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2025 AFGHANISTAN POLIO PROGRAM

COMPREHENSIVE PULL STRATEGY

APRIL 2025

Executive Summary

The shift in campaign modality in 2024 has significantly increased the number of children being missed during polio campaigns, particularly in the South. The most immediate response to this deterioration in campaign quality would be to return to a house-to-house (H2H) modality. This is not foreseen as a viable option at this time given current de facto authority opposition. The second response option is therefore to optimize the new site-to-site (S2S) modality and enhance operational efficiency to ensure that every eligible child is reached.

In order for the goal of eradication to realistically be accomplished in Afghanistan by the GPEI established deadline, classification of vaccination 'sites' must adopt a hyper-localized approach (e.g. one site defined as 5 households). The success of this approach has been demonstrated in the East and must be adopted throughout Afghanistan if the country is *to have a chance* for reaching all missed children, stopping virus transmission, and eradicating polio. The need for this was reinforced in February 2025 by the Technical Advisory Group (TAG).

The current ban on H2H campaigns has also resulted in an undeniable loss of key household level data which has been vital for directing UNICEF's evidence-based campaign interventions, and for harmonizing activities with routine immunization (RI) and integrated service delivery (ISD) for reaching *the most* at-risk children. Further, the inability to utilize female frontline workers (FLWs) to reach households in key high-risk regions prevents use of trusted, relevant, and culturally acceptable strategies to reach a key target audience – caregivers of children under five. Optimizing the S2S modality, and its resultant loss in programmatic data, underscores the urgent need for a revised strategy. At the same time, high-level advocacy by GPEI and others will continue to be crucial for a return to the most effective campaign modality (H2H) and increased participation of female FLWs.

In 2025, the polio program is focused on optimizing the S2S modality, which requires a clear "pull" strategy that extends beyond conventional efforts and leverages every tool to draw caregivers with eligible children to vaccination sites during campaigns. The four pillars within this pull strategy therefore prioritize: 1) creating an enabling environment to ensure caregivers have increased trust and acceptance of campaigns; 2) increasing community ownership and participation to improve caregiver knowledge, reduce misconceptions and increase vaccine uptake; 3) improving campaign quality by reducing missed children and improving vaccine security; and 4) applying insights for evidence-based decision-making.

UNICEF will lead and coordinate the pull strategy as a core partner of the polio program. This complements the "push" strategy led by our GPEI partners.

Contents

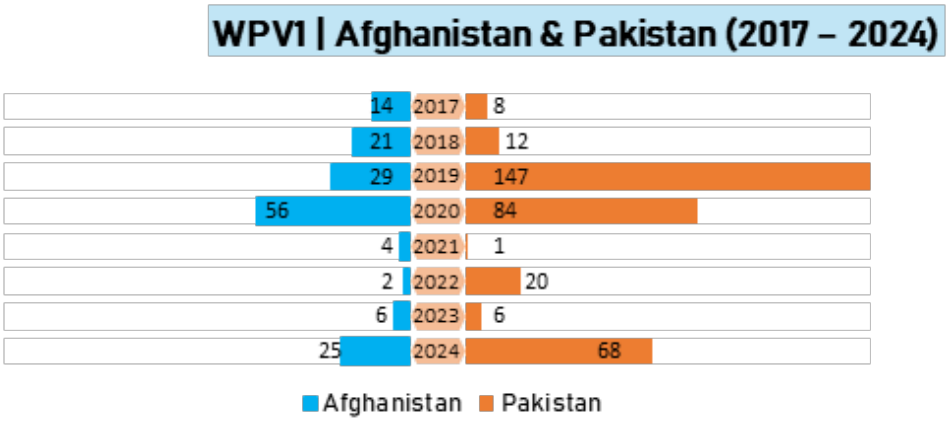
Background and current situation

Epidemiological overview

A surge in polio cases in 2024 in both Afghanistan and Pakistan marked yet another missed deadline for eradicating wild poliovirus. At its peak, the program in Afghanistan achieved unprecedented access to the population, implementing campaigns house-to-house (H2H) nationwide (except in Kandahar City) and achieving 89 per cent coverage in July 2024. However, this progress was short-lived as H2H campaigns were banned in October 2024, leading to drastically poorer campaign quality (e.g. 32 per cent LQAS pass rates nationwide and a mere 1.88 per cent passed in the four provinces of the South in the January 2025 SIA).

Twenty-five human cases of polio were identified in Afghanistan in 2024, with the majority concentrated in the Southern region, particularly Kandahar Province, which accounted for 14 of the 23 cases in the South. Additionally, 92 environmental samples (ES+) tested positive across the country, 62 of which were from the Southern region. See Figure 1.

Figure 1: WPV1 cases in Afghanistan & Pakistan (2017-2024)

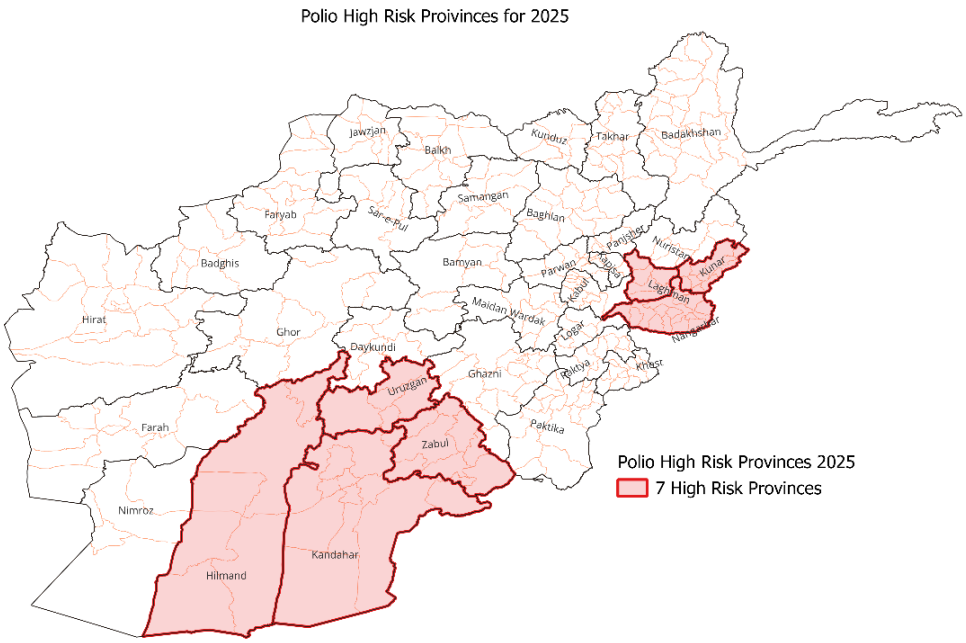


Risk categorization

In February 2025, the World Health Organization (WHO) issued a new classification of three 'very high risk' provinces in Afghanistan – **Hilmand** and **Kandahar** (South), **Nangarhar** (East). A further four provinces were classified as 'high risk' – **Urozgan** and **Zabul** (South), **Kunar** and **Laghman** (East). These **seven provinces** collectively accounted for 75 per cent of polio cases in Afghanistan over the past five years (2020-2024), of which 81 per cent were from the three very high-risk provinces.

The variables for risk categorization include epidemiology, lack of consistent access to house-to-house campaigns, campaign quality indicators, and other epidemiological and demographic factors (population immunity levels, presence of refugees/IDPs, in-country and cross-border travel patterns, population density, etc.).

Figure 2: Polio high-risk provinces (2025)



Shifting from H2H to S2S – Impact to campaign quality

A nationwide ban on H2H vaccinations from October 2024 onwards, alongside operational challenges associated with this abrupt transition, has significantly increased the number of missed children.

