

Reaching unvaccinated children in fragile, humanitarian, and conflict-affected settings

Cross-country learning from the Routine Immunization Strengthening Program

BACKGROUND

Immunization prevents an estimated 3.5 million to 5 million deaths each year,¹ and every dollar spent on immunization in countries supported by Gavi, the Vaccine Alliance returns about US\$21 in health and productivity gains.² Yet reaching children in humanitarian and conflict-affected settings remains a defining challenge. In 2025, 13.5 million children received *no* routine vaccines,³ and wild and vaccine-derived polio continued to circulate where coverage was lowest.

The **Routine Immunization Strengthening Program (RISP)**, launched by the Gates Foundation in 2019, works in subnational areas with low routine immunization (RI) coverage and high polio risk. From 2023 to 2026 the Gates Foundation partnered with PATH to lead the **RISP Learning Consortium (LC)**, which synthesizes evidence across the program countries to identify what works (and what does not work) to strengthen RI programs and foster cross-country learning.

This brief synthesizes the LC's findings across the RISP countries: **Afghanistan, Central African Republic (CAR), Chad, the Democratic Republic of the Congo (DRC), Niger, Pakistan, Somalia, South Sudan, and Syria**. Across countries, RISP supports a range of activities to improve RI coverage, which can be grouped into three archetypes: direct service delivery through partners collaborating with the government; memorandum of understanding (MoU) model working through government systems, including pooled basket funds designed to progressively transition financial responsibility to the government; and hybrid model of direct service delivery and government MoUs (Figure 1).

FIGURE 1: RISP LC countries by archetype.



PURPOSE AND AUDIENCE

This brief highlights crosscutting insights synthesized from country and thematic analyses. It complements [more detailed country case studies](#) (on Chad, the DRC, Niger, Pakistan, and Somalia) and thematic briefs (on data systems and integrated service delivery).

The brief is intended for **ministries of health, donors, and implementing and technical partners** who design, fund, and implement activities to improve RI coverage. It provides practical evidence on how and why approaches worked, which can inform program design across similar settings.

KEY FINDINGS

This brief highlights key lessons in the domains of governance and cofinancing, service delivery, data systems, and partnerships, which emerged across multiple countries and implementation models, making them the most transferable to future investments in fragile, humanitarian, and conflict-affected settings. The findings provide practical evidence on how and why approaches worked, offering actionable guidance for future program design rather than simply demonstrating success.

-  **Finding 1 - Governance and cofinancing.**
Governance and cofinancing mechanisms can secure government commitments to RI, but fulfillment depends on subnational fiscal capacity, political stability, and sustained advocacy.
-  **Finding 2 - Service delivery modalities adapted to fragile contexts.**
Service delivery platforms are most effective when tailored to the needs of the community through integration and mixed delivery models.
-  **Finding 3 - Data systems and use.**
Data systems that collect granular, timely, and actionable operational data enable timely performance management and are often supported by specialized data system partners and donor funding.
-  **Finding 4 - Multipartner ecosystem.**
Well-resourced partnership models that pair technical partners with complementary skills enable immunization service delivery in hard-to-reach and previously inaccessible communities. However, in resource-constrained environments, sustaining these models becomes challenging, especially in the absence of multiple funders and careful transition planning.



THE RISP PORTFOLIO AT A GLANCE (2019 to 2027)

RISP is a portfolio of **country-led and tailored efforts** to strengthen RI. Table 1 provides an overview of the RISP partners, investment activities, and geographical focus by country. RISP implementing and technical assistance (TA) partners covered a range of support areas, including implementation support, service delivery, political advocacy and coordination, performance management and data systems, community engagement, access negotiation, capacity strengthening, microplanning, coverage surveys, financial management, fiduciary agent, third-party fund manager, and evaluations.

Table 1: RISP technical (nongovernmental) partners, investment areas, and geographic focus, by country.

COUNTRY	TECHNICAL PARTNERS	INVESTMENT ACTIVITIES	GEOGRAPHIC FOCUS
AFGHANISTAN <i>DIRECT SERVICES</i>	- Acasus - Bu Ali Rehabilitation and Aid Network - Centre for Humanitarian Dialogue - McKing Consulting Corporation - United Nations Children's Fund (UNICEF)	Provided 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 <i>DIRECT SERVICES</i>	- 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.
CHAD <i>MOU MODEL</i>	- Gavi, the Vaccine Alliance - McKing Consulting Corporation - Solina Centre for International Development and Research - UNICEF - WHO	- Established an MoU with the national government to strengthen RI in three provinces. - Deployed a pooled basket fund that financed systems strengthening across governance and accountability, supervision, monitoring and evaluation, and service delivery, including outreach.	Focused on three border provinces (Hadjer-Lamis, Kanem, and Lac) with low immunization rates and social inequities.

