



**Assessment of Religious Engagement
Strategies in Polio outbreak responses:
Insights from 13 countries across WCAR,
MENAR, and ESAR**

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Introduction

Religious leaders are among the most trusted and influential figures in many communities, particularly in contexts affected by health emergencies, conflict, and social instability. Their role in shaping public opinion and guiding community behavior makes them critical allies in public health initiatives, including polio eradication efforts.

This rapid assessment was conducted across 13 polio outbreak countries—Angola, Algeria, South Sudan, Nigeria, Democratic Republic of Congo (DRC), Somalia, Kenya, Djibouti, Yemen, Benin, Cameroon, Chad, and Ethiopia—with the aim of mapping current strategies used to engage religious leaders in promoting polio and routine immunization. The consultation sought to:

- Identify existing approaches and practices in religious engagement
- Highlight gaps and challenges in implementation
- Provide recommendations for strengthening future collaboration

The assessment revealed a diverse range of engagement models, from formal partnerships with religious institutions to ad hoc involvement during campaigns. While many countries have successfully leveraged religious platforms to disseminate health messages and resolve vaccine refusals, others face challenges such as limited coordination, inconsistent involvement, and lack of tailored resources.

Insights gathered from this assessment will inform the development of more inclusive, strategic, and sustainable community engagement frameworks, enhancing the role of religious leaders as trusted advocates for polio eradication and routine immunization. By understanding what works, where gaps exist, and how to improve, countries can better harness the power of faith-based leadership to reach every child with life-saving vaccines.

This report synthesizes the findings to provide a consolidated view of the current religious engagement strategies in Polio outbreak settings, highlighting both operational realities and strategic opportunities.

Methodology

This report is based on a rapid online assessment conducted across 13 countries experiencing Polio outbreaks in the WCARO, MINARO, and ESARO regions. The assessment was coordinated with support from the respective UNICEF regional offices.

Data was collected through a structured online questionnaire designed to capture both quantitative and qualitative insights related to religious engagement strategies in Polio eradication. The questionnaire included a mix of closed-ended questions and open-ended prompts to elicit detailed responses on countries interventions, best practices, challenges and lessons learned from religious engagement in Polio eradication.

A total of 14 SBC specialists currently engaged in Polio eradication efforts participated in the assessment. Respondents were selected based on their active involvement in outbreak response activities and their affiliation with UNICEF at the country level.

The data were analyzed using a mixed-methods approach:

- **Quantitative responses** were aggregated and summarized using descriptive statistics to identify common trends and patterns.
- **Qualitative responses** were thematically analyzed to extract key insights that reflect the lived experiences and professional judgments of the respondents.

Executive Summary

This rapid assessment, conducted across 13 polio outbreak countries, explores the role of religious leaders in supporting polio eradication efforts. The findings highlight the strategic importance of religious engagement in improving vaccine acceptance, managing refusals, and enhancing community trust in immunization campaigns.

Key Findings

- **Widespread Engagement Models:**
 - 38% of countries (e.g., Algeria, Angola, Nigeria) have formal partnerships with religious institutions.
 - 54% engage with religious leaders consistently without formal agreements.
 - Only one country (Kenya) reported occasional, ad hoc engagement.
- **Multi-Level Implementation:**
 - Seven countries implemented religious engagement at all health system levels (national to facility).
 - Others showed partial implementation, often limited by operational capacity or strategic priorities.
- **Effective Interventions:**

Religious leaders contributed through:

 - Advocacy and commitment building
 - Message dissemination during worship
 - Refusal management and community mobilization
 - Participation in campaign launches and health talks
 - Collaboration with health authorities and use of religious spaces for vaccination
- **Positive Outcomes:**
 - Increased awareness and information dissemination (e.g., Benin, Chad, Ethiopia)
 - Resolution of vaccine refusals (e.g., Nigeria, Djibouti)
 - Improved vaccine uptake and trust-building (e.g., Yemen, Algeria)
 - Strengthened faith-based networks and institutional collaboration (e.g., Angola, Chad)
- **Challenges Identified:**
 - Late or limited involvement in planning
 - Engagement restricted to campaigns only

