Building community trust-addressing refusals in Southeast: Cluster Approach

Cluster Approach for Vaccine Refusals in the Southeast Afghanistan

Strengthening Community ownership and Confidence

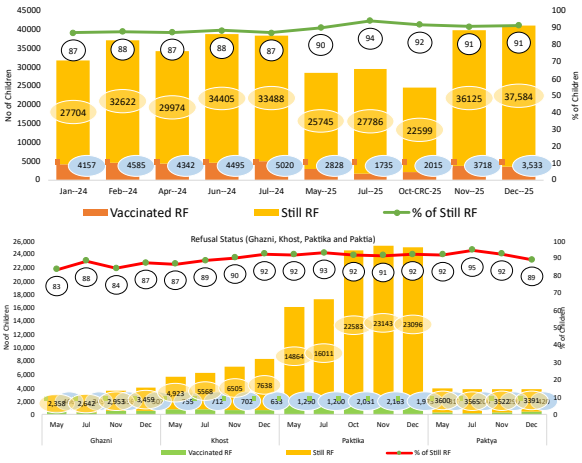
The polio eradication program in Afghanistan continues to face persistent challenges, largely compounded by the site-to-site vaccination modality. Access constraints, community mistrust, and chronic vaccine refusals have left many children unvaccinated, especially in high-risk districts of the Southeast region.

While significant progress was achieved in 2025 through the Pull & Push strategies and the cluster approach resulting in improved coverage in the East and gains in the South, the Southeast has seen a marked deterioration in vaccine acceptance. During the December 2025 campaign, nearly 30,000 children remained unvaccinated due to refusals, representing one of the highest refusal burdens in recent years.

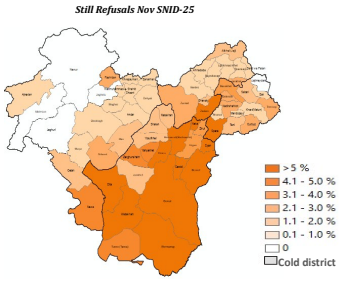
Programme analyses confirms that refusals in the Southeast are predominantly hard and chronic, mainly shaped by:

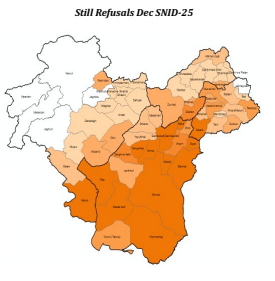
- Misperceptions and religious beliefs – 70%
- Other demands – 14%
- Unclear reasons – 12%
- Objections by influencers – 4%

Still Refusals (Admin Data)



- Increasing trend of refusals 3% against the target
- Highest still Ref are in Paktika and Khost province
  - 23096 (8.6%) against Paktika province target
  - Highest in districts Bermel, Dila, Gomal, Sarobi and Omna of Paktika
  - Spera, Musakhel, Gurbaz and Matun of Khost
- Demand by community
- Negative speeches by religious scholars





Ghazni

Province	District	Cluster	Cluster	Remaining Refusal
Ghazni	Giro	Batoor	3	188
Ghazni	Giro	Abdullah Qala	4	156
Ghazni	Nawa	Kala Khan	3	112
Ghazni	Nawa	Kandil	8	102
Ghazni	Abband	Badam kicha	4	91
Ghazni	Qarabagh	Baran Qala	10	88
Ghazni	Muqur	Larama	1	87
Ghazni	Abband	Bazi	6	86
Ghazni	Giro	Desai	5	86
Ghazni	Gelan	Tas	13	84

Paktika

Province	District	Cluster	Cluster	Remaining Refusal
Paktika	Bermel	Sedgi	9	680
Paktika	Bermel	Margha	4	528
Paktika	Gomal	Alizie	1	484
Paktika	Sarobi	Haibati	3	479
Paktika	Bermel	Karam	19	475
Paktika	Bermel	Sharifkhail	2	456
Paktika	Gomal	Shkeen	6	420
Paktika	Gomal	Khairmenzi	3	401
Paktika	Bermel	Navi Adda	10	386
Paktika	Wormamay	Mamay	4	366

Khost

Province	District	Cluster	Cluster	Remaining Refusal
Khost	Khost(Matun)	Sabario kalai	41	406
Khost	Khost(Matun)	Dandy	28	322
Khost	Spera	Asar Khil	12	319
Khost	Spera	Purra	8	303
Khost	Nadirshahkot	Shambawot	6	204
Khost	Spera	Passa Mella	7	202
Khost	Spera	Razghai	13	166
Khost	Gurbuz	Gulan Camp	9	165
Khost	Musakhel	Toot Pala	9	158
Khost	Spera	Toor Manda	6	153

