

GAVI EQUITY PLAYBOOK

A practical guide for equity-focused immunization programming under Gavi 6.0

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How to use this playbook

This playbook is a practical guide for immunisation programme managers at the national and subnational levels, health systems planners, and country teams seeking to integrate equity into immunisation programming. It outlines key considerations for programme planning and implementation and provides a step-by-step guide based on the IRMMA framework (Identify, Reach, Monitor, Measure, Advocate) to support action at each stage of the immunisation journey. It builds on learnings from tools and guidelines for immunisation and zero-dose programming, to ensure more focused equity considerations in country holistic plans and should not be used in isolation.

This playbook should be read alongside Gavi's Programme Funding Guidelines (PFGs). It complements the PFGs by helping countries apply an equity lens throughout programme design, implementation, and review. Drawing on the flagship interventions outlined in the PFGs, it highlights approaches and actions that can help address immunisation inequities and includes case studies from Gavi 5.0 to illustrate options of what worked, what did not, and key lessons learned.

As countries move into Gavi 6.0 with tighter funding envelopes, making deliberate choices about where and how to invest resources will become increasingly important. While the examples in this playbook can help inform those decisions, countries should further use the prioritisation guidance in the PFGs (Annex 1) to assess and prioritise investments based on their context, needs, and available resources. The key considerations in this playbook can help ensure that equity remains central to those decisions. Making the right trade-offs means choosing explicitly: concentrate resources in the highest-gap areas rather than spreading them evenly; invest in outreach for the hardest-to-reach rather than expanding services for populations already near care; choose demand generation where supply is adequate, or supply-chain improvements where delivery is the binding constraint; and work through CSOs or community partners where government services cannot reach. Every choice about where to invest is also a choice about who gets reached, those decisions should be driven by evidence of where children are being missed and why.

Introduction

Over the past two decades, Gavi-supported countries have immunised more than 1.2 billion children and averted over 20 million future deaths.[1] However, there are still gaps in equitable coverage and many children continue to remain unreached. **The children who are missed are not randomly distributed;** they are concentrated in specific places and populations, and excluded by clear, identifiable barriers such as remoteness, inconvenient service hours, ethno-cultural and language gaps, and the costs of access, among other characteristics. These children are not merely being missed by immunisation programmes only; **they are being systematically excluded from the broader primary healthcare system,** putting them at higher risk of death from preventable diseases and other deprivations.

[1] Gavi, the Vaccine Alliance, “Our impact”, gavi.org

As countries move forward in planning for the Gavi 6.0 strategic period, there is an opportunity to **make equity an operational and strategic priority, embedded into** planning and implementation. While equity will look different across countries depending on their epidemiological profile, health system, and population needs, the common objective is to ensure that underserved populations are protected against Vaccine Preventable Diseases (VPDs) and outbreaks. In many settings, this will mean extending the full immunisation schedule to zero-dose children and missed communities who are not currently reached at all. In others, where zero-dose levels are already very low, the same goal is pursued by sustaining reach, reducing dropout, and addressing persistent inequities among underserved populations.



Sources: Gavi 6.0 Strategy; WHA update 2026

The Immunization Agenda 2030 highlights that the goal of equity is that:

> ***"Everyone is protected by full immunization, regardless of location, age, socioeconomic status or gender-related barriers".***[2]

In 2026, the "Leap Into Gavi 6.0" Workshop described equity as follows:

> ***"Equity in immunisation means systematically identifying and reaching un-immunised (zero-dose) and under-immunised populations - especially those in fragile settings and pockets of exclusion - across routine services and campaigns, so that everyone receives a full course of vaccines".***

Equity in immunisation entails the provision of targeted, differentiated (& sometimes integrated) services so that vulnerable children and communities are given a fair chance at achieving the same immunisation and health outcomes. It involves addressing barriers, such as gender, that determine who is reached, who makes vaccination decisions, and who delivers services.

Example of Differentiated Services

A fixed clinic open from 9 a.m. to 3 p.m. offers equal access in theory, but for working mothers who cannot leave their shifts, it is deeply inequitable. Therefore, incorporating equity would entail working towards extending clinic timings beyond 3 p.m., such that working mothers are able to receive the care they need after their working hours.

Key Considerations for Equity-Focused Programming

[2] The IA2030, which establishes 'coverage and equity' as one of its seven strategic priorities, defines it as: "*everyone is protected by full immunization, regardless of location, age, socioeconomic status or gender related barriers*".

To integrate equity into immunisation programming cycles, countries should incorporate and adapt the following considerations as per their unique context and health system realities. These five considerations are cross-cutting principles to hold in view when making planning choices. They are distinct from the IRMMA framework in the next section, which sets out the step-by-step process for applying them.



1: Disaggregate data and use it to make decisions

To identify and reach missed populations, use disaggregated data at the lowest practical level to guide decisions and adapt strategies. National coverage averages often mask inequities, making it difficult to identify the underserved population; therefore, making more regular routine implementation monitoring and course correction essential. Combine quantitative data on *who* is missed and *where* they are (coverage broken down by district, community, wealth, and gender) with qualitative evidence on *why* they are missed - drawn from community dialogue, front-line worker insights, and behavioural and social driver assessments. Data should inform decisions at every level; therefore it is important to equip frontline workers with simple tools to collect and use data, train them on how to use them and why data is important, establish regular review processes, and adjust strategies and course correct activities when data shows that populations are being missed. In humanitarian and conflict-affected settings where connectivity is a challenge, use simple offline-capable tools and revise targets frequently, using bottom-up approaches.



2: Address multiple deprivations through integrated service

To reach missed children, integrate immunisation with primary healthcare, nutrition, and maternal and newborn health services where practical, from the planning phase to implementation. Zero-dose children often face multiple barriers to accessing care, so immunisation alone is rarely enough. Delivering services together can address several needs at once, make it easier for families to access care, and strengthen links with the health system.



3: Design programmes alongside communities, tailored to their needs

To improve access and increase uptake among missed populations, co-design services with the families, communities, women-led organisations, and local leaders at the centre, addressing the needs and socioeconomic and gender-related barriers specific to them. Use behavioural insights from interviews and discussions with caregivers and communities to understand the factors that drive acceptance, such as trust, past service experience, fear of adverse effects (including minor ones), misinformation, and gender barriers. Adopt a whole family approach to children's health, involving not just primary caregivers but also other family members (e.g. older siblings, grandparents). Because gender shapes access, uptake, and equity at every level, identify where gender-related barriers such as mobility, time, and decision-making power prevent vaccination. Engage male leaders and caregivers, female vaccinators, community health workers, and women in programme leadership.



4: Ensure reliable last-mile delivery, especially in fragile and humanitarian settings

Most zero-dose children live in remote areas, urban informal and temporary settlements, mobile communities, and fragile and conflict-affected settings. Reaching these children likely requires sustained outreach and mobile services built to address distance, insecurity, and population movement; integration with other

primary health services; supply chains that extend to the final delivery point; and delivery through actors who can actually reach the community - including CSOs and humanitarian partners with existing access and trust where government services cannot operate.

5: Build political commitment, champions, and accountability for equity

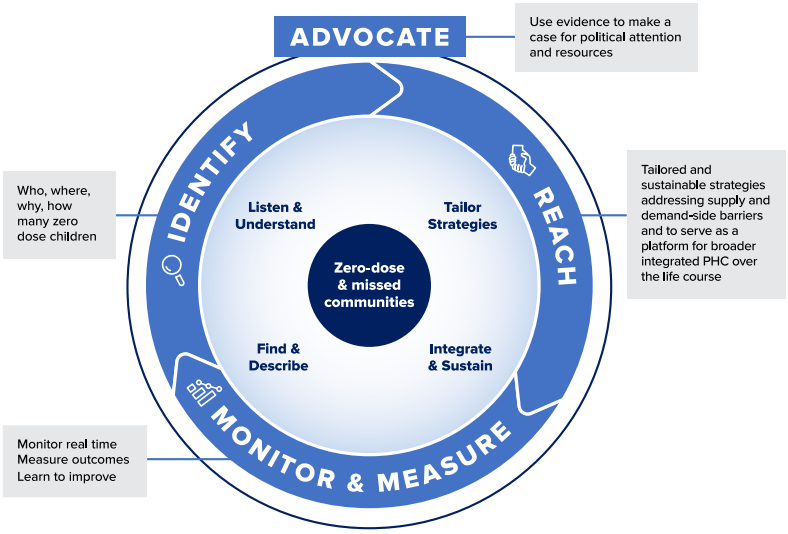
To sustain equity gains, secure political ownership on activities that focus on zero-dose and missed communities, proactively engage equity champions in immunisation programming, and put in place the right accountability mechanisms. Without this, well-designed interventions remain short-lived pilots. Secure explicit prioritisation of zero-dose and missed communities in national and subnational plans and budgets, cultivate champions such as ministers, governors, legislators, traditional and religious leaders, and put accountability mechanisms in place, such as reviewing coverage targets in performance routines, scorecards, and budget tracking. Advocacy is what converts technical solutions into sustained financing and action.

Key partners to engage!

