Report to the Programme and Policy Committee

28-29 October 2020

SUBJECT:	**ACCELERATING EFFORTS TO REACH ZERO-DOSE CHILDREN AND MISSED COMMUNITIES IN GAVI 5.0**
Agenda item:	03b
Category:	For Decision

Section A: Executive Summary

Context

Equity is the organising principle of Gavi 5.0, and the Alliance has made reaching zero-dose children and missed communities (which are also home to many under-immunised children) with a full course of vaccines our paramount common priority. This builds on the coverage and equity agenda during Gavi 4.0: since 2015, countries have reduced the number of zero-dose children[1] by 14%, following five years of stagnation in Gavi 3.0. However, with 10.6 million children remaining deprived of even a single dose of the basic diphtheria-tetanus-pertussis (DTP) containing vaccine every year in Gavi-supported countries, much remains to be done. After a successful replenishment, the Alliance has more resources to invest in its goal to leave no one behind with immunisation, scale up promising models of pro-equity programming at sub-national level initiated during Gavi 4.0 and help countries to accelerate progress.

The COVID-19 pandemic has created unprecedented disruption resulting in many more zero-dose and under-immunised children, with a disproportionate impact on poor and marginalised populations. It also means countries are facing higher costs as they adapt services to follow new safety protocols, intensify community engagement to rebuild trust and catch up missed children. The Alliance has stepped up to support countries in mounting an immediate response to COVID-19, and is now pivoting to maintain, restore and strengthen immunisation services. Countries are reprogramming Gavi support from their health system strengthening (HSS) and Partners' Engagement Framework (PEF) budgets to meet these needs. As both HSS and PEF budgets are currently set to decline in Gavi 5.0, with HSS declining by ~US$ 200 million, this risks undermining efforts to accelerate progress on equity unless additional resources are made available to countries.

Questions this paper addresses

1. How will the Alliance support countries to reach zero-dose children and missed communities, building on progress in Gavi 4.0?
2. How has COVID-19 affected immunisation and equity and how is the Alliance supporting countries to respond?

[1] Zero-dose children are defined for operational purposes as those not receiving a first dose of diphtheria-tetanus-pertussis (DTP) containing vaccine; under-immunised are those not receiving a full course of three doses of DTP-containing vaccine

3. What adjustments are needed to Gavi's investments to enable countries to accelerate progress on zero-dose while also responding to COVID-19?

4. How will Gavi strengthen its engagement with civil society in Gavi 5.0?

Conclusions

The Alliance's equity focus is more relevant, and more urgent, than ever in the context of COVID-19. However, countries will need additional support to be able to make further progress on the equity agenda and simultaneously maintain, restore and strengthen immunisation. Gavi's investment case for replenishment recognised the need for increased resources for the equity work and called for additional funding beyond the minimum ask of US$ 7.4 billion. Global leaders came together to strongly support the Alliance's vision of leaving no one behind with immunisation by 2030. This means a total of US$ 10.4 billion is available for 2021- 2025 (excluding COVAX Advance Market Commitment (AMC)), compared to the US$ 9.5 billion available during 2016-2020.

At its meeting in September 2020, the Board endorsed the need for additional resources to support the goals of the zero-dose agenda and asked the Secretariat to bring to the Programme and Policy Committee a detailed proposal on approach and resourcing. This paper presents options for the additional investment and recommends investing a further US$ 500 million in dedicated HSS. Access to this support would be contingent on countries identifying and planning to reach more zero-dose children, ensuring a laser focus on equity with more tailored and subnational programming. The paper also proposes to bolster technical support through the PEF, with an emphasis on engaging a full range of core, expanded and civil society partners to deliver targeted, differentiated, and innovative strategies. This includes investing in an expanded learning agenda on equity.

Section B: Content

1. The Alliance has made equity the organising principle of Gavi 5.0 in order to accelerate early progress from Gavi 4.0 in reaching zero-dose children and missed communities, build a foundation for equitable primary healthcare (PHC), and prevent avoidable child deaths and disease outbreaks, necessitating reactive investments

1.1 The Alliance's 2021-2025 strategy makes equity – with a focus on reaching zero-dose and under-immunised children with a full course of vaccines – our overarching priority. The rationale is compelling. These children, and the communities in which they live, are **among the most marginalised globally facing multiple deprivations** including poor health, lack of education, inadequate living standards, poor quality of work, the threat of violence, and exposure to environmental hazards. **Two thirds of zero-dose children live below the poverty line** and children in poor households are

three times more likely to be zero-dose than those in wealthy ones[2]. These communities are also more likely to have large numbers of under-immunised children with a significant correlation at district level rates[3] and drop-out rates in the poorest households are twice as high as those in the richest[4]. As illustrated in Figure 1, these children and their families often have limited or no access to health and social services, they are often politically marginalised and may not be officially registered or recognised. They are also often home to acute gender challenges where power relations in the household may limit mothers' access to education and their ability to access health services for themselves and their children, and lead to gender based violence, child marriages and teenage pregnancies.

1.2 As a result of all these factors, zero-dose children also have far worse health outcomes accounting for **nearly 50% of deaths from vaccine preventable diseases (VPDs)** despite being only 13% of the population[5]. These communities are prone to recurrent VPD outbreaks such as measles, which can spread rapidly necessitating reactive, repeated, and expensive investments in immunisation campaigns and outbreak response.

Figure 1

1.3 The Alliance's work to reach zero-dose and under-immunised children and their communities can help shine a spotlight on them, and the deprivations they face. We aim to ensure these communities are prioritised not only by immunisation, but also by other health programmes so that vaccines are delivered as part of an integrated package of primary health care (PHC)

[2] Sources: Fraym analysis of household survey data on immunisation coverage and household wealth, combined with World Bank data on poverty headcount ratios; International Center for Equity in Health analysis of Demographic and Health Surveys (DHS)/ Demographic and Health Surveys (MICS) survey data

[3] Analysis of Institute for Health Metrics and Evaluation (IHME) district-level coverage estimates shows that for every 1pp increase in % zero-dose, there is a 0.6pp increase in DTP drop-out rate on average in Gavi-supported countries

[4] International Center for Equity in Health analysis of DHS/MICS survey data

[5] Gavi internal analysis based on immunisation coverage and burden of disease estimates from WHO, IHME and other sources

services. This would be a **critical step towards the vision of the Sustainable Development Goals** to Leave No One Behind and achieve universal health coverage.

