

# Gavi's Zero-Dose Learning Hub IRMMA Aligned Interventions: October 2023 Semiannual Update

## Mali

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### **Gavi Zero-Dose Learning Hub (ZDLH)**

Funded by [Gavi](#), the Zero-Dose Learning Hub (ZDLH) serves as the global learning partner and is led by [JSI Research & Training Institute, Inc.](#) (JSI) with two consortium partners, [The Geneva Learning Foundation](#) (TGLF) and the [International Institute of Health Management Research](#) (IIHMR). Together, the consortium enables sharing and learning across four Country Learning Hubs (CLHs) in Bangladesh, Mali, Nigeria, and Uganda to advance the uptake of evidence by synthesizing and disseminating key learnings. The ZDLH also focuses on improving immunization equity and reducing the number of zero-dose (ZD) and under-immunized children globally by facilitating high-quality evidence generation and uptake.

### **Recommended Citation**

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### **Acknowledgments**

1. **Bangladesh Country Learning Hub:** Led by the International Center for Diarrhoeal Disease Research, Bangladesh (icddr,b) with partners Jhpiego and RedOrange Communications.
2. **Mali Country Learning Hub:** Led by GaneshAID with the Center for Vaccine Development-Mali (CDV-Mali).
3. **Uganda Country Learning Hub:** Led by Infectious Diseases Research Collaboration (IDRC) with partners PATH and Makerere University School of Public Health (MakSPH).
4. **Nigeria Country Learning Hub:** Led by the African Field Epidemiology Network (AFENET) with the African Health Budget Network (AHBN).

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## INTRODUCTION

The Zero-Dose Learning Hub (ZDLH) mechanism is rapidly underway to improve how data and evidence are used to successfully identify and reach the millions of children who have not yet received a single routine vaccine shot, known as “zero-dose” (ZD) children, and the missed communities in which they live. This ZDLH semiannual update informs Gavi, the Vaccine Alliance Board (Gavi Board) and other stakeholders about the mechanism’s work to use evidence to better understand the factors influencing implementation and performance of approaches to identify and reach ZD and under-immunized (UI) children and missed communities.

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## BACKGROUND AND COUNTRY SELECTION

The ZDLH helps generate, synthesize, and share ZD data and evidence at both the global and country levels. The structure is a hub-and-spoke model, where learning and evidence at the global level is managed by a global learning partner, and four country learning hubs (CLHs) (in Bangladesh, Mali, Nigeria, and Uganda) comprised of local partners/consortiums work that capture and use county-level programmatic data and evidence that contribute to performance reporting to the Gavi Board and other key stakeholders. The CLHs are implemented with the support of local organizations that have strong capacity to generate evidence, convene local stakeholders, and understand the national context and policies. They deploy resources to augment monitoring with implementation research (IR), along with other data collection activities. The CLHs are motivated to explore why children and communities are systematically missed and to evaluate effective practices to identify and reach those children. Each country is focused on targeted subnational geographies and will produce timely evidence on what is working, what is not working, what it takes to implement the approaches, and how processes can improve the use of evidence generated to ultimately inform future outreach strategies to better reach ZD children.

In the [Gavi 5.0 Strategy](#), the Alliance moved to a more targeted, differentiated, and systematic approach to programming to reach ZD and under-immunized (UI) children. The Alliance recognized the lack of complete answers on how to reach communities that have been systematically missed for generations, including those in complex country contexts, such as urban areas, remote communities, and populations in conflict settings. In 2020, the CLH approach was proposed to the Programme and Policy Committee (PPC) and the Gavi [Board](#) as an initiative to address the knowledge gaps. To this end, the CLHs were established to generate, synthesize, and share data and programmatic learnings at both the country and global levels across the IRMMA (Identify – Reach – Monitor – Measure – Advocate) Framework and to provide data to complement Gavi’s implementation monitoring approach. This approach includes a cross-cutting focus on gender equity, focusing on targeted subnational settings with high numbers or proportions of ZD children and across a diversity of settings, including rural, urban, conflict, and refugee settings.

