Evaluation of Gavi's Contribution to Reaching ZD and missed communities

Country Case Study: Cote d'Ivoire

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List of acronyms

AMP	Agence de Médecine Préventive
ANADER	National Agency for Rural Development Support
CCE	Cold-chain equipment
CCEOP	Cold-Chain Equipment Optimisation Platform
CCIA	Committee for Inter-Agency Coordination
CEA	Coverage and equity assessments
CHW	Community health workers
DDS	District Health Directorate
DGS	General Directorate of Health
DIIS	Directorate of IT and Health Data
DRS	Regional Health Department
DTP	Diphtheria, tetanus and pertussis
EAF	Equity Accelerator Funds
EPI	Expanded Programme on Immunisation
ERG	Equity Reference Group
EVM	Effective Vaccine Management
FPP	Full portfolio planning
GPF	Grand Performance Framework
HPV	Human papillomavirus
HSS	Health systems strengthening
IHME	Institute for Health Metrics and Evaluation
IRC	Independent Review Committee
IRMMA	Identify, respond, measure, monitor, advocacy framework
LQAS	Lot quality assurance sampling
MEL	Monitoring, evaluation and learning
MICS	Multiple Indicator Cluster Survey
MoH	Ministry of Health and Public Hygiene
MPM	Monitoring and Performance Management
MRS	Market Research Society
NITAG	National Immunisation Technical Advisory Group
NVS	New vaccine support
PEF	Partnership Engagement Framework
PNDS	Plan National de Développement Sanitaire; National Health Development Plan
TCA	Targeted Country Assistance
ToC	Theory of change
UHC	Universal Health Coverage
WUENIC	WHO/United Nations estimates of national immunisation coverage
ZD	Zero-dose

Context

Health system context

After experiencing political instability, in the last decade, Côte d'Ivoire has achieved rapid economic growth with overall strong macroeconomic performance. This is partly due to domestic reforms in public administration in key economic sectors, considerable public investment in rural infrastructure, education and healthcare[1]. However, despite this progress, the country's health outcomes are still poor and comparable to those of low-income nations. The proportion of people living below the poverty line of USD 3.2 per day increased steadily during the period of civil war and instability in Côte d'Ivoire, before declining to around 40% today[2]. Gender inequality is a significant issue in the country, Côte d'Ivoire ranks 155 out of 170, as measured by the United Nations Gender Inequality Index (GII) (0.613 in 2021)[3]. Inequality levels have remained high, with a Gini coefficient of 0.415 in 2015, and the overall loss in human development due to inequality is estimated to be 35.7%, which is the sixth highest value globally. As donor assistance decreases, domestic resource mobilisation and fiscal space improvement have become crucial considerations for sustaining progress. To address these challenges, the government has committed to implementing health sector reforms.

The Ministry of Health and Public Hygiene (MoH) is responsible for overseeing the healthcare system. The primary healthcare system in Côte d'Ivoire is organised into health districts, which are further divided into health areas. The government of Côte d'Ivoire established the Coordination Directorate of the Expanded Programme on Immunisation (EPI) in 2009. Immunisation was the fifth largest disease programme in 2016, and one of the most donor dependent[4]. Gavi, has been the largest funder of the immunisation programme in the country, disbursing over USD 150 million since 2001.

A National Health Insurance Scheme launched to provide universal healthcare (UHC) to citizens, combined with external funding from Gavi, the Global Fund and the World Bank, and public-private partnerships to leverage resources and expertise in healthcare, all contribute to financing the Côte d'Ivoire health system. There were 29 prioritised health districts for the EPI under the HSS2 grant 2017–2022. This target number increased to 51 after a revision of health district borders in 2019. Despite major efforts for health systems strengthening (HSS), the healthcare system in Côte d'Ivoire still faces a shortage of healthcare professionals, especially in rural areas, which limits access to quality healthcare. Additionally, the healthcare infrastructure needs to be developed and further strengthened to meet the growing healthcare needs of the population. Cost and location or geographical access are significant barriers to immunisation, despite vaccines being free in principle[5]. A 2022 study undertaken by AMP, one of Gavi's local partners, explained that the costs of vaccination could still be related to the cost of a vaccine: 100 to 200 francs. Indeed, this was also confirmed anecdotally by key informants interviewed. Additionally, cost could also encompass cost of travel and the loss of productive time. As such, location was also spotlighted as a barrier for missed communities by the AMP study and the most recent National Vaccination Coverage Survey (ENCV 2020). A distance beyond 5km would be a deterrent especially if there were associated transportation costs. Furthermore, the study identified remote communities and migrant communities to be missed communities where, despite overall good access, outreach and location of vaccination centres could hamper access and affect motivation. Wealth inequities, attitudes

[1] https://bti-project.org/en/reports/country-report/CIV
[2] https://www.bmz.de/en/countries/cote-divoire/social-situation-48426
[3] https://hdr.undp.org/data-center/thematic-composite-indices/gender-inequality-index#/indicies/GII
[4] Health Systems Assessment for Côte d'Ivoire – Accelerating reforms toward UHC (World Bank, 2020)
[5] AMP Mapping of zero-dose and under-vaccinated children in Cote d'Ivoire (AMP, 2022).; Health Systems Assessment for Cote d'Ivoire (WBG, 2020)

towards vaccination, and a mother's education level, are key determinates influencing vaccine demand, with almost a quarter (23 per cent) of all reported barriers having a gender dimension[6]. The need for improved efficiencies in service delivery, and reinforcement of microplanning derived at sub-national level are factors affecting the supply-side.

According to an internal study led by the Gavi MEL team in March 2023, an estimated 30% of under-5 deaths are associated with households with a zero-dose child (representing 22,790 under-5 deaths associated with zero-dose)[7].While the country has adopted all of WHO's new vaccine recommendations, introducing several new vaccines since 2017, management of immunisation funding is complex and not harmonised across all funding sources. For example, external financing sources are not consistently channelled through formal governance structures, which can undermine effective and predictable planning, However, even when external funding for immunisation is managed through formal government structures (e.g. Gavi grants through UCP-FE), it can difficult to establish consistent planning [8]. Immunisation coverage in Côte d'Ivoire is below average compared to other sub-Saharan African countries: DTP3 coverage at national level is 76%[9]. DTP1 coverage was declining prior to the COVID-19 pandemic [10]. There is also significant immunisation inequality based on region, and socioeconomic status. Primary care facilities and public facilities in Côte d'Ivoire offer immunisation services, but stock-outs of vaccines have been a persistent challenge in recent years.

The national administrative vaccination coverage for all antigens has generally been below the national target of 95% for the past 5-year period. There has been a decrease in vaccination coverage for all antigens since 2019, with a more significant decline in 2020 and a slight increase in 2021 (see Figure 2.2). The low performance of the vaccination programme in the past 2 years can be attributed to the COVID-19 pandemic and particularly strong vaccination hesitancy due to rumours surrounding COVID-19 vaccines. These factors have negatively affected healthcare service utilisation, particularly routine immunisation vaccination services. The vaccination coverage for newly introduced antigens, such as HPV2 (47.5%), HépB (67%) and MenA (85%), is significantly lower than the coverage for older antigens in 2021[11].

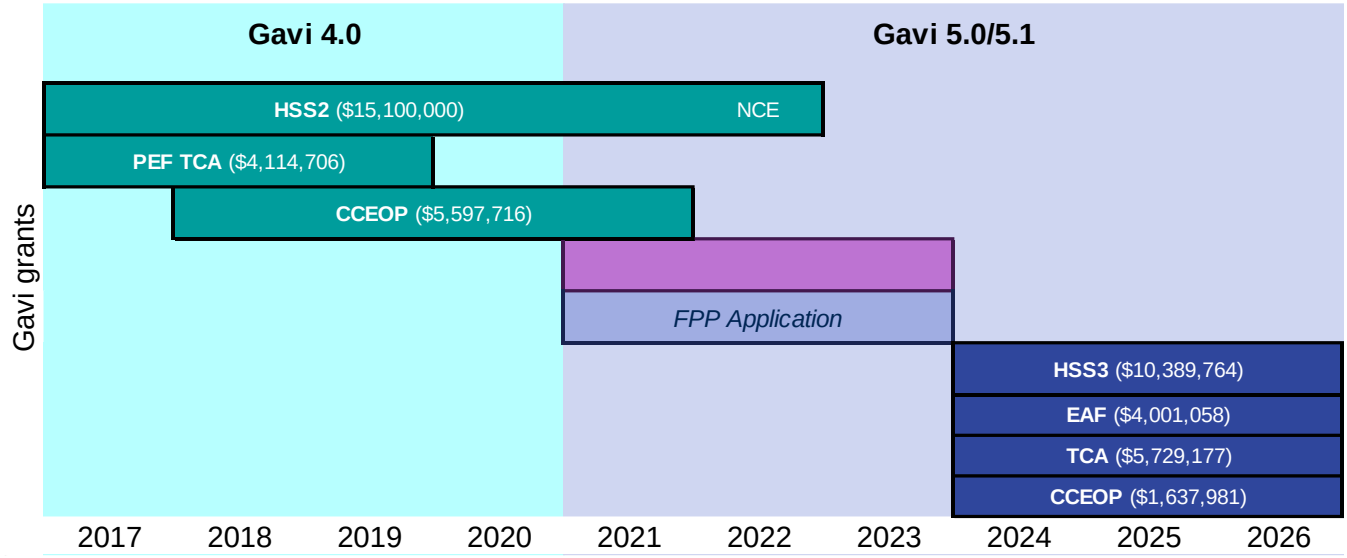
Gavi support

Côte d'Ivoire has been implementing Gavi grants with the Health Systems Strengthening (HSS2) grant from 2017–2022 combined with various new vaccine support (NVS) grants for routine immunisation and campaign against measles, meningitis A and HPV. Three tranches of COVID-19 Delivery Support grant from 2020 until this day, part of which have been reprogrammed for HSS activities. Furthermore, a Cold-Chain Equipment Optimisation Platform (CCEOP) grant from 2018 – 2021 has been providing much-needed support to maintain and reinforce the cold chain and supply chain throughout the country, which will extend the vaccination capacity to better cater to community needs. Targeted Country Assistance (TCA) 2017–2019 funding provided within the Partnership Engagement Framework (PEF) supported core Alliance partners (USD 1,678,394) and expanded partners (USD 2,436,312) on various aspects of technical assistance from vaccine management training to digitalisation of health data to financial management.