2. COVID-19 has exacerbated inequities and made the Alliance's equity goals more relevant and urgent; but also made it challenging for countries to maintain historic progress as programmes have been disrupted and service delivery has become more complex and costly.

2.1 **The COVID-19 pandemic is a global emergency, which risks major backsliding after decades of improvements in immunisation and health outcomes.** Recent estimates suggest that as many as one million more children could die within six months as a result of interruptions in services due to COVID-19[6]. As illustrated in Figure 2, the pandemic has created unprecedented disruption in immunisation programmes. While COVID-19 has affected each country differently, even countries which have had relatively few cases have seen their health systems strained by the need to respond to COVID-19 while simultaneously maintaining essential services. As a result, **many children who would have been immunised in 2020 will be missed**, risking increased mortality and outbreaks and making the focus on missed children even more relevant and urgent.

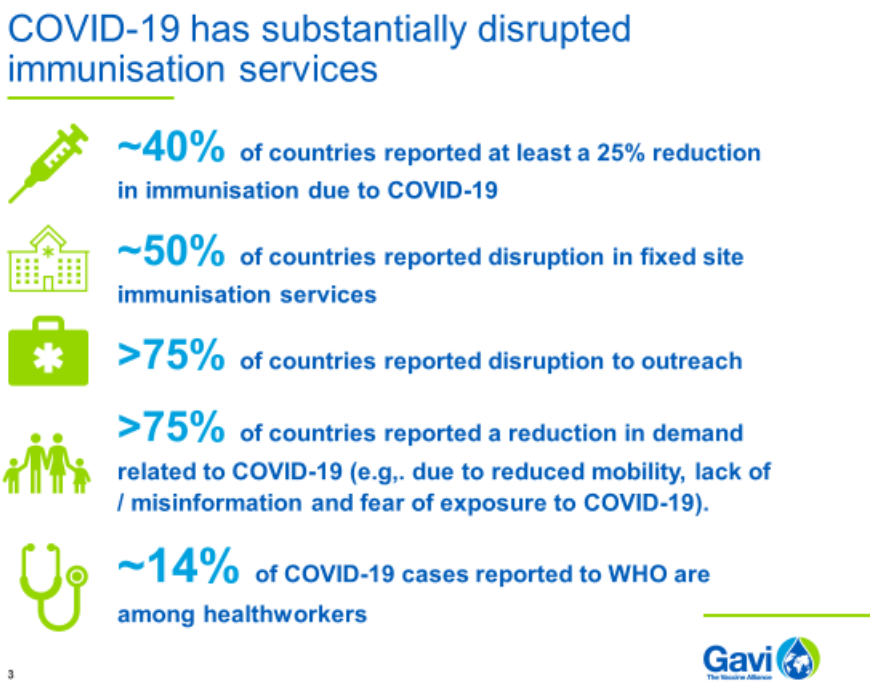

Figure 2

[6] Roberton, Timothy and Carter, Emily D. and Chou, Victoria B. and Stegmuller, Angela and Jackson, Bianca D. and Tam, Yvonne and Sawadogo-Lewis, Talata and Walker, Neff, Early Estimates of the Indirect Effects of the Coronavirus Pandemic on Maternal and Child Mortality in Low- and Middle-Income Countries (15 April 2020).
Available at https://ssrn.com/abstract=3576549. Precise estimate based on a scenario where coverage of health services declined by 45%.

2.2 **The pandemic is also exacerbating existing inequities** in many countries with the poorest and most marginalised communities more vulnerable to both the health and economic impacts of the pandemic. Those who contract COVID-19 in the poorest households are over 30% more likely to die than those in the richest households[7], while measures to combat COVID-19 have had a disproportionate impact on the health and income of the poorest households. In Pakistan, for example, the highest risk slums saw the largest decline in the number of immunisation visits during lockdown[8]. In Kenya, the poorest households reported 1.5 times more COVID-19 contacts than those in the richest, suggesting inequitable impact of transmission, while 86% of respondents reported a loss of income and 74% reported eating less or skipping meals due to having too little money for food[9].

2.3 In March 2020, Gavi made available a range of flexibilities to support countries' immediate response to the pandemic. The Secretariat has since approved **69 requests for reprogramming totalling over US$ 80 million in HSS and PEF** targeted country assistance (TCA). Over half of this has been to strengthen infection prevention and control (IPC) and provide personal protective equipment (PPE). This has been essential to help countries maintain health services, including immunisation. Other major areas of support have included risk communication and community engagement, laboratories and surveillance, and case management. The Alliance's capacity to respond rapidly and flexibly helped many countries meet immediate needs for which other sources of funding were not immediately available.