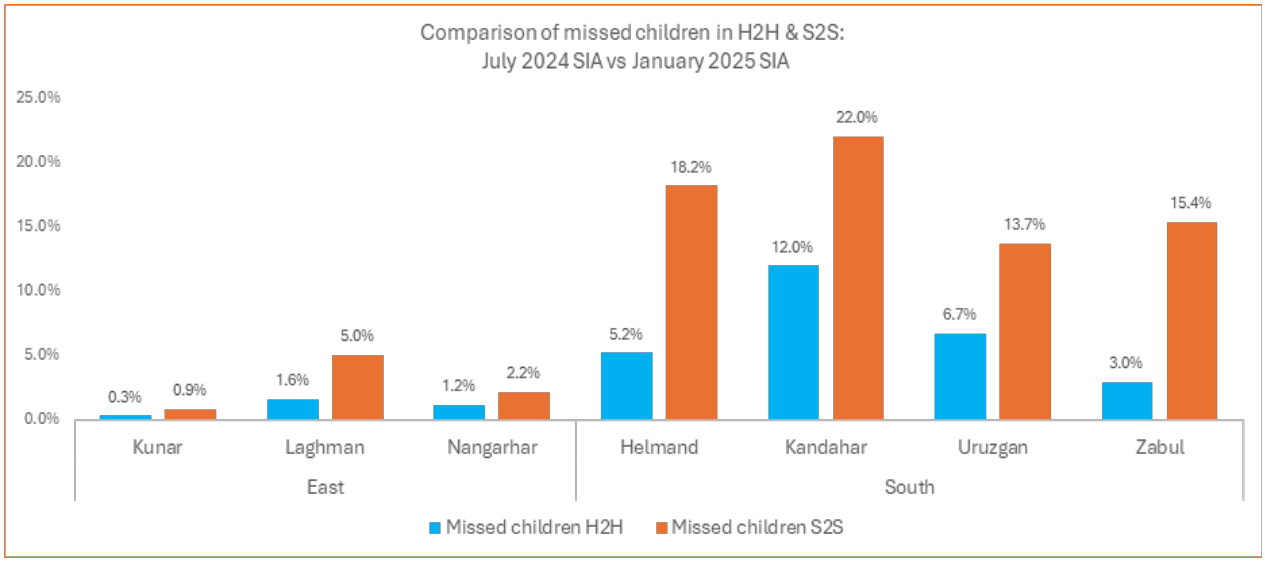
According to post campaign monitoring (PCM) data within the seven highest-risk provinces, the percentage of missed children during the July 2024 SIA campaign (just before the transition to site-to-site vaccination) was 4 per cent – this translates to 112,000 children missed for vaccination, including 47,411 due to refusals (with 58 per cent of refusals located in Kandahar and Hilmand provinces).[1]

The number of missed children in the seven highest-risk provinces is *estimated*[2] to have risen to 11 per cent in the January 2025 SIA following the campaign modality shift – this translates to approximately 417,000 children missed for vaccination (with absolute numbers of missed children and reasons for refusal unknown). See Figure 3.

1 Kandahar City is not included in this total due to lack of data.

2 In the H2H vaccination modality, data recording was based on tally sheets and existing micro-plans, enabling the program to track both vaccinated and missed children at the household level. With the shift to the S2S modality, however, tracking missed children at the household level is no longer possible.

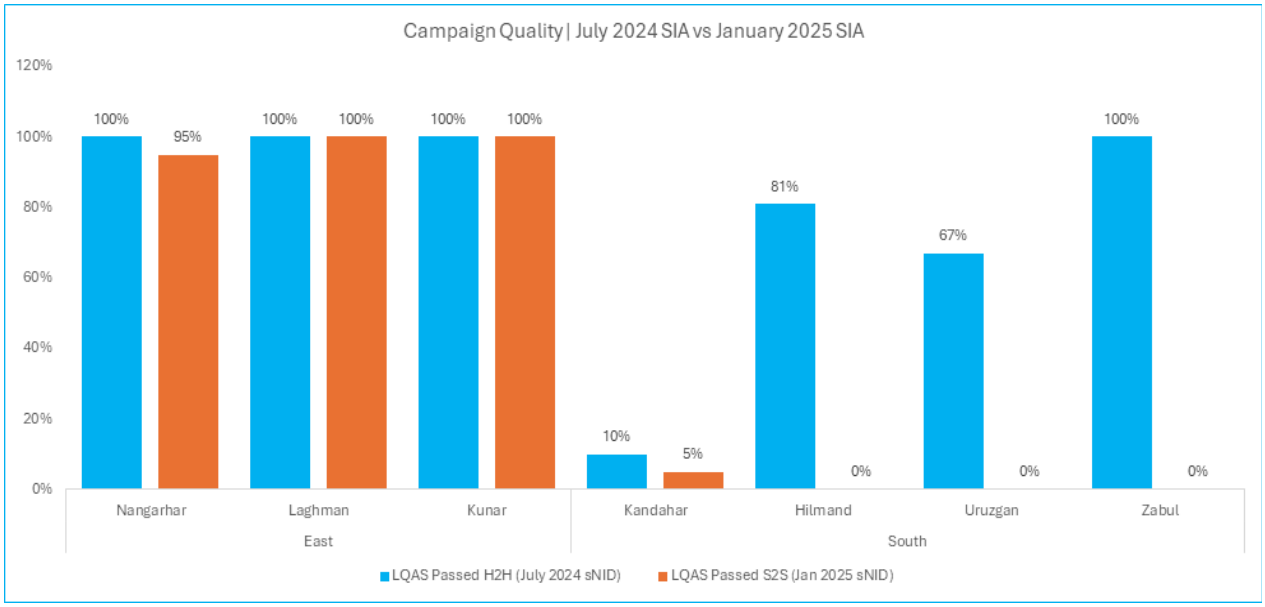
Figure 3: Comparison of missed children according to PCM – July 2024 vs. January 2025 SIA



Nationwide, lot quality assurance sampling (LQAS) data shows that 89 per cent of lots passed during the July 2024 SIA, dropping to 38 per cent in the January 2025 SIA. The most concerning decline was in the South, where the pass rate fell from 61 per cent to an alarming 2 per cent with only one out of 53 lots passing. The impact of the campaign modality shift was minimal in Kandahar as the S2S modality has been the primary method used in Kandahar Province for several years. See Figure 4.

Campaign quality in the East remained largely consistent across both H2H and S2S campaign modalities. Reasons for this impressive and rapid adaptation to changing de facto government policy are varied but can best be explained due to three interrelated factors: 1) a highly localized definition of 'site' characterized of approximately five households, 2) retention of female frontline workers (e.g. 100 per cent female social mobilizers), and 3) impactful engagement and buy-in of local authorities allowing for factors 1 and 2 to be implemented.

Figure 4: Campaign quality as assessed by LQAS – July 2024 SIA vs. January 2025 SIA



UNICEF's Household Awareness Survey data has demonstrated that community awareness of polio campaigns has not significantly been affected by the change of modality. For instance, the percentage of caregivers in the South who heard about the campaign increased from 87 per cent in July 2024 to 89 per cent in January 2025. It increased from 85 to 88 per cent in Helmand, 86 to 90 per cent in Kandahar, 82 to 96 per cent in Urozgan and 87 to 88 per cent in Zabul province. Social mobilizers are the main source of campaign awareness. However, caregivers' *intention* to vaccinate their children during the campaign reduced from 97 to 93 per cent in the South during this same period.

Other key factors influencing campaign quality

While the shift in campaign modality from H2H to S2S has played a significant role in the increase of missed children, several other political, operational, social, and cultural barriers contribute to missed children. These barriers include political restrictions on female health workers, resistance from de facto authorities, suboptimal operational planning, vaccine resistance, poor routine immunization (RI) performance, and high-risk mobile populations.

