



Strengthening routine immunization

Key lessons from **Pakistan**

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



Expanded Programme on Immunization (EPI) facility expansion drove gains in immunization coverage.

Weak coordination among implementing partners led to geographic overlap and facility gaps that partially undermined the investment.



Inconsistent government support hindered the expansion of a successful intervention to reduce dropout rates.

A rigorously piloted paracetamol intervention reduced vaccine dropout rates in Sindh by addressing caregiver concerns about side effects, but inconsistent funding structures and shallow government engagement prevented comparable results elsewhere.



Structured monitoring and frontline accountability routines resolved most immunization-related bottlenecks in Sindh.

However, the approach was not successful in addressing barriers at the provincial level in Sindh. Disciplinary use of data (rather than to inform improvements), lack of escalation mechanisms, and siloed review forums left system-wide performance largely unaddressed by provincial EPI teams.



Immunization monitoring systems captured facility inputs but were not designed to identify demand-side barriers, leaving insights into caregiver experience out of reach.

Demand-level data would have provided information on the acceptability of the services.



Nonbinding commitments and the absence of structured transition planning produced fragmented, delayed EPI facility handovers across provinces.

Even where facilities did transition, paper compliance masked persistent gaps in staffing, inputs, and genuine government ownership.



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BACKGROUND

In 2019, the Gates Foundation initiated the RISP to enhance RI for children residing in high-risk subnational areas (union councils union council) in Pakistan that are characterized by low immunization coverage and a heightened risk of polio transmission. These union councils fall in the provinces of Sindh, Balochistan, and Khyber Pakhtunkhwa (KP).

RISP organized consultative workshops to develop super high-risk union council (SHRUC) action plans with participation from across the national polio eradication initiative and EPI tiers—union council, district, provincial, and national staff—along with partner organizations. Government and partner organizations collaborated to commit to varying levels of support to achieve this goal.

Since 2022, the Gates Foundation has made additional RISP investments at the SHRUC level to support government systems strengthening and service delivery.



■ Provinces with Routine Immunization Strengthening Program funding

THE GOALS INCLUDED:

- **Provide direct service delivery.**
 - Directly fill RI service gaps with **model EPI** facilities.
 - Develop **public-private partnerships** for EPI delivery.
- **Strengthen government systems.**
 - Support bottom-up planning via the **SHRUC action plans**.
 - Build **accountability** through SHRUC governance processes.
 - Ensure sustainability of interventions through **provincial memoranda of understanding (MoUs)**.
 - Foster **EPI-polio eradication initiative synergy** and synergized planning.
 - Strengthen **service delivery for oral polio vaccine zero dose and Bacillus Calmette-Guerin vaccine**.
 - Introduce **third-party monitoring** of EPI in SHRUCs.

IN ORDER TO:

- **Rapidly expand RI services in high-risk polio areas.**
- **Achieve 90 percent coverage of fully immunized children in 40 SHRUCs across Pakistan.**

TA PARTNERS:

- **Service delivery.**
 - **Medical Emergency Resilience Foundation.**
 - **People's Primary Healthcare Initiative.**
 - **RIZ Consulting.**
 - **The Aga Khan University.**
 - **VITAL Pakistan Trust.**
- **Performance management and data.**
 - **Acasus.**
 - **Impetus Advisory Group.**
 - **Tameer-e-Khalaq Foundation.**

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.

TIMELINE

2018

Gates Foundation initiated a pilot to establish dispensaries in **Sindh** at the People's Primary Healthcare Initiative Maternal and Child Health Center Jannat Gul Hospital.

2019

SHRUC action plans were developed, and EPI facilities were established.

2020

RISP MoUs for EPI facility transition were signed in **KP, Sindh, and Balochistan**.

2021

Baseline assessment conducted in SHRUCs in **Sindh**.

2022

Pilot initiated for third-party monitoring, paracetamol intervention, and accountability routines in **Sindh**.

2023

Accountability routines launched for SHRUCs in **KP and Balochistan**.

2024

Scale-up initiated in **Sindh** and line item incorporated in **Balochistan** budget.

2025

Concept note developed to address critical RI challenges in **Balochistan**.

LESSON 1

EPI facility expansion drove gains in immunization coverage.

Weak coordination among implementing partners led to geographic overlap and facility gaps that partially undermined the investment.

