

Strengthening routine immunization

Key lessons from **Somalia**

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



Partnerships are critical to success in complex humanitarian settings.

Bringing together organizations with diverse yet complementary skills proved instrumental in overcoming barriers in unstable and previously inaccessible communities. By enabling service delivery in previously inaccessible areas, the partnership model contributed to increased uptake of vaccination and integrated services. Early indications suggest that moving away from this partnership model may be difficult, particularly in an increasingly resource-constrained funding climate.



Integrating immunization with other basic health services increases vaccination uptake.

The integrated model responds to community needs for vaccination and other health services and appears to have driven gains in vaccination uptake and other health interventions in previously unreached communities.



Integrated service delivery remains strong across both mobile and fixed delivery models, despite shifts in how services are delivered.

The shifting service delivery model highlights trade-offs between reach and continuity. Health camps and fixed sites effectively expanded access to integrated primary health care (PHC), offering complementary strengths and delivering services at comparable efficiency levels.



Persistent access barriers demand a mixed service delivery model and stronger monitoring.

As the Far-Reaching Integrated Delivery (FARID) program transitions between delivery models, access barriers rooted in distance and insecurity persist, underscoring the need for a mixed service delivery model and stronger monitoring of demand-side constraints to equitable coverage.



FARID has likely contributed to a substantial reduction in the number of zero-dose children.

Program data indicate that the number of zero-dose children in FARID-eligible communities has steadily declined, with the most recent vaccinations going to children who have already received at least one other vaccination.



Supply-side bottlenecks limit integrated service delivery.

Persistent supply-side and broader health system constraints limit the availability of fully integrated services. These systemic bottlenecks—most acute in the treatment of severe and moderate acute malnutrition—may constrain potential coverage gains and undermine community trust.

BACKGROUND

The Gates Foundation has supported the FARID program in Somalia since 2022. The program provides an integrated package of immunization, nutrition screening and treatment, maternal health, and other PHC services to inaccessible, conflict-affected areas. The program's integrated design directly responds to community preferences and evidence from polio campaigns indicating that uptake is substantially higher when immunization is offered alongside other essential health services.

The program operated mobile health camps from 2023 to 2025, deploying five-person teams to deliver services directly to insecure or hard-to-reach communities. FARID operates in 20 districts across Galmudug, Hirshabelle, and Jubaland—many of which had not received health services for more than a decade.

TIMELINE

FARID design and pre-implementation: FARID innovation ecosystem formed. Conducted three workshops to map problems, codesign solutions, define partner roles and responsibilities, and develop standards of practice.

Health camp scale-up: Phased rollout of health camps across inaccessible areas of the 20 FARID-eligible districts. By December 2024, more than 15,000 health camps had been conducted in 1,200 communities.

Transition to a flexible model including fixed-site delivery: Developed transition criteria and began transitioning FARID districts to a fixed-site delivery model.

2021

Gates Foundation begins RISP work in Somalia, largely targeting communities in newly accessible geographies

2022

Jul: First FARID design workshop conducted

2023

Sep: Access to all districts secured

Nov: Health camps functional in 20 districts (*El Bur added later*)

2024

Jan: Planning for transition to fixed sites begins

Dec: Piloted fixed sites in two districts (*Dolo and Haradhere*)

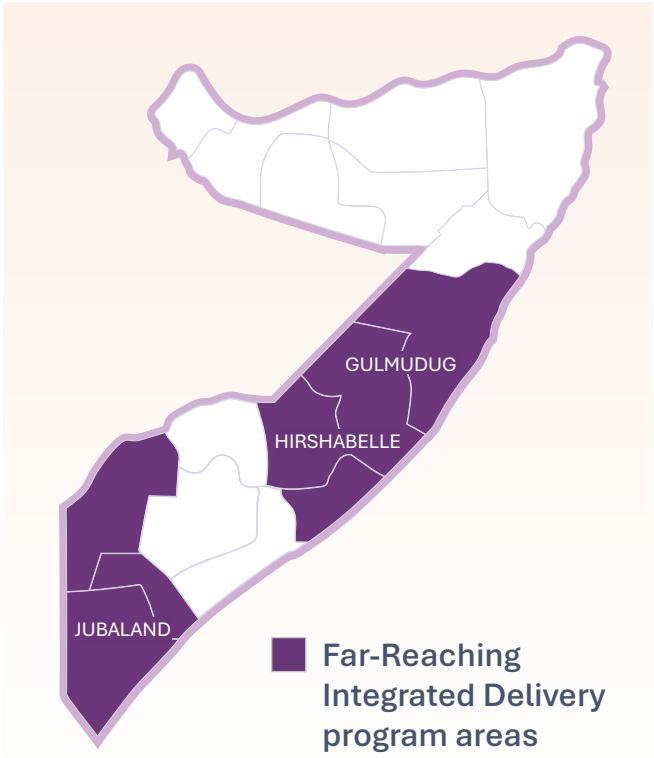
2025

Oct: Fixed sites functional in 19 of 20 FARID districts (*Aden Yabal unlikely to transition due to persistent insecurity*)

