

Zero-Dose Learning Week pre-event webinar (part 2)

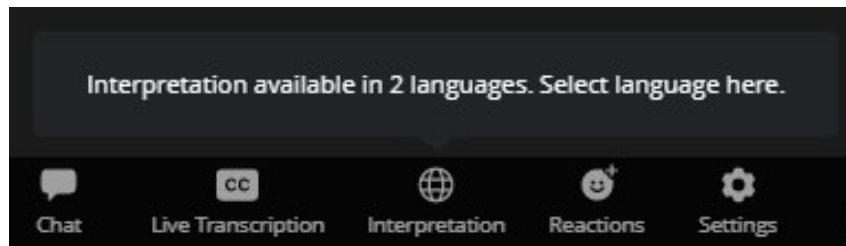
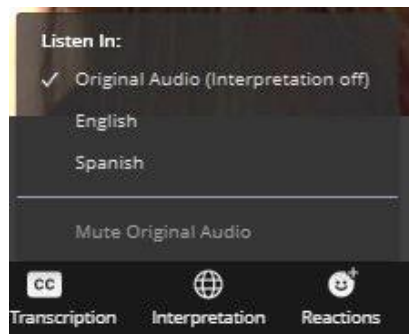
# Emerging evidence on reaching ZD children

26<sup>th</sup> August 2024  
16h CET

# ZOOM TRANSLATION

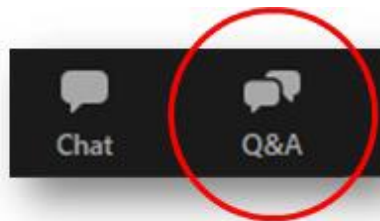
**English:** Click the Interpretation icon to have the option to hear the meeting in French.

**Français:** Cliquez sur l'icône intitulée "interprétation" pour avoir la possibilité d'écouter le webinaire en français.

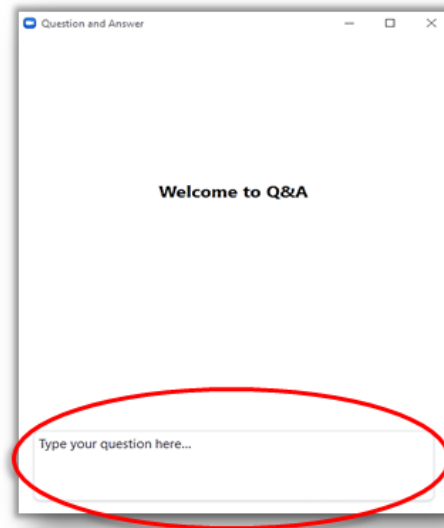


# QUESTIONS AND ANSWERS BOX

Please submit your questions for the panelists in the Q&A box.



Panelists will either reply to you via text in the Q&A box or will answer your question during the discussion portion of the webinar.

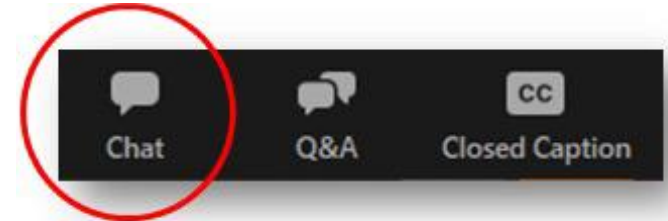


# ZOOM REMINDERS

- If at any point during today's webinar you are unable to hear the speakers, please make sure you've connected your audio by selecting the headphones icon.



- Please send a message to Everyone in the chat box to introduce yourself, send in your comments or ask for support during today's webinar.



- Please note that this meeting is being recorded.

# WELCOME!

## Speakers:

- Sunitha Srinivas Chandrasekhar, PhD – Zero-Dose Learning and Story Generation Project - Sabin Vaccine Institute
- Josephine Ihahi, MPH – Deputy Director - CORE Group Partners Project
- Meggie Gabida – Primary Health Care Specialist - UNICEF Zimbabwe Country Office

## Facilitator:

- Gustavo Corrêa, MD MPH – Evaluation and Learning Unit at Gavi, The Vaccine Alliance

# Zero-Dose Learning Abstracts

Identify • **REACH** • Monitor • Measure • Advocate

Sunitha Chandrasekhar, PhD (consultant)

26<sup>th</sup> August 2024

Webinar 2 – REACH & CROSS-CUTTING  
domains of IRMMA

 **SABIN**  
VACCINE INSTITUTE

 **PHC**  
GLOBAL  
ASSOCIATION OF PUBLIC HEALTH PROFESSIONALS

 **VACFA**  
vaccines  
for africa

 **ebsi**  
effective basic services

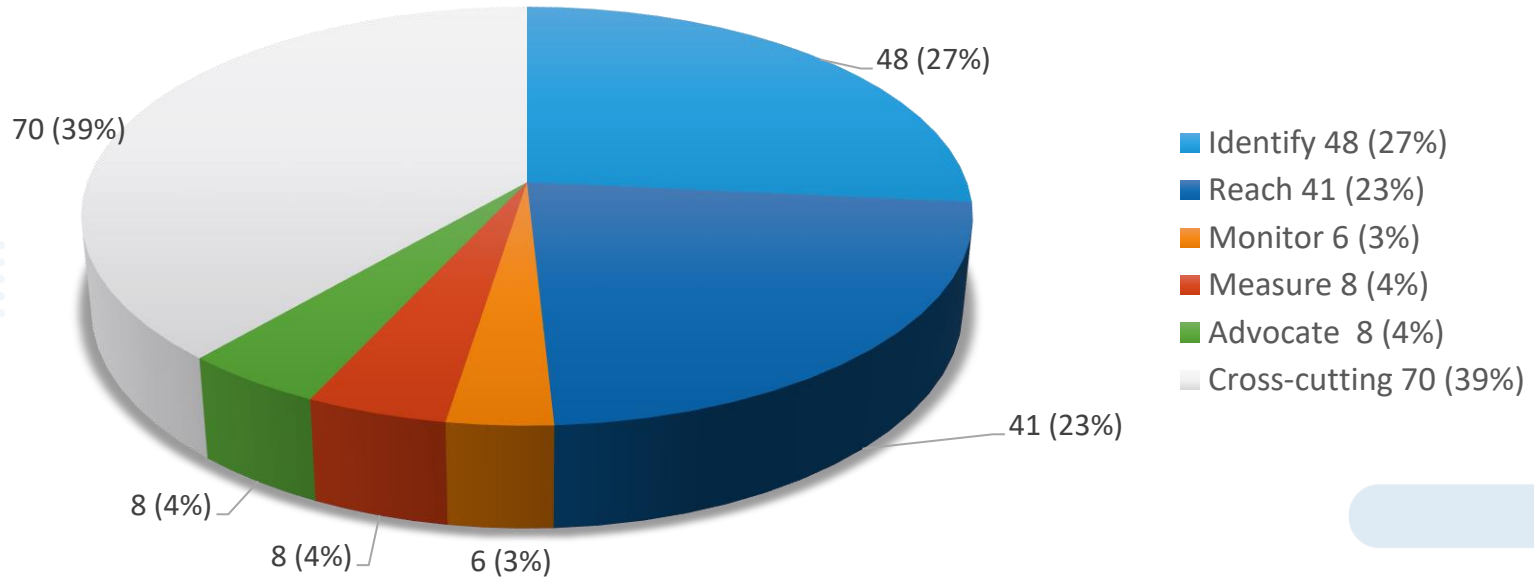


# Presentation Objectives

- **Provide an overview of the REACH and Cross-cutting abstracts**
- **Feature promising interventions to Reach ZDC**
  - Civil society and community engagement
  - Fragile settings
  - Mixed approaches
  - Methodologies—age-extended outreach; fragile/humanitarian settings
- **Reaching ZDC—context-specific challenges in LMIC**
- **Moving from Reach to Impact** – recommendations from the abstracts
- **Cross-cutting abstracts**
  - The role of digital innovation
  - Gender considerations
  - Community engagement