COUNTRY	TECHNICAL PARTNERS	INVESTMENT ACTIVITIES	GEOGRAPHIC FOCUS
DRC <i>MOU MODEL</i>	- Acasus - GRID3 - Kinshasa School of Public Health - McKing Consulting Corporation - PATH - University of California, Los Angeles - VillageReach	- Established MoUs with three provincial governments and supported the Mashako Plan, a national initiative launched in 2018 to revitalize RI systems. - Deployed pooled basket funding with phased government cost-sharing, transparent fiscal management, real-time monitoring and accountability, and capacity strengthening to gradually transfer program management to provincial authorities.	Focused on three provinces (Haut Lomami, Lualaba, and Tanganyika) with persistent vaccine-preventable disease outbreaks and low RI coverage.
GUINEA <i>MOU MODEL</i>	- Askaan Santé - McKing Consulting Corporation	- Established an MoU with the national government to strengthen RI in one province. - Deployed a pooled basket fund that financed systems strengthening across governance and accountability, supervision, monitoring and evaluation, and service delivery.	Focused on one rural province with low coverage, Kankan.
NIGER <i>MOU MODEL</i>	- Askaan Santé 2AC Associés Audit et Conseil - Bluesquare - McKing Consulting Corporation - Solina Centre for International Development and Research - The Center for Advancing Public Health	- Established an MoU with the national government—signed by the ministries of health, interior, and finance given Niger’s centralized health system—to strengthen RI in three regions. - Deployed a pooled basket fund with phased government cost-sharing, transparent financial management, real-time monitoring and accountability, and a gradual reduction of external TA.	Focused on three border regions (Diffa, Maradi, and Zinder) that hosted large numbers of refugees and internally displaced people and faced heightened conflict risk and significant disruptions to RI services.
PAKISTAN <i>HYBRID, GOVERNMENT MOU AND DIRECT SERVICES</i>	- Acasus - The Aga Khan University - Impetus Advisory Group - Medical Emergency Resilience Foundation - People’s Primary Healthcare Initiative - RIZ Consulting - Tameer-e-Khalaf Foundation - VITAL Pakistan Trust	- Supported service delivery by establishing Expanded Programme on Immunization (EPI) facilities and developing public-private partnerships for EPI delivery. MoUs were established to transition EPI facilities to provincial governments. - Provided TA to strengthen system accountability, supervision, community demand, and EPI synergies with the national polio eradication initiative.	Focused on super high-risk union councils in three provinces (Sindh, Balochistan, and Khyber Pakhtunkhwa) with high polio risk and low RI coverage.

COUNTRY	TECHNICAL PARTNERS	INVESTMENT ACTIVITIES	GEOGRAPHIC FOCUS
SOMALIA <i>DIRECT SERVICES</i>	• 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 (FARID) program, 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 <i>DIRECT SERVICES</i>	• 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 <i>DIRECT SERVICES</i>	• Assistance Coordination Unit • Save the Children International • WHO	• Supported RI operations through 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.

LEARNING APPROACH AND METHODS

The RISP LC applied a **robust, theory-driven mixed-methods approach** to generate insights on RI implementation across diverse contexts. Our methodology was anchored in country-specific or thematic theories of change (ToCs), which we refined iteratively, that articulated the pathways between RISP investments and intended outcomes. The ToCs were used to structure data collection, test assumptions, and guide analyses. The learning cycle ran on an *annual cadence*: Evidence synthesis surfaced assumptions and was used to refine ToCs, the revised ToCs generated new learning questions, and those questions drove the next round of data collection, analysis, and dissemination.

The RISP portfolio includes a range of investments across ten countries (Table 1). The RISP LC's role was to explain the mechanisms behind these investments' results, which required examining the underlying change pathways in the ToCs. We structured two workstreams: The first assessed the effectiveness of four country-specific models (DRC, Niger, Pakistan, and Somalia) and how and why outcomes were achieved; the second involved a cross-country analysis to identify common patterns and themes across a broader set of fragile and humanitarian settings (Afghanistan, CAR, Somalia, South Sudan, Syria).

Both workstreams relied on primary qualitative data to explain how RISP investments contributed to outcomes, including information from key informant interviews with government stakeholders and RISP implementing partners and review of program documents. Qualitative evidence was triangulated with secondary data shared by RISP grantees and partners (e.g., program monitoring data, partner progress reports, and coverage surveys) to generate lessons; these lessons were subsequently shared and discussed with country representatives for validation.

In Chad and Somalia, expenditure analysis was conducted to understand how RISP resources were spent on the government strengthening and direct service activities, respectively. For all countries, the RISP LC facilitated sessions with the Gates Foundation RISP team to share interim findings and lessons, gather additional insights, and iterate on the ToCs. Table 2 summarizes evaluation learning areas for each workstream. The [RISP LC overview brief](#) provides more detail on the broader RISP LC approach and methodology that shaped the country case studies and thematic briefs.

Table 2: RISP LC workstream learning areas.

WORKSTREAMS	LEARNING AREAS
COUNTRY MODELS FOR RI STRENGTHENING	Deep dives: DRC, Niger, Somalia, and Pakistan. • Assess the effectiveness of country-specific strategies. • Describe the outcomes that were achieved (or not) and why. • Identify approaches that can be sustained or scaled. • Assess progress of country-specific transition activities. • Estimate the costs of implementing interventions to strengthen RI (Chad and Somalia only).
DIRECT SERVICE DELIVERY IN HUMANITARIAN SETTINGS	Fragile and humanitarian settings: Afghanistan, CAR, Somalia, South Sudan, and Syria. • Examine strategies for and implementation of integrated service delivery and mixed models. • Describe the role of access/peace negotiations to reach inaccessible areas. • Document processes using data and contextual information to monitor changes, inform decision-making, and adapt program implementation.

The RISP LC’s learning approach had several limitations. First, the desk review relied on program reports and aggregated findings rather than raw quantitative data, which limited our ability to triangulate with the detailed qualitative data collected on implementation processes and immediate outcomes. Second, the qualitative interviews asked individuals to reflect retrospectively on program design, which may have introduced some recall bias. To mitigate this, we interviewed multiple stakeholders per setting and over several time points to capture changes over time. We also consulted with the RISP program officers who were closely involved in intervention design. Third, our analysis primarily relied on perspectives from RISP implementers, government officials, and Gates Foundation staff, and we were limited in our ability to collect data directly from communities and program participants.