Paktia

Province	District	Cluster	Cluster	Remaining Refusal
Paktya	Zadran	Khand /Shalam	3	188
Paktya	Zadran	Saheed Kalai	2	105
Paktya	Zurmat	Muqrab Khail	15	92
Paktya	Zurmat	Speeny Takhty	16	85
Paktya	Janikhel	Balkhil	2	83
Paktya	Zurmat	Gurji	13	82
Paktya	Zadran	Berey	5	80
Paktya	Zurmat	Guldad Khail	20	71
Paktya	Zurmat	Paeenda Khil	17	71
Paktya	Zurmat	Patak	28	67

A consistent finding across districts is 'a significant trust deficit between refusing households, health workers, and programme actors'. Households that reject vaccination tend to rely primarily on intracommunity sources, such as imams, elders, madrassa teachers, and family networks, rather than on institutional or health professional sources.

This dynamic has resulted in slow progress despite ongoing social mobilization efforts. For example, in November 2025, only 7% of children from refusing households were reached in Khost, highlighting the limitations of traditional campaign-based communication.

Rationale: To reverse this trend, a more sustained and systematic trust-centred approach is required, one that acknowledges local social structures, community hierarchies, and the influence of authorities, religious and cultural norms on decision-making.

This approach combines behavioral insights, trust-building mechanisms, and targeted community engagement focusing on the clusters that have the concentration of these refusals to address the root caused and find localized solutions.

Objectives

- % increase in enablers engagement through refusal oversight and conversion committees
- % reduction in refusals by December 2026 through localized trust-building interventions that engage and mobilize influencers, fathers and authorities that shape the decision-making within households.

These objectives will be achieved by systematically involving religious leaders, elders, influential male figures and other respected community actors, supported by improved evidence, social listening, and multisectoral collaboration.

Prioritization: Based on the agreement by partners to focus on **50 clusters based on high number of refusals (see the Annex)**, key actions will be taken as below.

3 step action plan

1 – Using enhanced evidence -generation and network Mapping

Refusal data will be used linked with detailed information on local social networks at the cluster level to identify resistant individuals and influential nodes within their networks. This more granular, behaviour oriented data will enable tailored engagement strategies, targeted mobilization, and more efficient resource allocation.

2 – Strengthening local system by re launching refusal oversight committees

The revised refusal oversight committees will be selected, oriented and given the target base don data to ensure that the local influencer/enablers are taking lead in changing the situation of their communities.

Evidence shows that trust in the messenger is more influential than the content of the message in refusal-prone areas. Communities consistently place greater confidence in information from familiar, respected individuals within their immediate social networks. Additionally, messaging will be co-created with imams, scholars, elders, madrassa teachers and shuras to address persistent rumours and religious concerns to ensure that messages are culturally appropriate, aligned with Islamic principles, technically accurate, responsive to community questions, and delivered in language and formats that resonate locally.

3 – Cluster focused interventions based on refusal data and operational plans followd by monitoring and reporting

Before each campaign, targeted activities will be held at the cluster level focusing on prioritized communities with high concentration of refusals. The interventions will be based on type and reason of refusals

Coordination with other partners

In high refusal clusters, the programme will coordinate with multisectoral humanitarian partners, inside and outside the health sector, to ensure better coverage and avoid overlap

and shared technical support. This will help address unmet needs that contribute to refusals and strengthen community confidence.

Roadmap

1. Foundation Phase (February 2026–March)

1. Analyze refusal data across the 50 prioritized clusters.
2. Segment refusals (religious, rumor-driven, service-related, chronic vs. passive).
3. Map influential networks: imams, elders, madrassa teachers, women influencers, youth, and anti-vaccine actors.
4. Identify priority hotspots for tailored intervention.

2. Relaunch refusal oversight committees

- Establish & orient:
    - PROC (Provincial Refusal Oversight Committee) – strategic layer
    - DROC (District Refusal Oversight Committee) – operational layer

Define roles, reporting lines, and weekly/monthly reporting tools. Hold launching meetings

3. Design & Planning Phase (March-April (pre-campaign)

A. Cluster-Level Microplans

Build detailed plans for each priority cluster:

- Which messenger (imam, elder, peer influencer)
- Which platform (mosque, shura, household forum)
- What message (religious, medico-religious, rumor correction)

4. Implementation Phase (prior to April campaign)

A. Cluster-Focused Field Engagement

Weekly sequence of activities:

- Mosque sermons
- Shuras/jirgas
- Madrassa dialogues
- Peer-to-peer engagement targeting resistant influencers

- Household follow-up visits

Specialized Interventions:

- Advocacy efforts led by local authorities

5. Monitoring, Learning & Adaptation (Continuous)

Creation of dashboard & Reporting

- Track: refusal trends, rumor correction rates, messenger deployment, coverage gains.
- DROC: weekly performance checks and course-correction.
- PROC: monthly problem-solving for underperforming districts.

