

Meeting of the South-East Asia Regional Working Group on Immunization



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With thanks to the Regional Working Group on immunization in South-East Asia region steering committee

Sunil Bahl, WHO SEARO (co-chair)

Rene Ehounou Ekpini, UNICEF ROSA (co-chair)

Günter Boussey, UNICEF ROSA

Jayantha Liyanage, WHO SEARO

Khin Devi Aung, UNICEF EAPRO

Collette Selman, Gavi

Pankaj Bhatnagar, WHO SEARO

Emmanuel Njambe Tondo Opute, WHO SEARO

Azhar Abid Raza, UNICEF ROSA

Nattha Tritasavit, UNICEF EAPRO

Hilary Adams, UNICEF ROSA

For more information, please contact:

Jayantha Liyanage, Regional Adviser, Immunization Systems Strengthening,
Immunization and Vaccine Development, WHO SEARO
liyanagej@who.int

Günter Boussey, Senior Health Specialist, UNICEF ROSA
gboussey@unicef.org

Khin Devi Aung, Immunization Specialist, UNICEF EAPRO,
kdaung@unicef.org

ACRONYMS

AEFI	Adverse Event Following Immunization	HW	Health Worker	OPV	Oral Polio Vaccine
ANC	Antenatal Care	IA	Immunization Agenda	PCV	Pneumococcal Conjugate Vaccine
CCEOP	Cold Chain Equipment Optimisation Platform	IFRC	International Federation of Red Cross and Red Crescent Societies	PEF	Partner's Engagement Framework
CDC	Center for Disease Control	IPV	Inactivated Polio Vaccine	PHC	Primary Health Care
CDS	COVID-19 Vaccine Delivery Support	ITAG	Immunization Technical Advisory Group	POSE	Polio Outbreak Simulation Exercise
CHW	Community Health Worker	MAC	Multi-Age Cohort	RCA	Rapid Convenient Assessment
COVID	Coronavirus Disease	MCH	Maternal and Child Health	RCT	Randomized Control Trial
CSO	Civil Society Organization	MIC	middle-Income Country	RI	Routine Immunization
DHIS	District Health Information System	MMR	Measles, Mumps, Rubella	RO	Regional Office
DPRK	Democratic People's Republic of Korea	MNCAH	Maternal, Newborn, Child and Adolescent Health	ROSA	Regional Office for South Asia
DPT	Diphtheria, Tetanus, and Pertussis	MR	Measles and Rubella	RVAP	Regional Vaccine Action Plan
EAF	Equity Accelerator Fund	MR-SIA	Measles and Rubella Supplementary Immunization Activity	RVIP	Regional Vaccine Implementation Plan
EPI	Expanded Programme on Immunization	NCD	Non-Communicable Diseases	RWG	Regional Working Group
FPP	Full Portfolio Planning	NGO	Non-Governmental Organization	SEARO	South East Asia/Regional Office
Gavi	Global Alliance for Vaccines and Immunization	NIAC	National Immunization Advisory Committee	TA	Technical Assistance
GIS	Geographic Information System	NIP	National Immunization Plan/Programme	TCA	Targeted Country Assistance
HCD	Human Centred Design	NIS	National Immunization Strategy	TCV	Typhoid Conjugate Vaccine
HIMS	Health Information Management System	NITAG	National Immunization Technical Advisory Group	UHC	Universal Health Coverage
HIV	Human Immunodeficiency Virus	NVI	New Vaccine Introduction	UNICEF	United Nations Children's Fund
HPV	Human Papillomavirus	Ops	Operational Support for Campaigns	VIG	Vaccine Introduction Grant
HQ	Headquarters			VPD	Vaccine Preventable Disease
HMIS	Health Management Information System			WASH	Water, Sanitation and Hygiene
HSS	Health Sector Strengthening			WHO	World Health Organization

PART 1: TECHNICAL SESSIONS



Re-injecting new momentum into immunization

Opening remarks by Eliane Luthi, Regional Chief of Communication, South Asia at UNICEF, on behalf of the Regional Director

South Asia is a region of extraordinary opportunities – and challenges. In the past year, as well as during the pandemic, we have seen climate-induced disasters, such as the floods in Pakistan, Nepal and India, which are putting the health and wellbeing of children and families at risk. But there are also opportunities, and there has been regional growth, despite the global downturn. We have seen the impact of immunization. There has been a reduction in diseases like polio, which has been eliminated in most countries in the region. We have also eliminated neonatal and maternal tetanus, and there has been progress in reducing measles, rubella, hepatitis B, and Japanese encephalitis.

COVID-19 is still with us. Over the past two years, we have all experienced, and contributed to, a historic period of time. We have seen the roll out of COVID-19 vaccines, with truly extraordinary results. However, the pandemic has taken a toll on essential health services, as well as access to these services by the most vulnerable.

This meeting comes at a time when we need to revitalize routine immunization (RI). The pandemic has set the region back several years. The zero-dose agenda has suffered. There is now also a risk of measles outbreak. The pandemic brought to the fore pre-existing inequities. We need to see how we can identify and prioritize vulnerable children and marginalized communities and make sure that they are reached. This meeting is an opportunity to come up with a concrete course of action to achieve this.

Objectives:

The main objective of this meeting is to **coordinate partner support to countries in the South-East Asia Region (SEAR) for the revitalization of routine immunization** following the COVID-19 pandemic, focusing on:

- Acceleration of equity agenda to reach zero-dose children and missed communities
- Integration of COVID-19 vaccination in RI
- New vaccine introduction and accelerated disease control

Expected outcomes:

- Participants have a better understanding of the Global Alliance for Vaccines and Immunization (Gavi) 2022–2025 strategy (Gavi 5.0/5.1), the Immunization Agenda 2030, and the Regional Vaccine Action Plan 2022–2026 to better align the priorities of countries.
- Participants discuss opportunities and challenges faced by countries related to Gavi grants and processes.
- Participants have a better understanding of the modalities to integrate COVID-19 vaccination with routine immunization.
- Partner support to countries is aligned to leave no one behind.
- The support of partners to implement the recommendations of the Immunization Technical Advisory Group (ITAG) 2022 is coordinated.

Reaching zero-dose and under-immunized children

Azhar Abid Raza, UNICEF ROSA

Globally, immunization coverage has declined since 2019. In 2021, 25 million children were un- or under-vaccinated, which is 2 million more than in 2020 and 6 million more than in 2019. In South East Asia (SEA), the decline in immunization coverage has resulted in an increase in zero-dose children. In 2021, SEA had 23% (5.76 million) of global un- or under-vaccinated children, 1 million more than in 2020, and 2.97 million more than in 2019.

However, there have been some notable recoveries:

- India conducted catch-up campaigns using a state-by-state approach to trace and vaccinate.
- Nepal focused on RI catch up and used the typhoid conjugate vaccine (TCV) campaign for tracing.
- Sri Lanka showed great political commitment and prioritized health service delivery.
- Bangladesh continued RI during the pandemic, and its coverage did not decline.
- Indonesia is conducting school-based vaccination and has a new electronic immunization registry (ASIK), reaching 16 million with measles and rubella vaccines.

One of the main entry points is **advocacy and commitment**. The zero-dose agenda is spearheaded by the Global Alliance for Vaccines and Immunization (Gavi), United Nations Children's Fund (UNICEF) and World Health Organization (WHO). There have been **numerous opportunities to accelerate recovery and strengthen immunization systems**, including the Immunization Agenda (IA) 2030, Gavi's 5.1 strategy, acceleration of coverage and equity initiatives, and the programmatic integration of immunization platforms with maternal, newborn, child and adolescent health (MNCAH), especially antenatal care (ANC) and primary health care (PHC) for universal health coverage (UHC). Zero-dose has also become a **top regional priority**, as reflected in the Strategic Framework for Regional Vaccine Action Plan 2022–2030 and Regional Vaccine Implementation Plan 2022–2026.

Another important lever for gearing-up zero-dose recovery is the regional Immunization Technical Advisory Group (ITAG) **recommendations**. ITAG's general recommendations include: improve the process of recovering RI services, focus on subnational high-risk areas with a large number of zero-dose children, implement catch-up immunization activities, strengthen screening for vaccination status, and build the capacity of immunization partners to support critical needs.

To reach zero-dose children, we need to identify who has been missed and where, and to clear the backlog we must expand the age bracket. It might be useful to substitute the term 'zero-dose children' with '**zero-dose communities**' to be more holistic. Learning from Bangladesh's example, line listing is important. If you don't know who has been missed, then how can you reach them? When strategizing, we need to ask if what we are doing is sustainable. Children need to be reached with a package of services, not merely vaccination – zero-dose needs **to be a key component of PHC for UHC**. We also need to look at how we address the overall health agenda from a health sector strengthening (HSS) perspective. Civil society organizations (**CSOs**) and **community networks** can help in identifying and reaching zero-dose communities. The push to reach the missed population should be more intentional – expanding that scope is important. **Registering births and vaccination events is key to identify, track and follow-up** missed children. There is a concomitant need to facilitate health workers and build their capacity to integrate multiple deliverables.

Regional Vaccine Implementation Plan 2022–2026 and status of immunization and VPD control in SEAR

Jayantha Liyanage, WHO South East Asia Regional Office (SEARO)

The Strategic Framework for Regional Vaccine Action Plan (RVAP) 2022–2030 is a regional adaptation of the Immunization Agenda 2030 endorsed in 2021. To operationalize the RVAP and provide a monitoring and evaluation framework, the Regional Vaccine Implementation Plan (RVIP) 2022–2026 was developed through a consultative process and endorsed by SEAR ITAG in 2022. At present, all 11 countries in the region have a national immunization strategy/plan (NIS/NIP), of which 4 ended in 2021. The new plans will align with the RVAP and RVIP.

An overview of the Strategic Framework for RVAP was provided in this session. In summary, the plan has 3 impact goals: to reduce overall mortality and morbidity from vaccine preventable diseases (VPDs) for all, across the life course; leave no one behind; and eliminate and control VPDs and pursue VPD elimination and control goals (including eliminating measles and rubella, sustaining polio and eliminating maternal and neonatal tetanus, and achieving hepatitis B control). The 7 strategic priorities and 17 strategic priority objectives include: immunization for PHC/UHC; commitment and demand; coverage and equity; life course and integration; outbreaks and emergencies; supply and sustainability; and research and innovation. In addition, there are 33 key areas of focus, with an emphasis on: under-served populations, programme performance, PHC integration, subnational systems, and public support.

The RVIP 2022–2026 priorities are:

- Coordinated operational planning
- Planning and implementation of COVID-19 vaccination
- Addressing the impact of COVID-19 on routine immunization and VPD surveillance
- Sustaining the gains of VPD elimination and control
- Ownership and accountability
- Monitoring and evaluation
- Communication and advocacy
- Regional and country-level implementation

The RVIP 2022–2026 implementation accelerators are:

- National quality improvement cycles
- Key performance indicators for key focus areas
- Regional expertise
- Peer support
- Leveraging disease control infrastructure
- Subnational accountability mechanisms and capacity building

The monitoring and evaluation framework is an integral part of the RVAP and RVIP: 5 out of 7 impact indicators are currently being reported by SEAR countries (the remaining 2 are estimated globally) and the 17 strategic priority objectives are being measured by 29 indicators.

There are also accountability mechanisms and feedback loops: the Ministry of Health and the National Immunization Programme/National Immunization Technical Advisory Group (NITAG) report to SEAR-ITAG, and there are feedback loops to SAGE, WHO SEARO, WHO CO, regional partners, and national partners.

An overview of the progress and challenges in the implementation of the RVIP in 2022, as well as the impact goal indicators and targets, were presented in detail in this session. As a region, there was a decline in immunization and VPD surveillance in 2020 and 2021. Countries with good monitoring mechanisms recovered in 2022, but some countries are experiencing challenges, especially at the subnational level. Efforts to revive RI and VPD surveillance have been initiated in most countries in the region. However, achievements in disease elimination and control are at risk of slow progress and even backsliding. The introduction of new and under-utilized vaccines has continued, despite challenges due to the pandemic, but will require further acceleration. Progress has been made in relation to the coverage of COVID-19 vaccination (primary series and booster doses), with a focus on priority population groups, but challenges remain.

UNICEF flagship initiatives to support IA 2030: Overview

Admadu Yakubu, UNICEF HQ

The COVID-19 pandemic had a great impact on immunization programmes globally, with 25 million children missing out on basic vaccines in 2021. Most of these children – over 18 million – did not receive a single vaccine (zero-dose children); 5 million more children are vulnerable to measles and other VPDs than in 2019. Globally, the number of measles cases has increased and 15 million more children have not been reached with their critical second dose of the measles vaccine.

The impacts of the COVID-19 pandemic on immunization programmes were presented in this session. In summary, health systems have been overburdened, with RI and PHC services facing significant challenges. Several countries postponed at least one VPD campaign. In 2020, there was a slowdown in new vaccine introduction (NVI) and disruptions to global vaccine availability, as well as declining financial space for health and immunization. In addition, the pandemic resulted in an erosion of trust and confidence around vaccines, as well as future uncertainties about pandemic preparedness. However, the COVID-19 pandemic has also shown the importance of immunization – strengthening immunization systems is essential to achieving universal access to life-saving vaccines.

The Immunization Agenda 2030 was launched in April 2021 with the aim to maintain the hard-won gains in immunization, recover from the disruptions caused by COVID-19, and achieve more by 'leaving no one behind' in any situation or at any stage of life. The UNICEF

Immunization Roadmap (2018–2030) was revised to articulate UNICEF's vision for the full realization of the right of every woman and child to immunization, with priority given to the most disadvantaged.

UNICEF flagship initiatives support the implementation of IA 2030 and the effective use of limited resources, with the aim to:

- Expand pro-equity strategies beyond reaching children in urban, remote, rural, conflict settings to include gender.
- Develop guidance and tools to reach underserved populations and use a geographic information system (GIS) to map populations in special settings, including border synchronization.
- Engage in documentation and implementation, as well as research, to test innovations and scale up solutions.
- Integrate dimensions of conflict, urban poor, remote/rural and gender in NVI.
- Expand the role of private providers and NGOs in reaching hard-to-reach populations.
- Employ innovative digital solutions in data collection and defaulter tracking, including electronic immunization registries and SMS reminders.
- Explore integrated planning and delivery with other programmes (nutrition, water, sanitation, and hygiene [WASH], HIV, etc.) to expand immunization outreach.
- Apply human centred design (HCD) to the planning and organization of immunization services.

- Use new approaches including engaging local community groups, and NGOs to expand coverage, reach and equity.
- Magnify the role of community health workers (CHWs) in mapping, facilitating demand, and social mobilization.

UNICEF flagship initiatives – 2022 and beyond:

- Refresh UNICEF Immunization Roadmap for strategic positioning and resource mobilization
- Integrated immunization service delivery within PHC
- Integrated outreach and mobile teams to improve access in fragile/conflict settings
- Promote immunization in schools
- Digitization of immunization programmes
- Capitalize on VPD outbreaks
- People centred approach to vaccine demand
- Improve social listening/digital engagement
- Enhance interpersonal communication skills of frontline workers
- Innovative last mile supply delivery
- Improve capacity and financing of in-country staff
- Improve data for evidence-driven planning and decision making (Thrive360)
- Establish immunization budget database to improve visibility of vaccine budgets
- Framework for measuring financial sustainability of zero-dose interventions
- Promote vaccine financing
- Integrated platform for immunization grants
- Transform recruitment processes

GAVI 5.0 moving to Gavi 5.1

Highlighting the shifts, with emphasis on partner expectations

Colette Selman, Regional Director of Core Country Segment and Regional Head of SEAR, Gavi

The Gavi 5.0 strategy (2021–2025) seeks to leave no one behind with immunization. With restructured classification of support for the three main groups of countries – high impact, fragile, and core – the key goals include:

- A 25% reduction in zero-dose children by 2025, and 50% by 2030
- 300 million children reached through RI, enabling a 10% reduction in child mortality; 7–8 million deaths to be averted and USD 80–100 billion in economic benefits unlocked by 2025

These goals are guided by the following principles (also enablers): introduce and scale up vaccines; strengthen health systems to increase equity in immunization; improve the sustainability of immunization programmes; and ensure healthy markets for vaccines and related products.

Overall, in 2022, the operation performance of Gavi 5.0 was approximately 1.5 years behind expectations. In light of the disruptions to RI due to the COVID-19 pandemic and evolving global health environment, the Gavi Board has renewed its focus on Gavi's core 5.0 priorities and developed Gavi 5.1, which is an evolution of 5.0 and a bridge towards 6.0.

