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## Constructing (Mis)trust: A Critical Discourse Analysis of Vaccine-Hesitancy Narratives Among Low-Literacy Populations in Pakistan

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## Abstract

Despite the success of vaccination programs in Pakistan, vaccine hesitancy remains a major challenge, particularly in communities with low literacy, where health messages are conveyed primarily through speech. This research adopts a critical discourse analysis approach to examine, line by line, how trust and mistrust in vaccines are constructed in the discourse of low-literacy communities in Khyber Pakhtunkhwa. The study treats hesitation not as a mere lack of knowledge but as something "constructed" through language, including the stories people tell, the words they borrow from religion and politics, and the silence they observe regarding health workers. Data were collected through thirty-two in-depth interviews, non-participant observation of vaccine visits, and a community talk via mosque announcements and WhatsApp voice notes. The text was analyzed using Fairclough's three-dimensional model of discourse, which examines text production and consumption as well as the social forces operating behind the text. Results demonstrate the nonrandom nature of mistrust. It is created through repeated assertions about foreigners' intentions, metaphors that pit vaccines against poison and testing against death, and a palpable and justifiable rage against government neglect, which was never about the vaccine. The study suggests that health communication in Pakistan should shift away from the mere task of correcting messages and toward the discourse of neglect that health communication surrounding vaccine talk in these communities has drawn its focus from.

| **Keywords** | Vaccine hesitancy, critical discourse analysis, low literacy, health communication, trust, Khyber Pakhtunkhwa, polio vaccination. |
|---|---|

## Introduction

Despite vaccines being among the most cost-effective tools ever developed by public health, in many parts of the world people refuse them or delay them even when offered for free and readily available nearby (MacDonald & SAGE Working Group on Vaccine Hesitancy, 2015). One of the most obvious examples of this puzzle is in

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Pakistan. It is one of the only two countries in the world where wild poliovirus is still found, and it has been battling for years against parents who deny their children the polio drops, are late on routine childhood vaccines, and have refused to take up the COVID-19 vaccine (Khalid et al., 2022). It is not just a lack of information. Even when a vaccine is available, free of charge, and people are aware of its existence, studies conducted in Karachi have revealed that many people are still hesitant to take the vaccine due to personal beliefs, rumors, and general distrust of the vaccinators (Qasim et al., 2022). Similarly, that refusal is not confusion at all, as demonstrated in work with frontline polio workers. Many parents are actually well aware of the benefits of the vaccine; however, they refuse, as refusal is the only means of protesting years of neglect by the state (Majidulla et al., 2025).

In addition, Pakistan has seen an influx of health misinformation across WhatsApp groups, local FM radio, and even via word of mouth in mosques and markets. Ittefaq et al. (2020) documented how social media in Pakistan became a terrain where, for all intents and purposes, politicians, religious leaders, and common users emerged as credible sources of medical information, thereby aggravating confusion. A recent participatory study with low-income Pakistani adults found that misinformation moves through exactly these informal channels — encrypted messaging apps, voice notes, and trusted community relationships — and that people's sharing behavior reflects a communal sense of moral obligation to warn others, not simple gullibility or a lack of media literacy (Sohail et al., 2025). A large matched case-control study in high-risk districts also reported that vaccine refusal clusters in certain districts and are related to specific social and administrative failures, not to the overall lack of intelligence among parents (Soofi et al., 2023). Fieldwork with women and community stakeholders in peri-urban Karachi similarly found that door-to-door visits by trusted community health workers, public announcements, and word-of-mouth channels remain essential for health messaging precisely because digital literacy and access are so uneven, even as WhatsApp and television reach smartphone users (Kumari et al., 2025). Collectively, these studies suggest that there is a significant thing at stake – vaccine hesitancy in Pakistan is language-carried and language-shaped. It resides in the language used to talk about the vaccine, the health provider, and the government behind them.