# Abstracts by IRMMA Framework


*\*197 abstracts submitted and 181 accepted by Gavi*







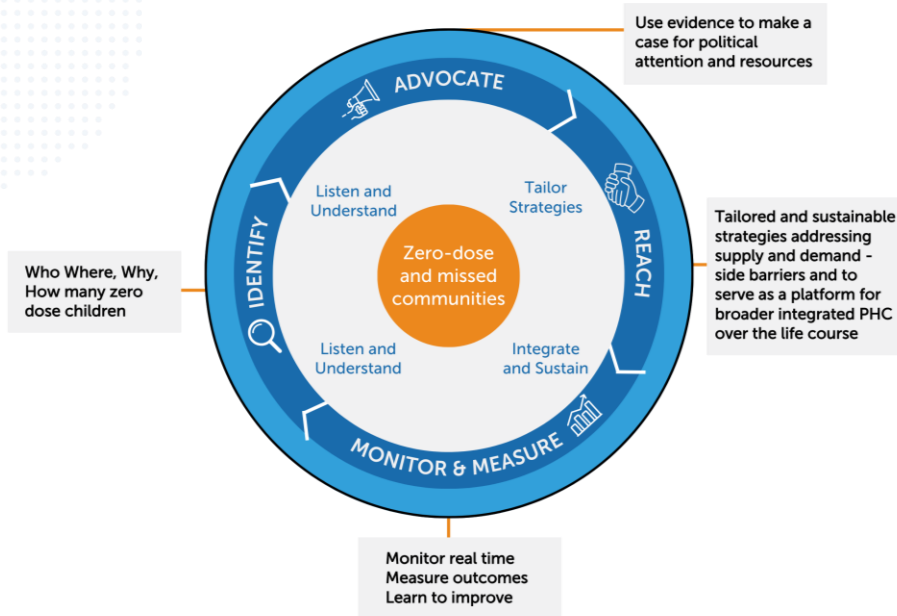
# REACH

- Addressing supply side barriers (service availability and quality)
  - Demand side barriers (vaccine confidence, service uptake, and utilization), while applying a gender lens
  - A coherent strategy to sustainably reach zero-dose children and missed communities
- 

# Identify • Reach • Monitor • Measure • Advocate

## REACH

Using zero-dose strategy to strengthen equitable  
Primary Health Care across the life course



### SUPPLY SIDE

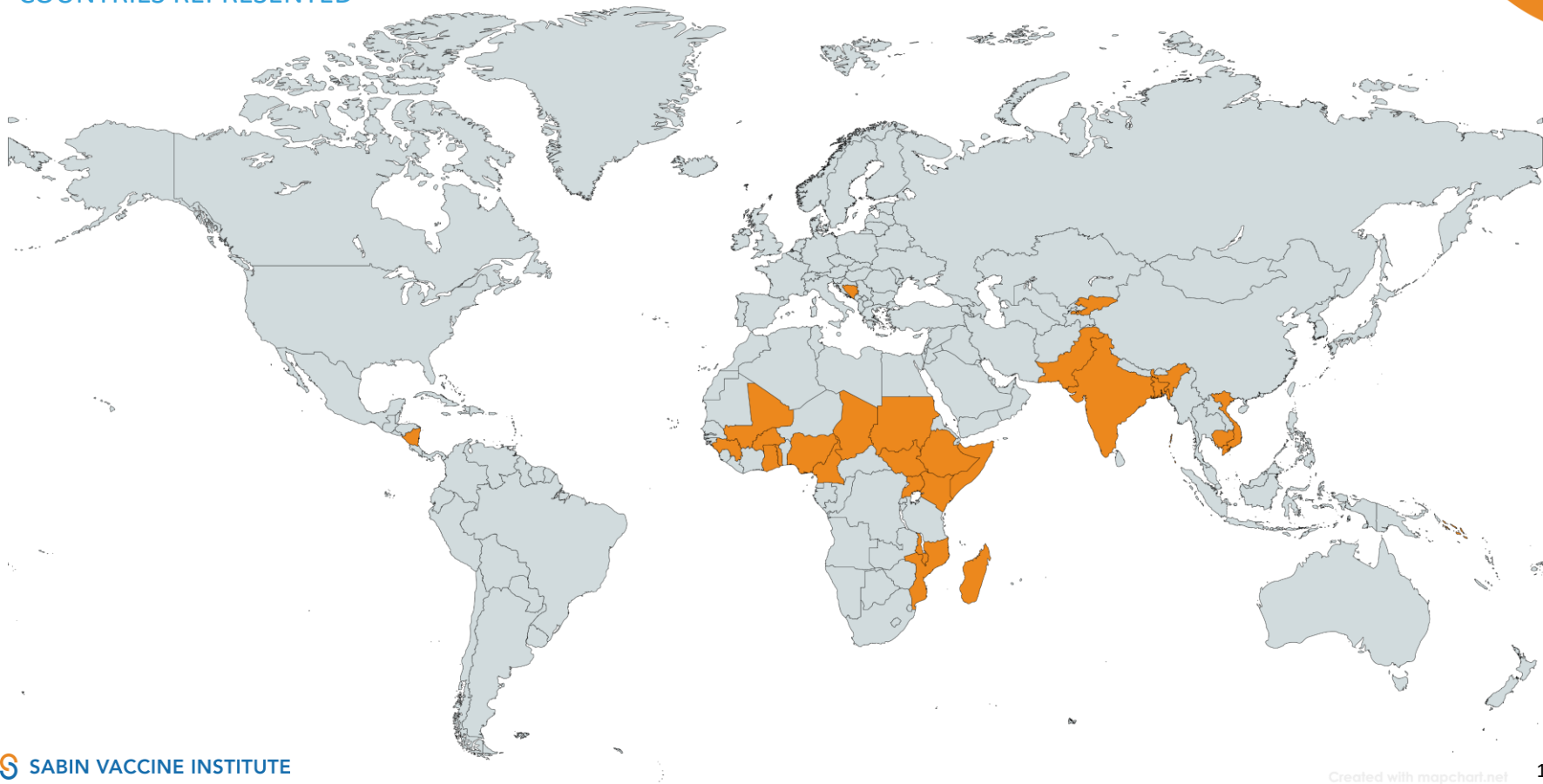
- Service availability, accessibility, reliability, and quality,
- Supplement fixed-post immunization with regular and reliable outreach services, mobile service delivery and periodic intensification of routine immunization
- co-delivering other essential PHC services such as nutrition, growth monitoring, and ante/postnatal care

### DEMAND SIDE

- Vaccine confidence, service uptake, and utilisation, while applying a gender lens
- Harness behavioral insights and improve the service experience of caregivers
- Tailored community-based services that improve equity for missed communities
- A coherent strategy to sustainably reach zero-dose children and missed communities