2.4 While immunisation was one of the health services most affected by the pandemic, it has also been one of the first to show signs of recovery with administrative data in many countries showing coverage starting to improve in recent months. Figure 3 provides some examples of the types of strategies countries have been employing to maintain and restore services. However, with the pandemic continuing to evolve, **health systems will remain under pressure and immunisation programmes will have to continue to adapt** to maintain services and catch up children who have been missed. Countries will need to adapt service delivery to reflect new safety protocols, intensify service provision to catch-up missed children and intensify community engagement to rebuild trust and demand for services. These will all increase the cost and complexity of service provision.[10]

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[7] Winskill et al. (May 12, 2020): https://www.imperial.ac.uk/media/imperial-college/medicine/mrc-gida/2020-05-12-COVID19-Report-22.pdf

[8] Chandir et al. (Lancet GH, June 2020): Impact of COVID-19 lockdown on routine immunisation in Karachi, Pakistan https://www.thelancet.com/journals/langlo/article/PIIS2214-109X(20)30290-4/fulltext

[9] Quaife et al. (pre-print, June 2020): The impact of COVID-19 control measures on social contacts and transmission in Kenyan informal Settlements suggesting an inequitable impact of COVID-19 transmission https://cmmid.github.io/topics/covid19/reports/LSHTM-CMMID-20200605-kenya_mixing.pdf

[10] See, for example, Moi, F, C.Banks and L. Boonstoppel (July 20, 2020). The cost of routine immunization outreach in the context of COVID-19: estimates from Tanzania and Indonesia. ThinkWell. http://immunizationeconomics.org/recent-activity/2020/7/21/the-cost-of-outreach-immunization-during-covid-19

Figure 3

2.5 The Secretariat is therefore pivoting to the **next phase of support to help countries maintain, restore and strengthen their immunisation programmes**. Countries are undertaking multi-stakeholder dialogues to review the impact of COVID-19 on their programmes, consider what programmatic adjustments might be needed and review how Gavi support might be repurposed. The Secretariat has provided countries with guidance (available here) on how its support can be used to maintain, restore and strengthen immunisation. This includes activities to identify and reach missed children (including zero-dose children), establish catch-up in routine immunisation, adapt training protocols, monitor and rebuild demand and engage communities. The guidance also highlights areas for which Gavi would encourage the use of domestic financing including PPE & IPC, capital investment, incentives and salary support, printing and traditional training.

2.6 The pandemic has also exposed weaknesses in immunisation programmes and the recovery presents **opportunities to build back better.** These include, for example, doubling down on geographies and populations with low coverage, rapidly scaling innovations to improve real-time data systems, addressing mistrust and hesitancy with stronger community engagement, promoting delivery approaches that encourage greater integration of PHC services and introducing digital training tools in place of traditional in-person training. To accelerate scale-up of these types of innovations the Secretariat has launched a catalogue of proven innovations (available here) that could contribute to maintaining, restoring and strengthening immunisation as well as identifying children and communities bereft of services.

2.7 Given their urgent needs, **the Secretariat is working with countries to re-programme existing HSS and Targeted Country Assistance (TCA) support** to maintain, restore and strengthen immunisation. While some of this can be reprogrammed from activities delayed due to COVID-19, many countries will likely need to de-prioritise other activities. Half of countries have already indicated they intend to reprogramme funding, on top of the US$ 80 million which was reprogrammed as part of the initial response. This will draw down on the US$ 1.2 billion in HSS and US$ 420 million in TCA

currently approved for Gavi 5.0, and reduce the resources available to countries to accelerate progress on reaching children who were not being reached even before the pandemic.

3. HSS and PEF support are currently set to decline in Gavi 5.0 at a time when countries' needs are increasing. Increasing HSS and PEF funding is needed to accelerate progress on equity.

3.1 When the Alliance set its replenishment target, the Board decided to include inactivated polio vaccine within the core ask, while maintaining Gavi's previous commitment that its ask for Gavi 5.0 would be lower than for Gavi 4.0. To accommodate this, **the HSS budget was reduced and HSS disbursements are forecast to fall from ~US$ 1.4 billion in Gavi 4.0 to US$ 1.2 billion in Gavi 5.0**, with most countries facing a reduction in their HSS ceiling as shown in Figure 4. The PEF budget is also forecast to decline.

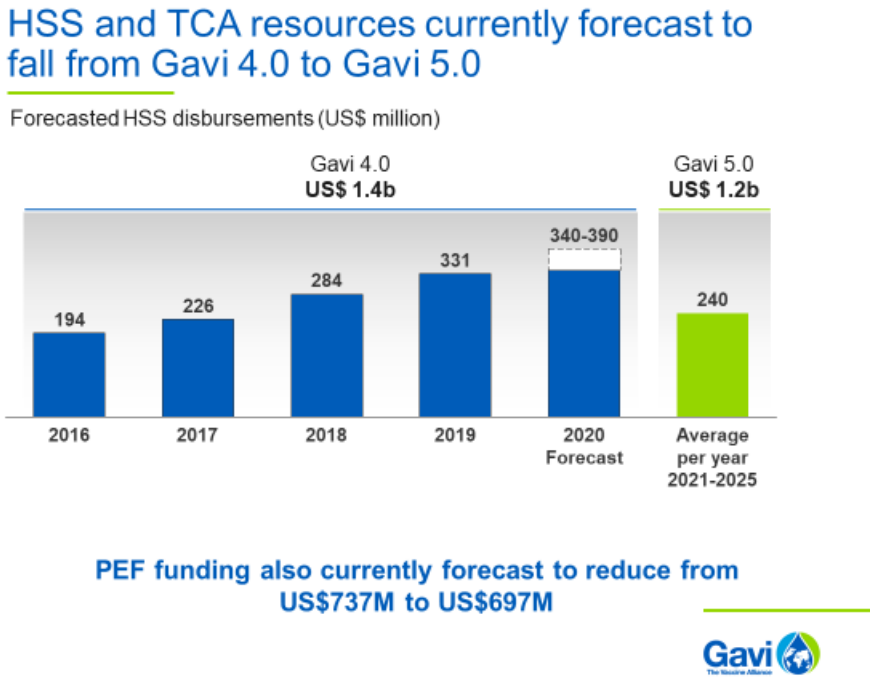

Figure 4

3.2 Recognising that additional HSS resources would be needed to deliver on the Alliance's equity ambitions with scaled-up work at subnational level, the Board agreed that the replenishment ask should be *at least* US$ 7.4 billion and to seek to mobilise additional financing. **The Alliance made a strong case to secure more support for the zero-dose agenda. This was recognised by donors who committed substantial additional resources** above the ask. As a result, US$ 10.4 billion is available for Gavi 5.0 which is higher than US$ 9.5 billion in Gavi 4.0. At its September 2020 meeting, the Board endorsed the need for additional resources to support the goals of the zero-dose agenda and asked the Secretariat to bring to the PPC a detailed proposal on approach and resourcing. Potential options for this investment include:

a) **Maintain HSS support at Gavi 4.0 level:** Maintaining HSS at the Gavi 4.0 level would increase the envelope for 2021-2025 by US$ 200 million to US$ 1.4 billion. Since the resources available would remain constant across strategy periods, it would likely not be sufficient to accelerate progress on equity from Gavi 4.0, especially given that COVID-19 has increased the number of zero-dose children and the cost and complexity of delivering services. This would require the Alliance to reduce its ambition on equity and focus more on preventing backsliding.