- Diverse theological views and vaccine skepticism
- Limited scientific literacy and communication gaps
- Logistical, political, and financial constraints
- Uneven regional engagement and weak follow-up mechanisms
- Resistance from conservative groups and overreliance on voluntarism

Recommendations

To strengthen religious engagement in polio campaigns, the report recommends:

- Formalizing partnerships and creating inclusive platforms
- Engaging religious leaders early and continuously
- Building capacity with tailored resources
- Leveraging religious platforms for message dissemination
- Enhancing coordination, microplanning, and gender-sensitive outreach
- Providing recognition and logistical support
- Addressing resistance through dialogue and inclusion
- Improving communication and feedback mechanisms
- Allocating dedicated resources for sustained engagement

I. Engagement of religious leaders in Polio campaigns

Countries with formal partnerships with religious leaders and Institutions ¹	Countries without formal Partnerships but with consistent Engagement ²	Countries without formal Partnerships and with occasional engagement ³
Algeria, Angola, Nigeria, Somalia and Yemen	Benin, Cameroon, Chad Djibouti, DRC, Ethiopia and South-Sudan	Kenya

Among the 13 countries surveyed on the engagement of religious leaders in polio eradication efforts:

38% (Algeria, Angola, Nigeria, Somalia and Yemen) have established formal partnerships with religious leaders and institutions. This indicates a structured and sustained collaboration, likely involving official agreements or frameworks for ongoing engagement.

54% (Benin, Cameroon, Chad Djibouti, DRC, Ethiopia and South-Sudan) reported that they engage religious leaders and institutions in every polio campaign even though they don't have a formal partnership. While these may not be formalized partnerships, consistent involvement suggests a strong recognition of the influence and trust religious leaders hold in their communities.

Only 1 country (Kenya) indicated that it engages religious leaders occasionally, suggesting a more ad hoc or campaign-specific approach, which may limit the potential impact of religious leaders in promoting vaccine acceptance and participation.

This distribution highlights a promising trend toward institutionalizing the role of religious leaders in public health campaigns, while also pointing to opportunities for strengthening engagement in countries where collaboration remains informal or infrequent.

¹ These countries have established official frameworks or agreements that integrate religious leaders and institutions into national or regional social and behavior change strategies. Engagement is structured, consistent, and often institutionalized through policies, memoranda of understanding, or joint programming.

² These countries do not have formal agreements with religious leaders or institutions, but they actively involve them in every campaign. Engagement is regular and strategic, recognizing the influence of religious actors in community mobilization and message dissemination, even without formalized structures.

³ These countries engage religious leaders and institutions on a case-by-case basis, depending on the nature of the campaign. Engagement is ad hoc and not part of a systematic approach, often driven by specific needs or opportunities rather than ongoing collaboration.

II. Level of implementation of religious engagement in Polio campaigns

All levels (National, Provincial, District and Health facilities)	National, Provincial and District levels	National and Provincial levels	National and District levels	Provincial, District and Health facility levels
Algeria, Cameroon, Chad, Djibouti, DRC, Kenya and South Sudan	Angola, Ethiopia and Nigeria	Yemen	Somalia	Benin

The survey revealed varying levels of engagement with religious leaders across different administrative tiers.

Out of the 13 countries surveyed, 7 have implemented religious engagement activities across all levels of the health system—namely, national, provincial, district, and health facility levels.

Among these, only Algeria has established a formal partnership with religious institutions, indicating a structured and institutionalized approach to religious engagement.

In contrast, Cameroon, Chad, Djibouti, DRC, and South Sudan—despite lacking formal partnerships—have consistently engaged religious leaders and institutions. Their ability to implement activities at all levels reflects a strong operational commitment and recognition of the strategic role religious actors play in social and behavior change, even without formalized agreements.

Additionally, three countries—Angola, Ethiopia, and Nigeria—implemented religious engagement activities at the national, provincial, and district levels. Among these, two have formal partnerships with religious institutions, indicating a structured approach to engagement across key administrative tiers, though not extending to health facility levels.