STRENGTH OF EVIDENCE: **STRONG**

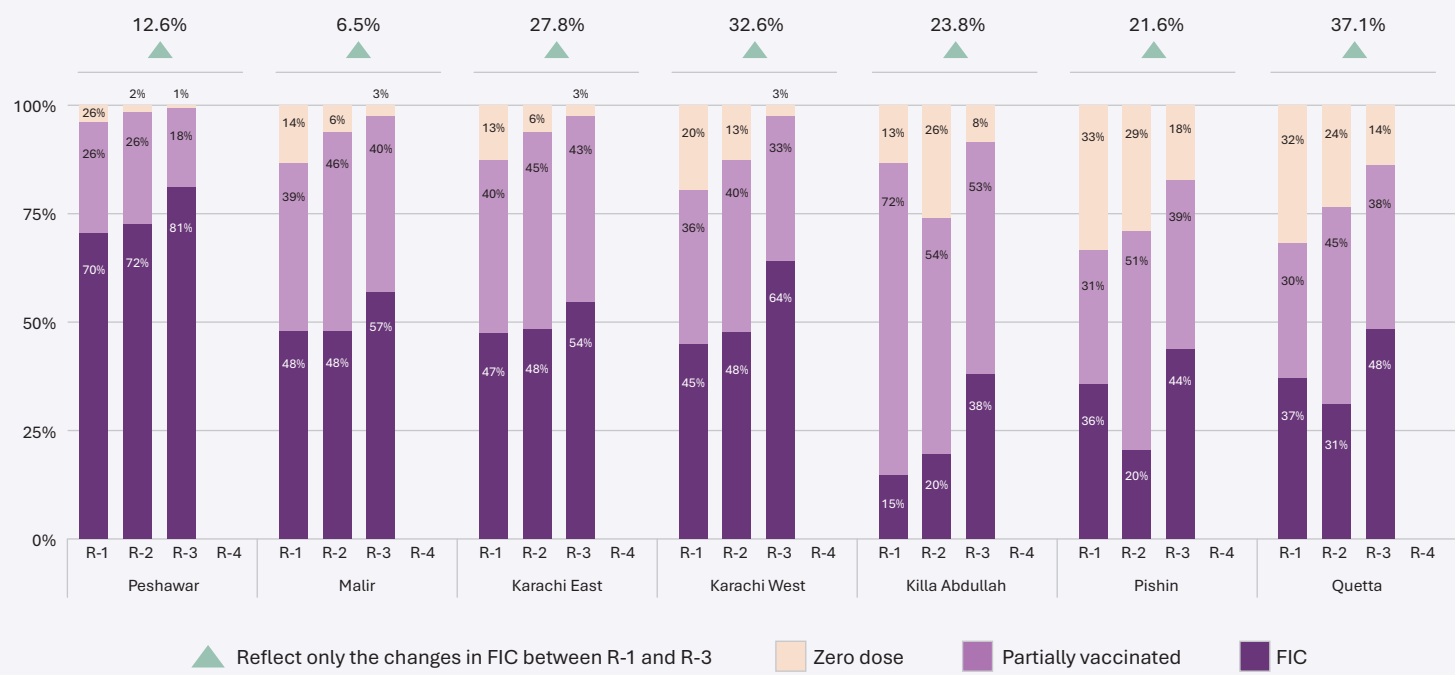
CONTEXT

Activities in Pakistan focused on closing service delivery gaps in areas with limited access to fixed and outreach services. Existing dispensaries were converted into temporary EPI facilities. Service delivery in temporary facilities transitioned to newly established primary health care-EPI (government) facilities in the same or nearby areas, maintaining continuity of care for project communities.

FINDINGS

- Guided by hyperlocal, multistakeholder SHRUC action planning, the establishment of 14 temporary EPI facilities in Sindh, 15 in KP, and 8 in Balochistan was associated with a 23 percent average increase in fully immunized children between 2020 and 2025. Government EPI officials and implementing partners reported that temporary facilities enabled increased patient volume, built community trust through repeat visits, and reduced vaccine refusal rates.

Establishment of EPI facilities results in coverage improvements in all SHRUCs.



Source: Third-Party Verification Immunization Coverage Survey (R-1 in 2022, R-2 in 2022, R-3 in 2023, R-4 in 2025).

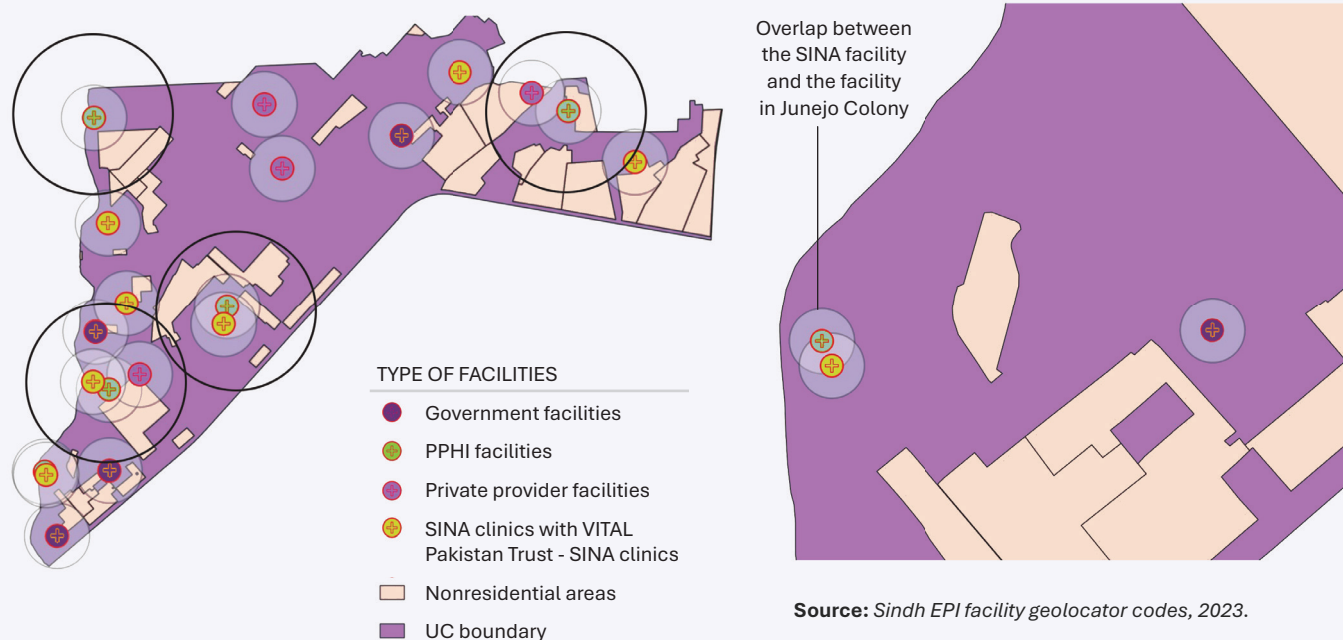
Abbreviations: EPI, Expanded Programme on Immunization; FIC, fully immunized children; R-1, Round 1; R-2, Round 2; R-3, Round 3; R-4, Round 4; SHRUC, super high-risk union council.