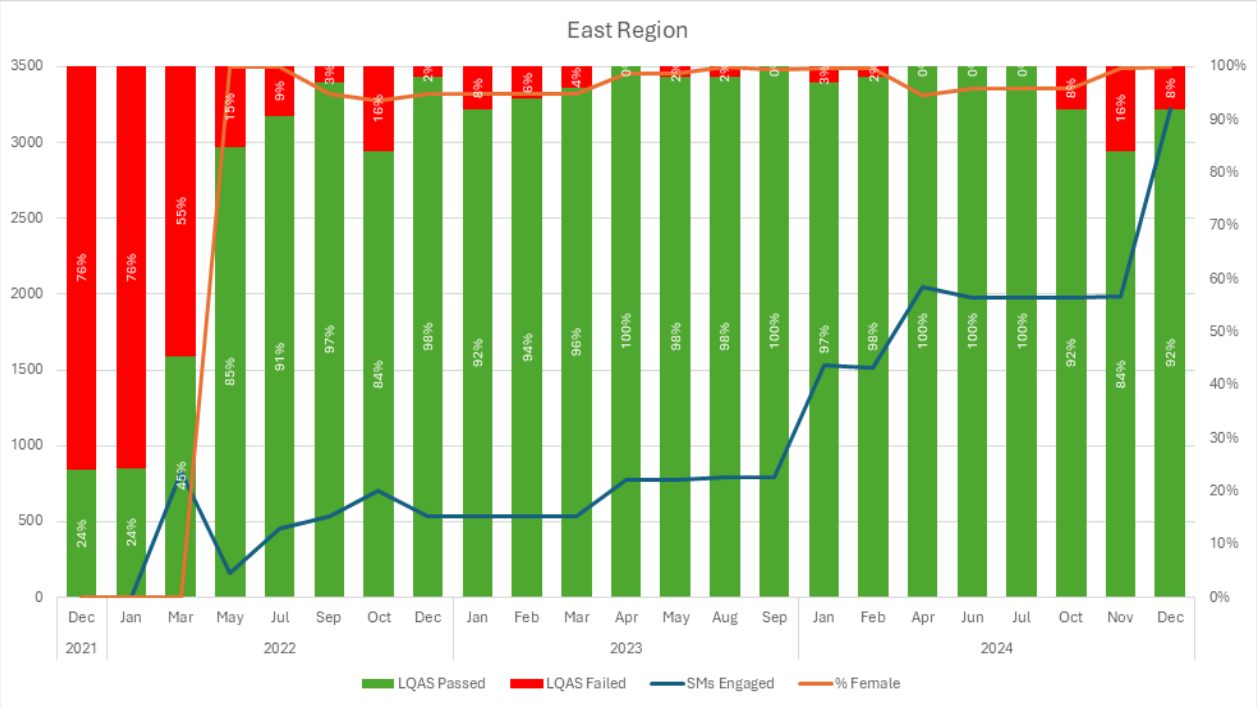
Restrictions on female participation (both during and between campaigns) significantly limits access to primary caregivers as mothers are hesitant to interact with male frontline workers and vaccinators. Restrictive Ministry for the Propagation of Virtue and the Prevention of Vice (PVPV) laws were enacted immediately in 2021 with the takeover by de facto authorities, however since this time they have been enforced with increasingly stringent restrictions placed upon women.

Bans on the use of female social mobilisers in all areas of Afghanistan (except for the East)[3] has led to the inability to reach primary caregivers with *the most effective methods* of peer-to-peer (e.g. female-to-female) intervention and communication strategies – significantly restricting access to vaccine eligible children. While the effectiveness of campaigns depends upon several interrelated factors, there is a clear correlation in campaign quality with the use of female social mobilisers.

Within the East region, which has consistently had the highest campaign quality in Afghanistan, a 99 per cent strong female social mobilizer workforce can enter households and inform caregivers about polio campaigns. Comparing this figure against campaign quality – as measured from Dec 2021 to January 2024 – there is a positive relationship between absolute numbers of female social mobilizers (SMs) engaged in campaigns and passed LQAS (See Figure 5). For example, in the December 2024 SIA, 99 per cent of female social mobilizers corresponded to 92 per cent of lots passed.

3 As of January 2025, within the two highest priority regions of the South – Hilmand and Kandahar – **0%** of social mobilizers are female. In the highest priority region of the East – Nangarhar – **100%** of mobilizers are female.

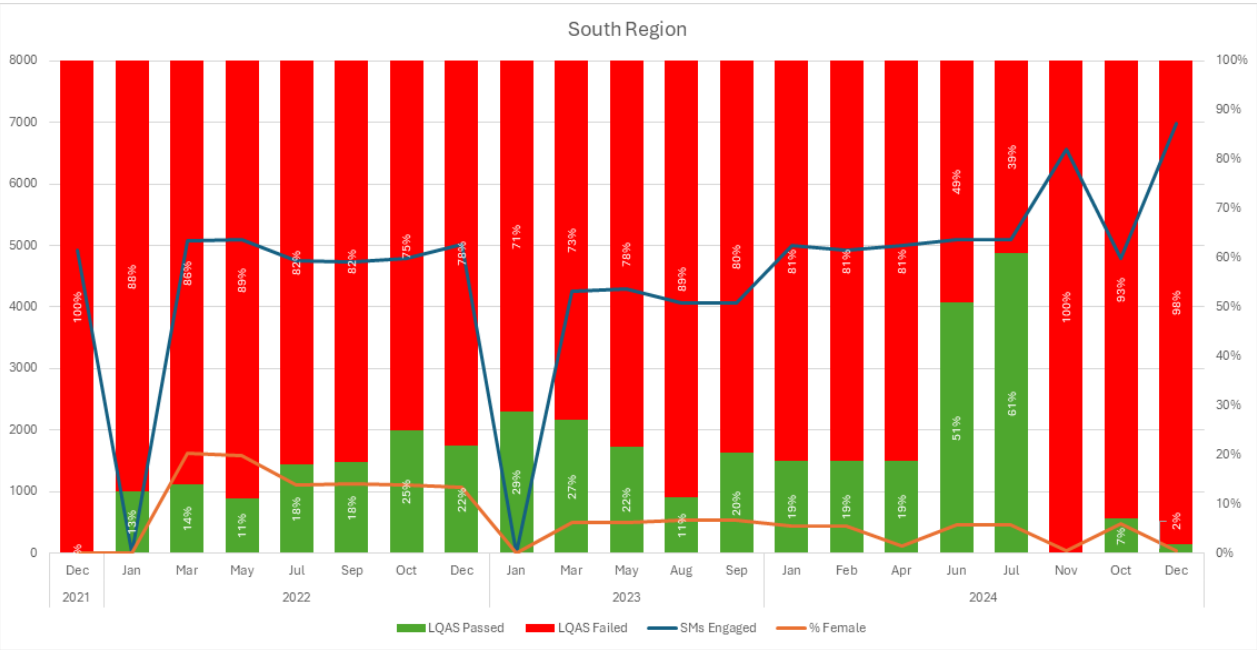
Figure 5: Comparison of % of female SMs engaged and campaign quality in East region



The continued success in the East despite the change in campaign modality suggests that greater female involvement is very likely to enhance campaign quality through improved access to caregivers. However, progress in the East is fragile. Without continuing advocacy with local de facto authorities, the continued use of female social mobilisers is uncertain given the restrictive trends on the female workforce throughout the remainder of the country.

In contrast to the East, the South region has seen a significant drop in both the number and percentage of female social mobilizers engaged in campaign activities – decreasing to a record low of 0 per cent in the December 2024 SIA where an abysmal 2 per cent of lots passed (See Figure 6).

Figure 6: Comparison of % of female SMs engaged in campaign quality in South region



It is uncertain at this time if de facto authorities in the South (and throughout Afghanistan) will allow for female social mobilizers to be a part of campaign activities as in the East. The current political environment, with increasingly tighter restrictions on women, including those placed upon the availability and utilization of other key female support staff (e.g. female vaccinators) are likely to continue without significant and localized advocacy for gaining de facto authority buy-in.