- **Core partners** – the programme's primary immunisation delivery partners, typically the Ministry of Health and its EPI, WHO and UNICEF
- **Expanded partners** – additional actors that extend reach into missed and underserved communities, for example:
  - Government (other health departments) – IT boards/HMIS/M&E, disease surveillance, MNCH, Nutrition, community health
  - Government (other departments) – national statistics office, civil registration, population census, planning, local government, social protection
  - Civil society and community actors – local CSOs, women's groups, religious and faith-based organisations, traditional community leaders
  - Humanitarian Organisations
  - Academic and research institutions – schools, universities

Step-By-Step Guide for Equitable Programming

The IRMMA framework, introduced by the Alliance in Gavi 5.0, helped countries adopt a structured approach to the immunisation journey to reach zero-dose and under-immunised children and identify interventions to address equity gaps. As countries move into Gavi 6.0 with tighter funding envelopes, this framework provides an opportunity to revisit the immunisation journey through an equity lens, reflect on what worked, what did not, and which interventions were most effective in reaching missed populations. This section uses the IRMMA framework to help countries design, implement and prioritise actions and investments that can accelerate progress towards closing immunisation gaps.



Element	What it does	What you should produce
Identify	Find out how many zero-dose and under-immunised children and communities exist, where they are and why they have been missed.	Priority populations table (3–5 groups, binding barrier and evidence for each)
Reach	Design or adapt context-specific strategies that address supply- and demand-side barriers while applying a gender lens to sustainably reach missed communities	Strategy prioritisation table linking each population to an intervention (or integrated bundle) and type of service
Monitor	Track whether strategies are reaching the populations they were designed for, and document insights to continuously learn and improve implementation	Monitoring matrix (implementation and coverage indicators, source, review frequency)
Measure	Determine whether strategies are changing outcomes for the missed	Measurement dashboard (equity target, baseline, current value, effectiveness) per population
Advocate	Turn evidence into sustained political commitment and domestic financing	Advocacy plan (strategy, decision sought, decision-maker, evidence, timeline)

Identify: Find the children who are being missed, and understand why

This section provides five guiding questions to support this identification process. The goal is to **identify a list of 3-5 priority populations or contexts** (see table below) along with the binding barrier faced by each, so that these populations may be targeted with differentiated services based on their respective barriers. Please note that these questions remain relevant even in countries with few zero-dose children or limited underserved populations. However, they should be adapted to reflect each country's unique context and equity challenges.

Example of List of Priority Populations:

Priority population	Location	Estimated size	Barrier	Evidence source
Working caregivers in urban slums	Dhaka North	~40,000 children	Clinic hours misaligned with work schedules	HMIS, BeSD survey 2024, FGDs/KIIs with caregivers

Guiding questions

Q1. Where are the pockets of zero-dose and under-immunised children in your community located (at the lowest administrative level your data allows)?
Drill down to the lowest administrative level your HMIS data allows (e.g., district, ward, community). Cross-reference coverage data with other data sources, such as household surveys, disease surveillance, and post-campaign coverage surveys, to identify which communities are persistently missed. Name them explicitly in your programme plan.
→ **Case Study: Bangladesh (E-screening), Zambia (GIS mapping)**

Q2. What patterns are observed among missed children, and are any population groups disproportionately represented? Profile missed children by their characteristics (geography, livelihood, gender, displacement). Draw on data sources that immunisation programmes do not always use routinely, such as gender analyses, humanitarian and displacement data, poverty and equity assessments, and civil registration records. Design your response around these patterns, not just the total number.

Characteristics	What to look for	Example groups
Geography	Where missed children concentrate spatially	Remote, peri-urban, or conflict-affected areas
Livelihood	Household economic activity that shapes access	Pastoralist, migrant, ethnic minority, or informal-economy households
Gender	How gender constrains who is reached	Children of caregivers with limited mobility or decision-making power
Displacement	Mobility and instability that disrupt coverage	Cross-border refugee or internally displaced populations

Q3. How well does administrative coverage data align with survey and surveillance data, and where do the gaps lie? Map the gaps between administrative data, surveys, disease surveillance, and frontline insight. These discrepancies might signal where coverage is being over-reported or where populations have fallen off the recording system entirely.

Surveillance data and recent VPD outbreaks can also inform targeting, pointing to where immunity gaps are already translating into disease.

Q4. For each priority group, what is the binding barrier (or barriers) to vaccination? Find the barriers and root causes[3] that, if removed, would unlock the most vaccinations. Prioritise barriers by scale (number of children affected), decisiveness (how completely it blocks vaccination), and evidence (what barrier, when removed in other instances, proved most consequential). Design your intervention against that barrier first.
→ **Case Study: Bangladesh (evening sessions)**

Q5. What is your evidence base for those barriers? Specify your evidence base (surveys e.g., MICS/NICS/DHS (Multiple Indicator Cluster Surveys, National Immunisation Coverage Surveys, Demographic and Health Surveys), coverage and equity assessments or commissioned evaluations, targeted focus group discussions (FGDs), Key Informant Interviews (KIIs), social listening, frontline worker insight). Where you lack data, collect it from caregivers and communities before designing interventions. Assumptions and anecdotes will lead to misdirected strategies.

Where this fits in your Gavi 6.0 programming

Gavi's PFGs identify flagship interventions across Demand Generation and Data, as well as microplanning interventions under Service Delivery, to strengthen identification. These interventions are likely to vary by context: transition phase, fragile settings, or humanitarian response, and coverage. Prioritise knowing why children are missed, not just where. Mapping tells you who to target, while analysis of barriers tells you how to reach them. With constrained budgets, choose identification activities that generate the most actionable data for designing equity strategies. Some examples of trade-offs that countries could face are door-to-door hotspot mapping in priority districts vs. improving HMIS data quality for broader coverage; social listening and community consultation vs. digital GIS mapping equipment; deep barrier analysis in selected high-zero-dose areas vs. a lighter-touch survey across more districts.

What identification activities are appropriate for your context will also depend on coverage and zero-dose prevalence in your country. For example, countries with a high overall coverage rate might be better served by mapping remaining pockets of zero-dose; countries with low coverage might need to focus on improving their understanding of social barriers and misinformation, while countries with high dropouts might need to improve tracking of under-immunised children.

Flagship interventions to strengthen identification

Investment Area	Flagship Interventions	Key considerations for programming	Guiding Questions
2. Demand Generation	ii) Strengthen country capacity to collect, analyse, and use social and behavioural data to better target interventions	• Are behavioural indicators embedded in routine surveys?	**Q4, Q5**

[3] Refer to Appendix 3 of the ZDLA LxD module for processes and tools to help identify barriers and root causes

		• Are populations with coverage gaps prioritised for behavioural data collection? • Do staff at the sub-national level have capacity to analyse behavioural data and identify barriers (gender related or others) for missed populations?	
6. Data	1.A Strengthen and sustain digitally enabled national data systems to improve routine data collection and management.	• Does your HMIS collect data at the lowest geographical unit? • Does your HMIS collect real-time and accurate coverage data? • Are you integrating census and demographic data in your HMIS for better identification of low coverage areas?	**Q1, Q2**
	1.B Support innovative measurement activities to supplement national data systems to fill data gaps and strengthen implementation monitoring.	• Are you conducting targeted periodic surveys to triangulate and supplement routine coverage data? • Are you conducting LQAS/RCAs in missed populations to identify hotspots? • Does your HMIS leverage AI and GIS tools for accurate mapping of missed communities?	**Q1, Q3, Q4**
	2.B Strengthen subnational data analytics and capacity to generate timely and quality data for periodic data-driven performance reviews and decision-making	• Does staff at the subnational level have data analysis skills for rapid identification and tracking of zero-dose hotspots? • Is data analysis effectively being used to identify zero-dose hotspots and dropouts?	**Q1, Q2**

Initial Self-Financing: Gavi can support a broad range of equity diagnostic activities such as coverage surveys disaggregated by population group, BeSD measurement focused on missed communities, and GIS infrastructure to map zero-dose hotspots. Technical Assistance (TA) for innovative identification tools (e.g., AI-assisted mapping, enumeration of displaced populations) is eligible. Use this phase to build the analytical foundation for equity-targeted programming, and embed disaggregated identification data in national data systems from the start. Plan clearly for how these systems will be sustained as Gavi support decreases.

Preparatory Transition: Shift towards embedding equity identification in domestic systems. Prioritise building surveys on demand and barriers to vaccination (e.g. BeSD surveys) into national surveys with gender and equity-focused analysis, strengthened HMIS disaggregated to the lowest administrative level, and MoH analytical capacity to identify and act on coverage gaps. Standalone diagnostic studies without a handover plan are increasingly ineligible.

Accelerated Transition: Most ongoing identification tools should be funded and run domestically. Gavi support is most appropriately used for catalytic improvements such as innovative methodologies, one-off deep-dives in new contexts, or capacity strengthening that has a defined endpoint.

In fragile and humanitarian (F&H) settings

Standard diagnostic tools may not be safe, feasible, or sufficient in F&H settings. The Gavi 6.0 F&H approach prioritises:

- Ensuring that displaced populations, including refugees, are systematically considered and included within the national immunisation programme
- Simplified offline-capable / mobile-based data collection tools (with offline data sync where connectivity is unreliable)

- Time-limited technical assistance support for hardware, platform, and software customisation, with parallel investment in sustainability planning
- Community-based surveillance and identification systems alongside (not in place of) traditional approaches
- Coordination with humanitarian actors and CSOs who often hold the best operational knowledge of displaced and mobile populations
- Extending catch-up identification to children up to age 5, not just under-2s, in line with the F&H age extension

Reach: Design and deliver services that meet missed populations where they are

This section provides **five guiding questions** to design specific strategies for your priority populations. The goal is to ensure interventions reach each priority population, that they address the barriers these groups experience, and that they are selected for feasibility, cost, and Gavi 6.0 alignment (see table below). These choices are where trade-offs become concrete: with constrained resources, deciding which populations to address first and which barriers to address requires prioritising equity.