b) **Invoke Fragility, Emergencies, Refugees (FER) policy:** Typically, when countries are faced with an emergency on the scale of COVID-19, Gavi would offer additional support through the FER policy which allows for up to 50% of additional HSS, higher operational costs for campaigns and programmatic flexibilities such as wider age vaccination. The level of additional HSS made available under the FER policy would be in the range of US$ 500-600 million. This would provide countries with additional funding to manage the impact of COVID-19 and strengthen their programmes. However, the support would likely be used for more immediate needs and general activities, and not fully targeted towards reaching zero-dose children and missed communities with a longer-term and more strategic focus on subnational planning and execution.

c) **Provide similar funding to FER policy but dedicated for equity:** Provide a similar level of support to option b, but with access to it being contingent on countries identifying and planning to reach additional zero-dose children and missed communities, and monitoring progress. This approach would ensure political focus on these communities, incentivise countries to identify and seek to reach them, and ensure additional resources were used in a more targeted way with a subnational focus. By shining a light on these communities, it could also help to catalyse investments from other financiers (such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Global Financing Facility and the World Bank) to co-deliver other reproductive, maternal, child, newborn health, nutrition and other essential services. This approach builds on the HSS flexibilities which the Board approved in 2018, which resulted in more targeted grant proposals by making funding contingent on countries submitting strong coverage and equity plans. It also reflects feedback received during the consultations on the Gender policy, during which several stakeholders stressed the importance of dedicated funding to make progress on equity and gender. Finally, by focusing on zero-dose children and missed communities, this approach reduces the risk of VPD outbreaks, reducing the future need for investments in outbreak response and disease-specific campaigns.

d) **Provide a higher level of dedicated additional funding for equity:** In light of the strong global support for the Alliance's vision to leave no one behind, as demonstrated by its successful replenishment, the Board could choose to invest the majority of the additional resources (e.g. US$ 1 billion) in the equity agenda. This would send a strong signal about the Alliance's commitment and maximise progress on equity over

this period. However, this option may not be operationally viable, given capacity constraints at both country and Alliance level – especially in the context of the COVID-19 pandemic. It also reduces the Board's ability to invest in other priorities, which was a concern raised by some Board members during the September 2020 meeting of the Board.

3.3 **The Secretariat would recommend option c**, making available an additional US$ 500 million in dedicated HSS for equity (~US$ 300 million more than in Gavi 4.0 reflecting our higher ambition on equity and the increased cost and complexity of providing immunisation services due to COVID-19), as well as augmented PEF support as illustrated in Figure 5 and described below.

3.4 **US$ 500 million in additional HSS funding:** It is challenging to quantify the precise level of additional HSS support which is needed for the equity agenda since there is limited data on the cost to reach zero-dose children, and country needs are extensive. Actual costs will vary across countries and contexts, depending on the state of the economy, income level (especially as labour typically accounts for 40% of delivery costs[11]), location of missed children and barriers to reaching them (e.g. reaching a child in an urban slum will be different than a remote conflict zone) and strength of the health system (e.g. availability of health workers to provide services to missed communities). Developing estimates of the cost of reaching zero-dose children in different contexts will be a key learning priority for Gavi 5.0. However, it is clear that additional resources will be required to accelerate the rate of decline beyond that seen in Gavi 4.0. An additional US$ 500 million in HSS (~20% higher than Gavi 4.0) balances providing adequate resources to increase the rate of progress with the absorption capacity of countries.

[11] Portnoy, A., Vaughan, K., Clarke-Deelder, E. et al. Producing Standardized Country-Level Immunization Delivery Unit Cost Estimates. PharmacoEconomics 38, 995–1005 (2020)

