Context-specific strategies for reaching zero-dose children

Reaching zero-dose children requires strategies tailored to specific contexts and barriers. The barriers these children and their caregivers face vary dramatically across settings from social fragmentation in urban slums to infrastructure challenges in remote areas and supply chain disruptions in conflict zones. Success demands innovative solutions that combine community engagement, health systems strengthening and technological innovations, carefully adapted to local contexts. The following examples highlight context-specific strategies for reaching zero-dose children.

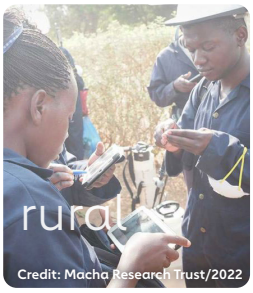
Success of extended clinic hours in Bangladesh urban slums

In Dhaka, urban poor populations have limited access to routine immunisation services. However, a 2010 pilot study combining extended clinic hours, vaccinator training, active surveillance and community engagement increased full immunisation rates from 43% to 99% over 12 months.[1] Since 2024, clinics like Surjer Hashi in Adabor began weekly evening sessions (Mondays, 4–8 pm) alongside regular morning clinics. These sessions attract 20–30 children weekly versus 15–20 during regular hours.

[1]https://pubmed.ncbi.nlm.nih.gov/24631083/

Reaching Every District (RED) plus geospatial modelling in Zambia

Zambia addressed low rural immunisation coverage through the RED strategy, using enhanced district microplanning with geospatial models, improved community health worker engagement and community mapping of unvaccinated children. Combined with supportive supervision and community dialogue, rural outreach campaigns achieved 98.9% coverage among identified measles zero-dose children: 73.3% during mass campaigns and an additional 25.6% through targeted follow-up sessions.[2]



[2]https://pmc.ncbi.nlm.nih.gov/articles/PMC8719156/pdf/bmjgh-2021-007479.pdf

Chad's integrated animal-human health strategy delivers vaccines to nomadic families

Pastoralists face barriers to accessing routine immunisations due to constant mobility and remote locations, resulting in low vaccination coverage. Chad's joint mobile teams of health workers and veterinarians provided simultaneous childhood and livestock vaccinations to nomadic pastoralists along migration routes using solar-powered cold chain equipment, increasing childhood immunisation coverage by 60% over three years, with measles vaccination rising from 35% to 78%.[3]

[3]https://pmc.ncbi.nlm.nih.gov/articles/PMC2725911/#:~:text=Conclusions,to%20endemic%20and%20epidemic%20diseases

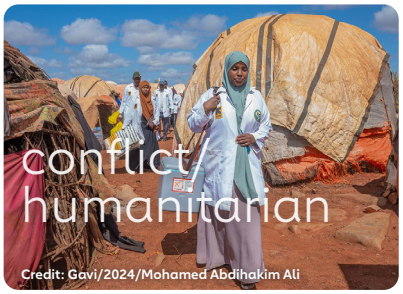
Emergency outreach post-earthquake and monsoon response in Nepal

Nepal's post-2015 earthquake and monsoon flooding response used mobile immunisation teams, helicopter-delivered vaccines and temporary vaccination sites in displacement camps to reach zero-dose children.[4] By 2016, the Nepal Demographic and Health Survey found that 78% of children aged 12–23 months were fully immunised.

[4]Nepal Ministry of Health and Population, "Post-Earthquake Health Sector Recovery Plan 2015–2020

Scaling immunisation in fragile settings across the Sahel

Through the REACH consortium, Gavi's Humanitarian Partnerships (ZIP) uses GIS-enabled microplanning, flexible service delivery models, local vaccinator training, strengthened cold chain logistics and community engagement to deliver vaccines in conflict zones. ZIP has administered over 9 million vaccine doses, achieved 96% community access rates and 985,000 children received DTP1, including 376,000 who got it after their first birthday.[5]



[5]https://www.gavi.org/news/media-room/9-million-vaccine-doses-administered-children-living-humanitarian-settings-horn-africa

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