Examples of Targeted Interventions:

Priority population	Barriers	Strategy	Flagship link
Working caregivers in urban slums	Clinic hours misaligned with work	Evening EPI sessions (3–7 PM)	Service Delivery ii (extended hours)

Guiding questions

Q1. For each priority population (see question 4 in Identify), what strategy directly addresses the barrier faced? Design strategies for each priority population that directly address their barriers. Multiple interventions may be necessary where compounding barriers exist. Co-design interventions with communities to ensure strategies are feasible and address real needs.[4]
→ **Case Study: Bangladesh (evening sessions)**

Q2. Have you adapted your service delivery approach to the populations you are serving, or are you using the same model everywhere? Standard models miss certain groups by design. Service delivery models should be adapted so that the specific context determines who delivers, where, when, and how (mobile teams, flexible schedules, insecure area protocols).
→ **Case Study: Kenya - Turkana (Chanjo Mashinani)**,

Q3. Do your demand-generation activities target a specific reason people are not vaccinating, or are they generic? Target demand-generation activities to the specific barrier, such as low awareness, gender norms, or fear of side effects. Generic campaigns are unlikely to impact coverage. Where possible, use human-centred design (HCD) with the communities themselves to ensure activities genuinely meet their needs. **DRC, Lesotho, Nigeria (Tailored Incentives)**

Q4. Are you considering gender in the design of all strategies, or only in a few gender focused ones? Integrate gender analysis into all strategies. Examine how decision-making

[4] Refer to Appendix 3 of the ZDLA LxD module for Human Centred Design (HCD) tools to co-create strategies with communities

power, mobility, access to information, and preferences vary by gender. Strategies that ignore these differences will miss their targets.
→ **Case Study: Bangladesh (evening sessions), Comoros (women's groups)**

Q5. Have you integrated immunisation with other services that caregivers value, or is it a standalone offer? Integrate immunisation with other services caregivers already value: nutrition, maternal health, growth monitoring. This reduces visit costs, creates repeated contact points, and improves uptake.
→ **Case Study: Cameroon (integrated services)**

Where this fits in your Gavi 6.0 programming

Gavi's PFGs identify flagship interventions across Service Delivery, Demand Generation, and Supply Chain to reach zero-dose children and missed communities. These interventions should be adapted to each country's coverage, transition phase and context, including fragile and humanitarian settings. Cost-benefit analysis of your Gavi 5.0 strategies is essential for choosing interventions based on their equity impact with reduced cash in Gavi 6.0. Examples of trade-offs that countries face could be: targeted outreach in missed communities vs. expanding health facility networks; training existing staff in interpersonal skills vs. hiring additional vaccination staff.

The scope, relevance, and prioritisation of your activities will also vary depending on your country's immunisation profile. For example, countries with a high overall coverage rate might benefit from strengthening their fixed sites to maintain coverage; countries with low coverage might need to focus on targeted outreach, while countries with high dropout rates need to increase uptake by strengthening follow-up and improving caregiver experience.

Investment Area	Flagship Interventions	Key considerations for programming	Guiding Questions
1. Service Delivery	i) Accelerate integration of immunisation and other PHC services at the last mile, prioritising zero-dose and missed communities	• Are immunisation activities integrated with other PHC services at the lowest level? • Is your frontline staff trained in providing integrated services? • Do you have mobile outreach models offering integrated services to inaccessible locations?	**Q1, Q5**
	ii) Improve service quality to drive a better experience at vaccination touchpoints, reducing zero-dose and drop-out	• Are you collecting data on caregiver experience with frontline services? • Are your frontline staff trained in interpersonal skills? • Have you deployed digital tools to enhance experience, reduce waiting times? • Have you adapted your service delivery strategies based on the needs of priority communities? • Are health workers optimally deployed to meet requirements in areas with equity gaps?	**Q2**

Investment Area	Flagship Interventions	Key considerations for programming	Guiding Questions
	iii) Strengthen integrated microplanning and extend and expand immunisation to reach un- and under-immunised children, including older age groups	• Does your microplanning incorporate targeted strategies to cover zero-dose hotspots? • Have you deployed strategies such as extended opening hours, increasing service delivery points to cover equity gaps?	**Q2, Q5**
2. Demand Generation	i) Scale up community engagement with digitally enabled demand generation to encourage caregivers in missed communities and reduce drop-out	• Is your demand generation strategy and messaging tailored to address barriers in your priority populations? • Do your demand generation strategies address gender and social norms?	**Q3, Q4**
5. Supply Chain	Expand, extend, and replace cold chain and critical immunisation supply chain infrastructure supporting PHC, particularly at the last mile.	• Is your cold chain storage, transport adapted to reach the last mile in areas with accessibility, electricity, internet connectivity challenges? • Is your cold chain equipment (CCE) integrated with other primary health care (PHC) infrastructure?	**Q2, Q5**

Initial Self-Financing: Gavi can fund recurrent equity-focused delivery - extended outreach, mobile teams, gender-responsive and integrated service delivery targeting zero-dose communities. The mandatory 10% cash budget allocation for CSOs, which applies across all transition phases, is a floor, not a ceiling: use it to fund women's groups, faith-based organisations, and CBOs that reach communities the government system misses. Plan for how the operational costs of reaching the hardest-to-reach will be sustained as co-financing obligations rise.

Preparatory Transition: Reduce reliance on Gavi for recurrent delivery costs while protecting equity gains. Invest in system-strengthening reach strategies such as institutionalisation of CHW programme and integrated planning structures that embed equitable delivery in national systems rather than reliance on Gavi-funded projects. The 10% CSO guardrail remains critical for gender-responsive, community-level demand generation and last-mile delivery in missed communities.

Accelerated Transition: Direct service delivery is generally ineligible except for only targeted outreach in zero-dose and under-reached populations. Equity-focused reach in the hardest communities is one of the last areas where Gavi operational support applies at this phase, so use it deliberately. CSO funding through the 10% guardrail remains available for gender-responsive community engagement where the government system does not reach.

In F&H settings

Priority activities to reach missed communities in F&H contexts include:

- Integrate vaccination with gender-responsive and emergency health services
- Adapt service delivery for privacy, acceptability, and safety for women and adolescent girls
- Engage women's and girls' organisations in community monitoring and accountability
- Update microplans during emergencies to align with preparedness and response plans
- Coordinate with NGOs and humanitarian actors where government engagement is limited
- Develop tailored delivery models for displaced, nomadic, and transit populations using mobile teams and transit-point vaccination centres

- Apply security-sensitive, community-led approaches in insecure areas
- Equip humanitarian partners with cold chain and logistics support to extend services in hard-to-reach settings

Monitor: Track whether your strategies are reaching the populations you designed them for

This section provides **four guiding questions** to design a monitoring system for your equity strategies. The goal is to produce a monitoring table (see table below) with an implementation indicator, a data source, and a review frequency for each strategy targeting priority populations. Monitor answers one question: are we doing what we planned? The next step, measure, asks whether it is working.

Example of Monitoring Matrix:

Strategy	Implementation indicator	Coverage indicator	Data source	Review frequency
Evening EPI sessions	Sessions held / planned	Children vaccinated per session	Session register + DHIS2	Monthly district review

Guiding questions

Q1. Are you tracking implementation, not just coverage outcomes? Regularly track implementation indicators (disaggregated by sex) such as sessions held versus planned, communities visited, populations targeted. These are also among the key indicators in the Grant Accountability Framework (GAF), which under Gavi 6.0 provides the structure for grant monitoring and accountability, so tracking them here helps make the GAF a driver of regular data review and course correction. Frequently available data on these indicators at the highest level of disaggregation will help identify what is working before you see actual changes in coverage, enabling early course correction.
→ **Case Study: Pakistan, Sindh (vaccinator tracking)**

Q2. Is your monitoring data regularly reaching the people who can act on it? Enable frontline workers, supervisors, and district managers to access relevant data within days, not months. Quarterly dashboards cannot support rapid operational decisions.

Q3. When the data shows a problem, are there established mechanisms to flag it and course correct? Structure performance reviews to make decisions. Ensure the right stakeholders are present, decisions are made and implemented, progress is regularly reviewed, and accountability and course correction are embedded throughout. Reviews that only discuss numbers will not improve implementation. Use monitoring data and reviews to actually adjust your implementation when it is not going well.

Q4. Are frontline workers and community actors feeding insight back into the system, or is monitoring one-way? Establish feedback loops for field observations and qualitative

insights: integrate insights from the field on service experience issues, rumours and misinformation, logistical challenges, into your monitoring systems.

Where this fits in your Gavi 6.0 programming

Gavi's PFGs identify flagship interventions in Data and Governance to strengthen monitoring of equity-focused implementation. These interventions adapt to your coverage, transition phase and context (fragile and humanitarian settings). With constrained budgets, choose monitoring activities that deliver timely information on the implementation quality of equity strategies. Examples of trade-offs that countries could face: monitoring and supervision visits in zero-dose hotspots vs. digital equipment for data collection; district reviews on implementation progress vs. staff training in monitoring and supervision. Where digital tools are involved, strengthen and interoperate with existing national systems rather than adding parallel tools or dashboards, so that data supports timely identification, defaulter follow-up and course correction.

What monitoring activities are suitable for your country will also depend on coverage levels and zero-dose prevalence. For example, for countries with a high overall coverage rate, strengthening and integrating monitoring data systems may be a priority; countries with low coverage might focus on conducting targeted supervision visits in zero-dose hotspots, while countries with high dropout rates need to strengthen district review mechanisms to address causes of dropouts.