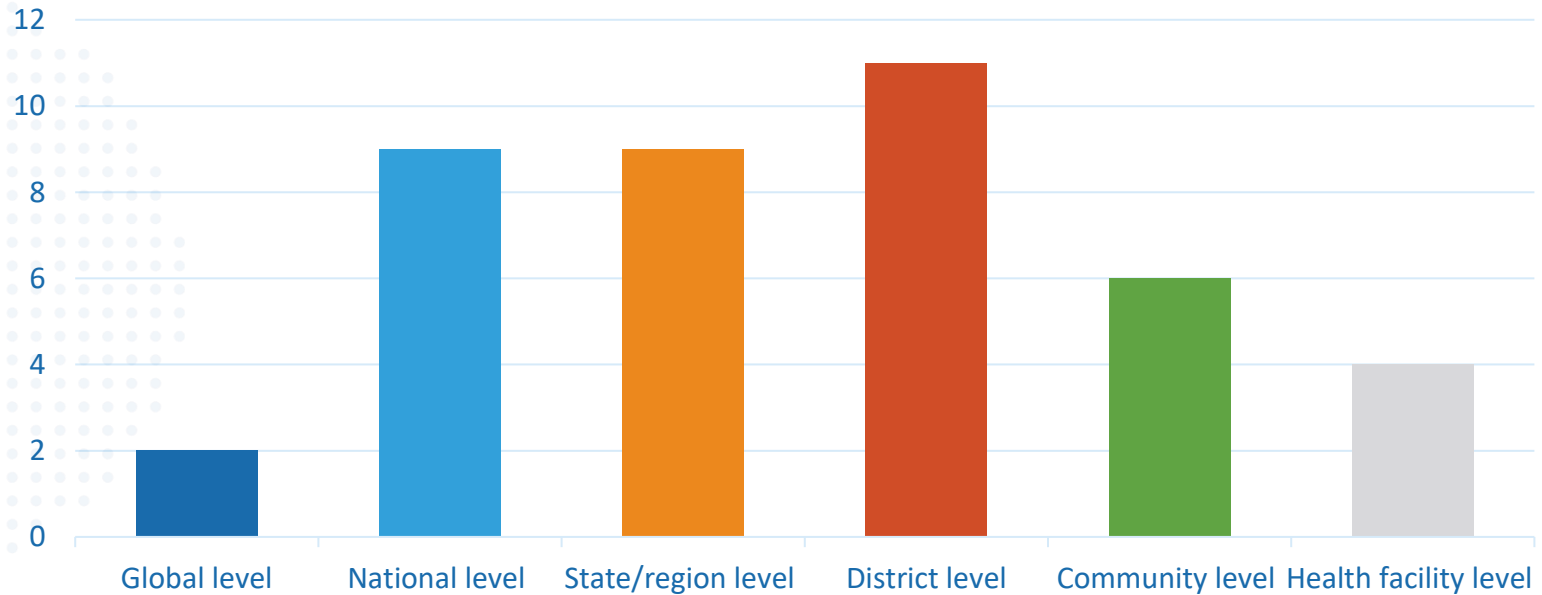
# REACH Abstracts

## COUNTRIES REPRESENTED

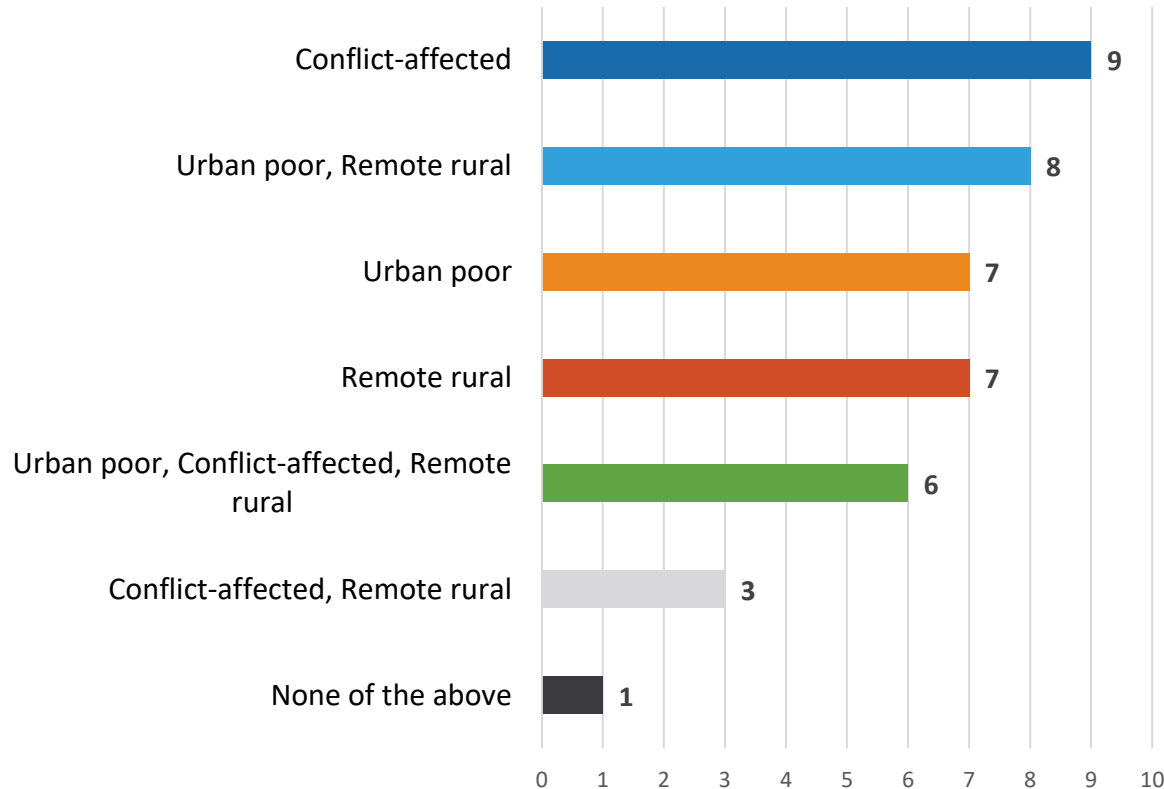


# Geographic Focus of Evidence

From the global to health facility and community level



# REACH: Equity Reference Group Setting



Half of ZDC and Missed Communities live in urban settings including peri-urban settlements and urban slums, remote rural contexts, or conflict settings

# Promising Interventions

## Civil Society and Community Engagement

Three key strategic priorities for civil society and community engagement – 19 (46%) projects engaged with CSOs

### Political Will and Accountability

Community centric approaches in refugee settlements (Uganda); Community mediators to reach out to Roma children where child marriage and discrimination are barriers (Bosnia & Herzegovina); Community watch groups and community leaders for security of HCWs to support humanitarian access to ZDC (Nigeria); Volunteer community members trained to administer priority vaccines in security challenged villages (Burkina Faso)

### Community Demand

Co-designed multi-level CE and vaccine education and communication ToT (Vietnam); Infant swaddle blankets with messaging appropriately designed to address health literacy barriers (Solomon islands); Support Demand promotion plan and use multifaceted SBC strategies (Kyrgyz republic); Journey mapping (Inspiration, Ideation & implementation of "Persona" development in Ethiopia); H2H female counsellor and social mobiliser counselling vaccine hesitant mothers (Pak); CE and awareness (Togo)

### Complementing Public Service Delivery

Social mobilizers (Guinea) and female vaccinators for integrated services (Somalia); Community volunteers (Malawi, Cameroon, Nigeria); health promoters working with midwives (Sudan); Defaulter tracing and surveillance of VPD (Ethiopia); Volunteer women activists for H2H visits and education (Mali)

Differentiated planning approach: These 3 priorities are supported by a crosscutting set of strategic enablers, including capacity enhancement, testing, learning and innovation.



# Promising Interventions

## Fragile Settings

- [Vaccine access in refugee settlements](#) with gender-inclusive outreach on weekends and evenings; mobile vaccination clinics; addressing hesitancy and misinformation; cultural and linguistic considerations in tailored communication translated into multiple languages (Uganda)
- [IDP and urban poor](#): mapped, CE, outreach teams working with District Health Teams; Female vaccinators with social mobilizers for integrated outreach (Vit A, IPV, MCV) (Somalia)
- [Conflict regions of Cameroon](#): [Negotiations with 16 Non-State Arm\\* groups](#) to gain access to ZDC
- [Routine Immunization Strategy in Conflict Areas \(RISCA\)](#): Mali's rapid assessment, desk review and mixed method analysis

# Promising Interventions

## Mixed Approaches

- Lit review: Costing of ZDC interventions- 11 articles (4 from India, 2 from Pakistan, 1 Bangladesh, 3 from Africa and 1 from Latin America); \$0.08 per additional dose for a cellular phone contact to encourage return visits in Kenya and \$67 per additional dose in Nicaragua for a cash transfer intervention
- Scoping review : [Joint animal and human vaccine service delivery](#); ONE HEALTH APPROACH for INTEGRATED vaccine delivery in rural, nomadic, pastoralist communities in LMICs
- Nigeria's HCD with key stakeholders for [Discover, Define, Dream, Design and Deploy](#) to identify barriers and produce [CONCEPT SHEETS](#) for testing and implementation
- Mobile immunization vans – Zindagi Mehfooz Electronic Immunization Register (ZM-EIR), [mapping ZDC with GIS coordinates](#); [integrate ZDC lists from polio campaigns](#); [unique IDs to ZDC](#); [new QR codes for subsequent tracking by vaccinators](#) (Pakistan)
- Key stakeholder collaboration, training of nurses, outreach sites, CE; [Private provider collaboration](#); [Day care and pre-school partnership](#) (Ghana)





# Methodologies involving extended age outreach and in other fragile and humanitarian settings

## South Sudan

Up to the age of 5 years for catch-up

Fixed, outreach and mobile units; Negotiate with non-state actors for 'beyond government' reach activities; HCD; Community dialogue

