KEEPING EVERY CHILD ON TRACK WITH THEIR IMMUNIZATIONS

Senegal, Benin and Chad | KIA12 – 22 October 2026

Why are children still being missed? KIA12 brought together three immunization programmes and members of the KLIC community to discuss real-world situations: children who are difficult to identify in Tambacounda, immunization sessions disrupted by flooding in Owodé, and follow-up undermined by transhumance in Chad. [1, 2]

We would like to thank Drs Ousseynou Badiane, Zoulkanéri Alassane and Djikini Djimornan, as well as all participants, for their questions, field experience and open discussions. The session was moderated by Dorothy Leab and Franck Hilaire Bete, with facilitation by Tommy Leab. [1]

Three key lessons for practice

- Identify children early and maintain contact. Birth notifications, community lists, immunization registers and tracking of doses due should make it possible to locate every child throughout their immunization journey.
- Organize services around families' needs. Travel routes, seasons, household movements, the availability of health teams and vaccines all influence whether planned immunization sessions can be delivered.
- Clarify who is responsible for follow-up. Following a referral, a cancelled session or a change of district, responsibility for the next contact and confirmation of vaccination must remain clearly assigned. [1, 2]

What participants highlighted

During the Mentimeter consultation, the identification of children and communities ranked highest among the gaps identified. Maintaining contact with families and tracking vaccine doses were also highlighted. The most frequently cited barriers included distance, seasonal constraints, insufficiently adapted microplans and population mobility. These trends reflect the responses collected during the session. [1]

The next step: A country clinic for each country

KLIC and GaneshAID propose three technical sessions to explore country-specific issues in greater depth and formulate actionable interventions. Experts and practitioners from the community are invited to contribute to this work alongside the country teams.

THE THREE COUNTRY CONTEXTS

Three operational questions to address

Senegal | Early identification and continuity of immunization in Tambacounda

Dr Ousseynou Badiane, Head of the Immunization Division and Coordinator of the Expanded Programme on Immunization (EPI).



The January 2025 coverage survey reported 87% coverage for the first dose of the pentavalent vaccine and 74% for the third dose, representing a gap of 13 percentage points. The teams have undertaken equity-focused microplanning, established contractual arrangements with community-based organizations, implemented outreach and mobile strategies, and conducted performance reviews. Birth identification and active follow-up remain challenging in geographically dispersed communities. [2]

The electronic individual-level register presented by Senegal offers an opportunity to strengthen follow-up, provided that initial identification and the transmission of community-level information are of sufficient quality. [2]

Senegal's question

How can early identification and follow-up of children through their scheduled doses be organized in the geographically dispersed communities of Tambacounda?

Benin | Catch-up vaccination and seasonal access in Owodé

Dr Zoulkanéri Alassane, Head of the Vaccination Service, Directorate of Vaccination and Logistics, National Agency for Primary Health Care.



In Owodé, in the commune of Tchaourou, flooding restricts the movement of health teams, while subsequent agricultural activities lead to the dispersal of families. As of 30 September 2026, the target population comprised 76 children under one year of age: 17 had received at least one dose, while 59 still needed to be reached through catch-up vaccination. The community census was incomplete, and follow-up for subsequent doses remained to be ensured. These figures call for individual-level verification of each child and their vaccination status. [2]

Benin's Question

What organization of immunization sessions and follow-up would make it possible to complete catch-up vaccination in Owodé, taking into account flooding and family movements?

Chad | Maintaining follow-up throughout transhumance

Dr Djikini Djimornan, Head of the Vaccination, Epidemic



Under the approach presented, from January to August 2026, 42,033 children had been referred using referral slips, and 35,927 had been vaccinated at health centres, representing a reported attrition rate of 14.5% between these two stages. Subsequent movements of temporary settlements further undermine follow-up across districts.

The mobile strategies presented combine human health services with livestock vaccination, following the One Health approach. The practices described in Goundi include registers for each camp, continuity of mobile teams, reminder cards and nomadic community relays. Their contribution to results should be documented before these practices are adapted elsewhere. [2]

Chad's question

How can children from mobile communities be kept on the immunization pathway, from initial identification through to completion of their vaccination?