Most public health research on the subject remains focused on whether individuals accept a vaccine and on identifying the "why" or "why not" — for instance, one recent survey-based study modeled vaccine hesitancy as an outcome predicted by misinformation exposure, with health literacy acting as a partial mediator (Khalid, 2025). This is good, but it is lacking. It fails to examine in depth the construction of the "no" in everyday discourse, particularly among those who cannot read a pamphlet or consent form and learn about vaccines from conversations, rumors, sermons, and voice notes. Where literacy is low, language plays an amplified role, as spoken words, tone, and repeated phrases are often the only health information available — a gap that recent public health commentary has linked directly to Pakistan's lack of standardized, locally adapted health terminology across its many spoken languages (Irfan et al., 2025). Vaccine hesitancy is not a static attitude, housed within the minds of individuals. However, it is something that is constructed and reconstructed via discourse – literally the words, stories, and arguments that are circulated in a community.

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**Research Problem**

Even after years of vaccination programs and communication, people with low literacy in rural and semi-urban areas of Pakistan remain hesitant to take vaccines; and current health communication practices largely assume that this "gap" is only a matter of providing more information. However, in the absence of a deeper conversation – composed of specific words, metaphors, and silences – that ordinary people use to make sense of vaccines, health workers, and the state, these strategies fall short. If people do not grasp how this discourse is produced and maintained in everyday communication, communication campaigns risk miscarrying, as the message is misunderstood and rejected. The voice, the history, and the intentions behind the message are rejected.

**Research Questions**

In Pakistan's low-literacy communities, what do they talk about vaccines and vaccination programs in their daily conversations to build or distrust?

What broader social, historical, and political factors help to maintain and inform this discourse of vaccine mistrust in these communities?

**Significance of the Study**

The importance of this study lies with three factors. First, it provides a voice for a population that is often discussed in the health research arena, but whose views are seldom heard, as most surveys in which they are included ask them to respond to questions on a form, with the answers being either yes or no. Second, it offers a novel perspective for public health planners in Pakistan, enabling them to design messages for the vaccine that attend to the words and stories circulating within these communities rather than just the facts. Third, it contributes to the development of what is still a relatively small literature of critical discourse analysis in the field of health in South Asia, in which most discourse studies have dealt with the news media rather than the ordinary discourse of low-literacy communities.

In addition to these three, there is a practical need for this study. Pakistan is still investing heavily in vaccination initiatives and staff. However, every refused vaccine dose represents money, risk, and delay to polio eradication and the prevention of vaccine-preventable diseases in children. However, unless the words and stories that inspire mistrust are studied, campaign planners will never know the underlying drivers of refusal. They are likely to end up using the same leaflets and slogans, none of which have proved to work for years. This study aims to provide planners with more useful information than a percentage of vaccine-hesitant parents, by listening very carefully to what people are saying about vaccines in their own families, mosques, and WhatsApp groups. It seeks to provide them with the “true form” of the mistrust itself and aid the creation of future messages to address the actual worry, rather than one that health officials imagine people may be feeling.

**Literature Review**

Global Vaccine Hesitancy, a Search for Meaning. The World Health Organization's (WHO) SAGE Working Group on Vaccine Hesitancy defined vaccine hesitancy as a delay or refusal to receive a vaccine despite its availability. It noted that it is not a simple challenge, as it varies over time, across geography, and even by vaccine type (MacDonald & SAGE Working Group on Vaccine Hesitancy, 2015). This definition marked a crucial shift, moving the focus from individual responsibility for being 'ignorant' to confidence in the system, the convenience of access, and complacency about the disease itself. Since then, researchers around the world have sought to

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dissect these three factors in various contexts, and confidence — in the vaccine, the provider, and the policymaker behind it — has consistently proven to be the trickiest of all.

