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

Country Case Study: India

March 2024

Contents

List of figures

List of tables

List of acronyms

BRIDGE	Boosting Routine Immunisation Demand Generation
CBO	Community-based organisations
CHAI	Clinton Health Access Initiative
CoP	Community of Practice
CSO	Civil society organisation
FIC	Full immunisation coverage
FPP	Full Portfolio Planning
GoI	Government of India
HSS	Health System Strengthening
IAG	Immunisation Advisory Group
IRMMA	Identify, respond, measure, monitor, advocacy framework
MoHFW	Ministry of Health and Family Welfare
MPM	Monitoring and Performance Management
NCCVMRC	National Cold-Chain and Vaccine Management Resource Centre
NGO	Non-government organisations
NHM	National Health Mission
PM	Programme manager
RfP	Request for Proposals
SBCC	Social and Behavioural Change Communication
SCM	Senior country manager
ToC	Theory of change
UIP	Universal Immunisation Programme
UNICEF	United Nations Children’s Fund
VHAI	Voluntary Health Association of India
VPD	Vaccine-preventable disease
WUENIC	WHO/UNICEF estimates of national immunisation coverage
ZD	Zero-dose

1 Context

Health system context

India is defined by Gavi as a high impact country, meaning it is critical to reaching Gavi's ambitious Zero Dose (ZD) goals outlined for the 2021–2025 strategic period, due to is high proportion of ZD children. India is the most populous country in the world, with an estimated population of ~1,417 million people (UN PoP) and birth cohort of ~26.7 million. In terms of governance, India is a federal union comprising 28 states and 8 union territories, over 700 districts, and more than 250,000 local government bodies.

India has a mixed healthcare system, comprising both public and private healthcare service providers, and is highly complex and devolved in nature. Healthcare In India is divided into two main systems, one servicing rural areas, and the other servicing urban areas. The former comprises three tiers, including: (1) health sub-centres; (2) primary health centres; and, (3) community health centres; each tier is differentiated by the catchment area served. The latter comprises a combination of urban primary health centres and urban community health centres.

As of 2022, India had a 95% diphtheria-tetanus-polio[1] (DTP1) coverage, with over 1.1m ZD children. This represents a significant proportion of the nearly 18 million ZD children globally. Effectively reaching ZD children in India is therefore crucial for achieving Gavi's 5.0 strategy and is a key reason why India was selected as one of the country case studies for this evaluation.

Gavi support

India has a special arrangement with Gavi due to its: (1) high proportion of ZD children globally; (2) status as an emerging lower-middle-income country; and, (3) key role in Gavi's vaccine procurement strategy. Unlike other Gavi case study countries, India is restricted to Health System Strengthening (HSS) and Technical Assistance (TA) funding leavers. Table 1.1 shows the grants India has had access under Gavi 4.0 and the planned 5.0 period. Table 1.2 shows the timeline for Gavi 4.0 and 5.0 grants; this is inclusive of HSS2 and HSS3, as well as Technical Assistance (TA) which was applied for with HSS3 under Gavi 5.0.

Table 1.1: Grants received and applied for by India under Gavi 4.0 and 5.0

Type of support	Amount approved (USD)	Time period
HSS2	107,000,000	2017 – 2021
Total approved amount under Gavi 5.0/5.1	133,000,000	1 Jan 2023 – 31 Dec 2025
HSS3 (budgeted)	122,547,564	1 Jan 2023 – 31 Dec 2025[1]
Technical Assistance (budgeted)	9,079,061	1 Jan 2023 – 31 Dec 2025[1]

[1] The Gavi Board approved timelines for HSS + TA were up to 2026, while all disbursements need to be disbursed by end of 2025.

Table 1.2: Gavi 4.0 and 5.0 grant timelines

Action/document	Submitted	Actor	Notes
Gavi 4.0: HSS2			
HSS2 application	December 2016	India MoHFW	Requested USD 100 million over 5 years USD 54 million approved to be disbursed in 2017 and 2018 7 months from application submission to approval for disbursement
Gavi approval[2]	July 2017	IRC Review	
HSS2 renewal request	November 2018	India MoHFW	USD 36 million approved to be disbursed in 2019 and 2020 6 months from renewal request to approval for disbursement
Joint appraisal 2018[3]	November 2018	Gavi Secretariat	
Gavi approval[4]	May 2019	IRC	
Joint appraisal 2019[5]	2019	Gavi Secretariat	USD 11 million approved to be disbursed in March 2021
Decision letter	March 2021	Gavi Secretariat	
Gavi 5.0: HSS3 and TA			
HSS3 application	September 2022	India MoHFW	
IRC review	October 2022	IRC	USD 122 approved for HSS3 and USD 9 million for Technical Assistance (TA)

Key stakeholders

Figure 1.1 shows the key actors involved in Gavi 4.0 and 5.0 activities. There are a few things to note about the diagram:

- In terms of funding channels, money is distributed directly from Gavi to its core implementing partners; however, these funds are designed in conjunction with the government of India (specifically the Ministry of Health and Family Welfare (MoHFW) and need to be reviewed and approved before being dispersed.
- Under Gavi 5.0, funds for civil society organisations (CSOs), Community Based Organisations (CBOs), and non-government organisations (NGOs) will be channelled from the United Nations Children's Fund (UNICEF).
- Note the UN agencies designated for managing the funds were UNDP, WHO and UNICEF who will in turn sub-grant to other entities depending on their capacity, experience and expertise in specific areas of activities Some of the UN agencies will sub-grant to CSOs, International NGOs or Private Sector, depending on the activities to be implemented.

[2] Gavi Secretariat. Approval of Health Systems Strengthening Support for India. 24 July 2017. Retrieved from: chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.gavi.org/sites/default/files/document/decision-letter-hss-india-2017pdf.pdf
[3] Gavi. Joint Appraisal Report 2018. Retrieved 26/09/23: https://www.gavi.org/country-documents/india
[4] Gavi Secretariat. Approval of Health Systems Strengthening Support for India. 22 May 2019. Retrieved from: chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://www.gavi.org/sites/default/files/document/india-decision-letter-hss-2019pdf.pdf
[5] Gavi. Joint Appraisal Report 2019. Retrieved 26/09/23: https://www.gavi.org/country-documents/indi

Strategy and theory of change to address vaccine inequity

Given the size of India's ZD population, complex and devolved health system, and status as an upper-middle-income country, all funding support is designed by Gavi to be catalytic**,** meaning that funding should ideally lead to successful initiatives which will be further scaled up by the government. Under Gavi 4.0, the overall goal of HSS2 funding was to improve *'the quality and level of immunisation coverage'* and to develop an immunisation programme that is capable of '*high performance'* even in settings where government infrastructure is limited.[6] This goal was to be achieved through the following four strategic objectives:

1. **Strengthen and maintain robust data systems** to improve evidence-based decision-making.
2. **Improve capacity of human resources** for service delivery and programme management for equitable and efficient immunisation services.
3. **Strengthen vaccine logistics and cold-chain management** through improved data systems, infrastructure strengthening and human resource capacity.
4. **Improve demand generation for immunisation services** to improve coverage and address inequities.

Objectives 3 and 4, in particular, were considered by Gavi in-country stakeholders to be crucial steps in laying the groundwork for the ZD agenda (see EQ5). Gavi 5.0 also saw a shift in focus from infrastructure development and cold-chain management, towards demand generation, data (including one third of the total investment in the U-WIN data system) and microplanning. Under Gavi 5.0, HSS3 funding intends to focus on the following investment areas: service delivery; human resources for health; health information systems and monitoring and learning; demand generation and community engagement; governance, policy, strategic planning, and programme management; and grant management and indirect costs.

Specifically, HSS3 and TA grants under Gavi 5.0 plan to target 143 districts located in 11 states. Funding will be directed towards four partners. Specific grant-funded activities include establishment of a Community of Practice on Demand (CoPD) ecosystem (via one UN partner) to help facilitate engagement with CSOs, CBOs and NGOs. This aim is to understand where there are gaps in vaccination service delivery and uptake, and design human-centred and context-driven solutions through the local CSOs and CBOs. In addition, almost one-third (31%) of the budget will be invested in the design and implementation of U-WIN, an electronic application to register and monitor vaccine uptake.