Investment Area	Flagship Interventions	Key considerations for programming	Guiding Questions
6. Data	2.B Strengthen subnational data analytics and capacity to generate timely, quality data for periodic data-driven performance reviews and decision-making	• Have you established a monitoring framework with clear indicators of implementation progress? • Do your data systems contain dedicated modules to gather data on implementation? • Are managers at national and sub-national level trained to analyse implementation data and do timely course correction?	**Q1, Q2**
4. Governance and Management	Flagship 2: Strengthen government capacity for planning, monitoring and performance management of immunisation at national and subnational levels	• Do you have an established mechanism for supervision visits to track implementation? • Are there established routines, (e.g. district reviews) to get insights on implementation from the frontline?	**Q3, Q4**

How this differs by transition phase

Initial Self-Financing: Invest in monitoring systems that make equity visible, such as disaggregated HMIS capturing zero-dose and under-immunised data at the lowest administrative level, subnational performance reviews, and community-based feedback mechanisms. TA for dashboards and data quality systems is eligible. The goal is to track whether equity strategies are reaching the populations they were designed for.

Preparatory Transition: Embed equity-focused monitoring in MoH operations. Subnational teams, not just central data managers, should also be able to interpret disaggregated data and act on it

without external support. TA investments must have sustainability plans. Build the analytical capacity to detect whether gaps between high- and low-coverage populations are narrowing.

Accelerated Transition: Predictive tools and AI-enabled monitoring are eligible where country digital infrastructures support them. Focus on integration with national digital health architecture, alignment with existing HMIS systems, conducting AI readiness assessments, and data quality assurance systems.

In fragile and humanitarian (F&H) settings

Standard monitoring systems often cannot operate in F&H contexts. Tailored approaches include:

- Simplified offline-capable, mobile-based tools with offline data collection capabilities
- Time-limited TA for hardware, platform, and software customisation, with budget secured for ongoing sustainability
- Community-based monitoring systems supplementing traditional surveillance
- Coordination with humanitarian actors for joint data collection and sharing
- Flexibility on reporting frequency in active conflict or emergency settings

Measure: Determine whether your strategies are changing outcomes for the missed

This section provides **four guiding questions** to assess whether your strategies are moving the needle on equity outcomes. The goal is to produce a measurement dashboard (see table below) with baseline and current values of outcome indicators, an equity target, and a strategy effectiveness assessment for each priority population.

Example of Measurement dashboard:

Priority population	Equity Indicator	Data Source	Target	Q1	Q2	Q3	Q4
Working caregivers in urban slums	Proportion of children vaccinated with DTP1.	HMIS					
Working caregivers in urban slums	Proportion of children vaccinated with DTP3	HMIS					
Working caregivers in urban slums	Under-immunised children measured by DTP1-DTP3	HMIS					
Working caregivers in urban slums	Proportion of target ZD children reached	HMIS					

Guiding questions

Q1. Have you set equity-specific targets, not just overall coverage targets? Set disaggregated equity targets such as zero-dose reduction in priority districts, dropout reduction in priority populations, and full immunisation coverage in equity reference groups (poor urban areas, remote rural communities, conflict areas). Equity progress cannot be measured by overall coverage targets alone.

Q2. Where strategies are not delivering, do you know why? Before dropping ineffective strategies, diagnose why they underperformed: were they the wrong fit for the barrier or poorly implemented, did the context change, was the target unrealistic? Use this diagnosis for mid-stream course correction.

Q3. What lessons have you documented in a form that other districts, partners, or countries can use? Document your programme learnings about what worked, what failed,

and why. Learning confined to team memory does not aid scaling and replication, whereas documentation builds a knowledge base.
→ **Case Study: Ghana (GhiLMIS)**

Q4. Is your measurement honest about what equity costs to achieve? Incorporate the real cost per child for reaching hardest-to-reach populations in equity measurements. Accurate cost estimates will help plan realistically and advocate for adequate resources.[5]

Where this fits in your Gavi 6.0 programming

Gavi's PFGs identify flagship interventions in Data and Demand Generation to measure equity outcomes. These interventions adapt to your transition phase and context (fragile and humanitarian settings). With a reduced envelope, prioritise interventions that most efficiently track equity outcomes. Examples of trade-offs that countries might face in measurement: third-party coverage surveys vs. RCAs in zero-dose hotspots; embedding coverage indicators in national surveys vs. improving HMIS for granular coverage data.

The measurement activities your country prioritises will also depend on coverage levels and zero-dose prevalence. For example, countries with a high overall coverage rate may conduct targeted immunisation surveys in remaining pockets of zero-dose; countries with low coverage might prioritise measurement of demand indicators to understand underlying barriers to vaccination, while countries with high dropout rates may need to strengthen the programme's data systems and analysis capacity to better track vaccination status.

Investment Area	Flagship Interventions	Key considerations	Guiding Questions
6. Data	1.B Support innovative measurement activities to supplement national data systems, fill data gaps and strengthen implementation monitoring	• Do you have specific coverage targets for each of your identified priority populations? • Does your HMIS collect data at the lowest possible geographical unit, to allow tracking of equity targets? • Does your HMIS function reliably, and provide timely, complete and good-quality coverage data?	**Q1**
	Flagship 3: Strengthen structured learning systems and peer-to-peer approaches through national, regional and global collaboration	• Do you have established frameworks to document learnings from successful equity focused strategies? • Do you have research activities integrated with programme implementation? • Do you compare progress in equity target against estimated costs of targeted strategies?	**Q2, Q3, Q4**
2. Demand Generation	ii) Strengthen country capacity to collect, analyse and use social and behavioural data to better target interventions	• Do you regularly collect behavioural data from your priority populations? • Are managers equipped with the necessary tools and skills to analyse demand indicators in conjunction with coverage outcomes and measure the success of demand side strategies?	**Q3,**

[5] Economics of Reaching Zero-Dose children

Initial Self-Financing: Gavi can support baseline coverage surveys, BeSD measurement infrastructure, and dedicated evaluation activities. Use this phase to set robust baselines that subsequent phases will measure progress against. Include cost of data collection from the start. Equity measurement without cost context is incomplete.

Preparatory Transition: Build domestic capacity for equity measurement. National statistical offices, MoH evaluation units, and academic partners should become the long-term home of this work. Coverage surveys integrated with broader national surveys are preferred over standalone Gavi-funded surveys.

Accelerated Transition: Routine measurement should be funded and run domestically. Gavi support is most appropriately used for catalytic measurement work - new methodologies, impact evaluations with explicit knowledge-generation objectives, capacity strengthening that has a defined endpoint. Recurrent survey funding is generally not eligible.

In fragile and humanitarian (F&H) settings

Measurement in F&H contexts requires flexibility and context-appropriate approaches:

- Rapid assessment methods (LQAS, phone surveys) where conventional surveys are infeasible
- Community-based measurement complementing traditional surveys
- Catch-up coverage measurement for age groups beyond standard targets (up to age 5 in F&H)
- Coordination with humanitarian needs assessments and cluster monitoring platforms
- Time-limited recurrent cost support where critical evaluation functions cannot be sustained otherwise

Advocate: Turn evidence into sustained political commitment and domestic financing

This section provides **six guiding questions** to build an advocacy approach that makes the case for continuous political commitment, greater involvement of local community leaders, and domestic financing based on evidence of impact. The goal is to produce an advocacy plan (see table below) that secures the resources needed to sustain equity gains beyond the Gavi support period. Advocacy is not complete when interventions are simply written into the National Immunisation Strategy, but achieves its goal when budgets are released and activities are actually delivered.

Example of Advocacy Plan:

Strategy	Decision sought	Decision-maker	Evidence used	Timeline
Evening EPI sessions	Enhance budget for additional HR to staff evening sessions	Finance ministry, MoH PS	1. Subnational budget analysis 2. HR capacity analysis 3. Impact evaluation of evening sessions	Next budget cycle

Guiding questions

Q1. Who are the specific decision-makers whose decisions would change the trajectory of equity targets, and do you have a relationship with them? Target advocacy at specific decision-makers: Ministry of Health leadership, Ministry of Finance officials, parliamentary health committees, governors, district/equivalent government leaders in charge of local budget allocations, traditional community and religious leaders. Structure advocacy bottom-up from communities through sub-national leaders to national budgets.

Q2. Are you using data as the foundation of your advocacy? Advocacy built on anecdotes or assumptions is easily dismissed. Data on equity gaps and progress (e.g., subnational coverage, zero-dose counts by district) gives decision-makers something concrete to act on and be held accountable for.

Q3. Is that data framed in the language decision-makers understand? Make the case for domestic support using data on equity gaps and priorities that is clearly articulated in a way that speaks to decision-makers. Tailor the framing, level of detail, and type of evidence to each stakeholder - fiscal implications for Ministry of Finance, programme performance for health authorities, local equity gaps for subnational leaders - rather than relying on a single factsheet for every audience.

Q4. Is your advocacy built into systems, or does it depend on individual champions? Institutionalise advocacy beyond champions: embed equity indicators in routine systems, establish joint review routines. These mechanisms ensure commitment is maintained even when leadership changes.