Nov: Health camps reintroduced in eight districts

The large populations in districts with conflict and geographic barriers were best reached through mobile service delivery. In 2025, FARID shifted from a fully mobile model to a fixed delivery approach, establishing primary health units and conducting regular outreach to surrounding villages, resulting in large populations losing access to health services. As such, in late 2025, health camps were reintroduced in eight districts, creating a mixed service delivery approach comprising fixed sites with outreach and mobile health camps.

FARID has delivered more than 1 million Expanded Programme on Immunization doses and provided PHC consultations across more than 1,200 communities. During implementation, the number of zero-dose children identified declined through repeated community visits, from a high of 40,777 in the first quarter of 2024 to 11,186 by the end of 2024.



► **FARID PARTNERS:**

- **Service delivery partners**
 - **CORE Group.**
 - **Development and Empowerment for Humanity.**
 - **Save the Children International (SCI).**
 - **Vision Corps Initiative.**
 - **WARDI Relief & Development Initiatives.**
 - **Zamzam Foundation.**
- **Additional implementation partners**
 - **Acasus**—data collection, management, and analytics (transitioned off the project in 2025).
 - **Centre for Humanitarian Dialogue**—community engagement and access negotiations.
 - **Health-E-Net**—routine data collection and transfer to DHIS2.
 - **HISP Tanzania**—DHIS2 system updates.
 - **World Food Programme Innovation Accelerator**—design, facilitation, and monitoring.

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.
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LESSON 1

Partnerships are critical to success in complex humanitarian settings.

Bringing together organizations with diverse yet complementary skills proved instrumental in overcoming barriers in unstable and previously inaccessible communities. By enabling service delivery in previously inaccessible areas, the partnership model contributed to increased uptake of vaccination and integrated services. Early indications suggest that moving away from this partnership model may be difficult, particularly in an increasingly resource-constrained funding climate.

STRENGTH OF EVIDENCE: **MODERATE****CONTEXT**

In humanitarian settings, it is difficult for a single actor to meet the complex and rapidly evolving needs of crisis-affected communities. A partnership approach enhances coordination and enables the pooling of diverse capabilities, resources, and knowledge. The collective model increases the likelihood of achieving outcomes that would be difficult for an individual organization to achieve. FARID is implemented through a multipartner ecosystem, with distinct roles and responsibilities for each organization.

CORE Group and SCI led service delivery and subcontracted with local implementing partners in FARID-eligible districts: Vision Corps Initiative and Zamzam Foundation for CORE Group, and Development and Empowerment for Humanity and WARDI Relief & Development Initiatives for SCI. The Centre for Humanitarian Dialogue supports community engagement and access negotiations, and the World Food Programme Innovation Accelerator provides overall facilitation and project management support. Initially, Acasus led data and analytics for the program, but it exited in April 2025. Subsequently, Health-E-Net assumed responsibility for transferring routine data into DHIS2, with HISP Tanzania implementing the necessary upgrades to the DHIS2 system in Somalia.

FINDINGS

- **Reaching inaccessible communities required engaging with trusted new and nontraditional partners.** The Gates Foundation's ability to engage such partners is a notable comparative advantage over other donors, including bilateral and multilateral agencies, that are required to work more directly within government systems. This flexibility allowed the FARID partnership to effectively navigate political sensitivities and operational barriers. New and nontraditional partners can be particularly facilitative when a context calls for neutrality amid ongoing conflict. Local partners provided access to conflict-affected settings, and international nongovernmental organizations contributed operational agility.

“

We have leveraged the power and assets of each partner to achieve the goals of the project, such as having the local implementing partners come on board to negotiate access and bring community trust. That support has been instrumental in achieving our goals.”

—FARID partner

- **Champions shaped the overarching vision; mobilized financial, technical, and operational support; and brokered relationships between partner organizations and government entities.** While Foundation program officers have fulfilled this role, long-term sustainability depends on institutionalizing these functions and cultivating new champions—particularly within government and among prospective donors, but also civil society—to reduce reliance on individual actors.
- **Fully integrating local partners into decision-making and agenda-setting processes is essential to sustain the FARID model.** Initially, local partners were not consistently represented in partnership-wide convenings, such as weekly consortium coordination calls or in-person workshops, which constrained their influence on strategic direction and learning. Local partner participation and inclusion have improved recently and should be reinforced; failure to do so risks undermining long-term ownership.
- **As the FARID partnership transitions toward a more streamlined, efficient, and sustainable model, shifting responsibility for data and performance tracking has proven challenging.** Provided that ongoing funding can be secured by partners, the transition assumes that remaining partners have the capacity, incentives, and operational bandwidth to absorb expanded roles, including monitoring, evaluation, data systems support, and community engagement and access negotiations. Early evidence suggests that this assumption may be overly optimistic, revealing gaps that could limit the effectiveness and continuity of the model.