[6] FPP Application Draft 2021; AMP Equity Report 2018.
[7] Cote d'Ivoire ZD Analysis, Gavi MEL team, March 2023
[8] Health Systems Assessment for Cote d'Ivoire (WBG, 2020); KIIs (2023)
[9] WUENIC 2022 https://www.who.int/teams/immunization-vaccines-and-biologicals/immunization-analysis-and-insights/global-monitoring/immunization-coverage/who-unicef-estimates-of-national-immunization-coverage
[10] Cote d'Ivoire ZD Analysis, Gavi MEL team, March 2023
[11] https://immunizationdata.who.int/pages/profiles/civ.html

Côte d'Ivoire's full portfolio planning (FPP) application started in June 2021 and, at the time of writing, had still not been approved by the Independent Review Committee (IRC). Under the FPP, Côte d'Ivoire has requested access to HSS3 to extend gains made with Gavi 4.0 grants, Equity Accelerator Funds (EAF). This is with the aim of intensifying mobilisation of community actors, local communication channels and mobile strategies to reach zero-dose (ZD) children and missed communities; TCA to reinforce technical, financial, programmatic, and managerial capacity; and CCEOP funding from 2023–2025 to achieve their vision that in 3 to 5 years, all individuals, regardless of location and age, fully benefit from vaccinations for their health and well-being.

Figure 2.1: Summary of Gavi support to Côte d'Ivoire



Key stakeholders

Key stakeholders under Gavi 4.0 and Gavi 5.0/5.1 are depicted in figure 1.2. They remain constant with the MoH departments and sub-units such as the Regional Health Directorate (DRS) and the District Health Directorate (DDS), core Alliance partners, including WHO and UNICEF, as well as expanded partners, Agence de Médecine Préventive (AMP), VillageReach, Jhpiego and Dalberg, being main receivers of Gavi support. Figure 1.2 below provides an overview of relationships between different actors under Gavi 4.0 and 5.0/5.1.

Under Gavi 4.0, HSS2 support was allocated to the MoH through the Project Coordination Unit (UCP-FE) that then disbursed funds to different implementing entities at regional level (DRS), district level (DDS), the EPI programme and FENOS-CI. Part of TCA was provided to core Alliance partners who managed their own funds according to their own procedures (WHO and UNICEF). Another part of TCA was provided to expanded partners including AMP, VillageReach, Jhpiego, Dalberg Law and others through results-based financing.

Under Gavi 5.0/5.1, funding mechanisms and funding channels remain similar with the possibility of merging UCP-FE with another unit managing other international donor funds to streamline disbursement and allocation, which have been key barriers to utilisation in the recent years.

Implementing actors under the MoH are varied with clear roles and responsibilities for each entity leading on different activities. The EPI leads the immunisation programme under the MoH with the General Directorate of Health (DGS), providing directives and the strategy at national level to DRS and DDS. DRS and DDS elaborate their own microplans based on a national strategy aligned with the national health policy (Plan National de Développement Sanitaire (PNDS) 2016–2020 and cMYP 2016–

2020) and local community needs. Community relays, community health workers (CHW), and different local liaison agents embedded in civil society organisations (CSOs) from the FENOS-CI carry out sensitisation activities. At central level, the EPI works closely with the Directorate of IT and Health Data (DIIS) and other health departments for advocacy, data management, planning and learning. Main coordination entities are the Committee for Inter-Agency Coordination (CCIA) and the Restricted Thematic Group on Vaccination that pilot the range of multisectoral stakeholders and inter-departmental actors.

Country zero-dose theory of change

The theory of change (ToC) developed for Gavi 5.0/5.1 grants under the FPP is depicted in figure 1.3, and shows the intended causal pathway to ensure that Gavi funds reach ZD children and missed communities. This ToC, although recognised in IRC pre-screening and received positive feedback, the overall application has not been approved and may still change.

Data collection timeline

Data collection activities included the following:

- Initial introductory call with the senior country manager (May 2023)
- Document review (June – September 2023) (list of documents in Annex)
- Semi-structured interviews with key 15 stakeholders: 3 strategic, 7 operational, 5 frontline (May–September 2023)
- Validation call with the senior country manager (September 2023).

Figure 2.2: Key actors in Côte d'Ivoire under Gavi 4.0 and Gavi 5.0/5.1

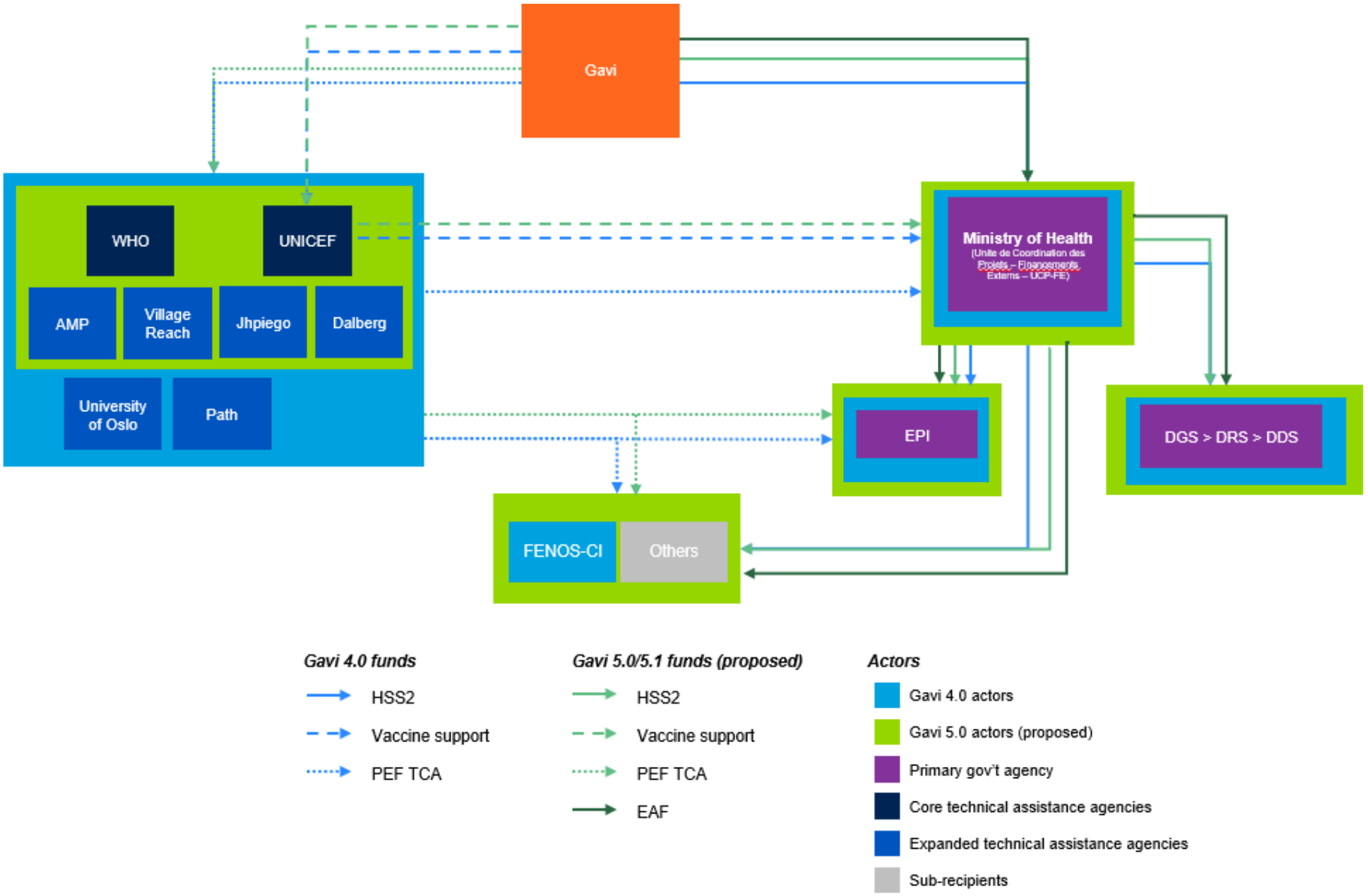
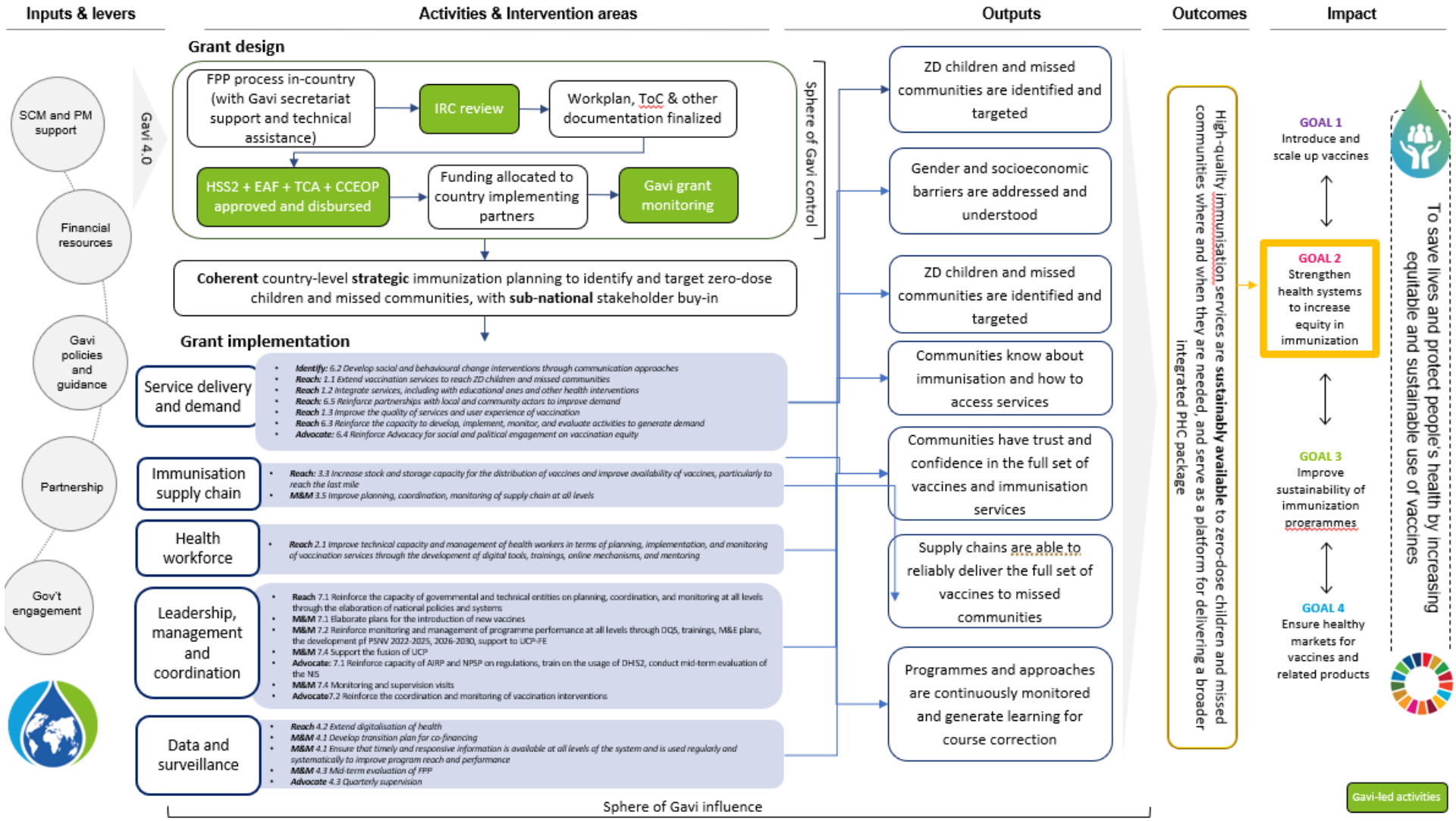