Q5. Are communities themselves visible in the advocacy, or only as case studies you cite? Start with community advocacy through trusted local actors such as women's groups, religious leaders and civil society organisations. Their political legitimacy often counts more than external advocacy.
→ **Case Study: Comoros (women's groups)**

Q6. Are you advocating for sustained domestic financing, or for one-off project funds? Embed equity funding in domestic budgets. Align advocacy efforts with long-term sustainability, not project timelines. **(CSO Advocacy Immunization Financing)**

Where this fits in your Gavi 6.0 programming

Gavi's PFGs identify flagship interventions in Health Financing to advocate for political commitment and domestic financing for equity. These interventions adapt to your transition phase and context (fragile and humanitarian settings). With reduced cash envelopes, advocacy for domestic financing becomes critical. Choose advocacy interventions that effectively engage the right stakeholders. Examples of important trade-offs that countries will face in their advocacy efforts: advocacy meetings with key stakeholders vs. awareness campaigns for domestic support; senior stakeholder engagement (MoH, Finance, Planning) vs. grassroots engagement with communities and sub-national actors.

Prioritisation of advocacy activities will also depend on the overall coverage and zero-dose prevalence in your country. For example, for countries with a high overall coverage rate, advocacy efforts might focus on developing self-financing roadmaps to domestically sustain coverage; countries with low coverage might advocate at the sub-national and community level to improve uptake, while countries with high dropout rates may prioritise advocacy to strengthen the government's immunisation data systems.

Investment Area	Flagship Interventions	Key considerations	Guiding Questions
8. Health Financing	Flagship 1: Strengthen domestic resource mobilisation by enhancing budgeting, forecasting and advocacy at national and subnational levels	• Does your HMIS provide you with the right data on equity progress to help advocate for domestic financing? • Do your advocacy efforts target decision-makers and stakeholders at all national and sub-national levels? • Do CSOs, partners and communities also contribute to your advocacy efforts for domestic financing?	**Q1, Q2, Q3, Q4, Q5**
	Flagship 5: Support transition planning for sustained vaccine financing, ensuring immunisation funding is incorporated into domestic budgets	• Do your transition and suitability roadmaps focus on increasing domestic funding while simultaneously protecting and furthering equity gains? • Do you have a transition monitoring framework in place to track progress on domestic financing while ensuring priority populations continue to be targeted?	**Q6**

How this differs by transition phase

Initial Self-Financing: Start building the domestic financing case for equity now, even while Gavi covers recurrent costs. Embed equity indicators in NIS, Medium-Term Expenditure Frameworks, and annual operational plans. The mandatory 10% CSO cash budget guardrail is not just a funding rule - it is an advocacy asset: CSO partners funded through this mechanism should be active voices for equity in national budget and accountability processes, not only service delivery.

Preparatory Transition: This is the phase where advocacy work is most consequential. Co-financing percentages are increasing; the case for domestic resource mobilisation must become concrete. Engage finance and parliamentary actors directly. Advocacy budget should be one of the most protected items.

Accelerated Transition: Advocacy shifts from mobilising resources to protecting equity gains already achieved. Focus on institutionalising mechanisms that will outlast Gavi support - equity indicators in national performance frameworks, CSO partnership structures, accountability frameworks that hold subnational actors to coverage targets in missed populations.

In fragile and humanitarian (F&H) settings

Advocacy in F&H settings often requires different actors and channels:

- Engagement with humanitarian coordination structures (e.g. health clusters) alongside or in place of formal government channels.
- Where government engagement is sensitive, advocacy may need to work through international organisations and humanitarian forums
- Domestic financing advocacy may be paused or reframed in active conflict — the priority is sustaining service delivery, not transition planning
- Gavi Resilience Mechanism and First Response Fund provide alternative pathways for unforeseen needs

The F&H Theory of Change envisions advocacy as part of building eventual recovery — but it recognises that political commitment in active emergencies looks fundamentally different from steady-state advocacy work.

Concluding note

Immunising the next billion children will require closing persistent equity gaps by reaching communities that have consistently been missed or underserved by routine immunisation services. The five principles and the IRMMA framework in this playbook are designed to make that work concrete by translating equity from a strategic commitment into daily programming decisions. Gavi 6.0 represents the most ambitious phase in the Alliance's history, and the countries that move fastest will be those that treat equity not as an add-on, but as the organising logic of everything they do. For teams that want to go deeper, **the annex contains individual country case studies** that bring each IRMMA element to life in context. The table below provides a **list of additional resources for more detailed technical guidance** on specific topics covered in this playbook.

Additional Resources

Resource	Overview of the Resource
1. Gavi 6.0 Strategy (2026–2030)	Overview of Gavi's strategic goals, ten operating principles, and the equity-focused vision that frames this playbook
2. Zero-Dose Analysis Card	Step-by-step guidance for countries to analyse their zero-dose population, understand barriers, and design IRMMA-aligned interventions.
3. ZDLH Pro-Equity Evidence Map	Evidence briefs on 13 pro-equity interventions mapped to the IRMMA framework, with effectiveness ratings across conflict, gender, remote, and urban settings.
4. ZDLH Resource Library	Full collection of toolkits, implementation research reports, country profiles, costing guides, and peer exchange findings from Bangladesh, Mali, Nigeria, and Uganda.
5. Immunisation Agenda 2030 (IA2030)	The global immunisation strategy co-led by WHO and UNICEF, setting the vision, three impact goals, and seven strategic priorities for the decade.
6. IA2030 Mid-Term Review (2025)	Assessment of global immunisation progress at the halfway point of the decade, with updated priorities, data, and recommendations for course correction.
7. https://immunizationdata.who.int/	Global dataset on immunisation coverage by country and antigen, updated annually and used as the basis for zero-dose estimates.
8. Gavi Zero-Dose Funding Guidelines (2021)	Guidelines on using Gavi funding effectively to reach zero-dose children and missed communities in line with the IRMMA framework
9. UNICEF Multisectoral zero-dose strategies to improve routine immunisation and other child outcomes (2025)	Operational guidance on multi-sectoral strategies to reach zero-dose children in a practical stepwise approach
10. Estimating the Costs of Interventions to Reach Zero-Dose Children, ZDLH (2025)	Operational guidance on conducting analyses measuring the incremental costs of interventions aimed at reaching zero-dose children, to inform budget allocation, prioritisation and planning decisions while balancing equity with feasibility.
11. WHO State of Inequality: Childhood Immunisation (2016)	Analysis of within-country inequalities in immunisation coverage across 69 low- and middle-income countries by wealth, education, subnational region, and place of residence — the foundational dataset behind the disaggregation arguments in Section 2.

Resource	Overview of the Resource
12. Improving immunization coverage and equity - technical resource repository	Repository of key guidance, selected from the TechNet Knowledge Hub, for use by national immunisation programme staff and partners for improving coverage and equity of immunisation services. Search by keyword or browse by topic, question, or IRMMA Framework for Zero Dose
13. Urban Immunization Toolkit 2.0	An updated, comprehensive, practical guide developed to help health stakeholders navigate the unique challenges and nuances of delivering equitable vaccination in complex, rapidly growing urban and peri-urban settings
14. Investing in Learn-by-doing (LxD): Insights from the immunization Zero-Dose Learning Agenda 2023-2025	Insights on learning by doing from the Zero Dose Learning Agenda. These include tools for root cause analysis, co-creating strategies using human-centred design (HCD) approaches, and effective reviews and adaptive management
15. Behavioural and social drivers of vaccination: tools and practical guidance for achieving high uptake	Guidebook on using Behavioural and Social Drivers of Vaccination tools to understand the reasons for low vaccine uptake, track trends over time and reduce coverage inequities by gathering and using data to systematically design, implement and evaluate tailored interventions.
16. Cold chain maintenance done differently: results from a human-centered design study in Niger, Kenya and Tanzania	Research case studies on using human-centred design (HCD) approaches to design innovative solutions for cold chain maintenance challenges
17. Participatory research and HCD guide	A technical paper to help organizations & EPI to plan and prepare for participatory research and design within immunization health initiatives. The paper highlights the value of participatory approaches and offers insights into the key principles and practical considerations necessary to engage communities effectively and inclusively.
18. WHO Digital Implementation Investment Guide (DIIG)	Guidance for planning, costing, implementing and scaling digital health interventions aligned with country needs, readiness and national digital architecture.
19. National Digital Health Information Costed Country Roadmap Toolkit	Guidance and templates to help countries prioritise, cost and implement digital health information investments that strengthen immunisation programmes and health systems.



CASE STUDIES - ANNEX

Annex: Country Case Studies

The following case studies are drawn from the evidence presented at the Leap into Gavi 6.0 Readiness Workshop and from Gavi's implementation research portfolio. They are organised by the IRMMA framework element they primarily address, with selected cases representing the strongest examples of measurable impact and replicable design. **Each case follows a consistent structure: the challenge, what was done, what was achieved, and the key lesson for equity programming**.

These cases are not intended as blueprints to be copied wholesale. They are illustrations of how the principles in Section 2 have been applied in specific contexts, and how the IRMMA steps in Section 3 translate into real programme decisions. The strongest common thread across all ten cases is that **equity gains come from designing around the realities of the most excluded populations**, not from scaling up systems that were never built to reach them.

IRMMA: Identify

Zambia - GIS-based Household Mapping and Community Enumeration

The challenge: Zero-dose and under-immunised children often remain unidentified because routine data systems only show aggregate coverage numbers at facility or district level. These averages mask significant pockets of missed children, particularly at the boundaries between facility catchment areas and in communities with long travel times to health posts.

What was done: Health teams under the Ministry of Health collaborated with a study team to use satellite imagery and GIS software to map every household structure across target catchment areas. Community health workers then walked each catchment, verifying boundaries and registering every child by name and vaccination status. Zero-dose children were flagged on a digital map available to CHWs via a mobile app, giving them a household-level view of exactly where the gaps were. Using these maps, CHWs developed microplans informed by the mapping data.