“Everyone has a specific role to play, but they cannot do all of those tasks that every organization is doing at the moment. So, the fact that every organization in this consortium has a role to play lessens the burden to us as an organization.”

—FARID partner

“The idea itself [reaching inaccessible areas with an integrated model] being unique in Somalia was one of the issues that had actually facilitated the partners to gel together and have that common vision and make their complementary contributions.”

—FARID partner

CONSIDERATIONS

- **The Gates Foundation and FARID partners should fully and formally integrate local partners into FARID's decision-making and learning structures.** Ensuring consistent participation in consortium coordination and planning processes will strengthen local ownership and equitable partnerships.
- **The Gates Foundation should assess and strengthen partner capacity for expanded roles, including data collection, management, analysis, and monitoring, and community engagement functions before shifting responsibilities to implementing and local partners.** Develop a transition plan that includes tailored capacity strengthening, clarified roles, and resourcing to ensure that remaining partners can effectively absorb expanded roles without compromising performance.

FUTURE LEARNING

- *How can champion functions, including leadership, convening power, and relationship brokering, be embedded within partner organizations and/or government structures? What competencies and organizational arrangements are needed to sustain these roles over time?*
- *How can access negotiation strategies be transitioned to local partners without compromising neutrality?*
- *What are the drawbacks to the partnership model?*

LESSON 2

Integrating immunization with basic health services increases uptake of vaccination.

The integrated model responds to community needs for vaccination and other health services and appears to have driven gains in vaccination uptake and other health interventions in previously unreached communities.

STRENGTH OF EVIDENCE: MODERATE

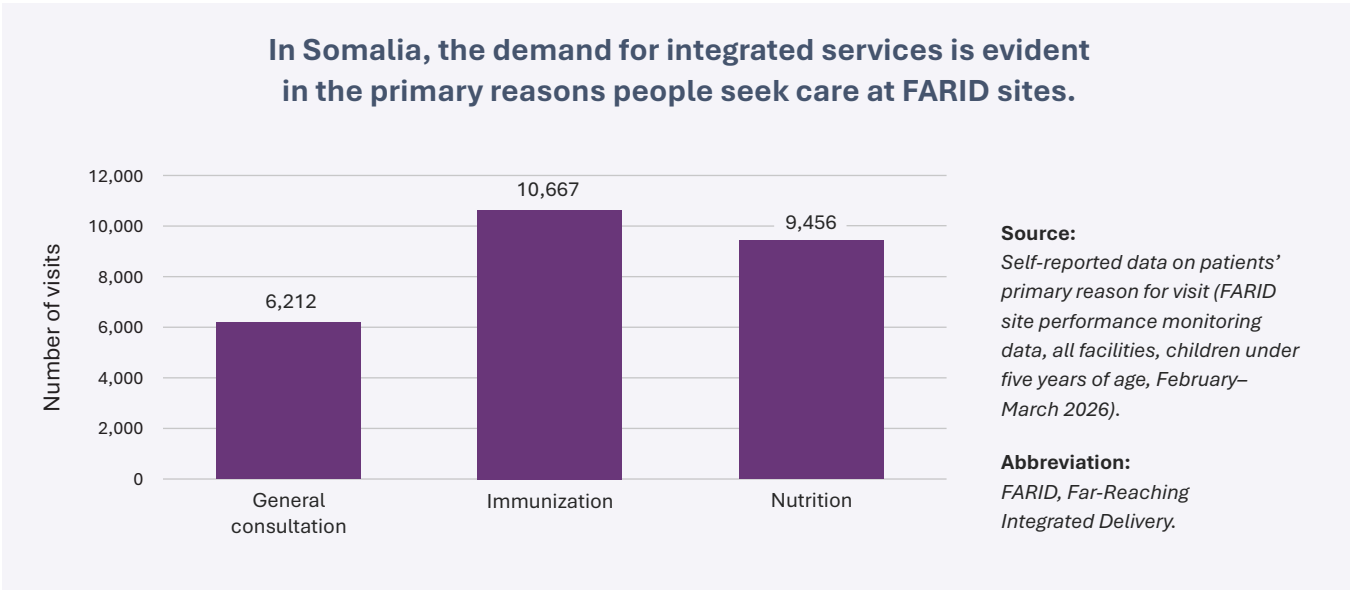
FINDINGS

- **Preventive services are unlikely to achieve optimal uptake without being delivered as part of a more comprehensive service package aligned with community priorities.** Evidence from polio vaccination campaigns in Somalia showed consistently lower demand for preventive services—such as RI—compared with curative care, especially treatment for malnutrition. FARID’s early community roundtables reinforced this pattern, with participants expressing a clear preference for broader PHC rather than immunization alone.