Meanwhile, Yemen and Somalia, despite having formally established partnerships with religious institutions, have implemented activities at limited levels.⁴

This suggests that while formal partnerships can provide a framework for collaboration, they do not automatically guarantee comprehensive implementation across all levels. Operational capacity, contextual challenges, and strategic priorities may influence the depth and reach of engagement.

⁴ In Yemen engagement activities were conducted only at the **national and provincial levels** and **Somalia** activities were implemented at the **national and district levels**

III. Religious engagement in Polio eradication efforts: Interventions implemented

Religious engagement has played a pivotal role in advancing polio eradication efforts across the 13 surveyed countries. Recognizing the influence of faith leaders and institutions, the programme strategically integrated religious advocacy and mobilization into its core communication and community engagement strategies. Below interventions have been implemented across 13 surveyed countries:

Interventions implemented	Benin	Cameroon	Somalia	Ethiopia	DRC	Yemen	Algeria	South Sudan	Chad	Djibouti	Kenya	Angola	Nigeria
Advocacy and Commitment building	✓	✓			✓	✓	✓		✓		✓	✓	✓
Message dissemination and vaccination during worship	✓	✓	✓	✓	✓	✓	✓	✓		✓		✓	✓
Community engagement and Refusal management	✓	✓			✓		✓		✓			✓	✓
Campaign inauguration and awareness				✓			✓						
Collaboration with Health authorities (Orientation and engaged as social mobilizers)		✓					✓	✓		✓			
Social mobilization in faith settings	✓		✓			✓		✓				✓	✓

- **Advocacy and commitment building**

At the national level, advocacy meetings were held with umbrella organizations representing religious groups, including diocesan health coordinators and Islamic councils. These sessions aimed to secure formal commitments from religious leaders to support polio campaigns. Similar engagements were replicated at provincial, district, and health center levels to ensure widespread involvement.

- **Message dissemination and vaccination during worship**

Religious leaders actively disseminated key vaccination messages during sermons and worship services. In Muslim communities, messages were shared during daily prayers and Friday sermons, often referencing the Qur'an and Hadith to emphasize the religious duty of protecting children's health. In Christian communities, messages were delivered during Sunday services, with some churches hosting vaccination teams to reach children who might otherwise be missed.

- **Community mobilization and Refusal management**

Faith leaders were instrumental in managing vaccine refusals and reaching defaulters. Their trusted voices helped address misconceptions and resistance, particularly in hard-to-reach or skeptical communities. Compound meetings, mosque gatherings, and church visits were used to facilitate dialogue and encourage vaccine uptake.

- **Campaign inauguration and awareness**

Religious leaders participated in campaign launch ceremonies, pre-campaign awareness activities, and outbreak response efforts. Their presence lent credibility and visibility to the campaigns, reinforcing the importance of vaccination as a shared community and spiritual responsibility.

- **Collaboration with Health authorities**

In collaboration with Ministries of Health and Religious Affairs, religious leaders were trained and oriented on key messages. They were engaged as community mobilizers and included in stakeholder engagement platforms. In some countries, letters were sent to churches and mosques ahead of campaigns, encouraging leaders to promote vaccination and motivate caregivers.

- **Social mobilization in faith settings**

Social mobilization activities were conducted in mosques, churches, and other religious gatherings. These efforts ensured that messages reached large audiences in culturally and spiritually resonant ways. In regions with traditional leadership structures, forums with Emirs and Northern traditional leaders were convened regularly to reinforce campaign goals.

However, it's important to note that the scope and nature of activities implemented through religious engagement in support of polio eradication efforts vary significantly across countries. These differences are closely tied to each country's strategic approach to engaging religious leaders.

IV. Outcomes of Religious engagement in Polio campaigns

Religious engagement has emerged as a critical strategy in enhancing the effectiveness of polio eradication efforts across multiple countries. By leveraging the influence and trust of religious leaders, the programme has achieved notable improvements in community awareness, vaccine acceptance, and refusal management.