Figure 1.2 denotes the Gavi India theory of change (ToC), highlighting where key outputs and outcomes of Gavi 4.0 fed into, and laid the foundations for, 5.0/5.1. Gavi 5.0/5.1 activities are structured around the grant design and implementation processes (i.e., full portfolio planning [FPP], etc.), as well as other planned activities for the 5.0 implementation period (1 Jan 2023 – 31 Dec 2026 in India).

List of other interventions happening in country

There are a few other interventions identified in the document review and interviews which are currently being implemented outside of the government. In relation to the government, the following broad strategies and policy initiatives should be noted:

[6] Application form for India: Health System Strengthening (HSS) Support in 2016. *Gavi: The Vaccine Alliance.* Document dated April 2017.

- **National Health Mission (NHM):** This is India's flagship centrally sponsored scheme, which aims to strengthen health systems and the *"attainment of universal access to equitable, affordable and quality healthcare which is accountable and responsive to the needs of people"*. The scheme is approved by the government of India and implemented by the MoHFW.[7]

- **Universal Immunisation Programme (UIP)[8]:** Under this programme, the government provides free vaccines against 12 vaccine-preventable diseases; 11 are provided nationally, while one (Japanese encephalitis) is provided sub-nationally. The programme targets around 30.4 million pregnant woman and 26.7 million newborns annually. One of the key objectives of the UIP is to achieve full immunisation coverage (FIC) of 90%; they are aiming to achieve this through the following schemes:
    - The original **Mission Indradhanush** was launched in 2014 to increase immunisation coverage in districts with pockets of low coverage and 'left-out' children.
    - An **Intensified Mission Indradhanush** was introduced in 2017 in select districts and urban areas to help achieve the FIC of 90% objective.

- **Ayushman Bharat (Health India):** This initiative was launched to achieve the vision of Universal Health Coverage and is designed on to meet the Sustainable Development Goals. The initiative largely aims to implement a holistic approach to addressing health via a continuum of care approach.[9]

Outside of this, Gavi has previously supported India with new vaccine introductions, including MR, Rota, PCV, IPV, JE, Hepatitis B and Pentavalent.

Data collection timeline

Data collection activities included the following:

- Initial introductory call with the India senior country manager (SCM) and programme manager (PM), which took place on 24 April 2023.
- Document review which took place between April and June 2023.
- Interviews with 16 stakeholders, which took place between May and July 2023.
- Final phone call with the India SCM and PM, which took place on June 2023.

Analysis took place from the end of July to the beginning of September, while the write-up took place near the end of August 2023.

[7] National Health Mission: Budget brief. *Accountability Initiative and centre for Policy Research*. Retrieved 26/09/23: https://cprindia.org/wp-content/uploads/2022/06/National-Health-Mission_2022-23.pdf
[8] Universal Immunization Programme. Comprehensive Multi-Year Plan: 2018-22. *Ministry of Health and Family Welfare.*
[9] Supporting narrative for theory of change for Gavi. *India Ministry of Health and Family Welfare.* n.d.

Figure 1.2: Key actors in India under Gavi 4.0 and 5.0

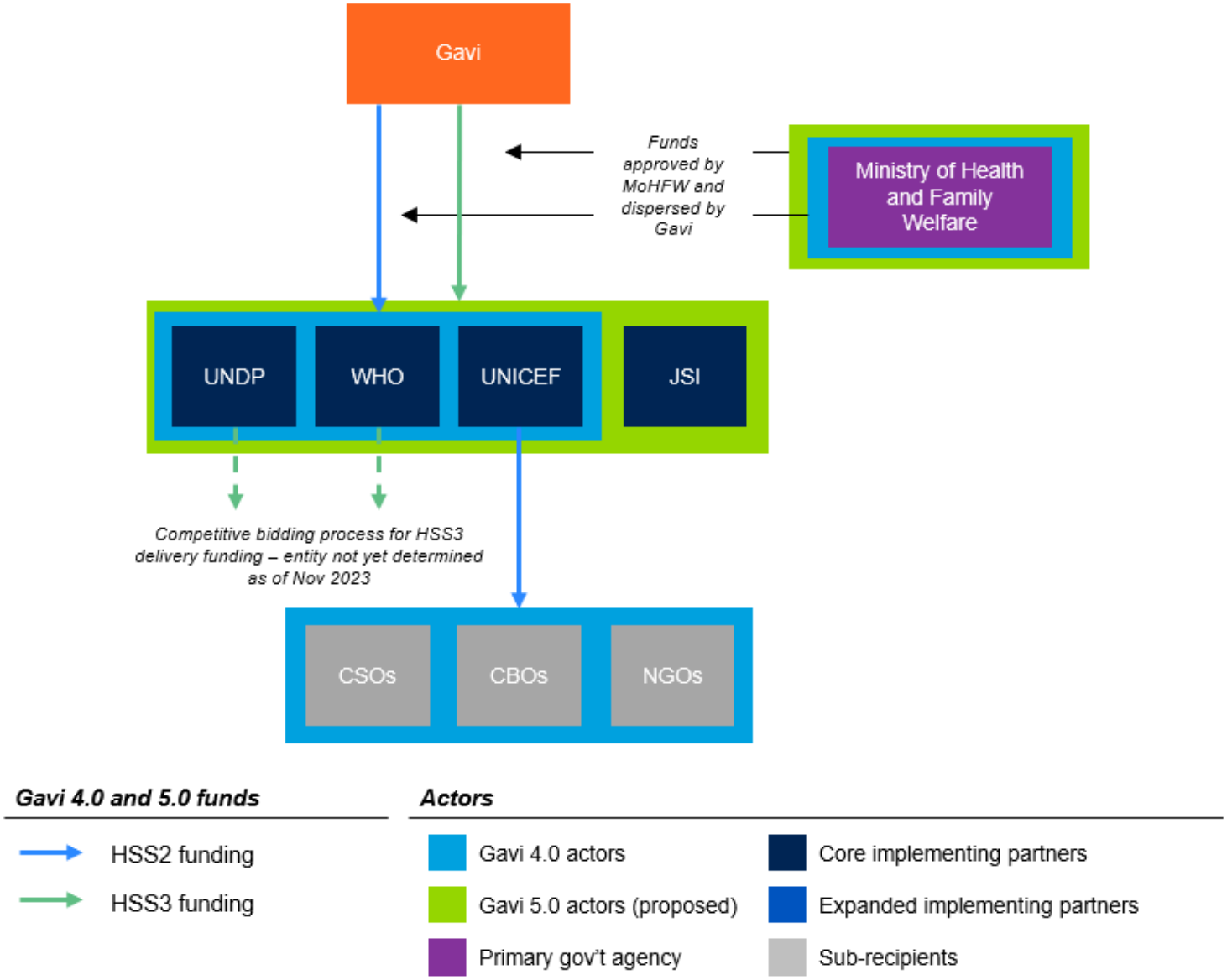
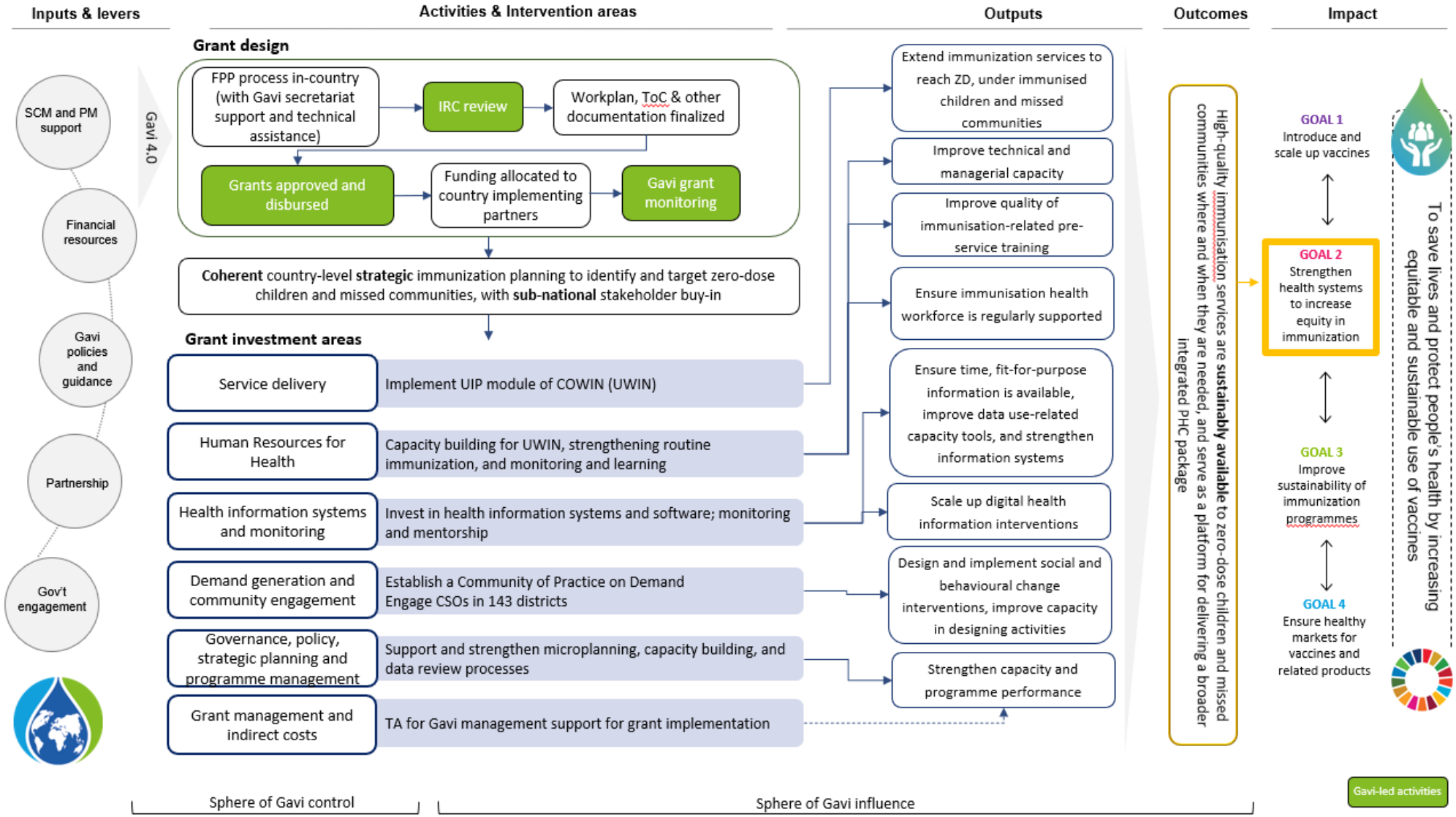