What it achieved: Community health volunteers visited 10,758 households and registered 13,519 eligible children, identifying 322 DTP1 zero-dose and 470 measles zero-dose children. Targeted campaign and outreach visits then vaccinated approximately 99% of these children. GIS mapping also revealed hidden patterns: higher zero-dose concentrations at facility catchment boundaries and in areas with longer travel times.[6]

Key lesson: When you can see every household on a map, 'hard to reach' becomes 'not yet targeted.' GIS mapping transforms coverage planning from community averages into identifiable zero-dose children with names and locations.

IRMMA: Identify

Bangladesh: E-screening Checklist Integrated into Routine Health Services

The challenge: Many zero-dose and under-immunised children are in households that do have contact with health services — but for reasons other than vaccination. These touchpoints are missed opportunities because health staff lack a systematic way to identify unvaccinated children when caregivers visit for antenatal care, illness treatment, or family planning.

What was done: The implementation research team provided an electronic screening checklist and training to Community Health Care Providers, Family Welfare Visitors, Sub-Assistant Community Medical Officers, and Midwives across 6 sub-districts. These trained staff asked every visiting caregiver — regardless of the visit reason — about eligible children and their immunisation status. If a child in the household was zero-dose or under-immunised, staff recorded them and automatically shared their data with vaccinators through a digital app.

[6] GIS Mapping: A Promising Approach To Identifying And Reaching Zero-Dose Children In Zambia, *Gavi*

What it achieved: The programme identified 1,138 zero-dose and under-immunised children, of whom 963 (84.6%) were subsequently vaccinated. Zero-dose prevalence in the intervention group was nearly half that of the comparison group (10.8% vs. 18.2%).[7]

> **Key lesson:** A simple digital screening tool linked to vaccinators ensures that every caregiver visit to a health facility becomes an opportunity to identify and record children missing vaccine doses. Identification does not always require going door-to-door — it can be embedded into the contacts caregivers are already making.

IRMMA: Identify (Gender Focused)

Pakistan (Sindh): Counselling and Referral by Traditional Birth Attendants

The challenge: Children born at home are often invisible to the immunisation system because they are never registered at a health facility. In Sindh, home births are common, and female caregivers frequently lack information about vaccination services or face barriers in accessing them. Without a mechanism to connect home births to the immunisation programme, these children remain zero-dose.

What was done: The implementation research team trained traditional birth attendants (TBAs), who support home births and regularly visit households, to counsel female caregivers and refer them to immunisation services. TBAs were provided one-on-one training on referral systems, health guidelines, and adaptive counselling, and offered referral incentives to help reach children missed due to at-home births and address caregiver concerns regarding immunisation.

What it achieved: Counselling and referrals helped identify children born at home who might otherwise have been missed entirely. Among women counselled by TBAs, 87% went on to vaccinate their children with Penta-1.[8]

> **Key lesson:** Engaging trusted community actors such as traditional birth attendants to counsel and refer caregivers helps reach children born outside the formal system and convert intent into high vaccination uptake. The people closest to communities are often the most effective identifiers of missed children.

IRMMA: Reach

Kenya (Turkana): Chanjo Mashinani — Redesigned Low-Cost Targeted Outreach

The challenge: In Turkana, long distances and extremely high transport costs meant conventional outreach — deploying large teams of vaccinators and social mobilisers — was

[7] Strategies for Reducing Zero-Dose and Under-Immunized Children in Bangladesh: Implementation Research Findings, *ZDLH Gavi, 2025*
[8] Zero Dose Learning Agenda – Pakistan, *2025*

both expensive and inconsistent. Standard outreach budgets were inefficient for the terrain, leaving many zero-dose children in remote, dispersed settlements unreached.

What was done: The team redesigned the outreach model around local realities: motorcycle transport replaced vehicle-based teams, smaller priority outreach teams were deployed instead of large convoys, community champions were engaged for social mobilisation, and referral mechanisms were created for families living within walking distance of outreach points. The design was co-created with local health workforce and community members, ensuring it was easily adopted and implemented by community health promoters.

What it achieved: The intervention reached 247 zero-dose children across four facilities, with an additional 51 reached via referrals. The cost per zero-dose child was reduced by over 70% compared to conventional outreach models. [9]

Key lesson: Conventional outreach involving large teams can be resource-intensive and still miss children. Locally adapted, lower-cost programmes — co-designed with communities — can be equally or more effective at reaching missed children while being financially sustainable.

IRMMA: Reach (Gender Focused)

Bangladesh (Dhaka, urban): Evening Immunisation Sessions for Working Caregivers

The challenge: Working caregivers in Dhaka's urban slums — especially mothers employed in garment factories and as domestic workers — could not access routine immunisation services during standard morning clinic hours. These women earn daily wages they cannot afford to lose, making daytime vaccination visits effectively inaccessible and leaving their children unvaccinated.

What was done: The study team introduced evening EPI sessions in urban slums running from 3 PM to 7 PM, specifically targeting working caregivers. EPI storage points dispatched vaccines and supplies to session sites, and Dhaka North City Corporation vaccinators and NGO clinics delivered the services at community-accessible locations during these extended hours.

What it achieved: The intervention spanned 119 sessions, with 1,099 children vaccinated. Caregivers explicitly cited timing as the reason they had been unable to attend before. The approach led to a measurable reduction in both left-out and drop-out children in the target communities.[10]

Key lesson: When clinic hours are the barrier, changing the hours is the intervention. Aligning services with caregiver schedules — especially for working mothers and women

[9] Applying Human Centered Design and Iterative Programming to identify and reach Zero Dose and Under Immunized Children in Kenya - Zero Dose Learning Agenda – Kenya, *2025*

[10] Strategies for Reducing Zero-Dose and Under-Immunized Children in Bangladesh: Implementation Research Findings, *ZDLH Gavi, 2025*

with daytime caregiving responsibilities — is not a minor logistical adjustment; it is a core equity lever and a critical gender consideration.

IRMMA: Reach

Ethiopia (Addis Ababa, urban): Bringing Services Closer to Urban Underserved Communities

The challenge: Many caregivers in urban slums were not accessing immunisation services due to long waits, repeated visits, and the time and income lost in travelling to facilities. The opportunity cost of a facility visit was too high for families living on daily wages, and standalone immunisation outreach was not sufficient to sustain engagement.

What was done: The study team co-created optimised outreach services with community members and clients to bring vaccination closer to communities. With the support of the municipality and health service, outreach sites were established within communities to reduce distance, waiting time, and opportunity costs for caregivers. Over time, the model was adapted to better meet community needs by integrating additional services — such as maternal health, nutrition screening, family planning, and basic NCD screening — alongside immunisation, making outreach sites more relevant and valuable for families.

What it achieved: Bringing immunisation services closer to communities reduced time and cost barriers, increasing uptake among underserved populations. Integrating other health services improved convenience for caregivers, strengthened health-seeking behaviour, and enabled delivery of both vaccination and other essential services through a single platform.[11]

Key lesson: Access is not just about distance — it is about convenience, time, and relevance. Bringing services closer to communities and integrating them with other health needs reduces opportunity costs, builds trust, and significantly improves uptake among underserved urban populations.

IRMMA: Reach

Cameroon: Providing Integrated Services

The challenge: In the remote island communities of Manoka Health District, most children were zero-dose. Low trust in the formal health system and widespread vaccine hesitancy meant that even when outreach reached these communities, uptake stayed low. The barrier was not only physical remoteness but weak demand for vaccination.

What was done: The programme trained Community Health Workers (CHWs) to provide an integrated package of health services to increase chances of contact with caregivers who otherwise had low trust and hesitancy towards vaccination. These services included malaria

[11] Zero Dose Learning Agenda – Ethiopia, *2025*

diagnosis, antenatal care, and diarrhoea management along with reporting and referral of zero-dose and under immunised children.

What it achieved: Bundling immunisation with other integrated services through CHWs resulted in increasing vaccination rates in the target communities. While no referred child got vaccinated in the first month of the intervention, the rate rose to 44% after 6 months and 64% by the end of the one-year intervention. This points to caregivers' preference for integrated services and the strong impact of such services in gradually building trust in the community and generating demand for vaccines.[12]

Key lesson: Integration builds trust to drive uptake. Embedding immunisation within broader, routine health services delivered by CHWs can increase contact with caregivers, gradually creating awareness and trust and significantly increasing vaccination over time.

IRMMA: Reach

Cameroon: Reaching nomadic communities through a One Health approach

The challenge: Nomadic populations in Cameroon were missing from immunisation records because the health service could not locate them, even though they were open to vaccination. Standard outreach runs on fixed schedules tied to fixed locations. These communities move with their livestock across multiple districts. Intensification based on the existing model would likely to be unable to reach nomadic populations.

What was done: The programme asked a different question: which service do these communities already use and trust? The Ministry of Livestock, Fisheries and Animal Industries followed nomadic movement patterns as part of routine veterinary work. Vaccination teams joined those existing visits rather than running separate health outreach. The team mapped routes across 17 districts in five regions and built them into the EPI microplan. The model was incorporated into Cameroon's 2026 annual work plan, making it a routine function rather than a project activity.

What it achieved: The approach reached 8,781 zero-dose children at approximately $7 per child, the same cost as routine outreach across Cameroon's 80 zero-dose districts, for a population routine outreach could not reach at all. By comparison, urban outreach in the same period cost $16 per child and reached 3% of its target, because the barrier there was service design, not access. When a 62% budget cut forced reprioritisation in 2026, nomadic route mapping was one of the few activities EPI classified as essential and protected in full.