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**

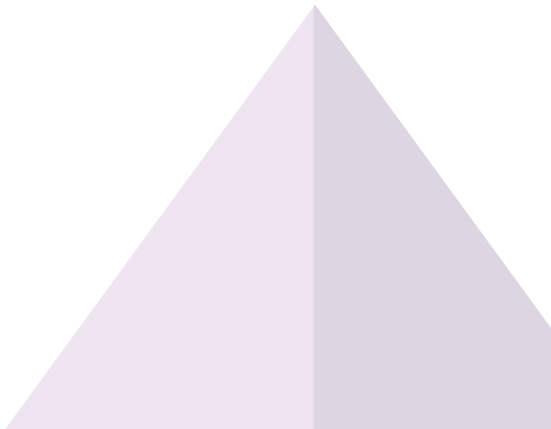
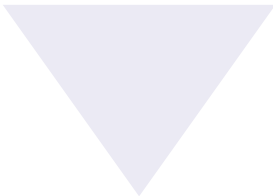
- Clear convergence across multiple, diverse sources; rich and credible evidence supporting program theory; minimal uncertainty.

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.



Governance and cofinancing mechanisms can secure government commitments to RI, but fulfillment depends on subnational fiscal capacity, political stability, and sustained advocacy.

In Chad, the DRC, and Niger, the Gates Foundation entered into MoUs with governments, characterized by pooled basket funding and phased government cost-sharing; these MoUs were intended to convert political will into a financed government commitment to RI. The MoUs were established with provinces and regions in the DRC and Chad respectively, mapping to their decentralized systems, whereas a national MoU was established with Niger.

The MoU addressed critical funding gaps and contributed meaningfully to governance, accountability, and service delivery. Where the MoU proved effective, it worked by increasing funding to extend RI coverage to populations that routine systems had failed to reach and by reinforcing the coordination structures already present within national systems. In the **DRC**, the MoU was a strong mechanism to mobilize domestic resources for immunization (see [the DRC case study](#)). In **Niger**, the MoU contributed most visibly in communities facing the greatest access barriers—notably the Diffa Region—where mobile strategies appear to have supported the observed reductions in zero-dose prevalence. In **Chad**, government coordinators regularly convened review meetings, rigorously monitored action points, and retained full ownership of agenda setting and preparation, leading to measurable improvements in coordination, elimination of vaccine shortages, and stronger data collection processes.

The MoU's resilience to political instability depended on the severity of the shock and the surrounding context. The nature of the shock and the context surrounding it shaped how well the model could withstand political disruption. Niger and the DRC illustrated two ends of this spectrum. In **Niger**, a severe and systemic shock—the unexpected 2023 government transition—interrupted implementation of the MoU and led to financing challenges, which meant the MoU was not renewed. The subsequent realignment of authority, compounded by fractured governance structures and diminished data transparency, eroded the partner trust and political conditions that the model depended on. The **DRC** faced a different disruption: Political shifts and frequent leadership turnover created challenges but did not stop the MoU implementation. Even as five governors changed in Haut Lomami and four in Tanganyika, the MoU continued to function, sustained by continuous advocacy from local actors and partners, such as the Parliamentary Network for Immunization Support (Réseau des Parlementaires Congolais pour l'Appui à la Vaccination) and the Gates Foundation. These efforts fell short of fully realizing the cofinancing commitments, yet the model's persistence through this degree of turnover pointed to a measure of resilience—evidence that, under less severe shocks and with sustained engagement, the model could hold.

Gaps in underlying system capacity and structures limited what the MoU model could achieve.

Beyond political shocks, the MoU model frequently presumed a foundation of system capacity that did not, in practice, exist. In the **DRC**, chronic underpayment left frontline workers dependent on financial incentives, prompting them to prioritize incentivized tasks and lose motivation to continue with Mashako Plan activities when payments lapsed. In addition, the Mashako supervision tool required intensive monthly data collection, which exceeded provincial technical and financial capacity and undermined both implementation quality and long-term sustainability. In **Chad**, the MoU did not fund demand generation activities based on the assumption that these were functional. Although most health facilities (60 percent) conducted community engagement, no mechanism linked those activities to vaccination service delivery—a missed opportunity to fund development of a more integrated and coordinated demand strategy.

Provincial financial management and accountability improved through embedded TA, though reliance on that assistance persisted. In the **DRC**, provinces assumed responsibilities that TA partners had previously led and strengthened their financial management and accountability accordingly, yet they continued to rely on embedded TA to offset human resources shortages, manage turnover, and reinforce accountability. In **Chad**, views on the need for continued TA support diverged. In a survey of district- and facility-level actors in MoU provinces, most respondents said they could take over after transition. National actors, who were more involved in the MoU discussions and familiar with the mechanics, expressed greater concern about leading these efforts without TA funding and support.

DRC • PROVINCIAL COFINANCING

The cofinancing model, which was supported by donor and national government political will, succeeded in securing provincial commitments, but provincial political instability and limited fiscal capacity affected the fulfillment of these commitments.