Figure 1.3: India theory of change for Gavi 5.0



2 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	▪ There is evidence to suggest that the Gavi 5.0 agenda is relevant to the vaccination needs in India, particularly in terms of the number of ZD children within the country and the state and community-specific barriers experienced by missed communities. ▪ There are some dissenting areas about specific aspects of the ZD agenda, specifically how states were selected, whether the focus should be on ZD or drop-outs, and if India should be included in Gavi's overall portfolio.			
Strength of the evidence	**1**	**2**	**3**	**4**
Rationale for this judgement	Evidence comprises multiple data sources, including quantitative data, academic studies, country-level and Gavi documentation, and qualitative interviews. There is good triangulation.			

India is highly decentralised, meaning different states have different disease burden and priorities; however, there are some overarching national-level priorities. Indian states face their own unique health challenges and operate under distinct jurisdictional authorities; therefore, assessing the countries' needs generally is difficult.[10] National public health policy is guided by Ayushman Bharat (meaning 'Healthy India') to achieve the vision of Universal Health Coverage. The focus of Ayushman Bharat is to tackle health from a holistic perspective and adopt a continuum of care across primary, secondary and tertiary health services.[11]

In terms of immunisation as a whole, India has made good progress on other vaccine priorities, and the ZD agenda represents a key aspect of achieving its targets by addressing remaining vaccination needs. The proportion of children receiving the full immunisation schedule[12] has steadily increased, from 44% in 2005/06, to 62% in 2015/16, to 76.5% in 2019/21 (see Figure 2.1 below).[13] More recent WUENIC data shows significant increases the coverage of individual vaccines within the immunisation schedule, including DTP1 and 3, BCG, and MCV1 and 2 (see Figure 2.1) Indeed, in 2014, India received a 'polio-free certification' from WHO following two decades of addressing polio rates through the Pulse Polio Immunisation Programme.[14] Interviewees reported that focusing on ZD and missed communities helps serve as a 'last push' to reach the remaining proportion of the population who have not received any vaccines and are not yet linked-up to health services.

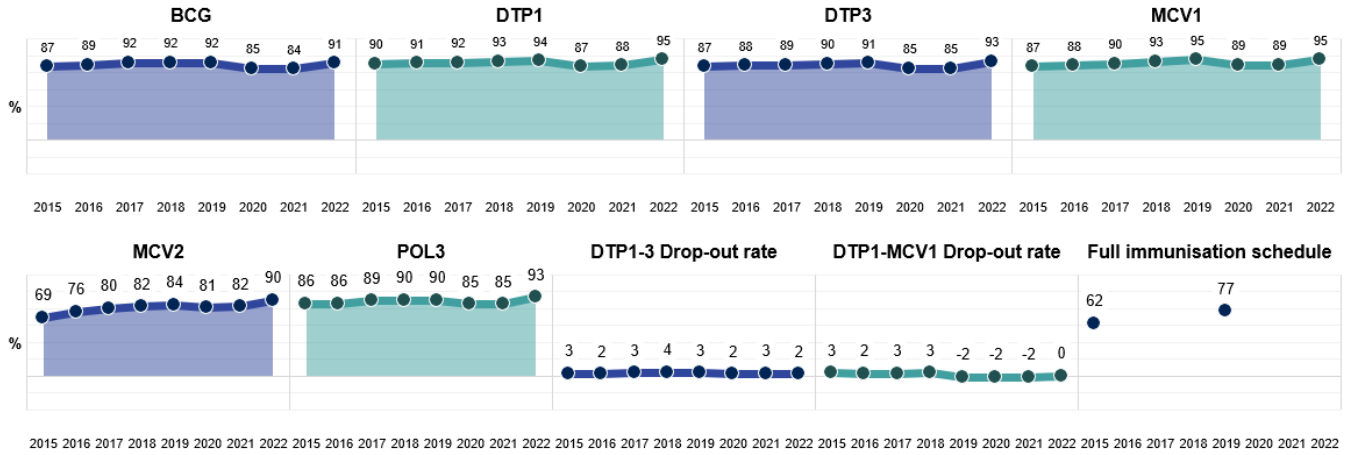
[10] Dandona, R. (2022). Public health priorities for India. *The Lancet Public Health, 7(2); E102-103.* doi: 10.1016/S2468-2667(22)00008-1
[11] Gavi and MoHFW. Supporting narrative for theory of change for Gavi support request from India. *Gavi internal documentation.*
[12] Full immunisation schedule means the child received one BCG, 3 doses of Penta or DPT, 3 doses of OPV and one measles containing vaccine.
[13] National Family Health Survey (NHSF-5), 2019-21: India Report. *Government of India, Ministry of Health and Family Welfare.* March 2022. Retrieved from: http://rchiips.org/nfhs/NFHS-5Reports/NFHS-5_INDIA_REPORT.pdf
[14] India: a push to vaccinate every child, everywhere, ended polio in India. *The World Health Organisation.* 7 April 2021. Retrieved from: https://www.who.int/india/news/feature-stories/detail/a-push-to-vaccinate-every-child-everywhere-ended-polio-in-india

Under-immunised, drop-outs, and ZD children represent the last major hurdle for India's overall vaccination coverage. As per National Family Health Survey (NFHS)-5 data, full immunisation coverage in India is 76.5%, with 19.9% partially immunised, and 3.6% who are left out.[15] Addressing those who are partially immunised is therefore a key vaccination need within India and further aligns with the Mission Indradhanush Strategy to achieve full vaccination coverage of 90% (see EQ3).[16] Strategic-level stakeholders reported that under-immunised children are the *'bigger number'* and represents a larger vaccine priority for the country than ZD. However, they also noted that the ZD agenda can sit alongside other vaccine priorities, provided this doesn't *'drop down the agenda'* (see EQ3). It should be noted that figures linked to the FIC and under-immunised children are based on NFHS-5 data from 2019, making it difficult to determine the exact proportion at the time of the evaluation.

