccines with maternal and child health services to increase uptake.

For example, if a community in Khyber Pakhtunkhwa experiences rumours about vaccine safety, a respected local scholar, supported by female health workers and provincial religious bodies, could deliver a Friday sermon and/or public lecture emphasizing Qur'anic principles of harm prevention, share his personal story of vaccinating his own children, and co-host a listening session where parents' concerns are addressed openly. Educational reels in Pashto could then be shared via WhatsApp and mosque loudspeakers to reinforce the message. By embedding polio eradication within broader, locally driven health initiatives and leveraging the trust placed in religious leaders, Pakistan and Afghanistan can overcome resistance, build vaccine confidence, and accelerate progress toward a polio-free future.

The Indian and Nigerian models demonstrate the power of faith-based advocacy. Cross-cutting lessons include the structured involvement of clerics in message framing, gender-sensitive recruitment of vaccinators, and linking vaccination with broader community welfare themes. However, context-specific nuances in Pakistan and Afghanistan, such as the countries' linguistic diversity, sectarian affiliations, governance structures, and varying interpretations of Shari'ah, must also inform the adaptive localization of polio vaccination. Programme success in Pakistan and Afghanistan will depend on community-led translation of these approaches into locally legitimate forms co-owned by respected ulema, female mobilizers, and local faith councils.

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CHAPTER 7

Discussion: Insights from Evidence, National and Regional Dialogue

The discussion in this section synthesizes insights from the desk review, national consultations, and, most critically, the regional dissemination webinar, which brought together UNICEF country teams, faith actors, researchers, and practitioners working at the intersection of immunization, faith, and gender in Pakistan and Afghanistan. While the evidence review established the structural and social drivers of immunization gaps, the consultations and webinar provided grounded, operational perspectives on *how* these dynamics play out in practice and *what has proven effective* in highly constrained environments.

Across the discussions, participants converged on a shared understanding: persistent immunization gaps are not primarily the result of insufficient technical knowledge. Rather, a misalignment between immunization strategies and the political, religious, and gendered systems that govern trust, authority, and access at the community level underpin existing immunization gaps.

7.1 Pakistan: From Fragmented Faith Engagement to Institutionalized Partnership

Discussions on Pakistan highlighted the clear evolution of faith engagement approaches over the past decade. Webinar participants described early efforts, initiated around 2013, as fragmented and limited in impact, often focused narrowly on polio messaging and delivered through isolated engagements with religious leaders. These approaches struggled to address the deeply rooted mistrust or the broader well-being concerns of communities.

A turning point emerged with the establishment of more structured faith engagement platforms, particularly through initiatives such as the Faith and Positive Change for Children, Families, and Communities (FPCC). Webinar participants emphasized that the success of the FPCC lay not in messaging alone, but in its conceptual shift from treating religion as a barrier to recognizing it as a system for promoting maternal and child well-being. By linking immunization to broader health, nutrition, and child protection concerns, faith engagement became more credible and socially resonant.

Concrete outcomes reinforced this shift. Participants identified imam-led health programmes, mosque-based health services, and madrasa-based health education as particularly effective in reducing religious refusals, which reportedly declined in targeted areas from approximately 50 per cent to less than 3 per cent. Webinar participants attributed these results to sustained engagement, local ownership, and collaboration with trusted community-based organizations, rather than external enforcement.

Importantly, Pakistan's experience also revealed forward-looking challenges. Participants stressed the need to mainstream faith engagement across UNICEF programming rather than confining it to polio programming. They emphasized engaging madrasa youth, who represent a significant proportion of the population and future religious leadership, as a strategic investment in sustainability. The Pakistan-focused discussion illustrated how institutionalized, multi-sectoral faith engagement can shift social norms when engagement moves beyond crisis response and becomes embedded in routine programming.