In Gavi 5.1, the Alliance will:

- Continue to focus on 5.0, but with recalibrated priorities (i.e., preventing further backsliding of RI, catching-up missed children, and accelerating efforts to reach zero-dose children and missed communities).
- Continue at pace introductions of essential Gavi-supported vaccines.
- Accelerate support to help countries optimize their vaccine portfolio and prioritize the most critical vaccines.
- Continue to highlight the importance of improving the sustainability of immunization programmes and ensuring healthy markets.

In Gavi 5.1, the following three targeted additions have been prioritized for 2023–2025:

- Re-launching of the HPV programme with accelerated adoption of the 1-dose vaccine.
- A move towards integration of the COVID-19 vaccine into the Gavi programme for 2024 and 2025.
- Enabling the evolution of Gavi's role in terms of pandemic preparedness and response (PPR), including greater support for regional manufacturing diversification.

Key expectations for the coming year include using all entry points and funding levers for better targeting towards equity and reaching zero-dose and under-immunized children, as well as the dynamic use of HSS grants for HPV relaunch, rotavirus and RI catch-up activities targeting missed children and re-programming towards reaching all zero-dose children.

The funds available across the SEA region and by country include: HSS, Equity Accelerator Fund (EAF), Cold Chain Equipment Optimisation Platform (CCEOP), Vaccine Introduction Grant (VIG), Operational Support for Campaigns (Ops), Partner's Engagement Framework (PEF), Targeted Country Assistance (TCA), and middle-income country (MIC) support.

Finally, the manufacturing diversification agenda is not aimed at taking away the government's capacities and oversight. Technical assistance (TA), HSS and funding levers can all be used to help countries build their capacity, because without a change in the way we are working, we will not see the impact we are after.

Integration of COVID-19 vaccination with routine immunization

Pankaj Bhatnagar, WHO SEARO; Hilary Adams, UNICEF RO

Most COVID-19 vaccines have been administered in parallel with RI. This has created inefficiencies, increased the burden on the health workforce and fragmented essential health services. A key priority for 2023 is the integration of COVID-19 vaccination into RI and more broadly into PHC. Programmes should leverage opportunities, innovations and insights gained from the COVID-19 vaccine roll-out to strengthen RI and essential services to improve coverage and reach.

Integrating COVID-19 vaccination can be defined as the “**partial or full adoption of the COVID-19 vaccine into the national immunization programme, PHC, and any other relevant health services**”, with the overall aim of **strengthening the health system, by:**

- **Improving programme efficiency and sustainability**
- **Enhancing demand and improving user satisfaction**
- **Achieving and maintaining satisfactory coverage**
- **Addressing inequalities**

Broad reasons ‘why’ integration of COVID-19 vaccination is essential include: **epidemiologically** (with waning immunity to COVID-19, high-risk groups are likely to require boosters); for **sustainability** (co-delivery and other health governance functions); to **leverage resources** (to capitalize on COVID-19 investments, innovations in digital health and real-time monitoring systems, including social listening mechanisms, microplanning, community engagement); and in furtherance of the **life course** approach (to deliver service packages that better respond to users’ needs, including for older persons and those with comorbidities).

Many countries have already used some innovative opportunities to integrate COVID-19 vaccination into their regular health services and are exploring new entry points for the vaccination of high-risk groups. For example, in Panama, during Vaccination Week 2022, COVID-19 vaccines were co-administered with influenza vaccines to high-risk groups at health facilities and house-to-house. In Sri Lanka, RI sessions provide an opportunity to screen parents and provide COVID-19 booster doses. In Nigeria, certain regions adopted the ‘whole family’ approach, combining COVID-19 vaccination with other healthcare services. Plans are in place in India to expand the use of their electronic registration system (CoWIN) used for COVID-19 vaccination to register priority groups, schedule appointments, and monitor adverse events following immunization (AEFIs). Countries need to consider how to strategize these approaches for integration.

The key steps for the integration of COVID-19 with RI and within PHC are:

- Step 1. Initiating/building on integration
- Step 2. Planning and developing country integration plan (delivery mode, interfaces with priority groups, outreach)
- Step 3. Implementation and monitoring
- Step 4. Post-integration and follow up action

Building on Step 1, countries should consider ‘how’, ‘who’, and ‘where’ COVID-19 vaccines should be delivered, as an entry point for planning and developing country integration plans. This will depend on the epidemiological and country contexts, population needs, and existing interfaces that PHC essential services have with high-priority groups. For routine delivery, fixed sites, outreach, PHC and wider public health services may be used (e.g., using a service package approach, or NCD or ANC clinics). Outreach sessions may be required including co-delivery with maternal, nutrition or child health services and for those in long-term facilities. A matrix of service delivery options is available in the recent WHO-UNICEF guidance. This tool can be used to guide the development of the country integration plan.

The acceleration of COVID-19 primary doses and boosters may still be required through periodic campaigns, depending on coverage and population needs. Temporary fixed sites dedicated to COVID-19 vaccination and mobile teams in parks, markets, workplaces, refugee camps, transit points/border points and home-visits may need to be included in preparedness and response plans.

Finally, the integration of COVID-19 vaccination goes beyond co-delivery with other interventions at fixed or outreach sessions: it involves leveraging opportunities gained through digital data systems and digitization, demand generation and community engagement, supply chain, cold chain, and planning and financing, and civil and birth registration for wider health system strengthening.

Bhutan: Integration

Anshu Kumar, UNICEF Country Office

The Government of Bhutan has not yet taken the policy decision to integrate COVID-19 with RI. The country has already achieved high coverage with second booster roll-out. Bhutan is waiting for clear global guidelines for additional boosters.

In terms of sustainable financing, over the past two years, all health facilities have been equipped with essential cold chain equipment for COVID-19 and RI, and staff capacity for COVID-19 vaccination has been strengthened.

Although COVID-19 is currently a standalone delivery, outreach clinics for RI and COVID-19 are organized jointly throughout the country.

In terms of communication and community partnership, district administrators, village heads, social media, community-based networks, and village health workers were fully engaged in COVID-19 vaccination activities. There was little or no vaccine hesitancy with COVID-19 vaccine roll-out. The high level of trust has been key to the high coverage.

COVID-19 investments have supported the installation of real-time temperature monitoring devices for all cold chain equipment, including for RI. The digitalization of records for RI will commence soon under the 13th five-year plan.

In terms of monitoring and evaluation, COVID-19 delivery has been included in routine monitoring and reviews carried out by the Ministry of Health, Drug Regulatory Authority, District Health Officers, Program Officers and NITAG members.

Sri Lanka: Integration

Priscilla Samaraweera, WHO Country Office

COVID-19 vaccines are already currently delivered with RI in fixed clinics and hospital clinics. RI services are integrated into health packages as part of school and maternal health care. Mobile home-based vaccination is also available for people who are unable to reach fixed sites..

There is no sustainable funding source for the supply of COVID-19 vaccines. For vaccines under the Expanded Programme on Immunization (EPI), sustainable funding was secured by the Government of Sri Lanka in a separate budget line with essential services; there is also a provincial budget.

Over the last two years, cold chain capacity has expanded and is adequate for current RI and COVID-19 vaccine storage.

Public health managers and nurses receive frequent training for RI through the public health programme. Staff received extra training for COVID-19 vaccination delivery.

Last year, all medical officers were advised to conduct at least four clinics per day for COVID-19 vaccination (two at RI clinics and two at other locations). Opportunistic COVID-19 vaccines were given at RI clinics and during ante natal check-ups for pregnant women. Outreach was also conducted at factories, universities, and schools. Children above 12 years were vaccinated in schools.

COVID-19 coverage data is compiled separately to RI data (district wise), by the Ministry of Health and sent to the Epidemiology Unit. This data is shared separately with the COVID-19 tracker.

Timor-Leste: Integration

Suddath Peiris, WHO Country Office

The Ministry of Health convened a national meeting in August 2022 to address RI disruption, following which it was agreed that COVID-19 vaccination will be integrated with RI. Thus, for fixed and outreach vaccination sessions, all vaccination teams carry both COVID-19 and RI vaccines.

All COVID-19 vaccines and related supplies were provided by bilateral partners and COVAX. Installed cold chain capacity at the national, regional and subnational levels is adequate for COVID-19 and RI vaccination needs. All RI vaccines are sourced with government funds through UNICEF Procurement Services (pneumococcal conjugate vaccine [PCV], HPV, inactivated polio vaccine [IPV]), supported by Gavi.

Human resources continue to be a major constraint at the subnational level. Training, outreach and communication needs have been estimated and costed for 2023, but there is no confirmed financial commitment yet. There is little commitment from the Government of Timor-Leste for operational needs, which are mainly driven by donor funding.

When the COVID-19 vaccines were introduced, existing human resources were unable to cope, and the government hired 300 additional temporary health professionals to support COVID-19 control and immunization across the health system. Their contracts are scheduled to end in December 2022. Hence, human resources for outreach will be a challenge in 2023 if temporary staff contracts are not extended or made permanent. Most of the planning, monitoring and supervision support at the subnational level is provided by international consultants deployed by WHO,

and their contracts end in February 2023.

Since August 2022, all vaccinations are fully integrated with outreach services provided in schools. COVID-19 vaccines were provided to children above 12 years at school vaccination posts and, on the same visit, the diphtheria and tetanus (DT) vaccine was provided to children in grade 1. In 2023, HPV vaccines may also be provided through schools.

In Timor-Leste, all partners are working together. There is a formal/informal community leadership system at the municipal/sub-district level, who are fully involved and support immunization activities. The Ministry of Education and school system supports both COVID-19 vaccination and RI. As a Catholic country, the support of the church is needed to reach the community. However, communication needs have not been systematically identified, and there is no strategic evidence-based communication plan.

Pre-COVID, there was the District Health Information System 2 (DHIS2), but the RI Health Information Management System (HIMS) was not fully functional. A COVID-19 tracker was developed, which led to data collection in parallel with the DHIS2. The RI HIMS system has been revived and is now fully functional. However, to sustain it long-term partner support is needed. An electronic birth and immunization registry is needed and may be piloted in Dili Municipality in 2023.

COVID-19 vaccination data is shared daily through official and social media channels. Healthy competition has been created among health staff to reach targets. Structured, supportive supervision is provided by international subnational consultants, together with Ministry of Health staff, which has created a culture of monitoring and evaluation. This led to an AEFI-free, high-quality COVID-19 vaccination campaign. Since the third quarter of 2022, monitoring and evaluation for COVID-19 and RI has been fully integrated.

Nepal: Integration

Vinod Bura, WHO Country Office

The National Immunization Advisory Committee (NIAC) is considering integrating COVID-19 and RI with a focus on strengthening PHC. Consultation with other programmes for integration is ongoing. Governance has been strengthened, including through working-group coordination structures such as the Inter-agency Coordinating Committee (ICC), National Immunization Technical Advisory Group (NIAC), and Emergency Operations Centres. Strengthening the multi-sectoral approach and engaging with non-traditional partners is ongoing. Nepal is also considering expanding the NIAC and strengthening AEFI committees.

During the pandemic, RI coverage declined by 7–8%, but is now back to pre-pandemic coverage levels. Nepal adopted a 'search and immunize strategy' and Full Immunization Declaration (FID). A comprehensive approach to reducing zero-dose children is planned under the Gavi third window COVID-19 Vaccine Delivery Support (CDS) application. Measles coverage is better than before the pandemic.

Following the pandemic, the national budget for the immunization programme increased threefold. The Ministry of Health realized that more human resources and better facilities are needed. Nepal was able to establish new vaccine posts and identify new populations and strategies. Cold chain capacity increased fivefold.

For COVID-19, the Government of Nepal received vaccines from bilateral sources and COVAX, with the operation costs funded by the government. Even after the main VPD programme was developed, two addendums were added with partner support. There remains uncertainty about the COVID-19 pandemic trajectory and the need for COVID-19

vaccination and boosters.

More than 10,000 health workers (HWs) have been trained on comprehensive immunization programmes and AEFI kits have been provided for immunization sessions. This has enhanced the capacity of the health workforce in terms of delivery strategies tailored to specific community needs, including for disadvantaged and prioritized population groups. Immunization waste management has improved.

The strengthening of micro-plans at all levels, together with the addition of new vaccination posts, has helped to identify marginalized communities. However, additional human resources are required for expanded service delivery within existing and new service points/platforms.

Plans are underway for the digitization of RI vaccination, development of an RI vaccination card with QR code, and creation of an immunization registry. HMIS capacity has been enhanced following installation of a new server. The vaccination software for COVID-19 will be used for RI. Risk communication teams are fully onboard to support RI. COVID-19 vaccination has been leveraged to engage and educate communities on vaccination. The monitoring of RI can also be used for COVID-19.

Accelerating new vaccine introduction

Human papillomavirus (HPV) vaccine and the single dose schedule

Paul Bloem, WHO HQ

This session provided an overview of WHO recommendations on HPV vaccines and their single dose schedule. HPV vaccines are part of the global strategy to eliminate cervical cancer, with the goal of reducing mortality from cervical cancer by 30% by 2030 (SDG 3.4).

Most girls (aged 9–14 years) in the SEA region have no access to the HPV vaccine, although the vaccine has been introduced, or partly introduced, in six countries. Several larger countries have not, or have only partly, introduced the vaccine (e.g., India, Indonesia). In addition, HPV vaccine coverage declined in several countries due to COVID-19 related disruptions, supply issues and other factors. As a result, only about 14% of girls in the region live in countries or areas with access to the HPV vaccine.

For SDG 3.4 to be achieved, HPV vaccines need to be (re)introduced in all countries and recovery efforts targeted to reach missed cohorts of girls to achieve the objective of 90% of girls fully vaccinated with HPV vaccine by 15 years of age by 2030.

In this session, the evidence behind the SAGE conclusions and recommendations (April 2022) for the use of off-label 1-dose schedule HPV vaccine was presented. Data from immunogenicity trials, post-hoc analyses of efficacy trials, and post-

licensure observational studies among females have demonstrated that a single dose of HPV vaccine provides similar protection to a multidose regimen against initial and persistent HPV infection. The modelling data confirms that the 1-dose and 2-dose regimens perform roughly the same. Hence, the new recommendation (WHO position paper due to come out in December 2022) is that, now, as an alternative, 1-dose can be used for the 9-29 year age group. However, those who are immune compromised should receive 3-doses (2-dose minimum criteria).

This off-label, single-dose option is also recommended from a public health perspective, as it is more cost-effective and offers more programmatic flexibility. This means that countries can reach twice the number of girls than with 2-dose or 3-dose programmes. For countries that are financially constrained, this can be an additional reason to introduce the HPV vaccine sooner.

The NITAG deliberations regarding the off-label single-dose use were also detailed in this session. (Note: WHO's updated recommendations on HPV vaccination schedule are available at: <https://apps.who.int/iris/bitstream/handle/10665/365350/WER9750-eng-fre.pdf>.)

Typhoid conjugate vaccine (TCV)

Jenny Walldorf, WHO HQ

Typhoid is an acute febrile illness that is transmitted through the faecal/oral route. There are issues with resistance of the germ to antibiotics, pointing to the importance of a vaccine. There are also concerns about

the risk of intestinal perforation and mortality. In terms of the global burden, there are 29 million cases and 60,000 deaths annually. The peak number of cases is in the 5–19 year age bracket. The SEA region has a relatively high burden.

In relation to TCV policy, the first SAGE recommendation was made in 2017. The WHO recommendations are coordinated at three levels and can be summarized as follows:

- TCV is the preferred typhoid vaccine type.
- It is suitable for younger children.
- It provides a longer duration of protection.
- Only a single dose is needed at 6 months of age, and adults can be vaccinated up to 45 years.

Since then, several new studies have been conducted. Currently, there are two qualified TCVs, and details are available at: <https://apps.who.int/iris/bitstream/handle/10665/345367/WHO-IVB-2021.04-eng.pdf>. The take home is that the two products are expected to be equally safe and efficacious. Current evidence on TCV from four efficacy trials shows that it is highly efficacious, with values at 81–85% and 95–97% in Pakistan and India.

Studies are ongoing to inform the need for a booster dose, but the current recommendation is for a single dose. There is no evidence of interference with other vaccines. There is evidence of the presence of antibodies for 7 years. TCV is licensed for adults up to 65 years. In the Asia region, TCV has been introduced by Pakistan (2019) and Nepal (2022).

Introduction of TCV in Nepal

Vinod Bura, WHO Country Office

Typhoid is an acute febrile illness that is transmitted through the faecal/oral route. There are issues with resistance of the germ to antibiotics, pointi Because of the high burden of typhoid cases, Kathmandu was known as the 'capital of typhoid'. There are approximately 351 cases per 100,000 people and 1,042 deaths per annum. It is the third most common cause of death among food and water related infections and fourth most common cause of hospitalization. There is robust data on the burden of disease in Nepal. Most infections are in the 5–9 year age group. There is strong evidence of contamination of public drinking water from collected water samples. The problem is spread across the whole country, and antibiotic resistance has been seen.