Figure 2.3: Côte d'Ivoire Gavi 5.0/5.1 theory of change



Findings

Objective 1: Relevance and coherence of Gavi's ZD agenda

EQ1. How relevant is Gavi 5.0/5.1's focus on ZD children and missed communities to countries' needs?

Summary of findings	▪ Vaccination challenges and inequities, exacerbated by the COVID-19 pandemic, remain a key priority for the MoH and the Ivorian government ▪ Prioritising ZD children and improving equity to extend and provide services to missed communities is essential to developing an effective approach to reaching national objectives and goals ▪ Data quality and variation on key coverage indicators vary noticeably making it difficult to assess the extent and severity of vaccination challenges ▪ Although information across datasets are not fully coherent, ZD children and missed communities were identified in non-remote rural and urban settings with variations in prevalence ▪ The IRMMA framework[12] supported the development of holistic context-appropriate interventions, although their effectiveness remains to be seen and is dependent on the FPP application being approved
Strength of the evidence	1 | **2** | 3 | 4
Rationale for this judgement	The evidence comprised multiple data sources from different stakeholders in different formats which enabled strong triangulation. However, the FPP application and its utilisation of the IRMMA framework have not been approved and the evaluation team does not have access to the latest IRC report to assess the IRMMA framework.

Vaccination challenges and inequities, exacerbated by the COVID-19 pandemic, remain a key priority for the MoH and the Ivorian government. World UHC service coverage index increased from 65 to 68 in 2021 since 2015. Côte d'Ivoire's UHC index continues to hover around 43% since 2015 (slightly below the index for the African continent at 44) with no major improvement[13]. In terms of service provision, the EPI is well integrated with other programmes (deworming, vitamin A, education, etc.) and made of very strong technical leads[14]. Health workers at all levels generally have the technical capacity and know-how to provide vaccination services and monitor coverage. Systems are in place to manage vaccine procurement and distribution. These are framed within a suite of national plans, standards and protocols that support the effective delivery of vaccination programmes. On a practical level, communication materials and plans have been adopted by local networks of community relays, and CHWs are utilised effectively. Nevertheless, vaccination coverage remains low with no clear patterns of increasing, and the number of ZD children remains proportionately high. Mobile strategies could benefit from being expanded at district level, and the continuity of vaccination services remains a challenge for healthcare services – particularly in the wake of the COVID-19 pandemic. Demand-side barriers such as low awareness and knowledge of vaccination for caretakers, parents, and pregnant women, fear and mistrust of health system or vaccination, still play a significant role[15]. Health outcomes and indicators lagged behind set targets. Supply-side barriers more generally affecting routine vaccination include

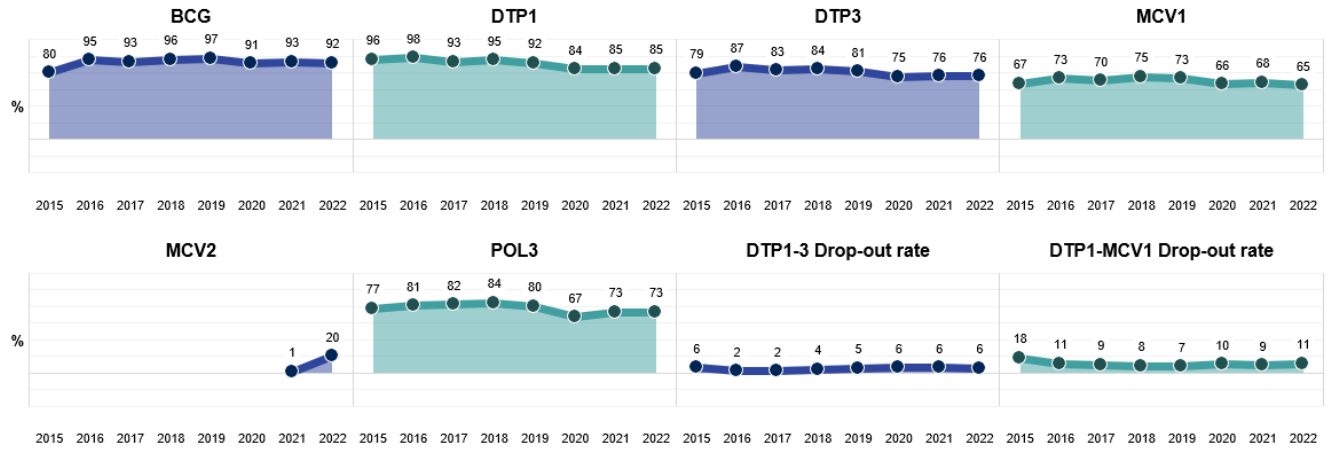
[12] IRMMA framework. (Gavi, 2019)
[13] https://data.who.int/indicators/i/9A706FD
[14] Country KIIs
[15] AMP Equity Assessment (AMP, 2023).

delays in the introduction of vaccines, heavy dependence on external donors and partners for the EPI, inconsistent planning at district level, and inefficient procurement. Health centres are not equally resourced, staffed, and accessible in different parts of the country. In rural areas, especially remote rural areas where ZD prevalence is higher, key informants indicated that the staff may not be trained and incentivised to deliver and report on vaccination. The lack of reliable data makes it very difficult for certain districts to drive the EPI programme. Furthermore, the challenges of recruiting appropriate staff with limited resources mean that, even with an established plan with community buy-in, it is difficult to carry out and implement it.

Prioritising ZD children and improving equity to extend and provide services to missed communities is essential to developing an effective approach to reaching national objectives and goals. Gavi's ZD strategy responds well to the need to adapt and address vaccination coverage issues in Cote d'Ivoire, particularly with the share rise of under-vaccinated children in the aftermath of the COVID19 pandemic. The focus on ZD children was perceived to be sensible and aligned with country needs in stated national plans. Respondents reported looking at ZD as part of a wider HSS picture, rather than an objective in its own right.

The number of ZD children has drastically increased (i.e., from 68,998 in 2019 to 135,333 in 2022) since the COVID-19 pandemic (as shown in Figure 2.1), with coverage of routine immunisation vaccines dropping below 90%, apart from the Bacillus Calmette-Guerin (BCG) coverage (as shown in Figure 2.2). During the COVID-19 pandemic, Côte d'Ivoire had to contend with a polio epidemic, and outbreaks of yellow fever and measles simultaneously[16]. Along with Ghana, Côte d'Ivoire was one of the first countries on the African continent to receive COVID-19 vaccines through the COVAX initiative. It was met with suspicion and fear, highlighting significant vaccine hesitation in the population, and driving down demand for vaccination in general, including routine vaccines. According to qualitative interviews, stakeholders explained that this mistrust would have been amplified in certain communities that previously already had low buy-in and vaccine confidence. The supply of vaccines and consumables to the districts was not significantly impacted by COVID-19. Routine distribution had already been carried out before the restrictive measures, and there were no stock shortages during the study period.

