Implementing the Polio Pull Strategy in South Afghanistan

Descriptive Narrative
October 2025

At a Glance

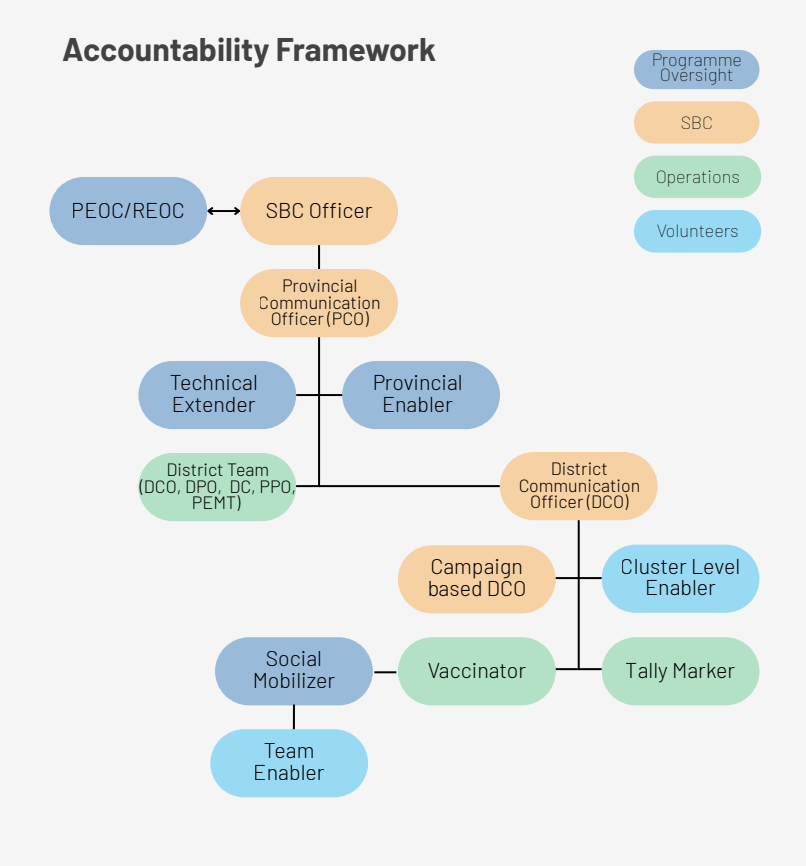
Goal

To maximise coverage in the south in partnership with the Ministry of Public Health (MOPH) using a site based modality by focusing communication planning and resources on high risk clusters by combining:

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

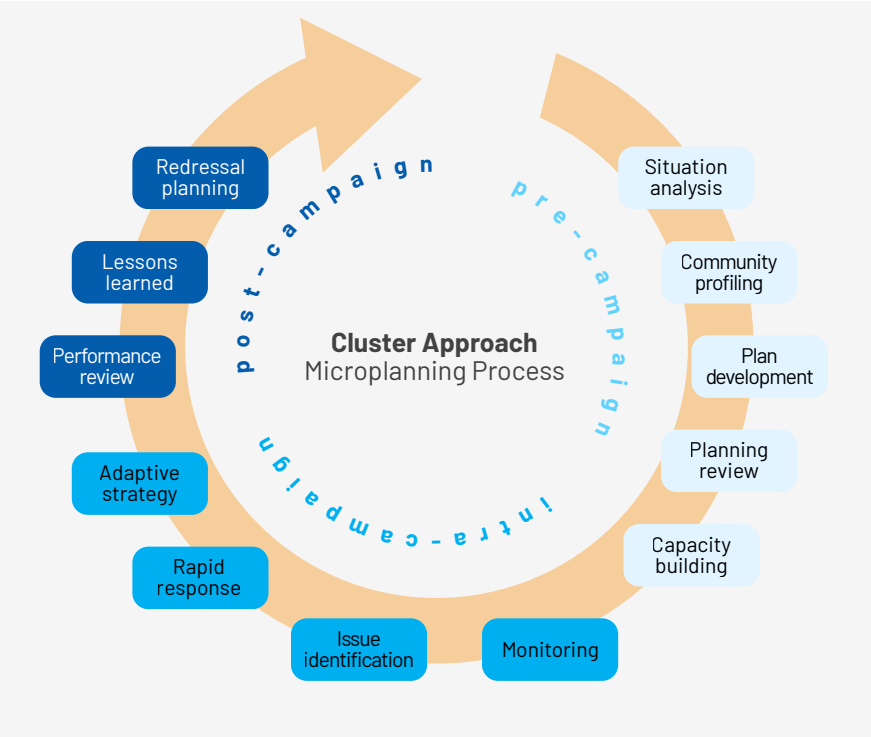
Staff, volunteers and supervision

The staff structure flows from national level to Social Mobilizer (SM) and vaccination team. The critical nexus for planning and monitoring is the District Coordination Officer (DCO) some of whom are full time with the majority campaign based. DCOs provide planning, monitoring and supervision to respond to issues such as refusals in high risk clusters and to develop microplans for the campaigns and action plans for cluster activities focused on identified issues and redressal of refusals. DCOs and teams are further supported by volunteer enablers at the cluster and team level.