Findings and learning generated through the CLHs will help identify: (1) effective strategies and approaches that should continue for ZD measurement and programming, (2) which strategies and approaches should be scaled up, and (3) what strategies and approaches are not effective and should be discontinued. Each CLH consists of local partners focused on three key objectives:

1. Generate and synthesize learnings based on the barriers to reach ZD children and apply these learnings to program planning and tailoring equitable approaches.
2. Strengthen the evidence base of effective approaches to identify and reach ZD children.
3. Improve metrics, measures, and methods to access and use data on a regular basis to improve outreach to ZD children and missed communities.

## LEARNING HUB PROVIDERS AND AWARD DATES

In addition to the four CLHs, the ZDLH mechanism includes a global consortium led by JSI Research & Training Institute, Inc. (JSI), in partnership with the International Institute of Health Management Research, New Delhi (IIHMR) and The Geneva Learning Foundation (TGLF) (see Figure 1). The global consortium provides technical and operational support to the CLHs and disseminates learnings at the community, regional, national, and global levels.

Figure 1. Timeline of Global and CLH Awards



The four CLHs include:

1. [Bangladesh](#): Led by the International Center for Diarrhoeal Disease Research, Bangladesh (icddr,b) with partners Jhpiego and RedOrange Communications.
2. Mali: Led by GaneshAID with the Center for Vaccine Development-Mali (CDV-Mali).
3. Uganda: Led by Infectious Diseases Research Collaboration (IDRC) with partners PATH and Makerere University School of Public Health (MakSPH).
4. Nigeria: Led by the African Field Epidemiology Network (AFENET) with the African Health Budget Network (AHBN).

The CLH countries were selected to ensure variation by region and context, including rural, urban, conflict, or refugee, and based on a relatively high number and proportion of ZD children. Other considerations included feasibility and risk mitigation. Table 1 illustrates different coverage estimates of the first dose of the Diphtheria-Tetanus-Pertussis vaccine (DTP1) and numbers of ZD children in the four CLH countries in 2022. The table highlights how estimates of ZD children can vary based on the data source due to a variety of reasons, including data quality and survey frequency (for estimates such as World Health Organization [WHO]/United Nations Children’s Fund [UNICEF] Estimates of National Immunization Coverage (WUENIC) that combine survey and administrative data).

Table 1. Comparison of Different Estimates of DTP1 Coverage (2022) in Children 12-23 Months of Age in Gavi CLHs

	Bangladesh	Mali	Nigeria	Uganda
Percent of DTP1 coverage (Administrative data 2022)	122	107	91	94
Percent of DTP1 coverage (Official estimate 2022)	n/a	78	70	94
Percent of DTP1 coverage (WUENIC 2022)	99	82	70	94
Estimated Number of ZD children in 2021 (WUENIC 2022)	29,405	160,626	2,271,265	100,096

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## CURRENT AND UPCOMING ACTIVITIES

Currently, the CLHs are conducting a rapid assessment of data and interventions across the IRMMA Framework in their subnational targeted areas; engaging stakeholders; defining learning agendas; conducting data systems assessments; and designing IR studies. Through their planned research and programming activities, the CLHs will also provide insights into the use of the behavioral and social drivers (BeSD) tools, costing of programs to reach ZD children, and ways to improve data systems for monitoring and measurement.

In March 2023, the ZDLH online platform launched to orient visitors to the purpose of the ZDLH, raise awareness of the IRMMA Framework, and connect to the ZD Community of Practice (CoP). A press release featured the website along with the formal announcement of the ZDLH and four CLH awards. The website includes a robust resource library featuring tools and materials to support ZD practitioners. The ZDLH resource repository already includes more than 40 resources, such as the ZDLH's recently published Typhoid Conjugate Vaccine (TCV) case study, Bangladesh and Mali Country Landscapes, and FHI 360's Pro-Equity Evidence Map. New resources will continue to be added, and the new website will work to serve ZD practitioners by acting as a global resource to increase access to key tools, learning, and evidence generation aligned with the IRMMA Framework.

In May 2023, the ZDLH hosted its first inter-country learning exchange, (ZDLH-X1), which featured Bangladesh and Mali and engaged nearly 2,000 immunization practitioners, primarily from the district- and facility-levels and directly involved in ZD work. Topics included identifying ZD and missed communities in Chattogram City in Bangladesh, and community engagement in urban and rural remote areas, and in areas of insecurity.