“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

“Immunization alone at times is not adequate enough ... so there is need for accompanying service provision to happen. Some of the key activities in health camps now include the treatment of minor ailments, nutrition screenings, community health education, IYCF [infant and young child feeding] messages, surveillance for AFP [acute flaccid paralysis], and measles.” —FARID partner

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



- **Even where fixed sites or health camps are geographically accessible, they often lack the breadth of services required to meet client needs.** Efforts to build a community-level referral system, including improved community awareness of where specific services (e.g., neonatal care or delivery services) are available, represent an emerging strategy to mitigate these gaps, though their effectiveness remains to be assessed.

“They have the services for the primary health unit. But with the lack of health center services, lack of inpatient services, lack of ambulances ... makes the situation very critical. They are expecting FARID to provide everything, and the reality is that FARID is providing the lowest service to communities in rural areas.” —FARID partner

- **The scope of services offered has remained narrower than partners had hoped, constraining FARID’s ability to fully respond to community-identified needs.** FARID partners initially assumed that other donors would finance the expansion of the integrated service package to include additional community-prioritized services. The additional funding has not materialized, largely because establishing proof of concept for delivering services in previously inaccessible areas takes time and because of broader disruptions in the global health financing landscape.

CONSIDERATIONS

- Donors and implementing partners should systematically incorporate community prioritization processes into future service package planning by using structured engagement mechanisms to inform which PHC components should be added or strengthened over time.
- Local partners and service delivery teams should strengthen community awareness of service availability and referral options through tailored communications to help mitigate gaps when FARID cannot provide the full PHC package.
- FARID partners should continue to proactively engage key donors with a clear, evidence-based case for expanding the FARID service package.

FUTURE LEARNING

- *Conduct implementation research to evaluate how community referral systems and other community-based approaches influence service uptake. Use the findings to refine and scale the most effective strategies.*

LESSON 3

Integrated service delivery remains strong across mobile and fixed models, despite shifts in how services are delivered.

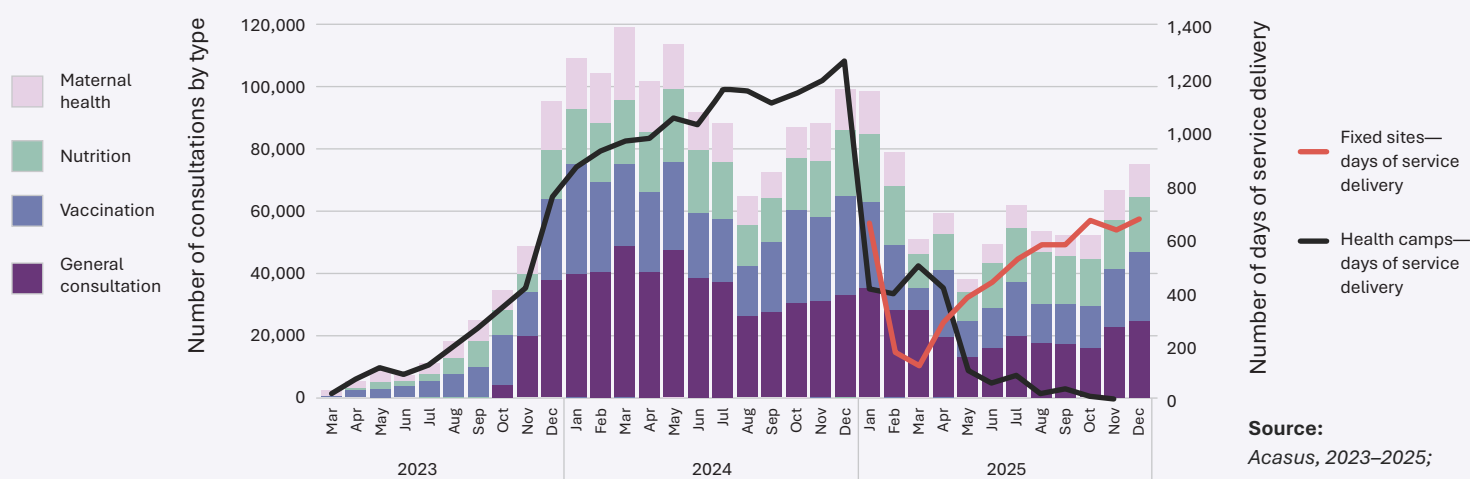
The shifting service delivery model highlights trade-offs between reach and continuity. Health camps and fixed sites effectively expanded access to integrated PHC, offering complementary strengths and delivering services at comparable efficiency levels.