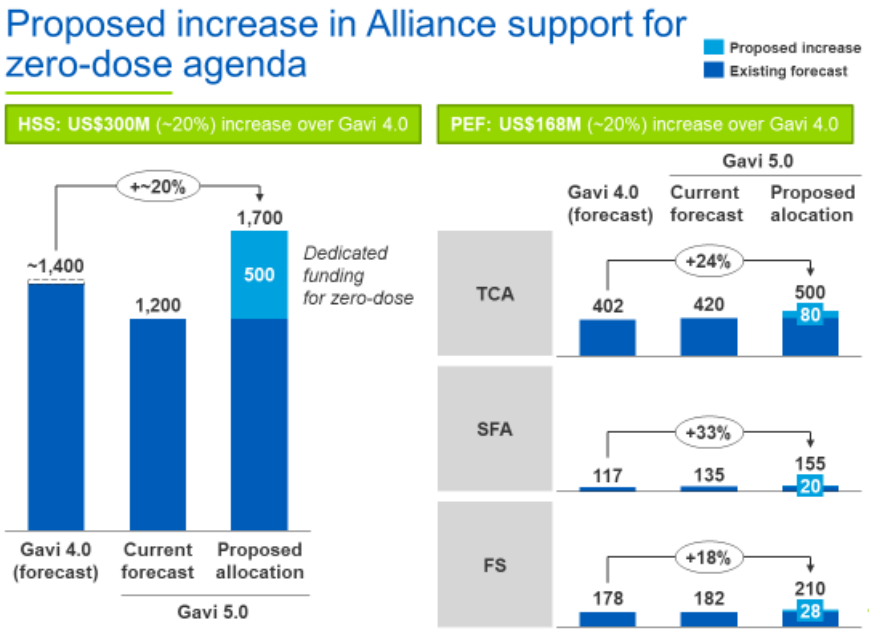

Figure 5

3.5 While data on the cost of reaching zero-dose children is currently lacking, it is possible to extrapolate some estimates from the available data. For example, one recent study modelling vaccine delivery in over 130 countries suggested that the cost to fully immunise each child already reached with all vaccines in the national schedule in Gavi-supported countries is ~US$ 22 on average (excluding vaccine costs)[12]. The cost of reaching zero-dose children is likely to be significantly higher given that many live in communities that are not currently served so countries will need to invest in building new service delivery infrastructure. Many live in areas that naturally have higher delivery costs such as conflict settings (over 50% of zero-dose live in fragile countries) and remote rural communities. These estimates also do not factor in additional costs to deliver services in the context of COVID-19. Assuming it will cost 50-100% more to immunise zero-dose children, the cost per targeted child would be US$ 33-44 (for five touchpoints per child in the first two years of life). On this basis, **US$ 500 million would allow countries to reach an additional 11-15 million zero-dose children** on top of those that might be reached through existing support. This is equivalent to 2-3 million additional zero-dose children reached per year out of a total of 10.6 million children who are zero-dose each year in Gavi-supported countries. This estimate is based on WHO-UNICEF estimates of immunisation coverage (WUENIC) from 2019, and the current number of zero-dose children might be higher

[12] Portnoy, A., Vaughan, K., Clarke-Deelder, E. et al. Producing Standardized Country-Level Immunization Delivery Unit Cost Estimates. PharmacoEconomics 38, 995–1005 (2020). Range depends on whether zero-dose children receive the average vaccines as those already reached or are fully immunised with all vaccines.

due to limitations in official population estimates[13] and the impact of COVID-19. Since drop-out rates are much higher in missed communities, this investment would also help reach additional under-immunised children.

3.6 By default, **Nigeria and India would not be eligible for this funding** as both have special strategies with specific Board-approved envelopes. Thus, this funding could help reach a reasonable proportion of the 5.8 million additional zero-dose children born in other Gavi-eligible countries every year. The Secretariat would propose the following approach to finance efforts to accelerate equity in Nigeria and India, and would welcome PPC feedback:

a) **Nigeria** has the highest number of zero-dose children globally. The Board approved exceptional support for Nigeria in 2018, which included US$ 260 million of HSS for the following ten years. A significant amount has been programmed towards low coverage States, but this did not yet fully adopt a zero-dose lens. The Alliance will work to ensure the support is adjusted towards reaching zero-dose and missed communities. To accelerate progress on equity, it may be necessary to also consider front-loading resources that were planned for the outer years of the ten-year period (subject to positive performance against Nigeria's Accountability Framework). We will keep the Board appraised of progress and, if progress is significant, there may be additional resource needs in the coming years.

b) **India** had the highest number of zero-dose children globally at the beginning of Gavi 4.0 but with catalytic support from the Alliance, through the partnership strategy approved by the Board in 2015, the Government has cut the number of zero-dose by 40% in the last four years. However, it still has the second highest number of zero-dose children globally (1.4 million), many of whom live in the poorest and most deprived areas of the country. There is an opportunity to build on existing momentum to substantially reduce this number in Gavi 5.0. The Secretariat plans to include targeted support for helping to reach these zero-dose children as part of a comprehensive new India partnership strategy to be brought to the PPC and Board in 2021.

3.7 The additional funding would be **operationalised through the portfolio management processes being redesigned** for Gavi 5.0 (see document 3a for details). Countries would be able to apply at any point during their grant cycle. For countries that apply for this funding as part of full portfolio planning, it would be included as part of the theory of change for Gavi support and accompanying application, workplan, budget and monitoring framework. For countries that apply outside the full portfolio planning cycle, the additional funds would need to be integrated into the existing budget, workplan and monitoring framework, with a short theory of change. The utilisation of the US$ 500 million will depend on country uptake. The

[13] Experiences from polio outreach, and Gavi's vaccine and campaign support highlight official population estimates in many countries do not fully reflect the denominator. Often populations such as migrants, refugees, floating populations along country borders are not included.

Secretariat will continue to monitor and report back lessons and evidence to the PPC and Board by 2022 at the latest, including any recommendations on whether adjustments are warranted due to either slow uptake or rapid progress.

3.8 **Increased PEF support for zero-dose:** In addition to additional HSS funding, the Secretariat proposes to adjust all primary components of the Partners' Engagement Framework to complement and catalyse HSS investments and help accelerate progress on the equity agenda:

a) **Targeted Country Assistance (TCA):** TCA would be maintained at the 2020 level for each year of Gavi 5.0 with a budget of US$ 500 million for 2021-2025 (an increase of US$ 98 million from Gavi 4.0 and US$ 80 million from the latest forecast for Gavi 5.0). Under Gavi 4.0, the partnership model was expanded to address key programmatic challenges, bring new expertise and provide technical support at subnational level in ~20 countries. The equity agenda will require further engagement of new partners including humanitarian actors in conflict settings, civil society organisations (CSOs) and other local institutions. While WHO and UNICEF will remain the primary partners of the Alliance, it will be necessary to continue to diversify provision of TCA and scale-up technical assistance at subnational level to complement HSS. Over time, the aim is for up to 30% of TCA to be used to engage and build capacity of local partners with a focus on the zero-dose agenda.

b) **Global and Regional level investments in Strategic Focus Areas (SFAs):** Investments would be needed in learning and innovation in new areas to reach zero-dose children and missed communities. For example, in line with Gavi's ambitious new Gender policy, there is a need to better understand gender-related barriers and design, test and evaluate new, gender responsive and transformative interventions. In addition, to mitigate the risks of vaccine hesitancy, a more systematic approach to social listening and community engagement needs to be rapidly developed. This will help develop a common taxonomy and approach to address misinformation. The proposal is to allocate a further US$ 20 million on top of the current forecast for Gavi 5.0, an increase of US$ 38 million over Gavi 4.0.

c) **Foundational Support (FS)**: Core partner staff at global and regional level will play a vital role in designing approaches to implement Gavi 5.0 and Immunization Agenda 2030. However, COVID-19 means many core partner staff are already fully occupied helping countries to maintain, restore and strengthen immunisation and prepare for introduction of COVID-19 vaccines. To address this, the proposal is to increase the FS budget from US$ 178 million in Gavi 4.0 to US$ 210 million in Gavi 5.0. This is in addition to dedicated support to be made available to WHO and UNICEF for global and regional staff and activities for COVID-19 vaccine delivery from the US$ 150 million approved by the Board; as well as any support which the Board may separately approve for partners as part of the approach to supporting middle-income countries

(see Doc 04).