Vaccine Hesitancy in the Pakistani context. Pakistan provides a stark illustration of how confidence can erode and remain low for years. The fight against polio in the country has been complicated by a widely publicized 2011 incident in which a fake vaccination campaign was used to track a wanted person, and this remains a point of contention among community members today due to a lack of trust in vaccination teams (Majidulla et al., 2025). In the wake of this, Khalid et al. (2022) conducted a literature review of COVID-19 vaccine hesitancy in Pakistan and observed overall vaccine hesitancy ranging up to thirty-five percent. More importantly, most studies measured vaccine hesitancy rather than exploring why it manifested in the particular way in that specific location. In a low-income settlement in Karachi, Qasim et al. (2022) went one step further, using in-depth interviews and focus group discussions to demonstrate the close relationship between hesitancy and personal belief systems and between acceptance and trusted sources of information, even if they are not necessarily official campaigns. Soofi et al. (2023) broadened the lens by linking vaccine refusal cases to community and household conditions. They found that vaccine refusal is not evenly distributed but rather concentrated in certain social conditions, namely neglect of basic services, which is associated with vaccine refusal.

In all these studies conducted in Pakistan, there is a common thread: declining the vaccine is not a lack of understanding about the vaccine itself; it is a message about something else. This was evident in the case studies of Majidulla et al. (2025), where frontline health workers reported parents who knew the benefits of the polio vaccine but refused it because it was the only means they had to voice their objections to the neglect over the years in water, sanitation, and basic health care. This reframes vaccine hesitancy as a form of communication – a communication with the state through the one method that will ensure a response: the vaccine visit.

In parallel to these public health research projects, a different research stream has examined the flow of health information in Pakistan. According to Ittefaq et al. (2020), during COVID-19, the Pakistani social media space became even more hybrid, and an ordinary listener could be convinced by both a religious leader and a politician, as well as a doctor. This mirrors a broader pattern documented in public health scholarship on religion: rather than treating religious authority as simply a "barrier" or "facilitator" to be measured, recent work argues that religious speech functions as a discursive exercise of power that shapes what counts as credible health knowledge in the first place (Fuller, 2025). This is important for communities with low literacy, who must rely even more heavily on a trusted elder's word, the tone of a trusted voice, or a forwarded voice note, when they cannot read a government pamphlet and need to determine what is true. A recent multi-country framework developed specifically to measure vaccine trust — including field data collected in Pakistan — likewise found that trust is not a single attitude but a layered construct spanning belief in the health system's promises, its actual delivery, and the vaccine itself, each shaped by lived, relational experience rather than facts alone (Bowen et al., 2025). In this kind of environment, trust is not something that only comes through facts. It is constructed through known words, voice, and the speaker's tone —a point the accompanying commentary on that same framework underscores by noting how little existing tools

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capture the everyday, relational texture of trust in lower-income settings (Kaufman & Danchin, 2025).

These findings should also be considered in the context of current knowledge on health communication in low-literacy environments. If they are unable to access this information when it is presented in print on a consent form, a vaccine card, or a public health poster, the information is, all practical matters being equal, as if it did not exist. Cross-cultural survey work on health information more broadly confirms that even where digital access exists, trust in a source depends heavily on who delivers the information and how, not merely on whether facts are technically available (Alhewiti, 2025). In that kind of environment, essentially meaning can only be conveyed orally, by the voice of a familiar old-timer, a religious leader, a family member, or neighbor, and by reiteration: if a phrase is repeated from different sources, many times in various contexts, it seems like a confirmed fact just because it keeps coming up — a mechanism directly consistent with recent experimental work showing that repeated exposure alone, independent of source or evidence, generates a growing subjective sense that a claim is true (Stump et al., 2025). That is why Pakistanis rely on social media and mobile messaging platforms more than on other media when it comes to health, because although a voice note or forwarded message might have traversed cities or even nations before arriving at a listener, it also feels intimate, like a conversation (Ittefaq et al., 2020). In low-literacy communities, this equates to vaccine hesitancy language often being developed from multiple sources. It is pieced together from a sermon, a rumour, a warning from a relative and a recollection of neglect from the past; and repeated and reinforced until it becomes one obvious truth — a dynamic that recent modelling of health rumour propagation describes as "trust hijacking," where messages travel fastest not despite intimate social ties but precisely because they borrow the credibility of kinship, neighborliness, and community trust to become self-reinforcing (Dong et al., 2025).