## Pakistan

Outreach in refugee and security compromised communities

Increased outreach; trust-building initiatives in communities

## Somalia

Vaccinating ZDC in climate shocks

Flash flooding in humanitarian conflict zone; Multisectoral approach

## Mozambique

Big catch-up: 2 to 5 years of age

Revised M&E plans, mapping, social mobilization, HF micro plans, refined vaccine delivery and demand strategies

# Reaching Zero-Dose Children

Context-specific challenges in LMICs



## INDIA

- Periodic Intensification of Routine Immunization (PIRI)
- Incremental cost/dose \$6.21
- Incremental cost per ZDC is \$82.99
- PIRI reduces ZDC
- Repetition for sustained coverage



## ETHIOPIA

- Strengthen PHC linkage in pastoralist areas
- Health extension workers – referral papers for vaccination
- H2H headcounts



## CAMBODIA

- Innovative border post-vaccination outreach
- Migrant workers in Cambodia-Thai border
- Missed opportunity for vaccination during peak border mobility

# Moving from REACH to Impact ...

## Recommendations from the studies

Improve data-driven methods to reach all children

Ensure the continued availability of vaccines

Digitalize gender disaggregated data of vaccinees

Identify funding for continued training of health workers, vaccinators and community volunteers

Strengthen culturally sensitive, language-appropriate communication on childhood vaccination aligned to health literacy of caregivers

Plan and implement monitoring and evaluation of community-centered vaccine services

# Role of Digital Innovation

These abstracts highlight the use of technology such as electronic immunization registries, digital health interventions, and geospatial data to improve health outcomes, but they are fewer in comparison to other themes like gender-related barriers or community engagement.



## EFFICIENCY & DATA QUALITY

Tools like District Health Information Software (DHIS2) in Uganda, Bangladesh and Mali, as well as the Zindagi Mehfooz Electronic Immunization Registry (ZM-EIR) in Pakistan significantly improved data quality, real-time reporting, and decision-making in immunization programs.



## URBAN IMMUNIZATION TOOLKIT

Developed by Urban Immunization Working Group (UIWG), this toolkit supports urban immunization strategies with tools like rapid convenience monitoring and lot quality assurance sampling.



## GEOSPATIAL MAPPING

Outreach Monitoring tools incorporating geospatial analysis, such as in Afghanistan and Mozambique, enhance outreach by identifying hard-to-reach communities and tracking zero-dose children.

# Gender Considerations

## Findings from 7 abstracts

These abstracts contribute to lessons related to gender, including gender-related barriers, gender-intentional evaluations, or the role of gender in health and immunization programs.

### GENDER-SPECIFIC BARRIERS



Targeted interventions in the Democratic Republic of Congo and Uganda addressed gender barriers in immunization by engaging male participants, using community-based campaigns, and enhancing peer education. Strengthening community involvement and monitoring were found essential for scaling and sustaining these efforts.



### IMPACT OF HOUSEHOLD DYNAMICS

Household power dynamics influence on immunization uptake, was investigated in Nigeria. Gender disparities exist in accessing and controlling crucial resources such as family finances, mobility rights, and decision-making authority regarding children's health. Strategies like Z-drop and Identify, enumerate and vaccinate (IEV) were found crucial and effective.



### GENDER-RESPONSIVE STRATEGIES

Involving women as community health workers, as seen in Bangladesh, is crucial for reaching underserved populations in rural areas.



### CHALLENGES IN DIGITAL ADOPTION

Gender-specific challenges, such as reluctance to share contact information with male vaccinators, was addressed in digital tool, Zindagi Mehfooz Electronic Immunization Registry (ZM-EIR) in Pakistan.



# Community Engagement

## Findings from 19 abstracts

These include various forms of community involvement, including mobilization, participatory approaches, and strategies to increase community participation in health interventions and immunization programs.

### LOCALIZED INTERVENTIONS

Local elders and clan leaders established Community Health Committees (CHCs) to rejuvenate the community-level health system in Somalia, while community sensitization efforts in Nigeria engaged local leaders, leading to improved vaccine acceptance and coverage, particularly in areas with high vaccine hesitancy.

### CIVIL SOCIETY INVOLVEMENT

Utilizing civil society organizations (CSOs) in Uganda to reach zero-dose children in urban slums enhanced community trust that overcame barriers to immunization.

### CULTURALLY SENSITIVE APPROACHES:

In India, community participation in program design fostered ownership and sustainability, leading to the development of localized interventions, enhanced community trust, increased immunization coverage, and reduced gender gaps.

### ZIP SCENARIOS (Fragile, conflict and cross border context):

Tailored community engagement strategies, including integrated immunization messaging in mother-to-mother support groups and a Payam Health Day, in South Sudan addressed unique challenges, ensuring effective program implementation.

A photograph of a classroom with several children sitting at desks. They are wearing light-colored, short-sleeved shirts. In the foreground, three children are smiling at the camera. The child on the left is a girl with dark hair, the middle one is a boy, and the one on the right is another boy. They are all holding red pencils. The text "What else did we learn?" is overlaid in white, sans-serif font across the center of the image.

What else did we learn?

# Additional Highlights

- ✓ **Multi-Sectoral Approaches:** Region-specific strategies, like collaboration between beach management units (BMUs) and healthcare providers, in Kenya, addressed local socio-cultural and economic factors in immunization programs.
- ✓ **Financial Sustainability:** Ensuring the financial sustainability of immunization programs is crucial for long-term impact, as demonstrated by Central African Republic, Ethiopia, Kenya, Laos PDR, Uganda, Tajikistan, with an emphasis on scalable and cost-effective interventions.
- ✓ **Equity & Accessibility:** Adjustments to service delivery initiatives such as tailored immunization hours for working mothers, are necessary to enhance accessibility and ensure equitable health outcomes.



# Thank You!

 **SABIN**  
VACCINE INSTITUTE

*2000 Pennsylvania Ave, NW, Suite 7000  
Washington, DC 20006  
+1 202 842 5025  
[info@sabin.org](mailto:info@sabin.org)*

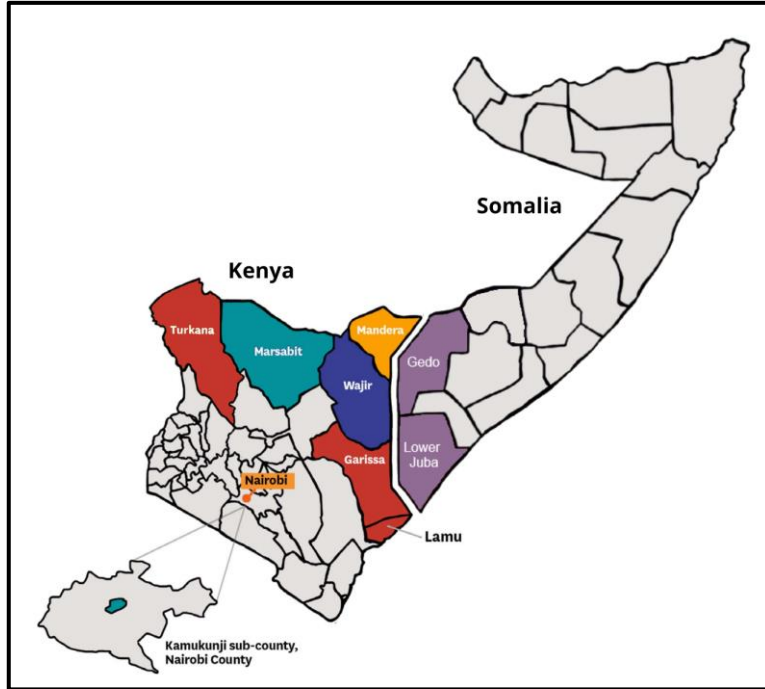
# Transit point vaccination and care group mothers: An innovative model to identify, reach, and vaccinate zero-dose children