Figure 3.1: Select vaccine coverage and drop-out rates (WHO/UNICEF estimates of national immunisation coverage - WUENIC) in Cote d'Ivoire: 2015–2022



[16] Rapport Biennal 2020–2021 (OMS, 2022).

Data quality and variation on key coverage indicators vary noticeably making it difficult to assess the extent and severity of vaccination challenges. Qualitative insights from key informants and secondary data show that key causes of poor data quality are the inconsistent use of existing data collection and monitoring systems, lack of digitalisation, and lack of capacity, which lead to high levels of error and analysis challenges at central level. Data from multiple sources, including WUENIC, the International for Health Metrics and Evaluation (IHME), and administrative JRF data, presented an inconsistent picture, speaking to wider challenges around population denominators and health reporting. Data quality assessments (DQAs) and lot quality assurance sampling (LQAS) have been conducted by core Alliance partners with additional technical assistance to improve data collection at all levels, including through digitalisation and training of using DHIS2. Gavi's monitoring, evaluation, and learning (MEL) team noted in its ZD analysis (2023) that DTP1 coverage estimates, used in much of the IHME analysis, were not correlated with the latest available survey data, which in turn were not correlated with sub-national admin data. The lack of standardisation and consistency across data sources presents significant challenges in terms of assessing the profile of ZD children and missing communities and the barriers that prevent them benefitting from vaccination services.

Although information on ZD children and missed communities remains inconsistent and patchy, target populations were identified by triangulating multiple data sources. These sources included Coverage and Equity Assessments (CEA) conducted in 2015 and 2019, an equity study led by AMP in 2022, and various secondary data sources which were validated by Gavi's MEL team. More than one-fifth (20%) of districts have *over 1,000 ZD children*, and almost one-third (30%) of have *over 1,000 under-vaccinated children*[17]. On average, between 2015–2021, ZD children comprised 39% of all children without full DTP immunisation in Côte d'Ivoire[18]. CEA analyses indicated that ZD children were predominantly found in the centre-south and south-east regions of the country, while under-vaccinated children tended to be located mainly in urban areas, particularly in the south. Another analysis showed that ZD prevalence appeared to be highest in in the north-west of the country, especially in Bafing region near the Guinean border[19]. According to Equity Reference Group (ERG), three-quarters (75%) of ZD children were in rural non-remote areas, and 11% in urban locations. These inconsistencies further highlight the monitoring and reporting challenge.

While most ZD children live in rural non-remote areas, prevalence remains slightly higher in remote rural areas[20]. ZD populations are often found within nomadic, gold-panning and fishing communities, as well as in underserved neighbourhoods, peri-urban environments, and classified forests. The main reasons cited for ZD and under-vaccination in these areas included: fear of secondary effects; rumours/ misinformation; lack of knowledge and awareness among parents; cultural factors; physical access challenges; lack of financial resources; and lack of awareness, especially in more remote areas[21]. Supply barriers include: limited access to enclaved populations; inadequate implementation of advanced strategies, lack of appropriate transportation vehicles to reach remote areas with no adequate roads; insufficient community participation in planning, and lack of information on side-effects and their management. Demand barriers included: cultural norms; negative influences from community leaders; lack of motivation among community relays; remote/ migratory and otherwise hard-to-reach populations; communication gaps; and prioritisation of economic over health activities at

[17] AMP Equity Assessment (AMP, 2023).
[18] Côte d'Ivoire ZD Analysis (Gavi MEL team, 2023).
[19] Côte d'Ivoire ZD Analysis (Gavi MEL team, 2023).
[20] Cote d'Ivoire ZD Analysis, Gavi MEL team, March 2023
[21] AMP Equity Assessment (AMP, 2023).

household level. ZD prevalence varies by wealth, religion, maternal education, ethnic group, urban and rural divide, however not by gender[22i].

The IRMMA framework was used in Cote d'Ivoire to support the development of context-appropriate interventions, although its effectiveness remains to be seen and will be dependent on the FPP application being approved. The Ivorian FPP application showed dedicated activities targeting ZD children. Respondents reported that IRMMA had been useful in supporting more concerted and 'intentional' programme design activities, however the framework itself did not play a transformative role in the design of activities under Gavi 5.0/5.1. Gavi 5.0 activities sought to embed ZD solutions within the broader HSS initiative (i.e., a more systemic and contextually adapted approach). Examples of this include strengthening of microplanning at sub-national level with additional involvement of the community to ensure buy-in; reinforcing community networks including through CHWs and community relays, strengthening the role of CSOs, widening communication channels to increase demand, and enhancing mobile and advanced strategies.

EQ3. How coherent is Gavi's ZD agenda with other international and national actors' focus?

Summary of findings	▪ The Gavi 5.0/5.1 strategy – its principles, goals, and objectives – align with national-level immunisation and health plans, including the PNDS and the cMYP 2016–2020, as well as equity assessment and DQA recommendations. ▪ Core partner strategies are closely aligned with Gavi 5.0/5.1, supported by clear roles and responsibilities, a strong working partnership with the EPI, and historical relationships with various stakeholders, expanded partners and CSOs. ▪ The CCIA functions effectively and is well attended, respected and coordinated in a participatory manner, where stakeholders from all backgrounds can engage and discuss constructively. ▪ Expanded partners and CSOs have a shared understanding of the ZD strategy and definition. ▪ Coordination and coherence with the approaches of other non-health and non-vaccination actors are also well aligned with Gavi ZD strategy.
Strength of the evidence	**1** (highlighted) / 2 / 3 / 4
Rationale for this judgement	The evidence comprised multiple data sources from different stakeholders in different formats, which enabled strong triangulation. The only missing evidence is from decentralised and frontline implementors.

Gavi's 5.0/5.1 strategy – its principles, goals, and objectives – align with national-level immunisation and health plans, including the PNDS and the cMYP 2016–2020, as well as equity assessment and DQA recommendations. Between 2016 and 2021, the government of Cote d'Ivoire demonstrated commitment to vaccination through new legislative and regulatory measures. These measures aligned with Global Vaccine Action Plan recommendations and Immunisation Agenda 2030. Examples include the decision of the council of ministers, to allow for the advance payment of vaccines and consumables (2016) and decree number 2019-756 enabled free dissemination of media products on EPI vaccination (2019). EPI priorities are also reflected in national strategic documents, for example, the National Development Plan, National Health Development Plan, and Medium-Term Expenditure

[22] Cote d'Ivoire ZD Analysis, Gavi MEL team, March 2023

Framework. cMYP priorities reinforce this coherent picture between Gavi 5.0/5.1 and national strategies, highlighting measures to: reach 95% coverage of all antigens; ensure equitable access of high-quality vaccine services; eradicate polio; introduce new vaccines and appropriate innovative technologies in a sustainable manner; and, improve the quality of vaccination data.

Government leaders have demonstrated they have the capability, opportunity, and motivation to constructively engage with the ZD agenda. Similarly, there are significant strategic overlaps between Gavi's 5.0/5.1 and the PNDS. While ZD indicators on DTP1/PENTA1 are not explicitly mentioned in national policies and strategies, participants interviewed were familiar with ZD definition and proxy measures. Moreover, the EPI has been meaningfully integrated across other relevant government departments (education, maternal health, nutrition), further indicating a strong degree of coherence in terms of implementation.

Core partner strategies are closely aligned with Gavi 5.0/5.1, supported by clear roles and responsibilities, a strong working partnership with the EPI, and historical relationships with various stakeholders, expanded partners and CSOs. Alliance stakeholders in Côte d'Ivoire reported that the ZD agenda is coherent with their own organisations' agendas. The CCIA, a coordination and decision-making body for vaccination in Côte d'Ivoire, has effectively convened relevant stakeholders to align strategies, approaches, activities, and funding streams. This convening function was praised by participants, with different entities and stakeholders chairing meetings on a rotating basis. Overall it was reported that CCIA meetings were well attended, and facilitated active participation and engagement.

In addition to core partners being well aligned to Gavi 5.0/5.1, there is also strong alignment across in-country health partners, CSOs and NGOs, that play an important 'supporting function' in the effective delivery of EPI activities. As an expanded partner under Gavi 4.0 grants, Agence de Médecine Préventive (AMP), an NGO that links and mobilizes scientific, biological, technical, human and financial resources to address the needs of developing countries in the area of infectious diseases, had already begun conducting door-to-door identification of ZD children before Gavi 5.0/5.1 was introduced. Similarly, VillageReach, an NGO that builds people-centred health solutions to improve equity and access to care, is also currently implementing mobile strategies for identifying undervaccinated children and sending out reminders to primary caregivers. CSOs supporting immunisation and health activities are united under the FENOS-CI, an umbrella organisation for health-focused NGOs. Within this wider network of partners, all those who participated in this study demonstrated a strong understanding of the ZD agenda and the proxy indicator to achieve equitable and sustainable use of vaccines. At sub-national level, the National Agency for Rural Development Support (ANADER) engages livelihood actors to coordinate activities and messaging to ensure greater coherence.