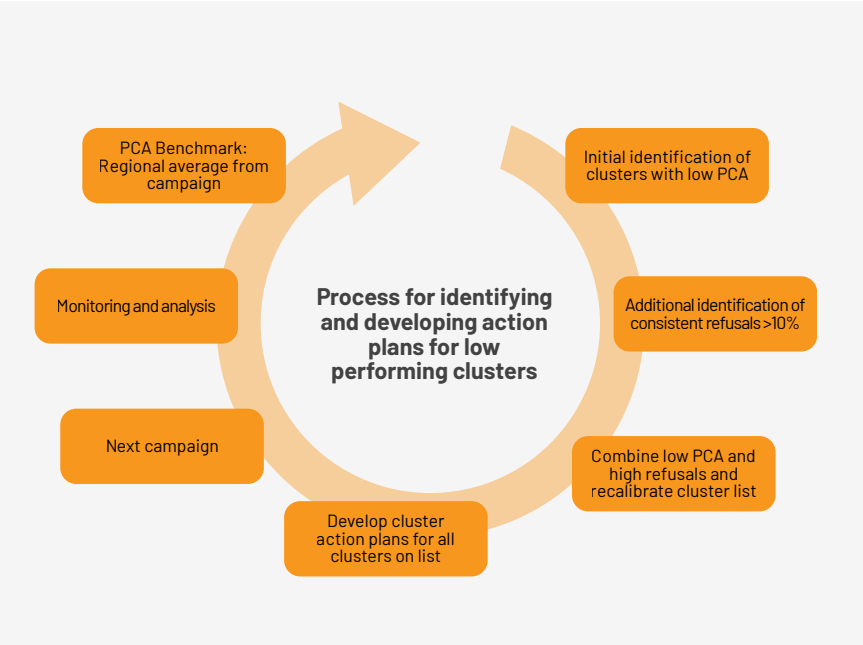
Planning and monitoring

The central planning unit is the cluster. Using a continuous microplanning process the DCOs develop and implement microplans for clusters, monitor and respond to issues during campaigns, analyse campaign outcomes and develop redressal plans. Cluster microplanning and action tools are used to guide this process and ensure accountable action plans are delivered.



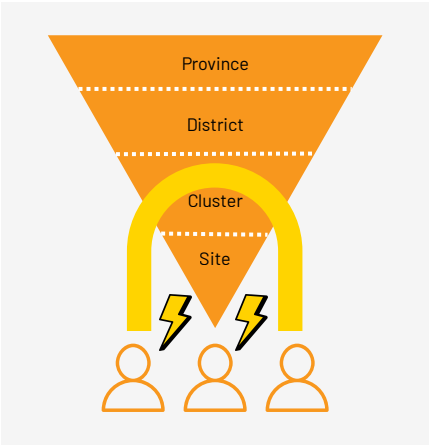
Identification and work in clusters

A list of high risk clusters is prepared after each campaign using a risk evaluation process that helps ensure limited resources are directed to the areas that need the most support to improve coverage. At present there are 928 clusters in 24 Districts in the South. Microplans guide work in clusters and action plans identify issues, actions, timelines and responsible people to address those issues.



The all important vaccination site

Teams made up of a vaccinator, tally marker and SM move along a vaccination route setting up sites as they go. Each site is positioned to be close to a small group of households (3 to 5) in a shop, mosque or influencer's house. Sites are set up for short periods with the vaccinator and tally sheet marker remaining at the site while the Mobilizer uses a megaphone to let households know the team is there and encourage caregivers to bring their children to be vaccinated. Teams are also supported by and a volunteer team enabler who can assist with issues and rapid response to refusals.



Context

The Afghanistan polio programme adopted a comprehensive pull strategy in April 2025. This was in response to a shift in campaign modality from one that 'pushed' the vaccine to every family by having vaccinators go to each household to delivery OPV, to a site based modality requiring the programme to 'pull' caregivers and their children from their homes to a site where OPV is administered. This shift was resisted by the polio programme as experience with site based vaccination in many parts of the world and over many years has demonstrated it is less effective in generating the high rates of coverage required for eradication. However, ongoing resistance to the house to house modality by the de facto authorities meant there was no alternative other than to robustly engage in the development and implementation of a focused strategy designed to maximize coverage through site based vaccination.

It should be noted that there are other compounding issues to achieving eradication level coverage in Afghanistan. The most important of these are the restrictions on women. These have led to large reductions in women working for the programme making it very difficult to communicate with female caregivers and have also created barriers for women to access information and reach vaccination sites. Other issues include, resistance to vaccination fueled by ongoing misinformation which continues to drive refusals in some areas and impacts the ability to find local advocates; interference in hiring; and issues related to poor operational and micro planning at the local level which contribute to missed children in each campaign through inappropriate staff and/or poorly planned and supervised campaigns. These issues are more pronounced in some areas and different areas face different combinations of issues which need localized response.

