

**POLIO** GLOBAL  
ERADICATION  
INITIATIVE

unicef   
for every child

# THE POWER OF COMMUNITY PARTNERSHIPS

A Polio Eradication Case Study from Afghanistan



## Background

The wild polio virus (WPV1) is endemic in just two countries, Afghanistan and neighbouring Pakistan. In Afghanistan, the virus continues to circulate, particularly in high-risk areas in 24 high and very high-risk districts in the southern part of the country.

In 2025, 21 cases of WPV1 were identified throughout country, seven cases in the South.

Despite ongoing challenges and access restrictions in the country, UNICEF and partners have continued vaccinating children while leveraging the polio program to provide other key health services for the hardest-to-reach communities.

## Challenges

In late 2024, polio eradication efforts in Afghanistan faced a significant setback when local authorities suspended house to house vaccination, preventing polio workers from conducting door to door visits. Without direct household access, many children, particularly newborns, those living in conservative households, and those whose caregivers have limited mobility, are at heightened risk of remaining unvaccinated. As a direct consequence, thousands of zero dose and previously missed children continue to fall outside the reach of the programme, increasing the risk of uninterrupted poliovirus transmission in the South region.

In addition, women who had been at the forefront of the campaign were still not allowed to work for the polio programme – all frontline workers are now men. These challenges severely hampered efforts to reach the global target of 95 per cent coverage.

Working in one of the most high-risk countries in the world meant that polio teams, at times, faced harassment by local authorities, despite higher-level task force meetings with governors.



Data collection, which is critical to the success of any campaign, also faced challenges. In Afghanistan, there has not been a census since long time. This means teams did not always know how many children under five lived in a community. There is also no birth registration in some areas, so teams have to rely on indirect methods and estimates of newborns.

Community rejection of polio vaccination also occurs in some areas, often due to deep-seated mistrust of foreign interventions, misinformation regarding safety, and religious misconceptions. Resources are also limited, meaning high-risk areas need to be prioritised.

Significant disparities in coverage exist across provinces, districts, and even individual clusters. These challenges vary and are more pronounced in some areas, and different areas face different combinations of issues which need a focused, evidence-based, localised response.

The initial ban on door-to-door polio vaccinations began in 2018 and lasted three years, leaving an estimated three million children unvaccinated. The ban was eventually lifted until late 2024.





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“Remember with house-to-house vaccination, we didn’t need to think, just go to a house, knock on the door and vaccinate. So now we needed to figure out how to get closer to where children lived, the closer you get, the better the outcome.”

*Kondwani Ng’oma, Team Leader (South)*

## Strategic Approach



1,154  
clusters in the South



1,500-1,700  
under 5s in each cluster

In the past, UNICEF polio campaigns were often focused at national and provincial levels – especially when millions of children needed to be vaccinated. With the challenges the polio team faced in Afghanistan, a new strategy was needed.

As house-to-house vaccinations were now banned, new solutions were needed on the ground. UNICEF, WHO, and the Global Polio Eradication Initiative (GPEI) developed the “push-pull strategy”. The “push strategies”, led by WHO, focused on fixing operational issues, including micro planning, team performance, and logistics. While “pull strategies”, led by UNICEF, aimed to increase community acceptance and demand for the vaccine through local leaders and community engagement. Issues like low-quality training were addressed by both organisations.

Early in 2025, the Technical Advisory Group (TAG) on Polio Eradication - an independent expert advisory body - encouraged the UNICEF team working in the South to conduct a deeper analysis of cluster-level data to better pinpoint issues and gaps. UNICEF and WHO then developed the “**cluster approach**” to deal with the new site-to-site requirement.

“**For the push-pull strategy, we asked ourselves: How can we push the team to be closer to homes? And how can we pull the children from houses to the vaccination sites?**”

*Aminullah Mahboobi, UNICEF SBC Team*

**The Cluster approach** reorganized how teams operate by breaking large catchment areas into smaller, manageable clusters and identifying and engaging locally trusted intermediaries who can meaningfully engage with households, women, and caregivers. This shift moved community outreach from traditional door to door mobilization toward working through influencers, community groups, and religious leaders who hold credibility and deep social access.

To support this new modality, staffing structures, roles, and responsibilities have been reshaped; training packages have been updated to reflect the interpersonal, community engagement, and problem solving skills frontline workers now require; and microplanning and missed children

identification tools have been revised to sharpen focus on high risk pockets.