> "[T]hat focus on zero-dose children, of course, they are critical, but that is a small number. The bigger number is the missed out, or the dropped-out children. So, that is also critical."
> Strategic respondent, interview

India has overall recovered from the COVID-19 pandemic, and DTP1 coverage in 2022 is higher than any previous year. As per WUENIC data, DTP1 coverage in 2019 was at 94%; this dipped to a low of 87% during the pandemic but has since recovered to 95% in 2022 (see Figure 2.1). This was unexpected; interviewees highlighted how the pandemic severely hindered India's ability to move forward with the ZD agenda and increased the number of ZD children overall. HSS funds were not reallocated towards COVID-19 as per a decision by MoHFW.[17] Given these gains, there is a question as to whether ZD support is relevant in a country that has made such stark improvements.

Figure 2.1: Select vaccine coverage (WUENIC) and full immunisation schedule (NFHS4 and 5) in India, %, 2015–2022



[15] Dhalaria et al. (2023). Exploring the pattern of immunization dropout among children in India: A district-level comparative analysis. *Vaccines (Basel). 2023 Apr 13;11(4):836.* doi: 10.3390/vaccines11040836. PMID: 37112748; PMCID: PMC10143302.
[16] Mission Indradhanush: Operational Guidelines 2016. *Ministry of Health and Family Welfare, Government of India.* Retrieved 26/09/23: https://main.mohfw.gov.in/sites/default/files/216846291201489665182.pdf
[17] Gavi. Report on Gavi 2020 multi-stakeholder dialogue: Immunisation planning in light of COVID-19. *Gavi internal documentation.*

There is strong consensus that the sub-national-level focus of the Gavi 5.0 strategy will help drive context-appropriate solutions and address considerable variations in DTP1 coverage from state to state. There are significant variations in the DTP1 coverage at the state and district levels in India; for example, Gavi 5.0 state-level consultations found 50% of India's ZD population live in just four states (Uttar Pradesh, Bihar, Rajasthan and Madhya Pradesh).[18] The types of communities and areas most at further risk varies down to the district level, and the current Gavi 5.0 strategy encompasses those living in urban and peri-urban slums, migratory populations, hard-to-reach populations, tribal populations, underserved populations, and those experiencing pockets of vaccine hesitancy.[19] An analysis of ZD children using NFHS-5 data further found "*the sub-national approach with a clear focus on geographies with the highest number and prevalence of ZD that the GAVI 5.0 strategy advocates for is therefore a step in the right direction*", thereby supporting this approach.[20] Stakeholders also reported that addressing these diverse barriers will require micro-level planning and tailored interventions down to the district level. They compared the Gavi 5.0 strategy approach, which included a situational assessment in consultation with states, favourably to the Gavi 4.0 strategy (which was implemented across all Indian states) and ideal for reaching ZD communities across India.

> "HSS3 has a very strong focus on sub-national interventions, specifically targeted at reducing the proportion of zero-dose children. HSS2 was more systems at a broader national and state level, while HSS3 is specific tactical interventions right at the district, that's sub-national district level and below, to, sort of, find and reduce the number of zero-dose children."
> Operational respondent, interview

There is some academic and country-level evidence to suggest that the selection of the 143 districts for Gavi support may be based on outdated data and may miss off some districts with a high ZD population. Gavi and state-level districts undertook a situational analysis and selected states for Gavi support through a country-level consultation process comprising three steps:

1. States and districts were first prioritised based on (a) those with the highest percentage of 'unimmunised'; (b) those with the highest proportion of 'unimmunised';[21] and (c) those with the highest number of unimmunised (which was done in consultation with other donors).

2. Districts which either (a) had a low number but high percentage of ZD children or (b) had a high number and high percentage of ZD children were considered for the project. Notably, districts with a high number but low percentage of ZD children were not considered for the project; no justification is given for this in the project narrative.

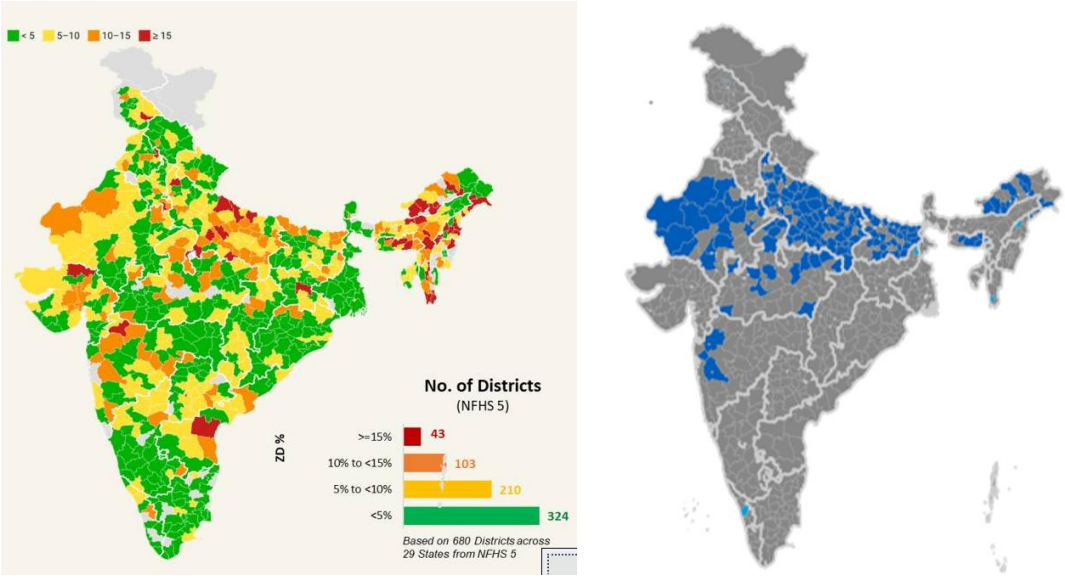
3. Multiple scenarios were developed to achieve a 30% reduction agenda nationally.

Based on this process: 16 districts across 4 states were selected from a coverage perspective (contributing to more than 50% of India's ZD population), 22 districts across 3 states were selected which had the highest relative share of ZD children (more than 10%), and an additional 5 districts across 4 states were selected as Government of India (GoI) priority districts based on low socio-economic index (see Figure 2.2, below left side). These were selected using available data[22] alongside state-level consultations. However, the exact data sources used in the process are not clear in the application, and

[18] Supporting narrative for theory of change for Gavi. *India Ministry of Health and Family Welfare.* n.d.
[19] Ibid.
[20] Taneja et al. (2023). An equity analysis of zero-dose children in India using the National Family Health Survey data: Status, challenges, and next steps. *Cureus. 2023 Feb 24;15(2):e35404.* doi: 10.7759/cureus.35404. PMID: 36851944; PMCID: PMC9963392.
[21] It is unclear from the project narrative what is the difference between percentage and proportion of unimmunised.
[22] Data sources were not made clear in the project narrative nor through respondent interviews.

some respondents hypothesised that districts may be selected based on outdated, pre-COVID-19 data. Furthermore, a separate analysis of ZD proportions at the district level using NFHS-5 data from Taneja *et al*. (2023) identified districts with the highest proportion of ZD children (on the left of Figure 2.2 below).[23] While there are clear areas of overlap with those selected for Gavi 5.0 support (on the right), there are inconsistencies, including only four districts selected in Maharashtra and no districts selected in Andhra Pradesh.