Non-health and non-vaccination actors, that also play an important role in supporting the EPI in Cote d'Ivoire, demonstrate alignment, buy-in and commitment to reaching ZD communities. Country stakeholders and other associated donors are incentivised through consistent engagement to develop coordinated strategies for contributing to improving vaccination outcomes and participate in efforts to streamline delivery and efficiency of ZD activities. These include the Rotary International, Catholic Relief Services, private sector laboratories that mainly support HPV initiatives, the Ministry of Interior, Ministry of Planning, Ministry of Defence, Ministry of Education, and the Ministry of Solidarity, Women and Protection of Children. Workshops and consultations were regularly held to share learnings and improve coordination, and – at the national level – ZD objectives will be incorporated into integrated multisectoral policies and plans of core partners according to key informants interviewed. Additionally, other associated donors such as the World Bank and USAID, frequently took part in various CCIA meetings, technical discussions and coordination workshops. One illustrative instance of learning and

alignment are efforts to improve the management capacities of UCP-FE based on lessons learnt from funding disbursement for the Global Fund.

Overall, the Gavi's definition of ZD has been widely accepted and used by the national level stakeholder community in Cote d'Ivoire, particularly to help identify and reach missed communities "leaving no one behind". There is currently insufficient evidence to state with certainty that the ZD concept has been adopted at the subnational/ decentralised level, for example, by DRS, DDS, community agents or CHWs.

EQ2. How relevant are the Gavi funding levers to the needs of countries with regard to reaching ZD children and missed communities?

Summary of findings	▪ Gavi support was essential for helping Côte d'Ivoire meet its vaccination demand, particularly the introduction of new vaccines through NVS, and the expansion and adjustment of the cold chain and supply chain through CCEOP. ▪ Cote d'Ivoire has consistently fulfilled its co-financing obligations by financing up to 50% of the EPI and other programmes since 2017. Key informants expressed concerns relating to Cote d'Ivoire's ambitious transition trajectory, that will see the country's contribution rise from an anticipated USD 3.95 million in 2020 to at least USD 20.72 million in 2025. ▪ The combination of Gavi 5.0/5.1 funding levers and channels were considered relevant and designed to help the country meet its public health priorities. ▪ The intention of funding levers were well-understood, however participants saw FPP application requirements as burdensome and costly, and integrating IRC feedback had resulted in confusion and frustration. ▪ Procedural and administrative issues with UCP-FE over the past five years reportedly led to delays and lower funding utilisation through Gavi 4.0 funding levers. ▪ It is not possible to assess the extent to which Gavi 5.0/5.1 funding levers are directed and appropriately tied back to ZD drivers given that the FPP application has not been approved and finalised.			
Strength of the evidence	**1**	**2**	**3**	**4**
Rationale for this judgement	Evidence comprises a range of data sources and types for proper triangulation but data for comparison and assessment were reported inconsistently. It was not possible for the evaluation to conduct a rigorous assessment to triangulate findings from various sources at similar time points. Without access to harmonised and consistent data or indicators on funding lever allocation, disbursement, and utilisation (i.e., actual vs planned progress), the evaluation team could not conduct a comprehensive analysis of the relevance, adequacy and responsiveness of individual funding levers in Cote d'Ivoire. With the FPP application still in review and limited data on progress around conversations that have taken place this year after IRC review in March 2023, the evaluation can only make assumptions that will need to be confirmed next year.			

Gavi support was essential for helping Côte d'Ivoire meet its vaccination demand, particularly the introduction of new vaccines through NVS, and the expansion and adjustment of the cold chain and supply chain through CCEOP. Qualitative evidence and some documentation evidence such as the GFP indicate that the strengthening of the vaccination supply chain, added support for MR and MenA routine and catch-up, and the introduction of the HPV vaccine were only possible thanks to Gavi support, with no other donor and no government capacity to fully cover those needs. The targeted funding and technical assistance dedicated towards these activities and enhancing outcomes around specific

coverage and systems improvements translated into stronger supply chains, no stock outs, and sustained routine immunisation activities. MCV1 coverage went from 86% in 2017 to 92% in 2019 before the pandemic, for example. As such, key stakeholders voiced concerns around accelerated transition out of Gavi eligibility which could lead to a major funding gap for the country's vaccination.

Cote d'Ivoire has consistently fulfilled its co-financing obligations. However, key informants expressed concerns around Cote d'Ivoire's ambitious transition trajectory, that will see the country's contribution rise from an anticipated USD 3.95 million in 2020 to at least USD 20.72 million in 2027[23]. Côte d'Ivoire has fulfilled its co-financing obligations consistently in the past decades with early payment in 2022 and no disruption during the COVID-19 pandemic. The government has been financing up to 50% of the EPI and other programmes since 2017[24] before its preparatory transition phase. Since 2022, Côte d'Ivoire's average co-financing share, for all antigens (i.e., Penta, PCV, Rota, HPV and MenA), has been ~15%, and 58% for routine MMR vaccines. TCA funds will support the accelerated transition through various activities by strengthening governance and sustainability of vaccination financing[25]. This includes supporting the finalisation of national level plans such as the new vaccination strategy 2026-2030. The feasibility of Cote d'Ivoire's accelerated transition worried key stakeholders interviewed given, for example, the effective vaccine management (EVM) improvement pan had budgeted USD 42 million to implement its recommendations across 4 years[26]. Key informants interviewed were less concerned about the overall grant ceiling changing (in the event the government was unable to meet its increased co-financing obligation) but were worried about the short timeline for the transition trajectory. These concerns grew during the COVID-19 pandemic, as the government's budget was heavily adversely affected, raising questions whether the government would have time to adapt and meet transition deadlines[27]. During the COVID-19 pandemic, the country received a freeze on its co-financing increase, delaying the transition trajectory to 2030. IRC comments, in pre-screening documents, hinted at concerns around the perceived lack of visibility on how increased financing would translate into concrete plans for transition, given the fact that microplanning activities are currently covered entirely by Gavi and Jhpiego, with no anticipated decrease in funding[28].

Table 3.1: Grant ceilings of Gavi 5.0 funding levers and main aims

Funding lever	Grant ceilings (USD)	Main aims of funds in country
HSS	10,389,764	Support for coordination, microplanning, supervision, vaccination campaigns, digitalisation, communications campaigns, sensitisation, development of urban strategy, trainings, elaborating PNDS 2026–2030, evaluating FPP Potential recipients: MoH (DGS, DRS, DDS, DIIS, EPI), FENOS-CI
EAF	4,001,236	Development of gender-sensitive strategies at community level, tailored communications campaigns, vaccination intensification, purchasing equipment for mobile teams, CSOs mapping in all 113 health districts

[23] Co-financing information sheet 2019.; Revised TCA Narrative 2022; IRC FPP Pre-screening 2022
[24] Joint Appraisal report (Gavi, 2017).
[25] Revised TCA Narrative 2022
[26] EVM Improvement plan (Gavi, 2021).
[27] KIIs; IRC FPP Pre-screening 2022
[28] IRC FPP Pre-screening 2022

		Potential recipients: MoH, FENOS-CI
CCEOP	1,637,981	Potential recipients: MoH, UNICEF
TCA	5,729,177	Support information management and utilisation of data for identifying and reaching ZD children and missed communities (32%) through microplanning, community action plans, supervision and monitoring, 26% for integrating of services with CSOs, 25% to reinforce advocacy and social engagement and political engagement, 17% to improve EVM Commissioning of studies, evaluations Potential recipients: UNICEF, WHO, WorldBank, AMP, VillageReach, Jhpiego, Dalberg

The combination of Gavi 5.0/5.1 funding levers and channels were considered relevant and appropriately designed to meet the country's needs and wider public health priorities. Stakeholder interviewed reported that funding levers were adequately designed to help the country carry out the ZD agenda. The HSS funding lever would be mainly dedicated to improving service provision, reinforcing human resources, generating demand, improving data monitoring and learning, ensuring sound financial management, and tackling governance, strategic planning and management. The EAF funding would be mainly dedicated to developing strategies and expanding or refining existing strategies to identify and reach zero-dose children and missed communities. TCA funding would be directed towards building the capacity of national actors especially UCP-FE and developing the transition plan.

The intention of funding levers were well-understood, however participants saw FPP application requirements as burdensome and costly, and integrating IRC feedback had resulted in confusion and frustration. The cost-benefit of a standalone FPP funding lever and application process was questioned by some of Gavi's in-country stakeholders. Stakeholders indicated that the purpose of the levers and funding targets were sensible, but the resources needed to complete the application were lacking. Teams struggled to manage both the resource-intensive application development process and continuation of service delivery. While some appreciated the separation of a top-up fund dedicated to the specific searching and reaching of ZD children and missed communities for more effective decision-making, others felt that that EAF could benefit from being fully integrated into the HSS funding application given that they are complementary.

Procedural and administrative issues with UCP-FE over the past five years reportedly led to delays and lower funding utilisation through Gavi 4.0 funding levers. Qualitative data pointed to general satisfaction of stakeholders with Gavi funding mechanisms. Indeed, the utilisation rate in 2019 was reported to be at 98% before the proposal submitted for additional HSS funding, with utilisation rates varying by implementing partner according to Joint Appraisal updates. However grievances were noted for funding disbursed through the UCP-FE. In the past 5 years, key informants indicated that many delays in payment of community relays, CHW and others had led to nefficiencies, and activities not taking place as planned. Procurement and protocols applied to funding disbursed through UCP-FE were perceived by key informants to be laborious and did not facilitate timely responses and planning. It is not clear that Côte d'Ivoire had the most effective systems and capacity in place to absorb Gavi support through UCP-FE, which was created to strengthen government management of immunisation related funds. Conversations are ongoing about the revision and restructuring or merging of UCP-FE.

It is not possible to assess the extent to which Gavi 5.0/5.1 funding levers are directed and appropriately tied back to ZD drivers given that the FPP application has not been approved and finalised. CSOs, NGOs and key community actors demonstrated high levels of capability, opportunity and motivation to take part and proactively engage in the FPP application process. There are multiple examples of the IRMMA framework being used to develop activities to engage the FENOS-CI, reinforce their technical and operational capacities, and participate more actively in the delivery of the ZD agenda whether that is through identification of ZD children and missed communities, outreach to caretakers, and raising awareness on vaccination. To tackle some of the aforementioned demand-side challenges, there was appetite among Gavi national stakeholders to more intentionally engage community members in the vaccination microplanning, a desire that was mirrored by community actors to help address issues including: poor mobilisation of CHWs and community relays due to delays; and, inconsistent payment linked with UCP-FE processes.