3.9 The Secretariat is seeking PPC and Board approval of this new funding now to enable operationalisation from the start of Gavi 5.0 and catalyse early progress on the zero-dose agenda. Without assurance that additional funding will be available and with the level of Gavi support otherwise declining, **countries would need to prioritise between their urgent needs to maintain, restore and strengthen immunisation in the wake of COVID-19 and investing in reaching zero-dose children**.

4. The Alliance will work systematically to help countries develop tailored and differentiated strategies to reach zero-dose children and missed communities.

4.1 Successfully reaching zero-dose children and missed communities will require highly differentiated strategies. Approximately half of zero-dose children are in urban settings, remote rural contexts or conflict settings, while other children are missed due to factors including gender, poverty, ethnicity and other socio-cultural barriers. Each of these settings and barriers will require their own tailored strategies. Building on lessons from Gavi 4.0, the Alliance has developed a **five-step framework to help countries design programmes to sustainably reach zero-dose children** as illustrated in Figure 6 and described further below. This will be supported by **three key enablers**: systematic engagement with a broader set of partners – especially civil society organisations; a more deliberate approach to the use of innovation; and a more deliberate learning agenda for equity.

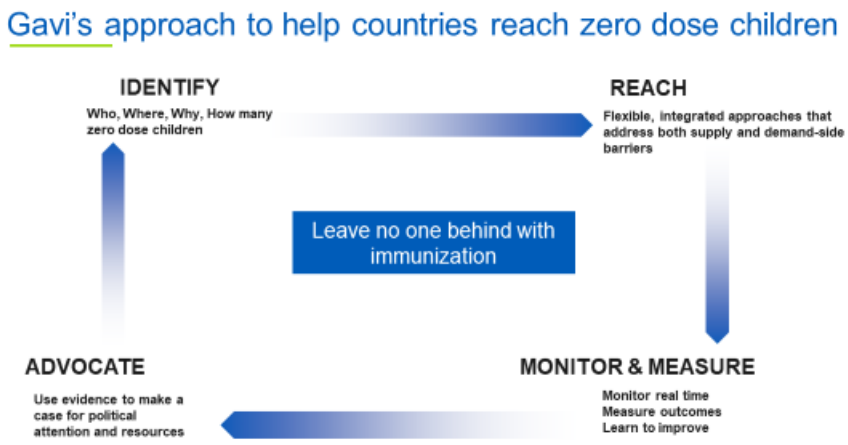

Figure 6

4.2 The Alliance will use the **Identify-Reach-Monitor-Measure-Advocate (IRMMA) framework** to help countries design tailored programmes to reach zero-dose children and missed communities:

a) ***Identify****:* A clear understanding of who, where, how many and why zero-dose children and missed communities have not been reached is a critical step in developing robust plans to reach them. These

communities are often not visible through existing data systems and assessments. They face profound barriers to vaccination including gender barriers, living in inaccessible or unrecognised settlements, migration, economic challenges and social or political stigma. Interventions including triangulation of existing subnational data, both within immunisation and other sectors (including nutrition and education), better enumeration of the distribution of zero-dose children, and geospatial mapping can help countries to identify these children and the barriers to reach them. In Pakistan, triangulating data from the Electronic Immunisation registry with polio-line-listing data helped identify pockets of zero-dose children in large districts and urban areas. In Kenya, administrative coverage data combined with geospatial estimates of coverage, socio-economic and gender survey data and estimated denominators from WorldPop helped improve the understanding of who zero-dose children and missed communities are, and how to target them (see Figure 7).

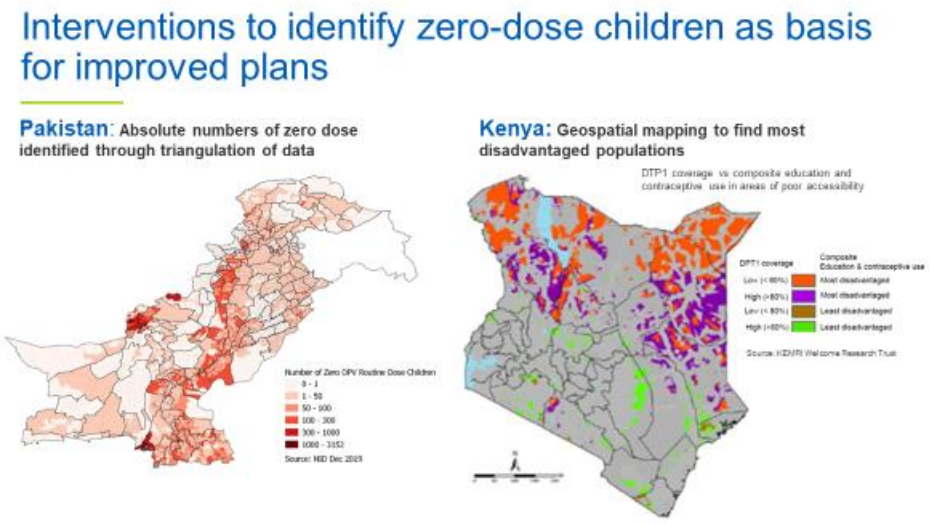

Figure 7

b) ***Reach:*** The Alliance will work with countries to make zero-dose children and missed communities the starting point for programming, designing targeted interventions to overcome supply and demand side barriers to reach them. This will require a subnational focus in planning and execution. On the supply side, the Alliance will work with countries to design more tailored and sustainable service delivery strategies for missed communities, grounded in strong routine immunisation and utilising the full spectrum of approaches from fixed post immunisation to outreach, mobile strategies, periodic intensification of immunisation, child health days and other supplementary activities. Gavi will also work with new partners based on their comparative advantage such as strengthening engagement with humanitarian and emergency organisations in conflict settings, and collaborating more closely with other financing organisations to co-fund delivery of a broader package of Primary Health Care (PHC) services to these communities (as illustrated in the South Sudan context in Figure 8). On the demand side,