Insights and learning exchanges from the ZDLH-X1 session focused on rapid convenience monitoring, microplanning, gender-related barriers and ensuring equity, and community ownership. Engagement with frontline staff through peer learning is powerful and can identify 'what works' and 'how' at the local levels and strengthen approaches for knowledge translation and evidence use. Progress on the second ZDLH-X event, ZDLH-X2, featuring CLHs in Uganda and Nigeria, will be included in the next semiannual update.

In June 2023, a [ZDLH launch meeting](#) held in Kampala, Uganda convened stakeholders from Gavi; the JSI-led global ZDLH consortium; CLH providers from Bangladesh, Mali, Nigeria, and Uganda; and the Uganda Ministry of Health (MOH) to increase alignment across the initiative and operationalize the peer-to-peer support component of the CLH model. The meeting focused on establishing common measures, strengthening existing monitoring systems, and tailoring program activities based on country-specific contexts. Key outputs included:

- Coordination with the JSI Monitoring, Evaluation, and Learning (MEL) team to convene ongoing meetings to harmonize; ensure alignment with the IRMMA Framework; and finalize country-level theories of change, monitoring and learning (M&L) plans, and measurements in line with the GAVI 5.0 Strategy and learning questions.
- Agreement that the birth cohorts for the rapid assessment across the four CLH countries consisted of 18 weeks to 23 months (as adopted by the Bangladesh CLH), and provided a grace

period of four weeks following expected uptake of the third dose of the Diphtheria-Tetanus-Pertussis (DTP3) vaccine.

- Establishment of a knowledge management system to support collaboration across the global consortium and CLHs and disseminate contextualized country-specific information. The attendees also determined next steps to contribute evidence to capture, synthesize, and disseminate learning through a gender- and equity-focused lens.

In 2024 and 2025, initiative activities will yield insights into progress in implementing ZD strategies through strengthened and more timely monitoring data, IR, and additional learning activities. Evidence use will be facilitated through a clear understanding of the review fora and timing, and targeted knowledge translation activities that include subnational staff, who are a recognized sources of local expertise and end-of-chain implementers who test evidence validity and applicability, alongside national partners. Critical users include partners developing Gavi funding applications, such as Full Portfolio Planning (FPP) and Equity Accelerator Funding (EAF), or justifying funding reallocation and annual performance review activities, including joint appraisals (JAs).



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## IMPROVED TIMELY MONITORING

Part of the ZDLH scope of work is to provide more timely monitoring data at the global level on key indicators (e.g., the number of children vaccinated with DTP1, DTP1 coverage rates, and dropout from DTP1 to DTP3) from the targeted subnational level in the CLH countries. Bringing this data forward is intended to provide more timely insight about progress in reaching ZD children. This information, combined with other learning about the interventions and the intensity of their implementation, will help global stakeholders understand what works and how to reach those children at risk of ZD or under immunization. WUENIC and country official estimates of the key indicators noted above are available in July of the following year. While the estimates are generally accepted to be more accurate because of how they are estimated, they are not timely, may not provide enough disaggregation to identify where pockets of ZD children are located, and do not provide information about what policies and program are driving change. Disaggregating data on key indicators by subnational level can help with some of this interpretation if one has information about the context and intensity of implementation of interventions, although disaggregated subnational data is not usually widely available at the global level except through occasional surveys or modeling.

To improve timely monitoring, the CLHs rely on routinely collected administrative data, such as data available through the District Health Information Software 2 (DHIS2), which are available on a more regular basis and at subnational levels in countries. But those data often suffer from poor data quality as indicated by coverage rates greater than 100 percent. The reasons for poor data quality are often due to inaccurate denominators, for example, estimating the number of surviving infants in a geographic area. Additionally, there could be inaccuracies with the numerator caused by the incorrect recording of immunization doses administered, which may be caused by several reasons, including the lack of data recording tools or human error. Moreover, data can fluctuate widely from month to month based on both supply- and demand-side factors such as vaccine stock outs, holidays, poor weather, health worker strikes, etc. Regular review of these data by health workers familiar with the context can reveal what those factors may be so they can propose and implement remedies. Nevertheless, at the global or even national level, all of these factors challenge our ability to interpret routinely collected data to understand the effect of interventions designed to identify and reach ZD children.

