Strengthening routine immunization

Key lessons from **integrated service delivery**

The Gates Foundation launched the Routine Immunization Strengthening Program (RISP) in 2019 to improve routine immunization (RI) in subnational areas with low immunization coverage and high risk of polio transmission. From 2023 to 2026, the RISP Learning Consortium (LC) synthesized evidence across RISP countries to foster cross-country learning, identify lessons from different implementation approaches, and generate practical evidence to inform future immunization policies, programs, and investments.

KEY LESSONS

Integrating immunization with basic health services increases acceptance and uptake of vaccination in humanitarian settings, where demand for standalone immunization services can be very low.

Afghanistan, Central African Republic (CAR), Somalia, South Sudan

Vertical and time-bound funding, misaligned incentives, and operational and coordination challenges across partners and programs limit opportunities for joint operations and discourage integration.

CAR, Somalia, South Sudan, Syria

Coordinated screening and referrals help to identify people for and connect them to vaccination services when integrated delivery is not available at the point of service.

Afghanistan, CAR, Somalia, South Sudan, Syria

ROUTINE IMMUNIZATION STRENGTHENING PROGRAM
LEARNING CONSORTIUM

BACKGROUND

Fragile and humanitarian settings

RISP directly funds humanitarian response actors to fill gaps in RI service delivery in fragile and humanitarian settings in Afghanistan, CAR, Somalia, South Sudan, and Syria. Investments are tailored to each country's context and summarized in the table below.

COUNTRY	TECHNICAL PARTNERS	INVESTMENT ACTIVITIES	GEOGRAPHIC FOCUS
AFGHANISTAN *DIRECT SERVICES*	• Acasus • Bu Ali Rehabilitation and Aid Network • Centre for Humanitarian Dialogue • McKing Consulting Corporation • United Nations Children's Fund (UNICEF)	• Provided technical assistance (TA), coordination, and support for RI delivery, including vaccinators and data systems.	Focused on high-risk polio areas, including Helmand, Kandahar, and Urozgan, due to ongoing wild poliovirus transmission and humanitarian challenges.
CAR *DIRECT SERVICES*	• Bluesquare • Centre for Humanitarian Dialogue • International Federation of Red Cross and Red Crescent Societies • International Medical Corps • McKing Consulting Corporation • New Horizons • University of California, Los Angeles • World Health Organization (WHO; and four local organizations)	• Provided TA to expand RI service delivery and increase the number of facilities offering immunization. • Strengthened capacity of the Ministry of Health and Population. • Improved immunization data quality for decision-making. • Increased support to strengthen community-level RI systems from 2024 onward.	Focused on 13 districts in regions 4, 5, and 6, which were affected by conflict and instability (2021–2023), then consolidated support in 3 districts in region 5 (Bamingui-Bangoran, Haute-Kotto, and Vakaga) from 2024 onward.

COUNTRY	TECHNICAL PARTNERS	INVESTMENT ACTIVITIES	GEOGRAPHIC FOCUS
SOMALIA *DIRECT SERVICES*	• Acasus • Centre for Humanitarian Dialogue • CORE Group • Health-E-Net • HISP Tanzania • Save the Children International • World Food Programme Innovation Accelerator	• Implemented the Far-Reaching Integrated Delivery program (FARID), which provided integrated services through health camps and fixed sites.	Focused on 20 districts across the Galmudug and Jubaland regions, where access to immunization was limited or absent.
SOUTH SUDAN *DIRECT SERVICES*	• Access for Humanity • McKing Consulting Corporation • New Horizons • The Center for Advancing Public Health	• Supported implementation of the Boma Health Initiative—a nationwide community health program—including support for supervision, training, and data reporting. • Strengthened cold chain systems, including installation and maintenance.	Focused on 30+ counties in the Greater Upper Nile region, a polio high-risk area (2019–2024), then reduced scope to 6 counties following transition under the Health Sector Transformation Project (2025 onward)—a national, multidonor approach to expand access to a basic package of health services and strengthen health systems.
SYRIA *DIRECT SERVICES*	• Assistance Coordination Unit • Save the Children International • WHO	• Supported RI operations through Expanded Programme on Immunization (EPI) units, including vaccinators for outreach, transportation, and operational costs. • Coordinated activities with the Syria Immunization Group led by UNICEF and the WHO.	Focused on 41 EPI units in northwest Syria, which are historically underserved with inconsistent RI delivery, then reduced support to 17 EPI units in 2025 following the political transition and shifts in health sector governance.