Against this backdrop, Nepal NIAC recommended the introduction of the typhoid conjugate vaccine. An application was submitted to Gavi for support, and TCV was planned to be introduced in 2022 as an f1-dose schedule for children aged 15 months to 15 years. TCV was the second vaccine introduced in Nepal during the pandemic. The aim of the TCV campaign was to introduce TCV as part of RI, as well as strengthen RI. The opportunity was taken to record children that missed RI doses and adults due for COVID-19 vaccination.

TYPHIBEV, a 1-dose vaccine produced in India, was used. There was strong coordination at all levels, including local municipalities. Robust information was available about this campaign and learning from COVID-19 was used. There was a strong linkage with RI and hygiene promotion. The timeframe for the campaign was set nationally, but within that interval, each municipality followed its own schedule. In total, 7.7 million children were vaccinated in 56,000 vaccination centres (schools and community sites). There

were 10,000 vaccinating staff and over 100,000 volunteers. Training was given at all levels prior to the campaign. Information, education, and communication (IEC) materials, social media and other forms of communication were used. Two types of vaccination cards used: An invitation card for families, which listed the RI vaccines and reinforced the message. HWs kept the second, which listed the vaccines the child had missed. The Prime Minister launched the campaign, reflecting the government's strong commitment.

Monitoring was done by external observers, including from other countries in the region. In total, of the 42,000 children monitored, 92% were vaccinated with TCV. A TCV coverage survey is being prepared. There were 8 serious AEFIs and 1 death. This campaign was successful despite the challenges of conducting it during a pandemic.

Accelerated disease control

Polio options

Dr Sudhir Joshi, WHO SEARO

There are one, two, and three dose options for IPV. Two doses provide much higher immunity against type 2 polio than one dose. Studies indicate that the later the first dose is given, and the longer the interval between doses, the higher the induced immunity. SAGE recommends the following two options:

Option 1 (Preferred): Provides highest immunogenicity, either full dose IPV or fractional IPV (fIPV) can be used:

- 1st dose at 14 weeks
- 2nd dose at least 4 months later

Option 2: Only full dose IPV should be used:

- 1st dose at 6 weeks
- 2nd dose at 14 weeks

The Regional Advisory Group recommends that all countries use 2 doses, which is aligned with ITAG and SEA Regional Certification Commission for Polio Eradication (RCCPE) recommendations.

Switching from 10-dose to 5-dose MR vial

Sudir Khanal, WHO SEARO

Health workers are often reluctant to open a 10-dose vial of MR when only 1 child presents for vaccination, because of the risk of wastage. One way to address this is to switch to a 5-dose vial. There is no difference in the vaccine properties, and both are produced by WHO prequalified manufacturers. The wastage rate for 5-dose vial is lower (10-dose 40%; 5-dose 30%). The price also varies (10-dose USD 0.721 per dose; 5-dose USD 0.909 per dose). There are also different cold chain requirements. In summary, in terms of total system effectiveness (TSE), the 5-dose has less wastage, is more expensive and more cold chain requirements. Transitioning to 5-dose vial has practical and cost considerations

How do countries know that it is time to transition to 5-dose?

- If HWs are hesitant to open 10-dose.
- Assess country-specific implications of transition on cold chain, funding, and delivery of vaccines (Linksbridge).

Any country that procures MR vaccines through UNICEF can access the 5-dose vial presentation. Gavi supported countries can submit a formal request for transition of MR vaccine through the Country Portal.

Explaining Gavi

Colette Selman, Regional Director of Core Country Segment and Regional Head of SEAR, Gavi

COVID-19 Delivery Support (CDS)

The third CDS window was launched in mid-2022 to support the scale-up of COVID-19 vaccination through to the end of 2023. Most of country applications are currently under review. Since 2021, Gavi has delivered 634 million doses of the COVID-19 vaccine to the region through COVAX and provided USD 54 million in delivery support. An additional amount of USD 69.55 million has been allocated to SEA countries for 2023.

The CDS has three objectives:

- Support the acceleration of vaccination of high-risk populations.
- Support rapid delivery scale-up to reach country targets for adult vaccination.
- Support the integration of COVID-19 into RI to achieve sustainable benefits.

The five guiding principles for the third CDS funding opportunity are: needs-based access to funds; mitigation of delivery risks (accelerate effective and equitable delivery of COVAX funded doses); funding complementary to other funding (including funding gaps); agility approach (funds implemented in a rapid and responsible way); and expanding in-country partnerships, including with CSOs and local partners.

A deep dive into the third objective – support for the integration of COVID-19 and RI to achieve mutual, sustainable benefits with a focus on equity – was presented. A key focus of this objective is the high-level approach required for the combined planning,

management and monitoring of COVID-19 and RI, which involves looking at delivery, bundling services together with RI and PHC, conducting joint advocacy and messaging, engaging with communities, and leveraging COVID-19 innovations and capacity for RI. Near, medium- and long-term high-level approach examples were discussed and presented.

Participants were encouraged to initiate discussions at the national level, with NITAG and the Interagency Coordinating Committee (ICC).

Middle-Income Countries Strategy

The objective of Gavi's Middle-Income Countries Strategy is to avoid backsliding and minimising inter-country inequities, with a focus on introduction of new vaccines like rotavirus and HPV, as applicable. In most former-Gavi countries, more than 90% of pre-COVID DPT3 coverage has been restored. To maintain and improve this coverage, Gavi is looking to work at two different levels: on building blocks (country-specific catalytic tools) and the introduction of new vaccines and sustained immunization coverage.

In relation to building blocks, Gavi is seeking to address systemic issues. It is working with partners to make sure that an enabling environment is in place, specifically by providing regional and multi-country TA, supporting peer-to-peer learning platforms and galvanising political commitment. Gavi will not support a whole menu of targeted interventions, but will be specific about the barriers and strategies. It will see how the most impact can be made and where the greatest potential lies. In terms of tools, Gavi aims to be catalytic by enabling the introduction of new vaccines, including support with procurement.

The MICs eligible are: Bhutan, Indonesia, Sri Lanka, Timor-Leste and the Maldives.

Diversification of partners and CSO strategy

The starting point for Gavi 5.0 was to do things differently to reach down to the community level. The focus was on equity in the broadest sense. Never vaccinated children might not go to school; they may also have difficulties with access to water and other services. New approaches and partnerships are needed to reach these children.

The comparative advantages of CSOs in this space is clear. They are anchored in the community, and 'actors' in the community are well positioned to voice the needs of marginalized and hard to reach groups. Hence, the Board approved the civil society and community engagement strategy.

Gavi's definition of CSO is broad and encompasses:

... the full range of formal and informal, non-governmental and not-for-profit organizations that represent the interests, expertise and values of communities (including CBOs, CSOs, FBOs, INGOs, civil society networks, non-governmental organizations, local professional associations, not for profit advocacy organizations).

To ensure that funding is made available to communities, countries are required to allocate 10% of their budget for combined HSS, EAF, and TCA funding for CSO implementation. In particular, TA should focus on community engagement and service delivery. This strategy is anchored in equity and leaving no-one behind. It is not Gavi's intention that a parallel structure be created, but for CSOs to play a complementary role. In many countries, the role played by CSOs is already strong.

The three priority areas for CSO engagement are:

- **Build demand, trust and confidence** for vaccines through active community engagement to address hesitancy and knowledge gaps.
- **Complement public sector service delivery** by extending immunization services to areas where government programmes have limited access or are not effectively used.
- **Safeguard equity by securing social and political will, ensuring visibility and accountability, and advocating for immunization commitments that leave no one behind.**

The strategy is not an independent competitive strategy, but a complementary one. CSOs are needed to reach zero-dose and missed communities. CSO engagement and collaboration will vary by country and depend on local government strategies in reaching those missed. The overall aim is to achieve the zero-dose agenda.

Full portfolio planning

A key Gavi focus is on full portfolio planning (FPP) and equity accelerator funding (EAF). The key shifts from Gavi 4.0 (which ended in 2019) to 5.0 are as follows:

- Zero-dose children and missed communities, as a starting point for country dialogue in planning for, or reprogramming of, Gavi investments
- Single theory of change at the country level for how all Gavi support aligns to identify and reach zero-dose children – a move away from too much fragmented support (where do we want to be and what are the funding levers to get there?)
- Greater focus on demand, community engagement, and overcoming gender barriers as key enablers of reaching zero-dose
- More deliberate approach to engaging a broader set of partners including CSOs and humanitarian actors
- More differentiation of Gavi support and processes across country types and contexts
- More purposeful advocacy to secure political commitment to prioritize zero-dose communities – engaging broader community partners

Funding levers include: HSS, EAF, CCEOP, VIG, Ops, PEF, TCA and private sector partnerships and innovation.

In Gavi 5.0, each country received a funding envelope, but there have been a lot of delays. The EAF was meant to be additional to accelerate efforts towards achieving the zero-dose agenda. For this, it is important to look at specific strategies – strategies for fragile settings and urban areas and strategies to reach missed communities.

Gavi has new guidelines, including Application Process Guidelines, Programme Funding Guidelines, Vaccine Funding Guidelines and Budget Eligibility Guidelines (to be included in the applications).

In relation to Programme Funding Guidelines, there are eight priority investment areas – service delivery, human resources for health, health information systems, (HIS), VPD surveillance, demand generation, community engagement, governance, and health financing.

The Application Kit is also new and has been simplified. In relation to applications, it is important for countries coming up for FPP to sit with the government and have a plan, including data, analysis, an improvement plan, gender analysis, and a zero-dose strategy. It is important for countries to define their strategic objectives, activities, budget and work plan. The theory of change should include gender barriers and the activities needed to include gender responsive activities. The next step is to bring the right stakeholders together and work on a planned step-by-step process. This needs to be included in the work plan and budget. Conversation is important; consultants can facilitate this to get the application off the ground.

Co-ordinated partner support to countries for the implementation of IA 2030 focusing on zero-dose children and new vaccine introduction: Panel discussion

Facilitated by: Gunter Boussery, UNICEF ROSA, and Khin Devi Aung, UNICEF EAPRO

Panellists: Gunjan Taneja, Bill and Melinda Gates Foundation; Michelle Morales, United States Center for Disease Control (US CDC); Sushma Bhusal, International Federation of Red Cross and Red Crescent Societies (IFRC)

Discussion topics:

Where and how can you support countries to implement their immunization agenda?

What is your support for zero-dose and new vaccine introduction?

Gunjan Taneja, Bill and Melinda Gates Foundation

In India, the Bill and Melinda Gates Foundation focuses on innovation, institutionalization, and impact – aligned with national goals and objectives. The Foundation believes that all lives are of equal value. It is reaching out to missed communities, working closely with national actors, and supporting the roll out of new vaccines (HPV and TCV). It is strengthening systems, including surveillance, and supporting COVID-19 vaccine rollout. All this work is guided by the government. Partnerships with WHO and others form the fulcrum. Coverage and equity are critical areas – as is the engagement of actors beyond health. In Bihar, the Foundation has engaged with Rural State Missions, pushing the agenda of urban local bodies. All of these different components contribute to the zero-dose agenda.

Sushma Bhusal, IFRC

IFRC is not an implementer. In many countries it works with national Red Cross and Red Crescent Societies. Health is a core element of IFRC's Agenda for Renewal (Strategy 2030). All of the seven priorities of the Immunization Agenda 2030 align with this Agenda for Renewal. It also has the same thinking around coverage and equity. IFRC understands the need to reach zero-dose children and missed communities and is focusing on strengthening PHC systems. Although IFRC does not specialize in immunization, it has a lot of reach. A lot of IFRC's work is about reaching last mile communities. These children are usually not going to school and do not have access to WASH. IFRC fits into the immunization agenda, it has a huge network. One of IFRC's key strengths is community engagement; it is also strong in outbreaks and emergencies, including early detection of outbreaks and early response. In terms of new vaccine introduction, during the COVID-19 pandemic, IFRC worked with communities on engagement and advocacy; IFRC mobilized through advocacy, building the trust of communities, and supporting service delivery – reaching the last mile. Now, this has to be maintained.

Michelle Morales, US CDC

Zero-dose immunization is one of the US CDC's primary focuses. It is integrating COVID-19 into RI in Nepal, Thailand and Indonesia. In Nepal and Indonesia, the CDC is focusing on workforce development. In Bangladesh and Bhutan, field tests will be conducted using rapid diagnostic tests on measles, mumps, rubella (MMR). In Timor-Leste there are plans to support measles, rubella, oral polio vaccine (OPV).

PART 2: COUNTRY PRESENTATIONS



India: Country update

Dr Puttaraju, WHO CO

Immunization coverage: India experienced a large drop in coverage in 2020, from 91% to 85%, becoming the country with most un- and under-vaccinated children globally.

What India did: In 2020, India deemed immunization an essential service and continued RI, even at the peak of the pandemic.

Outcome: The Programme to Improve Routine Immunization (PIRI) intensified India's Mission Indradhanush (health mission); in 2021 and 2022, 43 million children were vaccinated.

In April 2022, India held a national review meeting to bring the focus back to RI and zero-dose children. Every state looked at their own data to develop a plan to strengthen RI. Districts were categorized as high, medium or low risk, and strategies developed for each. Since then, 722 out of 766 states have completed training on zero dose and immunization campaigns have been held in 10 states, based on the categorization of districts, with a focus on urban areas (104 urban areas identified). These are tracked on the WHO dashboard and reported to the Ministry of health.

In terms of accountability, the top body is the Steering Committee, and there are also state, district and urban taskforces. To track the status of the micro-plans, capacity building was carried out and the development of the plans looked at, with a focus on high priority districts. The other system in place is concurrent monitoring: about 8 million children are monitored annually. The reasons why children are not immunized is analysed (the main issues are lack of awareness, information gap, and AEFI apprehension). This information is fed back to the district magistrate.

In the concurrent monitoring, the push at the state level is for states to devise their own indicators, which incorporate ANC and integrated PHC services to communities. The delivery of a package of services (nutrition, social and behavioural change [SBC], communication, advocacy and partnership [CAP], etc.) is also being considered.

In 2022, the number of zero-dose children came down (the number of states with more than 15% zero-dose children dropped from 22 to 10). The identification of zero-dose children and communities is good, as is community mobilization. DTP3 coverage is also promising.

Key issues:

- The identification of zero-dose children and communities needs grounding in the government system.
- The capacity of the system to consistently deliver high quality immunization services needs a system for review of performance at the grass roots.
- Urban immunization is not as well structured as immunization in rural areas – each urban area has its own system.

Solutions:

- Institutionalization of robust micro-planning process (whole of government needs to be involved) and community engagement in mobilization
- Regular capacity building, structured supervision by the health system, and reviews of immunization performance at all levels, with follow up on feedback
- Development of customized immunization initiatives for each urban area
- Political, governance and admin buy-in for immunization at national and state levels – needs to percolate down to lower governance structures for sustained community ownership and accountability.

Action plan: INDIA

Action points:

- State-level action plans have been prepared by all states for the strengthening and recovery of RI, with emphasis on reducing zero-dose children.
- An MR elimination strategy and implementation plan has been developed and disseminated to all states; a schedule of national immunization days (NID) for 2023 is being prepared; an additional fractional-dose inactivated polio vaccine (fIPV) at 9 months is planned from January 2023; and Universal Immunization Programme and VPD surveillance reviews have been completed in Punjab and are planned in Maharashtra in January 2023.
- A Polio Social Mobilization Network (SMNet) has transitioned to state governments in Uttar Pradesh and Bihar through government funding.
- The government has extended financial support to WHO- National Polio Surveillance Project (NPSP).
- NITAG has recommended the introduction of HPV for 9–14-year-olds, with a preference for girls, and the government has planned the introduction of HPV for 9–14-year-old girls, first as a campaign, then as part of RI. The draft operational guideline is ready.
- A COVID-19 vaccine post-introduction evaluation (cPIE) and PCV PIE have been conducted and results shared with the Government of India.

Requests for support for Gavi portfolio:

- The Gavi portfolio is specific to interventions in the 143 identified districts. Similar support is also required for other high-risk districts identified by states in order to achieve a sustained decrease in zero-dose children across the country. (Note: Gavi is not able to provide additional support, so this needs to be found elsewhere).
- A higher proportional allocation for RI micro-planning, monitoring, capacity building and community engagement processes would yield better returns for the portfolio.
- The entire portfolio planning and approval process needs to be faster to enable quick implementation on the ground to prevent VPD mortality and morbidity.