CLHs will be regularly reviewing and reporting administrative data for their targeted subnational areas (e.g., upazila in Bangladesh, Local Government Area [LGA] in Nigeria, and district in Uganda and Mali) which will allow us to examine subnational progress every six months and dive into the issues and root causes of important trends. Given the limitations noted above, the CLHs are taking the following steps: CLHs will provide administrative data for analysis of six-month trends, comparison of trends over time, and comparison against previous years' trends. Data available on other variables, such as stock outs and number of immunization sessions planned versus conducted, can provide some insight on the corresponding dips or peaks in immunization coverage. CLH activities such as systems assessments, activity implementation monitoring, and data reviews can help improve interpretation of trends, but also improve the availability and quality of ZD-relevant data over time. Information pulled from system assessments can also help determine actionable steps for addressing gaps in monitoring and measuring ZD and improve data quality. Therefore, a key benefit of the CLHs is not only the availability of more granular monitoring data, but also the analysis, interpretation, and use of the data for action at both the local and global levels, plus improvements in data quality and reliability in CLH study areas.

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# OVERVIEW OF THE MEASUREMENT AND LEARNING PLAN

The vision of success for the CLHs is reflected in the measurement and learning (M&L) plans at the global level (ZDLH) and with each CLH, and includes monitoring performance to describe successes and challenges of the model and approach. The ZDLH mechanism is working toward the outcome of timely, increased, and sustainable use of evidence to improve global, regional, and country immunization programs and policies in alignment with the Gavi 5.0 Strategy and IRMMA Framework.

M&L plan outputs include:

- CLHs have strong networks, technical expertise, and practices
- Cross-country evidence generated
- Evidence and learning available and accessible to identify and track ZD children and missed communities through a gender and immunization equity lens
- Project-generated evidence and learnings translated for use in local policy and programming
- Learnings around ZD barriers and effective interventions communicated globally to partners, stakeholders, and immunization practitioners

As mentioned above, the four CLHs came onboard at different times and are in different stages of implementation, which affects the depth of reporting for each CLH in this update. Nevertheless, several common findings are emerging across the four CLHs that merit follow-up in the second year of the initiative:

- There is a lack of demand-side insights based on validated instruments such as the BeSD tools in all CLH countries, particularly at the subnational level where insights are needed for specific geographic and sociodemographic contexts. The CLHs are responding to this gap by incorporating guidance and indicators from the BeSD tools in their planned research to understand reasons for low vaccination uptake and to inform planning priorities and intervention design.
- In all CLH countries, triangulation of existing data and identification of ZD children relies primarily on administrative data. The CLH data system landscapes and diagnoses currently underway are revealing similar results of data quality issues with numerators and denominators, and yet this is the main source of monitoring data going forward.
- While stakeholder engagement models are different in each CLH, they all recognize the importance of partner engagement at national and subnational levels and the need to engage frequently to influence policy decisions.
- The IR component in all CLHs is dependent on government and/or Gavi funding for the targeted interventions. The timing and scope of funding is outside the control of the CLHs, which is a risk worth noting.