it will scale-up innovative and tailored strategies to engage communities, harness behavioural insights, improve service experience and ensure services meet their needs. This will be even more important in countries where COVID-19 has increased concerns, generated new rumours and mistrust of immunisation, pushing up numbers of zero-dose children. This will be done with a particular focus on addressing gender-related barriers which hinder access to immunisation (e.g. in Pakistan, fewer girls were reached with catch-up immunisation as services resumed after the COVID-19 lockdown) or prevent mothers bringing their children for vaccination (e.g. due to unsuitable timing or inconvenient location of immunisation services, experience of poor service, stigmatisation).

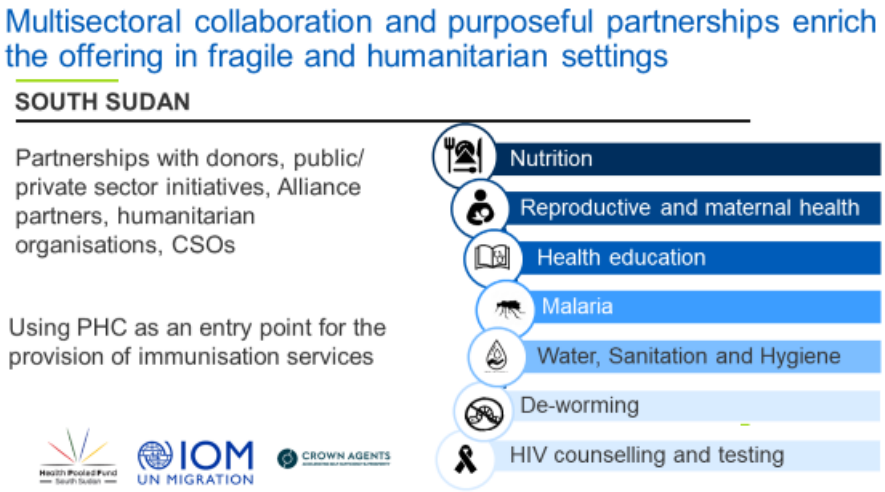

Figure 8

c) ***Monitor & Measure***: One of the challenges which the Alliance faced with the coverage and equity agenda was being able to track progress in a timely manner and understand what worked and did not work in its support to countries. The primary source for measuring progress has been WHO/UNICEF Estimates of National Immunization Coverage (WUENIC) but this is highly lagged (published seven months after the end of the reporting year), not sensitive to change (e.g. in many countries, sub-national surveys have picked up changes which do not show up in WUENIC) and subject to retrospective revision. This has made it very challenging to assess the overall progress being made on coverage and equity. The Alliance will therefore work to improve measurement including through targeted sub-national surveys and assessments, building country capacity and tools for generating insights from monitoring dashboards and analytics. This includes, for example, scaling up District Health Information Software 2 (DHIS-2) dashboards for district-level immunisation monitoring, strengthening data triangulation, and introducing real-time campaign monitoring. In Uganda an independent review found that use of the DHIS-2 Real-Time Monitoring module improved timeliness of the 2019 Measles-Rubella campaign, facilitated collection of results and feedback for corrective action and helped Uganda save on costs associated with transporting

data and printing forms.

d) ***Advocate**:* Gavi's experience from countries such as India, Pakistan and Democratic Republic of the Congo (DRC) have demonstrated that strong political leadership is one of the most important factors in catalysing rapid progress on immunisation equity. The Alliance will develop systematic strategies to make zero-dose children and missed communities part of the political discourse, encourage governments to prioritise resources towards them and highlight immunisation as a pathfinder for universal primary healthcare. The financing accelerator under the *Global Action Plan for Healthy Lives and Wellbeing for All* is also prioritising the zero-dose and equity agenda to create political momentum in priority countries.

4.3 **Three cross-cutting enablers will be critical for implementation of the IRMMA framework:**

4.4 ***New partnerships*** will be **needed** at each **step** of the framework.

a) **Closer collaboration with humanitarian organisations will be particularly critical** given that over half of zero-dose children are in fragile countries. The Alliance has begun developing such partnerships in this strategic period – for example working with the International Federation of the Red Cross (IFRC) and Afghan Red Crescent Society in Afghanistan and the International Organisation for Migration (IOM) in South Sudan to identify and reach missed communities. The Secretariat is working to institutionalise and scale these partnerships. Gavi signed a Memorandum of Understanding earlier this year to facilitate closer engagement of the IFRC and national Red Cross and Red Crescent societies and enable faster contracting where there are opportunities for partnership, and is working on similar agreements with other humanitarian agencies.