**Research Gap**

In comparing these two collections of works, a certain lacuna is evident. Public health research in Pakistan is excellent at reporting the prevalence of hesitancy, associated beliefs, and matched case-control designs, typically through surveys and/or interviews and subsequent theme coding. What they do not often do is examine the actual language of hesitancy—the words, the metaphors, the silences, the shirkings of responsibility, and so forth—as an object of study. However, media and communication studies have focused on discourse and misinformation, typically at the level of newspapers or TV or of a social media posting, and rarely at the level of a community's everyday, spoken communication—which is the medium that is least likely to reach them, and is most likely to reach them, via pamphlets. To date, no research has employed a full critical discourse analysis (CDA) approach, as conceptualized by Fairclough, to examine the actual discourse in low literacy communities in Pakistan, which are hesitant to vaccinate, and linked these discourse dynamics to the larger historical contexts of state mistrust, religious construction, and social neglect that surround them. This study is designed to meet this specific need.

**Methodology**

The two research questions in this study focus on meaning and power in language, not on the number of people who hold a certain view, which led to the use of a qualitative research design based on critical discourse analysis. CDA does not view language simply as a ‘container of facts' but as a means of social action, and questions how

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certain modes of discourse (ways of speaking) are constituted, and what social forces sustain them (Fairclough, 1992). Underpinning this study is Fairclough's three-dimensional model of discourse, which views three interconnected levels of discourse in any given communication. The first is the level of the text, that is, the words, grammar, and metaphor employed. The second level is discourse practice, that is, how the text is created, disseminated, reproduced, and received within the community. The third is sociocultural practice, which refers to the broader historical, political, and religious contexts that are manifested in the words and make them seem sensible. Fairclough, the most influential theorist in the field of critical discourse studies, maintained that language not only represents social life but also constructs it, and that everyday speech may be read as a field in which power and resistance are negotiated (Fairclough, 1992). The framework was selected over a simple thematic process because it does not stop at naming a theme (e.g., mistrust) but goes on to question how that mistrust is constructed word-by-word, and why it is sensible from a discursive point of view to the speaker(s). These did not involve the type of thematic organizing that Braun and Clarke would call for and were only a first, pragmatic step towards breaking down the vast amount of talk into smaller, more manageable groups, as a precursor to more in-depth discourse reading.

To assess the influence of the various communication channels, the study was conducted in six low-literacy villages and peri-urban settlements in Khyber Pakhtunkhwa, where low literacy rates and vaccine refusal history have been documented, and where spoken and religious channels of communication are the focus, to the exclusion of print. Using purposive sampling, participants were selected, and snowball sampling was then used to reach the remaining members of the community. Sampling continued until saturation was reached, where no new obvious pattern of talk was occurring in the data. Thirty-two people were included in the final sample: eighteen parents/carers of young children, six community and religious elders, four local vaccinators and lady health workers, and four school teachers who frequently serve as informal information brokers in these villages. The age of the participants varied from 22 to 68, and 20 out of 32 participants were unable to attend school or did not complete primary school.

Data collection was done in three ways to capture the discourse that occurred during the learning process, not just the discourse reported after the learning process. In the first phase, all thirty-two participants were interviewed in Urdu, Saraiki, and Pashto using an in-depth, semi-structured interview schedule, which lasted between forty and seventy minutes each, and was audio-recorded, with the consent of the participants, and subsequently transcribed and translated into English by the bilingual research assistants (checked for accuracy). Second, non-participant observation was conducted during eleven vaccination visits as well as two community health meetings, with the researcher making detailed field notes on who spoke, who did not, and how health workers and community members talked to each other. Third, field notes of four mosque announcements on vaccines and twenty-six WhatsApp voice notes from community groups were included as naturally occurring talk, as these are common daily spaces for the dissemination of health information and rumors in these communities. All participants gave written consent (or verbal consent, which, due to low literacy levels, was clearly explained and recorded on tape).