- **The EPI facility placement process did not account for EPI facilities already supported by the Gates Foundation, creating critical gaps in service delivery planning.** In Sindh, 6 out of 14 sites were in the same or nearby areas as the temporary facilities, consistent with the original plans. Not accounting for Foundation-supported facilities resulted in geographic overlap between partner and government sites. In some areas, this created duplicative coverage; in others, it may have introduced new access gaps.
- **EPI staff and district health officers (DHOs) were left out of the process, resulting in incomplete information.** Land availability largely determined the location of the new facilities. Additionally, polio staff, rather than EPI staff, identified facility locations despite being less familiar with the EPI landscape. DHOs, the most familiar with how and where services were reaching communities, were left out of the process. The resulting placement process was never updated to reflect where partner facilities already existed, which may have offset the intended transitional gains.

“If we talk about immunization coverage, then our data tells us that [vaccine] refusals in our [EPI facility] have reduced. Consequently, coverage has improved in both polio and routine immunization. The main reason for this is that people started receiving services in the form of adequate infrastructure and medicines.”

—District manager, Sindh

The planning process created potential overlap and duplicative coverage among partner facilities and newly constructed government facilities.



Source: Sindh EPI facility geolocator codes, 2023.

Abbreviations: EPI, Expanded Programme on Immunization; PPHI, People's Primary Healthcare Initiative; SINA, SINA Healthsystems Foundation; UC, union council.

CONSIDERATIONS

- Donors and implementing partners could make comprehensive service coverage mapping a prerequisite for facility placement. Up-to-date mapping of all existing services, gathered/shared by the implementing partners and government entities, should be a standard input for decision-making, supported by continuous updates and review processes.
- Donors and implementing partners should make an inclusive planning process a condition of funding. As district health system stewards, DHOs have a central role in co-development and oversight. Excluding some EPI staff and DHOs from placement decisions produced blind spots with operational consequences. EPI staff and DHOs should be included in key planning and financial decisions.

FUTURE LEARNING

- *Assess facility performance and contributions to coverage improvements over time. Apply an implementation research framework to assess how facilities are functioning post-establishment, including their impact on coverage, service quality, and equity.*
- *Explore the role of DHOs in coordination. Document how DHOs currently manage coordination across actors (the “One Health” plan) and explore how they can help improve alignment and accountability for facility performance.*
- *Examine whether and how partner dynamics can be strengthened to reduce redundancies and optimize resources during implementation. Explore how partner coordination can be improved, potentially through planning and kickoff meetings, regular check-ins, learning opportunities, and joint engagement with government entities.*

LESSON 2

Inconsistent government support hindered the expansion of a successful intervention to reduce dropout rates.

A rigorously piloted paracetamol intervention reduced vaccine dropout rates in Sindh by addressing caregiver concerns about side effects, but inconsistent funding structures and shallow government engagement prevented comparable results elsewhere.