7.2 Afghanistan: Navigating Faith Engagement in a Highly Constrained Political Context

The Afghanistan Country Office (ACO) discussions highlighted the distinct political and operational constraints shaping immunization efforts throughout Afgahnistan. Participants emphasized that while faith engagement had long been recognized as essential, earlier approaches were scattered, inconsistent, and insufficiently coordinated across institutions and levels.

Recent efforts mark a significant recalibration. Webinar discussions highlighted a deliberate shift toward structured partnerships with religious leaders, faith-based organizations, and religious institutions, including engagement with scholars affiliated with the de facto authorities. Rather than focusing solely on vaccination, these partnerships initially centred on child rights and well-being, creating space for immunization to be framed within a broader ethical and moral framework.

A particularly notable development discussed during the webinar was the collaborative drafting of the Child Rights Guidelines by a group of religious scholars, faith-based organizations, and UNICEF-supported partners. Participants framed this initiative as not merely an advocacy tool, but as a mechanism for embedding child protection and health within religious discourse that carries political and social legitimacy. Participants further identified a phased approach to capacity building, training master trainers, and cascading learning to provincial and district levels as critical for vaccination reach and consistency.

At the same time, the discussions on Afghanistan highlighted persistent constraints. Poor routine immunization coverage, weak WASH and nutrition services, and restrictions on women's mobility continue to undermine progress. Participants were explicit that while site-to-site vaccination remained necessary, female frontline health workers retained a unique ability to access households for mobilization and trust-building. However, movement restrictions on women had sidelined many female frontline healthcare workers, creating a direct link between gender constraints and immunization gaps.

The Afghanistan case illustrates how faith engagement can function simultaneously as an asset and a risk. When coordinated, inclusive, and context-sensitive, faith engagement enables trust and access; when fragmented or politically misaligned, it can reinforce exclusion. This context underscores the need for careful navigation, long-term investment, and adaptive strategies tailored to evolving realities.

7.3 Women's and Female Frontline Workers' Roles: Central but Constrained

Across both country discussions, the role of women emerged as a unifying analytical thread. Webinar participants repeatedly emphasized that women, particularly mothers and female frontline health workers, were central to immunization outcomes, yet structurally constrained in ways vaccination programmes often failed to address.

Importantly, webinar participants cautioned against framing women solely as barriers or victims. Instead, they emphasized women's potential as agents of change when programmes created enabling conditions through respectful engagement, credible information, and alignment with religious and cultural norms. This perspective shifts the focus from targeting women with messages to restructuring systems limiting their ability to act.

In Pakistan, Lady Health Workers (LHWs) were cited as among the most trusted actors in communities, capable of translating health guidance into locally meaningful terms. There have also been successful initiatives, including Grandmother Groups, where healthcare workers had capacitated elderly women to become advocates for immunization and child well-being. Webinar participants described female vaccinators and mobilizers in Afghanistan as indispensable for household engagement, even as their participation remained precarious due to movement restrictions and security concerns.

A key analytical insight from the webinar was that women's effectiveness depends on legitimacy and protection, not just deployment. Participants identified faith leaders as critical actors in legitimizing women's roles, both as caregivers making health decisions and as professionals delivering services. Where religious authority affirmed women's participation, acceptance and safety improved; where it was absent, women's roles remained vulnerable.

7.4 Faith Engagement as a System of Legitimacy, not a Messaging Channel

One of the strongest points of convergence across the desk review, national consultations, and regional dialogue was the recognition that faith functions as a system of legitimacy that cannot be reduced to communication or advocacy. Participants across the sessions emphasized religion as a system of meaning, authority, and social regulation, cautioning against approaches treating religious leaders as conduits for pre-defined messages, and noting such strategies often failed to resonate at the community level. As such, faith leaders not only act as messengers but as gatekeepers, negotiators, and exchange agents who shape norms and enable or restrict access.

The discussions also highlighted that religious authority shaped how households understand moral responsibility, care, and protection. Faith engagement is most effective

when it acknowledges this role and involves religious actors as partners in interpretation and dialogue. Participants from both Pakistan and Afghanistan stressed that communities did not respond to abstract theological arguments, but to guidance delivered by trusted local figures who understood their lived realities and could situate immunization within everyday moral reasoning.