Operational improvements are also central to the approach, including strengthened supervision, clearer task allocation, and integrated behavioural (vaccine hesitancy due to misconceptions or cultural barriers)—operational planning (microplan inaccuracies, unqualified or ineligible frontline workers or weak supervision team).

To be successful the cluster approach requires real time accurate data from the most local levels of campaign behavioural and operations activities. The focus is on improving vaccine coverage by combining triple actions:

1. Detailed analysis of campaign data (both during and after the campaign) to pinpoint areas with high numbers of missed children or refusals.
2. Tailored interventions to address identified issues, allowing for real-time course correction or refinement of micro-plans
3. Strategic resource allocation to areas most in need, ensuring that efforts are focused on where they can have the greatest impact.

In May 2025 campaign, the regional benchmark was 78 per cent and has since risen to 95 per cent. The benchmarks are critical for tracking progress by measuring the quality, coverage, and effectiveness of vaccination activities.



# SUCCESSFUL RESULT

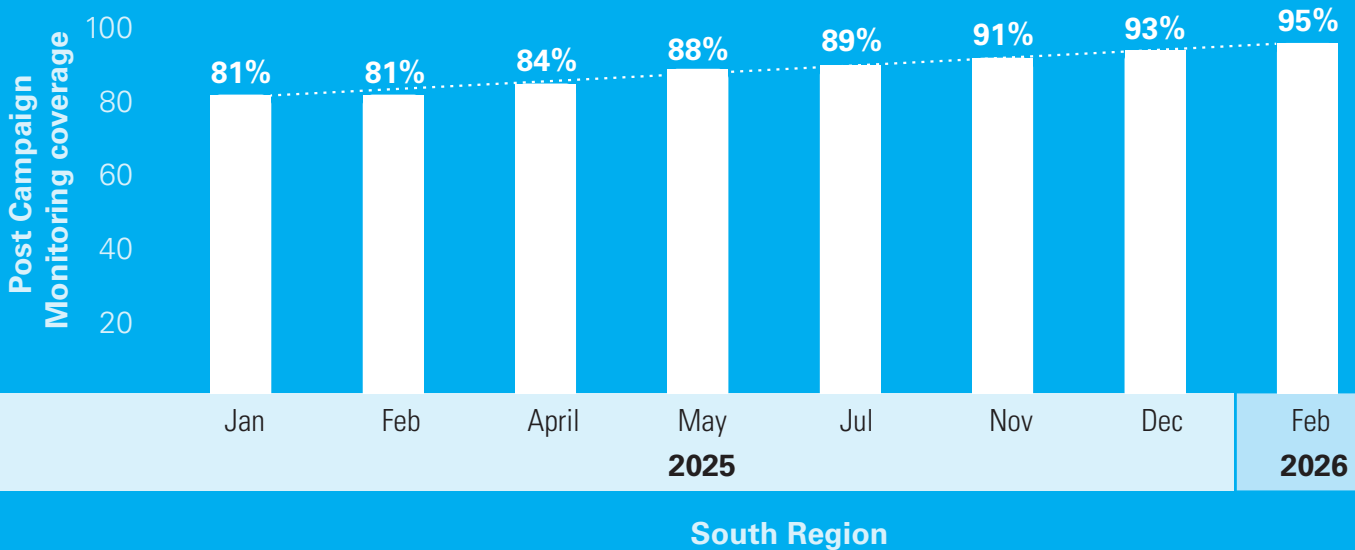
Post campaign vaccination coverage increased from

**81%**  
January 2025



**95%**  
February 2026

in high-risk districts (PCA – Post campaign assessment).



Cluster approach has become a cornerstone of the Polio campaign's success in the South, significantly expanding the programme coverage. This success is a combination of multiple programmatic shifts:

### Local influencers take the lead

The reasons behind low coverage differed across clusters, making it essential to understand the specific barriers in each location. In some areas, for instance, Madrasas allowed vaccinators to enter, while in others they refused access—requiring enablers and frontline workers (FLWs) to engage directly with madrasa leaders to negotiate entry and build trust. As Kondwani Ng'oma, UNICEF Team Leader South, explains: *"Different clusters have different bottlenecks and contexts; each place has different opportunities that you can leverage upon."*

To respond to these localized challenges, the programme invested heavily in community enablers. In 2025 alone, 8,382 enablers were identified and trained to strengthen caregiver engagement and address household-level concerns. Their efforts were particularly impactful in high-risk districts, where influencers conducted 68,176 information sessions, reaching 379,805 caregivers with tailored vaccination messages.