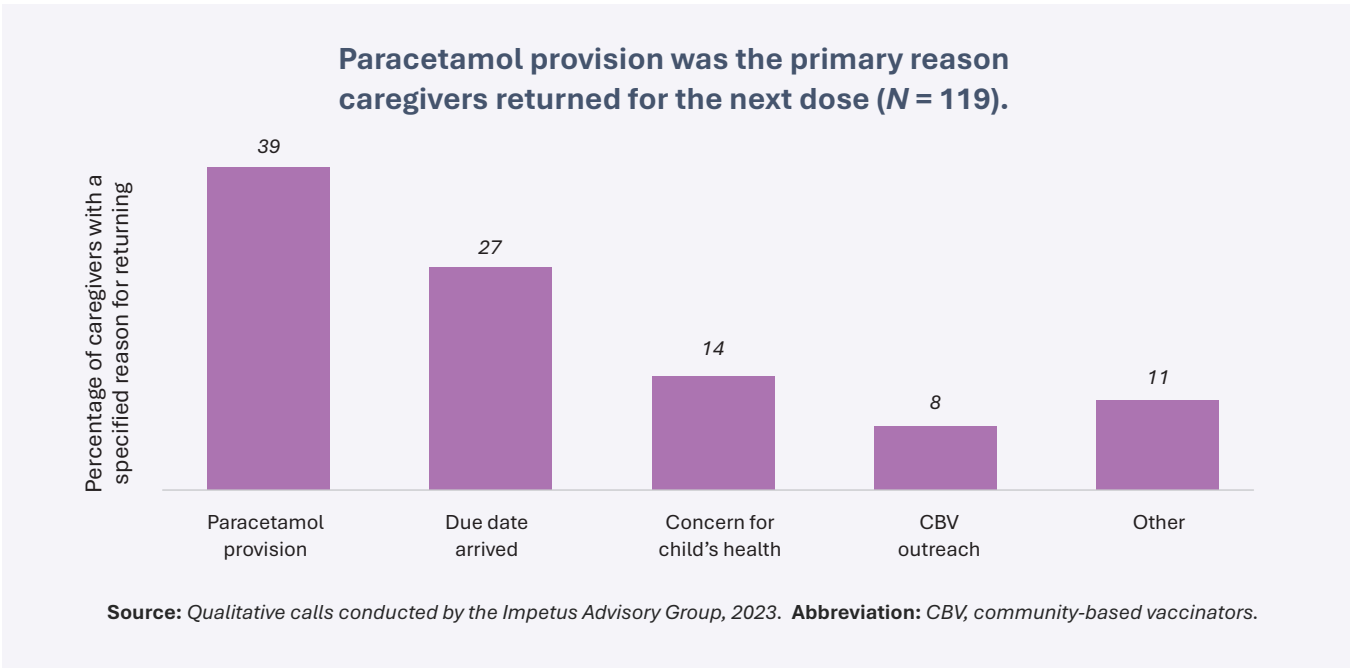
STRENGTH OF EVIDENCE: STRONG

CONTEXT

According to the 2021 Third-Party Verification Immunization Coverage Survey (TPVICS), fear of side effects was one of the four leading reasons parents reported for not vaccinating their children. Caregiver surveys and human-centered design workshops pointed to paracetamol provision—paired with caregiver counseling—as a community-level approach to address this barrier and improve vaccine uptake. The Impetus Advisory Group piloted, tested, and refined the intervention in Sindh before sharing it with the EPI program for broader adoption. Other provinces were encouraged to introduce it to address demand-side barriers to vaccination. Differences in funding structures, government engagement, and implementing partner understanding of their roles contributed to varied uptake across provinces.

FINDINGS

- **The paracetamol pilot in Sindh resulted in fewer defaulters, encouraging the Sindh Health Department to scale up.** The distribution of paracetamol at pentavalent vaccine (Penta) visits—alongside caregiver counseling, locally tailored communication materials, and active monitoring—proved effective. In the pilot communities, there was a 16 percentage point reduction in absolute defaults, with caregivers noting access to paracetamol as a key driver of return visits. There were measurable shifts in caregiver behavior, including improved vaccine acceptance and child retention, highlighting demand-side considerations beyond the immediate visit. The results contributed to the Sindh health minister’s push to institutionalize the intervention.



- **Scale-up required significant systems strengthening and capacity-building with the Sindh EPI, which proved critical for responding to challenges and maintaining program stability.** Several systems were developed and/or strengthened to ensure paracetamol availability at the time of vaccination for the first, second, and third Penta dose, including mapping supply chains, developing standard operating procedures, and cascading training to 170+ provincial staff. Paracetamol checks were integrated across existing digital platforms, ensuring the intervention was embedded at every level of the system and reflected in the provincial budget for 2025 to 2026. When confronted with institutional friction, such as delayed budget approvals and procurement constraints, the program had sufficient familiarity and systems in place to respond to barriers as they arose.
- **Paracetamol availability varied across provinces, shaped by differences in funding, government engagement, and provincial EPI systems.** Balochistan achieved policy adoption (paracetamol added to the Essential Medicines List for the fiscal year 2024 to 2025), but without a dedicated budget allocation, translating this into consistent delivery proved difficult. In KP, there was no meaningful engagement for the intervention at the provincial level, and paracetamol was made available only at implementing partner-supported sites.

“We used Impetus’s data, specifically how there was an increase of 13 to 14 percent in coverage. Maybe for other programs such an increase in coverage is not important; however, for EPI, even a 5 to 7 percent increase in coverage is very important. The reason for this is because the area we are operating in (SHRUCs) is very difficult to deal with. All of this was communicated to relevant policymakers, and they were made to realize the importance of this initiative.”

—EPI Program Director, Sindh

“There is no general discourse in the province for providing paracetamol with Penta antigens. The only time paracetamol or any kind of pain killers have been given out in the province was during the initial round of IOAs [integrated outbreak analytics]”

—Performance management and data partner, KP

CONSIDERATIONS

- Donors and governments need to jointly assess the full range of resources required to operationalize handover, with clear plans supported by dedicated budget allocations, procurement mechanisms, and delivery strategies in place prior to scaling down or transitioning support.
- Policy adoption does not equal service delivery. Government endorsements—whether through ministerial commitment or inclusion on the Essential Medicines List—are not sufficient evidence of sustainability.

FUTURE LEARNING

- *Explore the conditions that enable the scale-up and adoption of low-cost, effective strategies for reducing dropout rates.*
- *Examine how lessons can be shared between provinces and what materials—such as budgets, activity plans, and standard operating procedures—are needed to support provincial-level adoption.*

LESSON 3

Structured monitoring and frontline accountability routines resolved most immunization-related bottlenecks in Sindh.

However, the approach was not successful in addressing barriers at the provincial level in Sindh. Disciplinary use of data (rather than to inform improvements), lack of escalation mechanisms, and siloed review forums left system-wide performance largely unaddressed by provincial EPI teams.