QUESTIONS AND CONTRIBUTIONS FROM PARTICIPANTS

Better understanding the children who need to be reached

Reconciling targets with field data

Dr Didier Cabwine, from the Democratic Republic of the Congo (DRC), examined discrepancies between the targets used by health services, those used by partners and data collected locally. His question concerned the reliability of conclusions drawn from conflicting data sources. [3]

Dr Junior Bosenga, from VillageReach, DRC, described the discrepancies between demographic projections and village-by-village population counts in Maniema. He highlighted the implications for microplans, vaccine quantification and the resources required to reach children. [3]

Dr Sayi, a consultant who had worked in Benin, asked how targets should be adjusted when administrative coverage rates exceed 100%, how to estimate the number of remaining zero-dose children who still need to be reached, and how responses can be differentiated according to the specific barriers faced by each community. [3]

Issues to explore further during the country clinics: Reconcile estimates, community lists and immunization registers; clarify the dates, populations and geographical areas covered; and agree on the necessary verification steps before determining the scale of interventions.

Making appropriate use of geography and digital tools

Dr Yves Wasnyo, from Cameroon, proposed using population grids, the locations of health facilities, terrain and road networks to better assess travel times and access to services. He cited WorldPop and AccessMod as tools worth exploring to improve the geographical identification of hard-to-reach populations. [3, 5]

Dr Mohamed Ouédraogo, from Burkina Faso, proposed an exchange on digital applications, including approaches using artificial intelligence, to identify and map children. He clarified that this work was still at an early stage. The discussion opened up an opportunity to share experiences that could be documented. [3]

Financing and organizing sustained follow-up

Dr Placide Mukendi, from the DRC, raised a fundamental question: what institutional mechanisms would make it possible to sustain results once external technical or financial support comes to an end? This question needs to be examined in each context, taking into account national responsibilities, recurrent costs and available resources. [3, 6]

Malenga Fidele, from the DRC, asked how community-based surveillance could be better linked to local data to identify zero-dose children. He also raised questions about strategies to strengthen trust and ensure continuity of immunization services in day-to-day practice, beyond vaccination campaigns. [3]

QUESTIONS AND CONTRIBUTIONS FROM PARTICIPANTS

Ensuring continuity between families and health services

Community actors involved at every stage

Isaac Matene, from UNICEF Burundi, presented the role of community health workers, local administration and civil society organizations in identifying and following up children. He asked how these actors were engaged in Benin. In response, Dr Alassane confirmed that a community-based mechanism was in place and highlighted the need for further engagement with local organizations and opinion leaders. [3, 6]

Rafael, from Uganda, asked how to designate a trusted person responsible for follow-up when families move between geographical areas. In the chat, he also raised the importance of preparing households ahead of mobile immunization sessions and involving fathers and local leaders. Kounandji proposed greater involvement of sector chiefs, as well as traditional and religious authorities, in community mobilization. [4, 5]

Ensuring vaccine availability and functional equipment

Agumassie Kindu, from Ethiopia, asked how plans targeting zero-dose children could be linked to local maintenance, spare parts availability and temperature monitoring. Samuel Zongo Evindi further developed this question in the chat, highlighting the distinction between equipment that has been inventoried and equipment that is actually functional. [4, 5]

In response, Benin described the use of solar-powered equipment and insulated cold-chain equipment. Chad reported equipment needs and presented several arrangements, including vaccine storage at nearby health facilities, regular supply, inventory management and the involvement of technicians. Ensuring that equipment remains functional requires precise monitoring in the territories concerned. [6]

Adapting responses to communities and access constraints

Dr Muhammad Sharif, from Pakistan, linked missed children to incomplete mapping, inaccurate data, population mobility, absences during visits and coordination difficulties. He also highlighted the importance of trust, informing parents and addressing weaknesses in follow-up. [5]

Hounhozounkou Jean de Dieu Amour Mahouton asked how vaccination could be ensured in the “red zones” of Benin. Kounandji recommended stronger collaboration with humanitarian organizations to reach unreached populations in Chad. These access and security issues require further discussion with the relevant country teams and partners. [5]

Ahmed Haruna Danjuma, from Nigeria, proposed linking community-based identification, mobile strategies, vaccine availability and monitoring of results. His contribution emphasized the importance of connecting microplanning, logistics and community engagement to ensure that children complete their immunization schedules. [5]

The experiences shared provide approaches for further examination with the countries, with particular attention to their results, limitations and the conditions required for adaptation.

NEXT STEPS FOR THE THREE COUNTRIES

One country clinic, one actionable intervention

Each country clinic will be a technical working session focused on the respective country's operational question. National and local teams will define the problem to be addressed, examine options with experts and select an intervention whose feasibility and results can be monitored. The dates, participants and scope of each session will be agreed upon with the three countries individually.