STRENGTH OF EVIDENCE: **STRONG**

FINDINGS

- **Since the launch of health camps in 2023, service delivery has effectively increased access across immunization, maternal health, nutrition, and general medical care, demonstrating that the model effectively increased access to a broad range of PHC services.** Vaccination consultations comprised 29 percent of services provided through health camps.
- **Resource limitations and sustainability considerations prompted a shift from mobile health camps to fixed sites with periodic outreach while maintaining the same package of integrated services.** Each model offers distinct advantages. **Health camps** enabled broad geographic reach, with mobile teams periodically delivering integrated services to previously inaccessible communities. **Fixed sites** operated in 25 communities and conducted outreach to villages within a 10- to 15-kilometer radius to provide more continuous and reliable services.
- **As the number of health camps declined, the total volume of consultations dropped accordingly, indicating some reduction in access to services,** although the proportion of vaccination consultations was similar across health camps (29 percent) and fixed sites (28 percent).
- **Health camps and fixed sites demonstrate comparable efficiency.** Health camps delivered an average of 90 consultations per service day, and fixed sites delivered 94 consultations per service day.

The shift to fixed-site delivery showed an initial drop in total consultations, followed by a slow rebound during the remainder of 2025.



Source:
Acasus, 2023–2025;
Health-E-Net, 2025–
present.

CONSIDERATIONS

- **Governments and partners can strategically leverage mobile health camps to reach underserved communities.** Use geographic, conflict, and access data to prioritize where mobile teams can have the greatest impact beyond the 10- to 15-kilometer outreach radius of fixed sites.
- **Governments and partners can strengthen planning for the sustainability of both models.** Assess resource requirements for sustaining a hybrid model, including staffing, transport, and supply chain needs, to ensure that mobile service delivery remains feasible without compromising fixed-site operations.

FUTURE LEARNING

- *Conduct mixed-methods implementation research to evaluate how different service delivery modalities affect cost-effectiveness, service uptake, continuity of care, and equity of access.*
- *Assess how communities perceive the quality and reliability of mobile health camps and primary health units and examine how these perceptions shape care-seeking patterns and service utilization.*

LESSON 4

Persistent access barriers demand a mixed service delivery model and stronger monitoring.

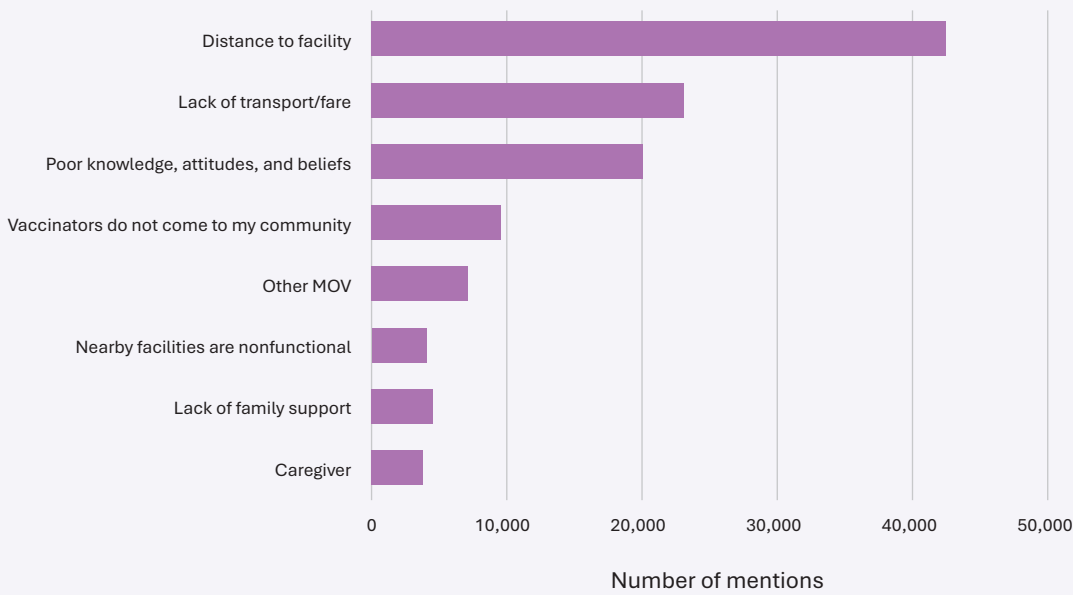
As FARID transitions between delivery models, access barriers rooted in distance and insecurity persist, underscoring the need for a mixed service delivery model and stronger monitoring of demand-side constraints to equitable coverage.