STRENGTH OF EVIDENCE: **STRONG**

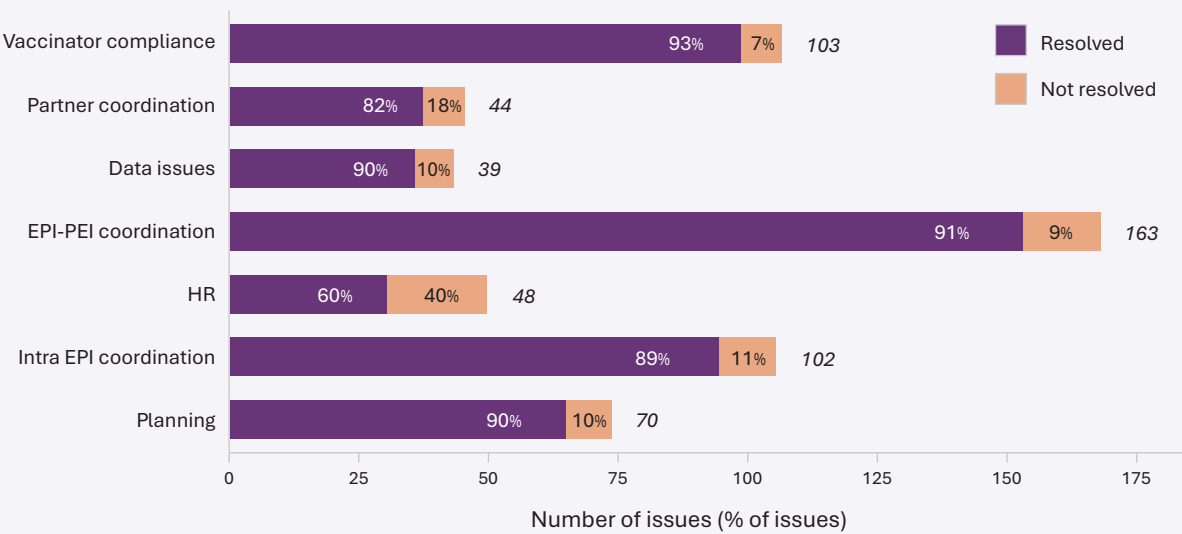
CONTEXT

In 2022, third-party monitoring and town-level performance data review routines were introduced in Sindh, initially to share data across programs and later evolving into structured forums to review gaps, identify sources of poor performance, assign responsibility, and follow up on whether issues were resolved. Partners worked to expand these practices to other provinces, adapting them to fit existing monitoring systems—including provincial monitoring units and structures already in place for reviewing facility-level data and identifying improvements.

FINDINGS

- **Structured on-site monitoring drove rapid and sustained improvements in facility readiness.** Regular, structured monitoring translated directly into stronger site performance. Third-party monitoring field visits to each EPI facility in Sindh led to noticeable gains in key supply-side inputs, including availability of coverage charts, defaulter lists, and adverse events following immunization kits.
- **Town-level accountability routines proved effective in resolving the issues causing poor performance.** These routines brought together EPI vaccinators, community-based vaccinators, area supervisors, community mobilizers, lady health workers, and town supervisors, resolving 88 percent of EPI bottlenecks between 2023 and 2024. Frontline staff consistently noted improved communication, coordination, and follow-up as the primary drivers, alongside greater empowerment to raise concerns and more structured approaches to problem-solving.

Town-level accountability routines led to the identification and resolution of a variety of challenges associated with immunization service delivery.

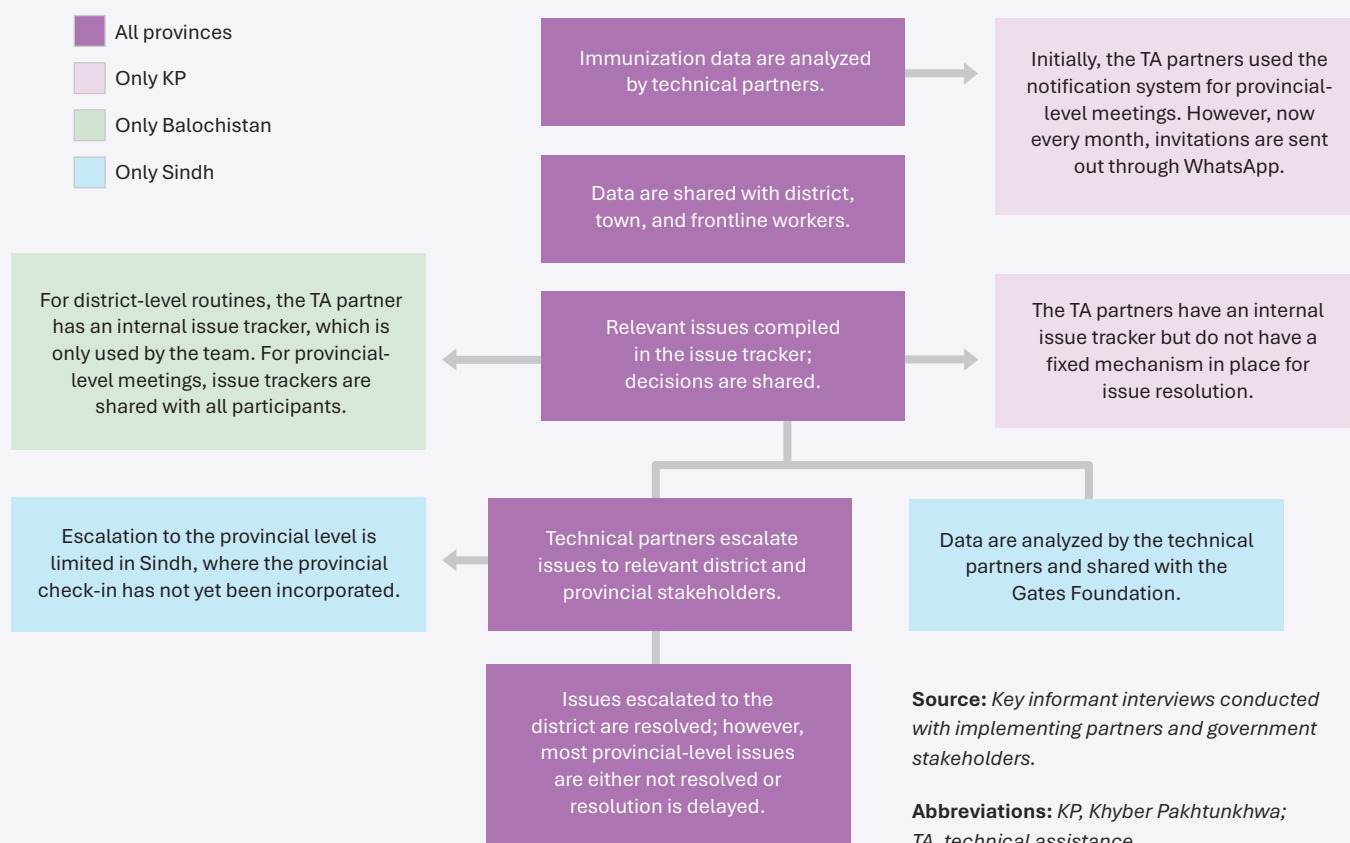


Source: Impetus Advisory Group data tracker, 2023–2024.

