# INCEPTION REPORT IMMUNIZATION ENGAGEMENT UNICEF EAPRO

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# 1. Introduction

UNICEF, as a leading global health development agency, relies on a network of strategic and operational partnerships from the global to community level to achieve its goals for child health and development. As well as UNICEF being a global leader in immunisation policy and vaccine supply chains, the agency is also focused on facilitating access by children and their care givers to a wider range of health and social services, especially for communities in social disadvantaged or emergency situations. Given this broad child health agenda of UNICEF, the complexity of the immunisation stakeholder environment, and emerging public health threats and opportunities in the coming decade, UNICEF is now proposing development of an Immunisation Engagement Strategy to ensure UNCEF programmes are more effective in achieving global and regional immunisation goals.

The purpose of this inception report is to inform development of an evaluation approach as well as to support an evidence base for development of a regional roadmap on engagement for immunisation in the East Asia Pacific Region of UNICEF (EAPRO). [1]

The report has three main sections. The first [General] includes a summary of relevant global regional and country strategies and policies for immunisation and related health strategies, and the implications these have for UNICEF engagement. The second [Evaluation Approach and Methodology] details information on theory of change, an evaluation matrix, ethical considerations and a proposed workplan. The final section [Annexes] provides detailed information on indicators, data trends and the detailed desk review.

# 2. General

## 2.1 Policy and Strategy Context

Current global and regional strategies on immunisation are outlined in UNICEF Roadmap on Immunisation, the Immunisation Agenda 2030 and WHO Regional Strategies for immunisation.

*The UNICEF Roadmap on Immunisation* identifies three main principles for programming covering rights to full imunisation and related accountabilities, strengthening delivery systems with a focus on the disadvantaged, and immunisation as a driver of integrated and multi sector interventions to improve child health. [1] The roadmap identifies shifts in strategy over the coming decade that include ensuring that immunization programmes are financially sustainable, and which are operated through stronger health systems that deliver integrated primary health care services. Further shifts include prioritizing marginalized communities and improving integrated service delivery, supply chain systems and front-line health workforces.

A further update of the immunisation roadmap in 2022 proposes a closer alignment with the IA2030 Agenda in terms of principles (equity, accountability, people centred, multisector and integrated, innovation, evidence based and gender transformative). It is also proposed to be more aligned with IA2030 as well as with existing strategic advantages of UNICEF through goals of: [summarised]

1. Addressing the needs of disadvantaged and underserved populations in development and humanitarian contexts, with particular emphasis on zero-dose children and communities

[1] Countries of the UNICEF Region of East Asia and Pacific – Cambodia, China, Indonesia, DPR Korea, Lao PDR, Malaysia, Mongolia, Myanmar, Pacific Islands (Cook Islands, Fiji, Kiribati, Marshall Islands, Micronesia, Niue, Nauru, Palau, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu and Vanuatu), Papua New Guinea, Philippines Thailand, Timor-Leste and Vietnam

2. Systematically reaching zero-dose children and community with potent vaccines and other essential Primary Health Care services in development and humanitarian contexts.
3. Ensuring that all people and communities value, trust and actively seek out immunization services.

*The Immunisation Agenda 2030* is a global health agenda that identifies seven strategic priorities all of which are relevant to engagement.[2] These *strategic priorities* include immunization programmes for primary health care and universal health coverage, commitment and demand, coverage and equity, life-course vaccination and integration, outbreaks and emergencies, supply and sustainability and research and innovation. The emphasis on "leaving no-one behind" in the vision statement highlights the focus throughout the document on equity and on tailoring of services for marginalised populations.

*The Global Vaccine Alliance (Gavi) 5.0 Strategy 2021-2025* [3] adopts a vison of "leaving no one behind with immunisation" which continues this theme of equity oriented global health programming. The strategy announces a strategic "shift" towards reaching "zero-dose" children and missed communities, as well as tailored and targeted approaches for countries and more emphasis on programmatic sustainability.