Requests for specific support from RWG and ROs:

- Funding support is required to implement Gavi strategies (micro-planning and community engagement) in remaining high-risk districts identified by states (2023–2024).
- Focused TA is needed by states/districts (beyond Gavi support areas) to fast-track capacity building and enhance the scope of monitoring and supervision and review mechanisms (2023–2024).
- Increased presence of WHO and UNICEF is needed in urban areas, with a long-term vision of strengthening and streamlining urban immunization delivery mechanisms and community engagement (2023–2027).
- At the moment, there are 3 to 4 year gaps between rounds of the National Health Survey (NHS) – support is needed for the annual evaluation of coverage in priority states (2023–2027).
- Reviews of the Universal Immunization Programme and VPD surveillance are infrequent; support is needed to review 2 to 3 priority states each year (2023–2027).

Bangladesh: Country update

Dr R Mohammed, UNICEF Bangladesh Country Office.

Immunization coverage: Bangladesh has 99% DPT1 coverage (indicator of zero-dose children).

What India did: During the pandemic, Bangladesh developed innovations to restore RI and developed tailor-made social and behaviour change communication (SBCC) strategies to sustainably create demand, especially among low-performing population groups.

Outcome: High vaccination coverage was maintained during the COVID-19 pandemic.

During the COVID-19 pandemic, Bangladesh was able to restore and maintain high vaccination coverage. Health workers went house-to-house and missed children were brought to the immunization centre. In addition, the child vaccination age under the national EPI was increased to three years.

In 2021, during World Immunization Week, Bangladesh took the opportunity to vaccinate missed and under-vaccinated children. During this week, 121,000 out of 338,000 children missed in 2021 were vaccinated with MR1 and 24,000 zero-dose children, out of 30,000 missed in 2021, were vaccinated with Penta1. In addition, 35,544 partial-dose children aged 2 to 3 years received their due doses.

Key achievements include: a draft National Immunization Strategy was submitted to the Ministry of Health; the National AEFI Guidelines were updated and training rolled out; HPV rollout was planned for 2023 (for multi-age cohort [MAC]); an application for TCV and Japanese encephalitis was submitted to Gavi; an Immunization Equity Strategy was drafted; national-

level discussion were initiated to integrate COVID-19 vaccination with RI; all subnational mid-level managers received midlevel managers training; and ITAG 2022 recommendations were implemented.

During the pandemic, a rapid convenient assessment (RCA) was carried out (in three phases) to identify zero-dose and under-vaccinated children. According to this assessment, the reasons given by caregivers for not vaccinating children included lack of awareness and lack of information; vaccinators not available at site when caregiver attended; and concerns about the child's wellbeing (AEFI). Strategies for reaching zero-dose children include the integration of EPI with other health interventions, as well as offering vaccination when a caregiver brings a sick child to a clinic.

Key issues:

Immunization staff repurposed to COVID-19 activities

- Fatigued health workers due to over work and repeated COVID-19 vaccination campaigns
- Ambiguity in determining correct denominator at different levels
- Vaccine and logistic utilization not synchronized with actual vaccination
- Zero-dose and low coverage in some pockets
- Monitoring data not used regularly to improve EPI

Solutions:

- Integration of COVID-19 vaccination with RI
- Campaigns replaced by regular vaccination through facility and outreach
- Strategy development with Bangladesh Bureau of Statistics using 2022 Census data, along with technology-based innovations (GIS-based online micro plan and E-tracker)
- Robust online vaccine and logistics management information system (VLMIS) introduced to track batch-wise vaccine up to last mile
- Targeted assessment and identification of bottlenecks around gender, ethnicity, socio-cultural, inclusion, and geography (in urban slums, peri-urban areas, hilly areas, islands, chars, marshlands)
- Introduction of app-based, session-wise supervision system with dashboard for all levels and data triangulation exercise at subnational level

Interventions planned to recover RI include:

- House-to-house search for line listing and vaccination of zero-dose and partially vaccinated children
- Targeted assessment of immunization coverage; identification of barriers for hard-to-reach (HTR) and high-risk groups; and vaccination of missed children
- Partnerships with local governments, religious leaders, schools, adolescents and communities
- Mobile evening sessions to reach street children and other high-risk groups
- Individual tracking of mothers to ensure enrolment of every child in EPI-tracker
- Implementation of technology-based innovations like TrueCover
- Online EPI micro plan, including GIS location, to monitor vaccination coverage
- Regular RCA
- Involvement of community support group in the identified 360 wards to identify zero-dose and under immunized children
- Involvement of immunization field monitors in low performing districts and city corporations
- Mid-level managers training for upazila (subunit of a district) managers
- Yearly review workshop for districts and city corporations to assess achievement
- Integration of EPI session with integrated management of childhood illness services in selected facilities
- Development of EPI vaccination centre Apps for city corporations to track vaccination sites
- Inclusion RI recovery interventions during phase-wise roll out of HPV vaccination

Interventions undertaken to recover RI included:

- Prime Minister instructed programmes to recover RI.
- Immunization services were resumed through hands on training of 26,000 HWs on interpersonal communication.
- Health management information system (HMIS) data was monitored monthly using the DHIS2, and the EPI Program Manager conducted virtual meeting with under-performing districts.
- Concurrent monitoring was carried out using real-time App.
- Mass/social media platforms, religious leaders, mosque announcements, and street miking were all engaged.
- Messages were disseminated to HW and guardians to continue vaccination.
- Periodic instruction was received from the national level (i.e., regarding the listing of dropout and left out children from tally sheet, followed by vaccination).

Key issues in accelerating zero-dose:

- No coverage assessment for high-risk groups and areas
- Chronic vacancies for immunization field workers leading to fatigue, overload, and fewer household visits
- Ambiguity in determining correct denominator at different levels
- No/little public immunization structure (human resources, budget) in urban areas

Solutions for accelerating zero-dose:

- Innovative approach to assessment of coverage in specific groups and areas
- Additional support for immunization volunteers; continue advocacy to recruit human resources; public-private partnerships; award performance
- Tailor-made strategies/approaches: sub-block e-micro plan; regular household visits; use Family Planning Eligible Couples (FP ELCO) register data, birth registration data
- Implement urban immunization strategy

Action plan: BANGLADESH

Action points:

- Increase reporting to NITAG on implementation status to twice a year. For this, an independent NITAG Secretariat with human resources is needed.
- Use lessons learnt from COVID-19 vaccination to strengthen RI. This is under discussion, but a national strategy/guideline is lacking; need technical support.
- Although gender responsiveness assessments for immunization programmes are included in Coverage Evaluation Survey (CES) and other assessments, there is a lack of understanding of gender responsive programming in the Ministry of Health; need capacity development.
- Triangulate various data sources to better identify immunity gaps and inform activities, and explore ways to improve real-time data. Data sources are being triangulated, but there are capacity gaps in Ministry of Health in terms of support for system development.
- Systematically collect and analyse data on behavioural and social drivers to understand the barriers. An SBCC strategy has been completed after assessment, but there has been a delay in the development of a targeted communication plan. The process to approve the SBCC strategy implementation needs to be expedited.
- Prioritize research to guide the immunization programme. Research has been conducted and results shared on the immunization tracker, but there is no guideline on how to conduct immunization research. Guidelines and more resources for research are needed.
- Immunization services have recovered to pre-pandemic coverage levels, but innovative efforts are needed to maintain high coverage.
- Identify and focus on subnational high-risk areas with a large number of zero-dose children, as well as on special populations. Assessment is ongoing and there are innovations to identify and vaccinate zero-dose children (Rapid Convenience Assessment [RCA], GIS-mapping, TrueCover, line listing, CSO engagement), but this conflicts with the national priority given to the COVID-19 vaccination campaign and RI. Need to implement innovations, immunization research and peer learning, and to re-prioritize RI.
- Identify opportunities to strengthen screening for vaccination status (e.g., at school entry) to close immunity gaps. This is under discussion, but a strategy and methodology are lacking. Technical support is needed for strategy development.
- Immunization partners must support critical needs, including the mobilization of human resources in areas with missed children. An additional 805 human resources have been provided under HSS3 and Margaret A. Cargill Philanthropies (MACP), but the use of temporary human resources is being continued and mainstreamed. The solution is advocacy and financial support (revenue) to regularize human resources.
- Country action plans have been developed to strengthen VPD surveillance, but this has been impacted by the COVID-19 pandemic, delays in implementation of the polio transition plan, and no expansion of the laboratory network. The solution is political commitment and ownership, as well as resources.
- Conduct periodic programme reviews, including VPD surveillance and environmental surveillance with NITAG engagement. VPD and environment surveillance information has been analysed and included in NITAG's annual report, but coordination between NITAG and other committees related to VPD surveillance needs to be improved.

Requests for support for Gavi portfolio:

- A tripartite agreement with Gavi is lengthy and time consuming; propose a bilateral agreement instead. (Colette: Tripartite agreement has been approved.)
- All partners (core, extended, local) are not equally responsive/pro-active, resulting in delays in planning, submission and implementation; propose a periodic joint review by Gavi with all partners.
- The Ministry of Health has a low level of awareness and incomplete understanding about the Gavi portfolio and implementation process; propose an orientation on Gavi portfolio and process for the Ministry of Health and other stakeholders.
- There is a risk of delays in the extension of existing grants impacting on planning and implementation (i.e., HSS3); propose the timely extension of grants. (Colette: Request has to come from the government.)

Requests for specific support from RWG and ROs:

- The Immunization Act has been drafted, but to finalize high-level advocacy is needed with the Ministry of Health, as well as a peer learning visit to a successful country.
- Technical support is needed to overcome the lack of local capacity for in-country production of cold chain equipment.
- To close the gap between administrative and survey coverage, system/approach/strategy support is needed to fix denominator at all levels.
- To address low immunization coverage in urban areas, peer learning is needed in relation to an effective urban immunization programme.
- Technical support and experience sharing with other countries is needed to develop a school vaccination strategy.
- Technical support and experience sharing with other countries is needed to integrate COVID-19 vaccination with RI.

Sri Lanka: Country update

Dharmica Rowel, UNICEF CO

Immunization coverage: In Sri Lanka, DPT1 coverage dropped from 99% in 2019 to 96% in 2020 and 2021.

What Sri Lanka did: RI was continued during the pandemic.

Outcome: The backlog of routine vaccinations was cleared by May 2020.

In Sri Lanka, the Epidemiology Unit (central level) is the main body, followed by the Regional Epidemiologist (district level) and Medical Health Officers (field level). Immunization happens in public clinics, maternal and child health (MCH) clinics (around 4,000), as well as in schools. The public health midwife registers every birth in the Birth and Immunization Register and defaulters are tracked. The Epidemiology Unit conducts quarterly and annual reviews.

One of the key strengths of Sri Lanka's Programme is that it is integrated with other programmes and delivered as a package (Child Health, School and Adolescent Health, and Maternal Care packages). The public health midwives are the ground-level focal points and are responsible for 2,500 people each. They have the phone numbers of their group and are responsible for bringing them into the clinic. There is a high level of trust in the Immunization Programme and mothers are very aware of the immunization schedule.

With parental consent, children are vaccinated at school, as part of RI. In 2019, there were 2,000 zero-dose children; this increased to 12,000 in 2021. However, there is a lack of data (the reviews are currently being repeated).

In March 2020, RI was suspended. In April 2020, vaccination by appointment started and clinics were conducted with extended hours. In May 2020, the backlog was cleared. School closures in 2020/21 also delayed vaccination. This was recovered after schools reopened. Children who missed vaccination at school could attend clinic on a Saturday. Routine MCH clinic services ensured RI. The age appropriateness of vaccines was affected during the COVID-19 pandemic, however, coverage was maintained. In 2022, immunization services continued as usual. Specific marginalized groups have not been identified, but there has been resistance by some groups. These are dealt with by the HW in that community. In relation to RI and acceleration of zero-dose agenda, ITAG has made the following comments:

- **Vaccine rollout was successful:** ITAG appreciates the high coverage of the first dose of COVID-19 vaccines.
- **Integration done:** ITAG commends the steps taken for integration of COVID-19 vaccination with RI.
- However, ITAG expresses concern about the negative impact of school closure on HPV and other vaccination.
- Lastly, ITAG notes the emerging challenges arising from the existing political and economic situation.

Key issues:

- EPI reviews – inability to conduct physically reviews and data quality checks compromised
- Trade union action by People's Health Movements meant that they stopped giving data in a routine manner, which has affected data quality.
- During the COVID-19 pandemic, the workload of HWs increased (by 500%).
- An immunization coverage survey was last conducted in 2017, at which time DPT1 coverage was 99.7%.
- Private sector reporting has been delayed or not reported.
- Continuous supply of vaccine stocks is the main challenge going forward.

Solutions:

- In 2022, EPI reviews were initiated – there has been no reduction in DPT1 coverage in the 8 districts completed so far.
- The Immunization Programme was prioritized by the Ministry of Health, Epidemiology Unit, districts, and Medical Officers of Health, even during the pandemic.
- The next immunization coverage survey is planned for 2023.
- Need to streamline private sector reporting.
- Vaccines are procured with government funding and the budget is not there for the next year. However, there is no issue at the moment – the country has adequate stock for 6 months.

Action plan: Sri Lanka

Action points:

- In consideration of the present economic situation, it is recommended that Sri Lanka keep in constant touch with WHO and the Regional Immunization Technical Advisory Group (RITAG) regarding availability (impending faltering) of vaccine supplies.
- Continue close monitoring of coverage data at the subnational level and timely ordering and distribution of vaccines and logistics at all levels through innovative approaches.
- Ensure that the transition is made from tetanus toxoid (TT) to acellular Tetanus-diphtheria (aTd) vaccine. (Note: The Ministry of Health has decided not to move to an aTd at the moment, but to continue the TT vaccination for pregnant mothers.)

Requests for support for Gavi portfolio:

- Sri Lanka is a Gavi transition country, but has requested support to overcome the current crisis, especially in relation to vaccine supply.
- There are risks around implementation.
- Support is needed for the maintenance of vaccination coverage, in the context of the current financial crisis.

Requests for specific support from RWG and ROs:

- The Ministry of Health has requested support for vaccine procurement to ensure uninterrupted vaccine supply (2023–2024).
- At the moment Sri Lanka has sufficient vaccines, but may need Gavi support going forward for uninterrupted vaccine supply (2023–2024).
- Due to the economic crisis, funds are needed for the continued training of HWs (2023–2024).
- Although there is pressure from academic organizations to introduce a pneumococcal vaccine, the true burden of the disease in Sri Lanka has not been studied. Hence, support is needed for a pneumococcal disease burden study (2023–2024).

Nepal: Country update

Dr Rahul Pradhan, WHO CO

Immunization coverage: Full immunization coverage in Nepal dropped to 65% in 2020, but recovered to 91% in 2022.

What Nepal did: In April 2021, an Interim Guideline was issued by the government for the continuation of essential health services, after which RI and the Measles and Rubella Supplementary Immunization Activity (MR-SIA) campaign resumed.

Outcome: RI has recovered to pre-pandemic levels and a new vaccine has been introduced.

A rights-based approach is taken to immunization in Nepal. The Immunization Act mandates the government to allocate funding to support immunization. The COVID-19 pandemic caused a dip in RI. In March 2020, RI service/outreach sessions and the second phase of the MR-SIA campaign were suspended. However, in April 2021, the government issued an Interim Guideline allowing the continuation of essential health services and RI sessions, and the MR-SIA campaign resumed. UNICEF and WHO worked closely with provincial health authorities and municipalities to monitor and support the resumption of RI, including the MR-SIA campaign.

From 2019 to 2021, an RI catch-up programme was completed for RI. Children missed during the pandemic were identified through an RCA and a search and immunize strategy was adopted. These children have now been caught up and RI coverage is at pre-pandemic levels. There was a whole village vaccination declaration initiative – 3 of the 7 provinces in Nepal have been declared fully immunized. However, full immunization is a dynamic thing, and this needs to be maintained. Towards this, the mapping/tracking of zero-dose children is carried out during vaccination

campaigns, such as the MR-SIA and TCV campaigns. A comprehensive approach to reducing zero-dose children is being plotted in the Gavi third window CDS application.

As well as recovering RI, Nepal has been able to introduce some new vaccines. In June 2020, during the COVID-19 pandemic, the rotavirus vaccine was introduced. In 2022, TCV was introduced; Nepal is the first country in the region to do so. Almost all of the vaccines in Nepal have been introduced through Gavi support, but the government has introduced some with its own funds.

In 2022, the Nepal Demographic and Health Survey showed that 20% of children aged 12–23 months are not fully immunized (80% had received all basic vaccinations), and the number of zero-dose children is increasing (4%). There are difficulties mapping zero-dose children. However, the percentage of children under 1 year immunized with Penta1 improved significantly from 2019 to 2022, despite the pandemic.