Integrated service delivery models

Integrated service delivery models—defined as the intentional integration of RI with other health services—are delivered primarily through health facilities and community-based platforms, including outreach and mobile sessions.

There are **varying degrees of integration** across settings:

FULL INTEGRATION →

	COORDINATION	COLOCATION	CONVERGENCE
Degree of integration	*Communication and information sharing*	*Physical proximity of multiple services during the same visit*	*Unified workflows or joint delivery through integrated packages*
Delivery approach	Coordination primarily through **referrals** between community and facility teams to identify and follow up with unvaccinated children.	Multiple **services are delivered together** in one visit/interaction with a health worker at the facility or community level.	Joint planning, staffing, supply management, and financing to deliver an **integrated package** of services.
Country examples	• **CAR:** Community health volunteers refer patients for immunization during home/community activities. • **South Sudan:** Boma Health Initiative health workers deliver community-based primary health care (PHC) services and, along with community health volunteers, identify eligible children in the community and share the list with mobile RI teams that visit monthly. • **Syria:** Social mobilizers and outreach teams coordinate by sharing information on children identified as needing vaccination or nutrition follow-up.	• **Afghanistan, South Sudan, Syria:** Health workers in facilities screen children for vaccination status and either directly vaccinate them or refer unvaccinated children to the EPI unit within the facility or a nearby facility. • **CAR:** At times, vaccination/polio campaigns include vitamin A supplementation and deworming interventions. • **CAR:** Integration of humanitarian activities (e.g., food distributions) with immunization. • **CAR, Somalia, South Sudan:** Out-of-facility platforms (outreach events, health camps, or mobile clinics) provide multiple child and maternal health interventions within a single visit.	• **CAR:** The Ministry of Health and Population's community engagement policy envisions integrated PHC delivery supported by two community health workers per village. • **Somalia:** Health workers provide integrated services (immunization, nutrition, maternal and child health) at the point of care at FARID fixed sites and health camps. They are expected to screen all children for immunization status during each visit; children with missing doses are vaccinated.

STRENGTH OF EVIDENCE

The RISP LC applied a strength-of-evidence rating (strong/moderate/limited) to each finding, reflecting the level of convergence across sources:

STRENGTH OF EVIDENCE: STRONG

- Clear convergence across multiple, diverse sources; rich and credible evidence supporting program theory; minimal uncertainty.

STRENGTH OF EVIDENCE: MODERATE

- Partial convergence or convergence within a smaller set of data sources; theory-supported with some remaining uncertainty.

STRENGTH OF EVIDENCE: LIMITED

- Mixed or inconsistent signals; lower information power; exploratory interpretations.

LESSON 1

Integrating immunization with basic health services increases acceptance and uptake of vaccination in humanitarian settings, where demand for standalone immunization services can be very low.

Afghanistan, CAR, Somalia, South Sudan

STRENGTH OF EVIDENCE: **MODERATE**

FINDINGS

Integrated service delivery is responsive to community demand for broader health services in humanitarian settings (CAR, Somalia).

> *Immunization alone at times is not adequate enough, so [there is a] need for accompanying service provision to happen. So, some of the key activities in the health camps now include the treatment of minor ailments, nutrition screenings, community health education, [infant and young child feeding] messages, surveillance for [acute flaccid paralysis], measles."* —Implementing partner, Somalia

Caregivers are more motivated to seek immunization when multiple health and nutrition services are offered together (CAR, Somalia, South Sudan).

> *We realized that with this integrated approach, we were able to mobilize more of the population than when we came with just vaccines against polio."* —Technical partner, CAR

In some humanitarian settings, vaccination is a lower priority compared to basic needs such as food, treatment, and/or safety (Afghanistan, CAR).

> *Women were not interested in seeking immunization because they didn't understand why health workers were coming to vaccinate children who are healthy rather than treating first the ones who have fevers."* —Implementing partner, CAR