Finally, resource limitations are a significant and growing issue requiring much greater focus on strategies focused on geographic areas that present the greatest risk to eradication.

The Pull Strategy: Pillars, Outputs and Activities

The pull strategy is built around four pillars with associated outputs and activities:

Pillar 1: Creating an enabling environment
Output 1: Caregivers have increased trust and acceptance of campaigns
Select Activities:

- Media partnerships with most popular channels and journalist training

- Media messaging for campaigns including TV and Radio Spots, influential voices outside the polio programme, roundtables, and leveraging radio in key high risk areas
- Access to accurate information through digital community engagement, social listening to track and address misinformation, call centres to provide accurate info and gather insights on campaign reach and impact, SMS and Interactive Voice Response for campaign awareness
- Engagement with de facto authorities through mapping local influencers and enablers, orientation of influencers and elders, advocacy conferences for religious influencers to secure endorsements, pre-campaign meetings of District Governors, influencers, elders, and police authorities.

Pillar 2: Increasing community ownership and participation
Output 2: Caregivers have improved knowledge of polio symptoms, reduced misconceptions of vaccination, and increased uptake of OPV.
Select activities:

- Building FLW capacity through revamping training materials, developing IEC packages for FLW community interactions, regular rapid assessments and consultations with FLWs, piloting ideas for gender sensitive programming to access children, incorporating family teams (Mahrams as mobilizers).
- Renewing local influencer strategies through micro-mapping influencers (elders, religious leaders, medical experts), regular engagement of influencers to build relationships, engaging grandmother groups, conducting community elder sessions, community listening, advocacy conferences for grassroots religious influencers, and working with Maleks and Wakil Gozars to map lists of community leaders.

Pillar 3: Improving campaign quality
Output 3: During campaign reduction in missed children and improved vaccine security.
Select activities:

- Train and deploy cadre of campaign-based SMs, activate local influencers networks during campaigns, use limited pluses to attract families, use integrated service delivery (ISD) to strengthen links to other health services, work with EPI and nutrition on community engagement, SM and newborn tracking, and coordinate with humanitarian partners doing CE and SM.

Pillar 4: 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.
Select activities:

- Streamline the M&E framework and SOPs, revise M&E tools (survey, indicators, QM checklist), capacity building for Regional/Provincial staff, ensure rapid assessment of interventions and pilots, assess capacity needs of FLWs and develop training, evaluate impact of pluses, increase utilization/visibility of call centres, and provide regular deeper dive analysis of data on polio dashboard.

The Pull Strategy: Monitoring and Evaluation

The comprehensive pull strategy measures progress for each pillar using the results framework below.

The Results Framework contains outputs, activities and inputs for each pillar. Essentially the framework focuses on trust, awareness, campaign quality and evidence gathering and analysis. In the Afghanistan context there is a significant emphasis on engaging with de facto authorities to gain and sustain their support for the programme and its activities.

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

The Monitoring and Evaluation Framework for the pull strategy elaborates on the results framework. It tracks impact in relation to the reduction of WPV1 and positive environmental samples and numbers of children vaccinated. It sets targets for levels of coverage; caregiver knowledge, trust, and belief in negative rumours; campaign awareness; percentage of missed children; and LQAS lots passed. It also tracks special elements of the programme such as pluses; OPV at health camps; and referral rates in the East. M&E indicators focus on evidence generation activities and data use meetings.

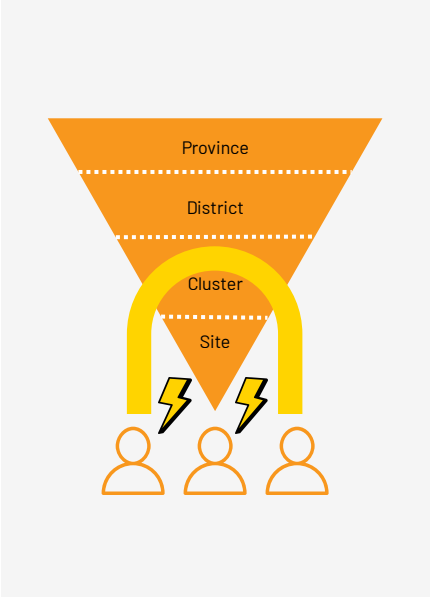
Monitoring and Evaluation Framework

	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 rumour	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

The South Afghanistan Cluster Approach: Focus on the Local

The cluster approach seeks to increase coverage in a site based campaign model; to identify local intermediaries that can engage with households and women at community level; to reorganise staffing structures, roles and responsibilities to adapt to this modality; to revise training to reflect the skills needed; to review tools for microplanning and missed children identification; and to assess indicators and M&E frameworks to measure impact.