Among the most effective were the 192 Grandmother Groups, whose respected status enabled them to conduct 12,363 community dialogues with 33,607 caregivers. Through persistent engagement, they helped overcome missed children and referred more than 15,000 previously missed newborn, sick, and sleeping children to the nearest vaccination sites—a significant breakthrough in Kandahar Province, where refusals had historically hindered campaign performance.

The programme also strengthened partnerships with faith-based institutions through the TAAVON initiative, which mobilized 122 groups and facilitated 11 dialogue meetings with refusal-prone madrasas and schools—ultimately securing the support of 36 institutions for the polio campaign.

Together with other local influencers and volunteers, including youth leaders and community elders at district, cluster, and team levels, this localized, trust-based engagement strategy played a critical role in addressing cluster-specific barriers and driving measurable improvements in vaccination coverage across the region.

### Building stronger team for impact

#### Stakeholders mobilized during polio campaigns in the South



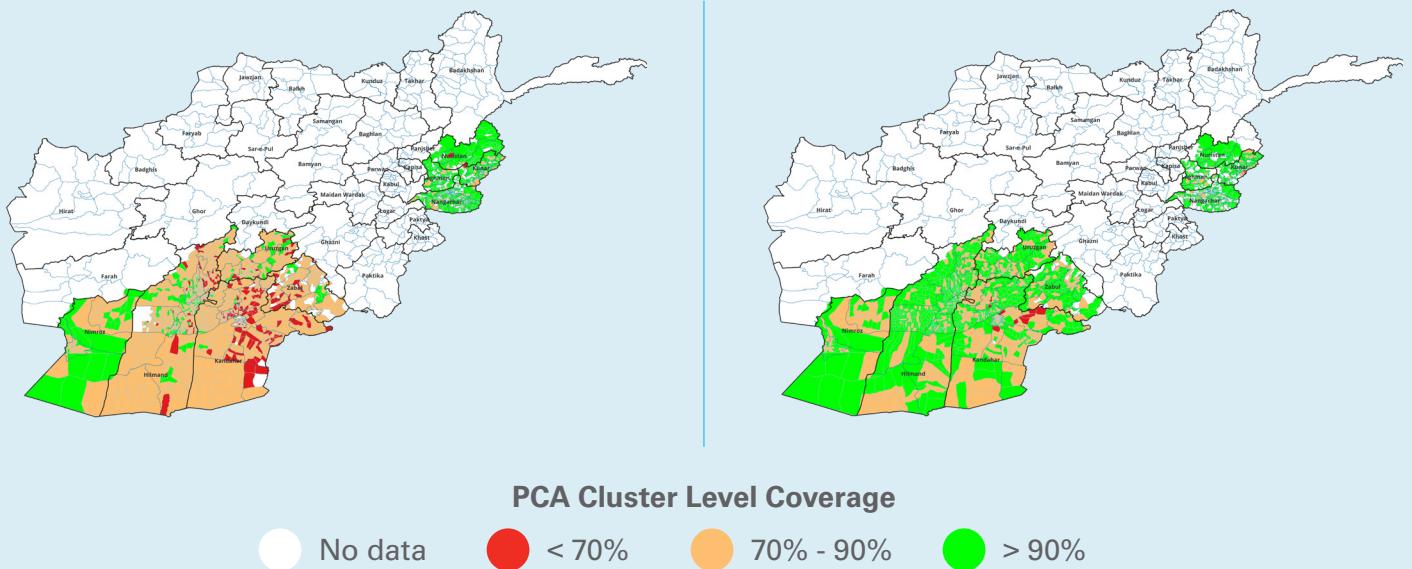
Efforts were also made to strengthen the capacity of frontline workers (FLWs), who are responsible for vaccinating children. Unqualified FLWs or those assigned from outside the community were replaced based on age, education, and experience, in consultation with communities and district authorities. The newly assigned FLWs received comprehensive training and were actively involved in tracking missed children, zero-dose cases, and refusal follow-up within their designated clusters.

Coordination at the cluster level improved significantly as district polio teams and partners

began reviewing data more frequently and addressing issues between rounds. Social mobilizers and SBC teams shifted from broad messaging to using cluster-specific data to design tailored community engagement plans. After each campaign, district-level review meetings were held with supervisors and teams from low-performing clusters to identify bottlenecks and develop targeted action plans jointly with UNICEF, WHO, and Emergency Operations Center (EOC) colleagues at cluster, district, provincial, and regional levels.