Key lesson: When your outreach model was built for settled communities, intensifying it will not reach mobile ones. The right question is which organisation already has trusted access to your priority population and whether immunisation can travel with them.

IRMMA: Reach (Gender-Focused)

[12] The use of community-oriented primary care (COPC) model to generate vaccine demand: The case of a remote fishing community in Cameroon

Uganda: Finding out why mothers were not coming and designing around the barriers

The challenge: Some district teams in Uganda were already adapting by extending clinic hours, fast-tracking men who brought children, and engaging religious leaders. But these were informal habits, invisible in any monitoring tool, inconsistent across districts. At the national level, demand generation was broadly targeted at women caregivers without evidence of what was actually keeping them away.

What was done: A gender assessment was conducted across 15 districts and all eight equity reference groups. It found four consistent barriers: women needed permission and money from men to attend the clinic; a triple load of domestic, productive and childcare work left no time for daytime visits; misinformation from religious and political leaders blocked male consent in some communities; and transport was controlled by men. These findings changed who the demand generation was talking to. Male engagement through CSO-supported community dialogues was added alongside standard outreach. Supervision checklists were revised so gender barriers were reviewed routinely, not only during dedicated gender visits. Microplanning tools were updated to include gender barrier identification as a standard step.

What it achieved: The assessment exposed what one health worker described plainly: "We are doing it but didn't know it was gender integration." Good practice was already happening, but it was just unnamed, unmeasured and unscaled. By putting it into supervision tools and microplans, the programme made it something districts could be held to rather than something that depended on individual initiative. Gender-responsive interventions were included in Uganda's Gavi 6.0 reprioritisation discussions within the Equity investment area.

> **Key lesson:** Generic demand-generation aimed at mothers does not increase coverage in households where men decide whether vaccination occurs. You need to know which barrier you are addressing and design for that barrier, not for the easiest-to-reach person.

Niger: Direct Facility Financing to ensure funds are where they are needed, when they are needed

The challenge: In Niger's Tahoua district, many children living in remote and underserved communities were missing routine immunisation services. A key challenge was that funds for outreach and vaccination activities passed through multiple administrative levels before reaching health facilities, often causing delays and reducing the availability of resources for frontline service delivery. These constraints limited the ability of health workers to conduct outreach activities and reach zero-dose children, particularly in areas affected by insecurity, difficult terrain and mobile populations.

What was done: To address these barriers, Niger piloted a Direct Facility Financing (DFF) model through Gavi's Sustainable Financing for Immunisation (SFA) portfolio. The model was designed to ensure that operational funds reached frontline facilities quickly and transparently by transferring resources directly to health facilities through mobile money rather than through multiple intermediary levels. Health facilities submitted expenditure reports electronically, strengthening accountability and oversight.

The pilot was implemented in Tahoua district, with Illéla district serving as a comparison area. Alongside the financing reform, the programme invested in training health workers and district staff on financial management and the new reporting processes. Community engagement was also integrated into the approach. Traditional leaders, religious leaders and community representatives helped identify children who had missed vaccinations, supported community mobilisation efforts and participated in monitoring immunisation activities. Community line lists were developed to track unvaccinated children and support their follow-up.

The objective was not only to improve financial management, but also to ensure that facilities had reliable resources to conduct outreach activities and reach children living in difficult-to-access communities.

What it achieved: After one year of implementation, the pilot reported a 10.5% increase in Penta1 coverage and a 13.3% increase in Penta3 coverage compared with the previous year. The programme also reported that 97% of children lost to follow-up were identified and vaccinated. Fund transfer times fell from more than 30 days to fewer than two days, while financial reporting and accountability improved substantially.

Key lesson: Improving equity sometimes requires fixing operational bottlenecks within the health system. By ensuring that funds reached frontline facilities quickly and transparently, the DFF model enabled health workers to carry out outreach activities more consistently and reach children who were previously being missed. Combining financing reforms with community engagement helped strengthen both service delivery and accountability for reaching underserved populations.

IRMMA: Reach

DRC, Lesotho, Nigeria: Tailored incentives to reduce financial barriers to immunisation

The challenge: Caregivers across Cameroon, the Democratic Republic of Congo, Lesotho and Nigeria faced practical and financial barriers to vaccination, including transport costs, time away from work and limited financial autonomy. At the same time, health facilities in Nigeria and the Democratic Republic of Congo lacked flexible resources to plan outreach and respond to local service-delivery constraints. A standardised intervention would not address the different barriers, infrastructure and delivery conditions across the four settings

What was done: The Demand-Side Incentives project tested context-specific cash and non-cash incentives. Cameroon used mobile-money payments and transport vouchers; the Democratic Republic of Congo used transport vouchers alongside direct facility financing; Lesotho used mobile-money and airtime incentives; and Nigeria combined transport vouchers with direct facility financing. Incentives were provided following vaccination verification. The project also worked through local community-based organisations and supported microplanning, community engagement and coordination with national and subnational immunisation stakeholders.

What it achieved: By the end of field implementation, the programme reported reaching 436,811 children, including 55,517 previously unvaccinated children, and supporting 44,768 fixed and outreach vaccination sessions. A total of 235,459 children and adolescents received incentives. Country-level reach comprised 53,444 children in Cameroon, 60,670 in the Democratic Republic of Congo, 31,947 children and adolescents in Lesotho, and 290,750 children in Nigeria.

The implementation demonstrated that incentive design and delivery mechanisms could be adapted to local barriers. Transport vouchers addressed access costs, while direct facility financing gave facilities flexible resources and greater autonomy to address operational needs. Two rendline evaluations will be finalised in 2026 and Gavi will be able to share final results and lessons learnt.

> **Key lesson:** Demand-side incentives should not be applied as a uniform solution. Their value depends on identifying the specific barrier faced by underserved populations, co-designing an appropriate incentive with local stakeholders, and ensuring that health facilities have the resources and readiness to respond to increased demand.

IRMMA: Monitor & Measure

Pakistan (Sindh): Vaccinator Community Tracking (Polygon Coverage)

The challenge: In Sindh province, immunisation programmes had limited visibility on where vaccinators were actually going and which communities were being missed. Outreach was often inconsistent and ad hoc, planning was not data-driven, and there was no systematic way to track whether communities were being visited or bypassed.

What was done: An implementation partner introduced a vaccinator tracking system using geo-location coordinates captured through vaccinators' mobile phones. Each community (polygon) was tracked: if a vaccinator visited it, the polygon appeared green on a dashboard; if not, it appeared red. Separate dashboards tracked individual vaccinators, districts, and provincial performance. The provincial dashboard was personally reviewed monthly by the Minister of Health, creating a direct accountability loop from the front line to political leadership.

What it achieved: Within two years, community coverage of vaccinators improved from 42% to nearly 90% each month across Sindh. A recent third-party survey in polio high-risk areas

showed immunisation coverage increased from 60% to 72%. The system replaced ad hoc outreach with structured, data-driven planning and accountability.[13]

Key lesson: Communities need outreach they can rely on: a known place, a known time, and a schedule that does not change. Even infrequent outreach works if it is predictable. Tracking who is delivering and which communities are missed is what turns ad hoc visits into a dependable norm, and the accountability loop it creates is what sustains it.

IRMMA: Monitor & Measure

Ghana: GhiLMIS — Building Real-Time Visibility Across the Supply Chain

The challenge: Frequent vaccine stockouts, delays in procurement, weak in-country distribution and logistics, lack of visibility on stock levels, and fragmented supply chain data systems led to inefficiencies in vaccine and commodity availability, especially at the last mile. Decision-makers could not see what was happening in the supply chain in time to intervene, and data availability lagged by up to three months.

What was done: The Ministry of Health introduced GhiLMIS, a national end-to-end digital supply chain platform that integrated all logistics management functions into a single system. The reform went beyond digitisation: it linked all logistics management system points, enabled real-time inventory tracking, integrated previously isolated tools, used barcoding and digital transaction capture, introduced forecasting tools, and rolled out infrastructure, training, and system champions across all levels of the health system.

What it achieved: Data availability improved from a three-month lag to near real-time access (approximately one day). Order processing time was cut from one week to two days. The system enabled better last-mile distribution, reduced stockouts and wastage, improved tracking of vaccine distribution, and strengthened decision-making through real-time data and predictive analytics.[14]

Key lesson: When programmes can track commodities in real time, they are able to make faster and more informed decisions. An end-to-end supply chain platform eliminates fragmentation and transforms logistics from a reactive to a proactive function.

IRMMA: Advocate

Nigeria (Bauchi, Borno, Kano, Sokoto): Nigeria Learning Hub — Multi-Dimensional Data-Driven Advocacy

[13] Improving immunisation coverage through health worker accountability, *Acasus*
[14] Ghana Integrated Logistics Management System: Improving supply chains to bring health for all – *Gavi 2024*

The challenge: Immunisation programmes in northern Nigerian states faced siloed data systems, non-specific budget allocations for immunisation, weak coordination between government and civil society, and limited political attention to equity-focused programming. Budget releases for immunisation were unpredictable and insufficient.

What was done: The Nigeria Learning Hub implemented a comprehensive stakeholder engagement and advocacy strategy targeting legislators, government officials, traditional and religious leaders, civil society organisations, and international partners. Leveraging the expertise of the Africa Health Budget Network and CSO networks, the Hub conducted data-driven budget advocacy using subnational budget analyses, Immunisation Accountability Frameworks, and scorecards to track funding flows and programme performance. Communities of Practice were established at the state level, co-chaired by government and civil society, and legislative champions were identified and engaged in health committees.

