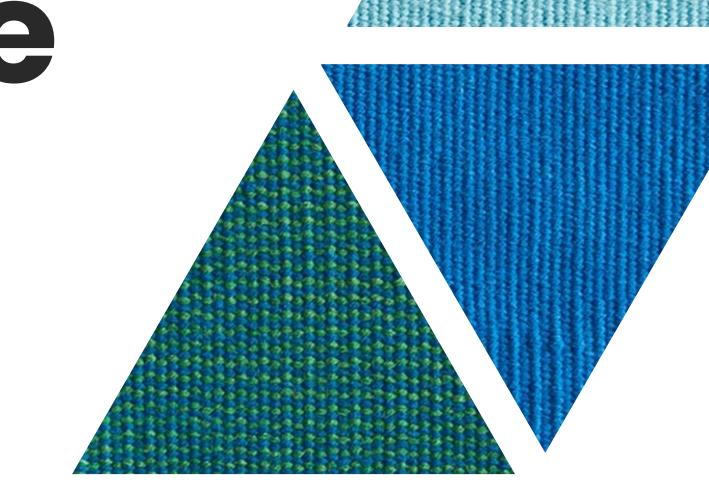
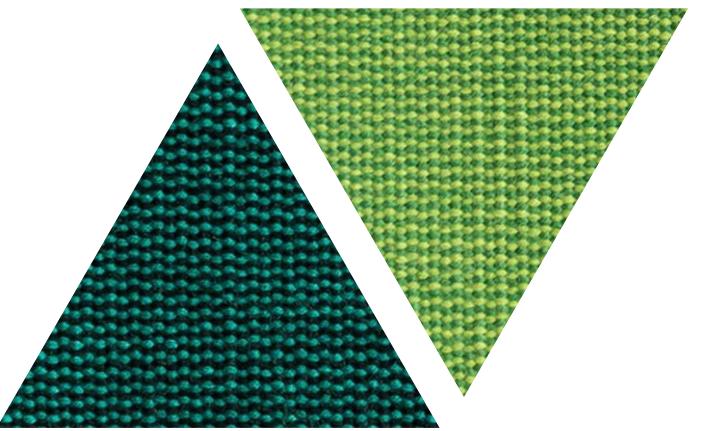
# Comprehensive training

28 June - 21 July 2022

HOSTED BY GAVI, WHO, UNICEF & US CDC





# Improving equity in immunisation

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Systems

GAVI – Health Systems and Immunisation Strengthing





# Definitions



**Zero-dose children** are those who have not received any routine vaccines. For operational purposes, Gavi defines zero-dose children as those missing a first dose of diphtheria-tetanus-pertussis containing vaccine\*.



**Under-immunised children** are those who have not received a full course of routine vaccines.

For operational purposes, Gavi defines under-immunised children as those missing a third dose

of diphtheria-tetanus-pertussis containing vaccine.



Missed communities are home to clusters of zero-dose and under-immunised children. These communities often face multiple deprivations and vulnerabilities, including lack of services, socio-economic inequities and often gender related barriers.



**Equity:** The organising principle of the Alliance's 2021-2025 strategy, whose vision is *Leaving* 

no-one behind with Immunisation. This entails a laser focus on using all Gavi levers to reach