STRENGTH OF EVIDENCE: STRONG

FINDINGS

- **The health camp model was originally designed to mitigate access constraints by sending mobile teams to communities that otherwise could not access existing facilities.** Throughout FARID implementation, distance to health facilities and lack of transportation have consistently emerged as the primary barriers to service uptake.
- **The transition away from health camps reduced geographic reach, particularly for populations facing conflict-related or geographic barriers, such as rivers.** FARID adopted a mixed model, reintroducing health camps in eight districts with substantial populations unable to access fixed sites, indicating the importance of a hybrid approach to maintain equitable coverage.
- **Demand-side barriers are no longer systematically measured within FARID, limiting the ability to measure how effectively evolving service delivery models address access challenges over time.** Given the scale of supply-side constraints, the program’s ability to simultaneously address demand-side barriers is inherently limited, underscoring the need for deliberate monitoring and adaptive strategies.

Based on exit surveys conducted during health camps, distance to the facility, transportation challenges, and poor knowledge are the main barriers to accessing services.



Source:
Acasus, 2023–2025.

Abbreviation:
MOV, missed opportunities for vaccination.

CONSIDERATIONS

- Implementing partners can consider surveys and other mechanisms to track community demand and service preferences across mobile and fixed sites to ensure the service delivery model is responsive to access barriers.

FUTURE LEARNING

- *Conduct mixed-methods implementation research to evaluate how different service delivery modalities affect cost-effectiveness, service uptake, continuity of care, and equity of access.*
- *Assess how communities perceive the quality and reliability of mobile health camps and primary health units and examine how these perceptions shape care-seeking patterns and service utilization.*

LESSON 5

FARID has likely contributed to a substantial reduction in the number of zero-dose children.

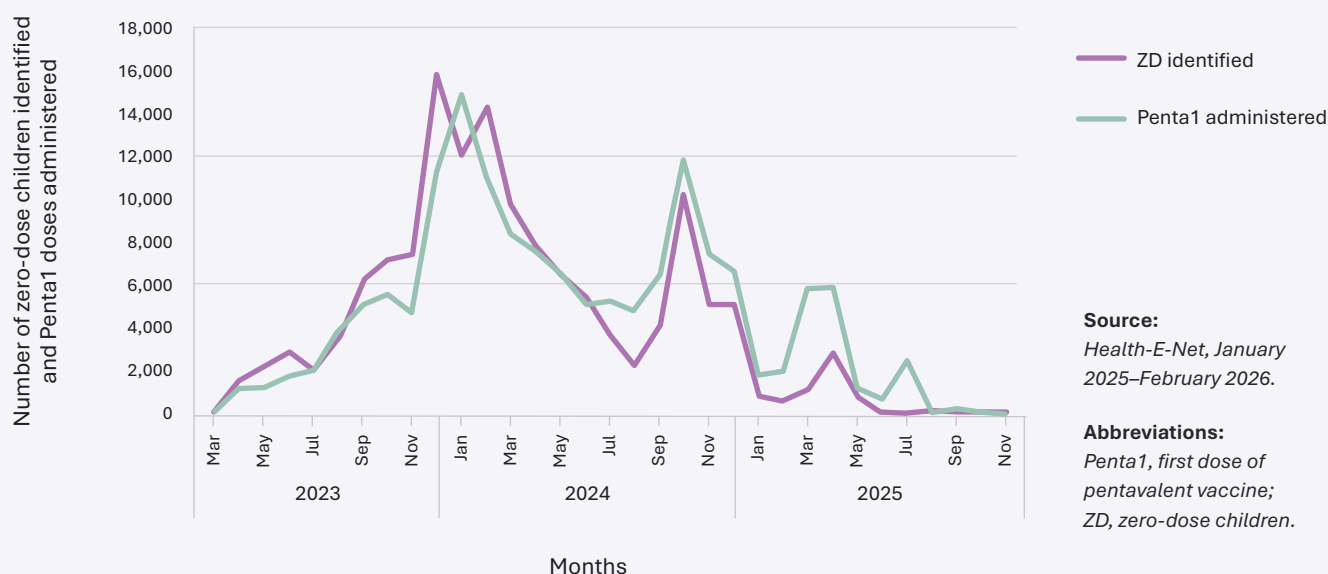
Program data indicate that the number of zero-dose children in FARID-eligible communities has steadily declined, with most recent vaccinations going to children who have already received at least one other vaccination.