In many ways this takes a programme known for its top down structure and turns it on its head. If you'll allow, this can be looked at from the perspective of a magnet. The 'pull' or magnetic force has to occur at the vaccination site. The magnetism of the vaccination site depends on how well it is supported by the cluster to carry out effective campaigns and identify and respond to local issues. The effectiveness of the cluster in supporting the sites depends on the strength of district analysis and support. The province and national levels have important roles to play in coordinating and directing resources and creating enabling environments through media and engagement with de facto authorities. However, the point at which children get vaccinated is the vaccination site and success at that level depends on the ability to attract caregivers and their children to them.



The pull strategy itself does not cover this need for local focus in detail but does emphasise its importance. The cluster approach, explicitly focuses resources down from the provinces, to the districts, to the clusters and ultimately during each campaign, the vaccination sites. Each high risk province has been divided into high risk districts and each of these districts into high risk clusters. Sites are then placed close to a small number of households (between 3 and 5). This intensely localized site placement reduces barriers to caregivers reaching the sites and also increases the programme's ability to make households aware of campaign days through local influencers and community groups. Approaches to reaching households with information have shifted from mobilization at the door to working through influencers, community groups, and religious leaders. Operational issues are being addressed through closer attention to the quality and appropriateness

Vaccination Sites: The Critical Nexus of Operations and SBC

Vaccination sites are designed to cover a small number of households in a relatively short period of time. Each vaccination team has a list of predetermined sites (usually at a shop, community elders house, or mosque) on their route where they set up for short periods, vaccinate as many children as they can and then move on to the next site. Vaccination teams include SMs who announce that they are there using a megaphone (where this is allowed) to let the small number of households know the site is there, a vaccinator who administers OPV and a tally marker who fills in the tally sheet. There is also a team level volunteer who is locally influential and while not moving constantly with the team can be called in to assist with covering missed children, resolving issues and assisting during revisits. No one is allowed to knock on doors and it is up to caregivers to bring their children to the site. At the site, caregivers are asked if any children have been missed in their household and tally sheet records are kept of vaccinated and missed children. In some places they are allowed to collect names in others only numbers.

Reaching all the children at each site is both critical and difficult. Encouraging caregivers to gather and bring their children has to be done through pre-campaign engagement activities with influencers such as religious leaders, medical doctors, teachers community groups etc. to inform them of the campaign and encourage them to let their communities know about the campaign and the importance of having their children vaccinated.During the campaign SMs set up banners at vaccination sites and use megaphones close to the households letting them know the site is there and encouraging them to bring all under-5 children to be vaccinated. The vaccinator delivers OPV to the children who come to the site and the tally marker records the number of children vaccinated. The team of three also has some dialogue with the caregivers and older children to determine if children have been missed and to further encourage caregivers to bring all children to the site for vaccination. Enablers assist in encouraging all children be brought to the site and will sometimes make phone calls to caregivers who have not shown up. However, team enablers do not follow the teams and are not always present at sites.

Tally Sheet Instructions for Vaccinator Teams

- Before announcing in the site, say Salam with respect and introduce yourself to the community.
- After the introduction, the team should conduct the session as per the itinerary at that site, ensuring that the site is appropriately located.
- Community mobilizers/village elders should inform the community and help to bring children <5 to the site.
- Ask the parents to bring all their children (including sleeping, sick, guest, newborn and neighbouring) for vaccination.
- Vaccinate all the children <5 years and ensure that no child is missed, mark little left hand finger with indelible finger marker, record in tally sheet.
- Once again, ask about the sick, sleep, newborn, guests and neighbours <5 children not at home and be sure no child is missed. During the process, the team should not insult anyone.
- The community mobilizer should provide volunteers for recording.
- All AFP cases <15 should be reported as soon as possible.

Equally important and difficult is gathering the kind of information at each site that identifies how many children have been vaccinated and how many missed. This has to be done through record keeping at the sites where children are enumerated and questions are asked to determine which

household children come from, whether they represent all the children in that household or whether some have not been brought, who those missed children are, and what the caregiver's vaccination intent is for those children. This information is supplemented with information from local influencers and enablers who often know how many children are in specific households. In some places noting the names of missed children is allowed in others only numbers can be recorded. Other data comes from local influencer and enabler recall. This means that the data sets at this level are not always compatible and the lists/numbers of missed children are approximate. Ensuring that this information is as accurate as possible depends on the quality of interpersonal communication skills and accurate record keeping by the teams coupled with information from enablers and influencers and double checked by supervisors and those at the cluster and district levels.

When a team leaves a site to move on to the next and children have been missed, revisits are planned for the afternoon. Revisits involve setting up the site again close to households where children have been missed. This is led by the SM in collaboration with the vaccinator and tally marker. Children that remain missed after the afternoon revisit are noted and incorporated into plans for the 4th day revisit where the process is repeated with the revisit itinerary based on the list of remaining missed children.The team comes with volunteer enablers and banners are set up in visible locations and miking is done close to the households with missed children. Mosque announcements are also made where possible. Children who remain missed are recorded (names or numbers as allowed) as still missed or refusal if the parents resisted vaccination. It should be noted that these distinctions are not always clear in the south context.