Key issues:

- Lack of data and scattered population, difficulty in mapping zero-dose children – unable to develop strategies for reaching ‘unreached population’ (urban poor, migrants, Terai Dalits, geographically isolated communities)
- Programmatic focus on meeting HMIS target, no mechanism to track missed children
- Annual targets (head counting) set from the centre (top-down vs bottom-up)
- Poor interpersonal communication by health workers, including discriminatory behaviour, use of abusive language, failing to explain health information, language challenges
- Limited knowledge and decision-making power of mothers and dependence on husbands and other family members for decision making
- Vaccination card not retained (when retained coverage was higher)
- Exact target population unknown: Census 2021 shows less total population than projected. However, final report with age-specific target population is not yet available. HMIS has updated target population, which is lower than previous.
- Competing priorities including COVID-19 vaccination, as well as activities that were delayed due to pandemic, which need to be conducted now
- Rapid urbanization

To date, the data shows that Nepal has high coverage for first dose and second dose of the COVID-19 vaccine. However, RI and COVID-19 vaccination need to be integrated in the National Immunization Programme (NIP).

An independent Immunization Monitoring System was established in 2018 by the Immunization Program Core Group. It includes immunization monitoring by surveillance medical officers (SMO), independent monitors, as well as other monitors, such as NIP committee members during their field visits. Monitoring is done at the district level, in health facilities and session sites, and at the community level, using established check lists and a risk scoring matrix. Using this system, more than 30,000 children have been monitored. The data for 2021 shows that age appropriate vaccination is 87% (data from 2020 was 80%). In 2021, service delivery was the main reason for not vaccinating (in 2019, knowledge was the main issue). In 2022, unavailability of vaccine was the main issue.

For the TCV campaign, more than 46,000 children were monitored, out of which there is GPS data for 24,000 children. All children aged 15 months to 15 years throughout the country were assessed for TCV (and MMR up to 23 months) – within that subset data was collected. GIS location is used to find those areas where children are more likely to be missed. This map can be used to identify risk areas. In 2021, only children up to 23 months were looked at for monitoring. In 2022, this was raised to 5 years. This is a large sample size, which means that the data is robust. Since GPS monitoring has been instituted, it is now known where the zero-dose children are located: the hotspots are Bagmati Province, Madhesh, and also in the east. However, ITAG expresses concern about the negative impact of school closure on HPV and other vaccination. Lastly, ITAG notes the emerging challenges arising from the existing political and economic situation.

Solutions:

- Updated micro-planning is needed. More human resources are also needed.
- Adopt a new approach to set annual targets (head counting), instead of setting targets from the central level (top-down vs bottom-up).
- Household surveys (head counting) should include the profiling of children under two to identify zero-dose/under-vaccinated children.
- Identify hard-to-reach and migrant populations through micro-planning (municipality leadership).
- Engage male caregivers in target communities for immunization through one-to-one counselling and community dialogue – use household profiling.
- Deploy additional human resources in remote and hard-to-reach locations.
- Compensate for opportunity costs for deprived communities.
- Implement social behavioural change interventions through human centred design, social mobilization, and capacity building of partners.
- Conduct training for HWs and female community health volunteers (FCHVs) on interpersonal communication and respectful service delivery.
- Develop an MCH handbook, as an integrated home-based record that contains health records and information (including vaccination records).
- Review monthly immunization coverage data.
- Third-party monitors need to be hired to track, search and immunize zero-dose children, especially those with socio-cultural barrier to seeking/ receiving services from local health care providers.

Action plan: NEPAL

Action points:

strengthening is required, especially to sustain coverage, as well as yearly verification in April (Baisakh in the Nepali calendar).

Development Plan (IDP) is being prepared by the Department of Drug Administration with support from SEARO.

Overarching recommendation:

- The NIP should be proactive and engaged in getting the maximum out of the new federal structure so that achievements in the field of immunization are maintained and improved further. Towards this, at the central level, the NIP is engaged in developing strategic guidelines and preparing a vaccine supply plan. During the TCV campaign, all levels of immunization coordination committees were activated. RI and COVID-19 review meetings are planned in all districts from December 2022 onwards: these meetings include the chief/mayor, administrative officer and health coordinator at the municipality level and the chief district officer (CDO) and chair of the district immunization coordination committee from the district, as well as district, provincial, and national health staff.

Strengthen and institutionalize the concept of 'fully immunized village':

- A Full Immunization Declaration (FID) Guideline has been reframed, as per the new federal structure (including the second year of life vaccination already developed in 2020 by the Ministry of Health and Population and the Ministry of Federal Affairs and General Administration) and is being implemented. During the pandemic, 13 new districts (out of 70) and 2 provinces (out of 3) were declared fully immunized. Further

Strengthen RI systems and VPD surveillance:

- The independent monitoring of immunization is ongoing (200 tablets have been provided to independent monitors to capture real-time monitoring data at all four levels: district, health facility, session, and community). The age limit for RI has been increased from 2 years to 5 years for all vaccines. An immunization monitoring chart has been implemented, including administrative offices. Review meetings have been held and training conducted on RI strengthening and vaccinating missed children.

Strengthen AEFI system:

- National and provincial level training, including for clinicians, was conducted on AEFI surveillance in November 2022, with global and regional experts as facilitators. Additional human resources are onboard to support AEFI surveillance. AEFI guidelines are being updated and AEFI surveillance will be initiated.

Strengthen regulatory capacity:

- Nepal participated in a regional training on the release of COVID-19 vaccines. National training on converting emergency use authorization (EUA) to full a licence is planned. An Institutional

Eliminate measles and rubella:

- Workshops for MR elimination were conducted at national level and in all provinces in 2022, with provincial level plans and commitment to MR elimination. Risk assessment is sent to the subnational level from the national level on a quarterly basis. Advocacy/information, education and communication (IEC) materials (40,000 posters) and VPD registers (1,500) for MR surveillance have been printed and provided to all levels.

Eradicate polio and transition:

- The national polio outbreak response plan is being updated and is targeted for completion by end of December 2022. A provincial consultative meeting has also been completed. A polio outbreak simulation exercise (POSE) is planned for December 2022. The polio transition is being updated – several national and provincial consultative meetings have been conducted. Two dose fractional IPV (fIPV) at 14 weeks and 9 months has already been implemented, as per SAGE recommendation, including delayed schedule with wide-interval. An IPV catch-up proposal for missed children is to be submitted in December 2022.

Maternal and neonatal tetanus elimination (MNTE):

- Elimination status has been maintained and periodic risk assessments, such as for MR and polio, are planned. The NIAC has identified the need for a booster dose and plans to discuss this.

Introduce new and underutilized vaccines:

- The HPV 1-dose schedule has already been recommended by NIAC. Impact studies/ surveillance for inflammatory bowel disease (IBD) and rotavirus are ongoing. A post-introduction evaluation (PIE) for rotavirus and TCV is planned for Q1/2 of 2023. Vaccination for cancer patients is under discussion. Vaccination for HWs is next on the NIAC agenda.

COVID-19 vaccine roll-out:

- Nepal has achieved high coverage of primary series. Coverage of the first booster dose is low, but increasing; the second booster dose is open for high-risk populations, as per WHO SAGE recommendation.

Issues obstructing implementation of recommendations:

- Delegation-task distribution between district and municipalities and health offices is obstructing implementation.
- The competency of human resources at municipalities/palikas, which have limited planning and monitoring activities and quality, is also an issue.

Requests for support for Gavi portfolio:

- Political changes (elections) can result in delays in implementation and changes in national priorities.
- The government needs support in relation to its capacity for financial management, compliance, and oversight to handle the fiscal transfer to the subnational level. The portfolio should include the improvement and strengthening of financial management.
- Consider strengthening governance and assurance framework, as there is no framework to guide Gavi on the decision to pool funding/budget support to Government of Nepal in a sector-wide approach (SWAP).
- Health administration structure needs support (district vs municipalities; tasks/delegation; distribution-transfers).
- Need support for a geo-enabled information system on who and where zero-dose children reside; this will make interventions more specific to local context.
- Shift the paradigm of full immunization declaration to 'zero municipalities, with zero-dose children'.
- Need support for supply chain human resource development, including advocacy and capacity building (resource mobilization).
- TCA funding for partners reduced.
- Global shortage of HPV vaccine may delay introduction or impact on MAC.

Requests for specific support from RWG and ROs:

- Continued TA required at subnational level through WHO network (surveillance medical officers) and UNICEF network. Sustained funding required from RO, RWG, Gavi (2023 onwards). There has been a change in TA modalities with UNICEF and WHO in new FPP. Reduced funding will impact on the support being provided at the subnational level.
- No information on who and where the zero-dose children reside – for this TA/guidance is needed from RO on equity analysis exercises (January–June 2023).
- TA support required from RO to identify and support international consultants for NIS (international support already secured through RO and HQ support, but country-level resources required through TCA); Urban Immunization Strategy (required in 2023, post-NIS); and HPV vaccine application (support required from early January onwards).

BHUTAN: Country update

Chandra Lal, Health Officer, UNICEF CO

Immunization coverage: Bhutan has 99% immunization coverage.

What Bhutan did: Bhutan continued RI during the pandemic and immunization services are integrated with other health care services.

Outcome: Routine immunization coverage in Bhutan has remained high.

Immunization services are integrated in Bhutan, not only with health and immunization, but also with family planning, nutrition, growth monitoring, deworming, and vitamin A. In 2021, 106 zero-dose children were reported. RI services are provided in hospitals (54), primary health care centres (186), and outreach clinics (552). There is also outreach in the community. Bhutan has not had any stock outs of vaccines and there are no issues with cold chain and the storage of vaccines.

In Bhutan, it is unclear where the zero-dose children are – perhaps they are among high altitude or nomadic people. Of course HWs plan to visit remote areas once or twice a year to vaccinate these children. There may also be children in urban areas who have not been vaccinated and are not reflected in the research. An assessment of zero-dose children is planned for 2023. Although Bhutan has already received an elimination status for MMR, a catch-up campaign is being conducted to sustain this status. There are no major bottlenecks to accelerating the reduction of zero-dose children in Bhutan.

Key issues:

- Inconsistent data at different levels: health facility, district and national levels
- Mistakes and data quality issues in HIMS reports
- Some districts reported more than 100% coverage of COVID-19 vaccine, which means that they are giving the vaccine to people from other districts.
- Data needs to be recorded in the HMIS, but many health facilities do not have access to the DHIS2 and send their report to the district health office.

Solutions:

- Sensitize health workers on accurate recording and reporting of immunization data into HIMS.
- Every opportunity should be used for vaccination (avoid missed opportunities).
- Plan data quality assessment to understand the errors in data reporting.
- Carry out an assessment of zero-dose children.
- Conduct an annual EPI review meeting with district health officers and Maternal and Child Health in charges.

Action plan: BHUTAN

Action points:

- A measles catch-up campaign in schools and institutions is planned for 2023.
- All new medical officers, laboratory technicians and technologists are trained on VPD surveillance.
- Monitoring and follow-up conducted for drop-out cases.
- Training of health workers on MR surveillance and zero-dose child concept is planned. However, with the recent civil service reforms in Bhutan, obtaining approval for training and meetings is becoming difficult.
- An immunization action plan for 2023–2026 is being drafted.

Requests for support GAVI portfolio:

- No support requested at present.

Requests for specific support from RWG and ROs:

- Guidelines: Support is needed to develop a manual and standard operating procedures on vaccine management, cold chain management, and supportive supervision (July 2023).
- Human resources: Support is need for financial technical assistance and technical assistance (FTA/TA) for a cold chain specialist (April 2023).
- There are areas where there is low immunization coverage and there are some zero-dose children. Support is needed to conduct a catch-up campaign for RI in low immunization coverage areas, such as among nomadic people, cow herders/drop-outs and zero-dose children (April 2023).

TIMOR-LESTE: Country update

Sudath Peiris, WHO CO

Immunization coverage: From January to October 2022, Timor-Leste reached 400,000 children through catch-up activities.

What Timor-Leste did: In 2021, RI services were disrupted due to lockdowns and the repurposing of health staff for COVID-19 vaccination; there was a 26% reduction in RI coverage, compared to 2019. The integration of RI with COVID-19 vaccination started in the second half of 2022.

Outcome: RI coverage has almost returned to pre-COVID-19 levels, and is expected to stabilize in 2023.

In 2020, the COVID-19 pandemic had a marginal impact on RI in Timor-Leste, with RI continuing in fixed sites and through outreach. There was only a 4% reduction in RI coverage in 2020, compared to 2019. In 2021, RI services were disrupted due to lockdowns and the repurposing of health staff for COVID-19 vaccination. RI was available only in fixed sites and there was a 26% reduction in RI coverage in 2021, compared to 2019. In the first half of 2022, COVID-19 vaccination continued, and there was less emphasis on RI. The integration of RI with COVID-19 vaccination started in the second half of 2022. However, a clear strategy is needed for COVID-19 in 2023, as part of full integration.

Key achievements in the last two years include recovering RI coverage from the COVID-19 pandemic and the integration of COVID-19 vaccination with RI, the expansion of digital health tech and cold chain storage capacity, and building the capacity of the health workforce in the maintenance and repair of cold chain equipment. A digital platform to monitor COVID-19 vaccination status and for the monthly monitoring of RI is now fully functional. In relation to recovery and catch up, over 100,000 more RI vaccinations were delivered in 2022 (January to October) than in 2021 (January to

October). Since June 2022, COVID-19 vaccinations have been fully integrated with RI. RI coverage has almost returned to pre-COVID-19 levels, and is expected to stabilize in 2023.

In terms of interventions undertaken and planned, DHIS2-based monthly reporting has been revived, with the aim to provide better data for action. An MR/OPV/PCV catch-up campaign for children under 5 years is planned for January 2023. However, concerns exist about denominator data (census) and will remain for some time. In addition, funding flows from the national to grass-roots level take time and the Ministry of Health needs support for financial management.

Key issues:

- Over 50% of births in Timor-Leste are home deliveries; 30% require door-to-door vaccination, which comes with high operational costs.
- Lack of a formal birth registration system leads to lack of accurate denominator data.
- Support is currently provided by international consultants.
- There is emphasis on COVID-19 vaccination, at the cost of RI.
- Timor-Leste has received small consignments of COVID-19 vaccine from COVAX with very short expiry times, and there is pressure for these stocks to be used before they expire.

Solutions:

- Fully integrate COVID-19 vaccination with RI.
- Reinstate pre-COVID supervision and monitoring systems for RI.
- Amalgamate the national coordination structure for COVID-19 vaccination with the RI coordination structure.
- Strengthen online data capture by DHIS2 and closely monitor vaccination coverage.
- Ensure regular availability of operational and transport costs at grass-root level.
- Carry out an assessment of zero-dose children.
- Conduct an annual EPI review meeting with district health officers and Maternal and Child Health in charges.

Action plan: TIMOR-LESTE

Action points:

- Although recovery of RI commenced in mid-2022, steps need to be taken for it to fully recover.
- Disease surveillance, particularly for measles and rubella, has bounced back, but needs to continue to maintain high level of surveillance indicators (except acute flaccid paralysis).
- An MR/OPV/PCV catch-up campaign is planned to begin on 12 January 2023.
- Distribution of the first and second doses of COVID-19 vaccine has achieved geographical equity, but the booster dose is yet to achieve this (there are concerns about equity in remote areas).

Requests for support GAVI portfolio:

- The Ministry of Health has not mobilized Gavi funds since 2019. The balance of funds with the Ministry is USD 709,000 (made up of a transition grant of USD 666,197 and a post-transition grant of USD 140,400).
- WHO: The funds allocated for Timor-Leste require reprogramming. Other activities are on track.
- UNICEF: The listed activities have been implemented within the grant timeline. There is a need to explore and advocate for additional resources to support health system strengthening activities beyond 2023.
- Gavi Post-Transition support ends in 2023; a no-cost extension is needed for 2024. (There are plans for the reprogramming of Gavi Post-Transition funds.)
- There is the possibility of MICs support once reprogrammed Post-Transition activities and results are completed.

Requests for specific support from RWG and ROs:

- Continued WHO/UNICEF TA is needed beyond 2023 (2024).
- High-level interagency advocacy and funding support is needed to establish a birth registration system. If the One UN approach is used, new legislation may be needed (2023).
- Best practice models from similar settings are needed to scale up RI to reach zero-dose children; need technical support for the country office (2023).
- Remote and in-person training is required to increase the capacity of the Ministry of Health immunization team, especially newly recruited staff members (2023).
- The last comprehensive external EPI review was conducted in 2015. As the Gavi funding cycle is ending, it is time to repeat such a review in 2023, and to plan and strategize the next steps accordingly. Support is needed to conduct such a review, specifically to obtain team members from WHO HQ, UNICEF HQ, WHO RO, UNICEF RO, Gavi, Centers for Disease Control and Prevention, National Centre for Immunisation Research and Surveillance (NCIRS) and other partner organizations, including a team leader who has led such missions before (GAVI CDS) (2023).
- TA is needed to pilot a digitized national immunization register in Dili Municipality, and suitable consultants need to be contracted (GAVI CDS) (2023).
- There is poor intellectual and technical capacity among national staff at all levels – support is needed for training and the continuation of subnational international consultants for another 2–3 years, otherwise the system will collapse (2023–2024).
- Continuous technical and logistical investments are needed for the digital HIMS system (2023–2024).
- Funding is needed for vaccines (2023–2024).
- Support is needed from RO to help the country level to move things forward.
- Capacity building is needed at country level for sustainable solutions.