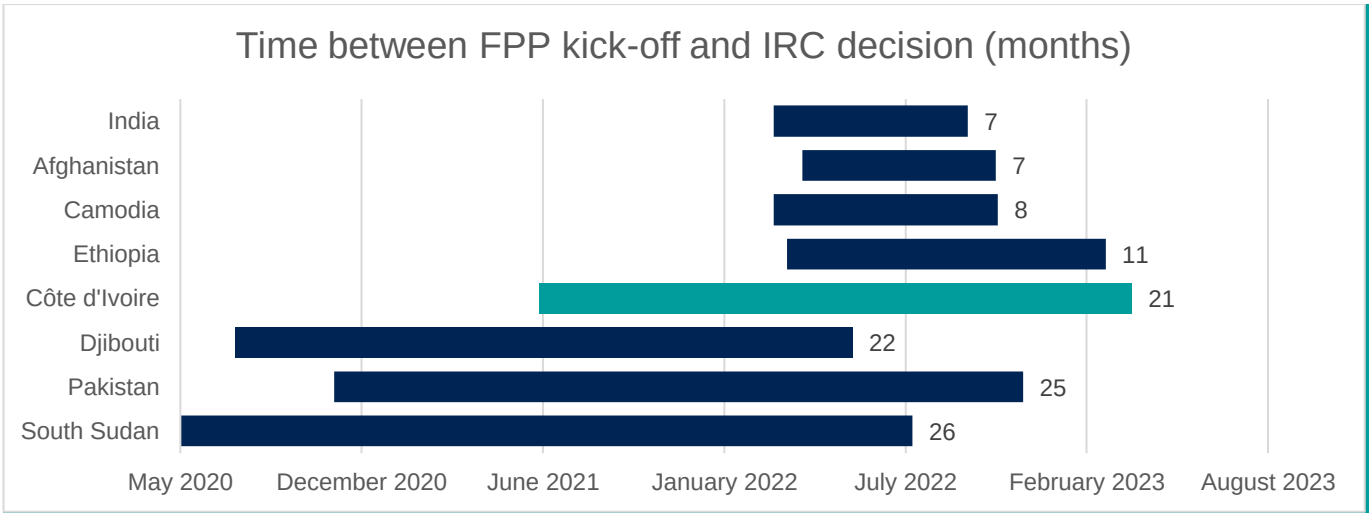
Objective 2: Operationalisation of the ZD agenda

EQ4. To what extent have Gavi 5.0/5.1 funding levers, processes and guidance enabled countries to focus their Gavi support towards reaching ZD children and missed communities?

Summary of findings	▪ Operationalisation of Gavi 5.0/5.1 in Côte d'Ivoire has not taken place as the country is still undergoing revisions to its FPP application, last rejected in spring 2023. ▪ Qualitative evidence highlighted that more effective operationalisation of grant development may be beneficial for implementation. ▪ Based on limited data, intended shifts within grant design will be taking place			
Strength of the evidence	**1**	**2**	**3**	**4**
Rationale for this judgement	The FPP application submitted in 2022 was not approved. The evaluation team does not have access to IRC review reports. Main data source for this analysis is a draft FPP from 2022, pre-screening IRC report, and qualitative interviews triangulated across stakeholders.			

Gavi 5.0/5.1 has not yet been operationalised in Côte d'Ivoire as its FPP application is currently undergoing revision after being rejected during its earlier spring 2023 submission. According to the Monitoring and Performance Management (MPM) tracker, Côte d'Ivoire's FPP application kick-off started in June 2021, with an IRC decision due to be provided in March 2023. Despite more than 21 months elapsing since the commencement of the application process, no Gavi funds have been dispersed to target ZD children. It was anticipated that funds allocated to CSOs and expanded partners through the TCA 2023 (e.g., AMP, VillageReach, Jhpiego, and others) would account for approximately half (46% or USD1,789,618) of TCA funding in 2023, however this has not been possible to verify. Within the FPP, Côte d'Ivoire applied to receive HSS3, EAF, CCEOP and TCA funding.

Figure 3.2: Time between FPP kick-off and IRC decision (months)



Qualitative evidence highlighted that more effective operationalisation of grant development may be beneficial for future implementation. There was general frustration and dissatisfaction regarding the FPP application process and the IRC review, which was said to detract time and resources from regular operations into application development. Many respondents fed back that a "long, tedious, and confusing application process distracted them from their day-to-day work and that the process was not pragmatic or realistic". IRC feedback was perceived to be too focused on details, hindering flexibility, adaptation and learning necessary to support timely implementation. Although guidance, tools and the application kit were generally considered useful, those did not simplify or accelerate the application process.

Based on the revision of a draft FPP application, and in-depth interviews, intended shifts within grant design of Gavi 5.0/5.1 have taken place. The current iteration of the application somewhat met requirements on IRMMA criteria, gender, CSO engagement, and demand generation:

- **Single ToC:** The IRC pre-screening report confirmed that Côte d'Ivoire has a strong single ToC, articulating how inputs would translate into outputs and outcomes generally strengthening the health system, partially through a ZD approach.

- **Identify:** The IRMMA framework was used to structure the country's ZD approach, using triangulated data sources to guide 'Identify' activities such as studies on social and behavioural barriers to vaccination, the development of communication strategies in local language to be shared on specific channels, community mobilisation, and development of gender-specific strategies and communications.

- **Reach:** 'Reach' strategies in the application aim to strengthen vaccine supply and accessibility of service by bringing services to the target communities through mobile and advanced strategies, improved supply chains, incorporation of missed communities in district-level microplanning, developing sub-national targeting and planning, for example. Reach strategies were also aimed at strengthening partnerships with local and community stakeholders to better generate demand for vaccination. This would include a mapping of CSOs in all 113 districts across the country.

- **Monitor and measure:** Activities suggested seem to build on what was initiated under Gavi 4.0 HSS2 grant which includes better data management, digitalised data collection and analysis, training of healthcare workers, and enhanced monitoring and supervision. There is a clear outline

that better data would enable improved targeted services for ZD children and missed communities.

- **Advocate:** Activities were planned to review existing health plans and cMYP and assessing progress of the FPP. Interviewees stated that these more nuanced approaches are inevitable evolutions and transformations of the implemented under Gavi 4.0 funds. The recent prioritisation has been on the Big Catch-Up but ZD children and missed communities represent a large proportion of those lost so stakeholders felt that the shifts under Gavi 5.0/5.1 were relatively sensible.

- **Gender:** No gender transformative interventions were detailed.

- **Demand generation through sub-national targeting:** To address demand-side barriers, activities planned to reinvigorate and revitalise CSO, community relay, CHW networks at sub-district level, including with financial incentives and more specific training to better identify ZD children and missed communities. On the supply side, activities would reinforce the management and delivery capacity of the health workforce through consistent and improved micro-planning that would involve community participation for better buy-in.

Objective 3: Contribution of Gavi 4.0 pro-equity and ZD grants

EQ5. How have Gavi grants initiated under Gavi 4.0 with continued implementation in 5.0/5.1 contributed to the delivery of the ZD agenda at the country level?

Summary of findings	▪ Activities under 4.0 enabled the possibility of undertaking the ZD agenda with Gavi 5.0/5.1 grants through HSS; however, those were not sufficient			
Strength of the evidence	**1**	**2**	**3**	**4**
Rationale for this judgement	Data and stakeholder triangulation was limited. Monitoring and recordkeeping on progress against initial plans was inconsistent and scattered which made triangulation and validation challenging. Workplans shared with the evaluation team show certain planned activities for 2020 but there is no tracker of work completed, aside of JA reports. Mission reports were available from 2016–2019 with a gap until 2022.			

Given the lack of consistent and reliable reporting on activity progress and indicators under Gavi 4.0, the evaluation team is not able to meaningfully assess the contribution of Gavi 4.0 inputs towards the ZD agenda in Côte d'Ivoire and its ToC. Grand Performance Framework (GPF) 2016–2020 data is missing across all indicators mapped to Gavi 4.0 activities. Where data does exist, it's not always available for all time points. Joint Appraisal reports and Multi-Stakeholder Dialogue reports are not available after 2020, making it challenging to assess progress, completion and success of activities made in the past 2 years, in parallel to the COVID-19 response. Where reporting indicators are available, comparability is not always possible given reporting in different formats, and lack of traceability of progress.

Activities under 4.0 enabled the possibility of undertaking the ZD agenda with Gavi 5.0/5.1 grants through HSS; however, those were not sufficient. A pro-equity intervention mapping study in 2022 identified two CEAs as pro-equity mapping. However, other activities may have partly contributed to the success of certain outputs. This included large CCEOP investments to strengthen supply chains, training and coordination efforts, and the building of new partnerships on which Gavi 5.0/5.1 funded activities would be carried forwards.