STRENGTH OF EVIDENCE: **STRONG** 

DESIGN	Beginning in October 2018 (in Haut Lomami and Tanganyika) and July 2021 (in Lualaba), the Gates Foundation signed MoUs with provincial governments to support the Mashako Plan , a national initiative to revitalize the routine immunization RI system. MoUs included pooled basket funding with phased government cost-sharing, transparent fiscal management, real-time monitoring, and capacity strengthening for transition to provincial authorities. In 2023, the Haut Lomami and Lualaba MoUs expanded into broader primary health care (PHC) MoUs, with the US Agency for International Development and Gavi, the Vaccine Alliance joining; total committed funding across the donors was US\$17.9 million .
RESULTS	Financial commitments from the DRC expanded over the course of the MoU. During that same period, coverage rose substantially across all three provinces. Between 2017/2018 and 2024, coverage for the third dose of the pentavalent vaccine rose from 50 to 83 percent in Haut Lomami, 35 to 62 percent in Lualaba, and 25 to 76 percent in Tanganyika . System readiness scores captured under Mashako rose from below 48 percent in 2019 to over 90 percent across all MoU provinces by 2025; in November 2024, Haut Lomami ranked first nationally with a 96 percent composite score—a 54 percentage point improvement over its 2019 average. The relationship between funding and coverage was not linear: Tanganyika contributed the smallest share of committed funding (30 percent for 2020 to 2024) but achieved the largest gains (coverage for the third dose of the pentavalent vaccine of +51 percentage points; full immunization coverage of +47 percentage points).
FACILITATORS	• National-level political momentum (the Kinshasa Declaration on Vaccination and Polio Eradication in the Democratic Republic of the Congo and the launch of the Mashako Plan) created the impetus to secure first-time provincial RI financing. • Embedding cofinancing in existing provincial governance structures gave the MoUs a foothold. • Performance tied to real-time monitoring and bonuses drove accountability. • Sufficient provincial fiscal capacity in mining-rich Lualaba allowed commitments to be met in full.

CHALLENGES

- **Political instability:** There was frequent governor turnover during the MoU period in Haut Lomami and Tanganyika.
- **Limited fiscal capacity:** Lualaba excepted, provincial respondents stated that the basket-fund target was *structurally unattainable given their revenue base*.

RECOMMENDATIONS

- **Calibrate cofinancing to realistic subnational fiscal capacity.** Targets that exceed achievable revenue undermine the model's credibility. Donors should target MoUs with cofinancing agreement toward provinces with sufficient fiscal capacity—and consider alternative financing for provinces with weaker revenues.
- **Build safeguards for leadership turnover and political instability.** Institutionalized commitments reduce vulnerability to governor and minister changes.
- **Invest in sustained, locally anchored advocacy.** Parliamentary networks and other standing institutional voices keep RI financing visible to political actors across cycles.
- **Match the model to the governance structure.** In centralized systems, subnational MoUs require explicit mechanisms to devolve authority for subnational decision-making and system strengthening. Designing MoUs to reflect existing government structures—or a future state the government has articulated—offers the greatest potential for success and reduces approval delays across the chain of decision-makers, from the ministry of health to subnational ministries and the EPI.
- **Assess RI system building blocks to inform MoU investments.** Assess existing RI systems, structures, and partner activities to inform MoU investments. Demand generation is one overlooked area where coordinating with other partners (such as UNICEF and the WHO) could build synergies.

Service delivery platforms are most effective when tailored to the needs of the community through integration and mixed delivery models.

In fragile and humanitarian settings, service delivery must be tailored to what communities need—and the RISP evidence points to two levers for doing so: **integrating services** and using **mixed delivery modalities** that can adapt to local conditions.

- **Integration:** Demand for immunization and other preventive services is often low in these settings, with caregivers prioritizing curative care, nutrition, food, and safety. There is strong evidence from RISP countries that integrating RI into a broader health package can drive uptake. The level and type of integration across the RISP portfolio cover a spectrum, from limited coordination between health programs to joint planning and delivery of multiple services in a single visit.
- **Delivery modality:** Where access barriers stem from distance, insecurity, or seasonal disruption, the choice of modality determines whether services reach communities. Evidence from the RISP LC shows that mobile, outreach, and fixed-site delivery each have a role, but their effectiveness depends on the specific access conditions. In many fragile and humanitarian settings, a mixed approach, with the flexibility to use a combination of modalities or shift between modalities as needs change, is required to maintain coverage.

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

Folding RI into a broader health package drove acceptance and uptake across RISP countries. The degree of integration varied across settings (see Figure 2) depending on context and resources. Where programs could not integrate services at the point of delivery, coordinated screening and referrals still connected people to vaccination services. **Somalia** illustrated the fuller model: Through the FARID program, a single visit provided clients with immunization services and a range of other PHC services, including nutrition, maternal health, and general medical services.

Even when services were designed to be integrated, supply-side gaps and broader health systems limitations sometimes affected the availability of the full package of services. In **Somalia**, this was most acute in the treatment of severe and moderate acute malnutrition. These constraints capped potential coverage gains and, where communities encountered missing services, risked eroding their trust.

Mobile delivery models reached communities that fixed sites alone could not, indicating that mixed delivery strategies can help extend access in settings with persistent insecurity and/or geographic constraints. Where distance, insecurity, or seasonal disruption blocked access, a flexible, mixed approach proved essential for delivering RI services. In **Somalia**, FARID ran mobile health camps from 2023 to 2025 to overcome distance and transport challenges, and persistent insecurity. In doing so, it vaccinated zero-dose children by reaching previously inaccessible areas. In **Niger**, mobile strategies mattered most where access was hardest, accounting for 13 to 15 percent of vaccinations in Diffa, a remote community, against 2 to 3 percent in Maradi and Zinder, and likely helping cut zero-dose prevalence in Diffa from 9 to 7 percent.