Presented by: Josephine Ihahi, MPH  
Deputy Director of CGPP Horn of Africa

BILL & MELINDA  
GATES *foundation*



# Introduction



*CGPP project areas in Somalia and Kenya*

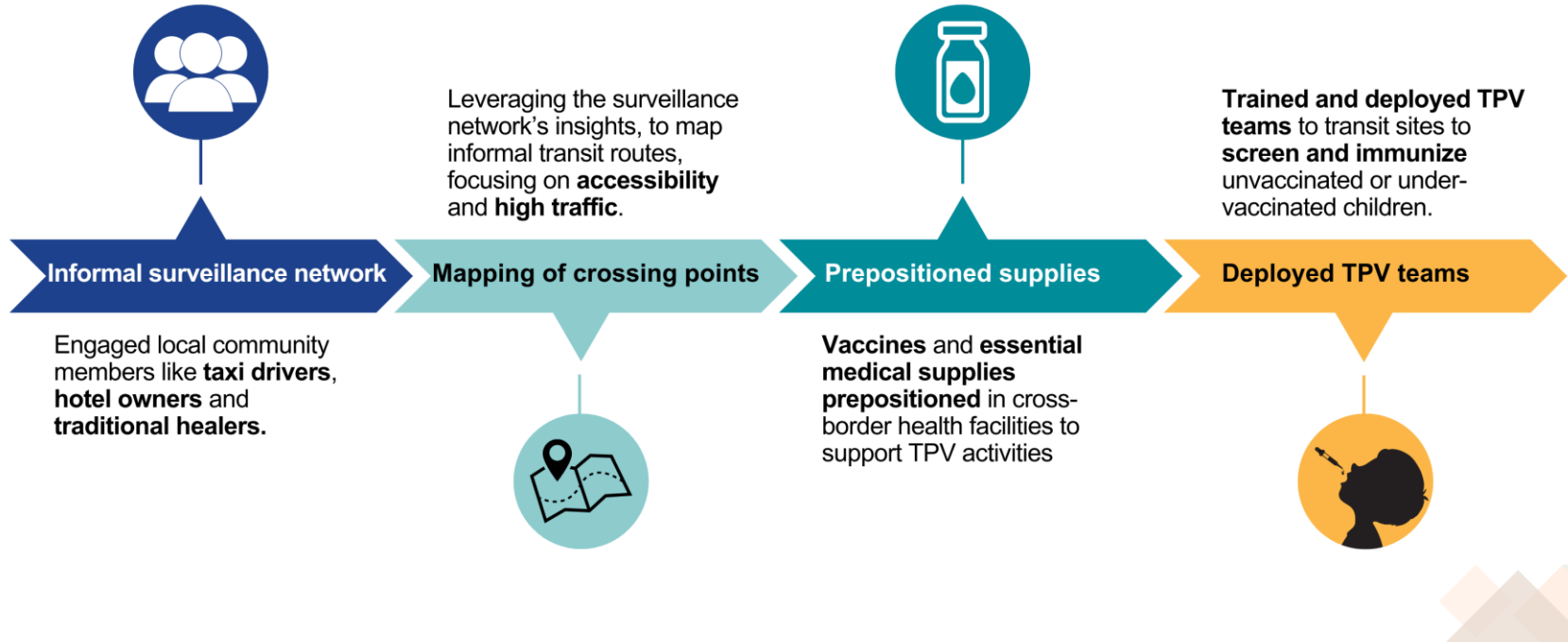
CORE Group Partners Project (CGPP) works in Somalia and Kenya focusing on polio eradication initiative and health system strengthening.

Somalia prolonged conflict coupled with climate change has resulted in:

- Loss of lives and livelihood
- Humanitarian crisis
- Population displacement, disease outbreaks, famine, etc.
- Weak healthcare systems
  - One of the lowest health indicators globally
  - Estimated 60% are zero-dose children (ZDC)