➤ **Increased awareness and Information dissemination in the latest Polio campaign Benin, Chad, Kenya, Ethiopia and DRC**

- Over 6,000 messages disseminated by Christian and Muslim religious leaders in latest Polio campaign in Benin
- 10% of households in N'Djamena (Chad) informed by religious leaders before campaigns.
- 6%–6.21% awareness recorded through independent monitoring and supportive supervision surveys in Ethiopia
- Use of mosques and churches for health talks and campaign messaging in Kenya

➤ **Refusal management and resolution in Nigeria, Benin, Somalia, DRC and Djibouti**

- 387+ refusal cases resolved through religious leader intervention in Benin
- Religious leaders involved in non-compliance teams and refusal case management in Nigeria, Cameroon and DRC
- Engagement helped reduce refusals and increase resolution rates in Nigeria, Somalia and Djibouti

➤ **Improved vaccine acceptance and uptake in Yemen, Algeria and Somalia**

- Increased acceptance among fathers, who are key decision-makers, in Yemen
- Addressed misconceptions rooted in religious beliefs in Yemen, Algeria, South-Sudan
- Decrease in refusals and greater acceptance of the polio vaccine reported in Angola

➤ **Trust Building and Community Confidence in Yemen, Algeria and South-Sudan**

- Religious leaders helped build trust in vaccination efforts in South-Sudan
- Their involvement contributed to greater credibility of health messages in Algeria and Yemen
- Faith-based engagement helped prevent non-compliance and fostered community ownership in Nigeria

- **Access to Religious Spaces for Health Communication in Yemen, Ethiopia, Algeria and Cameroon**
 - Churches and mosques opened for campaign-related communication in Cameroon
 - Health talks conducted during Friday prayers and Sunday services in Somalia, Angola
 - Some religious spaces even served as **vaccination points** in Angola and Ethiopia
- **Institutional collaboration and alliance Building in Angola**
 - Formation of the Alliance of Religious Institutions in Angola.
 - UNICEF co-chairing with religious representatives and supporting provincial governments.
 - Development of action plans and indicators for sustained engagement.
- **Strengthened faith-based networks and Information Flow in Chad, Ethiopia and Angola**
 - Faster information sharing among faith-based organizations in Ethiopia and Angola
 - Umbrella organizations facilitated coordinated mobilization at national and community levels in Chad
 - Religious leaders organized social mobilization meetings with local faith leaders in Ethiopia

V. Methods used to assess religious engagement contribution in Polio campaigns

The methods used to assess religious engagement contribution in polio campaign outcomes vary across the surveyed countries as described in the table below:

Countries	Somalia	Algeria	Benin	Yemen, South Sudan and Angola	Kenya	Nigeria	Cameroon	Chad	Djibouti	DRC	Ethiopia
Results assessment methods used	Activity report from partner	Activity report from partner	Admin data	Own observation	Own observation	Own observation	Own observation	Own observation	IM data	IM data	Qualitative study,
	Admin data	Qualitative study	IM data	Activity report from partner	Activity report from partner	Admin Data	Admin data	Admin data	Activity report from partner and	Admin data	IM data
	Qualitative study	Survey	Survey	Qualitative study	Survey	Activity report from partner	Activity report from partner	IM data	Qualitative study	Survey	Survey

Findings indicate that **Somalia** stands out for using a diverse mix of methods (partner reports, admin data, qualitative study) while **Yemen, South Sudan, and Angola** rely heavily on structured data (admin, IM, survey), possibly due to formal partnerships.

Kenya, Nigeria, Cameroon, and Chad combine formal and informal methods, including own observation, suggesting adaptive monitoring practices.

Ethiopia and DRC use a broad mix of methods, indicating robust evaluation frameworks.

These variations highlight the need for more standardized and robust evaluation frameworks to better capture the outcomes and effectiveness of religious engagement in immunization campaigns.