Resistance from de facto authorities often takes the form of influencing hiring decisions within the program (e.g. securing jobs for their people). Effective campaign implementation relies on well-trained and motivated personnel. However, if FLWs are not carefully selected based on their gender, age, community acceptance, skills, knowledge, and ability to engage with communities, vaccination efforts will be compromised. As learned through multiple local forums, including the strategic timeout discussions with key polio stakeholders held in July 2024, resistance from the de facto authorities Interference in the recruitment of FLWs has been and remains a major challenge in the South. In the East, several strategies have been implemented to bring local authorities on board – regular provincial coordination meetings, district-level recruitment committees, family-based team approach – to ensure a hyper-local definition of 'site' for vaccination efforts can continue without interruption. Similar strategies can be explored for the South.

Suboptimal operational planning has resulted in children being left out of immunization efforts. Inadequate micro planning, limited mapping of high-risk and mobile populations (HRMP), and challenges in coordination with local authorities and community networks have created persistent gaps in immunization coverage, making it difficult to reach the most vulnerable children. In the South, although micro plans have been updated for all areas apart from Kandahar city, the methodology used was sub-optimal. For example, instead of counting actual numbers of children, houses were counted, and the number of children per household was estimated. The actual number of children expected to be targeted for SIAs is therefore unknown. This, coupled with the ban on collecting missed children's data from households in the current S2S modality, has a dire consequence on the quality of program operations. In the East, there exist opportunities to utilize planning tools not currently possible in the South (e.g. child registration books), however good practices have been modeled which can be further explored for utilization in the South (e.g. record keeping of site-based missed children, integrated micro planning approaches) to better enable tracking of eligible children, enhanced caregiver engagement, and increased overall immunization coverage.

Vaccine resistance remains a significant challenge, particularly in high-risk regions. In 2023, UNICEF conducted a survey to understand community knowledge, attitudes, and practices (KAP) regarding polio vaccination, as well as to identify sources of awareness.

Key facts from the KAP highlighted there is an ongoing misconception that polio can be transmitted through mosquito bites (particularly in the East at 50 per cent). Thirty percent of people surveyed thought that polio is curable with 52 per cent indicating that polio is curable with antibiotics (this perception was highest in the South at 55.8 per cent). Positive points were strong awareness of the vaccine as the best prevention of the virus (94.1 per cent) and the awareness that polio can be prevented (89.5 per cent. Over seventy percent of persons surveyed nationwide, voiced their intention to vaccinate their children every time a polio vaccine was offered.

Per a 2024 study conducted in high-risk regions on 'hard' refusals (i.e. those who refuse vaccination every time it is offered) caregivers can be categorized into two primary groups. The first group consists of individuals who believe polio is a hoax—often influenced by conspiracy theories, misinformation, and distrust of international organizations. The second group acknowledges the existence of polio but rejects the vaccine as a solution, either due to skepticism about its effectiveness or concerns about potential side effects. Additionally, there are caregivers who, despite neither actively opposing the vaccine nor denying the disease, simply choose not to vaccinate their children due to complacency, lack of prioritization, or a general disinterest in immunization efforts. The frequency of campaigns also has a double edge impact of ensuring accessibility but also lowering opportunity cost of missed vaccination as caregivers know that another campaign will be coming. Further, 90.1 per cent of hard refusal families felt they are unaware of how the virus is transmitted. None of the refusal households believed the OPV could prevent polio, and the majority thought it can be treated through 'Islamic treatment.' Negative sentiments towards polio vaccination were generally higher among those who had negative experiences with public health service. The study also highlighted that 95.7 per cent of survey respondents (i.e. those classified as 'strongly agree' or 'agree') are suspicious of OPV, and 91.2 per cent do not believe the polio drops protect children from the polio virus. No respondent believed that the polio drops prevented polio to any degree.

While these studies provide useful information for understanding the knowledge, motivations, beliefs and practices of high-risk populations, the insights they provide are a 'snapshot' in time – a snapshot which can quickly become outdated. Up-to-date programmatic data on missed children delivered in near real-time is vital for directing evidence-based interventions and activities to achieve polio eradication.

The campaign modality switch from H2H to S2S erased our ability to track missed children. Innovative and rapid methods of data collection are now needed as a priority to begin to recover this data loss.

Poor routine immunization (RI) performance remains persistently low in high-risk polio provinces. While vaccination campaigns play a crucial role in stopping transmission, they cannot substitute for a strong routine immunization system. Coverage gaps leave many children unprotected, creating conditions for the virus to continue circulating. As recorded by the Afghanistan MICS 2023, the percentage of children who have received all basic vaccination in the South is far below the national average of 37 per cent. It ranges from 3 per cent in Urozgan, 9 per cent in Helmand, 11 per cent in Zabul, and 20 per cent in Kandahar. RI coverage in the Eastern region, particularly in Nangarhar (40 per cent), Kunar (45 per cent), and Laghman (44 per cent), is higher compared to the South. A key factor in ensuring greater RI coverage is the utilization of female mobilization vaccinators (FMVs). In the East, which currently has 241 FMVs across the three highest risk provinces, current planning is to adopt a more community-centric approach where they can conduct community outreach and caregiver education sessions. Similar opportunities will be explored for increasing the number and utilization of FMVs in the South – the four highest risk provinces currently have 152 FMVs.

High-risk mobile populations are a critical challenge, particularly in border areas between Pakistan and Afghanistan. The movement of people across borders – including internally displaced persons in the East, seasonal laborers, and nomadic communities – creates gaps in vaccination coverage, allowing the virus to persist and spread. Long-term success across this 'epidemiological bloc' will only be achieved through coordinated, timely and effective interventions to stop transmission. A tailored strategy – inclusive of regular cross border coordination forums, joint micro-analysis of data, synchronization of campaigns and border entry / exit flow improvements – is needed to track and vaccinate children from these mobile populations effectively. Without dedicated measures such as cross-border coordination and transit vaccination points, the risk of undetected transmission remains high.

Comprehensive Pull Strategy

Given the current context, a comprehensive 'pull' strategy is required to optimize the S2S modality and address other key factors influencing campaign quality by:

- Creating an enabling environment to enhance community trust and acceptance of campaigns.
- Increase community participation and access to vaccination through improved knowledge, reduction in misconceptions and increased uptake of OPV.
- Improving campaign quality by drawing every eligible child to vaccination sites and improving vaccine safety.
- Apply insights for evidence- based decisions to inform eradication strategies.

This is visualized within the theory of change:

Theory of Change

for Polio Eradication "Pull" Strategy in Afghanistan

Impact

To protect all children across Afghanistan by eradicating polio and securing a polio-free future for all.

Result

Increased quality of oral polio vaccine (OPV) coverage.

Pull Strategy

To activate community engagement and mobilization to 'pull' beneficiaries to vaccination sites (S2S modality) during campaigns as well as to leverage broader communications to create an enabling environment for the programme beyond campaigns. This complements the "push" strategy led by our GPEI partners.

Pillars

- Create an enabling environment
- Increase community ownership & participation
- Improve campaign quality
- Apply insights for evidence-based decisions

Output

1. Caregivers have increased trust and acceptance of campaigns	2. Caregivers have improved knowledge of polio symptoms, reduced misconceptions of vaccination, and increased uptake of OPV.	3. During campaign reduction in missed children and improved vaccine security.	4. Robust evidence is systematically generated to inform eradication strategies leading to caregiver trust, higher coverage and reduced missed children.
Assumptions			
- Positive media and DfA engagement will create an enabling environment to increase caregiver trust and acceptance of campaigns.	- Local influencers will effectively promote vaccination in their communities. - Well trained FLWs will effectively apply IPC skills to improve caregiver knowledge, reduce misconceptions, and encourage vaccination.	- New interventions to optimize S2S modality will effectively reduce missed children, complementary approaches will successfully attract caregivers to vaccination sites, and a secure vaccine supply will enhance campaign quality.	- Data collection tools are user-friendly with findings are translated into actionable steps.
Risks			
- Rapid and widespread misinformation and rumors spread via non-media/social media platforms. - Lack of active and meaningful participation of DfA polio eradication initiative.	- High turnover of FLWs. - Lack of female FLWs. - Lack of accountability mechanism for influencers. - Weak capacity of FLWs and influencers to address caregiver concerns.	- Caregivers refuse vaccination if pluses are stopped. - Nomadic and returnees not accounted for in micro-plan.	- Poor data quality. - Lack of evidence-based decision making (i.e. having data but not using for course correction or programmatic decisions).