STRENGTH OF EVIDENCE: **MODERATE**

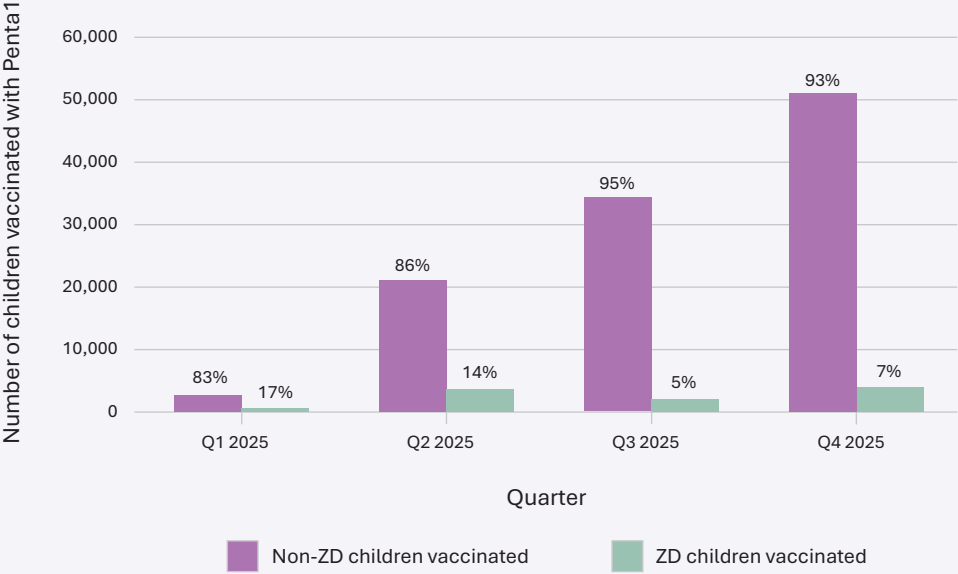
FINDINGS

- **Through health camps, FARID identified nearly 144,000 zero-dose children.** Based on surveys with caregivers, many of these children had never received vaccinations because the nearest health facility was too far and/or because they lacked adequate transportation.
- **Declines in zero-dose identification suggest FARID is driving meaningful reductions in zero-dose prevalence.** Between 2023 and 2025, Acasus tracked the number of zero-dose children identified in health camps but did not systematically record whether those children ultimately received vaccination, making it difficult to quantify the precise extent to which FARID contributed to reductions in the number of zero-dose children.
- **Program data indicate that the number of zero-dose children identified through health camps declined substantially after peaking in 2023.** This likely reflects repeated visits to the same villages and the resulting vaccination of previously unreached populations.

Trends in first pentavalent vaccine doses administered closely mirror patterns in zero-dose identification.



Data from 2025 indicate that the majority of vaccinations were delivered to children who had already received at least one prior dose.



Source:
Health E-Net January–December 2025.

Abbreviations:
Penta1, first dose pentavalent vaccine; Q, quarter; ZD, zero-dose.

Note: In 2025, Health-E-Net began distinguishing between zero-dose and non-zero-dose children vaccinated. Zero-dose children represented 8.5 percent of all children vaccinated through both fixed sites and outreach.

CONSIDERATIONS

- Implementing partners can strengthen zero-dose tracking by establishing a mechanism to follow up children identified through health camps and verify whether they have received vaccination and are in need of any other services. Stronger tracking incorporated into routine monitoring will improve the accuracy of zero-dose estimates and enable more tailored outreach to children who remain unvaccinated.

FUTURE LEARNING

- Assess how shifts in service delivery models—particularly the scale-down of health camps—affect trends in the number of zero-dose children over time, with a focus on whether areas no longer reached by health camps experience a resurgence in zero-dose prevalence.