Abbreviations: EPI, Expanded Programme on Immunization; HR, human resources; PEI, polio eradication initiative.

- **Accessible and interpretable data gave town hall actors a clearer picture of what drove performance gaps, leading to coverage increases across all antigens, ranging from +3 to +9 percent between 2023 and 2024—a pattern recognized by staff at the union council level.** “Data packs”—reports that include vaccinator-level coverage and supply data in accessible formats—enabled faster identification of the root causes of challenges and more specific corrective actions. Structured review forums strengthened issue tracking and discussion, with meeting records documenting sessions of up to two hours, participation across multiple cadres, and more than 20 action items per meeting.
- **Together, these mechanisms were associated with short-term coverage gains across Karachi SHRUCs.**
- **The accountability gains observed in Sindh were not replicated in other provinces where existing structures were not set up to support the same routine processes.** Balochistan and KP have provincial monitoring units with some capacity to leverage existing monitoring efforts, but immunization indicators were limited in scope and the additional variables needed to drive meaningful review were not examined. The broader context did not support consistent review and follow-up—issue identification, responsibility assignment, and corrective action remained dependent on ad hoc facility-level efforts rather than structured, routine processes.

Provinces took different approaches to monitoring and accountability, resulting in varied responses to frontline challenges.



- **Downstream accountability did not translate into system-wide responsiveness or joint accountability.** Lower-level accountability did not feed into coordination across district, provincial, and frontline levels. Stakeholder interviews across three provinces indicated that many issues requiring district or provincial intervention were either unresolved or experienced delays. Without appropriate escalation mechanisms, locally identified issues were not resolved effectively.
- **Punitive use of data undermined data integrity and limited its use for improvement.** Data were primarily used for enforcement rather than learning. Issues escalated to higher levels were often met with punitive actions—contract terminations, salary withholding, and pay reductions—which likely contributed to data falsification. This is reflected in implausible coverage spikes (e.g., exceeding 100 percent) and inconsistencies between reported coverage and vaccine availability.
- **The availability of granular vaccinator data—reinforced by investments in town-level accountability routines—narrowed attention to vaccinator performance as the problem, despite it accounting for only about 20 percent of the identified challenges.** This drove useful frontline change but left provincial-level system issues unaddressed, and over time, accountability forums shifted from joint problem-solving to disputing reported results (particularly on coverage and input availability), a pattern cited across multiple district- and town-level interviews as a key driver of delayed or absent action.

“Additionally, we have also seen another case where the vaccinator’s attendance and coverage data is perfect. However, a deeper data analysis might show that despite good coverage, the vaccinator did not procure any vaccines from the department.”

—Department of Health officer, Sindh

“But after TKF [Tameer-e-Khalaq Foundation] started checking things, things began to get completed properly. Staff coverage has improved because, earlier, the Penta charts weren’t maintained. When everything is properly maintained, the vaccinator is on time, the charts are all updated, then naturally the coverage goes up as well.”

—Union council program officer, Sindh

CONSIDERATIONS

- **The EPI should formalize escalation and response mechanisms to strengthen system-wide accountability.** If accountability systems move beyond local problem identification, this will ensure issues are systematically escalated, tracked, and resolved at the district and provincial levels. Clear roles, decision-making authority, and structured workflows will support timely follow-up and resolution.
- **Shift data use from enforcement to learning to improve immunization data integrity and decision-making.** Programs can reduce reliance on punitive performance management and promote a culture of data use for continuous improvement. This requires reinforcing feedback loops, supportive supervision practices, and incentives that encourage accurate reporting and problem-solving.
- **Integrate immunization monitoring and coordination across levels of government to enable joint accountability.** A redesign of monitoring systems and review forums will better integrate data across levels and domains. Greater emphasis can be placed on collective problem-solving rather than individual performance tracking, supported by regular action-oriented review processes.

FUTURE LEARNING

- *Assess the recent transition to World Health Organization–standardized monitoring tools, which include an EPI data module, and its implications for monitoring and accountability processes. Examine how the shift toward the World Health Organization–standardized tool has been implemented, how it has changed data review platforms, and whether critical elements from previous monitoring approaches and accountability routines have been retained or lost, including their roles in identifying and resolving issues.*
- *Examine the risks of government monitors also serving as supervisors, as combining these roles may introduce bias or inaccurate reporting. Explore models for separating the two functions and develop an investment case for the staffing and capacity required to do so, including how these models could operate within current human resources (HR) for health constraints across the EPI.*

LESSON 4

Immunization monitoring systems captured facility inputs but were not designed to identify demand-side barriers, leaving insights into caregiver experience out of reach.

Demand-level information would have provided insight into the acceptability of the services.

STRENGTH OF EVIDENCE: **MODERATE**

CONTEXT

TPVICS data show coverage gaps across the three intervention provinces. Process data collected through monitoring tools focus on facility-level inputs captured by third-party monitoring systems. Behavioral surveys collect relevant indicators but are conducted as one-time data collection efforts, and only a subset of those indicators is included in routine monitoring tools.