Contribution claim 1: Zero-dose children and missed communities are targeted and identified

Gavi support enabled activities under 4.0 grants sustainably created new partnerships, including engagement with communities, CSOs, and expanded partners	
Claim assessment	
Confidence and strength of evidence: 1	A range of data sources and from various different stakeholders show that partnerships fostered under HSS2 grant activities, between the EPI, WHO, UNICEF, World Bank, AMP, Jhpiego, VillageReach, Dalberg and the DGS, DRS and DDS, as well as the FENOS-CI and ANADER, enabled the creation of a strong platform of actors to carry out vaccination and immunisation activities. FENOS-CI and ANADER still have room for growth in terms of technical and operational capacity but a strong network of actors at all levels of the health pyramid, well integrated with non-health actors shows strong potential for reaching out to ZD children and missed communities. Supporting evidence includes: ▪ CCIA meetings take place with rotating leadership to foster ownership and engagement. Most stakeholders are said to participate regularly ▪ Partners at various levels work together and share learning, embedding lessons learnt and good practices into different activities ▪ Technical assistance provided by core partners supported the development of FENOS-CI ▪ FENOS-CI and ANADER conducted awareness-raising activities in 33 districts ▪ 32 CSOs were trained on health concepts, communication and social mobilisation techniques ▪ M-Vaccin application to send reminders to mothers ▪ AMP supported strategy and planning at central, regional and district levels ▪ Partner strategies and policies embed into one another ▪ Joint Appraisals and monitoring have strong participation and engagement ▪ Qualitative feedback from a range of strategic, operational, and frontline stakeholders portray the CCIA and collaboration of actors in a positive manner
Alternative explanations	
CCIA meetings may not be as consistent and there is no written record of meetings available to the evaluation team. Partnerships may have historically existed and key actors have personalities and individual leadership capacity that contributes to fostering strong networks and relationships, more so than mechanisms do.	

Gavi support enabled activities under 4.0 grants that helped better understand socio economic barriers preventing appropriate vaccination of all children highlighting the community-specific barriers that may be gender-related.	
Claim assessment	
Confidence and strength of evidence: 3	Studies were conducted to better understand the profile of ZD children and missed communities. These helped identify the key populations in which ZD children reside and in which communities they may be the most prevalent: migrants (fishing and nomadic communities), goldminers and other living illegally in parks, forests and reserves, communities in remote areas (mountains), those with cultural barriers, border communities, certain religious groups and traditional medicine practitioners. Supporting evidence includes: ▪ Two main pro-equity interventions identified by Ducharme et al.'s mapping study are CEA conducted under HSS1 in 2015 and 2019 ▪ AMP mapping studying focusing on ZD children and missed communities showed that there were noticeable differences based on wealth, rural/urban divide, ethnicity, religion, education of the mother but not based on sex ▪ Gavi's MEL team conducted a Côte d'Ivoire ZD analysis ▪ More granular quantitative data such as GPF evidence is missing on the difference in PENTA3 coverage between the highest and lowest wealth quintiles (30% in 2016), PENTA3 coverage between children of educated or uneducated mothers (22% in 2016), PENTA3 coverage between children of urban and rural residences (9% in 2016)
Alternative explanations	
The current studies are still insufficient to identify key barriers that would have to be taken into account in district microplanning. The available data is not the most reliable when it comes to identifying ZD children and missed communities, which makes targeting still challenging and activities under 4.0 insufficient.	

Contribution claim 2: Health systems sustainable reach all ZD and under-immunised children and their communities with a full range of vaccines as a first

Gavi support enabled activities under 4.0 grants that triggered detailed microplanning involving communities and key sub-national actors	
Claim assessment	
Confidence and strength of evidence: 3	Microplanning took place but planning and reporting on progress was inconsistent across regions and districts. Activities under Gavi 4.0 grants may only have partially contributed to the output. These did not always did not meet targets and additional efforts are planned under Gavi 5.0/5.1 grants with increased participation from communities and their leaders. Supporting evidence includes: ▪ 85% of outreach sessions conducted against planned (GPF – short of 100% in 2020) ▪ 100% of health districts have an EPI microplan in 2019 GPF but data is missing since ▪ 24% of vaccination children in advanced and mobile strategies (short of 90% GPF in 2020) ▪ 91% of fixed and advanced strategies planned were implemented (GPF – meets 90% target in 2020) ▪ Only 25% of CCIA coordination meetings planned took place, short of 100% target in GPF in 2020 ▪ No meetings undertaken by UCP-FE and CNP–UCP although qualitative data indicated otherwise ▪ 90% of surviving infants in HSS targeted areas received at least PENTA (GPF2020 – meets target) ▪ Admin data reported through GPF shows that the number of surviving infants who receive DPT1 was over a million in 2019 and consistently over set targets since 2016 ▪ There is limited and incoherent tailored outcome data in the GPF ▪ No data reported on the percent of districts with updated microplans that include activities to raise immunisation coverage. No quantitative data is available on EPI management capacity
Alternative explanations	
Supervision of microplans may have been inconsistent or roles and responsibilities at subnational level for different staff may not have been clear, creating accountability gaps as well as data quality issues. External factors may have affected the engagement of community leaders.	

Gavi support enabled activities under 4.0 grants contributed to building health workers' capacity around reaching ZD children and missed communities	
Claim assessment	
Confidence and strength of evidence: 2	Training sessions were provided under Gavi 4.0 grants, such as the training of vaccinators, or communications and sensitisation on health messages, but it is not clear to what extent those are relevant and useful for reaching ZD children and missed communities. Targeted training dedicated to providing quality services to hard-to-reach populations was not consistent or a priority of its own. Supporting evidence includes: ▪ 95% of health facilities offer immunisation (GPF – short of 100% target in 2020) ▪ Only 9% of district health facilities received communications training in 2020 (short of 100% target GPF) ▪ 90% of vaccinated children were reported and identified by CSOs and CHW (GPF – meets 25% target in 2020) ▪ 600 CHW trained in 2020, 960 trained in 2019 on communications and identification of under-vaccinated children (GPF – meets target) ▪ However, only one sensitisation campaign led by CSOs was recorded in November 2020 and 1 in 2019 in the GPF, short of 29 per quarter target set ▪ 25 health staff trained in using DHIS2 for analysis of vaccination data in 2020 (GPF – short of 125 target)
Alternative explanations	
CHW and community relays may already be equipped to reach ZD children and communities through their support or work on other health priorities.	

Gavi support enabled activities under 4.0 grants that foster the development and use of tailored accurate monitoring and data systems	
Claim assessment	
Confidence and strength of evidence: 3	Gavi 4.0 activities contributed partially to fostering the development and use of tailored monitoring and data systems for immunisation through training and digitalisation. However, their accuracy remains to be seen and analysis skills, beyond data collection and management, needs to be integrated into training for better monitoring at sub-national level. Supporting evidence includes: ▪ 98% of vaccination centres share monthly reports with the district health facilities (GPF – meets target of 80% in 2020) ▪ Several data quality assessment and LQAS reports in 2017, 2019, 2020 ▪ Only 9 districts (short of 10 target GPF 2020) use DHIS2 to report vaccination data ▪ 100% of health district benefited from regional supervision in 2019 (GPF) but only 50% at regional level. Inconsistent reporting on the monthly reporting of district health facilities 57% and 91% in 2019 (GPF) ▪ Missing core and tailored denominator data in the GPF beyond 2020 ▪ Technical assistance supported the strengthening of monitoring systems to improve detection for EPI target diseases ▪ Technical assistance through University of Oslo and UNICEF supported the integration and usage of DHIS2
Alternative explanations	
UNICEF and other donors may have led on data management and improvement through other grants or platforms in collaboration with DIIS.	

Contribution claim 3: Supply chains are able to reliably deliver the full set of vaccines to missed communities

Gavi support enabled activities under 4.0 grants that build, expanded and rehabilitated vaccination supply chains and trained health workers to for EVM management	
Claim assessment	
Confidence and strength of evidence: 3	The CCEOP grant introduced in 2018 enabled the purchasing of equipment for better coverage with large acquisition of cold-chain equipment, the hiring of a technical support, training for users of SODETAP with more recent evidence contrasting the current situation with frequent vaccine stock-outs before. Additional CCEOP funding is requested under the new FPP, which hints at greater needs unmet. Supporting evidence includes: ▪ No occurrence of national or district-level stock-outs for Gavi-supported vaccines since 2019 (GPF) ▪ EVM score in 2021 of 71% (GPF – meets target of 70%) ▪ 87% of cold-chain equipment are functional at the time of the last annual physical inventory (GPF – short of 100% target in 2020) ▪ Cold-chain capacity is sufficient at national level and in regional antennas (GPF 2020) – 100% of warehouses at district level have a functional cold chain (meets GFP 2020 target of 95%) ▪ Technical assistance provided to strengthen stakeholder capacity on cold-chain equipment (CCE) maintenance at all levels and improve the implementation of monitoring and data quality assessment plans ▪ Technical assistance partners contributed to supporting the harmonisation of immunisation and surveillance data as well as integration of data into DHIS2 ▪ Technical assistance partners strengthened the capacity of EPI and central-level surveillance data managers and prepared the joint WHO–UNICEF annual report ▪ New vaccines were introduced
Alternative explanations	

Other actors maybe have contributed to the expansion of the supply chains and training, although UNICEF would have been on of the lead actors.

Contribution claim 4: Programmes and approaches are continuously monitored and generate learning for course correction

Gavi support enabled activities under 4.0 grants that encouraged partners to share learning and embedded those in the development of new activities and strategies	
Claim assessment	
Confidence and strength of evidence: 4	Very little evidence was visible in terms of integrating learnings but evidence suggested that reflections, discussions and consultations took place between stakeholders to improve and rethink vaccination activities and strategies, particularly for grants under Gavi 5.0. Supporting evidence includes: ▪ Qualitative feedback indicated that joint monitoring and appraisals as well as workshops and consultations were conducted with strong participation of stakeholders. ▪ Audits and assessments were conducted feeding into the development of new activities and coordination with other actors.
Alternative explanations	
Learning may have taken place during CCIA and National Immunisation Technical Advisory Group (NITAG) meetings but recordkeeping was not clearly maintained.	