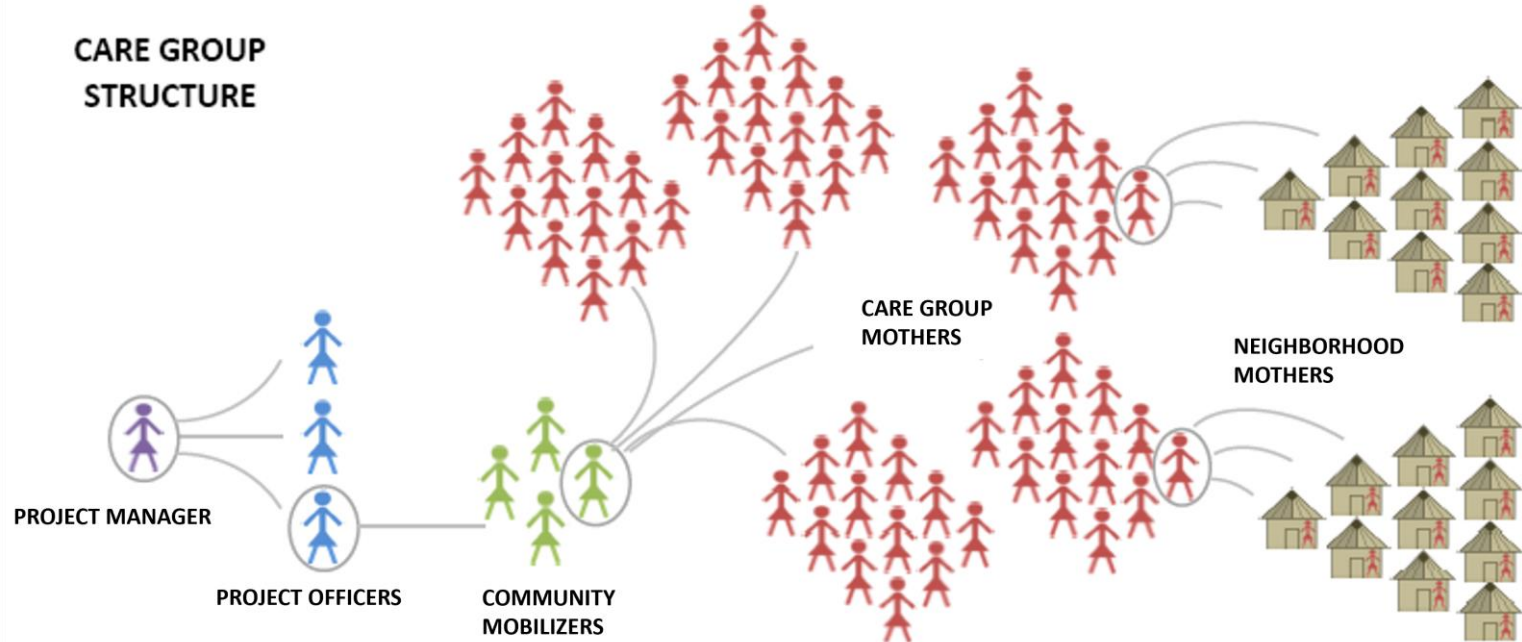
# Method 1 of 3

## Transit point vaccination (TPV) sites



# Method 2 of 3

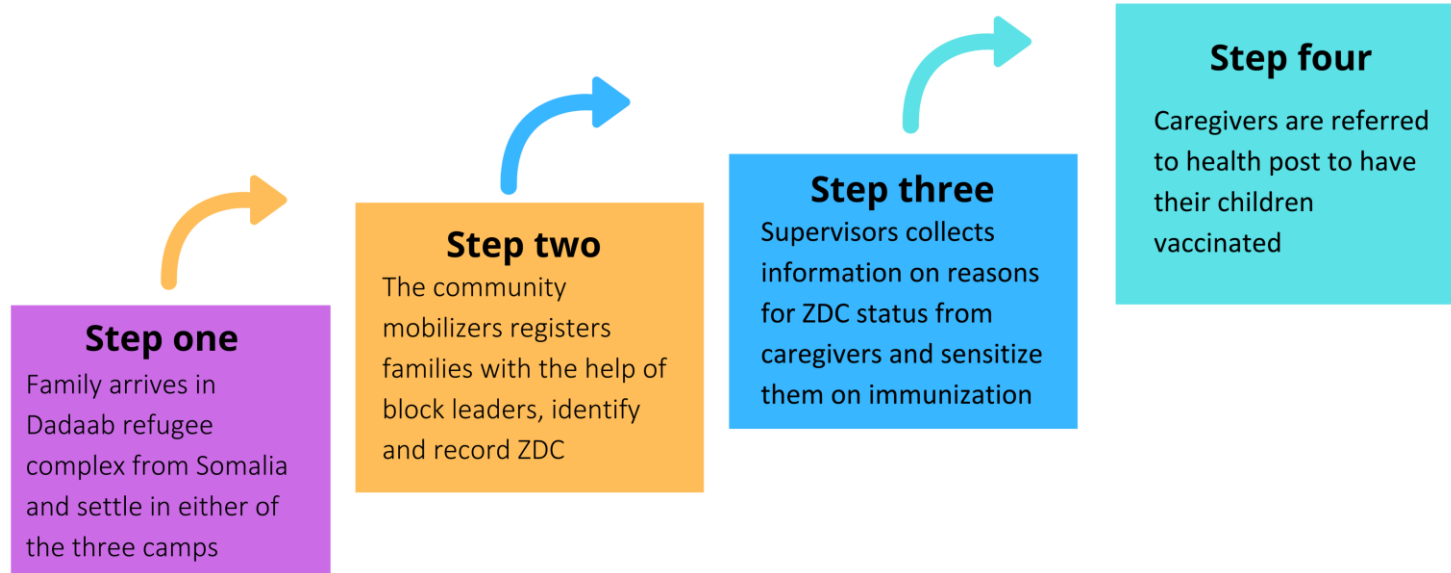
## Care group mother (CGM) model



# Method 3 of 3

## Tracking children in Dadaab Refugee Complex

Tracking of zero-dose children in Dadaab refugee complex



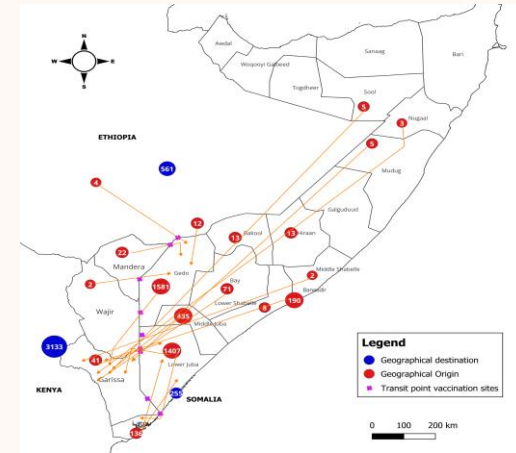
# Results 1 of 3

Between July 2023 to June 2024

- 3,949 children were screened and vaccinated at nine TPV sites
  - Female 2346 (59%), male 1603 (41%)
  - ZDC were 1,365 (35%)
  - Origin was Lower Juba (1,407), Gedo (1,581) and Middle Juba (435) other regions (526) .

Destination

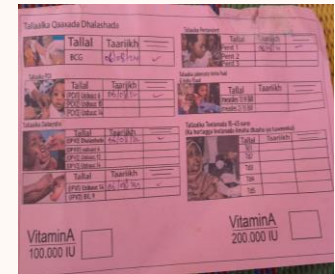
- Kenya's Dadaab refugee complex, 3,132 (79%)
- Ethiopia 561(14%)
- Other areas 256 (7%)



Geographical origin and destination of the children screened at transit points



A TPV team vaccinating a child on transits at Tulo-Barwaqo TPV site



Proof of vaccination at TPV site verified in Dadaab refugee camp

# Results 2 of 3

## Identified 100 CGM

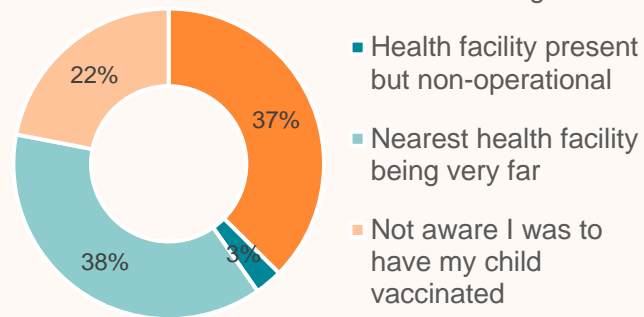
- Trained on immunization
- Provided with airtime to sensitize mothers back in Somalia
- Support tracking of ZDC
- Motivational incentive

## Sensitized 660 neighborhood mothers back in Somalia

- Had 1,380 <5 children, of whom:
- 863 (63%) were ZD (female 417, male 446)
- 215 (25%) ZDC referred and immunized

- Immunization barriers
  - Access (lack or distance)
  - Non-operational HF's

## Reason for zero-dose status





# Results 3 of 3 (ZDC Tracking)

Families registered: 283

- Majority 130(46%) hailed inaccessible middle Juba region
- Point of entry
  - Dhobley (230), Diff (50) and Tula Barwaqo (20)
- Identified 597 <5 children
  - 502(86%) were ZDC
  - 91 (15%) vaccinated at point of origin
  - 4 (1%) by TPV



 **COMMUNITY REFERRAL FORM**


Name of CBH: \_\_\_\_\_  
Center: \_\_\_\_\_  
LIMIT FACILITY: \_\_\_\_\_  
REG DATE: \_\_\_\_\_

**MINOR IN PATIENT/CHILD DATA**

DOB: \_\_\_\_\_ Date of referral: \_\_\_\_\_  
Name of the patient: \_\_\_\_\_  
Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Age: \_\_\_\_\_  
Place of origin: \_\_\_\_\_  
Reason(s) for referral: \_\_\_\_\_  
How identified: \_\_\_\_\_  
Treatment given: \_\_\_\_\_  
Comments: \_\_\_\_\_

Referring Officer: \_\_\_\_\_  
Name: \_\_\_\_\_ Title: \_\_\_\_\_  
Name of the officer: \_\_\_\_\_  
Profession: \_\_\_\_\_  
Name of the health facility: \_\_\_\_\_  
Address: \_\_\_\_\_

Officer/Referral Officer's Signature: \_\_\_\_\_



Process of zero-dose tracking: (1) ZDC are identified, (2) ZDC registered and referred to HF, (3) Confirming vaccination of referred children



# Conclusion

Access is the biggest barriers to immunization services in Somalia, especially in hard-to-reach and inaccessible areas resulting in:

- Unidentified high number of ZDCs
- Untapped opportunities for vaccinating vulnerable children in hard-to-reach areas
- Knowledge gaps on benefits of immunization among caregivers in remote settings
- Competing community priorities (livelihood vs. immunization)

# Recommendations to enhance ZDC



## Identification

Strengthen CGM model as an innovative strategy to enhance immunization awareness for sustainability

Establish reception and screening center in Dadaab refugee complex

Enhance coordination mechanisms aimed to address ZD challenges across board

## Reach and vaccination

Increase coverage of TPV sites in major border crossing points

Expansion of FARID project approaches eg health camps

Public-private partnership

- Sensitization of public transport owners
- Community leaders
- Security officers on cross border health and immunization
- Supply of cold chain equipment's and vaccines to private health service providers in hard-to-reach and inaccessible areas

BILL & MELINDA  
GATES *foundation*



**USAID**  
FROM THE AMERICAN PEOPLE



Thank you



# Optimizing Primary Health Care to Reach Every Zero Dose Child in Urban Poor, Peri Urban and Rural Communities in Zimbabwe, 2022-2024

**Meggie Gabida, Health Specialist Primary Health Care**

**UNICEF Zimbabwe**

Adjagba A, Hama N, Machacha R, Dhege C, Makwabarara E, Mwale J, Kazonga E, Tshuma E, Shahabuddin A, Mwamba R



# Introduction

- Zimbabwe witnessing rapid demographic, epidemiological and socioeconomic transition and over stretched health system
  - Increasing urbanization (33%:2012 to 39%:2022) [Census, 2022]
  - Rapid increase in informal settlements in urban settings (60%) [UNDP Report, World Bank]
  - Highly mobile population (~women artisanal miners -10%)
  - Increasing urban poverty (21%:2011 to 38%: 2019)
  - Shocks and outbreaks (measles, polio, cholera; now El- nino)
- Increase in number of unvaccinated children
  - 17% of children under 1 unprotected against vaccine preventable diseases (VPDs)
  - Past decade, DTP1 coverage dropped from 98% in 2013 to 83% in 2021
  - Commitment towards Immunization Agenda 2030 and Gavi's 5.0 Strategy