Examples shared during the webinar, such as male-to-male engagement through mosques, negotiating safe passage for female healthcare workers, and training madrasa teachers, demonstrated how faith-based strategies operated at multiple levels simultaneously. This insight reinforced the desk review's finding that global religious declarations, while important, require local translation to be effective. The webinar further clarified that the credibility of faith engagement depends on consistency over time and visible alignment with community well-being, rather than one-off endorsements or crisis-driven outreach.

7.5 Implications for Strategy and Programming

Taken together, the national consultations and webinar discussions deepen the evidence base in three critical ways. First, they demonstrated that institutionalized faith engagement, rather than episodic outreach, was essential for sustained impact. Second, they revealed how gender dynamics, particularly women's mobility, authority, and safety, were directly linked to immunization performance. Third, they showed that community fatigue did not reflect resistance to vaccines per se, but dissatisfaction with narrowly focused, repetitive interventions that were disconnected from broader well-being.

The lessons emerging from the evidence and dialogue point to a clear conclusion: the final phase of polio eradication in Pakistan and Afghanistan hinges on aligning immunization strategies with the social systems governing trust, authority, and access to healthcare. Faith engagement, women's roles, and workforce protection are not supplementary considerations but central determinants of success in the final mile of polio eradication, and they must be among the core components of any effective strategy.

The following section translates these synthesized insights into actionable, strategic recommendations aimed at institutionalizing faith engagement, supporting women and girls, protecting frontline workers, and addressing intersecting vulnerabilities in a coherent and sustainable manner.

CHAPTER 8

Strategic Recommendations

The evidence from the desk review, national consultations, and regional webinar underscores that the final phase of polio eradication in Pakistan and Afghanistan will not be achieved solely through technical optimization. Progress depends on socially intelligent, faith-aligned, and gender-responsive strategies that address how trust, authority, mobility and access operate in practice. The following six pillars consolidate all key recommendations into a coherent framework that is both strategic and operationally actionable.

- Pillar 1: Institutionalize Faith Engagement as a Core Immunization Strategy
- Pillar 2: Legitimize and Enable Women's Roles Through Faith-Consistent Pathways
- Pillar 3: Protect, Professionalize and Advance Female Frontline Health Workers
- Pillar 4: Reduce Community Fatigue Through Integrated and Dignified Service Delivery
- Pillar 5: Strengthen Information Ecosystems and Counter Misinformation Ethically
- Pillar 6: Embed Intersectionality, Accountability and Learning

Pillar 1 Institutionalize Faith Engagement as a Core Immunization Strategy

Faith engagement must be embedded as a sustained system of partnership rather than episodic outreach.

Key Recommendations

- Establish long-term partnerships with local imams, ulema councils, madrasa leaders, and female religious scholars at district and provincial levels, prioritizing grassroots legitimacy over distant authority.
- Transition from one-off sensitization sessions to continuous, two-way dialogue, positioning religious leaders as co-interpreters of child well-being, rather than merely messengers.
- Utilize mosques and madrasas as trusted platforms for immunization awareness, community dialogue, and service delivery, including mosque-to-mosque campaigns welcoming mothers and children.
- Localize theological justifications by supporting the development of context-specific fatwas, declarations, and religious literature in local languages, endorsed by respected local Islamic councils.
- Institutionalize the role of religious leaders in health policy dialogue and accountability forums, ensuring faith perspectives shape rather than react to programme design.

Pillar 2 Legitimize and Enable Women's Roles Through Faith-Consistent Pathways

Women are central to immunization outcomes but remain structurally constrained. Their roles must be enabled through culturally and religiously legitimate approaches.

Key Recommendations

- Frame mothers' caregiving and health decision-making as religiously grounded responsibilities, emphasizing the protection of all children, girls and boys alike.
- Engage fathers, male guardians and senior women (especially mothers-in-law) as key influencers in household decision-making through mosque-based seminars, targeted sermons for men, and community dialogues.
- Prioritize women's religious education, including training female scholars (alimaat) to lead health discussions, workshops, and advocacy within faith settings.