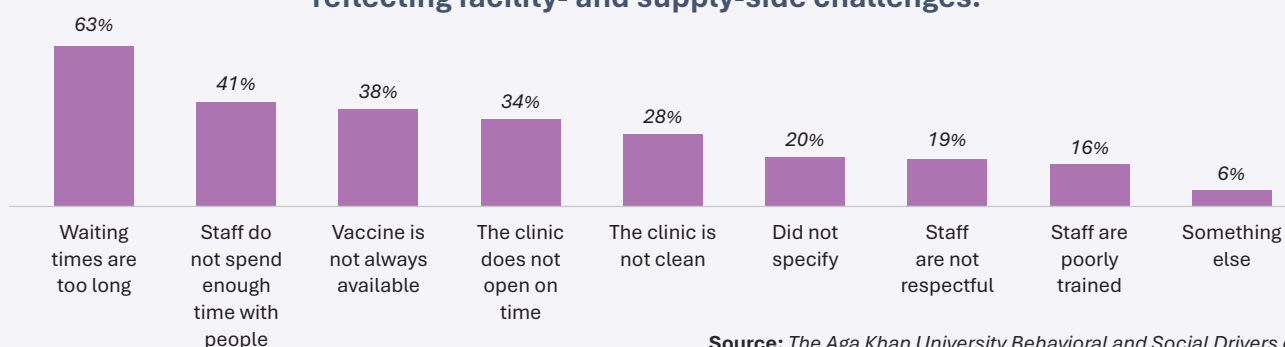
FINDINGS

- **Caregiver experience data highlight significant demand-side and service delivery constraints.** Findings from the 2023 Behavioral and Social Drivers of Vaccination Childhood Vaccination Survey for Caregivers indicate that 31 percent (2,434/7,829) of respondents reported dissatisfaction with immunization services.
- **Monitoring systems remain overly focused on facility inputs, limiting visibility into demand- and quality-related barriers.** Monitoring activities were initially scoped to follow government checklists, which were heavily weighted toward facility inputs, with only 3 of 149 indicators assessing quality. No indicator captured caregiver experience or demand dynamics, representing a critical information gap.
- **The introduction and eventual scale-up of paracetamol dispensation were informed by behavioral insight data integrated with coverage data to improve coverage outcomes.** Where demand-side insights were combined with coverage data, program performance improved. Data showed first to third dose pentavalent vaccine dropout rates of up to 29 percent in SHRUCs; community surveys (e.g., TPVICS) identified fear of side effects as a key barrier. Addressing this through paracetamol dispensation reduced dropout by 16 percent, demonstrating the value of integrating demand-side evidence into intervention design.

“Yes, the current tools capture most operational issues, including vaccine availability, cold chain, staffing, and data accuracy. However, they could better incorporate community-level dynamics, behavioral insights, reasons for cancellation, or poor-quality outreach.”

—EPI Program Director, Sindh

Caregivers report myriad reasons for dissatisfaction with immunization services, reflecting facility- and supply-side challenges.



Source: The Aga Khan University Behavioral and Social Drivers of Vaccination Childhood Vaccination Survey for Caregivers, 2023.

CONSIDERATIONS

- **The EPI should expand monitoring beyond inputs to include demand, quality, and caregiver experience.** A comprehensive monitoring framework can capture demand-side barriers, service quality, and client perspectives to ensure these insights inform program design.

FUTURE LEARNING

- *Assess the impact of newly expanded supervision tools that collect demand-side data and community-level contextual information. EPI and data partners can establish processes to triangulate supervision data with coverage information to strengthen the monitoring system.*
- *Understand how new demand-side investments (led by a consortium of JSI, Aga Khan University, and Impetus) inform program design and monitoring. Explore how emerging insights from demand generation efforts are being used to strengthen intervention development, targeting, and adaptive monitoring approaches.*

LESSON 5

Nonbinding commitments and the absence of structured transition planning produced fragmented, delayed EPI facility handovers across provinces.

Even where facilities did transition, paper compliance masked persistent gaps in staffing, inputs, and genuine government ownership.

STRENGTH OF EVIDENCE: **STRONG**

CONTEXT

Following the establishment of new facilities, the donor signed sustainability MoUs with the provincial governments to support the transition of EPI facilities to government financing and management.

FINDINGS

- **Nonbinding commitments and the absence of transition frameworks in the original program design left provinces without clear guidance on capacity transfer, HR readiness, or post-handover monitoring.** As a result, timelines shifted repeatedly—from full transition by 2024 to refurbished dispensary handovers by the end of 2026—while KP transition discussions have stalled entirely.
- **Without a defined transition framework, provinces navigated handover differently, producing sharply uneven outcomes.** Sindh transitioned 13 facilities between 2021 and 2024, driven by strong leadership and sustained advocacy. KP and Balochistan required alternative approaches and extended timelines, but these were undermined by high turnover among health secretaries (14 in Balochistan since 2019), land disputes, and administrative instability—all of which disrupted continuity and slowed progress.
- **Fragmentation obscured post-transition performance, leaving service quality gaps largely undetected.** Where monitoring arrangements were not agreed upon up front, MoU-aligned quality indicators were rarely integrated into government systems (Acasus, Internal Monitoring Unit, Minister Monitoring Unit), reducing visibility into service quality after handover and constraining the systems' capacity to independently identify and respond to problems.

“No facility has been transitioned so far. The transition is expected to take place in 2026, although progress has been gradual given other competing priorities and activities.”