Investments that addressed service delivery gaps produced real gains, but those gains could not be sustained through transition. Across fragile and humanitarian settings, direct investments to close service delivery gaps, whether through fixed EPI facilities or mobile health camps, drove real coverage gains, yet the transitions were not planned from the start. In **Pakistan**, action planning by super high-risk union councils guided the establishment of 37 temporary EPI facilities across Sindh, Khyber Pakhtunkhwa, and Balochistan. Fully immunized coverage rose by an average of 23 percentage points between 2020 and 2025—but the original design lacked a transition framework to guide capacity transfer, human resources readiness, and post-handover monitoring. Handover of temporary EPI facilities to the government stalled and was inconsistent across provinces. In Sindh, where the EPI and partners provided strong leadership and advocacy, 13 facilities transitioned between 2021 and 2024. Khyber Pakhtunkhwa and Balochistan—beset by land disputes, administrative instability, and constant turnover among health secretaries—had limited facility transitions, only three facilities in Balochistan and no facilities in Khyber Pakhtunkhwa.

FIGURE 2: Varying degrees of integrated service delivery across RISP settings.

FULL INTEGRATION 			
	COORDINATION	COLOCATION	CONVERGENCE
Degree of integration	<i>Communication and information sharing</i>	<i>Physical proximity of multiple services during the same visit</i>	<i>Unified workflows or joint delivery through integrated packages</i>
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 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.

SOMALIA • INTEGRATED SERVICES AND MIXED DELIVERY MODALITIES (FAR-REACHING INTEGRATED DELIVERY PROGRAM)

In Somalia, the Far-Reaching Integrated Delivery (FARID) program delivered an integrated package of services to communities that were previously inaccessible due to conflict and distance. Services are delivered through a mix of mobile and fixed modalities, effectively expanding access to integrated services at comparable efficiency levels.

STRENGTH OF EVIDENCE: **STRONG** 

DESIGN	FARID operates in inaccessible districts of Somalia, where distance and lack of transportation are the primary barriers to service uptake. The program initially addressed these constraints through mobile health camps that brought services directly to communities unable to reach fixed facilities. In 2025, FARID shifted to a fixed-site model with outreach to surrounding villages to improve efficiency and sustainability, but this reduced geographic reach, prompting the reintroduction of health camps later that year in selected districts. The resulting mixed model—combining fixed sites, outreach, and mobile health camps—demonstrates that blended delivery approaches are often necessary to balance reach with efficiency in settings facing persistent access barriers. Demand-side insights also shaped the packages of services offered by FARID: Community roundtable discussions and experience with past polio campaigns showed lower demand for preventive services, such as RI, compared with curative care and reinforced preferences for broader PHC rather than immunization alone. In response, FARID was designed to deliver an integrated package of immunization, nutrition, maternal health, and other PHC services to communities previously inaccessible due to conflict and geographic barriers, strengthening both access and acceptability of essential services.
RESULTS	Since 2023, FARID has delivered more than 1 million EPI doses and PHC consultations across 1,200+ communities. Demand for the integrated package is evidenced in patient-reported reasons for visits: Among children under five years of age at FARID sites, caregivers sought a broad mix of immunization, curative, nutrition, and counseling services. This pattern supports the program’s core design assumption that demand for integrated services creates an opportunity to increase vaccination uptake. After the 2025 shift to mixed delivery, total consultation volume initially dropped before rebounding through the remainder of the year. Over time, the health camp model and the mixed model (i.e., fixed sites with outreach) demonstrated comparable effectiveness: 90 versus 94 consultations per service day, with the share of vaccination consultations similar across models (29 percent of overall consultations at health camps and 28 percent at fixed sites). The mixed model thus preserves reach for populations facing conflict-related or geographic barriers (e.g., rivers) while providing continuity for populations within the fixed-site catchment.

FACILITATORS	• Community engagement to inform the design of the integrated package. • Partnership approach with organizations filling unique and complementary roles to reach previously inaccessible areas with health services. • Coordination with government around vaccine procurement. • Adaptive learning that adjusts the delivery model and operational context based on data review.
CHALLENGES	• Persistent access barriers rooted in distance and insecurity constrain efforts to shift to a more sustainable model while maintaining coverage. • Lack of ongoing measurement of demand-side barriers to understand how the evolving model affects access. • Supply-side bottlenecks: Persistent nutrition commodity stockouts and distance to referral sites meant approximately 40 percent of children diagnosed with acute malnutrition were neither treated nor referred. • Overstretched health care workers: Five-person facility teams are stretched across a wide service range.

RECOMMENDATIONS

- **Design integrated packages around community-prioritized services.** Implementing partners, governments, and communities should codesign an integrated package that is feasible, context-specific, and built on existing PHC platforms. Assess community priorities through structured engagement rather than adding services onto immunization without the health system capacity to sustain them.
- **Match modality to access conditions.** Mobile and outreach models were most appropriate where distance and insecurity dominated (e.g., Diffa in Niger, and the FARID program health camps in inaccessible districts of Somalia), and fixed sites with outreach offered continuity within catchment areas. In fragile settings, a mixed model—retaining mobile delivery for populations beyond the fixed-site radius—showed promise; governments and partners should plan explicitly for the staffing, transport, and supply chain needed to sustain it.
- **Align donor financing and accountability with integration.** Donors should align funding time frames and reporting frameworks with the realities of coordination and prioritize integration over short-term “quick wins”; flexible funders able to finance across health sector verticals are better positioned to advance integrated service delivery models.
- **Strengthen screening and referral pathways.** Where integrated delivery is not possible at the point of service, coordinated screening and referral should be a deliberate design choice: Strengthen referral-tracking systems and community health worker incentives, coordinate microplanning and outreach so vaccination can occur at the time of screening, and invest in readiness of the receiving facilities, which will improve the continuity of care and prevent gaps that undermine the effectiveness of integrated screening.

Data systems that collect granular, timely, and actionable operational data enable timely performance management and are often supported by specialized data system partners and donor funding.