Operational and Management Plan and Reporting Flow

The South Region has identified 24 very high and high risk Districts and within these Districts 928 clusters to focus on. Special attention is paid to micro-planning and monitoring in each of these clusters. The major indicator for monitoring progress and performance in these clusters is PCA (Post-Campaign Assessment) data. However, a range of data is being incorporated to ensure "robust data systems and localized intelligence to guide targeted, evidence-based actions and ensure that resources are deployed where they can have the greatest impact". 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 several key actions:

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

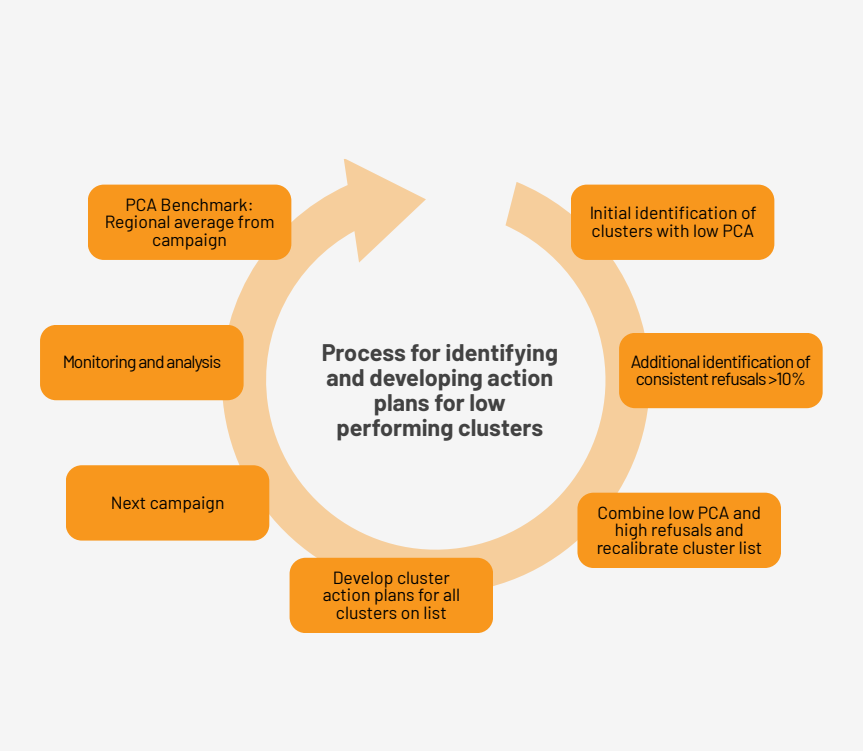
Which clusters to focus on is determined at the end of campaigns with UNICEF and WHO jointly identifying low-performing clusters using the following criteria:

1. Benchmark setting

A benchmark for PCA coverage is established based on the regional average from the most recent campaign.

2. Initial Identification

Any cluster with PCA coverage below the regional benchmark is flagged as potentially low performing.



3. Consistent Underperformance

Clusters are then classified as low performing based on two key criteria. First, any cluster that recorded PCA coverage below the regional benchmark for three consecutive rounds is designated as low performing. Second, to capture persistent demand-side challenges, clusters that reported a refusal rate exceeding 10% for three consecutive rounds were also included in the low-performing category. This dual-criteria approach is intended to incorporate both coverage gaps and chronic community resistance in the selection process.

4. Monitoring and recalibration

The list of low-performing clusters is dynamic and subject to regular recalibration. New clusters are added based on the latest performance data, while existing ones remain under monitoring until they demonstrate sustained improvement. Specifically, a cluster will exit the low-performing category only after achieving PCA coverage above the global benchmark of 95% for three consecutive rounds. This ensures that improvements are consistent and not one-off, maintaining accountability and focus on sustained performance.

The Action Plan Process

Once the list of low performing clusters are determined a planning process coordinated between WHO, UNICEF and the EOC begins to ensure that behavioral and operational issues are well captured and solutions are jointly planned. This process includes:

1. Low performing cluster standardized action plan template

Once the list of low-performing clusters is finalized, a standardized action plan template is used to identify actions as either 'Pull', 'Push' or 'Pull/Push'. 'Pull' actions are largely focused on SBC and 'Push' on operational issues. The standard action plan is designed to ensure consistency and improve quality of planning across all targeted clusters.

2. District level analysis and intervention planning

The list of selected clusters is shared at both provincial and district levels to facilitate joint review and the design of tailored action plans for the upcoming campaign.

To deepen the understanding of local challenges, district and provincial teams review and analyse the past three campaign's vaccination and SBC data and organise focus group discussions with frontline field teams, including SMs and DCOs. This analysis and dialogue helps identify specific behavioral and operational barriers in each cluster so targeted interventions can be designed accompanied by a clear accountability framework.