C. Document & Scale Success

- Identify positive deviance patterns and replicate in adjacent clusters.

6. Expected Results

- 25% reduction in refusal-driven missed children.
- Expanded network of influential religious and community advocates.
- Noticeable reduction in misinformation.
- Increased vaccine uptake across SIAs

Annex

List of prioritized clusters

UNICEF will strengthen cluster-level data analysis to:

- Categorize refusal cases by underlying determinants (religious, rumor-driven, service-related, fear of side effects, institutional mistrust).
- Distinguish passive refusals, driven by low prioritization or misunderstanding, from active refusals, rooted in ideological resistance.
- Map influential networks—including religious leaders, shuras, madrassa teachers, elders, influential men, respected women, and youth groups.
- Identify targeted interventions to address cluster refusals bottlenecks
- Using cluster-level refusal mapping to identify priority communities.
- Aligning cluster microplans with behavioural segmentation and social network analysis.
- Incorporating trusted messengers and community influencers into existing cluster engagement teams.

Targeted Religious engagement for belief-driven refusals

For groups where refusals are primarily rooted in religious beliefs, UNICEF & partners will lead a focused response driven by credible religious authorities, in collaboration with the Ministry of Health, councils of ulema, and local religious institutions.

Highest Refusal Clusters total 14998 Refusal Dec-25

Province	District	Cluster	Cluster	Remaining Refusal
Paktika	Bermel	Sedgi	9	680
Paktika	Bermel	Margha	4	528
Paktika	Gomal	Alizie	1	484
Paktika	Sarobi	Haibati	3	479
Paktika	Bermel	Karam	19	475
Paktika	Bermel	Sharifkhail	2	456
Paktika	Gomal	Shkeen	6	420
Khost	Khost(Matun)	Sabariokalai	41	406
Paktika	Gomal	Khairmenzi	3	401
Paktika	Bermel	Navi Adda	10	386
Paktika	Wormamay	Mamay	4	366
Paktika	Bermel	Tangay	3	351
Paktika	Urgun	Pirkotay	3	338
Paktika	Bermel	Makhay	20	337
Paktika	Sarobi	Tawoskhail	4	337
Paktika	Omna	Spina	1	336
Paktika	Wazakhah	Tarhay	7	330
Khost	Khost(Matun)	Dandy	28	322
Khost	Spera	Asar Khil	12	319
Paktika	Sarobi	Shabadina	5	315
Khost	Spera	Purra	8	303
Paktika	Bermel	Torgandai 22	22	299
Paktika	Omna	Omna Center	7	299
Paktika	Bermel	Torgandai 6	6	296
Paktika	Bermel	Nakhal	8	287
Paktika	Omna	Sakmar	3	285
Paktika	Sarobi	Rabat	6	276
Paktika	Gomal	Bokhan	2	261
Paktika	Dila	Manari	4	256
Paktika	Bermel	Chawni	16	249
Paktika	Gomal	Charbaran	17	249
Paktika	Dila	Dila	8	248
Paktika	Bermel	Zhawar Karay	7	242
Paktika	Yahyakhel	Qarabden	4	226
Paktika	Dila	Mula Khudai Noor	7	218
Paktika	Urgun	Dara Pushtai	5	218
Khost	Nadirshahkot	Shambawot	6	204
Khost	Spera	Passa Mella	7	202
Paktika	Bermel	Lar Ahmadzi	12	202
Paktika	Gomal	Bobi	15	202
Paktika	Zarghunshahr	New Konak	10	200
Paktika	Dila	Khoshamand	1	199
Paktika	Bermel	Malakshi	11	195
Paktika	Wazakhah	Gharbi Gwashta	3	193
Paktika	Gomal	Petaway	8	189
Ghazni	Giro	Batoor	3	188
Paktika	Wazakhah	Fatanay	8	188
Paktika	Bermel	Godikhail	5	187
Paktika	Omna	Mirat Khan	5	186
Paktika	Naka	Bazak	3	185

Core actions include:

- Clarifying religious interpretations that support vaccination.
- Countering narratives such as “the vaccine is haram.”
- Producing khatib-led messages, localized fatwas, and Friday-sermon content endorsing vaccination.
- Increasing the visibility of pro-vaccination religious leaders across community media, local radio, and social platforms.

Provincial Level - Strategic Direction (PROC):

The Provincial Refusal Oversight Committee (PROC) will provide overall strategic leadership, coordination, and accountability. It will ensure that refusal-reduction actions are:

- fully integrated into provincial microplans;
- aligned with the mosque-to-mosque vaccination modality.
- supported by provincial-level influencers, services, and partners.
- consistently implemented across districts through structured oversight.