b) **Strengthening civil society engagement** will be equally critical. While civil society has been a core member of the Alliance since its inception, they have not been engaged systematically enough in the design and implementation of Gavi-supported programmes at country level. A 2018 evaluation identified a number of opportunities for the Alliance to strengthen civil society and community engagement. Following this evaluation, and recognising the critical role of civil society in helping to advocate for, identify, reach and monitor delivery of immunisation to missed communities, the Secretariat initiated work on a new engagement approach, working with the CSO Steering Committee. The first phase has focused on addressing one of the principal findings of the 2018 evaluation – that Gavi had not articulated a clear vision for how civil society supports the Alliance's strategic goals. Based on consultation with the Steering Committee and others, the Secretariat is proposing a new vision for civil society engagement to ensure that "Meaningful engagement of civil society and communities furthers the delivery of Gavi 5.0" through three strategic objectives and a set of crosscutting enablers, which are aligned to the IRMMA framework:

i. **Political will & accountability:** Civil society has a critical role to play in advocacy and securing social and political will for equitable and sustainable immunisation programmes. They also have an important role in monitoring progress and holding authorities accountable for delivery

ii. **Community demand:** Civil society and community-based organisations are uniquely positioned to build communities' trust, confidence and active demand for immunisation and primary healthcare as part of efforts to reach missed children.

iii. **Complementing public sector service delivery:** Civil society can help reach missed communities by extending the provision of immunisation services to areas which governments cannot reach.

iv. **Strategic enablers** will include enabling civil society engagement in national, subnational and Alliance health sector planning processes, and supporting capacity building, funding and innovation for civil society and community-based organisations.

c) The Secretariat and Steering Committee will refine this vision over the next month through consultations with CSOs and other Alliance stakeholders. The next phase of work will be to put in place the mechanisms to operationalise the vision, while in parallel testing new models of engagement to better understand what works and could be scaled up. The Secretariat has already identified a number of best practices in current programmes (e.g. see example of Mali in Figure 9) which we can learn and build from as well as a set of operational pain points that will need to be addressed – including, most critically, adjusting Alliance processes and approaches to make it easier for CSOs to receive Gavi funding whilst maintaining adequate financial assurance. This would be a particular priority for the proposed new funding to accelerate progress on equity. At its September 2020 meeting, the Board emphasised the importance of the PPC discussing the emerging approach. The Secretariat would welcome feedback and guidance from the PPC on this as well as the overall process, which is further described in Annex A. The Secretariat will bring the full approach for discussion to the May 2021 PPC.

Figure 9

4.5 ***Innovations:*** In Gavi 4.0, the Alliance tested a range of innovations to strengthen immunisation, making investments through SFAs, private sector partnerships and the Innovation for Uptake, Scale and Equity in Immunisation (INFUSE) initiative. This has enabled the Alliance to better understand how it can catalyse investments in scalable innovative solutions to meet country needs, and helped identify a range of innovations with the potential to have an impact across the portfolio. This includes innovations that could have an impact at each step of the IRMMA framework such as using geospatial data analysis to identify missed children; reaching children with new products such as micro-array patches, heat-stable vaccines, barcoding and other products; monitoring the implementation of programmes via real-time monitoring; improving supply chain visibility through electronic logistics management information systems; and strengthening engagement with missed communities via digital tools and behavioural interventions. Building on lessons from Gavi 4.0, the Secretariat is developing a deliberate strategy for investing in and governing innovation in Gavi 5.0 to be brought in the next governance cycle.

4.6 ***Learning Hubs:*** To better measure progress, support cross-country synthesis, inform key strategy and policy questions, and help identify best practices to share across countries, the Secretariat is planning to create a number of learning hubs. The Alliance will work with local partners in a subset of countries to develop these hubs, which will supplement routine monitoring with deeper measurement, analysis and understanding of factors influencing the performance of approaches to reach zero-dose children and missed communities. More details are provided in document 05.

4.7 ***Improved management of fiduciary risk:*** As requested by the Board at its November 2018 meeting, the Secretariat is developing a strategic approach for fiduciary risk assurance and financial management capacity building in Gavi-eligible countries. Two factors make this even more pressing: as described above, Gavi's approach to zero-dose children will entail new partnerships including with local partners and more funding

disbursed at sub-national levels, where financial management capacity is weaker; and COVID-19 disruptions may impair grant oversight, increasing risk of misuse.

4.8 Less than one third of Gavi support has been channelled directly through governments in this strategic period. However, **Gavi has made progress in supporting countries to make the switch to government systems** and has implemented a range of fiduciary risk mitigation mechanisms such as monitoring and fiduciary agents in countries including DRC, Chad, Côte D'Ivoire, and Uganda. With the new approach Gavi aims to significantly increase the share of countries using their own systems to channel Gavi funds with a target of 35 (or ~70%) Gavi-eligible countries using country systems by 2025 (up from 25 today). This would bring the total share of funds flowing through governments to ~60%.

4.9 **Institutionalising this approach without diverting resources from programmatic investments requires dedicated funding**. In the last strategic period, US$ 93 million was spent on fiduciary risk assurance, technical assistance, capacity building, and programme support costs, with funding from health system and immunisation strengthening (HSIS) grants, TCA and a special "Change 3 Facility" approved by the Board for this purpose. As the Change 3 Facility expires by the end of 2020, the Secretariat is requesting bridge funding of US$ 25 million for 2021. The Secretariat will come back to the Board in June 2021 with the full approach including a funding request for the remainder of Gavi 5.0.

Section C: Actions requested of the PPC

The Gavi Alliance Programme and Policy Committee is requested to **recommend** to the Gavi Alliance Board that it:

a) **Approve** an additional US$ 500 million in health system strengthening (HSS) for the strategic period 2021-2025 as dedicated funding for zero-dose children and missed communities. This amount is in addition to the US$ 1.2 billion in HSS included in the forecast presented and previously approved by the Board at its July 2020 meeting;

b) **Approve** an increase in Partners' Engagement Framework (PEF) spending of US$ 128 million to support efforts to reach zero-dose children and missed communities. This amount is in addition to the funding amounts included in the forecast presented and previously approved by the Board at its July 2020 meeting;

c) **Approve** US$ 25 million in bridge funding for 2021 for fiduciary risk assurance and financial management capacity-building, **noting** that a full strategy and associated funding request will be brought to the May 2021 PPC meeting.

Annexes

Annex A: Vision for Civil Society and Community Engagement in Gavi 5.0