Figure 2.2: Analysis by Taneja et al. (left) compared with Gavi-selected districts (right)



Within the global context, Gavi support in India is relevant from a ZD perspective, but there are debates as to whether it is relevant from a value for money perspective. As stated, since 2021, India was home to approximately 2.7 million ZD children, comprising the largest proportion among Gavi-eligible countries (15%). Including India is crucial for the realisation of the ZD agenda. However, India possesses the fifth highest gross domestic product (GDP) globally (USD 3.3 trillion), surpassing even high-income nations like the United Kingdom and Canada.[24] Moreover, at the beginning of the Gavi 4.0 strategy in 2016, India was expected to be fully self-financing by 2021,[25] yet has been approved for USD 250 million funds under Gavi 5.0. These funds are approved under 'strategic partnerships' between Gavi and the GoI, including one in 2016,[26] and a renewed one in 2023.[27] The key consideration for Gavi is whether the funding directed towards a country such as India, which has a large ZD population but also the means to address this

> "[I]f we really want to reach, and make a big dent on the global zero-dose campaign programme, I don't see how you can do that without India…I know [there are] super intense debates at the board level, because some donors are saying what I'm saying, and are, like, 'We've got to figure this out.' Others are, like, you know, the example that the board members were using is, 'Well, [India have] started a space programme'. I mean, really, are they the priority for investments now?"
> Operational respondent, interview

[23] Taneja et al. (2023). An equity analysis of zero-dose children in India using the National Family Health Survey data: Status, challenges, and next steps. *Cureus. 2023 Feb 24;15(2):e35404.* doi: 10.7759/cureus.35404. PMID: 36851944; PMCID: PMC9963392.
[24] Worldometer. *GDP by Country.* Retrieved 26/09/23: https://www.worldometers.info/gdp/gdp-by-country/
[25] Gavi. *Historic partnership between Gavi and India to save millions of lives.* Retrieved 26/09/23: https://www.gavi.org/news/media-room/historic-partnership-between-gavi-and-india-save-millions-lives
[26] Ibid.
[27] Gavi. *Gavi and Government of India establish new partnership to protect millions of children by 2026.* Retrieved 26/09/23: https://www.gavi.org/news/media-room/gavi-and-government-india-establish-new-partnership-protect-millions-children-2026#:~:text=Collaboration%20between%20Gavi%20and%20India,US%24%201.7%20billion%20in%20funding.

internally, might be better directed towards countries which have smaller ZD populations but less means to address it.

Box 1. The IRMMA framework

Interviewees had mixed awareness and feedback of the IRMMA framework; some were aware and felt that it was ideal for developing interventions and was described by one operational respondent as "the natural cycle of programme planning". Still, others were unaware of the framework, especially those outside of core partners. There was some criticism that the IRMMA framework was difficult to translate down to sub-national and community levels; one strategic respondent explained that during the FPP process they "[struggled] *to get the more local, kind of, staff to really understand it, grasp it and not diverge".* This suggests varying levels of absorption, especially outside of national-level stakeholders and core partners.

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	▪ India has a unique arrangement with Gavi in terms of funding; the GoI spends significantly more on vaccination priorities than Gavi makes available, and only has access to HSS and TA funds. From this perspective, funding is relevant to reaching ZD as opposed to other vaccination priorities. ▪ Funding is intended to be 'catalytic' in that it will lead to the scale-up of successful government programmes; there are successful examples of this occurring in Gavi 4.0, and this will be a key area of enquiry during subsequent years of the evaluation.
Strength of the evidence	1 | **2** | 3 | 4
Rationale for this judgement	Evidence comprises multiple data sources which are mainly qualitative, including government documents, Gavi documents, and qualitative interviews. Good triangulation.

Gavi and the government of India have a unique relationship, and this is reflected in the design and purpose of Gavi grants in India. As discussed under EQ1, the GoI has a 'strategic relationship' and is classified as 'fully self-financing' under Gavi's co-financing policy. There is recognition among country-level stakeholders that the amount of funding Gavi provides to the GoI is tiny compared to what the GoI spends itself; for example, the amount of funding provided by Gavi is around USD 25 million per year, while the amount the GoI spends on their UIP is roughly USD 1 billion per year, and on their NFHM USD 10 billion per year.[28,29] Funding is therefore intended to be 'catalytic' and limited to the HSS grants and TA (now bundled with HSS under Gavi 5.0).

[28] Statista. Expenditure on immunizations in India from 2013 to 2017 with a forecast from 2018 to 2022. Retrieved 26/09/23: https://www.statista.com/statistics/1128776/india-immunization-expenditure/

[29] National Health Mission: Budget brief. *Accountability Initiative and centre for Policy Research*. Retrieved 26/09/23: https://cprindia.org/wp-content/uploads/2022/06/National-Health-Mission_2022-23.pdf

In terms of vaccination priorities, the funds which Gavi provides in India are relevant to the ZD agenda. As detailed in EQ1, vaccination priorities in India are centred on achieving a full immunisation schedule of 90%; to succeed in this, the government will need to address under-immunised children (20% of the remaining target population) and 'left-out' children (4% of the remaining target population).[30] Given the relative size of Gavi investments and the resources needed for addressing both priorities, targeting Gavi funding towards ZD children as opposed to missed children or drop-outs is the right approach.

> "I think Gavi investing is the right thing in the right place, it is reaching community and increasing the quality and increasing the demand and supply services so I think Gavi should keep continue focusing on the equity increment of public health along with technical support that can be given at national level or state level."
> Frontline respondent, interview

Gavi 5.0 funding in India are designed to be 'catalytic' and leverage mechanisms and infrastructure from Gavi 4.0 to be scaled up effectively. Respondents highlighted how Gavi funding in India is insufficient to address the number of ZD children; therefore, funding is intended to be 'catalytic' and anticipated that effective interventions would be scaled up by the government. Under the Gavi 4.0, activities such as the electronic Vaccine Intelligence Network (eVIN) were successfully scaled up through partnerships with state-level governments (see EQ5).[31] The project narrative states that Gavi 5.0 grants will be *"fully leveraged to strengthen synergies with the health system and health ministry"* and that government institutions have already been identified for sustaining initiatives covered under HSS3.[32] However, HSS3 investments are not the same as HSS2 investments; as detailed under EQ1, HSS3 funds are more targeted and meant to be context-appropriate, potentially down to the district level. Therefore, scaling-up solutions may require a different approach than in Gavi 4.0. The ability of Gavi and the GoI to scale up successful interventions will be a key area of enquiry in subsequent years of the evaluation.

The design of the Gavi 5.0 project contains potential areas of operational complexities which will need to be evaluated in subsequent years of the evaluation. This includes the following components:

- **The increased number of implementation partners.** Under Gavi 4.0, there were a total of three core implementation partners (UNDP, WHO, UNICEF), with an additional fourth partner (JSI) and possible sub-grantees under UNDP, WHO and CSOs under UNICEF being added under Gavi 5.0. HSS3 funding will be directed to each of these four partners to implement specific activities in the ToC. While oversight of partners will be provided via quarterly Immunization Advisory Group (IAG) meetings, the IRC review notes that each partner submitted separate, independent proposals, which risks duplication or harmonisation across partners.[33] The evaluation will critically assess the degree to which activities are harmonised and the effectiveness of the quarterly IAG meetings in achieving this.

- **Development and roll-out of U-WIN.** While almost one-third of the budget has been earmarked for U-WIN, there's little by way of reference to how that money will be spent and how it will translate into meaningful results on the ground.[34] Indeed, the IRC report states in reference to this