Pillar I: Creating an enabling environment

Output 1: Caregivers have increased trust and acceptance of campaigns

Media engagement and access to information

Increasing trust involves disseminating accurate information and key messaging to caregivers to reinforce/change attitudes and perceptions that impact decisions to vaccinate their children. This will be particularly important in 2025 in the context of S2S campaigns and additional interventions to provide OPV and other services to communities. Efforts will continue in 2025 to leverage traditional and social media to create a more enabling environment for the program's work.

Regular orientation sessions with journalists will provide an opportunity for them to ask any questions they have about polio-related issues and support stories that can provide positive perceptions of the polio program and progress, as well as provide accurate information about the vaccine and disease. Roundtables will feature medical professionals, community leaders, and mullah/imams and key topics tailored to high-risk provinces will be broadcast by independent TV and radio channels with broad viewership/listenership in targeted areas.

The program's digital footprint reaches 36 million through dedicated social media channels (Facebook, X, and Instagram) and website (*Polio Free Afghanistan*). These platforms will continue to share information on campaigns and messaging about the importance of vaccination, how polio spreads, and symptoms of the disease. Social listening, however, is currently undertaken on an ad-hoc basis and needs to be further strengthened to monitor and address the spread of misinformation.

Media and social media engagement demographics point to an overwhelmingly male audience. For example, the social media audience for *Polio Free Afghanistan* platforms is over 80 per cent male-identified[4], aged 18-34, and urban. Radio is by far the best way of reaching polio high-risk communities and is the platform most likely to reach women. It is important to note that engagement is uneven – factors like rural versus urban locations, education level, economic status, and ethnic affiliation impact women's access to media of any sort. For example, in conservative, Pashtun-majority communities (especially those that are poor, rural and poorly educated), women are often not permitted to switch on the radio or television. Text-based print and web media have no entry point to women in these communities. The vast majority are illiterate, and those who can read may only be able to access proscribed religious texts for fear of repercussions. Specific ways to leverage radio penetration to promote influential voices and highlight key issues in different high-risk communities will be explored. Engaging with polio survivors and visuals of the disease will help increase risk perception.

Crisis communication

Crisis communication is a critical and important component in polio eradication that involves strategic efforts to manage and convey information during polio outbreaks or other critical situations such as AEFI (Adverse Event Following Immunization). Some key aspects include 1) Rapid Response for Immediate communication is crucial to inform the public and stakeholders about the event, its risks, and the steps being taken to control it 2) Developing clear, accurate,

4 It is common for Afghan women to create fake male profiles on social media, to engage without facing retribution. The program cannot accurately determine the real gender balance of digital engagement.

and consistent messages to address concerns, dispel myths and rumors, and continue to encourage vaccination 3) Understanding the target audience's perceptions, beliefs, and behaviors to tailor communication strategies effectively 4) Coordinate and collaborate with various partners including GPEI, government agencies, health organizations, and community leaders, to ensure a unified and effective communication approach 5) Continuously assessing the impact of communication efforts and making necessary adjustments to improve effectiveness 6) Adjusting communication tactics as the situation evolves, from immediate response to long-term maintenance.

De facto authority engagement

Increasing caregiver trust in the programme also crucially requires transitioning polio eradication from an externally driven initiative to a nationally owned public health priority– by fostering trust, aligning with local governance priorities, and engaging decision-makers at all levels.

The engagement of key interlocutors – including leadership of the National Emergency Operations Centre (NEOC), the de facto Ministry of Public Health, Provincial and District Governors and their health departments, as well as elders and influencers – will be pivotal. Their disengagement – or worse, opposition – presents the greatest risk to the program's success given their considerable influence over both policy decisions and public perceptions, particularly in the South.

The program will aim to create an ecosystem of trust and cooperation that will facilitate unimpeded vaccination efforts through campaigns as well as routine immunization. The goal is to transform perceptions of the polio program from an externally driven initiative to a nationally owned public health priority, ensuring sustained commitment and long-term success in eradicating polio from Afghanistan. This strategy will go beyond standard advocacy approaches, incorporating relationship-building, negotiated trust, and co-designed initiatives that align with local governance priorities and community values. An understanding of the power configurations as well as the centers of power will be necessary in defining who to target for this advocacy.

At the same time, high-level advocacy by GPEI and others will continue to be crucial for a return to the most effective campaign modality (H2H) and increased participation of female FLWs.

Key activities:

Media partnerships

- **Build and maintain partnerships with most popular channels and functional media channels** in key high-risk areas to ensure timely information-sharing about upcoming S2S campaigns and who communities can turn to with questions, accurate messaging about the importance of polio vaccines for protecting children and curb the spread of misinformation. This includes regularly updating the list of functional media channels within each key area to ensure messaging from polio program is reaching all key audiences.
- **Conduct pre-campaign orientation sessions and media training workshops with journalists** to improve vaccine-related reporting and maintain open channels of communication with media.

Proactive media messaging in advance of, and during, campaigns

- **Develop TV and radio spots to air key messaging.**
- **Nurture willing and influential voices outside the polio program** in key areas who can amplify messaging in media and/or at community level to bring more families on board to polio vaccination efforts. This includes **leveraging voices of religious leaders with influence in highest-priority areas on traditional and/or social media platforms** to address common misinformation specifically related to religious beliefs.
- **Conduct local media roundtables with influential voices (e.g., religious leaders, community elders, polio survivors, medical experts),** highlighting key messaging around polio campaigns and safety of polio vaccine and routine immunizations, amplifying risk perception around polio as a disease, and tackling misinformation rampant in specific communities.
- **Leverage radio as a critical platform in key high-risk areas** and as best channel to reach women with critical messaging during regular programs, through localized and most suitable messaging and interactive discussions.

Ensuring accurate information access through social media and other platforms.

- **Establish Digital Community Engagement (DCE) to leverage social media platforms,** as an essential pillar within the SBC framework for polio campaigns to strengthen social listening for systematically tracking and addressing mis-/disinformation and enhancing public health crisis communication, as well as to promote vaccination among social media users.
- Continue use of Afghanistan polio call centers to provide essential information to communities about immunization activities and to provide insights on campaign reach and impact via remote (phone) follow-up with community members.
- The potential for use of SMS and IVR (Interactive Voice Response) broadcast will also be explored to raise awareness of campaigns and vaccination site. Approximately 85 per cent of Afghan households own a mobile phone, and this is even higher in endemic polio regions like Kandahar where about 92 per cent of households own a mobile phone.

Engagement with de facto authorities

- **Map local influencers/enablers by district** and categorize by reach, credibility, and potential impact.
- **Conduct rapid assessment** to assess barriers and enablers.
- **Organize orientations of identified influencers and community elders with influence over decision-makers** to share key messages and ensure buy-in.
- **Conduct targeted advocacy conferences for national religious influencers in high-risk regions** to secure support and religious endorsements from key authorities and their statements of commitment and support for polio eradication and vaccination to the public. Conferences will be at national level (led by NEOC and National Islamabad Advisory Group) and engage highly influential religious figures and key authorities.
- **Organize pre-campaign meetings of district governors, community influencers, elders and police authorities**[5] (where needed) to solidify their support and involve ment before, during and after polio campaigns.

5 Engagement with police authorities will be done on a case-by-case basis where prior issues have been identified, and to avoid association of the program with the (potential) public perception of forced vaccination.

Pillar II: Increasing community ownership and participation

Output 2: Caregivers have improved knowledge of polio symptoms, reduced misconceptions of vaccination, and increased uptake of OPV.