Country case study: Integration in Somalia

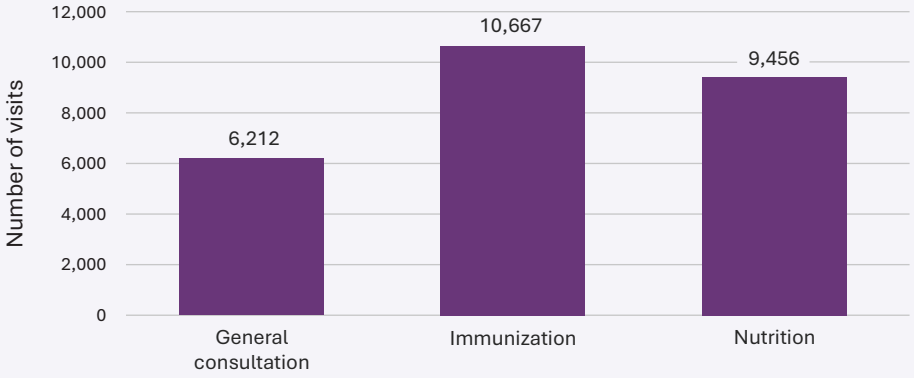
The Far-Reaching Integrated Delivery (FARID) program in Somalia was designed in response to community and local authority feedback that immunization was not acceptable as a standalone service. In previous efforts, partners observed that caregivers were unlikely to bring children for polio vaccination in the absence of other services. As a result, FARID partners jointly plan and deliver immunization and other essential health services through fixed sites and health camps.

Benefits: The integrated package of services is widely acknowledged as being responsive to community demand. Delivery of the FARID integrated package of services in previously inaccessible areas has led to an increase in the number of vaccines administered.

Challenges: A team of three to five facility-based staff delivers a wide range of integrated services (nutrition, maternal health, and other PHC services), stretching its available capacity. Additionally, the integrated model can face challenges when there are stockouts and referral networks are not well established.

> *The most evident success has been the provision of essential health services in one place and at one time, eliminating the need for individuals who come from distant areas to return on different days for separate services. In a single visit, clients can access child immunization, nutrition screening, medication, health counseling, antenatal checkups, and general outpatient services. People quickly understood the value of receiving all these services at one location and at the same time."* —FARID partner, Somalia

In Somalia, the demand for integrated services is evident in the primary reasons people seek care at FARID sites.



Source:
Self-reported data on patients' primary reason for visit (FARID site performance monitoring data, all facilities, children under five years of age, February–March 2026).

Abbreviation:
FARID, Far-Reaching Integrated Delivery.

CONSIDERATIONS

- **Implementing partners, governments (as relevant), and communities should codesign integrated services to meet community demand.** Assess community priorities for immunization and other services and codesign an integrated package of services with communities to increase vaccination uptake.
- **Implementing partners and governments (as relevant) should ensure sufficient staff and other inputs to deliver integrated services.** Delivering a range of integrated services can stretch staff capacity. Integration should encompass planning for human resources, as well as supplies, financing, data systems, and other health system inputs to enable effective integrated service delivery.

FUTURE LEARNING

- *Which integrated services are most valued by community members and serve as the primary drivers for accessing service delivery points?*

LESSON 2

Vertical and time-bound funding, misaligned incentives, and operational and coordination challenges across partners and programs limit opportunities for joint operations and discourage integration.

CAR, Somalia, South Sudan, Syria

STRENGTH OF EVIDENCE: **STRONG**

FINDINGS

Vertical, insufficient, and time-bound funding

- **Short project timelines limit opportunities for coordination** (CAR).
- **Integration depends on the donor mix and funded services** (CAR, Somalia, South Sudan, and Syria). In Syria, services are largely donor-funded and coordinated across vertical programs without explicitly financed integration, leaving integrated packages vulnerable when priorities shift or funding ends.
- **Insufficient funding limits follow-through on integration plans** (CAR, Somalia, and South Sudan). In CAR, the Ministry of Health and Population's ambitions exceed available resources; in Somalia, the FARID program could not offer services such as water, sanitation, and hygiene or labor and delivery without complementary donor support; and in South Sudan, lack of funding limits the availability of Boma health workers.
- **Political will is necessary, but not sufficient to support integrated programs without adequate resources.** In CAR, there is strong national-level support for integration, yet the Ministry of Health and Population's community engagement policy has not been operationalized due to high human, financial, and logistical requirements.

Misaligned incentives

- **Activity-based payments discourage collaboration.** In CAR, frontline health workers are incentivized to implement separate services and collect payment for each service.

> *"In a context where life is expensive and wages are very low, if there are four activities, we'll do them one by one so that we can benefit from the small advantages of each activity. For some people, even if it's clear, it's more advantageous for them to do something separately."* —WHO representative, CAR

Operational and coordination challenges

- **Subnational coordination is inconsistent.** In South Sudan, county-level coordination meetings are held inconsistently and often depend on local leadership capacity and partner engagement.
- **Weak interdepartmental linkages and poor communication lead to fragmented planning and duplication across programs.**
- **Differing security protocols among organizations limit joint operations** (CAR and Syria).
- **Insufficient joint microplanning limits coordinated outreach** and reduces shared use of resources (e.g., transport) (Syria).