District Level – Operational Delivery (DROC):

The District Refusal Oversight Committee (DROC) will function as the operational arm of the strategy. It will translate provincial direction into cluster- and mosque-catchment level actions by:

- assigning trusted community messengers to priority areas;
- organizing and sequencing community norm-shifting forums;
- triggering service-delivery fixes in response to community feedback;
- tracking household follow-up after engagement to address remaining refusals.

Refusal oversight committee roles across the programme cycle

Programme cycle	Provincial Refusal Oversight Committee (PROC)	District Refusal Oversight Committee (DROC)
1. Assessment & Prioritization	Consolidates and reviews refusal trendlines by district, cluster, and mosque catchment to identify provincial hotspots; validates segmentation and influencer mapping from districts.	Compiles cluster level ledgers distinguishing passive vs. active refusals and maps high influence networks (Imams, Elders, Madrassa teachers, men's groups, women's influencers, youth), including anti-vaccine influencers
	Sets provincial priorities (e.g., which districts require intensified medico religious dialogue, integrated caravans, or peer to peer engagement first).	Flags bottlenecks from social listening/AAP (rumours, service gaps, access, campaign fatigue) and proposes local remedies.
2. Planning & Design	Endorses district refusal reduction plans and ensures they are aligned to provincial realities and national PEI guidance; confirms integration with SIAs and routine services.	Builds time phased micro plans per cluster (which platform, which messenger, what message, when; what service fix accompanies the dialogue).
	Brokers provincial level partnerships (PPHD–BPHS/EPHS NGOs, ulema councils, media) and schedules province wide Community Feedback Days and medico religious events.	Assigns trusted messengers to specific networks and defines the sequencing: (i) norm shifting forums → (ii) targeted household follow up by trusted facilitators.
3.Implementation	Secures provincial enablers (religious endorsements, fatwas, sermon kits; integrated service caravans with MoPH/BPHS; radio/community media slots).	Runs the weekly cadence of activities: sermons and forums (shuras/jirgas, men's/women's groups, madrassas), peer engagements with anti-influencers, and household reconvenes once community norms shift, etc.
	Coordinates cross district surge (e.g., sending high credibility religious scholars or mobile health teams to priority hotspots following the influencer network mapping).	Issues Rapid Service Fix Tickets to facilities/BPHS and coordinates community requested integrated services.
4. Social Listening, AAP & Rumour Management	Maintains a provincial action tracker (issues → actions → proof of fix) and ensures AAP feedback from districts is closed out with visible changes.	Operates a Rumour & Misinformation Log; pairs each rumour with a messenger, venue, and follow up.
	Curates province wide myth busting guidance and medico-religious FAQs co-created with scholars and clinicians.	Ensures two-way communication—community concerns are relayed to providers, and the resolution is communicated back to communities.
5. Monitoring, Learning & Adaptation	Aggregates refusals results dashboard: refusal rate, influencer activitated, rumors corrected, AAP closures and coverage gain in targeted clusters	Reports weekly on cluster performance; adjusts messenger assignments and engagement platforms in real time based on what moves acceptance.
	Convenes Problem Solving Reviews for underperforming districts and redirects resources (e.g., additional scholars, caravans, media).	Documents positive deviance (who influenced whom, how, in what forum) and scales effective patterns to adjacent clusters.

Accountability & Interfaces

- **PROC accountability:** To the provincial polio tasking meeting/EOC line, measured by hotspot reductions, % rumor correction within 2 weeks, % service-fix tickets closed within 30 days, and improvement in acceptance in priority clusters.
- **DROC accountability:** To the PROC, measured by timely delivery of the weekly activity plan, messenger deployment, AAP closures, and conversion of refusals following community forums.
- **Interface with GPEI operations:** Neither committee replaces operational campaign structures; they steer the trust-building layer that makes SIAs and routine services more acceptable (religious engagement, peer-to-peer, AAP, integrated services) while staying within national policy and local norms.

Snapshot (who does what)

- PROC – ***Accountable*** for provincial strategy, endorsements, multi-district prioritization, action tracking, escalation; ***Responsible*** for provincial influencer mobilization and integrated service enablers.
- DROC – ***Responsible*** for district & Cluster refusals micro-plans, messenger assignment, scheduling of forums and follow-up, service-fix tickets, and weekly reporting.
- PPHD/BPHS/EPHS – ***Responsible*** for enacting service fixes and co-hosting Community Feedback Days and caravans.
- Religious/Community leaders – ***Responsible*** for norm-shifting forums, sermons, peer engagements, and validating rumor corrections.
- UNICEF/WHO/REOC/PEI partners – ***Consult/Support*** on segmentation, identification, training, AAP systems, medico-religious content, and monitoring dashboards.