MYANMAR: Country update

Khaing Khaing Gyi, WHO CO and Nang Mya Nwe Tra Tun, UNICEF CO

Immunization coverage: Penta3 coverage improved in 2022, from 37% in 2021.

What Myanmar did: A three-day workshop was conducted on the strengthening of RI in November 2022, and recommendations for RI strengthening were agreed.

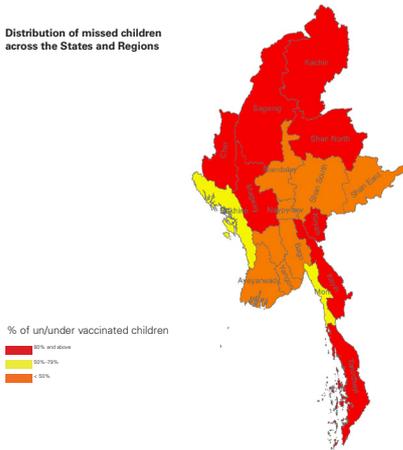
Outcome: An estimated 1.6 million children under 5 (33% of this population group) are being targeted for catch up (zero-dose or under-vaccinated).

In April 2020, following detection of the first confirmed case of COVID-19 in Myanmar in March, RI services were temporarily halted to allow the health sector to focus on COVID-19 prevention and response. RI services resumed in June 2020 and 60,000–80,000 children were reached per month until February 2021, when the country's political situation changed.

As a result, RI coverage in Myanmar has dropped drastically. According to the Ministry of Health, national Penta3 coverage for 2021 was 37%, significantly lower than in 2019 and 2020. Although immunization coverage improved to some extent in 2022 (the data for 2022 will be available when the Ministry has completed the electronic joint reporting form [eJRF] for 2022), it is estimated that over 1.6 million children missed basic vaccines from 2018 to 2022.

UNICEF and WHO country offices have been supporting the Ministry of Health in conducting catch-up campaigns as an utmost priority. However, the health system requires significant support to deliver routine services, COVID-19 vaccinations, and additional catch-up activities, while facing political conflict and social barriers. Planning and resource mobilization for the catch-up activities are in progress.

Distribution of missed children across the States and Regions



Key issues:

After country's political situation changed in February 2021, there has been a:

- Shortfall of skilled staff at all levels (CDM)
- Limited data management
- Limited accessibility to the health facilities due to conflict and security specially in hard-to-reach areas
- Limited in-country logistical support
- Limited operational cost/support
- Competing priorities (COVID-19)
- Threat of VPD outbreaks with possible spread within and outside the Myanmar borders . Indonesia

Solutions:

UNICEF/WHO are supporting the Ministry of Health to strengthen RI, as follows:

- EPI annual evaluation supported in April 2022.
- Cold chain workshop supported in August 2022.
- RI strengthening workshop supported in November 2022.
- Gavi HSS 2 reallocation is supported for 2023–2025.
- Support catch up activities plan in 2023.

Action plan: MYANMAR

Action points:

Overarching recommendation:

- NIPs to optimally implement the recommendations made by NITAG and SEAR-ITAG and report to NITAG at least twice a year on the status of implementation (on track). The implementation status of NIPs will be reported to future NITAG meetings for further evidence-based decision making and intervention.

Strengthen RI systems and VPD surveillance:

- Identify and focus on subnational high-risk areas with large number of zero-dose children, as well as on special populations (migrants, displaced people, vulnerable populations) (on track). As per recommendations from the strengthening of RI workshop in November 2022, the COVID-19 vaccine post-introduction evaluation (cPIE) has to update detailed micro-plans and area prioritization to identify areas for zero-dose children through risk assessment.
- Review implementation of catch-up immunization activities, including catch-up campaigns and, where necessary, increase the age limit of target populations (on track). Catch-up activities are tentatively planned for the first quarter of 2023, in consultation with NITAG. Strategy shared in Ministry of Health workshop in November 2022 is under review.
- Ensure that country action plans are developed to strengthen VPD surveillance (on track). Myanmar

is enhancing VPD surveillance with available resources. Funding support is required for Regional Surveillance Officer (RSO) network.

- NIPs to undertake periodic programme reviews, including VPD surveillance and environmental surveillance reviews, jointly with NITAG (on track). VPD surveillance workshop was conducted by Central Epidemiology Unit in July 2022 and NITAG members participated.
- Review strategies for risk communication and community engagement (on track). Risk communication and community engagement plan will be updated by UNICEF according to the current context.

Introduction of new and under-utilized vaccines:

- Encourage countries to assess disease burden and, accordingly, introduce new and under-utilized vaccines. Countries with high burden of typhoid and cholera could take Gavi funding opportunity to introduce these vaccines (not started). The plan for new vaccine introduction in 2022–2023 has not yet been decided.
- Assess progress on implementation of VPD surveillance guidelines for all priority diseases (on track). An updated VPD surveillance guideline is being developed by the Central Epidemiology Unit, with technical support from WHO.
- Ensure good laboratory surveillance performance through participation in the quality control and external quality assessment activities (on track). The National Health Laboratory (NHL) has planned to participate in external quality assessment activities in 2022.

- Countries are encouraged to consider implementation of the recent SAGE recommendation on HPV vaccine introduction and schedule and coverage improvement activities (on track). NITAG recommended the one dose schedule be used for HPV vaccination in October 2022, in accordance with the SAGE recommendation.

Adverse events following immunization:

- Countries to develop workplans for 2022–2023 for further strengthening of AEFI reporting, investigation, and causality assessments, with support from WHO (on track). The strengthening of AEFI reporting, investigation, and causality assessments was recommended in the EPI evaluation meeting in 2022 and an AEFI Committee Meeting was conducted in June 2022. Guidelines to be updated and trainings planned.
- Countries that do not meet the AEFI surveillance sensitivity indicator of one serious AEFI per million population for EPI antigens need to improve AEFI reporting (on track). AEFI reporting system needs to be strengthened to meet the indicator. Trainings will be planned.
- National AEFI committees to conduct timely causality assessments for serious AEFIs (not started). Due to political situation, this component needs to be improved to address the no/under reporting and capacity building for basic health staff, etc. (planned for 2023–2024).

Measles and rubella elimination:

- All countries to conduct outbreak preparedness and response assessment for measles and rubella at national and subnational levels, including simulation exercises, to ensure a high level of preparedness (not started). Outbreak response preparedness is enhanced among states and regions for timely response, but simulation exercise has not started. Need support from RO.

Polio eradication and polio transition:

- Update national polio outbreak response plan, as per most recent global guidance (March 2022) (on track). Updating of the response plan is in process.
- Countries are encouraged to conduct POSEs (on track). With technical support from WHO, the Ministry of Health plans to conduct a POSE in Q4 2022–2023.
- Expansion of environmental surveillance (on track). Myanmar plans to expand environmental surveillance sites in 2023.

Maternal and neonatal tetanus elimination:

- Vaccination of pregnant women, booster doses for children and adolescents, and revitalization of school-based health services (on track). A catch-up immunization plan is proposed for 2023.

COVID-19 vaccine roll out:

- Continue to enhance risk communication and community engagement in relation to adverse events and responses to misinformation related to vaccination (on track). A national vaccine deployment plan was being developed including a risk communication and community engagement plan.
- Leverage the investment in cold chain and digital technology for COVID-19 vaccination to benefit RI and health systems (on track). Development of a national cold chain expansion plan and an electronic logistics management information system (eLMIS) for RI is ongoing.

Country-specific recommendations for Myanmar:

- Based on the eJRF, there are concerns about the very low coverage of all routine antigens across the country in 2021, which makes the country vulnerable to large outbreaks of VPDs (on track). Intensification of RI through catch-up is already proposed. Updating of the national polio outbreak response plan is in progress and, with technical support from WHO, the Ministry of Health plans to conduct a POSE in Q4 of 2022–2023.

Requests for support for Gavi portfolio:

- High level advocacy is needed from Gavi (and the RO) to ensure equity and risk mitigation, particularly among children in border areas and hard-to-reach areas.

Requests for specific support from RWG and ROs:

- High level advocacy is needed from the RO (and Gavi) to ensure equity and risk mitigation, particularly among children in border areas and hard-to-reach areas.
- Advocacy should include reducing the number of zero-dose children across the country through timely microplanning, vaccine availability and mobilization for vaccination.
- Financial support is needed for outbreak response activities in hard-to-reach areas (2022–2023).
- Technical support is needed for POSE, Web Information for Action (IFA), specimen tracking technology, and to improve data completeness at the global level (e.g., Polio Information System [POLIS]) (2022–2023).
- Laboratory support is needed for VPD and rota surveillance, and training for direct detection (2022–2023).
- Consultancy support is needed for the development of a comprehensive multi-year plan (cMYP) now and a national immunization strategy in 2022–2023.

DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA: Country update

Asha Pun, UNICEF CO

Immunization coverage: In 2022, a catch-up campaign for Penta was conducted in September and another shipment of RI vaccines was made in November.

What DPRK did: During the COVID-19 pandemic, RI stopped entirely in DPRK, due to stockouts of vaccines.

Outcome: Catch-up campaigns are planned for December 2022 and January 2023.

During the COVID-19 pandemic, RI stopped entirely in DPRK due to stockouts of vaccines. However, RI is a priority programme and there is a strong network of health workers, with one immunization session organized per month.

In terms of interventions undertaken: A new transportation modality has been established for the shipment of vaccines via land, due to the suspension of air shipments. The catch-up campaign for Pentavalent has been successful, resulting in the vaccination of 296,310 children in September 2022 (1st dose). The cold chain system has also been strengthened: Three units of walk-in cold rooms (WICRs) are ready for use at the point of entry into DPRK, at Dandong, China. In addition, 425 units of various types of refrigerators and their spare parts were delivered to the country in November 2022, although these are yet to be installed at each level of the supply chain, according to the Effective Vaccine Management (EVM) Implementation Plan. The following vaccines were recently shipped to DPRK: Penta (542,100 doses), IPV (87,000 doses), MR (690,500 doses), tuberculosis (BCG) (657,200 doses), and tetanus and diphtheria (TD) (433,300 doses).

More interventions are planned, including a catch-up campaign at the end of 2022, with EPI vaccines delivered to DPRK in November 2022. Shipment of the undelivered vaccines (GAVI, co-financing and UNICEF supported) for the next catch-up campaign is planned for April 2023 to cover the remaining missed children and to restart RI. RI will resume for BCG, Penta, IPV, MR, and TD from January 2023, after completion of catch-up in December 2022 and January 2023.

Key issues:

- Import of vaccines, devices, and cold chain equipment difficult due to prolonged border closure and new customs rules in China
- Unable to implement activities to strengthen RI and cold chain system due to lack of funds and international professional staff
- Gap in capacity building of EPI staff
- No international staff to provide technical support
- Unavailability of earmarked funds to support catch-up campaign

Solutions:

- Strong coordination, collaboration and communication among UNICEF Supply Division, China, Pyongyang and Bangkok teams, and government officials from China and DPRK – every opportunity was taken to transport vaccines and supplies into DPRK
- Negotiated with Ministry of Public Health to conduct capacity building activities with reimbursement
- Exploring alternative route for transportation of vaccines
- Cascade training to build capacity of EPI staff at each level for catch-up campaign
- Advocacy with government of DPRK to reopen borders for vaccines and allow international professional staff back
- Agreement from Gavi for reprogramming of grants to support planned catch-up campaign

Action plan: DPRK

Action points:

- All international professionals are not in country, therefore, have not yet had the opportunity to discuss or initiate the implementation of recommendations with the Ministry of Population and Health officials.

Requests for support for Gavi portfolio:

- Risk: Preventive measures introduced during the COVID-19 pandemic (border closure) have stopped international professional staff from returning to the DPRK, hence, many planned activities could not be implemented.
- Mitigation: Advocate with government to allow international professional staff to come back to DPRK and mobilize UNICEF and WHO national staff to monitor the RI programme.
- Risk: The sustainability of the RI programme is at risk. The Gavi allocated funds could not be utilized as per the agreed plan and the grants are expiring on the 31 December 2022. No funds are available for 2023 to sustain the RI programme.
- Mitigation: Request Gavi to give a no-cost extension for the current grants to allow the strengthening of RI. Simultaneously, review and update the HSS3, in close coordination with the Gavi country team. Request Gavi to consider disbursement of CCEOP approved in 2020, which aimed at replacement, expansion and extension of cold chain equipment countrywide.

- Risk: The introduction of a new policy for transit goods by China Customs has posed challenges for bringing vaccines via China and could lead to vaccine stock outs again.
- Mitigation: Advocate with China Custom to give special approval for DPRK to transport vaccines, and explore alternative approaches and routes for the transportation of vaccines.

Requests for specific support from RWG and ROs:

- Support is needed for programme coverage data and supply chain data from the subnational level (village and county level). Disaggregated data by sex is not available, hence, it is difficult to analyse gender sensitivity and equity aspects. Reporting is still paper-based at village and county levels. Support is requested from the RO for TA for the digitalization of immunization coverage data and supply chain management data (Q1 2023).
- Due to the limited quantity of vaccines available to conduct the catch-up campaign, all children missing vaccination might not be covered. Support is requested from the RO to provide TA for a coverage evaluation survey to assess the impact of acceleration efforts (Q1 2023).

INDONESIA: Country update

Stephen Chacko, WHO CO

Immunization coverage: More than 1 million children were missed for immunization during the COVID-19 pandemic.

What Indonesia did: A catch-up campaign (BIAN) was conducted from May to September 2022.

Outcome: BIAN reached approximately 70% of the target for MR, 60% for DTP-HB-Hib, and 50% for polio. However, there are still many missed children remaining to reach.

During the COVID-19 pandemic, more than 1 million children were missed for immunization in Indonesia. RI of DPT (1st dose) dropped from 97% in 2019, to 86% in 2021. While catch-up campaigns have been run, as of October 2022, most antigens were between 62 and 75%, which is significantly short of the target coverage for all antigens at the national level of 95% by the end of 2022.

Some of the challenges include the fact that financial resources are not evenly distributed, especially at lower levels. The catch-up campaign started late in some provinces, due to delays in logistic distribution and was interrupted in the middle due to the long school holiday. In addition, health workers are suffering from fatigue and there has been inadequate social mobilization due to lack of funds, among other issues.

Some of the key immunization barriers are: lack of defaulter tracking data (unimmunized children's data was not tracked); multiple injection issue (parents are worried about side effects and health workers are afraid of giving multiple injections); children under 5 years of age did not come for vaccination; and parents also feel that catch-up immunization is not important. In addition, there are four confirmed cases of vaccine-derived poliovirus (VDPV) in Indonesia.

To revitalize RI, Indonesia needs to firstly increase activities in the community, including by training community workers on demand generation and target mobilization. There are gaps in the capacity of health workers, for which training and TA are required. Home-based immunization records have proved useful and need to be retained and reinforce by the digitization of certificates. The Red Cross is a potential partner in terms of the outbreak response and immunization activities. Finally, school-based immunization needs to be strengthened.

Key issues:

- Lack of default tracking
- Hesitance among public and health workers in relation to multiple injections
- Limited capacity of health workers
- Inadequate social mobilization
- Inadequate monitoring and evaluation

Solutions:

- Focus on micro-planning, local area monitoring, defaulter tracking and multiple injections.
- Conduct regular short sessions on various topics through monthly mini workshop at health centres; collaboration with training centres and professional organizations.
- TA is needed from partners to build the capacity of health workers (WHO, UNICEF).
- More socialization is needed for parents and teachers, especially fathers.
- Support is also needed from local leaders, religious leaders, Pemberdayaan Kesejahteraan Keluarga (PKK) and cadre for social mobilization and advocacy.
- Improve monitoring and evaluation by intensifying analysis and feedback (biweekly desk review; monthly and quarterly bulletin).
- Digitize supportive supervision tools and increase supervision activities.
- Integrate monitoring with VPD surveillance.

Action plan: INDONESIA

Action points:

- Develop provincial and district-level plans (ongoing).
- Develop better coordination and accountability between national, provincial, and district levels (planning is underway to develop a task force).
- Vaccine availability at all levels will be better monitored with a centralized electronic immunization registry that integrates with a cold chain monitoring system.
- Implement a data quality improvement plan (deploying more technical staff).

Requests for support for Gavi portfolio:

- Indonesia has graduated from Gavi, but is currently working on a Gavi middle income countries (MICs) proposal, including zero-dose and new vaccine introductions.