All transcripts, field notes, and translated voice notes were read multiple times and organized according to Fairclough's three-dimensional model. The text analysis

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included word choice, repetition of words or phrases, metaphors, and sentence placement of blame or responsibility at the textual level. The analysis at the level of discourse practice identified how some phrases circulate in the community, such as the phrase from the mosque announcement that a mother used in her private explanation of why she would not vaccinate her child. At the sociocultural level, the analysis related these patterns of talk to historical events known to the participants from the literature set in Pakistan, including the "fake vaccination campaign" of 2011, and to current local grievances, including the lack of water supply, clinics, and political neglect, to account for the significance of some of the words. The data were coded by the two researchers separately and then read and interpreted in accordance with the results of each other's reading through discussion, if there were any differences, until the differences were resolved, which supported the trustworthiness of the data interpretation. Consent for the study was obtained following the usual procedures of informed consent, voluntary participation, anonymity, and the freedom to withdraw at any time for any reason without repercussions.

The analysis was carried out in a manner that sought to enhance its trustworthiness, in line with common practice in qualitative analysis. By spending longer in each village during the vaccination visits and follow-up interviews, instead of rushing through a village to get the data, more time was given for a greater feel for safety for participants to speak openly. On the one hand, triangulation was inherent in the design itself, as interview talk and observed talk during visits to the vaccination centers, as well as naturally occurring talk from voice notes and mosque announcements, were compared. Critical discourse analysis entails the reader's awareness of their own assumptions and reactions, which were documented in the reflexive journal during the data collection and analysis. Member checking was done with an eight-person subset of the original group and involved presenting the major patterns they found in the plain language summary to them and asking them if they thought the interpretation was correct in terms of how they thought they were talking and how they thought they were being interpreted.

**Data Analysis**

The results are organized around the three levels of Fairclough's framework, ranging from the smallest level of analysis—actual words used—to the largest—social and political history that makes those words significant. An overview of the participants discussed in this section is provided in Table 1.

**Table 1:** ***Overview of Participants and Data Sources***

| Participant Group | Number | Data Collected | Average Age (years) |
|---|---|---|---|
| Parents or caregivers | 18 | Interviews, observation | 34 |
| Community or religious elders | 6 | Interviews, mosque announcements | 56 |
| Vaccinators and lady health workers | 4 | Interviews, observation | 29 |
| Schoolteachers (information brokers) | 4 | Interviews | 31 |

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| | | | |
|---|---|---|---|
| Total | 32 | Interviews, observation, WhatsApp voice notes, mosque announcements | 37 |

**Textual Dimension: Words that Carry Doubt**

Three patterns emerged in the interviews, at the level of the text itself, and were evident in nearly all thirty-two interviews. The first was the use of the term 'test' as a substitute for the word 'vaccine' used several times. Some parents referred to the vaccination visit as an "azmaish" (trial/test), not as treatment or prevention. One mother (Rukhsana, 28) pointed out, “They are putting an experiment on our children; we are not certain what. In this one-word decision, the whole event is changed. A test implies a process of uncertainty, experimentation on the community, and not a gift or service to the community. The second pattern concerned body and poison metaphors. Despite not being able to identify a particular harmful ingredient, several participants referred to the vaccine as "cutting," "weakening," or "poisoning" the child's body. The metaphors do not have to be literally true to be politically resonant: they resonate socially because they invoke an abiding fear of strangers interfering with the body of a child without full knowledge or consent. The third pattern that appeared in the texts was the grammatical shift of the acts from the government to faceless actors. Sentences were typically constructed to avoid identifying a clear actor of the harmful action, and instead used language similar to "it is done to us." This type of language was passive or denied agency; no one would explicitly accuse anyone, and no one could verify or disprove it with facts.

The Fourth and lesser (though not insignificant) was the comparison words, where the vaccine was compared to other items in the community's inventory of items to be distrusted. One elder (61 years old), in a statement that also referred to a general distrust of having one's name recorded or counted by outsiders, likened the vaccination team to 'the survey people who come and write our names for other reasons'. However, Shazia, 27, a vaccinator herself, detected this pattern from the other side, as she said: “sometimes they ask me if I am really from health or from somewhere else?” — revealing the suspicion is not only about the vaccine as a substance but the visit itself as an event that is akin to other unwanted forms of official contact. Individually, these are seemingly innocuous word choices. However, they combine to put the vaccine in a family of suspicious outside visits, not a family of caring and protective actions—and this is done silently, before any fear of safety or ingredients is even mentioned.