In contexts where national health management information systems (HMIS) cannot support timely performance management, RISP engaged dedicated data partners to generate granular operational data that enabled timely course correction. These partners captured information on vaccine stocks, cold chain functionality, vaccinator presence, outreach logistics, and community-level demand drivers, among others. The data were synthesized into accessible dashboards and performance scorecards, and reviewed during routine data review meetings, allowing teams to identify root causes of coverage trends and adjust implementation accordingly.

Data systems introduced in humanitarian settings filled critical gaps where no systems existed or where HMIS data were insufficient, enabling effective program monitoring and performance management. In humanitarian settings, HMIS were frequently absent, incomplete, or unable to capture activity in areas outside government control. Dedicated data partners filled these gaps, generating the timely, disaggregated visibility on vaccine coverage, vaccine stocks, and periodic assessment of demand that program managers needed to monitor performance and manage delivery. In **Somalia**, implementing partners reported vaccination data into DHIS2, but aggregation with data from non-supported facilities obscured performance specific to the FARID model. Aligning **implementing partners** under a single common data system enabled tracking of FARID performance across partners and geographies. Although each implementing partner maintained its own monitoring system, data partners consolidated data and led data reviews, producing a comprehensive view of performance and enabling coordinated, data-driven responses. This independent triangulation function was decisive in helping all partners see the whole picture.

The collection of timely service delivery and community-level data in humanitarian settings enabled program adaptations and timelier resolution of operational bottlenecks. A defining innovation across these settings was the collection of timely service delivery and community-level data. Compared with the monthly facility reporting available through DHIS2, these data offered more timely and granular insight—allowing partners to identify operational bottlenecks and adapt in near real time. Data collected by supervisors on vaccine availability, staff presence, cold chain functionality, and outreach logistics pinpointed the root causes of weak vaccination performance rather than simply recording service delivery outputs.

In **Afghanistan's** Southern Region, outreach monitoring significantly expanded service reach: Visits to priority communities rose from 31 to 58 percent between 2022 and 2024, alongside an estimated 25 to 27 percent increase in children vaccinated during outreach sessions. In **Somalia**, monitoring of mobile health–camp visits improved outreach planning and coverage; by June 2024, 58 percent of visited villages had been reached at least five times over five months—enough to complete the full immunization schedule. In **Somalia**, respondents identified community-level data on client satisfaction and demand drivers as the most valuable insight for tailoring approaches, building trust, and securing community buy-in among underserved populations—all central to the FARID model's success. Together, these examples show that combining service delivery, supervision, and community-level data enabled more effective, responsive performance management than facility reporting alone.

The dedicated data partners improved program performance by generating data, institutionalizing review processes, and strengthening partners' capacity to analyze and use data. Through accessible dashboards, performance scorecards, on-the-job training, and regular data review meetings, partners became better able to identify implementation challenges, improve data quality, and take timely, coordinated action. A strong field presence made this possible: Hands-on coaching enabled vaccinators, facility staff, and EPI managers to translate data into improved service delivery.

In **Afghanistan**, data partners spent 60 to 70 percent of their time working alongside national and provincial EPI teams—interpreting data, providing problem-solving support, and facilitating use through review meetings, peer coordination (including WhatsApp groups), and joint facility visits. This adaptive learning support drove measurable gains: EPI service delivery performance indicators rose, on average, from 82 to 92 percent between 2021 and 2024. In **Pakistan**, data partners Impetus Advisory Group and Acasus developed vaccinator-level data packs summarizing key indicators, which were reviewed and discussed in data review meetings to inform action.

A dedicated, independent data partner that scrutinized the data and flagged problems held implementing partners accountable for addressing operational issues. In **Somalia**, implementing partners triangulated Acasus data with reports from local implementing nongovernmental organizations to verify and resolve inconsistencies in self-reported figures, and data generated by an independent partner were perceived as more reliable.

Developing data systems outside government structures led to data ownership challenges as government engagement increased. As governments engaged more deeply, independent, parallel data systems raised questions about ownership, control, and long-term financing. In **Somalia**, concerns about ownership and the sustainability of parallel systems prompted efforts to integrate the FARID data system into the national DHIS2. In the **DRC**, the performance monitoring system was co-developed with the national EPI, yet reliance on an externally managed platform (Gestion PEV) raised concerns about provincial data ownership and long-term technical and financial sustainability. Stakeholders questioned whether government could absorb the required resources—system maintenance, server capacity, device replacement—and noted that limited access to raw data reinforced dependence on partners to generate monthly performance scorecards. Across all three settings, early ownership questions signaled the need for earlier government engagement on transition planning. In **Afghanistan**, the partner-supported monitoring system scaled from an initial 100 PHC facilities toward near-national coverage, prompting discussions around data ownership and sustainability.

Monitoring systems were most effective when embedded within existing routines, implemented by trusted local actors, and supported by structures that promoted constructive use of data for problem-solving rather than punitive accountability. The evidence consistently favored systems designed for constructive problem-solving over those built around external verification or performance-based incentives. Embedding data collection within existing routines and relying on health system actors, rather than external partners, improved community acceptance, supported adoption of new practices, and strengthened prospects for sustainability across Afghanistan, the DRC, and Pakistan.