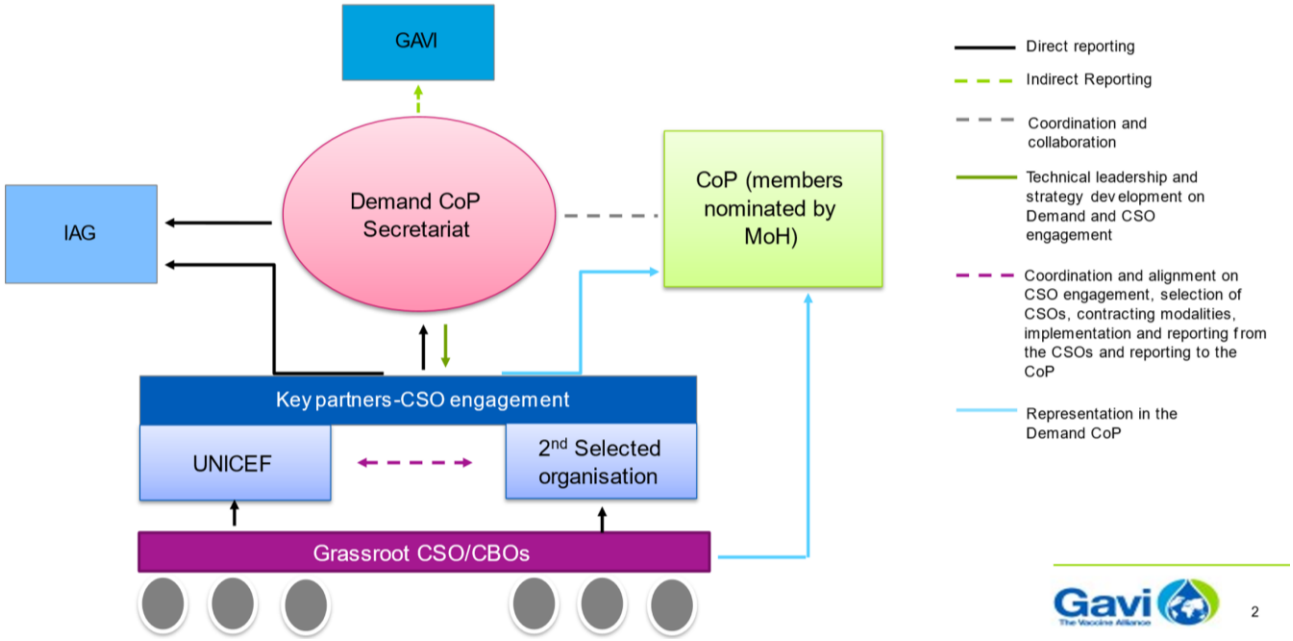
[30] Dhalaria et al. (2023). Exploring the pattern of immunization dropout among children in India: A district-level comparative analysis. *Vaccines (Basel). 2023 Apr 13;11(4):836.* doi: 10.3390/vaccines11040836. PMID: 37112748; PMCID: PMC10143302.
[31] Gavi. *Performance Review: Gavi Health System Strengthening Grant to India: 2017-22.* July 2021.
[32] Supporting narrative for theory of change for Gavi. *India Ministry of Health and Family Welfare.* n.d.
[33] Supporting narrative for theory of change for Gavi. *India Ministry of Health and Family Welfare.* n.d.
[34] Ibid.

activity that *"the rationale supporting this large investment appears weak as little evidence was presented to the IRC on the extent to which it will benefit ZD children"*.[35]

- **Evaluation of the demand CoP–CSO engagement ecosystem.** The India project narrative proposes the setting-up of a CoP Secretariat, which is intended to inform appropriate and context-specific demand-generation activities. The ecosystem is relatively complex[36] and requires the set-up of a Secretariat, reporting and leadership mechanisms, identification of a key partner through an RfP process, and then identifications of CSOs, detailed below (see Figure 2.3).[37] Components of this ecosystem will be evaluated to understand how it is being operationalised in practice and how much it contributes to stated objectives.

- **The RfP approach to engaging CSOs**. FPP documentation sets out an approach for engaging CSOs, who will be selected and onboarded by UNICEF.[38] This will need to be critically evaluated to understand how CSOs were selected, capacity of CSOs, UNICEF to engage with this process, and effectiveness in terms of the portfolio of CSOs ultimately selected.

Figure 2.3: Demand CoP ecosystem functioning proposal (from India project narrative)



The allocation of resources under HSS3 does not always align with the intended activities in the ToC. The IRC India review of the FPP submission highlighted several discrepancies between the planned activities and what was allocated in the budget.[39] Initially, the IRC reallocated certain areas of the budget to different investment areas based on their own review process (Table 2.1 depicts the initial allocation, prior to IRC re-allocation). Following this, the IRC re-assessed areas of investment against the allocated budget. They identified a 'priority investment area' in the ToC as demand-generation-related activities; however, a higher proportion of the reallocated budget is dedicated to data-related activities (48%) over demand-generation activities (44%). Alignment of the budget with activities in the ToC will be a key area of enquiry in subsequent years of the evaluation. Without this, there is a critical

[35] Gavi. *Independent Review Committee (IRC) Country report: Inda FPP Review.* October 2022.
[36] Note: Evaluators' professional judgement.
[37] Supporting narrative for theory of change for Gavi. *India Ministry of Health and Family Welfare.* n.d.
[38] Ibid.
[39] Gavi. *Independent Review Committee (IRC) Country report: Inda FPP Review.* October 2022.

causal link assumption in the ToC (i.e. that funding is used to develop effective results-driven, relevant programming) that will not hold true.

Table 2.1: Investment area of HSS3

Investment area	Estimated proportion of budget	Selected tailored ZD interventions
Demand generation and community engagement	30%	The interventions for Gavi 5.0 will be developed during the implementation phase (see previous section 1.2.2).
Health information systems and monitoring and learning	26%	
Human resources for health	15%	
Governance, policy, strategic planning, and programme management	12%	
Service delivery	11%	
Grant management and indirect costs	6%	

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

Summary of findings	▪ The GoI drives coherence of the ZD agenda with other actors' focus in India through the FIC target of 90%. ▪ Different actors, including the government, core partners and Gavi, work towards different elements in different priorities to help achieve this target. The funding mechanism may also contribute to this coherence. ▪ Understanding the degree to which interventions developed under Gavi 5.0 are coherent with state-level activities will be a key area of enquiry in subsequent evaluation years.
Strength of the evidence	1 **2** 3 4
Rationale for this judgement	Evidence comprises multiple data sources which are mainly qualitative, including government documents, Gavi documents, and qualitative interviews. Good triangulation.

The Gavi 5.0 strategy is coherent with national-level strategies, including the Universal Immunisation Programme's comprehensive Multi-Year Plan (2018–2022) and Intensified Mission

Indradhanush. The UIP cMYP Strategic Plan is to reduce mortality and morbidity due to vaccine-preventable diseases and achieve FIC of 90% nationally (at 76% as per the last NFHS-5 in 2019–2021). Gavi's 5.0 strategy compliments the cMYP Strategic Plan by focusing on a sub-set of children who have not received FIC, i.e., those who have not received DTP1. Areas of focus and activities are also aligned, for example, the cMYP 2018–2022 recognises that strategies to increase coverage in unvaccinated or under-vaccinated populations is a crucial step in addressing the state and district-level inequities.[40] The plan also identifies demand generation (a key area of investment under HSS3) and service delivery (a smaller but still key area of investment under HSS3) as overarching objectives for achieving FIC.[41]

By centring vaccination activities and actors around national strategies, this ensures coherence across core partners. Specifically, the government leads on the overall strategy; Gavi provides catalytic support to ZD-linked initiatives with government leadership and support from core implementing partners; while core partners support with the ZD agenda and assist government bodies with other immunisation priorities. Core implementing partners reported that the Gavi 5.0 strategy is aligned with their own strategies and compliments existing activities within India. Other sources of financial funding for immunisation are presented in Table 2.2.

> "The bottom line [is] that we have to cover each and every children present in the country. There, I think a unified role we are playing, the government of India, the partners and the funding of Gavi also. They are all synchronising with that objective." Operational respondent, interview

The funding mechanism in India (see Figure 1.1) may help to ensure a degree of coherence with the GoI and core implementing partners. Under this funding mechanism, Gavi grants are approved by MoHFW, and then disbursed by Gavi directly to core implementing partners.[42] Activities are approved and signed-off by the government, while funds are sent directly to the partners implementing the activities. This limits the risk of transaction and operating costs associated with cascading funds through multiple agencies.

There is emerging evidence to suggest the FPP process has helped ensure Gavi 5.0 activities are coherent with state-level activities; however, this should be a key area of enquiry as Gavi 5.0 grants are disbursed and implemented. There was an extensive consultation process with the 11 states selected for Gavi 5.0 funding, and the Gavi Secretariat, core partners and immunisation officials discussed and planned tailored, state and district-level approaches for the different target populations and areas identified through the situational analysis. Theoretically, this process should have ensured a degree of coherence with state-level activities; the project narrative mentions achieving a 'catalytic effect' by 'dovetailing local resources with…programmes through the PIP [Programme Implementation Plan] of NHM' (as was successfully done under Gavi 4.0).[43] However, it is difficult to make an assessment of yet-to-be-developed interventions with state-level actions; subsequent years should therefore focus on Gavi 5.0 funded activities in specific states, and critically assess whether these activities are coherent with state-level activities in practice.