**Discourse Practice Dimension: Who Speaks, Who Is Silenced**

On the discourse practice level, the analysis followed the trajectories of these words and phrases, as they circulated among different speakers and contexts. A clear trend of borrowing from mosque announcements to private household discussions could be discerned. Two of the villages observed had an imam who announced a Friday sermon: "Be careful with outside medicine," which was then reproduced verbatim by the mothers when they spoke to a health worker days afterward. Voice notes via WhatsApp served a similar purpose, but were quicker, could go further, and would often repeat what they had heard from a family member from overseas or from a well-meaning “doctor” no one in the chain could vouch for, but whose message was nonetheless accepted because a trusted family member received it, and often began with something along the lines of “for the sake of your children, please listen.” During

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the process, vaccinators and lady health workers were in an odd place in this discourse. However, their words were rarely personal blame, but rather "just doing their job," and they were often spoken of sympathetically, but they were not as significant as the words of an elder or an imam. This demonstrates a discourse practice involving the polite uptake of official health messages without necessarily accepting them as truthful in isolation, and treating unofficial health advice from the community as more credible simply by virtue of who is communicating them and how these are communicated personally. However, the health workers themselves were seldom allowed to speak in their own terms about the science in their home visits, as these were brief and were aimed after the task, so the official discourse of public health did not often enter the same everyday spaces where the discourse of suspicion was being rehearsed and refreshed.

**Sociocultural Practice Dimension: Greater Forces behind Bigger Words**

On the broadest scale, nearly all the patterns mentioned above related to historical and political events that participants mentioned spontaneously. Seventeen of the thirty-two informants (including younger parents who were children at the time) referred to the 2011 fake vaccination campaign, used to locate the wanted individual, indicating that such an event can become a community memory, with a negative effect on subsequent vaccination visits. However, this particular event was not an isolated one, and a general pattern of neglect was evident in nearly all the interviews. Participants often shifted from discussing the vaccination to discussing a lack of clean water, doctors not being present at the local clinic, and roads that flood yearly and are never repaired; they used the vaccine visit as an opportunity to bring up grievances about the state, which they could not go anywhere else to address. This is very similar to what is seen in the case of frontline polio workers across Pakistan who sometimes refuse to take part to indicate protest (Majidulla et al., 2025). Finally, there was a sociocultural theme in which vaccines were made to appear as linked to an external, foreign agenda, sometimes loosely related to the international political climate or religious concerns about the contents of the vaccine, which also resonates with the broader phenomenon of unverifiable claims in Pakistani social media, as highlighted by Ittefaq et al. (2020). Another sociocultural dimension was added alongside gender and household decision-making. A few mothers described how, although they felt it was safe to use the vaccine, they still did not have the final say; it was their husband's or an older male's, and they had no hesitation in questioning these decisions in front of others. This meant that the discourse of mistrust was sometimes not the mother's own belief but rather a belief she expressed using the authority of another, usually another woman, within the home, where health workers, who were also mostly women, sometimes had difficulty directly challenging them out of social politeness. This layer is consistent with broader findings from other Pakistani studies that household and community structures of authority and influence shape a person's hesitancy, as do individual beliefs (Qasim et al., 2022). These three dimensions have been combined into a single table (Table 2), together with short illustrative extracts from the data.

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**Table 2:** ***Summary of Discursive Themes Across Fairclough's Three Dimensions***

| Dimension | Key Pattern | Illustrative Extract | Interpretation |
|---|---|---|---|
| Textual | Vaccine renamed as "test" | "They are testing something on our children" | Reframes prevention as risky experimentation |
| Textual | Poison and harm metaphors | "It will weaken the child's body" | Draws on fear of unseen bodily harm |
| Discourse practice | Sermon phrases repeated at home | "Be careful with outside medicine" | Religious authority spreads and repeats suspicion |
| Discourse practice | Health worker words carry less weight | "She is just doing her job" | Official message respected but not fully trusted |
| Sociocultural | Memory of the 2011 fake campaign | "We have not forgotten what happened before" | Historical event still shapes present suspicion |
| Sociocultural | Vaccination visit used to voice neglect | "First bring us water, then talk about vaccines" | Refusal doubles as protest against state neglect |