missed communities and zero-dose children with immunisation



## What is the context of zero dose? (1/2)

#### **POVERTY**

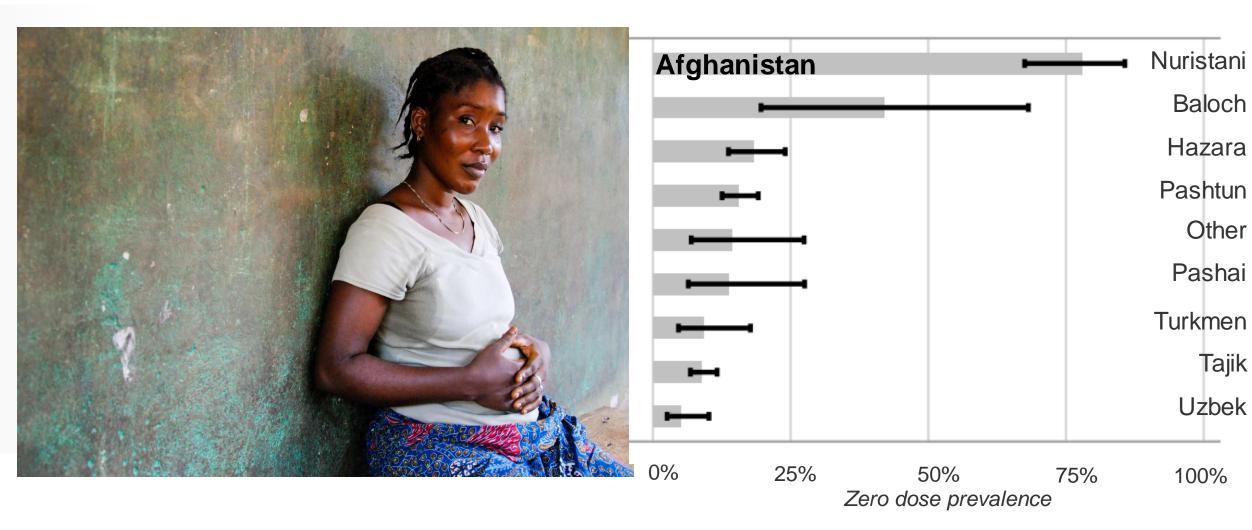
# — US \$1.90 — ◆POVERTY LINE 2 out of 3 zero dose children

1 in 8 children in Gavisupported countries are Zero dose, and yet they account for nearly half of all children dying from vaccine preventable diseases.

live in households surviving on

less than \$1.90 a day

#### **GENDER**



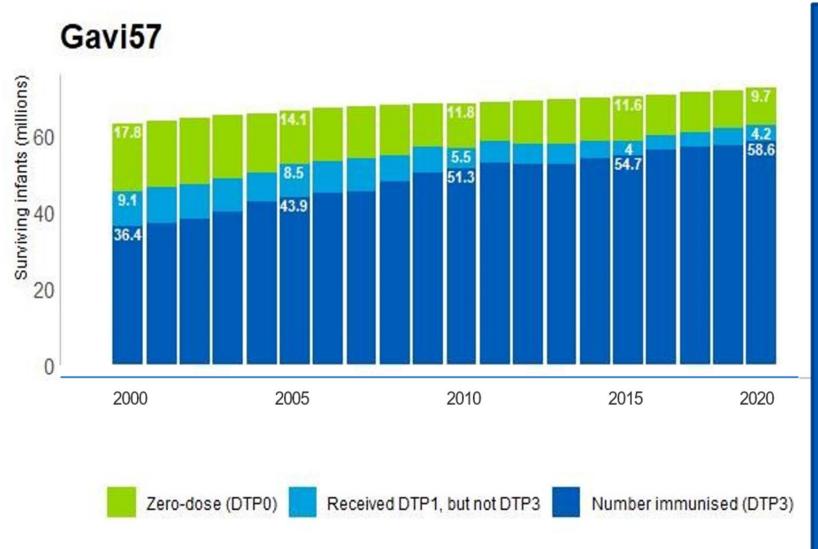
47% zero dose less likely to have mother receiving antenatal care or skilled birth attendance

Large differences in zerodose prevalence by **ethnic groups** in many countries

**ETHNICITY** 

# What is the context of zero dose? (1/2)

9.7 million infants lack access to vaccination services, 4.2 million drop out before receiving a third dose of a DTP containing vaccine



Of the 13.9 million infants that are not fully vaccinated with DTP3, 9.7 million did not receive an initial dose, pointing to a lack of access to immunisation services.

A further 4.2 million were partially vaccinated without completing the required 3 dose schedule in the first year of life.

- Every year approximately 13.9 million of the 72.5 million children targeted with Gavi support do not receive their third dose of DTP-containing vaccine.
- 70% of these children, 9.7 million in total, do not receive a single dose of DTP- containing vaccines and are defined as "zerodose".
- Reduction in number of zero-dose has plateaued over last decade pointing to persistent inequities



# Why should we invest in reaching zero-dose children and missed communities?



Sustainable Development Goals: Reaching every child with immunisation is a first, realistic step to *leaving no one behind* and universal health coverage



**Value for money:** Immunisation most cost-effective health intervention – countries will need to prioritise health spending as they recover from COVID



Greatest impact: Zero-dose children often live in missed communities suffering multiple deprivations, who are least resilient to VPDs



