

Southeast Afghanistan Refusals Desk Review Findings and Programmatic Considerations

Introduction

This document presents the key findings from a comprehensive desk review of vaccination refusals in the southeast region of Afghanistan. It synthesizes available data to identify where refusals are concentrated, the underlying social and behavioral drivers shaping refusal patterns, and the profiles of families most likely to decline vaccination. The analysis also highlights some programmatic areas that limit the effectiveness of current interventions and outlines some strategic considerations to address both the root causes of refusals and the structural constraints within the existing delivery system. Together, these insights aim to inform a more targeted, network-driven, and sustainable approach to reducing persistent refusals in the region-driven, and sustainable approach to reducing persistent refusals in the region.

1. Key Findings – Southeast Afghanistan Refusal Deep Dive

- **Refusals are highly concentrated and persistent**
 - Paktika remains the main hotspot with 23,096 still-refusal families, followed by Khost with 7,630.
 - Over 2025, still-refusal rates show no improvement in Paktika (91–92%) and a worsening trend in Khost (87% → 92%), indicating current strategies are not shifting behavior.
- **Majority of refusals are belief-driven and deeply entrenched**
 - Hard/chronic refusals account for 70% of all cases, rooted in religious, cultural, and ideological beliefs, namely: Polio vaccine doesn't align with Islamic teachings, vaccine is haram, vaccine causes infertility, vaccine is a western weapon against Muslim countries, etc
 - These families consistently reject vaccination across campaigns, showing strong resistance to engagement through Polio frontline workers.
- **Multiple refusal types require differentiated approaches**
 - Beyond chronic refusals, demand-based refusals concentrated among Pakistan refugees, Afghan returnees (14%), soft/silent refusals (9%), influencer driven refusals led by some religious leaders, government officials and medical

personnel (4%), and unreachable households (3%) each have distinct motivations and engagement needs.

- **Refusal decisions are shaped by male authority and local social networks**
 - Men (husbands) make 74% of refusal decisions; elders account for another 22%.
 - Decisions are strongly influenced by religious leaders, madrasa teachers, and local elders, not by health workers.
- **Trusted information sources exclude the health system**
 - Refusal families (hard and chronic) rely on family members and local religious/social networks for information.
 - Health professionals are not trusted by chronic and hard refusals families. Women rely primarily on husbands and senior family members
- **Key refusal drivers are belief-based**
 - Religious interpretations, vaccine safety fears, misinformation, and social network approval are the dominant drivers.
 - These drivers reinforce each other, creating a self-sustaining ecosystem of refusals.

2. Programmatic Factors Contributing to Refusals

Efforts to reduce refusals in the Southeast Region continue to be hindered by several structural and operational weaknesses:

- **Limited integration of refusal data with social reference networks.** Refusal data is not systematically mapped to families' social and relational networks, making it difficult to identify key influencers and tailor engagement strategies. As a result, interventions remain generic and less effective.
- **Campaign based rather than continuous engagement of religious leaders.** Religious leaders are primarily mobilized during campaigns, with limited religious dialogue or trust building. This approach weakens their ability to effectively counter misinformation or influence deeply rooted beliefs. **Frontline workers face capacity and trust challenges.** Polio frontline workers often lack the skills, confidence, and community trust needed to effectively engage refusal families, especially hard and chronic refusals. Because they operate outside trusted social circles, their outreach has limited impact. Engagement led by individuals outside these networks further reduces acceptance and behavior change.
- **Weak influencers' selection and monitoring systems.** Influencers are sometimes chosen without assessing their actual credibility or connection to refusal families. There is no systematic process to assign specific families to each influencer or to monitor their performance, resulting in inconsistent and ineffective engagement.

- **Weak local systems for designing and overseeing targeted interventions.** Local structures responsible for planning, implementing, and monitoring refusal reduction strategies are underdeveloped. The absence of clear mechanisms, follow-through, and defined accountability leads to fragmented interventions with limited ownership and sustainability. This weak system capacity significantly constrains efforts to reverse persistent refusals.

3. Programmatic Considerations to Address Persistent Refusals

➤ **From Campaign centric- to continuous, network driven- engagement**

Move beyond campaign only outreach by establishing year-round engagement with religious leaders, elders, and madrassa teachers. Build structured platforms and position local influencers as ongoing community educators. **Why:** Hard refusals (70%) are belief driven and reinforced daily, not during campaigns only. only outreach by establishing yearround engagement with religious leaders, elders, and madrassa teachers. Build structured platforms and position local influencers as ongoing community educators. driven and reinforced daily, not during campaigns.

➤ **From Frontline worker–led to Trusted network–led engagement**

Shift engagement from frontline workers, who lack trust, to credible insiders such as husbands, elders, and religious figures. Frontline workers become facilitators who activate trusted networks. **Why:** Refusal families trust local social networks, not health workers.

➤ **From generic messaging to tailored, data driven- social network mapping**

Map each refusal family’s social reference network (religious leader, elder, madrassa teacher) and assign the right influencer accordingly. Develop microplans based on specific belief drivers and decision makers. **Why:** Refusal behavior is shaped by social ecosystems; tailored engagement increases impact.

➤ **From ad -hoc Influencer use to a structured, Accountable influencer system**

Define clear criteria for influencer selection, assign specific refusal families to each influencer, and monitor performance. Provide training and recognition to sustain motivation. **Why:** Influencers are powerful only when credible, strategically selected, and accountable.

➤ **From Fragmented oversight to strong, accountable local systems**

Establish provincial, district and community level refusal oversight committees with clear roles, responsibility and accountability framework. Introduce routine reviews and strengthen local capacity for targeted interventions. **Why:** Weak local systems undermine implementation and sustainability. and communitylevel r

➤ **From one-size-fits all to segmented strategies based on refusal Profiles**

Tailor engagement to each refusal type:

- **Hard/chronic** (70%) → long-term religious and norm shifting work-term religious and norm-shifting work
- **Soft/silent** (9%) → reassurance and interpersonal communication
- **Service demand** (14%) → link to community needs (WASH, health, education)
- **Influencer driven** (4%) → engage the specific influencer-**driven**
- **Unwilling to speak** (3%) → indirect engagement via trusted intermediaries.

Why: Different refusal drivers require different solutions.