Requests for specific support from RWG and ROs:

- The capacity of health workers needs to be built. Support is needed from WHO and UNICEF RO to conduct mid-level managers training for health workers (2023).
- There is inadequate social mobilization and awareness among general public. Support is need from UNICEF RO for high-quality demand creation activities, including with immunization champions and ambassadors (2023–2024).
- Support is needed for improved monitoring and evaluation by the RWG, including through monthly online meetings (2023).

PART 3: CONCLUSION



Conclusion and way forward

Reaching zero-dose and under immunized children:

- Reaching zero-dose children should be an opportunity to identify unimmunized children in high-risk communities, then follow-up with complete immunization. Among the most vulnerable populations, there is often population movement; migrants and internally displaced populations are often missed.
- The goal is to reach zero-dose children, regularly follow them up for completing age-appropriate immunization, and sustain this long-term.
- Context specific actions are required to reach zero-dose, which is part of a global call to address inequities in access to immunization, including identifying, line-listing, and reaching missed children, using all opportunities and immunization platforms (Programme to Improve Routine Immunization [PIRI], NVI, Multi-Antigen Campaign [MAC], World Immunization Week), and exploring PHC levers.
- The expansion of age eligibility in catch-up campaigns (up to 5 years in most countries) is recommended to reach those missed during the COVID-19 pandemic. Countries that have expanded the upper age limit should continue practising this beyond COVID-19 catch-up and monitor by age bracket.
- Messaging about immunization should be part of the UHC agenda, and immunization services should be integrated in a package of PHC and broader health services for communities. We need to be aware of missed opportunities for RI, which can be delivered with other services that are

already institutionalized in the community, such as ANC and nutrition services.

- Urban immunization requires streamlining, collaboration with partners, and learning from other countries.

Reaching zero-dose and under immunized children:

- Some countries have started implementing the ITAG recommendations to reach zero-dose and under-immunized children. However, this requires constant and regular follow-up by countries and partners.
- Business as usual needs to change, hence, Gavi's diversification strategy for impact, bringing in partners that are connected at the community level who can help reach Gavi 5.1 goals, as well as building the capacity of governments and local partners in terms of management and implementation for sustainability. The problem is not about funding, but the ability to use the resources available (capacity).
- Reaching all children requires committed community health workers who track and immunize all children born in the community through antenatal registers, following all births and including newborns in the child immunization register/due list of beneficiaries for RI.
- School-entry screening and school-based immunization could be an opportunity to reach under-immunized children and contribute to the life cycle approach. Examples from region:

Sri Lanka has shown how immunization can be delivered via outlets in the community, such as schools, in a systematic way, set up before emergencies, and can continue to deliver directly into communities.

- Immunization needs to be integrated into PHC; RI is a platform to reach missed communities with essential services (ANC, nutrition).

Integration of COVID-19 with RI and PHC:

- The sustained integration of COVID-19 with RI and PHC requires high-level leadership/commitment, sustainable financing, and equitable service delivery that reaches missed communities and the most vulnerable. For this, the human resources gaps for outreach needs to be addressed.
- As per SAGE recommendation, countries need to provide first and second boosters to health care workers, adult populations and immune-compromised persons. Towards this, the integration of COVID-19 vaccination with RI should be considered.
- Acceleration of new vaccine introduction:
- As recommended by ITAG, countries need to look at the option of using a HPV-single dose schedule and introduce TCV.

Accelerated disease control:

- As recommended by ITAG, countries need to introduce the second dose of IPV, if not already introduced.
- Countries should also consider shifting the measles vaccine from 10-dose to 5-dose vial and analyse missed opportunities for measles vaccination.

Gavi: Diversification of partners and CSO:

- Doing things differently to reach equity at the community level: Gavi 5.1 calls for the diversification of partners and the inclusion of CSOs that are present on the ground and are, therefore, better placed to understand the barriers and able to voice the needs of communities. New strategies central to Gavi 5.0 include 10% (HSS, EAF, TCA) funding for CSO engagement with local partners.
- Gavi full portfolio planning:
- Gavi MIC support (for Gavi, former and never Gavi countries) provides opportunities to mitigate backsliding of RI.
- Concerted partner support is required by countries for implementation of IA 2030.

Specific country examples:

- In Sri Lanka, partner support for sustainable funding for COVID-19 vaccines to be part of integrated package of care delivery.
- In Timor-Leste, micro-plans, funding and service delivery, integrated COVID-19 and RI need to be addressed.

Closing Remarks

René Ekpini, UNICEF ROSA

Looking to the future, how can we best support COs? How can we work better and push the agenda for immunization and broader health? We are at a turning point in our immunization agenda in the region. The impact of COVID-19 on the progress we have made has been significant. It is important to catch up. We all know that this region is facing a humanitarian crisis. But there are windows of political commitment here. There is momentum behind the zero-dose and missed communities agenda, and there are opportunities that should not be missed.

Topics to highlight: We need to refine the narrative around the zero-dose agenda. The priority is immunization, but this agenda goes beyond immunization to the needs of these children and communities. There is a strong like between immunization, health and nutrition.

Second, we need to document good practices around urban strategies. We also need to engage with CSOs. As part of this, it is important to look into actively engaging communities and community structures.

Data is also important in terms of knowing where we are going and leveraging what we have in terms of innovation.

In this meeting, we discussed the broader issue of how our narratives are integrated in the wider agenda – the PHC and UHC agendas – as well as missed opportunities.

Drawing on my experience in public health around coordination for HIV for immunization, there are a few things I would like to highlight. We are not stopping here with these action points. We need to come up with a consolidated action plan to make sure that we are clear about the expectations of countries. This will be important moving forward, in terms of what needs to be done, by whom, and if there is need for financial support.

This group is not just about technical support or programmatic support. It is about how we bridge the political agenda with the programmatic agenda. We need to leverage the leadership in different organizations for a high level of advocacy. We need to link this discussion with action – we should not wait until the next meeting.

ANNEX 1: Q&A



Q&A: Zero-dose agenda

Comment: The way forward for reaching zero-dose is to be sensitive – we need to expand the age bracket. We also need to identify missed children.

When looking at Gavi 5.0 and IA 2030, the goal is not just to reach zero-dose children, but to regularly reach zero-dose children. While DTP1 is the correct proxy indicator at the global level, we are not bound to DTP1 alone. **Substitute the term ‘missed communities’ for zero-dose, with no constraint imposed by DTP1, and think of other approaches to identify affected populations.** MNTE communities are probably zero-dose communities. Let’s not wait for the data before we fix the problem.

Comment: There is not one strategy for reaching missed communities. Some entire communities (urban slums or remote communities) miss out on every service. Understanding the barriers to access and demand issues is key, and CSOs and community partners can help illuminate this.

Understanding the situation from the perspective of the caregiver or health service provider is important.

Question: Some countries sustained immunization coverage during the pandemic. In Sri Lanka there is one community-based midwife for every 3,000 people – so they were able to register every birth and follow up with immunization. In Timor-Leste we do not have such a system – so how do we identify who needs to be immunized?

Answer: We would be keen to support moving towards things like birth registration for Timor-Leste.

Comment: We need different strategies for different communities. The National Health Survey showed an increase in immunization of first-born children. We need to focus on sub-layering of population groups.

Comment: Three things need to be in place: (1) enough HWs; (2) birth registration; and (3) reporting of new births on the immunization registry. Some countries monitor what they are doing, e.g., in Bangladesh, birth registration is not essential, but newborns are automatically registered on the immunization register.

Comment: Immunization is part of a bigger picture and we need to pay attention to the narrative. The way we are selling this is critical. The most important push at the moment is about PHC for UHC. We need a clear articulation of how immunization fits into the political agenda. **Zero-dose needs to be a key component of PHC for UHC. We need to include how we address the overall health agenda.**

Comment: There is a **population movement crisis around migration and immunization, including for internally displaced populations. Documented children may be reached, but children and families that are undocumented and on the move are vulnerable and are often missed in conversations.**

Question: In Bangladesh, we are suffering from a shortage of frontline vaccinators – one in three positions are vacant. To address this gap, **think about micro-planning. What are the local resources? Look for CSOs or faith-based organizations, and use them to do the listing and vaccinations.** Trigger community engagement – it is their children. **If you have an excellent maternal health programme, this is an opportunity.**

Comment: We need to discuss mapping – there is a capacity gap at the local level.

Comment: Day-to-day implementation by HWs and programme managers has been affected by COVID-19, as they are doing both COVID-19 activities and RI. **Many are not being paid the same way for RI as they are for COVID-19, so they prioritize COVID-19. We need regular training.**

Comment: In 2022, coverage in DPRK was zero, as we have no vaccines. There are constraints on local funding and no international staff. The customs for vaccines is a big hurdle. In November 2022, we were able to transport some vaccines into country, but not enough to cover everyone.

Q&A: Gavi 5.1

Question: In relation to the diversification of partners, there is a key performance indicator (KPI) in terms of cash to government of 30%. How do we go down to subnational level when there is a lack of maturity and capacity?

Answer: In terms of targets for transferring funds to governments, 70% of our funds go through core partners such as UNICEF and WHO. We identified eight countries, including Bangladesh, which we want to manage funds directly. I don't think that is in contradiction to the diversification strategy. We have to think about how we can support countries with fund flows from immunization programmes down to the local level. This involves budget planning and timely execution, fund flows to the local level, and local level capacity to spend the funds. **CSOs have a role to play in the oversight of services and helping with micro-planning. Local partner diversification is in response to the need we see at the local level. If we want to reach zero-dose, we can't rely on UNICEF to reach missed children in missed areas. We need to create the ability at the community level in a sustainable way, on the service delivery side, the demand side and in relation to oversight. The diversification agenda is not aimed at taking away the government's capacities and oversight. Let's use our TA, HSS and funding levers to help countries build their capacity, because without a change in the way we are working, we won't see the impact we are after.**

Question: In relation to the routinization of COVID-19 vaccine, at the global level, COVAX should talk about the long-term efficacy of these vaccines. **What is the best platform to routinize the COVID-19 vaccine?**

Answer: In terms of the COVID-19 platform and the efficacy of vaccines, we are trying to see what this programme will look like. Is it a booster programme? Is it a programme to reach the most vulnerable? **It is up to countries to decide what vaccines suit them. In terms of the platform, countries need to come up with a platform that works for them, and we will see how to best support them.**

Question: There has been a change in zero-dose in India – the numbers went up and then down again. Each of these groups represents a different birth cohorts. But how do you monitor these children? **What is the status of the current programme for birth cohorts and how to monitor all children previously missed?** Efficient systems are not necessarily in place and in efforts to catch up children. Has a good way to monitor this come up?

Answer: All of these things (HCD etc.) are the focus of Gavi 5.1. There is now a global demand hub with a lot of funding. We are keen to see what works and bring it to scale.

Question: Is there an objective on behavioural change communication (BCC)?

Answer: Demand, behaviour change, social mobilization, and HCD are still focuses of the 5.0 strategy, including CSOs, demand, and gender focus. There is a global demand hub and innovation in the space, which is being translated to local levels with a lot of funding behind this.

Question: I wanted to understand the positioning around global health security and IA 2030. How does this come into the agenda for the region and for countries?

Answer: **We need to provide as much support as possible to countries to detect outbreaks of significance and to share information as quickly as possible to help countries to take action to prevent the spread of disease. We need to strengthen surveillance for high levels of transparency. Strengthening lab capacity for diagnosis and sharing information quickly so that other countries can take necessary steps are both important.**

Experience sharing: In Bangladesh, when the pandemic struck, everything shut down for 3 months. Then the government developed a strategy to identify missed children, followed by coverage. In 2021, the government decided to do extra activities to reach drop out and left out children during 1 week of immunization, and around 1 billion drop out children were reached. In 2022, the government conducted live visits and vaccination. The age for government vaccines was increased from 2 to 3 years. Another 400,000 children

were vaccinated. The government is now conducting real time monitoring (with the support of its partners) followed by rapid coverage assessment to find drop out and missed children. We have already reached 1.4 million children. Political commitment was high in Bangladesh – this is essential.

Experience sharing: In India, Mission Indradhanush was already in place. During the pandemic, the states took up the task and reached a lot of children. Now the districts are prioritizing these children in a systematic way. Many state level catch-up campaigns have extended the age of children up to 5 years so that children missed during the 2 years of the pandemic are caught. Advocacy with the national government is needed for the catch-up campaigns.

Experience sharing: In Nepal, we do not have a systematic way to monitor zero-dose children, but the government has a policy to search and immunize children up to 5 years of age (vaccination age has been lifted from 2 to 5 years). Also, when we conduct campaigns, we search for zero-dose children and vaccinate them. In the recent PCV campaign, 46,000 children were identified and their immunization status established; 45% were zero-dose and 11% were partially vaccinated. We focused on measles. Now we are focusing on zero-dose and drop outs. We are going to write guidelines on the process of identifying missed communities, so that we have a proper strategic document in place to guide us.

Comment: What this region has done in regards to lifting the age limit is impressive. Countries in the region have made various efforts to catch up. What I am not clear on is whether or not the age limit has been expanded in the monitoring. Is there a plan to maintain the expanded age limit in the long term, or is it just a catch up activity?

Question: In Bangladesh, for HPV, support is to be increased up to 18 years. At the moment it is 11–15 years. How will this thing be processed? Will Bangladesh be eligible? Bangladesh is the best value for money in the region, as it is sustaining coverage.

Question: The focus is on diversification, we agree, but governments are the service providers, and there is limited capacity. Institutions are weak in terms of providing sustained demand generation and community engagement. Does Gavi see a facilitating role for UNICEF to act as a bridge to build CSO capacity to support governments?

Answer: Unless partnerships at the local level are diversified with those who are integrated in the community, it will be difficult to achieve the zero-dose agenda. In remote areas, why have communities continuously been missed? Business as usual needs to change. That is why the Gavi Board has said that 10% of funding will be to CSOs. Who are the actors that can partner with the government to achieve the goals? For example, in relation to demand, we need to work with traditional leaders and mothers. UNICEF could also build the capacity of local partners in terms of management and implementation. The goal is diversifying for

impact, not looking at diversification through the lens of funding division. We are interested in building government capacity. In countries like Bangladesh, why are intermediate agencies still needed, as all the funds go to programme implementation anyway? Is it financial risk management? Are certain parts of the government more risky? Is it about fund flow? The eye is on the sustainability of the programme.

Answer: It is up to countries to come with the justification for the age they are trying to reach – bring a good justification in terms of value for money or the diversification agenda. Gavi is here to support services and enable countries in their programmes. Gavi does not have ownership of these programmes, we just support the programmes.

Q&A: CDS

Question: In relation to the safety and efficacy of COVID-19 vaccines, while the **COVID-19 vaccine has helped to reduce mortality and hospital admissions, infection and transmission have not been reduced as much. So there is a need to give a primary dose (focusing on adults, HWs and immune-compromised) and for a booster (prioritizing the elderly, HWs and immune-compromised, as well as people with comorbidities). A second booster is also recommended, but there is no recommendation yet for a periodic booster, only for some populations.**

Question: In terms of the timeframe, we are talking about the **new CDS window. Implementation might be extended beyond the end of 2023 and integrated with HSS support. After the first quarter of 2023, we will be able to give more guidance on this. What is important is to finalize the applications, as there is a risk that the funds will go to another country that is able to move quicker.**

Question: What is the difference between these two categories – CDS and HSS? CDS funds are less restrictive than HSS, but CDS can only be used for COVID-19. HSS follows a country cycle, and there can be delays with HSS grants due to COVID-19. The application process for the next five years of HSS is delayed. Now, at end of 2022, we see a number of countries developing applications. The HSS objective and what can be financed hasn't changed.

On the other hand, **the objective for CDS has changed. We are now moving towards integration. The donors have been very clear that the funds are for COVID-19, but integration touches on system strengthening and capacity building. When Gavi receives an application, it will look at what is already in the HSS and make sure that there is no duplication and that it is aligned. The applications that are moving forward and approved are around COVID-19, integration and system support. It is true that we incentivize countries in certain ways and countries are prioritizing CDS and not putting the time into HSS – which is an unintended effect.**

The Timor-Leste proposal was about the cost of human resources; it was sent back, as it was not in line with the CDS objectives. Proposals might end up being partly approved. It is not a free ride. There is some sensitivity about how to manage the donors, as they expect clear deliverables around COVID-19.

Question: As we move along with RI and the life course approach, we realize that we need more platforms. The traditional platforms are saturated. Under CDS, TA could be used to develop these platforms – we are looking at broader platforms. For Gavi, it would have to be part of integration.

Question: In terms of PHC integration, especially for outreach, if they decided to include growth monitoring and they need to procure equipment (e.g., scale and weighing machine), but the CDS would not support this.