- Apply social and behavioural change approaches that leverage peer norms, neighbourhood visibility, and collective participation to encourage uptake.

- Address logistical barriers to access by introducing community-based transport solutions, particularly in Afghanistan, where vaccination is site-to-site. This includes:
  - Organizing group transport for women and children from the same locality
  - Coordinating safe travel windows and accompaniment where culturally required

Pillar 3 Protect, Professionalize and Advance Female Frontline Health Workers

Female frontline health workers (FFLWs) are a system enabler, not a supplementary workforce.

Key Recommendations

- Expand recruitment of FFLWs from conservative communities and ensure safe mobility, secure transport and clear safety protocols.

- Strengthen protection through community-level endorsement by religious leaders, public condemnation of attacks, and framing women's work as a religiously legitimate service.

- Provide fair and timely remuneration, hazard pay, health insurance, and psychosocial support to improve retention and morale.

- Establish peer support networks, mentorship programmes, and leadership pathways, enabling FFLWs to progress into supervisory and planning roles.

- Use faith narratives and historical precedents (e.g., Rufaida bint Sa'ad al-Aslamiyah) to legitimize women's participation in healthcare.

Pillar 4 Reduce Community Fatigue Through Integrated and Dignified Service Delivery

Fatigue reflects misalignment between programme design and lived realities, not resistance to vaccines.

Key Recommendations

- Reduce repeated household visits by allowing trained social mobilizers to administer the oral polio vaccine (OPV), eliminating unnecessary follow-up visits.

- Streamline data collection by conducting one comprehensive survey for planning and limiting future data collection to what is only essential.
- Integrate polio vaccination with broader maternal and child health services, including nutrition screening, antenatal care, deworming and health education.
- Organize community and mosque-based health camps, jointly led by religious leaders and health professionals, to provide holistic services alongside vaccination.
- Introduce carefully designed incentives (e.g., health kits, educational materials) while avoiding practices that raise unsustainable expectations.

Pillar 5 Strengthen Information Ecosystems and Counter Misinformation Ethically

Misinformation thrives where trusted, accessible information is absent.

Key Recommendations

- Provide religious leaders with direct access to health experts to build confidence and accuracy in health guidance.
- Digitize madrassas and modernize curricula to include public health, science, critical thinking, and child rights, alongside religious studies.
- Build a responsible faith-based digital presence by training scholars in ethical social media engagement and multilingual content creation.
- Introduce polio dial tones on mobile networks during campaign periods, building on the success of COVID-19 public service announcements to reach households at scale.
- Establish rapid response mechanisms, endorsed by Islamic institutions, to counter emerging rumours and misinformation through trusted channels.
- Facilitate open community forums where local people can voice concerns and ulema and health experts can address them together respectfully.

Pillar 6 Embed Intersectionality, Accountability and Learning

Immunization strategies must intentionally address overlapping vulnerabilities.

Key Recommendations

- Conduct gender and social inclusion (GESI) analyses during planning stages to identify populations excluded due to poverty, displacement, disability or minority status.
- Design flexible delivery models adapted to diverse settings rather than uniform approaches.
- Establish feedback mechanisms enabling religious leaders, FFLWs, and community members to share their experiences and identify areas for improvement.
- Strengthen monitoring, evaluation, and learning systems to document effective practices and enable cross-country learning.
- Systematically document and share success stories where faith actors and communities have improved immunization outcomes.

Together, these six pillars translate evidence and dialogue into a coherent, context-responsive strategy. They demonstrate that faith engagement, women's inclusion, workforce protection, service dignity, information integrity, and intersectional equity are not parallel tracks, but mutually reinforcing levers. When aligned, they can move polio eradication efforts beyond diminishing technical returns toward sustained, community-owned success.

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FAITH, GENDER, AND IMMUNIZATION:

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