**Discussion**

Combining these three levels, the results indicate that vaccine hesitancy in these communities does not seem to be a mere lack of information, as it cannot be filled with more pamphlets, posters, or awareness slogans. Rather, it is better thought of as a discourse – a system of language, shared meanings, cultural memories, and repeated narratives – that influences people's attitudes and choices towards vaccination. In this discourse, refusal is not interpreted as irrational or uninformed by community members. Instead, it can seem rational, moral, and "socially legitimate" because known narratives, trusted sources, and familiar practices of marginalization back it. The interviews show that community members seldom talk about vaccination as a stand-alone health action. Rather, they link it to other issues including state intentions, foreign influence, religious obligations, and community safety. As such, vaccine refusal gets laced in a larger narrative of caution as good citizenship, not necessarily anti-science.

This is in line with earlier studies performed in Pakistan that found vaccine hesitancy is not merely due to medical knowledge and understanding. The study findings of Majidulla et al. (2025) and Qasim et al. (2022) suggest that a significant number of parents are aware of the health benefits of immunization and that immunization vaccines are meant to prevent diseases. However, education does not always lead to acceptance of vaccinations. The present study extends this by demonstrating why factual knowledge often does not lead to behavior change. Critical Discourse Analysis shows that information must pass through prior discourses of mistrust before being accepted or rejected. Medical explanations thus have to contend

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with these kinds of narratives that have been perpetuated over many years of "everyday" discourse, religious meetings, family talk, and social media interaction. Therefore, scientific evidence is often viewed through a lens of suspicion rather than trust.

One of the great merits of this study is the discovery of the linguistic devices by means of which this discourse is preserved. The analysis shows that the words, metaphors, and recurring expressions themselves are important in actively reproducing mistrust, and not only attitudes or beliefs. One obvious indication is that the word 'test' is used repeatedly rather than 'vaccine'. The lexical choice has meaning that goes beyond its dictionary definition. It implies experimentation, uncertainty, possibly the use of local populations for activities which are unknown to them. In the same way, metaphors portray vaccines as dangerous or hidden threats, making medical intervention a threat to personal/family wellbeing. These language patterns are practiced over and over in various contexts. What is said in a sermon on a Friday can be conveyed to family members, sent via WhatsApp, and then end up being part of an individual's rationale for not getting vaccinated. In the ongoing circulation, language not only renders fear intelligible, but also generates and legitimates fear.

The results also suggest that historical memory is a key element in sustaining this discourse. Participants consistently associated vaccination campaigns with broader experiences of political neglect, inadequate public services, and unequal treatment by state institutions. Vaccination issues were often linked to complaints about poor health care, lack of education, unemployment, or insufficient government commitment. Thus, vaccination campaigns were not seen as 'stand-alone' health measures but as part of a broader relationship between the state and marginalized communities. If people feel this is the first time the government has shown interest in their daily lives, the sudden appearance during vaccination drives can seem sinister rather than comforting. This history reinforces stories of vaccination programs serving external interests rather than the well-being of local people. This, in turn, fosters distrust of vaccines as well as of institutions.

In practical terms, the results indicate that traditional approaches to health communication might not be effective if they remain rooted in paradigms that focus on correcting misinformation or adding more scientific information. Information campaigns that explain what vaccines contain, how they are safe, or how they work at the clinical level are based on the belief that misinformation stems from a lack of information. However, the current results show that it is more a question of trust than of knowledge. Successful interventions must thus address the discourse of neglect and mistrust that contributes to local understandings of vaccination. This means recognizing community members' lived experience and taking on board their often expressed frustrations in a way that does not dismiss them as irrational. This understanding can help open the door to conversation that purely informational campaigns cannot seem to get a foothold in.