VI. Effective strategies for religious leader engagement in Polio campaigns

Across the surveyed countries, several strategies have proven effective in engaging religious leaders to support polio eradication efforts. These approaches have contributed to increased awareness, improved vaccine acceptance, and reduced refusal rates. The most impactful strategies include:

- **Identification and engagement of influential religious leaders in refusal management in Benin, Algeria, Somalia, Ethiopia, Nigeria**

Targeting respected and influential religious figures—such as imams, pastors, and “Mourchidates” (in Algeria)—was consistently cited as the most effective strategy. Their support helped amplify campaign messages, manage refusals, and build trust within communities.

- **Early advocacy and strategic planning in Cameroon, Angola and Chad**

Conducting **upstream advocacy** with religious leaders and umbrella organizations at national and sub-national levels ensured early buy-in and alignment with campaign goals. This included regular advocacy meetings before each campaign and involvement in planning and decision-making processes.

- **Capacity building and tailored messaging in Ethiopia, Djibouti and Algeria**

Training sessions equipped religious leaders with accurate health information and supported them in framing messages within religious teachings. This enabled them to confidently address misconceptions and promote vaccination as a religious and moral responsibility.

- **Integration into religious platforms in Somalia, Ethiopia, South Soudan, Algeria and Nigeria**

Health messages were consistently delivered during religious gatherings, including Friday prayers, Sunday services, and religious classes. In some cases, places of worship were used as vaccination sites, increasing accessibility and visibility.

- **Gender-sensitive outreach in Algeria and Yemen,**

Leverage both male and female religious leaders to address gender-specific barriers and misconceptions. Female religious counselors (Mourchidates) played a vital role in reaching women, especially mothers, through home visits, youth centers, and health clinics in Algeria. Their engagement created safe spaces for dialogue and helped address concerns specific to caregivers.

- **Collaboration with Religious associations in Angola, Cameroon, DRC, Nigeria, Somalia, Chad, Djibouti and Kenya**

Deploying faith-based associations to collaborate with health teams facilitated broader community mobilization and message dissemination. These partnerships also helped resolve refusals and supported non-compliance teams.

- **Structured and decentralized engagement in Angola and Chad**

Align efforts with national religious institutions and umbrella organizations to ensure consistency and legitimacy. Countries with a **decentralized engagement model**—featuring clear accountability frameworks from national to community levels—reported stronger outcomes. This structure enabled consistent messaging and localized action.

- **Dual engagement approaches in Angola, Algeria and Chad**

Maintaining both **vertical (top-down)** and **horizontal (community-based)** engagement approaches allowed for strategic coordination with high-level religious authorities while empowering grassroots actors to mobilize their communities.

- **Continuous feedback and adaptation in Algeria and Angola**

Regular communication and feedback loops with religious leaders helped refine strategies and sustain their commitment. This two-way engagement fostered ownership and responsiveness throughout the campaign cycle.

- **Integration with broader health initiatives in Angola and Ethiopia**

In some contexts, such as Angola, religious engagement extended beyond polio to include other health responses like cholera. This integration strengthened partnerships and institutionalized religious involvement in public health.

These strategies demonstrate that meaningful, structured, and inclusive engagement of religious leaders is essential for enhancing the reach and impact of polio vaccination campaigns. Institutionalizing these practices within national immunization frameworks can further strengthen community trust and improve health outcomes.

VII. Challenges and less effective strategies in religious engagement for Polio campaigns

While religious engagement has contributed positively to polio eradication efforts, several strategies have proven less effective or faced implementation challenges across surveyed countries. These limitations highlight areas for improvement in future planning and execution.

- **Late or limited involvement in planning in Benin and Angola**

In many cases, religious leaders were informed about campaigns too late, limiting their ability to mobilize effectively. Their involvement was often restricted to the implementation phase, rather than being integrated into the planning and strategy development stages.

- **Campaign-only engagement in Cameroon and DRC**

Religious leaders' participation was often limited to vaccination campaigns, with little to no involvement in broader immunization or health promotion efforts. This narrow focus reduced opportunities for sustained community influence and trust-building.