Increasing front line worker (FLW) communication skills and engaging local influencers

Considering the current limitation in accessing individual households, strong engagement with influencers and tailored community engagement strategies are critical to further enhance community knowledge, reduce misconceptions, and increase demand for polio vaccinations - particularly in high-risk regions. This requires building the capacity of frontline workers in interpersonal communication (IPC) to improve their skills for better interactions with community members and for preventing and addressing missed children and refusals; boosting women's participation as social mobilizers to increase the program's access to households; and engaging key community elders and local influencers to promote campaigns and vaccinations on behalf of the polio program.

Identification, engagement, and deployment of localized influencers will be critical to the program's success in 2025. This will ensure a range of voices outside the program are able to disseminate accurate information and messaging to communities, address community concerns and rumors, enable access to different community forums (mosques, schools, medical facilities and community groups), create spaces for dialogue with vaccine-hesitant or refusal communities and caregivers – and, during campaigns to direct eligible families to take their children to vaccination sites.

Key activities:

Strengthening FLWs capacity

- **Revamp training materials for social mobilizers** and include on-the-job practical IPC training.
- **Develop tools and information, education and communication (IEC) package** to facilitate community interactions with FLW teams.
- **Conduct regular rapid assessments and program consultations with both male and female FLWs** to understand challenges faced by FLWs in different areas, capacity needs for program improvement, and their ideas for how the program can address these barriers and better support their capacity-building. Adapt FLW training accordingly.
- **Pilot innovative ideas for gender-sensitive programming to improve access to children**. For example, utilize evening vaccination teams to address women's inability to decide about vaccinating their children without the father's consent; establish all-female vaccination sites (feasibility to be discussed with local teams); and engage older children as health champions in key communities with high numbers of missed children and low/no female social mobilizers.
- **Incorporate family teams**, including Mahrams as mobilizers.

Intensifying local influencer strategies

- **Conduct micro-mapping of influencers** (e.g., community elders, religious leaders, medical experts) at local community levels.
- **Regularly engage influencers in each community to ensure ongoing relationship-building throughout the year and equip them with key messaging** – this includes grandmothers' groups

as influential female leaders in communities to ensure better access to missed children, as well as religious leaders at community level. Develop Training of Trainers (ToT) module on polio eradication, conduct workshops for handling misinformation and addressing vaccine hesitancy, and share specific asks ahead of each campaign.

- **Organize community elder-led sessions** for male vs. female caregivers (by male vs. female elders); organize mosque-based awareness sessions for fathers and male caregivers; conduct outreach programs using female mobilizers; and launch "polio champions" networks.
- **Organize regular community listening** to understand community concerns, gather insights and perceptions from elders and caregivers. Adapt FLW training accordingly to address key themes that arise ahead of each campaign.
- **Conduct targeted advocacy conferences for grassroots religious influencers in high-risk provinces** across high-risk regions to secure support and religious endorsements from key authorities and their statements of commitment and support for polio eradication and vaccination to the public. Conferences will be held at provincial level to engage religious scholars, local influencers and community leaders at grassroots level.
- **Coordinate through Malek/Wakil Gozar to** map line lists of community elders, religious leaders, and medical experts in each priority district; identify a focal point in each priority district to ensure health education activities are being conducted; and create basic set of indicators and assign a focal point to track performance and create reports.

Pillar III: Improving campaign quality

Output 3: During campaign reduction in missed children and improved vaccine security.

Campaign day mobilization to reduce missed children

Improving campaign quality and ensuring every eligible child receives the polio vaccine on campaign days requires transforming trust-building and community ownership efforts into effective, coordinated action to exploit all opportunities available to bring children out for vaccination.

To achieve this, the primary structure for mobilization will continue to be campaign-based social mobilizers, who will provide information on vaccination sites. UNICEF will strengthen accountability for planned actions on campaign day by leveraging its Information and Communication Network, which includes District Communication Officers (DCOs), Provincial Communication Officers (PCOs), and Extenders.

Additionally, local networks will play a key role in mobilization efforts. Grandmothers will be engaged to encourage vaccination within their neighborhoods, while youth will be encouraged to bring their younger siblings for immunization. Mobilization efforts on campaign day will be further enhanced through the use of line-listing for eligible children and newborn tracking to ensure no child is missed. In the South, a community health approach centered around the health post will be piloted to aid newborn tracking and line listing in high-risk districts through integrated service delivery approaches.

This mobilization approach will be reinforced by complementary strategies, including the use of pluses as incentives, strengthening the linkages between campaign structures and routine health services through integration, and leveraging resources available through humanitarian partners to enhance outreach and impact.

Targeted and strategic use of ISD and polio 'pluses'

ISD is a critical component of Afghanistan's polio eradication efforts. In 2024 for instance, health camps in Kandahar not only vaccinated over 64,000 children under five with OPV (including earlier missed and under-immunized children) but also provided Penta vaccine for about 6,000 children, outpatient services for over 136,000 people, nutrition screening and referrals for about 18,000 children and mothers, and social and behavioral change messages especially on routine immunization and polio to 280,000 caregivers. ISD will be implemented through co-delivery of services (e.g. Nutrition, EPI, MCH) to maximize children vaccinated against polio while also addressing other critical health needs (i.e., to deliver polio vaccines alongside other essential health interventions, such as measles immunization and vitamin A supplementation, integration of polio efforts into the Expanded Program on Immunization (EPI), health camps[6] to co-deliver polio vaccines and primary healthcare services in Kandahar) as well as service synchronization to intentionally align polio efforts with other critical health and development interventions in high-risk polio districts (e.g., WASH, Nutrition). Additionally, a revamp of the Integrated Service Delivery model is currently under development to be rolled out in the South and East.

Strategic use of pluses can serve as an effective incentive to increase vaccination uptake as part of broader community engagement, particularly in cases where caregivers lack decision-making power or are indifferent to immunization. In such contexts, pluses can play a valuable role in overcoming passive resistance and encouraging participation (as seen with the introduction of soap, as well as additional incentives such as diapers and baby blankets, in Kandahar). However, pluses also carry the risk of creating dependency, where caregivers begin to expect incentives as a prerequisite for vaccination. This challenge is particularly evident in Kandahar, where reliance on pluses has become entrenched. Given this risk, the use of pluses in Kandahar City will remain limited and strategically deployed to prevent long-term dependency while still supporting immunization efforts. Further, an exit strategy will be developed to plan for the discontinuation of the use of pluses in future.

Leveraging existing humanitarian partnerships also presents a significant opportunity to enhance polio eradication efforts by expanding vaccination reach, diversifying community engagement partners, and integrating polio and health messaging into broader humanitarian interventions in underserved and hard-to-reach areas. These partnerships will continue to play a critical role in post-campaign follow-ups, enabling targeted vaccination efforts in areas with low campaign coverage or where operational challenges have resulted in missed children and engaging mobile health teams to identify and immunize children who were left out during routine vaccination rounds. Beyond direct immunization efforts, these partners also embed vaccination awareness into ongoing activities and support the dissemination of accurate immunization information within the communities they serve. Whether through WASH programs, nutrition interventions, or educational initiatives, these partnerships will help sustain community awareness and drive vaccine demand over time.

6 There are currently four health camps in Kandahar City and two in Zheray District. These camps provide essential medical care to populations living beyond the catchment area of health facilities, ensuring that children and families in underserved regions receive both preventive and curative health services. Health Camps serve as a vital strategy to reach missed children and improve overall vaccine uptake.

Vaccine security

Vaccine security has been defined as the timely, sustained, uninterrupted supply of affordable vaccines of assured quality. For a large-scale vaccination initiative like the polio eradication program, robust vaccine and cold chain management systems are essential to ensuring seamless service delivery. Given the high degree of control over vaccine storage and distribution, a strong and well-maintained cold chain system helps prevent disruptions—such as vaccine stockouts, equipment failures, or temperature lapses—from contributing to missed children. Ensuring continuous and efficient vaccine availability is crucial to maintaining high immunization coverage and eliminating operational gaps.