The study also indicates that, to be effective, communication should rely more on trusted local networks than on outside institutional voices. Elders, other trusted members of the community, teachers, and local religious leaders are even more likely to be trusted than government authorities or visiting health officials. They have an impact not only through their formal authority but also through the discursive process of producing and sharing discourse in ordinary social relations. Responsible figures can thus play a role in vaccination campaigns that increases the chances of messages

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being understood in a caring and responsible context, rather than a suspicious one. Importantly, such collaboration should not use community leaders simply as messengers for official messages. They should instead be actively involved in conceiving communication strategies that take into account local concerns, language, and cultural values.

The results also confirmed the core of Fairclough's (1992) argument that discourse is not merely a reflection of people's beliefs but a social power that constantly shapes future beliefs and behaviors. Each time vaccination is replaced by "test," each time a rumor circulates on WhatsApp, and each time a sermon references vaccine hesitancy in a religious and/or political context, vaccine hesitancy is perpetuated. Thus, discourse becomes a self-reinforcing process. These messages are repeated frequently, become more familiar and accepted the more they are repeated, and make other explanations harder to accept. That is why a successful awareness campaign does not lead to lasting change with a single campaign. Even if people take the state's message on a one-time basis, they remain in a communication space where alternative narratives are constantly disseminated through family talk, in public spaces, on social media, in informal faith communities, and in other settings.

This has a significant impact on the implementation of the recommendations for frontline health workers. Vaccinators, especially women who are often from outside the immediate community, need preparation that goes beyond accumulating scientific information or rote memorization of communication texts. Training programs should be designed to help them understand the root causes of vaccine hesitancy, such as social neglect, fear of surveillance, beliefs about religion and religious identity, and household power dynamics that can affect health choices. Vaccinators can then be better informed to address the issues raised in the community and avoid repeating information that community members may already have heard and disregarded. This approach takes health communication beyond merely correcting misinformation to building trust and listening to lived experiences, and eventually changing the social conversation in which vaccine hesitancy is constantly being created and reinforced.

**Conclusion**

This study aimed to explore how trust and mistrust are developed through the language of people in low-literacy groups in Pakistan in everyday scenarios, and what larger factors sustain this discourse. Through critical discourse analysis based on Fairclough's three-dimensional model, the study identified various manifestations of mistrust, including lexical devices (naming the vaccine "a test" instead of "a vaccine"), metaphors of bodily harm, the use of religious idioms in everyday household talk, and the long historical memory of the 2011 fake vaccination campaign. Perhaps most importantly, the study found that vaccine refusal can also be a symptom of mistrust in a much broader system of state neglect; the vaccine is not necessarily the only object of mistrust.

The results indicate a need to shift focus from merely delivering the right information loudly or more frequently in health communication in Pakistan. They have to listen to the real conversation that is going on in these communities, acknowledge the history behind it, and then address the grievances of neglect that are often just behind a parent's rejection. Teaching first responders about these communication trap levels – and collaborating more closely with local religious

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leaders or community figures as collaborators, not barriers – may be more effective in establishing a long-term trust-building relationship than a new pamphlet or slogan.

This study has several limitations that should be considered. The six villages were located in Southern Khyber Pakhtunkhwa, and the words and metaphors used there may not be the same as those used in other parts of Pakistan, such as the northwestern regions studied in other polio research. Also, because of translation from Urdu/Saraiki/Pushto to English (and bilingual checking), although every attempt has been made to retain the original emotion of the text and the wordplay, some of these elements may have been lost. More research might be beneficial to compare discourse patterns across various parts of Pakistan; to track the same communities over a longer time frame to observe changes in discourse when a vaccination campaign is either successful or unsuccessful; or to use the same critical discourse approach with the language of health workers themselves to identify any hidden assumptions in official communication that quietly undermine the trust that official communication is meant to build.

Ultimately, the anti-vaccination rhetoric people spout is not idiotic or pointless. They are influenced by memory, by religion, by the roles of men and women within the home and by years of feeling excluded by the State. The first and most important step towards restoring such trust, which only a leaflet could not establish, might be to listen carefully to these words and not rush past them to correct a fact.

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## VOL-3, ISSUE-1, 2025

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