## COMPARISON CLUSTER POST CAMPAIGN ASSESSMENT PERFORMANCE

April 2025 vs February 2026



Cluster performance data show a steady decline in clusters with less than 80% PCA coverage and a corresponding increase in clusters achieving more than 95% administrative coverage across all provinces, demonstrating the impact of strengthened frontline capacity, data-driven planning, and improved coordination.

The infrastructure built for polio eradication also supports broader health priorities, including routine immunization.

### Prioritization and Focus drive Results

A targeted focus on persistently underperforming clusters proved to be one of the key success factors of the cluster approach. Through detailed and integrated microplanning (operations and behavioural), strengthened coordination between rounds (WHO-UNICEF and Regional EOC), and the strategic deployment of field staff to the areas of greatest need, programme teams were able to address the root causes of low performance.

## Coverage (May 2025)



The graph illustrates substantial coverage gains in prioritized clusters, confirming the effectiveness of concentrated efforts in the most challenging areas.

This focused strategy also contributed to reducing missed children. When the approach began in May 2025, monitors identified **7,014 missed children**; by the February 2026 campaign, this number had fallen to **3,414**.

As Kondwani Ng'oma, Team Leader (South), reflected: *"When we started, we didn't know it would give us these kinds of gains. It gave us the passion to use it more and to make it work even better."*

## Partnerships

UNICEF's work to eradicate polio focuses on communication, social mobilization, social and behaviour change and vaccine supply. UNICEF collaborates with a number of partners including:

WHO (World Health Organization): technical support, surveillance, and monitoring.

EOC - The National Emergency Operations Center under the Ministry of Public Health. Supports national immunization campaigns, surveillance and testing.

DHO: Localised engagement with District Health Offices to support greater involvement and ownership.

CDC – Technical and epidemiological support  
Rotary International – Advocacy and funding

Bill & Melinda Gates Foundation – Major financial and technical donor

Gavi – Financing immunization systems and integration initiatives.

UNICEF's WASH programme: In Kandahar, the team worked together with UNICEF's Water and Sanitation (WASH) programmes. Five solar powered water supply systems reached 4,700 people with safe drinking water and promoted good sanitation and hygiene practices.

UNICEF's Nutrition Programme collaboration included 2,223,646 Vitamin A capsules distributed during April 2025 NIDs and 1,516,000 Mebendazole (worm medication) distributed during May 2025 NIDs.

## Lessons Learned

### Push

- Improve collaboration with WHO and humanitarian partners to better track missed children.
- Ongoing refinement of micro plans enables teams to continuously identify and resolve operational gaps, ensuring more effective planning and implementation with each campaign.

### Pull

- Ensuring a stable workforce of qualified, locally recruited frontline workers remains essential, especially in areas where engagement with authorities continues to pose challenges.
- Strengthening collaboration with Community Health Workers enhances community level capacity, reinforces outreach quality, and improves coordination across interventions.
- Mapping and meaningfully engaging polio survivors in community activities and as District Communication Officers (DCOs) provides a powerful, trusted voice in high refusal or hard to reach areas.
- Conducting detailed data analysis, including baselines, targets, outputs, and outcomes, enables more informed decision making and helps identify performance gaps early.
- Regular engagement sessions, tailored influencer training, and focused discussions at the cluster level lead to stronger community ownership and more effective demand-generation outcomes.

### Push-Pull

- Strengthen hygiene promotion through WASH in areas with high environmental positive polio samples.
- Target influential engagement drives results.
- Sustained advocacy for the return of female vaccinators and social mobilizers, and the expansion of the grandmother programme, remains critical for building community trust, improving household access, and ultimately enhancing campaign quality and coverage.

## Recommendations

### Push

- Implement evidence-based and context-specific approaches at the lowest administrative levels.
- Enhance accountability & feedback loops to strengthen district-level ownership and introduce rapid feedback mechanisms for mid-campaign adjustments.

### Pull

- Think Outside the Box: Adapt strategies creatively when traditional methods are restricted.
- Involve polio survivors and supportive religious leaders in community outreach to build greater trust.
- Leverage digital tools by using WhatsApp broadcast lists and ENA/Epi Info dashboards for faster data sharing and decision-making.

### Push-Pull

- Advocate for policy changes, such as allowing female frontline workers, which is believed could dramatically increase vaccination coverage.
- Expand prioritisation criteria to include emerging low-performing clusters and integrate real-time data for adaptive planning.
- Institutionalise the cluster-level approach into campaign planning and monitoring cycles.



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