Gavi support did not lead to activities under 4.0 grants explicitly encouraging local and national-level leaders to advocate for the ZD agenda	
Claim assessment	
Confidence and strength of evidence: 4	The pro-equity mapping of 4.0 activities did not show any relevant advocacy activities in Côte d'Ivoire. However, explicit advocacy for the ZD agenda did not take place and no evidence was provided. Supporting evidence includes: ▪ EPI review conducted in 2019 ▪ CEA 2015 and 2019 ▪ Joint appraisals and Partnership Engagement Framework TCA workplans showed intention to address some ZD agenda priorities of identifying and generating data and evidence around ZD children and missed communities
Alternative explanations	
The ZD agenda was not a priority under Gavi 4.0 grants. It may be that advocacy took place informally and organically, particularly during the development of the FPP application and through Joint Appraisal visits. Partners like AMP had led their own initiatives to map ZD children and missed communities and understand barriers to immunisation for that population.	

A further assessment against the Gavi ZD agenda contribution to these outcomes will be done during the next phase of the evaluation, through secondary data analysis, by reviewing the assumptions, analysing enforcement and monitoring data, and further investigation through qualitative interviews. This will provide more reliable evidence as to the likely and expected contributions of Gavi-supported activities towards ZD agenda outcomes.

Table 3.2: Mapping ZD-related outputs to pro-equity interventions implemented under Gavi 4.0

ZD-related outputs	Indicators	Pro-equity interventions programmed/ implemented	Plausible contribution of Gavi (insufficient evidence, partial, full)
ZD children and missed communities are identified and targeted	DTP drop-out in targeted areas – no data DTP1 coverage in targeted areas – no data 14% DTP drop-out Geographic equity (DTP3 coverage) – no data 135 222 No. of ZD children 90% Percentage of districts or equivalent administrative area with Penta3 coverage greater than 80% 91% Difference in Penta3 coverage between the highest and lowest wealth quintiles 91% Difference in Penta3 coverage between the highest and lowest wealth quintiles Penta3 coverage difference between the children of educated and uneducated mothers/care-takers – no data Difference in Penta3 coverage between children of urban and rural residences – no data Percent of districts with updated microplans that include activities to raise immunisation coverage – no data but might be in JA	Coverage and equity assessments (CEA) 2015 and 2019 to gather numbers for indicators Training of health staff for better recording of data Introduction of DHIS2 Microplans at district level and supervision visits	Partial evidence
Gender and socioeconomic barriers are understood and addressed	Country addressing gender-related barriers support Percent of gender work plan activities executed - none	Coverage and equity assessments (CEA) 2015 and 2019 to gather numbers for indicators No gender work plan	Full evidence

Communities know about immunisation and how to access services	Percent of functional health facilities providing routine immunisation services – no data Percent of demand work plan activities executed – no data Country implementing tailored plans to overcome demand barriers	Coverage and equity assessments (CEA) 2015 and 2019 Tailored plans (ATMs in French) created and implemented	Partial evidence
Supply chains are able to reliably deliver the full set of vaccines to missed communities	Closed Vial Wastage (DTPcv) – no data Stock availability at health facility levels – no data EVM Score (composite score) CCE expansion in existing equipped sites – no data CCE extension in unequipped existing and/or new Sites – no data	EVMA report available from Nov2018 but haven't seen it No CCEOP in 2020 but previous yes but can't find data on it	Missing evidence
Programmes and approaches are continuously monitored and generate learning for course correction	EPI management capacity – no score	Activities implemented through TCA funding	Partial evidence

Annex

Table 4.1: Desk review documents

Source	Document title	Year
AMP	Mapping of ZD and under-vaccinated children in Côte d'Ivoire	2022
Gavi	HSS2 IRC report	2016
Gavi	Country Mission Report	2027
Gavi	Joint Appraisal report (2017)	2017
Gavi	TCA Plan 2017	2017
Gavi	Country Mission Report	2018
Gavi	Joint Appraisal report (2018)	2018
Gavi	Orange, Gavi and Côte d'Ivoire Ministry of Health join forces to boost child immunisation	2018
Gavi	TCA Plan 2018	2018
Gavi	Co-financing information sheet	2019
Gavi	Country Mission Report	2019
Gavi	Joint Appraisal report (2019)	2019
Gavi	TCA Plan 2019	2019
Gavi	Multi-stakeholder dialogues (2020)	2020
Gavi	EVM improvement plan	2021
Gavi	FPP Application Draft including pre-screening document, narrative FPP application, budget, CCEOP budget, CCE Inventory Gap Analysis	2021
Gavi	FPP Application Draft including MMR campaign proposal in 2024	2021
Gavi	FPP Application Draft including TCA narrative	2021
Gavi	Grant Performance Framework 2016–2020	2021
Gavi	Country Mission Report	2022
Gavi	FPP application	2022
Gavi	Côte d'Ivoire Zero-Dose Analysis	2023
Gavi	Gavi Côte d'Ivoire Factsheet 2021 data	2023
Gavi	HSS Key shifts tracker	2023
Gavi	MPM	2023
MoH	cMYP 2016-2020	2016
MoH	Plan d'action chaque nouveau-ne Côte d'Ivoire 2018-2020	2018
UCP-FE	UCP-FE Progress Report	2022
UNICEF	Situation des Femmes et Enfants en Côte d'Ivoire MICS 2016 (UNICEF, MPD, 2016)	2016
UNICEF	Analyse qualitative des effets de la COVID-19 sur les ménages vulnérables et les services sociaux de base en Côte d'Ivoire (UNICEF, 2021)	2021
WHO	Rapport Biennal 2020–2021 (OMS, 2022)	2022
WHO	Soutien matériel et financier de l'OMS aux Journées nationales de vaccination (JNV) 2023, contre la polio en Côte d'Ivoire (OMS, 2023)	2023
World Bank	COVID-19 Vaccines: From rejection to Shortage, how Côte d'Ivoire Became a Model for Managing Vaccine Hesitancy (World Bank, 2021)	2018

Table 4.2: Desk review documents

Source	Document title	Year

Agbe, Traore	Defis de la vaccination contre la COVID-19 en Côte d'Ivoire : connaissances, perception et confiance des populations vis-à-vis des vaccins anti-COVID	2022
Aplogan et al.	Effects of monitoring 'out of area' vaccinated children on data quality, San Pedro Health District, Côte d'Ivoire 2019	2020
Aplogan et al.	Performance of the Strategy to Catch Up with Drop Out and Unvaccinated Children in Côte d'Ivoire in 2018	2020
Ducharme et al.)	Mapping of Pro-Equity Interventions Proposed by Immunisation Programs in Gavi Health Systems Strengthening Grants	2023
Vroh et al.,	Qualité des données de vaccination chez les enfants de 0 à 11 mois en Côte d'Ivoire	2015

Table 4.3: List of stakeholders

ID	Position	Organisation	Categorisation	Remote / in-person
1	Head of programmes	UCP-FE	Operational	Remote
2	EPI manager	MoH	Operational	Remote
3	Head of organisation	FENOS-CI	Frontline	Remote
4	Liaison agent	MoH	Operational	Remote
5	Data specialist	WHO	Operational	Remote
6	Immunisation focal point	UNICEF	Operational	Remote
7	Project manager	Gavi	Strategic	Remote
8	Senior country manager	Gavi	Strategic	Remote
9	Director	AMP	Operational	Remote
10	General Director	MoH	Strategic	In-person
11	Deputy EPI manager	MoH	Operational	Remote
12	Deputy programme manager	VillageReach	Frontline	Remote
13	Technical advisor	Jhpiego	Frontline	Remote
14	EPI supply chain manager	MoH	Frontline	Remote
15	EPI M&E supervisor	MoH	Frontline	Remote

Relevant national policies

- Plan National de Développement Sanitaire (PNDS) 2016–2020
- Comprehensive Multi-year Plan for Immunisation (cMYP) 2011–2015

Our standards and accreditations

Ipsos' standards and accreditations provide our clients with the peace of mind that they can always depend on us to deliver reliable, sustainable findings. Our focus on quality and continuous improvement means we have embedded a 'right first time' approach throughout our organisation.

ISO 20252

This is the international market research specific standard that supersedes BS 7911/MRQSA and incorporates IQCS (Interviewer Quality Control Scheme). It covers the five stages of a market research project. Ipsos was the first company in the world to gain this accreditation.

Market Research Society (MRS) Company Partnership

By being an MRS Company Partner, Ipsos endorses and supports the core MRS brand values of professionalism, research excellence and business effectiveness, and commits to comply with the MRS Code of Conduct throughout the organisation. We were the first company to sign up to the requirements and self-regulation of the MRS Code. More than 350 companies have followed our lead.

ISO 9001

This is the international general company standard with a focus on continual improvement through quality management systems. In 1994, we became one of the early adopters of the ISO 9001 business standard.

ISO 27001

This is the international standard for information security, designed to ensure the selection of adequate and proportionate security controls. Ipsos was the first research company in the UK to be awarded this in August 2008.

The UK General Data Protection Regulation (GDPR) and the UK Data Protection Act (DPA) 2018

Ipsos is required to comply with the UK GDPR and the UK DPA. It covers the processing of personal data and the protection of privacy.

HMG Cyber Essentials

This is a government-backed scheme and a key deliverable of the UK's National Cyber Security Programme. Ipsos was assessment-validated for Cyber Essentials certification in 2016. Cyber Essentials defines a set of controls which, when properly implemented, provide organisations with basic protection from the most prevalent forms of threat coming from the internet.

Fair Data

Ipsos is signed up as a 'Fair Data' company, agreeing to adhere to 10 core principles. The principles support and complement other standards such as ISOs, and the requirements of Data Protection legislation.

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