What it achieved: The Communities of Practice institutionalised coordination, data validation, and sustained advocacy. Targeted engagement with policymakers increased political attention to immunisation and influenced financing decisions, resulting in improved budget releases and prioritisation of immunisation. At the frontline, increased outreach stipends enhanced health worker motivation and service delivery.[15]

Key lesson: Advocacy is most effective when it is data-driven, institutionalised, and politically embedded. Sustained engagement, clear accountability tools, and strong local ownership translate evidence into financing and action.

IRMMA: Advocate (Gender-Focused)

Comoros: Engaging Women's Groups to Raise Vaccine Awareness and Increase Uptake

The challenge: Low vaccine demand and uptake were driven by limited caregiver awareness, fear of adverse effects, and weak community-level outreach. Many children had lost contact with the EPI programme, and there was no systematic mechanism to identify them at the community level or to address caregivers' concerns about vaccination.

What was done: Under the leadership of EPI Comoros, community-based women's groups were engaged across nine health districts. A total of 196 women leaders (mother leaders) were identified and trained in interpersonal communication on vaccine confidence, the child immunisation schedule, and vaccination during pregnancy including tetanus toxoid. They were equipped with simple social and behavioural data tools to identify under-immunised children, address vaccine-related concerns, and refer families to health facilities.

What it achieved: Within four months: 13,554 parents and caregivers were sensitised on the safety and benefits of vaccines; 3,890 children aged 0–5 years who had lost contact with the EPI were identified and recorded; 2,189 children completed their routine vaccinations through

[15] Gavi's Zero-Dose Learning Hub IRMMA Aligned Interventions: Semiannual Update – Nigeria – *ZDLH Gavi 2025*

targeted follow-up; and 520 previously unvaccinated pregnant women were vaccinated against tetanus.[16]

Key lesson: Trusted women leaders are powerful drivers of immunisation uptake. Female caregivers are more receptive to messages delivered by influential women from their own communities. Community-level advocacy through women's groups can simultaneously identify missed children, address hesitancy, and generate demand.

IRMMA: Advocate

Uganda: Keeping equity visible after the grant ends

The challenge: Uganda's national DPT1 coverage appeared strong, but zero-dose children were concentrated in populations that were not captured in routine data. Different partners tracked different indicators in different systems. No single platform reviewed equity performance across districts and held anyone accountable for it. When dedicated funding and partner support ended, the risk was not that Uganda would stop caring about equity, but that the system would stop seeing it.

What was done: Zero-dose indicators were moved from partner dashboards that would close with a grant and written into DHIS2, the National Immunisation Strategy, the Integrated Immunisation Plan and the MEL framework. The Service Delivery Technical Working Group already existed; its Terms of Reference were revised to make monthly zero-dose data review and district follow-up a standing agenda item. A Senior Medical Officer within UNEPI was designated as the national zero-dose coordinator. In two focal districts of Butaleja and Buikwe, review meetings were restructured so that data produced documented action points, in addition to performance summaries.

What it achieved: By 2025, national DPT1 coverage reached 98%, and zero-dose children fell 18% year-on-year. In Butaleja, the number of zero-dose children dropped by 80% over the grant period. The SD-TWG and DHIS2 indicators continue post-EAF, though the honest risk is that physical meeting frequency may decline without dedicated transition support, which could weaken the accountability loop even as the structures remain.

Key lesson: If equity data only lives in a partner system, equity accountability ends when the partner does. Embedding zero-dose indicators into the national HMIS and revising the terms of reference for an existing coordination platform costs less than building something new and is more likely to survive.

[16] SBC Works! Women Leaders in Action for Under-Immunized and Zero-Dose Communities in Comoros – *UNICEF 2023*

IRMMA: Advocate (Gender-Focused)

Cameroon: Building gender integration that EPI would protect, not just tolerate

The challenge: In Cameroon, gender-related activities were supported by external partners and were not reflected in dedicated EPI budget lines. This meant that key aspects of the work were being delivered through arrangements that sat outside EPI's routine planning and financing processes. The experience raises questions about how gender interventions can be more fully integrated into core immunization systems over time

What was done: Over fourteen months, gender integration moved from external advisory to EPI-owned practice. Central EPI staff were trained on gender mainstreaming. A gender-in-vaccination training module was co-developed with UNICEF, validated by EPI, and embedded within existing vaccination-in-practice training rather than run as a standalone course. This meant that future vaccination training would include gender content, whether or not a dedicated gender budget existed. EPI led the workshop that produced gender champions and a draft accountability framework. On the protection side, EPI validated a manual on protection from sexual exploitation and abuse and drafted a Code of Conduct, both of which are anchored in EPI's permanent HR and legal structures. A barriers assessment completed in June 2026 across six districts now provides the evidence base for the next phase: a Gender Focal Point network across 80 zero-dose districts and 1,000 health facilities, with four proposed indicators to be integrated into the M&E system.

What it achieved: When a 62% budget cut forced EPI to deprioritise across the HSS portfolio, gender champion training was one of the activities EPI chose to keep. EPI defended it on its own terms. Gender commitments now appear in the EPI 2030 vision, the Human Resource Development Plan and the 2026 Annual Work Plan. The Gender Focal Point network, the training cascade and the proposed gender indicators all still run on Gavi funding. No government budget line covers them yet, and they are at risk when Gavi support ends. Securing the necessary line within the government's domestic budget remains to be done.

Key lesson: Gender integration survives budget cuts when EPI co-designed it and owns the training content, not when a partner manages it on EPI's behalf. Putting the gender module inside vaccination-in-practice meant EPI was protecting its own curriculum.

IRMMA: Advocate

Civil Society Advocacy for Sustainable Immunization Financing: Experiences from Cameroon, Côte d'Ivoire, Ghana, Kenya, Laos, Liberia, Madagascar, Nigeria, Sierra Leone, Zambia)

The challenge: As countries transition towards greater responsibility for financing immunization programmes, vaccine budgets often compete with other fiscal priorities. In many countries, immunization financing lacked sustained political visibility, parliamentary oversight, and public accountability, contributing to delayed co-financing payments, funding gaps, and uncertainty around long-term sustainability.

What was done: Through Gavi's partnership with GHAI and local civil society organisations across ten countries, advocacy efforts brought together parliamentarians, ministries of health and finance, media, and community stakeholders to elevate immunization financing on national agendas. Civil society partners conducted financing gap analyses, developed domestic resource mobilization strategies, engaged parliamentary champions, established immunization caucuses, disseminated evidence on fiscal space and budget needs, and used media campaigns to strengthen public accountability for vaccine financing commitments. By mid-2026, the programme had engaged 187 parliamentarians, supported the creation of nine parliamentary caucuses, and generated more than 2,700 media stories and social media outputs focused on immunization financing.

What it achieved: The advocacy programme contributed to tangible financing outcomes, helping sustain immunization financing commitments through challenging fiscal environments and political transitions. Countries also achieved important policy and budget gains, including commitments to increasing immunization budget, and dedicated funding provisions for future vaccine financing. Across 10 countries, the programme recorded 22 policy and budget wins, demonstrating how civil society advocacy and parliamentary engagement can strengthen political commitment, accountability and domestic ownership of immunization financing.

Key lesson: Sustainable immunization financing is not only a technical budgeting issue. When civil society, parliamentarians and government stakeholders work together to create political accountability for vaccine investments, immunization becomes a national financing priority rather than a donor-funded programme. Strong advocacy can help translate financing commitments into budget allocations, payments, and long-term sustainability.

Further Reading & Resources

1. Gavi 6.0 Strategy (2026–2030): www.gavi.org/our-work/strategy/phase-6-2026-2030

2. Zero-Dose Analysis Card: www.gavi.org/sites/default/files/support/Gavi_Zero-dose_AnalysisCard.pdf

3. ZDLH Pro-Equity Evidence Map: zdlh.gavi.org/resources/evidence-map

4. ZDLH Resource Library: zdlh.gavi.org/resources

5. Immunisation Agenda 2030 (IA2030): www.who.int/teams/immunization-vaccines-and-biologicals/strategies/ia2030

6. IA2030 Mid-Term Review (2025): cdn.who.int/media/docs/default-source/immunization/strategy/ia2030/ia2030_mid-term-review_2025_final.pdf

7. WHO/UNICEF Estimates of National Immunisation Coverage (WUENIC): immunizationdata.who.int

8. Gavi Zero-Dose Funding Guidelines (2021) https://www.gavi.org/sites/default/files/support/Gavi_Zero-dose_FundingGuidelines.pdf

9. UNICEF Multisectoral zero-dose strategies to improve routine immunization and other child outcomes (2025) https://www.unicef.org/documents/multisectoral-zero-dose-strategies-improve-routine-immunization-and-other-child-outcomes

10. Estimating the Costs of Interventions to Reach Zero-Dose Children, ZDLH (2025) https://zdlh.gavi.org/resources/operational-guidance-estimating-costs-interventions-reach-zero-dose-children

11. WHO State of Inequality: Childhood Immunization (2016) www.who.int/data/inequality-monitor/publications/report_2016_immunization

12. Gavi 6.0 Funding Guidelines: www.gavi.org/sites/default/files/support/guidelines-2026/gavi-60-funding-guidelines-annexes.pdf

13. Zero-Dose Learning Agenda repository: Zero-Dose Learning Agenda - TechNet-21