# Methods

**Design:** Embedded sequential mixed methods - quantitative and qualitative before and after intervention

**Initiative:** Reaching Every Child and Adolescent through Primary Health Care Optimization (RECA-PHCO) initiative

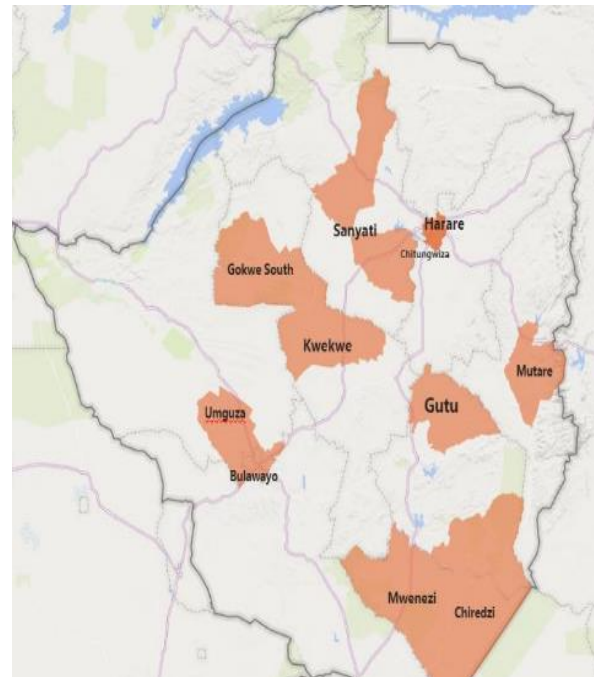
- ❑ **Broad objective:** Strengthen integrated PHC services to accelerate routine immunization, VAS, C-19, HPV and Td vaccination in zero-dose communities
- ❑ **Specific Objectives**
  - **Obj 1:** Identify, co-design strategies and reach zero-dose, missed and under vaccinated children
  - **Obj 2:** Identify health system bottlenecks for supply and demand of essential health services for children, adolescents, and adults

**Duration:** 24 months (June 2022- June 2024)

**Target Population:** U5s, adolescents, women and men

**Setting:** 11 low performing districts for immunization with DTP3 coverage below 70%

## Implementation Areas



# Intervention: 3 phases – respond, close persistent gaps in reaching ZDC



## Inception Phase

- Community ZD Mapping (Census), GIS enabled ODK questionnaire targeting households with under 5
- Desk reviews and gender analysis
- Village Health Workers (VHWs) electronically registered every child
- Microplanning with community leaders & VHWs



## Co – creation Phase

- Development of standardized integrated package of services with subnational structures guided by the Modified Tanahashi Model
- Defining the Multi Disciplinary Team Composition
- Recruitment and deployment of VHWs from special population groups (Vaccine hesitancy & Artisanal miners)
- Community leadership contribution
- Targeted SBC strategies defined



## Implementation and Scale-up Phase

- Household visitation and tracking by VHWs & CCWs – referrals/ accompanying
- Multidisciplinary Team Monthly and Quarterly Integrated Outreach (facility & district based)
- Targeted mobile clinics to artisanal miners' community
- Super Sunday" initiative and flexible facility opening hours
- Deployment of climate smart transportation system
- Impilo Engage Mobile App for tracking, reporting, follow up

**Data Collection & Analysis: IDIs** - Mothers/ Caregivers of ZD; **KIIs** – DHTs, SHCs, Community Leaders, CHWs & **FGDs** – Community members/ significant others accessing PHC services

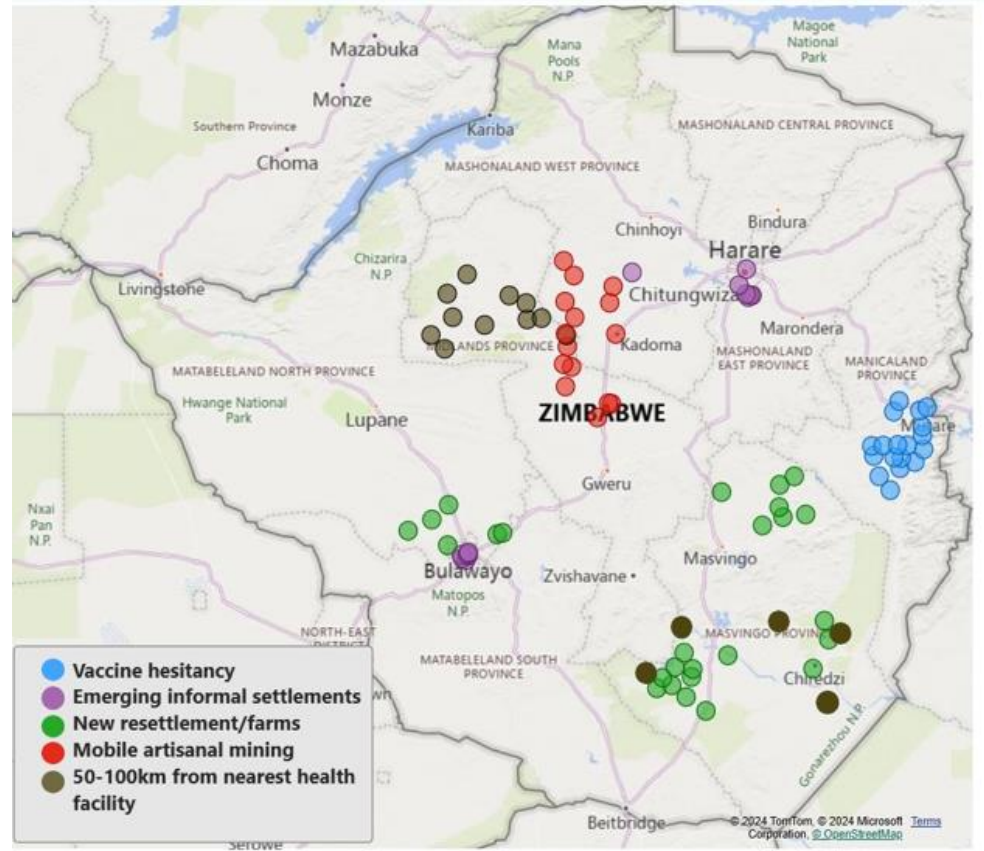
**Ethical Approval:** Informed consent obtained; privacy and confidentiality maintained



# Results

- 51.9% of ZD concentrated in urban informal settlements and remote rural resettlements
- Factors associated with being unvaccinated for DTP1 were:
  - No Child health card: **OR: 6.1; 95% CI (5.82-6.46)**
  - No birth certificate: **OR: 2.81; 95% CI (2.72-2.95)**
  - Vaccine hesitancy: **OR: 2.94; 95% CI (2.75-3.15)**
  - Challenges in accessing health service delivery points: **OR: 1.61; 95% CI (1.49-1.74)**
  - Functional difficulty: **OR: 2.57 95% CI (2.11-3.13)**
  - Children of young mothers who never attended ANC/ received counselling: **OR: 5.61; 95% CI (5.39-5.85)**