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# COUNTRY-SPECIFIC CONTEXT

## MALI

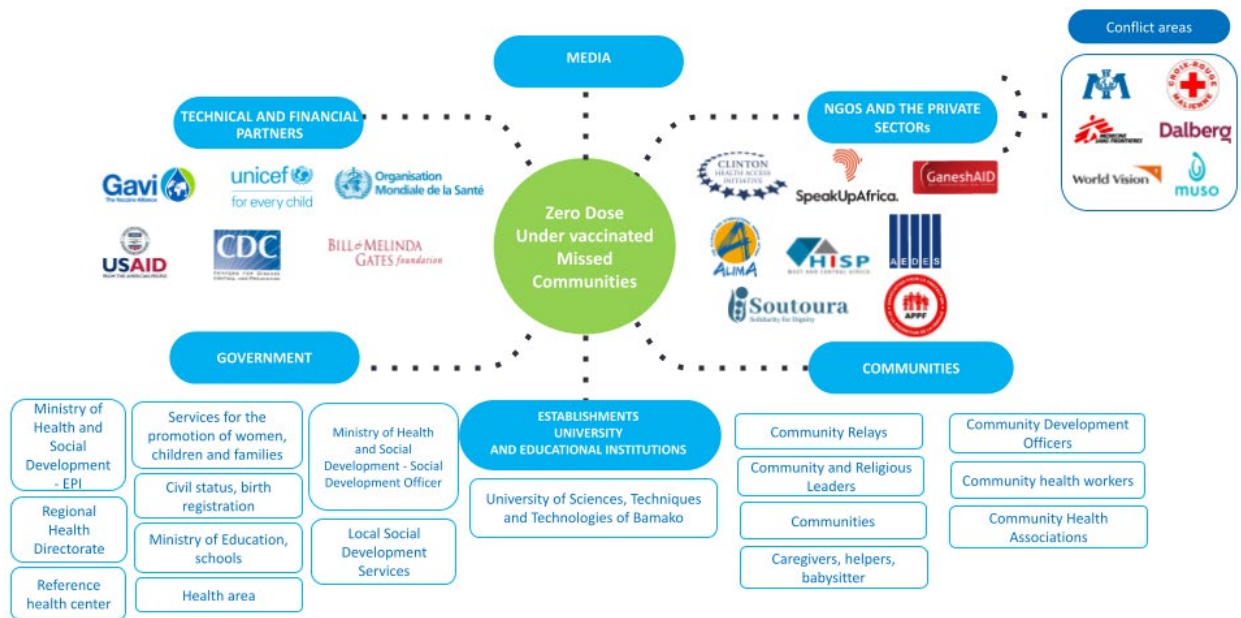
### Context

Mali was designated as a fragile country by Gavi in 2021 and received over \$81 million of Gavi vaccine investments. The current estimated number of zero-dose (ZD) children in Mali is 157,055 (World Health Organization [WHO]/United Nations Children’s Fund [UNICEF] Estimates of National Immunization Coverage [WUENIC] 2021) with a corresponding proportion of 18 percent. The proportion of Diphtheria-Tetanus-Pertussis (DTP1) national coverage was 82 percent based on WUENIC estimates in 2021, though the country’s administrative data estimated DTP1 coverage from the same period at above 100 percent, indicating a likely error in the documentation of the number of children receiving the Penta 1 vaccine or in the estimates of the total number of children. The country, overall, has low vaccination coverage with high numbers of ZD children scattered throughout several provinces in the center and south of the country (e.g. Mopti and Koulikoro). Additional information about the context and a comparison of ZD estimates can be found on the Zero Dose Learning Hub (ZDLH) website in the [Mali Zero-Dose Landscape](#), developed by the ZDLH.

### Accomplishments

During this reporting period, a key highlight of the Mali Country Learning Hub/Centre d’Apprentissage pour l’Equité en Vaccination (CAPEV) activities is partner engagement. A collaborative intelligence approach is currently underway after the design, preparation, and validation of the primary documents during this period, including: a mandate for collaborative intelligence, a learning program, and a partner engagement plan. The collaborative intelligence platform is a mechanism to engage national stakeholders in the design, adoption, implementation, and monitoring of the ZD program in Mali. The Mali CLH is currently completing the final version of the platform interface by integrating the CAPEV and Coach2PEV collaborative platforms and adopting a user-centered design approach. Exchanges are underway with the University of Science, Technology Techniques, and Technology of Bamako (USTTB), on the future collaboration in implementation research (IR), and a Memorandum of Understanding is being signed by both parties and included in the CLH Engagement Plan. Figure 4 shows the constellation of partners in the ZD ecosystem in Mali.