The limits of relying on implementing partners to substitute for routine government supervision functions were visible in **Pakistan**, particularly in maintaining regular supervision processes. In Sindh, an implementing partner was deployed to collect information from newly established facilities in high-risk areas. The role was intended as a stopgap for gathering monitoring data until EPI supervisors could take over oversight of the new facilities. Several years on, the implementing partner still carries this work. Monitoring data remain complete, but the arrangement risks leaving health care workers without the mentorship and support EPI supervisors would provide. In Balochistan and Khyber Pakhtunkhwa, the data partner supported the build-out of provincial monitoring units atop existing efforts, but without routine processes for review, follow-up, and accountability, issue identification and corrective action remained ad hoc.

Challenges were noted with externally driven, verification-focused approaches. In **Pakistan**, data served enforcement rather than learning. Issues escalated upward were often met with contract terminations, salary withholding, and pay reductions—likely contributing to data falsification, which was evident in implausible coverage spikes (exceeding 100 percent) and inconsistencies between reported coverage and vaccine availability. In the **DRC**, performance scores were used to rank provinces and health zones and were tied to performance-based bonuses; the prominence of the rankings created incentives to inflate metrics, shifted supervisors toward indicator collection over coaching, and prompted work-arounds that undermined data credibility.

In **Afghanistan**, nongovernmental organization implementing partners drew an explicit contrast between RISP-supported systems and third-party monitoring used in other donor-funded projects (e.g., World Bank). They observed that verification-focused third-party monitoring—often linked to performance-based financing—can generate perceptions of punitive external oversight, erode trust in monitoring capacity, and heighten politicization through its ties to payment.

PAKISTAN · ACCOUNTABILITY ROUTINES

*In 2022, RISP introduced **monitoring support and town-level performance data review routines** in Sindh, initially to share data across programs and subsequently as structured forums to review gaps, identify sources of poor performance, assign responsibility, and follow up on resolution.*

STRENGTH OF EVIDENCE: **STRONG** 

DESIGN	Monitoring and accountability were designed as a data-to-action cycle linking TA-generated evidence to routine performance review at every administrative tier. TA providers were expected to produce and regularly disseminate data packs of key RI performance indicators, disaggregated to the union council, district, and provincial levels. These data would anchor monthly review meetings convened at the town, district, and provincial levels, bringing together RI actors—including vaccinators, supervisors, and district managers—to interrogate performance data, diagnose bottlenecks, co-develop solutions, and track implementation of agreed actions. Frontline actors, particularly vaccinators and town-level supervisors, were to receive hands-on support in interpreting and acting on the data, positioning these forums as joint accountability and learning platforms rather than reporting exercises. The cycle would close through the use of data to inform decisions, populate issue trackers, escalate unresolved items to higher tiers, and motivate performance improvement, with particular attention to low session attendance, defaulter tracking, and coverage gaps. This approach was initiated in Sindh. Partners then worked to extend these practices to Balochistan and Khyber Pakhtunkhwa, adapting them to each province’s existing provincial monitoring units and facility-level review structures.
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RESULTS	Structured on-site monitoring drove rapid, sustained gains in facility readiness: Monitoring field visits to each EPI facility in Sindh improved key supply-side inputs, including the availability of coverage charts, defaulter lists, and adverse event following immunization kits. Town-level accountability routines resolved 88 percent of EPI bottlenecks between 2023 and 2024, convening EPI vaccinators, community-based vaccinators, area and town supervisors, community mobilizers, and lady health workers. Accessible data packs summarizing vaccinator-level coverage and supply data enabled faster root-cause identification and more specific corrective action and were associated with short-term coverage gains across Karachi super high-risk union councils of 3 to 9 percent (2023 to 2024).
FACILITATORS	• Improved coordination and follow-up: Frontline staff credited better communication, follow-up, and greater empowerment to raise concerns, alongside more structured problem-solving. • Legible vaccinator-level data: Simple data packs made performance drivers visible to town-level actors. • Structured data review forums: Meeting records documented sessions of up to two hours, multicadre participation, and more than 20 action items per meeting.
CHALLENGES	• No escalation mechanisms: Downstream accountability did not translate into system-wide responsiveness; issues requiring district or provincial action were delayed or left unresolved. • Punitive use of data: Contract terminations, salary withholding, and pay reductions undermined data integrity and likely drove falsification, which was evident in implausible coverage spikes (exceeding 100 percent) and inconsistencies between coverage and supply. • Eroded joint accountability: Overemphasis on town-level data shifted review forums toward contesting reported results rather than resolving problems. • Unable to replicate and scale: Gains were not translated upward within Sindh, nor replicated in Balochistan and Khyber Pakhtunkhwa, in part because existing structures did not support the same routine data review.

RECOMMENDATIONS

- **Reframe monitoring investments as performance management systems.** Funders and partners should position these investments as strengthening performance management rather than “third-party monitoring,” a term that carries connotations of external, potentially punitive oversight. Framed this way, the systems more readily enabled frontline workers and other delivery actors to use data to inform decisions and improve performance.
- **Invest in timely, actionable, and complementary data.** Donors should continue to support data partners that generate granular, actionable data, complementing existing HMIS, avoiding duplication where government systems already function well, and engaging government early on data ownership and sustainability. Monitoring of outreach (to verify coverage and locate geographic gaps) and community feedback mechanisms (to track demand-side drivers as interest waned and dropout rose) emerged as particularly valuable complements.
- **Codesign data systems with end users and strengthen capacity for sustained use.** Data partners should co-develop systems with intended end users from the outset, defining clear use cases and applying human-centered design to refine them iteratively. End user engagement and capacity strengthening—hands-on coaching, collaborative data review, and peer mentoring—should be embedded throughout implementation to support consistent data use, recognizing that this capacity took years to build, not months.
- **Strengthen supervision so it is driven by data use.** Immunization programs should move beyond periodic review meetings toward more continuous data review and validation, and toward need-based facility visits that respond to emerging issues rather than fixed-interval supervision. Where feasible, data collection should be embedded within the supervision system rather than run through parallel external processes—recognizing that this depends on a functional supervision structure being in place.
- **Plan early for sustainability and transition.** Data partners should develop sustainability and transition plans from the outset, focused on institutionalizing data processes, tools, and capacity within government systems. This includes aligning with national systems, building local ownership, and engaging government or relevant authorities early on data ownership to plan DHIS2 interoperability—so that partners can step back without compromising coverage or data quality.