The resulting cluster-level action plans are compiled, reviewed, and validated at the provincial level in consultation with the Provincial Emergency Operations Centers (PEOCs), and then submitted to the regional team.

3. Regional review and quality assurance

The regional teams utilise an action tracker to ensure identified issues are addressed systematically. The tracker is routinely reviewed at regional, provincial and district level. This allows for plans to be analysed and feedback provided to highlight key issues and urgent interventions requiring immediate attention.

Finally, a coordination meeting between regional and provincial teams is held to provide strategic guidance and agree on key priorities for implementation.

4. Accountability and Supervision

An accountability framework and a detailed supervision plan are agreed upon to ensure effective implementation at all levels.

All of the above is captured in the standard action plan template. Below is an example for Shahwalikot District in Kandahar. This plan identifies the cluster, coverage in the previous campaign as per PCA, the behavioural and operational issues, the plan to resolve them, and whether they are 'Pull' or 'Push' actions.Accountability elements provide a timeframe for action, identify the person responsible, set out expected results for the action, and establish a projected coverage goal for the next campaign.

Low performing clusters Action plan for July campaign (Shahwalikot district Kandahar)

S/N	Province	District	Clusters No	Village	Coverage Overall (Previous campaign coverage)	Main behavioral and Operational issues	Action Plan	Strategy	Timeframe	Responsible Person	Expected results	Expected coverage (July 2025)
188	Kandahar	Shahwalikot	3	Shajoy	79%	Non eligible SM in team 3	Replace, select and orient eligible SM	Pull	14-Jul	Abdul Razaq(DC)	Non-local SM repalced by Eligible SM.	92%
189	Kandahar	Shahwalikot				Community misperception of Polio vaccine in Team 2	Conduct community engagement meeting with elders	Pull	15-Jul	Abdul Razaq(DC)	2 Meetings has been conducted with elders to support polio.	
190	Kandahar	Shahwalikot				Less # of vaccination site in in team 1	Update Microplan to increase numbers of sites .	Push	15-Jul	Abdul Razaq(DC)	Site increased for this campaign	
191	Kandahar	Shahwalikot	11	Yatiman	82%	Volunteers not present on time in Team 1	Replace and provide on-job orientation to new hired Volunteer	Push	15-Jul	Sharifullah DC	Volunteer replaced	92%
192	Kandahar	Shahwalikot				4 Refusal houses in 4 Team	Train enablers and engage them in refusal resolution dialogue with the heads of the families	Pull	15-Jul	Sharifullah DC	Refusal families convinced	
193	Kandahar	Shahwalikot				6 Refusal houses in 3rd team	Train enablers and engage them in refusal resolution dialogue with the heads of the families	Pull	16-Jul	Sharifullah DC	Refusal families convinced	
194	Kandahar	Shahwalikot				Non eligible SMs in team 3	Replace, select and orient eligible SM	Pull	16-Jul	Sharifullah DC	Eligible SMs assigned	

Cluster Level Mobilisation and Engagement Microplan

While the low-performing cluster action plan focuses on identifying key bottlenecks and prioritizing corrective actions, the micro-plan provides detailed guidance on community engagement and social mobilization activities at the cluster level. The micro-plan translates that strategy into concrete, day-to-day activities needed to reach children and engage communities.

The micro-plan is structured around three key phases — Before, During, and After the campaign— to ensure a continuous cycle of planning, implementation, and learning.

1. Before the Campaign

- *Cluster level situation analysis:* As part of the community engagement and social mobilisation micro-planning process, teams begin by reviewing recent PCA data, refusal trends, and reports on missed children to identify clusters with persistent challenges. This analysis is complemented by a deeper exploration of behavioral and social barriers — such as misinformation, distrust in health services, or cultural beliefs — that may be contributing to low coverage.
- *Community profiling:* Key influencers and enablers are identified (e.g., elders, teachers, religious leaders) who can support solving or understanding local issues and barriers, preferred communication channels within the clusters, language spoken and high-risk groups.
- *Plan development:* Tailored community engagement and social mobilization plans are prepared for each cluster, including specific actions, timelines, and responsible actors. In the case of any operational issue, adjustment is made to the microplanning.
- *Planning review:* Community engagement and social mobilization plans are validated to ensure alignment with identified needs.