Table 2.2: Total financial resources for immunisation by source

Donor/source	Main aims of health spending
Gavi	USD 133 million from 2022 to 2026
World Bank	USD 1.6 billion through two COVID-19 health projects and one public health project

[40] Universal Immunization Programme. Comprehensive Multi-Year Plan: 2018-22. *Ministry of Health and Family Welfare.*
[41] Ibid.
[42] This includes UNDP, WHO, UNICEF under Gavi 4.0, with the addition of JSI, CHAI, Group M, and Jhpiego under Gavi 5.0.
[43] Supporting narrative for theory of change for Gavi. *India Ministry of Health and Family Welfare.* n.d.

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	▪ Gavi processes are considered complex, particularly in terms of their length and the capacity required to complete them. The IRC process was also considered lengthy. ▪ Despite this, the FPP process was considered useful in terms of agreeing and coordinating activities across various stakeholders. ▪ Not all the shifts under Gavi 5.0/5.1 were present in the FPP documentation; however, this may be because of the nature of the project in India.			
Strength of the evidence	1	2	3	4
Rationale for this judgement	Evidence comprises fewer data sources, including Gavi documentation and qualitative interviews. There is limited quantitative data to draw from. Despite this, there is good triangulation between the few data sources.			

Gavi processes are reported by stakeholders to be complex to operationalise, due the expertise and capacity required to complete them. The FPP process was described as '*tedious and time-consuming*' by a sub-set of respondents; they pointed towards the complex documentation which was required, including developing the ToC, the budgeting exercise, i.e., ceilings for different components, and different sheer number of forms which needed to be completed throughout the process. The capacity of country staff was highlighted as a barrier towards effectively completing these areas; respondents specifically referenced Gavi jargon-y language and the time required to engage with the process. As per Monitoring and Performance Management (MPM) data, the length of time it took from the FPP kick-off to the IRC confirmation was 7 months – the shortest amount of time of any of the country case studies selected for this evaluation.

> "The different formats were not very friendly.... That [took time] to understand and I feel that Gavi is also in the process of developing those formats, so it is evolving… so that took quite a lot of time to understand and then to fill those things and [in] some places, it felt repetitive."
> Operational respondent, interview

Interviewees reported that the IRC process was lengthy with some criticism directed towards the composition of the panel. The time it took for the IRC to review the country submission was considered time-consuming by interviewees, although the corresponding MPM data for India was not made available to the evaluation team, making it difficult to corroborate these findings. Reasons why interviewees singled out the IRC process were largely linked to the demands of the IRC panel. One country-level interviewee explained that the composition of IRC members included experts on specific areas of health and were not familiar with the country-context, meaning they had to re-explain certain aspects of the approach to these members. Indeed, the IRC review itself notes 'a lack of familiarity of some [partners] with Gavi rules and procedures' indicating some tensions between both parties.

The FPP process was considered useful in terms of agreeing and coordinating activities, despite some challenges in working across different levels of government and various actors.

Respondents reported that bringing together all actors involved in the Gavi 5.0 strategy to plan out the HSS3 in detail helped to bring everyone 'on the same page' and coordinate activities. Internal mission reports from Gavi note state-level authorities were 'appreciative' of the consultation, as well as the 'transparency and level of inclusion'.[44] There were some challenges noted by respondents and the internal mission reports on understanding of certain Gavi methodologies at the state level (including the Identify, Reach, Monitor, Measure and Advocate [IRMMA] framework[45]). It was also noted that using Gavi methodology may potentially distance MoHFW from leading on this process.

The FPP process facilitated the intended shifts under Gavi 5.0 to varying degrees. Despite some reservations from interviewees (see Box 1), the different components of the IRMMA framework were well represented in the FPP documentation. However, there was limited representation of gender shifts in the workplan, with no sex disaggregated coverage rates or mention of adolescent/young mothers or adolescent girls. This is despite noted gender-related barriers in the situational analysis. There are also notable gaps related to comprehensive vaccine management, including alignment of interventions with immunisation supply chains.

These gaps may be partially due to the proposed approach in the FPP documentation. A key component of the funds will be directed towards a demand CoP mechanism which will develop tailored interventions through local CSOs. Accordingly, the specific interventions and target beneficiaries have not yet been developed nor identified and will be informed by engagement with CSOs at the sub-national level. Therefore, certain granular requirements within Gavi 5.0/5.1 shifts may not have been determined at the time of the FPP documentation.

[44] Mission report: Strategic Partnership between India and Gavi. *Gavi internal document.* 05 May 2022.
[45] Identify, respond, measure, monitor, advocacy framework.

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	▪ Gavi 4.0 grants contributed to strengthening supply chains, which is anticipated to enable vaccine services to better reach ZD communities; establish the infrastructure needed for demand-focused activities; and expand vaccine-preventable disease (VPD) surveillance to better identify ZD communities. ▪ Key enablers included tapping into pre-existing programmes and buy-in from the GoI, while barriers included the COVID-19 pandemic and inequalities between states.
Strength of the evidence	1 | **2** | 3 | 4
Rationale for this judgement	This section largely draws on findings from the Gavi Performance Review of the HSS Grant to India: 2017–2021. This was undertaken by Gavi and consists of a review of documents, including country documents, intervention documents, Gavi Secretariat documents, and other data sources. These are triangulated with findings from the in-depth interviews where appropriate.

The Gavi 4.0 objective to strengthen immunisation supply chains is a key contributor to delivering the ZD agenda. Under HSS2, Gavi and core partners supported the implementation of activities aimed at strengthening the national immunisation supply chain. These activities focused on capacity-building programmes directed at cold-chain technicians, and vaccine and cold-chain handlers, the development of three digital applications used to capture information on cold-chain and vaccine logistics management, state-level effective vaccine management assessments, and introduction of the electronic Vaccine Intelligence Network (eVIN) across all 36 states and Union Territories[46] All targets were met or exceeded, and there is recognition among respondents that this was a key area of contribution.

> "The immunisation supply chain strengthening which happened under HSS2 was something pretty remarkable because India went from something like an EVM [effective vaccine management] score of 51% when you started HSS2…At the end of HSS2, it's now 82%, so it's well beyond the global standard of 80%."
> Operational respondent, interview

Respondents reported that Gavi 4.0 also helped to establish the infrastructure needed for demand-focused activities planned under Gavi 5.0/5.1. Gavi 4.0 activities which met their targets and were identified by stakeholders as contributing to this focused on developing skillsets of frontline health workers, including interpersonal communication skills under the Boosting Routine Immunisation Demand Generation (BRIDGE) programme, and establishing Social and Behavioural Change Communication (SBCC) cells across 11 states. Gavi also aimed to engage with CSOs and CBOs to facilitate demand generation for routine vaccination; however, this target was not met. Still, in attempting to implement this activity, Gavi established relations with the Voluntary Health Association of India (VHAI) and Self-Employed Women's Association and leveraged their pre-existing relationships to engage with CSO/CBOs – a key learning point for the Gavi 5.0 strategy.[47]

[46] Gavi. *Performance Review: Gavi Health System Strengthening Grant to India: 2017–2022.* July 2021.
[47] Ibid.

Capacity-building activities implemented under Gavi 4.0 supported the expansion of VPD surveillance which should help to better identify ZD communities. This activity aimed to expand the previous National Polio Surveillance Project network to include diphtheria, pertussis and neonatal tetanus outbreaks – key indicators of ZD and missed communities. Gavi provided capacity technical assistance, while national and state-level governments provided additional laboratory costs and operational costs. The target of 15 states was exceeded and 17 states were ultimately supported.[48]

Successful activities were nearly always enabled by tapping into pre-existing architecture; this also helped to ensure sustainability. For example, the capacity-building programmes implemented under the cold-chain strengthening objective were supported by the National Cold-Chain and Vaccine Management Resource Centre (NCCVMRC) alongside the National Cold-Chain Resource Centre; while the VPD expansion was co-financed by the GoI and state governments. Even where activities were unsuccessful, i.e. the CSO/CBO engagement, improvements were noted once Gavi established relations with established organisations.[49]

Government buy-in, specifically from the federal government, was noted as a key enabler by the HSS2 Performance Review and respondents. This ensured that new initiatives, for example the eVIN platform, were championed nationally and would lead to effective uptake throughout different states and Union Territories.