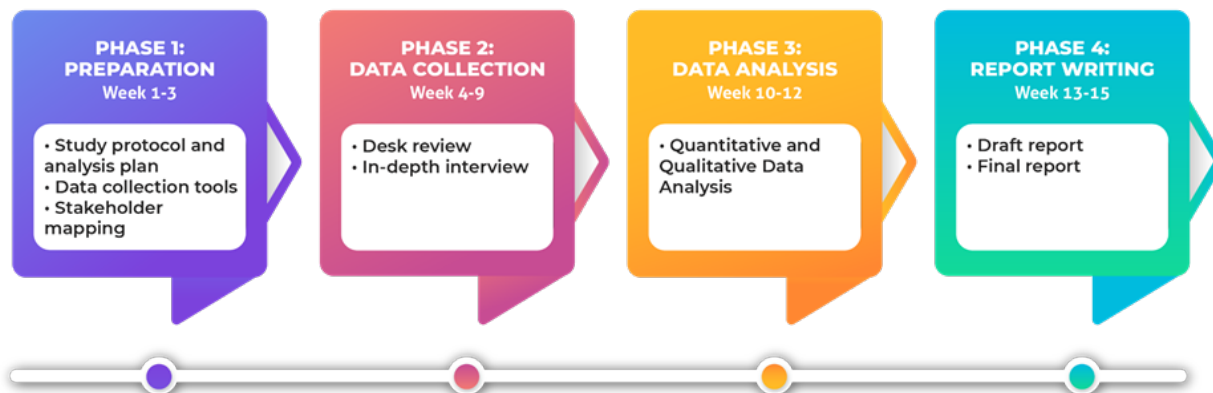
Figure 2. ZD Ecosystem in Mali



It is important to note that GaneshAID has also facilitated the recent full portfolio planning (FPP) process in Mali and supported addressing questions from the Gavi IRMMA Framework, including reviewing existing data and considering to what extent the rapid assessment could be based on these results. The desk review has already been conducted by GaneshAID in support of the recent FPP which enabled CAPEV to collect secondary data on the situation of ZD in Mali, and to assess demand- and gender-related barriers to vaccination. The CLH envisions possible learning products to be developed based on the Mali IRMMA Framework data and additional data from the rapid assessment. Building on GaneshAID’s work to support the recent FPP process, CAPEV will focus on answering selected questions from the FPP learning agenda that can be answered through IR in its target areas. Participatory approaches will be used to get stakeholder input and refine the selected questions. The overarching draft learning agenda is in process.

Development of the research protocol for the rapid assessment (see Figure 5) began with a virtual design workshop with members of the Mali FPP team. Using Mural, a virtual platform for brainstorming and notetaking, workshop participants identified important information for developing the protocol, including data sources for key indicators, barriers to reaching ZD children, evaluation of the administrative data system, and content of data collection tools. The protocol specifies the research questions, methods of data review, and quantitative and qualitative assessment approaches. The report of the rapid assessment design workshop was shared with national actors.

Figure 3. Key Phases of the CAPEV Rapid Assessment Process



During this reporting period, The Geneva Learning Foundation (TGLF), a member of the ZDLH global consortium, organized the first Zero-Dose Learning Hub Experience Sharing (ZDLH-X) event featuring Mali and Bangladesh. GaneshAID team members joined this event as participants and connectors between TGLF and the Mali EPI director. During the event, the CLH listened to stories from Malian health professionals to understand the current challenges they are facing to reach ZD and missed communities, and what they have done to overcome these challenges. The report of the event was shared with stakeholders during a CAPEV workshop on the validation of the rapid assessment protocol.

### Learning and Results

Lessons learned to date are primarily related to key ZD interventions proposed by stakeholders to overcome demand-side barriers:

- Systematic mapping of ZD and under-immunized (UI) children: each month, the data quality group makes it possible to identify the zones of concentration of ZD by studying administrative data by reviewing the monthly vaccination bulletin.
  - **Lessons learned** for the new health system strengthening (HSS)/targeted country assistance (TCA) grants (in the FPP): The health districts will map ZD children from the tally registers (village by village, fraction by fraction) and the data quality review will be continued.
- Partnerships between health establishments and the community are required for a more equitable delivery of immunization services, grounded in an accountability framework. The partnership and leadership in promoting regular immunization were strengthened through the signing of accountability frameworks on action plans for strengthening the EPI in priority districts. It has been possible to strengthen communication and restore community confidence in immunization services due to the implementation of the EPI communication plan, developed within the context of COVID-19, at the central level and at the regional and district level, as well as the regular organization of educational talks and home visits. A national strategic communication plan and 11 integrated communication plans were developed, but their implementation was not possible due to financial reasons.