Country and objective	Proposed work with experts	Expected outcome of the clinic
Senegal Link early identification to follow-up of scheduled doses in Tambacounda.	Clarify birth notification processes, referral to health services, follow-up responsibilities, and the reconciliation of community lists with immunization registers.	A targeted intervention to strengthen the link between the community, health services and the district, with a clearly defined target population, an assigned person responsible for follow-up, tools to be adapted and indicators to be monitored.
Benin **Organize catch-up vaccination and subsequent doses in Owodé.**	Consolidate the list of children and their vaccination status. Cross-check the flooding calendar, family presence, transport options, health teams and vaccine availability. Plan for the rescheduling of cancelled sessions.	A seasonal catch-up microplan, including safe access arrangements, family preparation, individual-level follow-up, the resources required and confirmation of administered doses.
Chad **Ensure continuity of follow-up when children move between districts.**	Document the practices used in Goundi. Define the vaccination information that accompanies each child, the role of nomadic community relays, information-sharing between districts and feedback following vaccination.	A continuity mechanism to be examined with the relevant districts, specifying the responsibilities of sending and receiving districts, the tools used, and the review of children referred and vaccinated.

Prepare for the session using a concise briefing package

The country team will compile the priority question, available and dated data, tools already in use and implementation constraints. Representatives from the relevant districts, health services and communities will be involved as needed. Data shared with experts will consist of aggregated or anonymized information.

Conclude with an actionable decision

The proposed format is a session of approximately 60 minutes. The action plan will specify the intended change, implementation steps, responsibilities, resources required, baseline situation, monitoring measures and timing of the review. Implementation will depend on validation by the country team and the resources that can be mobilized.

KLIC and GaneshAID will facilitate preparation, connect country teams with experts and support the sharing of lessons learned. Operational decisions and implementation arrangements will remain the responsibility of the country teams.

INVITATION TO CONTRIBUTE

Experts and practitioners, join the country-led work

Help each country formulate its next action

We invite experts, programme managers, district teams, community actors and technical partners to contribute to the three country clinics. The objective is to help each country formulate an intervention that can address its operational question, taking into account its available resources and constraints.

Areas where contributions are sought

For Senegal, relevant experience includes birth identification and notification, community-based follow-up, individual-level registers and tracking of doses due. For Benin, relevant experience includes seasonal microplanning, the organization of immunization sessions, logistics and family mobilization. For Chad, relevant experience includes follow-up of mobile populations, coordination between districts, integrated services, and referral and feedback mechanisms.

Expertise in data quality, geographical analysis, operational financing, maintenance and implementation evaluation will be valuable across all three countries. Contributions may focus on an existing practice, documented results, an adaptable tool or an analysis of the conditions required for successful implementation.

To contribute, please reply to the email sharing this summary, indicating the country or operational question you would like to support, your relevant experience and your availability. A brief description of the practice, the results observed and the conditions for its application will help prepare the discussions.

Resources to support further exchanges

Requests for presentations and documents, raised in particular by Dr Belmondo Beauclair Nonnonhou, Dr Didier Cabwine and Madoussou Koné, will help extend this work. KIA's follow-up activities will include a targeted selection of resources covering three areas:

- Identification and microplanning;
- Logistics and continuity of immunization services;
- Community engagement and trust.

Country teams will be able to specify their intended use of these resources and the adaptations required for their national tools. [5, 6]

Source references

The references below point to the session materials and transcripts of the recording from 22 October 2026. The figures presented are those reported in the country presentations.

[1] KIA12 recording: session introduction from 00:12:19 to 00:26:17 and Mentimeter consultation from 01:06:23 to 01:12:28; session presentation.

[2] Country presentations included in the KIA12 presentation materials and country interventions: Senegal, from 00:27:32 to 00:37:27; Benin, from 00:38:58 to 00:48:09; Chad, from 00:50:06 to 01:02:16.

[3] Discussion with participants, recording transcript, from 01:15:21 to 01:29:24 and from 01:33:53 to 01:40:34.

[4] Contributions in English, based on the subtitles of the recording: Agumassie Kindu, from 01:30:29 to 01:32:59; Rafael, from 01:42:02 to 01:43:46.

[5] KIA12 session chat, written contributions, particularly from 04:35:14 to 06:14:43, according to the timestamps in the exported file.

[6] Country responses, from 01:44:38 to 01:50:38; resources and continuation of discussions, from 01:50:42 to 01:58:46 and from 02:01:29 to 02:02:45.