CONSIDERATIONS

- **Donors, governments, and implementing partners should design an integrated service package that is feasible, context-specific, and built on existing systems.** The integrated service package is most effective when it aligns with available financing and leverages existing primary prevention platforms. Early engagement with local leaders and partners can determine whether established platforms are appropriate for integrated immunization service delivery. TA partners can provide practical, context-specific guidance on using existing systems.
- **Donors should ensure their financing and accountability structures enable integration.** Donors can align funding time frames and reporting frameworks with the realities of coordination, prioritizing integration over short-term "quick wins." Flexible funders have a comparative advantage in their ability to fund across health sector verticals where other donors are constrained to single-sector support.
- **Health system leaders and implementing partners should reform frontline health worker incentive structures to support integration.** Current incentive structures reward siloed service delivery; revised workflows could incentivize integration.
- **Donors and implementing partners should embed implementation research to guide incentive design and scale-up.** Systematic implementation research helps to strengthen the evidence base on whether and how financial incentives drive integrated care, including comparative analyses of different incentive models across contexts.

FUTURE LEARNING

- *How have barriers to integrated service delivery in humanitarian settings been successfully overcome? What are the enablers of integration?*
- *How might financial incentives for frontline workers be reformed to drive integrated care? Which incentive models are most effective in different contexts?*

LESSON 3

Coordinated screening and referrals help to identify people for and connect them to vaccination services when integrated delivery is not available at the point of service.

Afghanistan, CAR, Somalia, South Sudan, Syria

STRENGTH OF EVIDENCE: **STRONG**

FINDINGS

- **When children come for other health services, it creates an opportunity to screen their immunization status.**

> *"Routine immunization wasn't the main reason people came. Instead, they came for medicine or nutrition, and vaccination happened while they were already at the facility."* —Implementing partner, Afghanistan

- **Effective screening and referrals can identify unvaccinated and under-vaccinated children and connect them to vaccination services, reducing missed opportunities for vaccination and improving immunization coverage.**
  - In North Syria, the cross-referral program helped identify more than 1,100 zero-dose children and 1,700 malnourished children across facility and outreach settings in the first and second quarters of 2025.
  - In South Sudan, Boma Health Initiative outreach teams check for missed vaccinations and malnutrition during the same visit and share the list of under-vaccinated children with mobile RI teams that visit monthly. An implementing partner reported that home visits by Boma health workers identified 3,989 zero-dose children and 5,066 defaulters across seven counties in 2024.

- **There are barriers to operationalizing coordinated screening and referrals:**

BARRIERS TO **COMMUNITY-BASED** SCREENING AND REFERRALS	BARRIERS TO **FACILITY-BASED** SCREENING AND REFERRALS
• **Lack of a referral tracking system.** In Syria, outreach teams are siloed, which limits the ability to follow up with referred children. • **Underpaid or unpaid community health workers.** The lack of motivation or incentives may contribute to limited community mobilization, screening, and defaulter tracking. • **Poor physical access to communities** Poor road quality, flooding, and insecurity limit the implementation of outreach activities in CAR, South Sudan, and Syria. • **High costs of outreach activities in hard-to-reach areas, funding shortages, and delayed disbursement of funds.** These barriers limit integrated outreach activities in CAR, South Sudan, and Syria. In South Sudan, failure to pay vaccinators halted outreach activities.	• **Human resource constraints.** Overstretched health workers may not have sufficient time to screen/provide services in Afghanistan and Somalia, may have unclear responsibilities for screening/referrals in Afghanistan, and experience frequent staff turnover in South Sudan. • **Female vaccinator workforce shortages.** This limits follow-through on referrals in Afghanistan and CAR, where cultural norms prevent women from engaging with male providers. • **Lack of sufficient operational inputs for immunization.** For example, insufficient cold chain capacity, vaccines, or vaccinators impede immunization delivery in CAR, Somalia, and South Sudan.

CONSIDERATIONS

- **Donors should invest in strengthening health systems to remove key barriers to integrated screening and referral.** Investments in health system fundamentals (e.g., human resources for health, cold chain, supplies, data systems) will address many of the bottlenecks that limit effective screening and referral processes.
- **Implementing partners and health system managers should coordinate microplanning and outreach to deliver an integrated package of services.** Reorganizing or coordinating siloed outreach teams can enable vaccination at the time of screening, eliminating the need for community-based referrals. Joint microplanning and shared resources (e.g., transportation) can improve efficiency and better respond to community demand for integrated services.

FUTURE LEARNING

- *What strategies worked (or did not work) to overcome key barriers to coordinated screening and referrals in humanitarian settings?*

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