- **Lessons learned** for the new HSS/TCA: This partnership is insufficiently used and needs to be reactivated as part of monitoring the performance of the EPI.
- Geospatial analysis to improve health service delivery and target ZD communities is underutilized.
  - **Lessons learned** for the new HSS/TCA: United Nations High Commissioner for Refugees (UNHCR) analyzes the geospatial distribution of conflicts and insecurities affecting the lives of populations: clashes between armed groups, military operations, inter- and intra-community clashes, and destruction of infrastructure. As part of the vaccination strategy in conflict zones, Mali could get closer to UNHCR to use the data needed to strengthen service delivery and better identify ZD and UI children in vulnerable and mobile populations.
- Mobilization of non-traditional immunization stakeholders (including private sector, civil society organizations, and community organizations) to support RI activities: Security Sector Reform/Réforme du Secteur de la Sécurité (RSS) supports 735 community health workers (CHWs) in 12 districts. Technical support is provided by the Non-Governmental Organization (NGO) Musso with funding from the Global Fund in 2022, in particular for the implementation of training and the community digitalization strategy: the total number of CHWs is 3,345 in 11 regions and 71 districts, funded by seven donors, 80 percent of which comes from the Global Fund and Gavi.
  - **Lessons learned** for the new HSS: Support the CHWs in the new areas targeted by RSS and EAF. Their involvement in vaccination and the identification and reach of ZD children in the targeted areas should be specified.
- Strengthening integrated primary health care and vaccination services in conflict and fragile situations through the mobile clinic approach in the northern regions.
  - **Lessons learned** for the new HSS: There are synergies to be developed across World Vision International’s humanitarian and food security/nutrition-oriented projects in Mali, in particular: cash transfer actions in displaced people camps (IDP camps) (30 percent for the displaced and 70 percent for host communities) and the importance of coupling vaccination activities with food distributions.
- Consideration of gender-related obstacles: the urban strategy reinforces the participation of men in vaccination activities and the adaptation of the schedules of vaccination services to the needs of women to eliminate gender-related obstacles.
  - **Lessons learned** for the new HSS: The development of a gender strategy within the framework of Programme de Développement Socio-Sanitaire (PRODESS) will enable staff capacity building on gender issues and the adaptation of vaccination services by involving community representatives in the planning, implementation, and monitoring of immunization activities.
- Improving the availability of vaccination services through the establishment and pursuit of vaccination strategies tailored to the context of each region and each district.
  - **Lessons learned** for the new HSS: The importance of involving community relays and community health workers to search for ZD and missed children.

- The implementation of the urban strategy in the district of Bamako with daily vaccination sessions, including weekends, as well as advanced strategy vaccination sessions targeted at hard-to-reach communities, including sites for IDPs.
  - **Lessons learned** for the new HSS: The extension of the urban strategy and the intensification of the forward and mobile strategies are taken into account in the FPP/EAF.
- Humanitarian organizations are called upon (International Medical Corps [IMC], the Alliance for International Medical Action [ALIMA]), in particular, for the delivery of vaccines by plane.
  - **Lessons learned** for the new HSS: The vaccination strategy in conflict zones is taken into account in the FPP/EAF because 22 prioritized districts are in the conflict zones of Mali.

### Evidence Use

With the support of various partners, the country set up a District Health Information Software 2 (DHIS2)-centered Health Management Information System (HMIS) several years ago. Considerable efforts are undertaken routinely to keep the system up-to-date. However, data reported with multiple quarter lags and many inconsistencies (for example, leading to a negative number of ZD children), there is still a need to strengthen the reporting system because the culture of effective and systematic data and evidence use is still weak and partner-led in Mali. Collaborative routine activities for planning, implementation, and overall programmatic decision making in a participative way will help foster and sustain a culture of partnership and collaboration.

### Challenges

Key challenges faced this quarter are related to the linguistic barriers that require the translation into French of the various technical resources for the appropriation of local actors, as well as delays in the planning caused by a conflict of agendas between the different stakeholders. As an approach to solve this problem, a Collaborative Intelligence Platform is in development by GaneshAID to facilitate coordination among immunization stakeholders.

### Data on Key Indicators

Administrative data in Table 7 below are summarized for four districts selected for the CLH rapid assessment (Kayes, Bourem, Commune III, and Segou) and the 44 Gavi targeted districts for the period April-June, 2023.