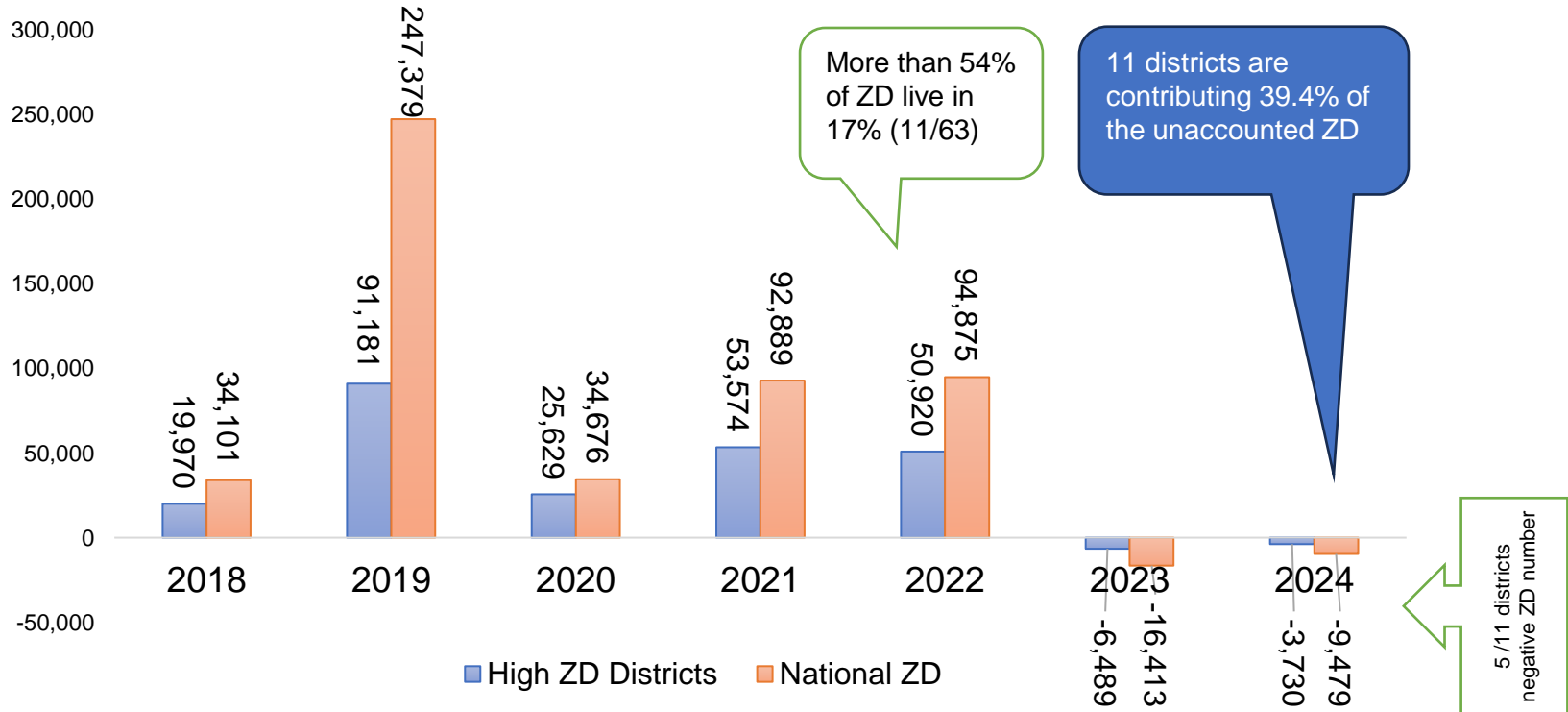
Figure 1: Description of Zero Dose Children by Place



# Zero Dose Analysis with Admin Data

## Zero Dose Analysis in 11 Districts Compared to National Average

Source: Admin Zim Stats 2022



# Proportion of Zero Dose Children Identified and Reached with DTP1

Median age first contact - 3 months

At first contact, ZD received BCG, DTP1, Hep B- Hib 1, OPV1, PCV1, Rota1



1 100%

ZD children identified in 2022 in the major urban cities were successfully tracked and vaccinated

3 90.2%

ZD children in vaccine hesitancy communities reached

2 92.3%

ZD children in highly mobile artisanal miners' communities were reached

4 86%

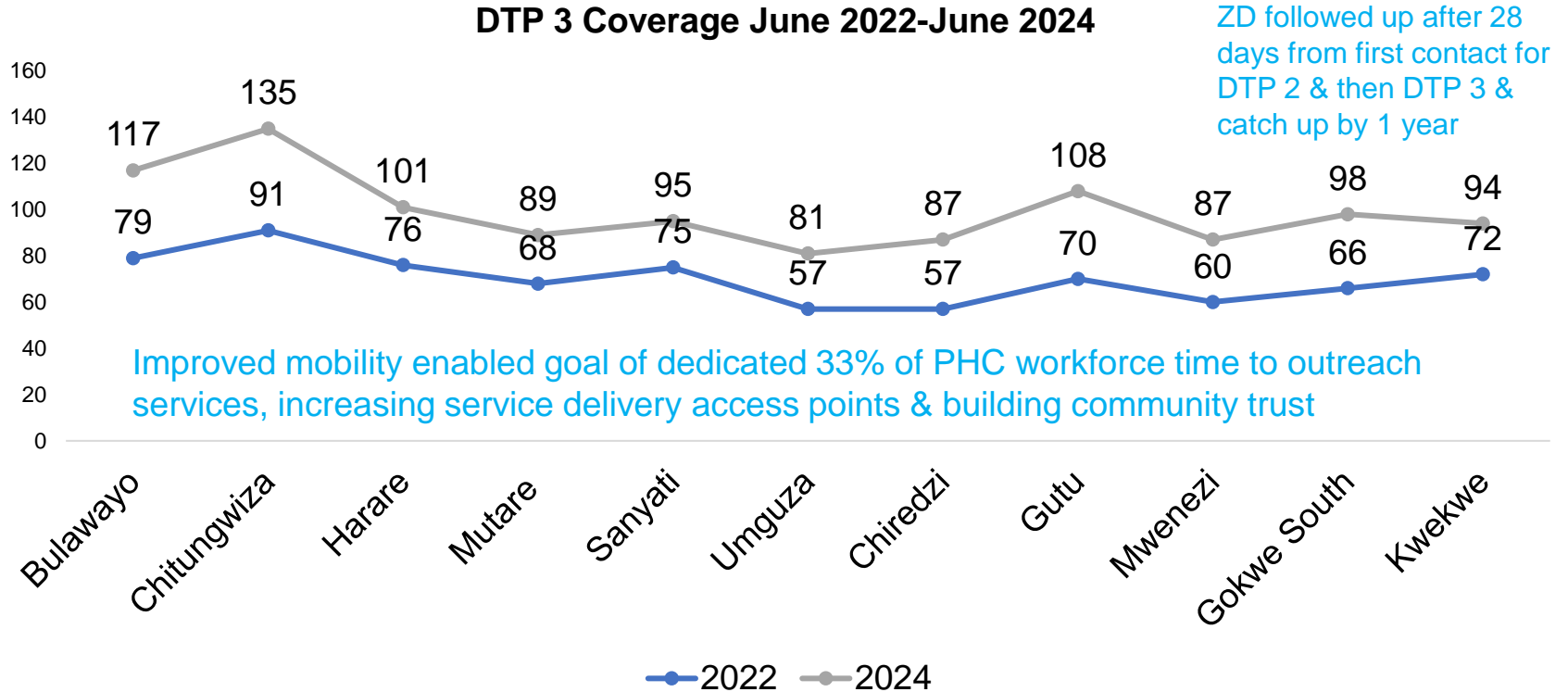
ZD children in newly resettlements were reached

## Enabling Factors

- Time spent at an outreach point of 5 or more hours was associated with high yield of ZD children
- Use of Multi Disciplinary Team integrating RI with FP, NCD treatment, ANC booking, Eye care, Rehabilitation services

# Effect of the intervention

## Comparison of DTP 3 Coverage at Baseline in June 2022 and Endline in June 2024



# Conclusion

- ❑ Communities where children do not have access to PHC services are more likely to be zero dose
- ❑ RECA-PHCO initiative acknowledged by communities to expand availability, accessibility, acceptability and contact coverage of PHC services including immunization
- ❑ Accounting for every child using a robust community health platform, and deployment of Multi Disciplinary team reduces missed opportunities
- ❑ **Integrating routine immunization with other primary health care services (8-15 packages) is feasible and increases number of ZD reached**

# Recommendations

- ❑ Prioritize implementing tailored service delivery models and strategies codesigned with affected/ marginalized communities
- ❑ Revitalize/ establish multi-sectoral coordination platforms for community oversight on IRMMA
- ❑ Expand RECA-PHCO in high ZD districts with additional partnerships
- ❑ Expand electronic registration and tracking systems for all pregnancies, newborns and children under five to reduce ZD
- ❑ GIS mapping of service delivery platforms and community led GIS enabled microplanning
- ❑ Further in-depth analysis on data quality, accuracy of population data and triangulation

# Acknowledgements

- National Primary Health Care and Immunization Team
- Provincial Medical Directors & Provincial Health Executives,
- District Medical Officers & District Health Executives, District Multi Disciplinary Teams and Health Facility Teams
- Community leaders, Communities
- Village Health Workers & Case Care Workers
- Funding Support
  - Gavi, the Vaccine Alliance (with funds from the Government of France)
  - Health Resilience Fund



# THANK YOU!