—Data partner, KP

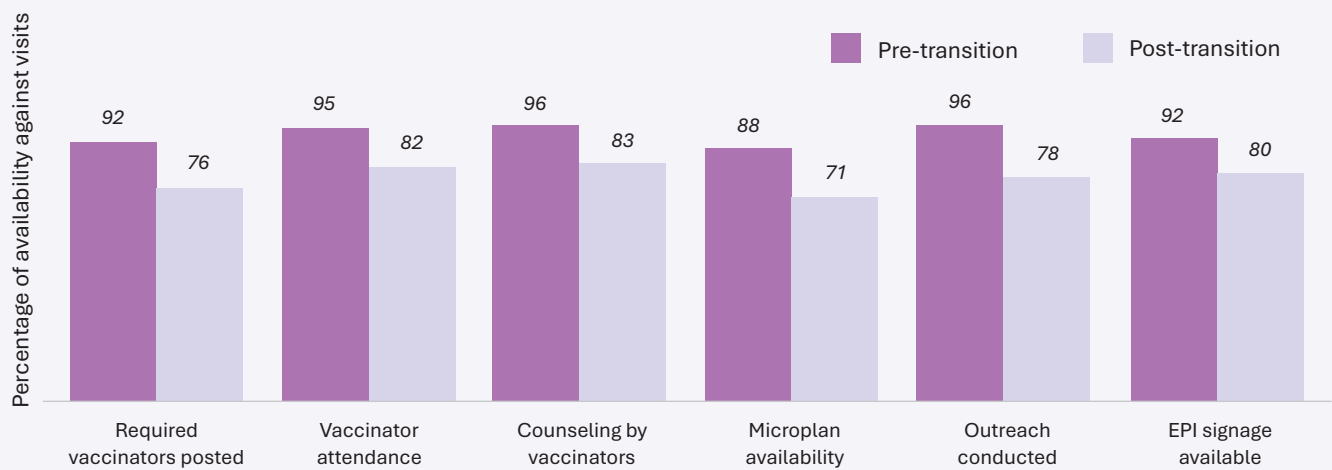
CONTEXT

Once EPI facilities transitioned, third-party monitors conducted a baseline assessment across the overall service domain indicators outlined in the sustainability MoU. The continued presence of monitors enabled improved tracking of service quality pre- and post-transition (calculated as two months pre-transition and two months post-transition). Data triangulation helped assess successes and gaps following the transition in Sindh (but these have not yet been assessed in the other provinces due to delays in the transition).

FINDINGS

- **Facility assessments suggest that while transition criteria were met on paper, underlying gaps in inputs, staffing, and system readiness persisted.** Assessments across MoU service delivery domains and third-party monitoring data indicated that facilities generally met transition criteria. However, post-transition trends in Sindh showed declines in key operational indicators. Baseline assessments flagged performance concerns, with at least one domain per facility falling below the 50 percent threshold—particularly in HR and medicine availability.
- **Service delivery remained dependent on partner support, limiting true system ownership.** Despite a formal transition, core RI functions continued to rely on external support. In Sindh, 13 of 14 vaccinator positions remained funded by partners, reflecting limited absorption of critical roles into government systems and raising concerns about sustainable service delivery.
- **EPI and Ministry of National Health Services, Regulations and Coordination stakeholders consistently perceived the transition as premature, citing gaps in readiness and facility conditions.** Provincial and district stakeholders reported that facilities were not adequately prepared for transition, pointing to persistent issues in staffing, infrastructure, and overall system functionality. Field observations reinforced concerns; facility conditions often fell short of expected standards.

Facility inputs declined in Sindh once EPI facilities transitioned to the government.



Source: Facility assessments conducted in RISP-funded EPI facilities before and after transition, 2021 vs. 2024.

Abbreviations: EPI, Expanded Programme on Immunization; RISP, Routine Immunization Strengthening Program.

“I made a couple of field visits and found a number of issues in PPHI [People’s Primary Healthcare Initiative] facilities. So, for instance, some EPI centers have been relocated, while in other facilities, a good/decent room is being occupied by the medical officer. Additionally, I saw that the cleanliness standards were not met. ... PPHI should have its own vaccinators, but they don’t have any vaccinators.”

—Provincial EPI officer, Sindh

“There are solar panels in PPHI [People’s Primary Healthcare Initiative] facilities, so there is a fan that works inside the doctor’s room but doesn’t cater to patients as it is not present in the EPI room. Another issue is that the district managers are constantly changing. Moreover, as per the MoU, it was decided that PPHI will assign its own vaccinators, but so far, vaccinators have not been assigned.”

—Union council program officer, Sindh

CONSIDERATIONS

- **Donors and implementing partners should incorporate political economy analysis as an input to the design of the investments and MoU.** Governance and decision-making tend to vary significantly across provinces; mapping that variability early would inform engagements and program design.
- **Donors could embed resource transition as a core part of program design.** Plan for sustainability from the outset with clear timelines, milestones, and capacity transfer (especially HR), treating transition as a distinct phase rather than an end-stage activity.
- **Base transition on functional readiness, not just compliance.** Ensure facilities meet minimum staffing, input, and performance standards, supported by structured frameworks and monitoring systems to track readiness and post-transition performance.
- **Align and sequence the transition with system capacity and context.** Phase handover based on demonstrated readiness and adapt approaches to political, leadership, and system realities while prioritizing absorption of core functions into government systems.

FUTURE LEARNING

- *Identify effective advocacy strategies to advance sustainability MoUs and resource mobilization. Examine which advocacy approaches (e.g., high-level political engagement, local champions, community alignment, and budget advocacy) are most effective in contexts with instability, including frequent leadership turnover or weak governance. Explore how timing, actors, and incentives influence success and what combinations of strategies will secure sustained government commitment to take over as part of the transition.*
- *Define and assess transition readiness. Clarify what “readiness” entails across key domains (e.g., HR absorption, financing, supply chains, governance, and service quality) as it relates to RI. Identify practical readiness criteria to guide decision-making. Assess how different readiness activities—capacity-building, joint planning, phased handover, and shadow management—contribute to successful and timely transition.*



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