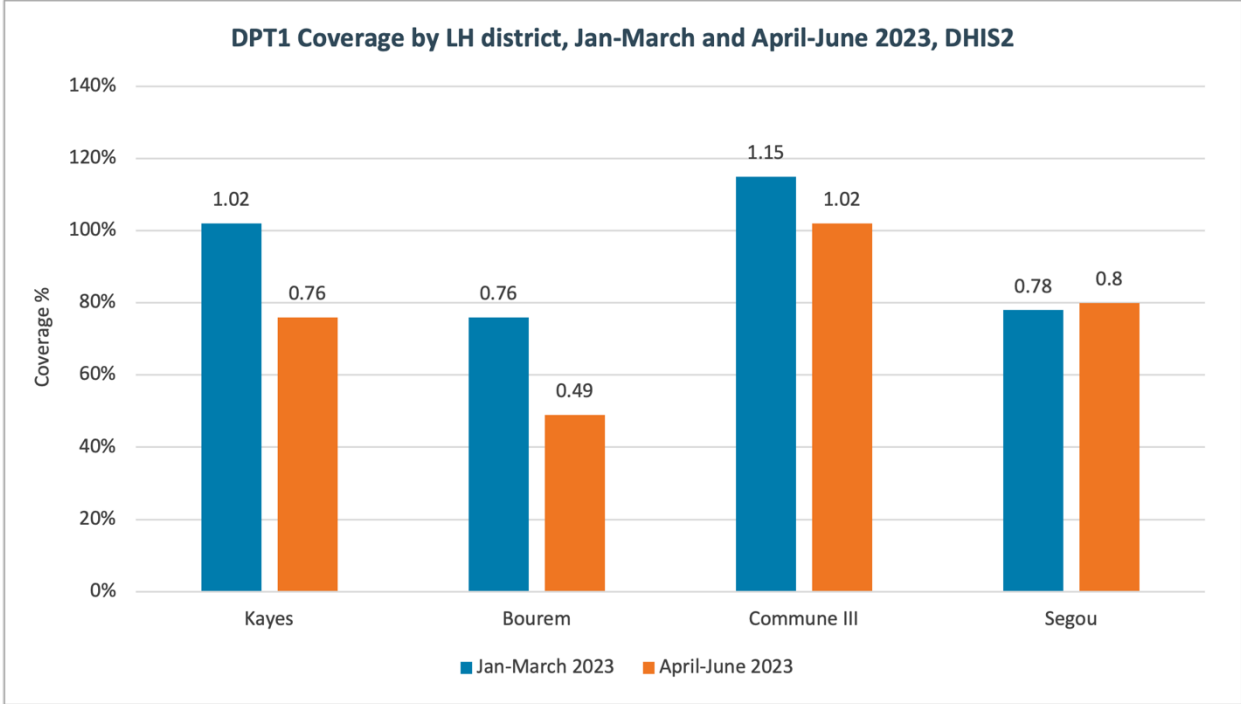
Table 2. Administrative Data Aggregated for Mali CLH and Gavi Target Districts for the Period of April-June, 2023

Indicator	CLH Target Districts April-June 2023	Forty-Four Gavi Target Districts April-June 2023
Number Of Children Vaccinated With DTP1	14,538	170,944
Coverage of DTP1	76.75%	96.0%

Dropout DTP1-DTP3	9.25%	13.99%
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Figure 6 compares DTP1 coverage rates from January-March 2023 and April-June 2023 in the four Mali CLH target districts based on data from the DHIS2. Data on dropout from DT1 to DTP3 and DTP1 to last measles are available for the same districts and timeframe, but not shown here. Data on other Gavi indicators are not available yet, but will be reported in future updates.

Figure 4. Comparison of DTP1 Coverage from January-March and April-June, 2023 by CLH District in Mali



The figure above shows variation in DTP1 coverage across the four CLH districts, with over 100 percent reported in Commune III district in both periods and in Kayes district in the first quarter. Such overreporting indicates potential issues with the quality of the administrative data and/or inconsistency of vaccination service provision. It is noteworthy that coverage has dropped substantially in both Kayes and Bourem districts from the first to second quarter, but the reasons for this require deeper investigation.



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