The CDS is not for the expansion of PHC. It is about the integration of COVID-19 into PHC. Applications needs to be COVID-19 delivery based.

Take home message: **Boosters will need to be provided, and this needs to happen with minimal disruption to the RI programme. Hence, the integration of these activities is crucial. There are Gavi funding opportunities for this. Look at HSS proposals and previous CDS, and be ready to make your application. Do not wait for the funding windows to open. Discuss at the national level in Inter-agency Coordinating Committee meetings, and be prepared.**

Q&A: Accelerating new vaccine introduction

Question: Can TCV and COVID-19 be co-administered? Yes, but with monitoring. TCV can also be co-administered with Japanese encephalitis – it can be delivered with all vaccines in the EPI programme.

Question: WHO has always had 9–18 years as the catch up age group for HPV. However, Gavi's policy is catch up is most effective from 9–14 years (before sexual contact). With single dose, countries will need to ask Gavi for the additional doses and make the co-payment. The biggest challenge will be supply – particularly for the large multi-age cohort catch up. The vaccine that Bangladesh has chosen is not available at the moment, but may be in the future if Bangladesh wants to increase the age, but they will have to co-finance it.

Question: In Nepal, we decided on 15 months for TCV because the typhoid burden is less for younger children. At 9 months we are already giving 3 vaccines, and our coverage at 9 months and 15 months is the same, so we will not miss them if we wait to give the TCV till 15 months.

Q&A: Polio

Question: There is an urgency regarding polio due to ongoing circulating vaccine-derived poliovirus type 2 (cVDPV2) outbreaks; it is important that countries give it priority. All countries that were giving one dose of IPV should introduce a second dose of IPV, as per SAGE recommendations. Most countries that have planned to introduce a second dose of IPV have applied to Gavi for support.

Question: While integrated campaigns are preferred, we should be mindful of issues like hesitancy, such as in Aceh, Indonesia. Based on the local context, it should be determined if there will be any loss of coverage if we integrate polio outbreak response SIA with RI. In the nOPV2 campaign, we need high coverage (more than 90%).

Question: There is no compulsion for countries to use fractional IPV, either full dose IPV or fractional intradermal IPV (fIPV) can be used in 2-dose option. Bhutan is administering full dose IPV and it is fine.

Q&A: MR: 10-dose or 5-dose vial

Comment: HWs having a fear of wastage is given as the reason for not wanting to open a 10-dose vial, but it is also fear of stock out. The problem is the system. We sometimes assume the same wastage rates for all facilities, but rural facilities have higher rates.

Alternatively, we should adjust the wastage rates in rural settings so there is a lower fear of stock out. But let's not let children who come to a facility return unvaccinated.

Question: DPRK has one session per month, so would 10-dose be ok? If children are not being asked to come back later, we do not need to switch.

Q&A: MICs strategy

Question: We will start operationalizing this approach now, setting up a MICs team with in-country support. We are staffing it and recruiting a director. This will be an important precursor for Gavi 6.0 – if we do not include these countries then the sustainability of Gavi is at risk, so it will continue in 6.0. We need to be flexible when we talk about catalytic support. **Countries will need to justify how things will be sustainably financed moving forward.**

Q&A: Diversification of partners and CSO strategy

Question: There are concerns that this strategy effectively means a reduction in the space for TA. There are concerns that as long as CSOs are funded, activities will happen and results will be achieved on the ground, but once the funding dries up, this is not necessarily sustainable. There must be a system where governments are the service providers, but, at the moment, governments do not know how to accept voices from the ground. Moreover, resources for TA are being diverted to CSOs, but the government may need more resources to expand services.

Answer: The 30% for CSOs is directional. It might be that only 10% is actually given to CSOs; we are not at 30% yet. It is not about the actual percentage, but the role that these stakeholders can play in reaching the unreached. The Gavi Board decided to be explicit about this. I know UNICEF has many years of experience with working with CSOs, and we rely on partners like UNICEF to build their capacity and manage the fund flow to CSOs. Countries with the highest zero-dose receive most of the funding. If we think about vaccinating all children, we should think about all groups – **which actors have access to these communities, who can translate their voice and who knows how to overcome their barriers?** The gender barriers may be cultural or social; overcoming them will not happen in a year. In terms of sustainability, we should think about how that looks over time. We would see the

government embrace these stakeholders as part of the response. That will require advocacy. There are different strategies to address this over time. A lot of CSOs are not set up to receive funding, so we need intermediate organizations. Approaches need to be country-tailored. Our procurement system is not set up for local partner engagement. The strategy will need to find its way. We need to hear from you on what the challenges are.

Question: Where does surveillance fit into this strategy? No CSO can do surveillance.

Question: We need to involve CSOs in demand creation. The focus on service provision overlooks the need for demand. When you have funds everything goes well; when there no funds then there are no CSOs.

Question: Funding is a time bomb. In Bangladesh, CSOs always take time to start. Secondly, they do not feel comfortable to work with the government system, but create their own parallel system. Immunization in Bangladesh started with two CSOs, but after 30 years the same CSOs do not exist.

Answer: Gavi does not select CSOs. We are working in different ways; one is by using partners to do mapping. Who are the key stakeholders currently playing a role in the country? So a number of countries have worked on that. Based on comparative advantage, they will be

selected, no matter which organization (be it UNICEF, WHO, JEPIGO). We have not been able to deliver – we all have accountability. We often see UNICEF and WHO in the same place. Who is going to do what?

We need complementarity. We encourage countries to run a Request for Proposal (RFP). In certain hotspots we want to do more work. We run an RFP at the country level to see who is interested and then selected suitable CSOs. That is, by the way, the same for other actors. Single sources can be considered. We deliver on milestones. We encourage CSOs to contribute to regular coordination meetings and so forth.

In terms of the timing, we are moving to multiple approval of TA in two years, with an extension to four years. There is more predictability in the funding. I take your note on the project approach and sustainability.

But, frankly, we have not been successful in sustainability with our country partners. Why do we need a consultant to come in and do the same training again and again? There is an issue with the capacity training of our country counterparts. There is always an inevitable risk – e.g., of funding finishing. But if, for example, you manage to get fathers involved then it can be sustained over time. I see a lot of lack of sustainability anyway.

In relation to surveillance, we are struggling with this, because Gavi does not want to be seen as taking over surveillance. The opportunity I see is through the CDS funding window. Some of the TA for the funding of surveillance can be included in the third CDS window. The idea is that countries take over some of these things.

Comment: Maybe the local government could be included as a CSO; if this was included, then a lot could be done.

Comment: I get your point about some issues of concern – how we communicate community engagement. Maybe the issue is not about the type of partner, but about the structure you are using. The definition of CSO – at the country level, you have the traditional HW, then the CHW, then you have CSOs.

In Afghanistan, you have the Sudras, elders, traditional leaders and HWs. What you are talking about is not just about communication, it is about accountability and resilience. The most important thing is that the strategy you are pushing for is strengthening the structure in the community, otherwise the CSOs will come when the funding is there, but then leave when it finishes – and then there is nothing. We need to look more innovatively at how to engage the community structure in a sustainable way.

Comment: The strategy is not an independent strategy, but a complementary one. We need communities to help us reach zero dose. No one can convince me that UNICEF or WHO is better placed for this. We rely on you at the countries to help us – to identify the gaps and who is out there. This is not competitive, but complementary. In some countries, maybe it is the local government that can reach communities, and there is not much space for CSOs; in other countries there is a lot of space. The aim is to achieve the zero-dose agenda.

Question: There has been a lot of discussion on how to work with non-traditional ministries. It would make sense to see how other line ministries are engaged.

Question: The entry point is who we are serving – that child and their family. As I said, the 30% TCA is directional. It is something we are striving for across the whole – in Africa we already have 30%. In the Stans (Tajikistan etc.), it is a lot more difficult. It might mean that we are looking at 5% there, especially EAF. We encourage you to play a role in this and see this develop over time. There is learning and risks – we will figure it out. Your TCA plan will not be returned if you don't meet the 30%.

Q&A: FPP

Answer: The normal cycle for a HSS grant is five years. We would expect a country to start the FPP process a year ahead. Each country has the right to a one-year no-cost extension (six years for HSS grant). Sit with your Gavi senior country manager (SCM) and make sure that you have a plan. When is your funding ending and when will the next payment/first disbursement take place so there is no gap? If Bangladesh is looking at FPP in 2024, then now is time to start planning. The sooner we as a team (you and the SCM) plan together the better. Don't take short cuts on the preparation.

A week from now, the Gavi Board will make its decision on the extension of accelerated transition from five years to eight years. What that implies is that we would like to see governments engaged in transition periods to take more ownership of the costs of the programme. There are a couple of things going on. We are looking more at what are human resource costs and what are human resource-related costs (per diems, etc.). Under the EAF, Bangladesh cannot apply for human resources-related costs. So what is now being questioned is operational costs for vaccines. The Independent Review Committee (IRC) thought that there was a lot wrong with the budgets – there will be an attempt to bring more flexibility, but there needs to be better justification that activities are needed to reach the last child. It is a space we are discussing. With the three-year extension,

there will be more funding and more TA. Budgets with human resources costs will not be accepted – these need to be funded by the government. We will try to create clarity on what we will fund and what we will not fund. We cannot see a country like Bangladesh come in with a budget that at least half of should be funded by the government.

Q&A: Coordinated support – Panel discussion

Question: Have you encountered any challenges in implementing these interventions?

IFRC: One challenge is that national Red Cross societies are auxiliary to the government. However, IFRC faces relative isolation from national level programming and is only engaged when there is an urgency to fill a gap and during emergencies. There is a lack of orientation. IFRC can build on the existing relationships that it has; there are opportunities to work together beyond emergencies. However, ad hoc partnerships are not sustainable. The challenge is to sustain CSOs when donor support is withdrawn. The network that IFRC works with has a large volunteer base, which reduces costs and has good reach into communities. If you want to reach the last mile, we need to identify the partners on the ground.

Question: Do you have a suggestion?

IFRC: The answer is long-term engagement, beyond emergencies. IFRC is often the first responder. IFRC participates in global discussions, and there is a lot of commitment at that level. The question is: How can that commitment be mobilized at the country level? How can we sit together to exchange knowledge? Do we have to establish new partnerships or should we review what we have?

Bill and Melinda Gates Foundation: Engagement with all the immunization partners and governments to offset challenges – that is where the role of the countries, RWG, and UN agencies is.

US CDC: One challenge facing the CDC is lack of staff in the region. Another is that it is currently in the process of setting priority countries, so it is difficult to start projects.

Question: What are the new initiatives you are planning to support the immunization agenda?

Bill and Melinda Gates Foundation: The Foundation works across the various sectors in India. It plans to support the zero-dose agenda, consolidating gains and reaching out to the government, as well as the supporting the roll out of HPV, strengthening surveillance, and ensuring engagement of in country institutes in monitoring. In relation to the zero-dose agenda, the Foundation has investments in Bihar and Uttar Pradesh – its direct partners are working with WHO and the government. The Foundation is involved in subnational discussions on the Gavi proposal. It is involved in two specific aspects of the zero-dose agenda: newborns and identifying zero-dose children. The Foundation is also working on gender and vaccine demand. In relation to the identification of CSOs, the Foundation is working on a landscaping exercise.

US CDC: New areas for support include consequential geographies where viruses are being exported from and to places within the country. The CDC is looking at targeted support for countries like Timor-Leste and how to support integrated approaches, as well as how to support data management and information systems – all of which will be done through coordinated work with partners.

IFRC: Under its Agenda for Renewal 2030, IFRC has several flagship programmes: One is pandemic preparedness and response (outbreaks, surveillance), and IFRC is mobilized to deliver vaccines. It is not only about health, but bringing other perspectives to health. IFRC is directly engaged in vaccine administration, if mandated by the government (like in Pakistan), as well as in other sectors, such as WASH. IFRC is looking at community-based WASH interventions and how they can contribute to the reduction of epidemics.

Question: How do you see better coordination among the partners (country, regional and global levels)?

IFRC: We should not wait for another regional meeting to happen. The network is already there. If we are talking in terms of advocacy for immunization and reaching zero-dose, UNICEF has a greater voice with the government and the advantage of being a partner that is well established in immunization agenda. The question is: How to use the comparative advantage of other partners and how can these be used to reach the under vaccinated? As auxiliaries, IFRC can bring in some niche and comparative advantages.

Bill and Melinda Gates Foundation: Coordination is important. Different structures are set up in India at the district, state and national levels. Although the government is the driver, the partners also have an important role to play. In India, a very comprehensive governance mechanism has been established from the national level down. We need to be clear about what the expectations are and where the Foundation can provide support. The onus is on the Foundation to give space and bring in other partners that might have a comparative advantage. There is a focus on vaccine demand – the government played the role of managing expectations and the partners complemented that. The Gavi proposal came out well, possibly because of the role of the government. We all have the same goals, which makes coordination easier. For the immunization programme, we need to be more targeted, which requires more coordination.

ANNEX 2: Participants

Name	Designation and office address
Bangladesh	
Dr Chiranjit Das	National Professional Officer, WHO, Bangladesh
Dr Riad Mahmud	Health Specialist, UNICEF, Bangladesh
Zahid Hassan	Health Officer, UNICEF, Bangladesh

Bhutan	
Anshu Kumar	Cold Chain Specialist, UNICEF Bhutan
Chandrala Mongar	Health Officer, UNICEF Bhutan
Sonam Wangdi	National Professional officer,WHO Bhutan

DPR Korea	
Dr. Kim Kwang Jin (virtual participation)	Consultant
Dr Asha Pun	Chief of Health, UNICEF DPRK
Zahid Hassan	Health Officer, UNICEF, Bangladesh

India	
Dr. Puttaraju A K Jetty	National Professional Officer, Immunization, WHO, India
Ranganai Matema	Immunisation Specialist, UNICEF India
Mainak Chatterjee	Health Specialist, UNICEF, India

Myanmar	
Dr Khaing Khaing Gyi	National Professional Officer (Immunization & Surveillance), WHO, WHO Myanmar
Nang Mya New Tra Tun	Health Specialist, UNICEF, Myanmar

Name	Designation and office address
Nepal	
Dr. Vinod Bura	Team Lead, IPD, WHO Nepal,
Dr. Rahul Pradhan	National Professional Officer, Immunization, WHO, Nepal
Budhi Setiawan	Chief of Health, UNICEF Nepal
Pradeep Shrestha	Health Officer, UNICEF Nepal
Tariku Berhanu	Immunisation Specialist, UNICEF Nepal
Haruko Yokote	Health Officer, UNICEF Nepal

Sri Lanka	
Dr Preshila Samaraweera (virtual)	National Consultant – Communicable Disease Control. Sri Lanka
Dharmica Rowel	Health and Nutrition Officer, UNICEF, Sri Lanka

Timor Leste	
Dr. Sudath Peiris	Technical officer- EPI , WHO Timor Leste
Shyam Sharan Pathak	Health Manager, UNICEF, Timor Leste

Thailand	
Khin Devi Aung	Regional Health Specialist, UNICEF EAPRO,
Nattha Tritasavit	Immunization Consultant, UNICEF EAPRO,

Name	Designation and office address
GAVI	
Dr. Colette Selman	Director, Core Countries team, GAVI

WHO HQ	
Dr. Samir Sodha	Medical Officer (Immunization Strengthening), WHO HQ
Dr. Fina Hikayati Tams	Technical Officer, Integration, EPI Unit, WHO HQ,

WHO SEARO	
DR. Jayantha Liyanage	Regional Adviser- Immunization Systems Strengthening, WHO SEARO
Dr. Pankaj Bhatnagar	Technical Officer, Health Systems Strengthening for Immunization, Immunization and Vaccine Development, WHO SEARO

Gates Foundation	
Dr. Gunjan Taneja	Programme Officer, Vaccine Delivery, Bill & Melinda Gates Foundation

IFRC	
Dr Sushma Bhusal	Regional Emergency Health Coordinator, International Federation of the Red Cross and Red Crescent Societies(IFRC)

Name	Designation and office address
UNICEF New York, HQ	
Anisur Rahman Siddique	Seniro Advisor C&E, UBICEF HQ
Dr. Ahmandu Yakubu	Senior Advisor Health C&E, UNICEF HQ,

CDC	
Morales, Michelle (CDC/DDPHSIS/CGH/GID)	US CDC
Sonalini Khetrupal Khetrupal	Asia Development Bank

UNICEF ROSA	
Eliane Luthi	Regional Chief of Communication, UNICEF ROSA
Rene Ehounou Ekpini	Regional Health Advisor, UNICEF ROSA
Gunter Boussery	Regional senior health specialist, UNICEF ROSA
Azhar Abid Raza	Regional Immunisation Specialist, UNICEF ROSA
Hilary Adams	Regional Health Specialist, UNICEF ROSA
Lalita Gurung	Programme Associate, UNICEF ROSA