To reinforce this critical infrastructure, UNICEF will work collaboratively with partners to strengthen last-mile vaccine and cold chain systems, ensuring that vaccines are delivered safely, stored correctly, and consistently available at the point of immunization. This effort will include enhancing monitoring mechanisms, optimizing distribution networks, and ensuring rapid response systems for addressing cold chain failures.

Additionally, given the significant amount of waste generated by the program, UNICEF will support efforts to improve waste management systems. This will involve strengthening maintenance of existing waste disposal facilities and, in rare cases, constructing new facilities where necessary to ensure safe and environmentally responsible disposal of immunization-related waste, including used vials and syringes. To maintain vaccine efficacy and cold chain integrity, UNICEF will also provide technical and operational support for the maintenance of cold storage facilities at various levels, ensuring that storage conditions remain optimal.

Key activities:

- **Train and deploy strong cadre of campaign-based social mobilizers** (primary structure for mobilization on campaign days), who will accompany vaccination teams and provide/announce the information on vaccination sites. UNICEF will strengthen accountability for planned actions on campaign day by leveraging its Information and Communication Network, which includes District Communication Officers, Provincial Communication Officers, and Extenders.
- **Identify and activate local influencer networks during campaigns** – local community elders and leaders will be identified and activated on campaign dates to help draw families with eligible children to vaccination sites. Grandmothers and religious leaders will be engaged to encourage vaccination within their neighborhoods, while youth will be encouraged to bring their younger siblings for immunization. Mobilization efforts on campaign day will be further enhanced using line-listing for eligible children and newborn tracking to ensure no child is missed.
- **Utilize complementary approaches to attract families**, including limited and time-bound use of **pluses** in targeted areas and **integrated health service delivery** to strengthen linkages with routine health services.
- Work with the EPI & Nutrition team to **map out and deploy incentivized community health workers to support community engagement, social mobilization and newborn tracking** in the south.
- Through the REOCs, **support the coordination of humanitarian partners** involved in community engagement and social mobilization for Polio vaccinations.

Pillar IV. Applying insights for evidence-based decisions

Output 4: Robust evidence is systematically generated to inform eradication strategies leading to caregiver trust, higher vaccine uptake and reduced missed children.

Ensuring that robust evidence is systematically generated to inform eradication strategies is a cross-cutting pillar. Updating the polio programme's monitoring and evaluation framework and associated tools, for example, is vital to account for the loss of key programmatic data due to S2S modality and to align with the optimization of this modality as represented within pillars 1-3. This requires careful assessment of data collection feasibility (given current modality challenges and risks to FLWs in collecting H2H data) and increased utilization of rapid assessments and innovative data gathering methods and analysis to fill informational gaps.

Key activities:

- Streamlining M&E framework and SOPs to inform program design and course correction.
- Revising M&E tools (polio awareness survey, indicator guidance, quality monitoring checklist, etc.).
- Building capacity of regional/provincial staff on generation and use of evidence.
- Conducting rapid assessments to test interventions and pilot new and existing interventions.
- Assessing capacity needs of FLWs (e.g., social mobilizers, PCOs, DCOs, FMVs, extenders) to understand gaps in programming and develop tailored training strategies.
- Evaluating impact of 'polio pluses' in Kandahar City and ISD in South and East.
- Increase utilization and visibility of call centers.
- Produce regular 'deeper dive' analysis of data utilizing the UNICEF polio dashboard.

Results Framework

Impact: To protect all children across Afghanistan by eradicating polio and securing a polio-free future for all.			
Outcome: Increased quality of oral polio vaccine (OPV) coverage.			
Pillar			
I. Creating an enabling environment	***II. Increasing community ownership and participation***	***III. Improving campaign quality***	***IV. Apply insights for evidence-based decisions.*** ***(cross cutting)***
Output			
1. Caregivers have increased trust and acceptance of campaigns.	2. Caregivers have improved knowledge of polio symptoms, reduced misconceptions of vaccination, and increased uptake of OPV.	3. During campaign reduction in missed children and improved vaccine security.	4. Robust evidence is systematically generated to inform eradication strategies leading to caregiver trust, higher coverage and reduced missed children.
Activity			
-Engaging media with proactive messaging -Ensuring caregivers have access to accurate information -Managing crisis communications -Ensuring buy-in from de facto authorities	-Strengthening FLW IPC skills -Intensifying local influencer strategies	-Piloting/scaling-up new interventions to reduce missed children -Strategic utilization of complementary approaches (ISD, pluses) to attract caregivers to vaccination sites -Ensuring vaccine security	-Polio awareness survey (PAS) -Implement formative research and rapid assessments to evaluate new interventions and inform strategies -Utilization of call center -Production of infographics and data for action (D4A) blogs -Revision and utilization of M&E data collection tools
Input			
-Media partnerships -Polio key messages -DCE strategy -Polio call center -Crisis communication SOP -DfA engagement SOP	-Updated FLW training materials -Updated IEC package -Influencer advocacy and engagement strategy -Mapping of local influencers	-Campaign based social mobilizers -ISD strategy -Polio pluses (diapers, soaps) -VCCM supply	-M&E Manager, Officers, IM, Extenders, Call Center system & staff -M&E indicator guidance, handbook, data collection tools -UNICEF polio dashboard -Data use SOP -Research/assessment plan -Polio newsletter and monthly reports

Monitoring and Evaluation Framework

	Indicators	Baseline	Target	MOV
Impact	Number of WPV1 cases	1 WPV1 case (West)	0 WPV1 cases	Surveillance report
	Number of ES positive samples	9 ES positive samples (8 in South, 1 in East)	0 ES positive samples	
Outcome	# of children U5 vaccinated against polio during a campaign	11.7 million children U5 (June NID 2024)	11.7 million children under five	Admin data (APMIS)
Output 1	OPV vaccination coverage in high-risk areas	98% (East) 81% (South)	100% (East) 90% (South)	PCM (APMIS)
Output 2	Knowledge score of caregivers in high-risk areas	67.4/100 (East) 57.9/100 (South)	80/100 (East) 70/100 (South)	Polio Awareness Survey
	% of caregivers in high-risk areas who believe in at least one rumor	12.6% (East) 45.9% (South)	5% (East) 30% (South)	
	% of caregivers in high-risk areas who intend to vaccinate their children	99.3% (East) 93.4% (South)	100% (East) 95% (South)	
Output 3	% of caregivers who are aware of campaign dates and sites prior to the start of campaign	NA (East) NA (South)	100% (East) 95% (South)	Polio Awareness Survey
	% of missed children	2% (East) 19% (South)	<1 (East) 10% (South)	PCM (APMIS)
	% of lots of passed	98% (East) 0% (South)	100% (East) 50% (South)	LQAS (APMIS)
	OPV wastage rate	10.7% (East) 7.2% (South)	7% (East) 7% (South)	Admin data (APMIS)
	# of children who received pluses and were vaccinated (South)	98% (Kandahar)	100% (Kandahar)	Polio pluses report
	# of OPV administered during health camps (South)	6,019/mo (Kandahar)	9,000/mo (Kandahar)	OPHCD monthly reports
	# of children U2 identified and referred by the social mobilizers for RI (East)	NA (Jalalabad)	40% (Jalalabad)	Child registration book
Output 4	# of evidence generation activities conducted	0	6	Assessment reports
	Number of data-use meetings conducted	1	9	Meeting minutes

Geographic prioritization of key activities

Beyond the updated (2025) risk categorization of ‘very high-risk’ and ‘high-risk’ provinces, 42 districts are prioritized in Afghanistan for pull strategy activities (See Figure 7 & Table 1). GPEI partners agreed upon these 42 districts for prioritization because of the switch to S2S modality, loss of programme focus, persistent gaps in programme leadership and coordination, continued population movements across borders, and persistent low routine immunization (RI) coverage in important geographies despite years long efforts.