> "The main enabler is the presence of political will and administrative support for these initiatives."
> Frontline respondent, interview

Key barriers to implementing Gavi 4.0 activities were linked to COVID-19 and state inequalities. COVID-19 had impacted Gavi's ability to move forward with activities, specifically roll-out of the BRIDGE programme and training programmes for cold-chain management. State inequalities, specifically the amount of human resources states had available to engage with Gavi activities, was mentioned as a key barrier to establishing SBCC cells.[50]

[48] Ibid.
[49] Ibid.
[50] Ibid.

Table 2.3: Mapping ZD related outputs to pro-equity interventions implemented under Gavi 4.051

ZD related outputs	Pro-equity interventions implemented	Enablers to achieving outputs	Barriers to achieving outputs
ZD children and missed communities are identified and targeted	**Capacity building at national, state and district levels for expansion of VPD surveillance** Gavi provided technical assistance to help leverage the National Polio Surveillance Project network to identify diphtheria, pertussis, and neonatal tetanus, along with polio and measles. The target of 15 states was exceeded with 17 states implementing the expanded VPD surveillance[52,53,54]	▪ Gavi support was catalytic, providing technical assistance through the WHO: ▪ The GoI supported laboratory costs for VPD. ▪ Operational costs were borne by state governments; this was eventually covered by the NHM.	No barriers identified – intervention exceeded the target.
Communities know about immunisation and how to access services Communities have trust and confidence in the full set of vaccines and immunisation services	**Skills development of frontline workers in interpersonal communication for BRIDGE** Gavi developed content and training of master trainers to delivery interpersonal communication skills to frontline health workers **Establishment of SBCC cells** Through Gavi funding, UNICEF led the establishment of state specific SBCC cells in 11 states to develop social and behavioural communication strategies. **CSO/CBO engagement to facilitate demand generation for routine**	Bringing partners VHAI and Self-Employed Women's Association onboard to help engage CSOs through pre-established pathways)Panchayat Raj institutions and women self-help groups).	COVID-19 pandemic halted the roll-out of BRIDGE training. CSO engagement was a challenge initially due *to 'delays while figuring out the interventions they need to be engaged in to get measurable results.'* Variation in resources across states to establish SBCC cells.

[51] Gavi. *Performance Review: Gavi Health System Strengthening Grant to India: 2017–2022.* July 2021.
[52] Percentage districts in a state reporting VPD data: May 2020 at 99%.
[53] Proportion of measles outbreaks investigated as per guidelines: 2017 at 57%; 2018 at 59%, 2019 at 65%.
[54] Percentage VPD cases investigated by government officer: 2019 at 90%.

	immunisation and COVID-19 prevention. Continued engagement in 14 states and 54 districts.		
Supply chains are able to reliably deliver the full set of vaccines to missed communities	**Support to strengthen the cold-chain management capacity, vaccine availability and quality of vaccines,** thereby improving coverage and equity. Five interventions implemented: ▪ Capacity building for cold-chain management[55,56] ▪ Augmentation of National Cold-Chain Management Information System and Immunisation Supply Chain-Cold-Chain data harmonisation[57] ▪ Review implementation of Effective Vaccine Management improvement plans[58] ▪ Strengthening of institutions, cold-chain infrastructure and equipment[59,60] ▪ Establish electronic Vaccine Intelligence Network (eVIN) system infrastructure[61]	Support from the NCCVMRC alongside the National Cold-Chain Resource Centre, both developed under HSS1 in partnership with two government institutes, in delivering training sessions. Thorough region by region assessment ahead of the scale-up of the eVIN system. Buy-in from the government of India, including championing of the eVIN platform from the MoHFW. Robust standard operating procedures (SOPs), developed by the MoHFW.	COVID-19 pandemic hindered the implementation of training programmes. Still gaps in cold-chain management, including maintenance of equipment and waste management.

[55] Number of HSS supported states where cold chain breakdown rate meets the national standard: May 2020 at 9.
[56] Percentage of trainees with positive increase in cold chain knowledge score: 2018 and 2019 both 100%.
[57] Percentage of High Priority Districts updating National Cold Chain Management Information System once a month: 2017 at 50%; 2018 at 65%; 2019 at 74%.
[58] Percentage of states with an improvement plan after effective vaccine management assessment: 2018 at 100%; 2019 at 100%.
[59] Percentage of monitored session sites in UP where all vaccines and diluents are available: May 2022 at 94%.
[60] Percentage of monitored session sites in Bihar where all vaccines and diluents are available: May 2022 at 82%.
[61] No of states and UTs with eVIN reflected in state PIP: 2018 at 12.

3 Annex

Table 3.1: Desk review documents

Source	Title of document	Year
Accountability Initiative and centre for Policy Research.	National Health Mission: Budget brief	2023
Gavi	Application form for India: Health System Strengthening (HSS) Support	2016
Gavi	Approval of Health Systems Strengthening Support for India.	2017
Gavi	Approval of Health Systems Strengthening Support for India	2019
Gavi	Gavi and Government of India establish new partnership to protect millions of children by 2026	n.d.
Gavi	Historic partnership between Gavi and India to save millions of lives	n.d.
Gavi	Independent Review Committee (IRC) Country report: Inda FPP Review	2022
Gavi	Joint Appraisal Report	2018
Gavi	Joint Appraisal Report	2019
Gavi	Mission report: Strategic Partnership between India and Gavi	2022
Gavi	Performance Review: Gavi Health System Strengthening Grant to India: 2017-22	2021
Gavi	Report on Gavi 2020 multi-stakeholder dialogue: Immunisation planning in light of COVID-19.	2020
Government of India	National Family Health Survey (NHSF-5), 2019-21: India Report.	2019
Ministry of Health and Family Welfare	Comprehensive Multi-Year Plan: 2018-22	2018
Ministry of Health and Family Welfare	Mission Indradhanush: Operational Guidelines	2016
Ministry of Health and Family Welfare	Supporting narrative for theory of change for Gavi	n.d.
The World Health Organisation	India: a push to vaccinate every child, everywhere, ended polio in India.	2021

Table 3.2: List of academic sources

Source	Title of document	Year
Dandona et al.	Public health priorities for India. The Lancet Public Health, 7(2); E102-103.	2022
Dhalaria et al.	Exploring the pattern of immunization dropout among children in India: A district-level comparative analysis. Vaccines (Basel). 2023 Apr 13;11(4):836.	2023
Taneja et al.	An equity analysis of zero-dose children in India using the National Family Health Survey data: Status, challenges, and next steps. *Cureus. 2023 Feb 24;15(2):e35404.*	2023

Table 3.3: List of stakeholders

ID	Position	Organisation	Categorisation	Remote vs in-person
1	Rise Developer	JSI	Operational	Remote
2	Demand generation manager	UNICEF	Operational	Remote
3	Demand generation manager	UNICEF	Strategic	Remote
4	Vaccine distribution manager	Government medical store depots	Operational	Remote
5	EPI stakeholder	Government MoH	Strategic	Remote
6	Monitoring and evaluation lead	Gavi	Operational	Remote
7	Regional head	Gavi	Strategic	Remote
8	Monitoring and surveillance stakeholder	WHO	Strategic	Remote
9		UNDP	Strategic	Remote
10	Master trainer developer	WHO	Operational	Remote
11	Gavi SCM and PM	Gavi	Strategic / operational	Remote
12	Frontline worker	VHAI	Frontline	In-person
13	Frontline worker	JSI	Frontline	In-person
14	Frontline worker	JSI	Frontline	In-person
15	Frontline worker	AIH	Frontline	In-person

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.

For more information

3 Thomas More Square
London
E1W 1YW

t: +44 (0)20 3059 5000

www.ipsos.com/en-uk
http://twitter.com/IpsosUK

About Ipsos Public Affairs

Ipsos Public Affairs works closely with national governments, local public services and the not-for-profit sector. Its c.200 research staff focus on public service and policy issues. Each has expertise in a particular part of the public sector, ensuring we have a detailed understanding of specific sectors and policy challenges. Combined with our methods and communications expertise, this helps ensure that our research makes a difference for decision makers and communities.