Well-resourced partnership models that pair technical partners with complementary skills enable immunization service delivery in hard-to-reach and previously inaccessible communities. However, in resource-constrained environments, sustaining these models becomes challenging, especially in the absence of multiple funders and careful transition planning.

In complex fragile and humanitarian settings, no single actor can meet the rapidly evolving needs of crisis-affected communities. Interorganizational partnerships pool diverse and complementary capabilities, increasing the likelihood of achieving outcomes that would be difficult for a single organization. The LC found partnerships to be instrumental in enabling service delivery in previously inaccessible and hard-to-reach geographies in Afghanistan, the DRC, Pakistan, and Somalia, leveraging local partners for access and trust, international nongovernmental organizations for operational agility, and specialist partners for data and community engagement. However, such partnerships proved difficult to replace as funding declined.

In countries where partners directly delivered services, coordination among organizations with diverse but complementary skills was what overcame barriers in unstable and inaccessible communities. No single organization held all the capabilities needed to reach fragile or previously inaccessible areas; success depended on assembling partners with complementary strengths and coordinating them, so their efforts reinforced rather than duplicated one another. In **Somalia**, this model enabled service delivery in previously inaccessible areas and increased uptake of vaccines and integrated services. However, early indications suggest that moving away from it would be difficult as funding tightens. In **Pakistan**, although the program developed fit-for-purpose tools for the varying contexts across the three RISP provinces, limited coordination within and across provinces led to missed opportunities to share best practices on data use and community incentive scale-up.

In MoU settings, TA built essential financial and performance management capacity, but without a transition plan reliance on TA persisted. TA strengthened capacity in core functions such as financial and performance management, but absent an explicit transition plan, country partners consistently reported that TA would still be needed to sustain these functions despite investment in their own capacity. In the **DRC**, to revitalize the immunization system, the Gates Foundation signed three provincial MoUs to support the Mashako Plan and engaged seven TA partners, each with a specialized function: McKing Consulting Corporation (political advocacy and coordination), Acasus (data systems), GRID3 (automated microplanning), the Kinshasa School of Public Health (coverage surveys), VillageReach (supply chain), University of California, Los Angeles (evaluations), and PATH (advocacy and financial management). Despite assuming these responsibilities, provinces remained reliant on externally funded, embedded TA to offset human resources shortages, manage turnover, and reinforce accountability. TA handover was uneven across provinces, pointing to the need for province-specific rather than uniform transition timelines.



RECOMMENDATIONS

- **Name and value nontraditional partner contributions.** The Gates Foundation’s ability to engage new and nontraditional partners—a comparative advantage over bilateral and multilateral donors bound to work through government systems—let the partnership navigate political sensitivities and reach conflict-affected communities. Donors and lead partners should recognize the access, neutrality, and operational agility these partners bring as distinct, deliberately resourced contributions, not as residual capacity to be absorbed when budgets tighten. Funders and partners should formally and consistently include local partners in decision-making, planning, and learning structures from the outset, treating them as equal partners rather than subcontracted implementers.
- **Build transition planning with realistic capacity assessment.** As partnerships streamlined, they assumed remaining partners could absorb expanded monitoring, data, and community engagement roles—an assumption that early evidence suggested was overly optimistic and a risk to continuity. Before shifting responsibilities, the Gates Foundation and implementing partners should assess each remaining partner’s capacity and bandwidth and develop a transition plan with tailored capacity strengthening, clarified roles, and dedicated resourcing to ensure successful handover.

CONCLUSION

Where outcome measures are available in the RISP geographies, improvement is noticeable but uneven. Several provinces and border regions posted gains in coverage for the third dose of the pentavalent vaccine and reductions in zero-dose children, whereas others saw only modest change. The relationship between RISP investments and outcomes was not consistent. For example, in the DRC’s Tanganyika Province, coverage gains were strong, but government cofinancing was not fully dispersed. This is an important reminder that contextual factors and intervention intensity and quality are also important factors driving outcomes, in addition to funding and disbursements. The [RISP LC country case studies and thematic briefs](#) provide further details on how and why interventions contributed to observed changes. Financing commitments also grew substantially, particularly through cofinancing MoUs that secured first-time government commitments to RI, but disbursement lagged behind commitment in several countries, showing that securing political will is not the same as securing fiscal follow-through. There were also important limitations noted in expectations versus the reality of areas’ capacity to generate resources to contribute to those commitments. Where the RISP LC’s mixed-methods approach was applied most intensively, it generated rich, mechanism-level evidence on how and why specific models, including multipartner delivery ecosystems, integrated and tailored service platforms, and adaptive data systems, contributed to improved RI performance. Key insights and recommendations from the RISP LC will help with future planning and to mitigate some of these observed challenges in the future.

¹World Health Organization. *Vaccines and immunization*. Accessed August 11, 2026.
<https://www.who.int/health-topics/vaccines-and-immunization>

²Gavi, the Vaccine Alliance. *Mission & vision*. Accessed August 11, 2026.
<https://www.gavi.org/our-alliance/about>

³World Health Organization. *Immunization coverage*. Accessed August 11, 2026.
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