Foundation for Primary Health Care: Immunisation services can be a pathfinder for reaching missed communities with essential PHC services



Health security: Missed communities' potential source of VPD outbreaks

# Identifying zero dose children and missed communities is the first step – 50% in urban/remote rural and conflict regions







**Urban poor** 

Remote communities & nomadic groups

Populations in conflict settings

#### **Initial Analysis**

- Substantial variations
   between & within countries
- DRC & Ethiopia have largest number of zero dose children in remote rural areas
- Nigeria has the largest number of zero dose children impacted by conflict

## What is the impact of COVID on the zero-dose agenda?

**Equity agenda more** relevant than ever

Will exacerbate challenge of reaching zero-dose

Also presents opportunities

- Many more children will be zero-dose
- Exacerbated inequities, highlighted vulnerability of missed populations (e.g., urban poor)
- Reduced fiscal space (may not mean reduced health expenditure)
- Population movement will stretch services and conflate data
- Diverted health system capacity for COVID response
- Impact on trust and demand
- Highlights threat of infectious disease outbreaks
- Exposes weaknesses in health systems
- Catalyses efforts to increase integration within immunisation
- Catch-up efforts are an opportunity to reach previously missed communities

How can we address these challenges and capture the opportunities?



# How do we tailor the approach in different contexts? (e.g. Low coverage & acute fragility)

Illustrative

Expected outcome: increased availability of essential services and coverage in key regions

#### **IDENTIFY**



#### **REACH**





#### **ADVOCATE**

#### **Country context**

- Low coverage nationwide
- Very weak health system
- Many parts of country conflictafflicted – limited access
- Fragmentation / weak governance and coordination
- Humanitarian partners

- ✓ Zero-dose children reside in most areas – less precision needed to identify
- Partner with humanitarian actors to identify missed populations in conflict areas
- ✓ Triangulate data e.g., integrate EPI in assessment of migrants, IDPs, refugees
- ✓ Focus on identifying barriers for refugees and large displaced populations

- ✓ Focus on scaling up basic health services/
   PHC evolve from outreach to strengthen facility-based EPI
- Specific efforts to rebuild trust in conflict-work with affected communities
- Partnerships with humanitarian actors and local CSO in areas inaccessible for vaccine supply and service delivery

- Monitoring focused on basic operational data e.g., number of sessions conducted
- Triangulation with other data sources
- Explore community monitoring
- Agree on critical indicators amongst partners
- ✓ Targeted surveys
- Explore integrated implementation research

- Focus on advocating for availability of maintaining essential health services (e.g., risk of outbreaks)
- Partner with
  humanitarian
  agencies to –try to
  align multiple
  authorities in conflict
  settings
- Advocate for access to geo / populations



# How do we tailor the approach in different contexts? (e.g., High coverage, high concentration)

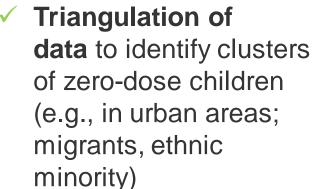


Expected outcome: targeted improvements in coverage in specific zero-dose communities

### Country context

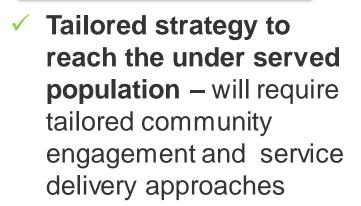
- High coverage nationwide
- Concentration of zero dose in localised communities or pockets
- Strong systems
- Decentralised governments?

#### **IDENTIFY**



- Special studies/
  research to
  understand deep
  rooted demand side
  barriers
- ✓ Focus on identifying access side barriers at community level, e.g. service quality, anti Vx lobby, AEFI issues

#### **REACH**



- ✓ Partnerships with CSO; community/faith leaders may be needed to access marginalised populations
- Ensure HRH and communication adapted and sensitive to local gender dynamics, language / culture

# MONITOR & MEASURE

- ✓ Targeted cluster surveys in communities to learn and adapt strategies
- Monitoring focused on subnational/community based data in target communities
- Rapid research to adapt strategies

#### **ADVOCATE**

- Advocate for prioritisation of services and financing for marginalised groups
- Help build accountability framework at local level to reach marginalised communities
- Work with and identify existing advocacy platforms and local government institutions
- ✓ Use participatory methods to work with community advocacy in specific missed communities