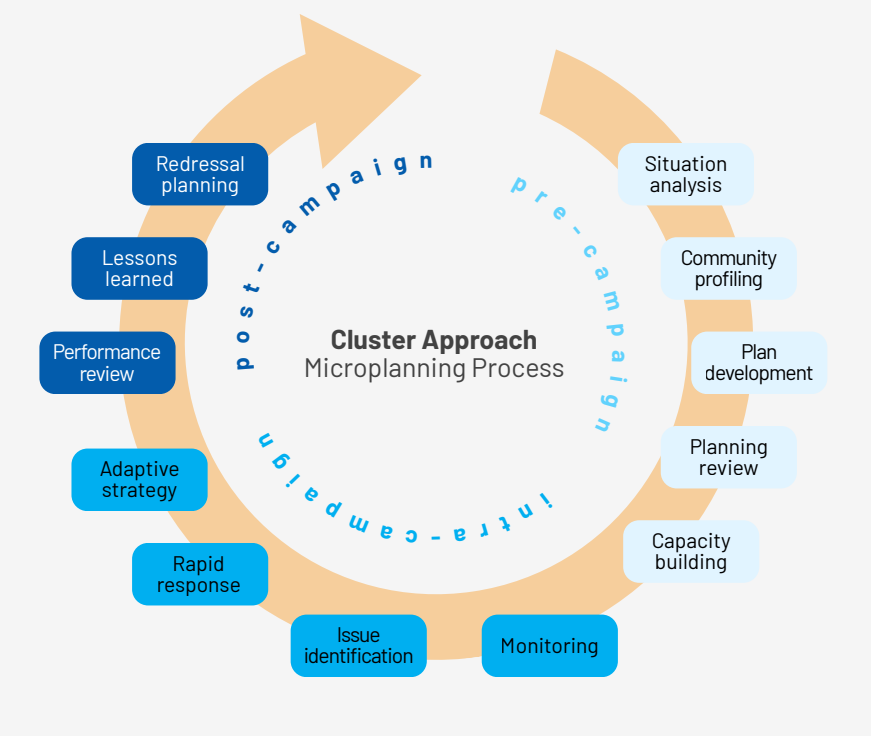
- *Capacity Building: SMs, volunteers, and cluster enablers are trained on key messages, interpersonal communication, and refusal handling, where a gap of knowledge has been identified as a key issue, or in case of replacement of underperforming or non-eligible FLW.*

2. During the Campaign

- *Real-Time Monitoring:* Progress is tracked using administrative data and intra-campaign monitoring tools by the DCO who participates in daily monitoring meetings at District level to identify or share field issues and influence action for course adjustment.
- *Issue Identification:* SMs and vaccinators identify missed children and community-level challenges and communicate with the DCO for immediate support. The first response is through the afternoon revisit. In the case of stronger resistance, the team involves influencers and local authorities. For really stubborn cases there is a forth day follow up.
- *Rapid Response:* Cluster enablers and the DCO support immediate resolution of issues, including refusals and access barriers through implementation of different strategies.
- *Adaptive strategy:* Community engagement and social mobilization plans are adjusted for interventions based on daily findings and field feedback.

3. After the Campaign

- *Performance Review:* Campaign implementation is assessed, missed children households identified together with reasons, and CE/SM effectiveness is evaluated.
- *Lessons Learned:* Successful interventions and enablers, as well as gaps and failures, are identified.
- *Redressal Planning*: Action plans are developed and implemented to address challenges before the next campaign.



Below is the community engagement/social mobilisation cluster microplan template. It identifies and defines clusters, target populations, number of households, vaccination sites, and teams. It lists the CE team members for each cluster and the teams they are assigned to. It describes the communities in the cluster, the influencers in them, the main risk factors, identifies challenges, and mitigation measures. It assigns responsibility for carrying out mitigation measure and sets timelines. It breaks these down into behavioural (pull) and operational (push) actions. It also identifies social mobilisation activities with timelines and persons responsible. Finally, it establishes plans for cluster monitoring and supervision and post-campaign review.

Community Engagement, Advocacy and Social Mobilization Cluster Microplan

1. Cluster identification

Province	District	Cluster Name/Code	Target Population (0–59 months)	Number of Households	Number of Missed Children (last round)	Number of Sites	Number of team

2. Cluster Community engagement team

Name	Role	Contact	Language(s) Spoken	Assigned team

3. Cluster Community mapping

Type of Settlement	Number	Key Influencers	Risk Factors (e.g., refusals, insecurity)

4. Cluster key behavioral and operational issues

Identified challenges	Mitigation Measure	Responsible	Timeline

5. Cluster Social mobilization activities

Activity	Date	Location	Target Audience	key message	Responsible Person	Timing	Materials Needed