LESSON 6

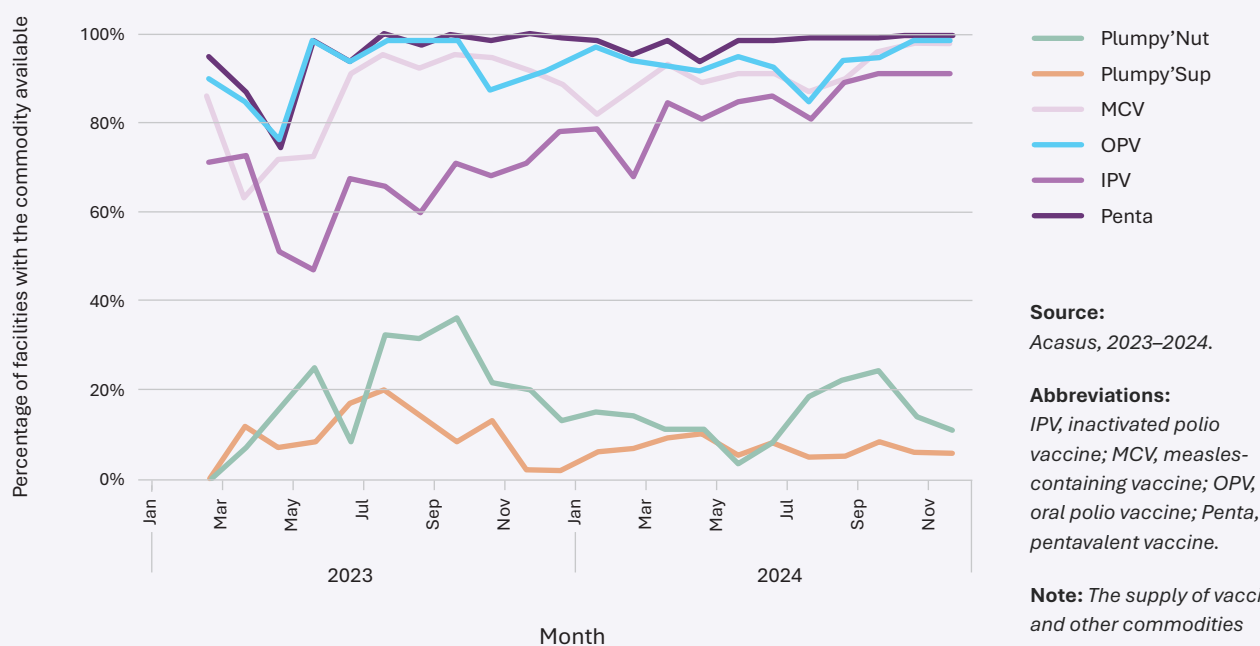
Supply-side bottlenecks limit integrated service delivery.

Persistent supply-side and broader health system constraints limit the availability of fully integrated services. These systemic bottlenecks—most acute in the treatment of severe and moderate acute malnutrition—may constrain potential coverage gains and undermine community trust.

STRENGTH OF EVIDENCE: **STRONG****FINDINGS**

- **Working through established government procurement channels and maintaining strong coordination with the Ministry of Health and Human Services contributed to a relatively stable vaccine supply at FARID sites.** Despite early stockouts, the model demonstrated that reliable supply is achievable when procurement systems are well established and donor support is aligned, underscoring the importance of integrating FARID vaccine supply requirements into national mechanisms.
- **The supply of nutrition commodities remained highly unstable throughout FARID implementation, resulting in persistent stockouts that prevented clients from receiving point-of-care treatment for severe and moderate acute malnutrition.** Data from 2025 indicate that only 32 percent of clients presenting with acute malnutrition received treatment at FARID-operated primary health units, illustrating the extent to which commodity insecurity constrains service delivery effectiveness. Nutrition commodities in Somalia do not appear to be supported by robust national procurement systems, forcing implementing partners to rely on parallel and ad hoc arrangements that do not ensure consistent availability.

The supply of nutrition commodities has consistently lagged behind that of vaccines.



- **Referral pathways for acute malnutrition are not functioning as intended, and the absence of referral tracking means there is no visibility into whether referred clients receive the services they need.** Although children who cannot be treated at FARID sites should be referred to higher-level facilities, program data show that roughly 40 percent of children diagnosed with acute malnutrition were neither treated nor referred. This gap reflects multiple factors: client refusal due to distance and travel barriers, stockouts at referral sites, and health care workers' reluctance to record referrals they believe are unlikely to be completed. These dynamics point to both operational and data-quality challenges that obscure the true performance of the referral system.

“When we have identified some cases of severe malnutrition with complications, we don't have any other partner that is implementing services. So when this case comes, you don't even know how you can manage it because maybe this case is in some remote area and the nearest district hospital is 80, 90, 100 kilometers. And it's really very hard to reach at this point.”

—FARID partner

Gaps remain in the treatment and referral of children diagnosed with malnutrition.



CONSIDERATIONS

- The persistent lack of nutrition (and potentially other) key commodities could reduce demand for vaccination at FARID sites if clients are unable to receive the services they prioritize.
- When designing integrated service delivery models, ensure the models are embedded within functional referral pathways and paired with an assessment of higher-level facility capacity to provide the services clients may need. Strengthening both the referral linkages and the readiness of receiving facilities will improve continuity of care and prevent gaps that undermine the effectiveness of integration.
- Consider ways to strengthen the supply of nutrition and other key commodities by supporting the development of a supply strategy that clarifies sources of nutrition commodities and identifies reliable procurement channels.
- Reassess partners' capacity to advocate for the supply of nutrition commodities, first documenting the extent of the stockouts and raising the issue persistently to stakeholders and coordination platforms, including internal organizational leadership and the health and nutrition clusters.

FUTURE LEARNING

- *Conduct implementation research and evaluations to understand how nutrition commodity stockouts affect client demand for other services, including care-seeking and utilization patterns. Identify mitigation strategies employed by FARID and other partners to minimize service disruption and ensure demand.*