Figure 7: Mapping of high-risk districts

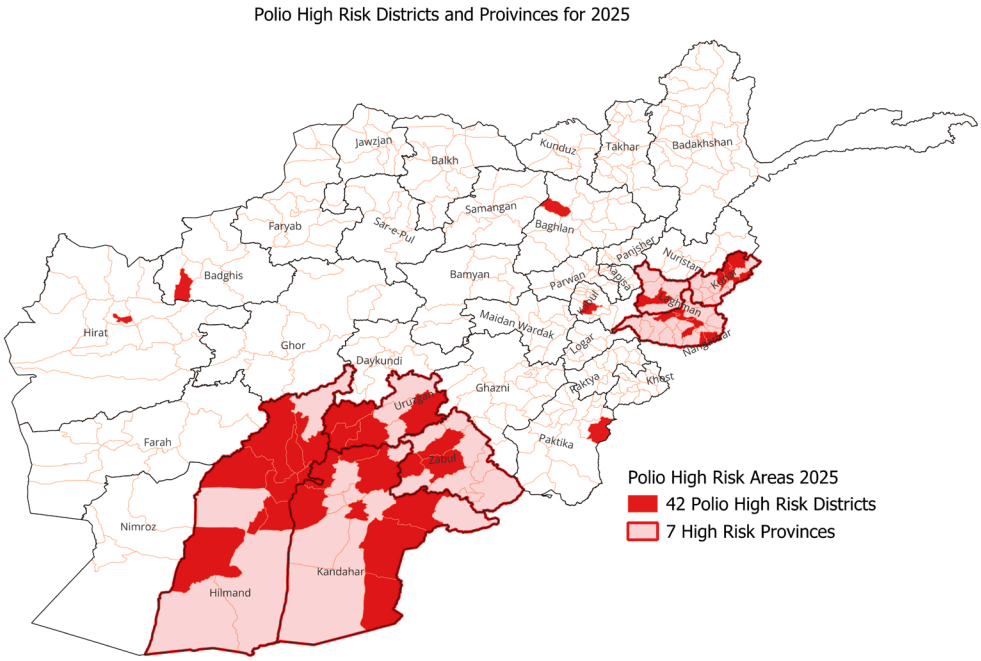


Table 1: List of 42 high-risk districts

Region	East			South			
Province	**Nangahar**	**Kunar**	**Laghman**	**Kandahar**	**Hilmand**	**Uruzgan**	**Zabul**
District	Jalalabad Behsud Batikot Surkhrod Durbaba Nazyan Kot	Asadabad Dangam Watapur Ghaziabad Shigal Wa Sheltan	Mehtarlam	Kandahar Shahwalikot Spinboldak Ghorak Nesh Arghestan Shorabak Maywand	Lashkargah Nahr-e-saraj Nawzad Washer Reg Musaqalah Sangin Nawa-e-barakzaiy Kajaki	Tirinkot Khasuruzgan Dehrawud Shahid-e-hassas	Qalat Arghandab (Z) Mizan

Region	Southeast	Central	West		Northeast
Province	Paktika	Kabul	Hirat	Badghis	Baghlan
District	Bermel	Kabul	Herat	Qala-e-naw	Pul-e-khumri

Within district **prioritization** is based upon the follow **criteria**: 1) urban and peri-urban densely populated areas, 2) dense rural areas, areas with virus circulation in past two years, and areas bordering another high-risk district, and 3) rest of the district. In alignment with this geographic prioritization and criteria, the following key activities (Pillars 1-4) will occur.

Table 2: Key activities for pull strategy

National activities	-Creating media partnerships with proactive messaging -Ensuring vaccine security -Develop SoPs for influencers/enablers engagement, campaign quality checklists, tools for community engagement and capacity building packages -Develop promotional materials -Coordinate with NEOC TWGs (technical working groups) -Crisis communication

Region	East	South
Activities	-Develop detailed operational plans including: -Media round tables with local influencers - increase female mobilizers and develop training plans and conduct trainings of FLWs in IPC and use of child registration books -Print and disseminate promotional materials as per the target audience -Advocacy efforts with district authorities through task forces -Tools and SoPs for community influencers with operation teams -Collaborate with SBC for community engagement sessions to leverage community networks (grandmother groups, youth volunteers) -Promotion and utilization of call center -Revision and utilization of M&E data collection tools -Develop promotional materials as per the target audience	-Develop detailed operational plans including: -Media round tables with local influencers -Develop and implement IPC training plans for FLWs -Organize influencers orientation and engagement through NIAG members -Develop promotional materials as per the target audience -Advocacy planning with district authorities through task force -Collaborate with SBC to leverage community networks (grandmother groups, youth volunteers) -Work with districts and clusters to implement pull strategy in HR districts -Promotion and utilization of call center -Revision and utilization of M&E data collection tools
Province	**Nangarhar** Kunar, Laghman	**Hilmand, Kandahar** Urozgan, Zabul
Activities	-Media round tables with local influencers -Promotion and utilization of call center -Polio awareness survey (PAS) -Implement formative research and rapid assessments to evaluate new interventions and inform strategies	-Media round tables with local influencers -District governor advocacy meetings and task force meetings at PHD -Health education sessions by FMVs before and during campaign -Community meetings by elders before the campaigns -Piloting the innovation of community leaders and youth groups identification and orientation and engagement during campaign -Promotion and utilization of call center -Polio awareness survey (PAS) -Implement formative research and rapid assessments to evaluate new interventions and inform strategies

District	Jalalabad , Behsud	Kandahar
Activities	-Strategic utilization of complementary approaches (ISD) to attract caregivers to vaccination sites -Health education sessions by FMVs in the health facility -Organize community engagement sessions between campaigns -Advocacy meetings by district Governors for community elders -During campaign support to resolve refusals and find missed children	-Strategic utilization of complementary approaches (ISD, pluses) to attract caregivers to vaccination sites -District governor advocacy meetings and task force meetings at PHD -Organize health education sessions by FMVs -Community meetings by elders before the campaigns -Piloting the innovation of community leaders and youth groups identification and orientation and engagement during campaign

Operational management

UNICEF with partners will lead and coordinate the pull strategy as part of a core technical team of the polio program. In 2025, the program also plans to continue engaging technical working groups and a diverse array of additional partners to implement discreet activities within this strategy in different high-risk areas. These partners include WHO, Rotary on pluses, integrated service delivery), select non polio humanitarian actors and organizations already engaged with the program (e.g., ARCS/IFRC, UNFPA, etc. to implement specific community engagement activities and religious leader engagement in specific areas), and others as needed.

The **Operations Working Group (OWG)** at the NEOC will review and endorse the overall strategy in consultation with all technical working groups. The **Communication Working Group (CWG)** will develop a detailed pull approach with operational plans together with REOCs and partners while the **M&E Working Group** of the NEOC will review and finalize the revised M&E framework and tools. The endorsed content from this strategy will be included in the NEAP for 2025.
As next steps, the regions will work with REOCs to operationalize this pull strategy by developing province- and district-specific operational plans tailored to each unique context. **The East region** has been able to engage a social mobilizer workforce that is nearly all female, utilize micro plans that include child registration book/micro census data, and set up vaccination sites covering fewer numbers of households each. These factors have enabled the program to better engage mothers with eligible children during and after campaigns, ensure awareness of eligible children requiring protection against the virus, and strengthened the ability to bring families to each site. The East region has been able to maintain relatively high levels of immunization coverage despite a sub-optimal campaign modality – and the impact is clear, with the turning of the tide on the outbreak in East region once considered the engine of the virus, though continued improvements are needed to get to zero. **The South region** is operating under more restricted conditions: a nearly all-male workforce that limits the program's ability to reach all caregivers and children, lack of updated micro plans and limited information on eligible children requiring protection against the virus, and fewer vaccination sites during campaigns, which requires families to bring children further distances to receive polio vaccines and other health services.

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