6. Cluster Monitoring and Supervision

Supervisor Name	Areas and team to cover	Supervision date	Timing

7. Post campaign review meeting and IBRA planning

Participants name	Participant title	Date	Location	Responsible	Key outcome

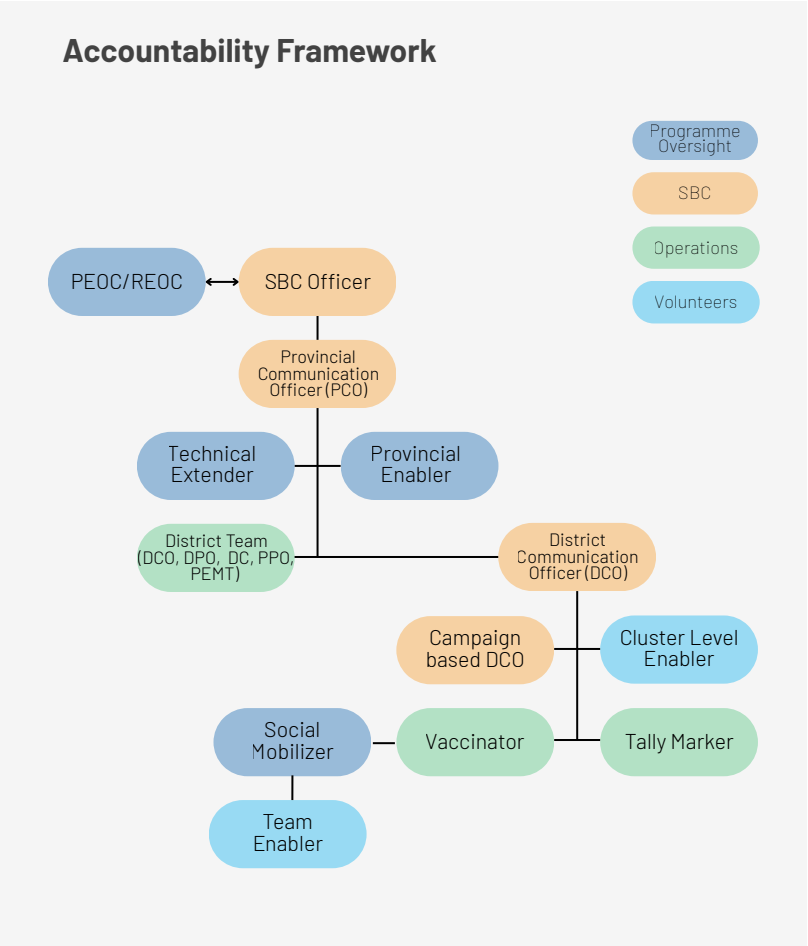
Signature of DCO and DC	Signature of the Cluster Supervisor

Staffing at the Critical Front Lines

The quality of planning and implementation rests on the quality of the staff doing the work and the training and supervision they receive. In the South the following staff positions are responsible:

Position	ToR
Provincial Communication Officer (PCO)	This position has a range of responsibilities but in relation to the cluster approach focuses on the coordinating the implementation of the cluster approach and ensuring that micro-plans are well designed, reports compiled and coordination with REOC, UNICEF and WHO.
District Communication Officer (DCO)	The DCO and campaign-based DCO positions have the same responsibilities during campaigns. DCOs are also responsible for community engagement between campaigns, as well as supervision of campaign-based DCOs and SMs during campaigns. DCOs have been reallocated from non-high-risk districts of the South to high-risk districts, with at least two DCOs per high-risk district.
Campaign-based DCO	Campaign based DCOs provide additional DCO capacity to identify issues and data-driven interventions in low-performing clusters. They are hired for 15 days (8 days pre-campaign + 4 days for intra + 3 days post) to engage community leaders and influencers, provide training and supportive supervision to SMs, and compile cluster data during the campaign for the full-time DCO. They also participate in post-campaign reviews, cluster-level planning, and district reviews.
Social Mobilizer FLW	SMs provide community engagement for campaigns and work for 8 days (1 day training, 3 days pre-campaign, 4 days intra-campaign) to create community awareness through mobile miking, community-level meetings, collaborating enablers/ influencers, collecting data of missed children, and addressing refusals.
Female Mobilizer Vaccinator	*A concept note has been developed and ToR developed but these posts are not presently in place.*
Cluster Level Enabler Volunteers	Enablers are community elders or anyone who has positive influence within the community and are identified and authorized by District Governors to mobilize families to come to vaccination sites during campaigns. They are a team-level resource during campaigns, listed on campaign microplans; and unpaid.
Team Level Enabler Volunteers	

The reporting flow for provinces in the South Region is laid out in the organogram which includes the full complement of the vaccinator team including the vaccinator and tally marker who are categorised as operations positions but have obvious and important communication roles as front line workers in direct contact with caregivers and children.



The success of the cluster approach and, one could argue, eradication, depends on how well these positions perform their duties. If S2S is to reach enough children to take Afghanistan off the endemic list, coverage rates must increase significantly and over a sustained period in very high risk and high risk areas. The most critical positions for maximising the 'pull' of vaccination sites are:

- DCOs (extenders and campaign based) who support planning and monitor implementation at cluster level
- SMs, Volunteer Vaccinators and Tally Markers who directly engage with communities during pre, intra and/or post campaign activities, identify missed children and refusals, report issues to cluster and team enablers and support resolution
- Cluster enablers who work at cluster level and team enablers who work with vaccination teams support issue resolution, directly engage with caregivers and support/implement actions

These are the positions that need the most attention, support, supervision, and training. They are also the positions that need the most monitoring to ensure their planning, data gathering and analysis are identifying and resolving issues effectively.