- **Diverse beliefs and attitudes toward vaccination in Algeria, Chad and Nigeria**

Religious leaders represent a spectrum of theological views. While many were supportive, others expressed skepticism or hesitancy due to doctrinal concerns or misinformation, particularly in conservative communities

- **Limited scientific literacy and communication gaps in Chad and Algeria**

Some religious leaders lacked sufficient understanding of medical and scientific concepts, making it difficult for them to confidently and accurately convey health messages. This sometimes led to misinterpretation or dilution of key messages.

- **Political, logistical and resource constraints in Ethiopia, DRC and Yemen**

Coordinating training, follow-up, and mobilization activities across diverse religious networks posed logistical challenges. Funding constraints further limited the ability to sustain engagement in DRC and Angola. In Angola, due to ongoing political and financial crisis, one of the key barriers of religious engagement is the expectation of financial incentives as a prerequisite for participation—making sustained mobilization difficult.

In Yemen, the situation is further complicated by political and administrative barriers. In the northern regions, some local authorities have actively impeded partnerships with religious leaders, restricting their ability to participate in health promotion activities, including those in educational settings.

- **Uneven regional engagement in Chad and Algeria**

Engagement levels varied significantly across regions. While some areas saw strong participation, others experienced limited involvement due to local leadership dynamics, lack of motivation, or competing priorities. This inconsistency affected the overall reach and impact of campaigns.

- **Weak follow-up mechanisms in Algeria and Chad**

Initial training and engagement were not always followed by ongoing support or communication. Without regular updates and encouragement, momentum declined, and religious leaders became less active over time.

- **Inconsistent message delivery in Algeria**

Some religious leaders lacked confidence in delivering health messages or altered them based on personal interpretations. This led to diluted messaging or confusion among congregants, undermining the intended impact.

- **Resistance from conservative segments in Algeria and Kenya**

A minority of religious leaders, particularly in conservative communities in Algeria, expressed skepticism about vaccination or hesitated to align religious teachings with public health messages. Addressing such resistance required more intensive and sustained engagement than was often available.

In Kenya, engaging special religious sects in immunization efforts has proven more challenging compared to mainstream religious affiliations. These groups often exhibit lower levels of trust in public health initiatives and are more resistant to vaccination, making outreach and mobilization efforts more complex and less effective.

- **Overreliance on voluntarism in Algeria and Angola**

Many religious leaders participated on a voluntary basis, without formal recognition or compensation. While this demonstrated goodwill, it limited their availability and commitment, especially in resource-constrained settings.

- **Limited gender integration in rural areas in Algeria**

While female religious counselors (Mourchidates) in Algeria were effective in urban settings, their presence in rural areas was limited. This created gaps in outreach to women and mothers in communities where vaccine hesitancy was often highest.

- **Passive communication approaches in Angola**

In Angola, traditional methods such as distributing leaflets (e.g., comunicado de púlpito) were used without active engagement. These passive strategies failed to foster a sense of ownership or initiative among religious leaders.

- **Lack of innovation and engagement fatigue in Nigeria**

Repeated use of the same engagement formats and messages led to fatigue among both religious leaders and caregivers. Without fresh approaches or updated materials, interest and motivation waned over time.

These challenges highlight the need for more inclusive, well-planned, and sustained engagement strategies, supported by proper mapping, capacity building, and resource allocation. Addressing these barriers is essential to fully leverage the influence of religious leaders in advancing polio eradication efforts.

- **Involvement of religious leaders in campaign supervision, engagement activities in schools and media in DRC, Yemen and Kenya**

In both the Democratic Republic of Congo (DRC) and Yemen, the involvement of religious leaders in immunization campaigns has faced notable challenges, particularly in the areas of **campaign supervision** and **school-based engagement**. In Kenya, efforts to engage religious leaders through webinars and television talk shows have yielded limited results. These platforms often lack the personal connection and contextual relevance needed to effectively mobilize religious leaders.

VIII. Actionable recommendations for strengthening religious engagement in Polio Campaigns

Religious leaders play a vital role in shaping community attitudes and behaviors, particularly in contexts where trust in public institutions may be limited. Across the surveyed countries, their involvement in polio eradication efforts has proven to be a powerful tool for enhancing community mobilization, addressing vaccine hesitancy, and promoting health-seeking behaviors.

However, the effectiveness of religious engagement varies significantly depending on how partnerships are structured, the level of involvement, and the support provided to religious actors. Drawing from country-level experiences and lessons learned, this chapter outlines a set of actionable recommendations aimed at strengthening and sustaining meaningful collaboration with religious leaders in polio programmes.

These recommendations are designed to guide programme managers, and implementing partners in developing inclusive, culturally sensitive, and results-driven strategies that leverage the influence of religious institutions to improve immunization outcomes.

1. Formalize and institutionalize partnerships

- Establish formal agreements with religious organizations and umbrella bodies to ensure structured collaboration and long-term commitment.
- Create national and sub-national platforms for religious engagement, ensuring representation across denominations and sects.

2. Engage religious leaders early and continuously

- Involve religious leaders from the planning phase of campaigns to foster ownership and alignment with community values.
- Maintain engagement between campaigns through regular meetings, community activities, and feedback loops.

3. Build capacity and provide tailored resources

- Conduct training workshops that combine scientific knowledge with religious framing to help leaders confidently promote vaccination.
- Develop and distribute IEC materials that reflect religious perspectives and are suitable for use in sermons, social media, and community gatherings.

4. Leverage religious platforms for message dissemination

- Encourage integration of health messages into regular religious activities such as Friday prayers, Sunday services, and women's study groups.

- Utilize religious leaders in media outreach, including video messages and talk shows, to expand reach and credibility.

5. Strengthening coordination and microplanning

- Map all religious institutions to improve planning and ensure comprehensive coverage.
- Involve religious leaders in microplanning and community-level mobilization to reach hard-to-access areas.

6. Provide recognition and incentives

- Acknowledge contributions through certificates, public testimonials, and community media.
- Consider modest logistical support (e.g., transport, phone credit) to facilitate participation, especially in resource-constrained settings.

7. Enhance gender-sensitive approaches

- Expand the role of female religious counselors (Mourchidates), particularly in rural areas, to improve outreach to women and caregivers.
- Ensure gender balance in training and engagement activities.

8. Address resistance through dialogue and inclusion

- Engage conservative or hesitant leaders through respectful dialogue, peer influence, and tailored messaging.
- Use testimonies from trusted religious figures to counter misinformation and build trust.

9. Improve communication and feedback mechanisms

- Establish relay systems between national and community-level leaders (e.g., WhatsApp groups, newsletters).
- Set up simple reporting and feedback tools to ensure religious leaders feel heard and valued.

10. Allocate dedicated resources

- Include dedicated budget lines for religious engagement activities, such as sermon development and training.
- Co-design communication materials with religious leaders to ensure cultural and theological relevance.

Conclusion

The rapid survey conducted across 13 polio outbreak countries highlights the critical role of religious engagement in enhancing the effectiveness of immunization campaigns. Religious leaders, as trusted community figures, have demonstrated their capacity to influence public attitudes, address vaccine hesitancy, and mobilize caregivers—particularly in contexts marked by social, political, or environmental challenges.

The survey findings reveal that successful religious engagement is strongly linked to structured, inclusive, and sustained approaches. Countries that formalized partnerships, integrated religious leaders into planning processes, and provided tailored training and resources reported stronger outcomes in terms of community awareness, trust-building, and refusal resolution.

However, several challenges persist, including inconsistent engagement across regions, limited early involvement, logistical constraints, and difficulties in reaching certain religious sects or informal institutions. These barriers underscore the need for more strategic coordination, improved mapping, and continuous support mechanisms.

Drawing from both successes and challenges, the survey offers a set of actionable recommendations to guide future efforts. These include formalizing partnerships, fostering early and inclusive collaboration, enhancing gender-sensitive outreach, and investing in capacity building and communication tools tailored to religious contexts.

Ultimately, religious engagement must evolve from a campaign-specific tactic to a sustainable, community-centered strategy embedded within national immunization frameworks. By doing so, countries can harness the full potential of religious leaders as allies in the fight against polio and broader public health initiatives.