These global strategies align well with shifts of strategy identified in the two WHO regional strategies for immunisation. A *Regional Strategic Framework for Vaccine Preventable Diseases and Immunization in the Western Pacific* (2021-2030) aims to expand the scope of immunization, maximising benefits of vaccines and programmes and further accelerating control and elimination activities for vaccine preventable diseases (VPDs) "beyond those originally targeted." [4] *A Strategic Framework for the South-East Asia Regional Vaccine Action Plan 2022–2030* [5] defines three impact goals that include reducing overall mortality and morbidity from vaccine-preventable diseases for all across the life-course, pursuing vaccine-preventable disease elimination and control goals and regional priorities and achieving measles and rubella elimination, sustaining polio-free status, maintaining MNT elimination, achieving hepatitis B control and leaving no one behind by increasing equitable access and use of new and existing vaccines.

There are several themes in these strategy documents which have important implications for engagement. Integration is expressed through linkages of immunisation to health system strengthening PHC and UHC. All strategies highlight the increased complexity of immunisation programming related to the emergence of life course vaccination, and external impacts of decentralisation, pandemics, urbanisation, new technologies, anti-vaccine movements and humanitarian emergencies. The challenge of social marginalisation and gender inequities are expressed frequently across all four strategies with the related practices of "tailoring" of services a common theme. There are frequent references to models of partnership with civil society, the private sector, development partners, other health programs and interventions, research partners, sub national authorities. There are also strong emphases on governance and accountability.

## 2.2 Details of the Programme in EAPRO.

As explained in more detail in the Desk Review Annex, the reduction in immunisation coverage between 2016 and 2020 is largely an outcome of the 2019 pandemic impacts which resulted in coverage declines in 10 of the countries between 2019 and 2020. Of the 25 countries that can be assessed between 2019 (pre covid) and 2020, 10 countries had a decline in DPT3 coverage. These include larger population countries including Indonesia, the Philippines, and Myanmar. The largest "zero dose" percentages and numbers are in large population countries. Various observations on zero dose confirm that these populations cluster in conflict zones, in populations that are otherwise marginalized and excluded, including the urban poor, culturally diverse, migrant and remote

populations, and populations subject to misinformation or hesitancy in relation to vaccination. Analysis of trends between 2015 and 2020 for measles cases demonstrates that 11 countries have reported significant *measles outbreaks* between 2015 and 2020. These outbreaks are being reported from reported "high coverage" countries such as Mongolia, Vietnam, and Thailand. Analysis of trends between 2015 and 2020 for *polio cases* demonstrates 7 out of 25 countries have reported confirmed polio cases in the last 5 years. These data trends also demonstrate that zero dose populations and vaccine preventable outbreaks are largely occurring in urban poor, remote, ethnic minority, conflict affected and otherwise socially disadvantaged contexts. This has significant implications for the way that UNICEF engages with these populations as well as with implementing partners who work with them. Table 1 below provides a summary of the social context for low coverage and disease outbreaks in EAPRO countries which are detailed further in the Desk Review in the Annex.

| Country | Context | Reference |
|---|---|---|
| Myanmar | Incomplete vaccination coverage was independently associated with low SES<br>Lower immunisation coverage is also associated with location, ethnicity, and presence of conflict, with remote ethnic minority states along the border with China more subject to lower rates of immunisation coverage.<br>Hard-to-reach populations in mountainous areas, border areas and peri urban communities in major cities….Mobile and migrant populations in work sites and temporary settlements and socially hard to reach populations.<br>Polio outbreaks have occurred in remote ethnic, and conflict affected States of Rakhine State in 2015 and in Kayin State 2019 | Nozaki et al (2009)<br>WHO (2019)<br>MoH (2017)<br>WHO (2015)<br>WHO (2019) |
| China | Highest incidence of vaccine preventable diseases in Western Provinces<br>Ethnic minority women in China are statistically far less likely to immunise their children compared with majority Han women | Pan (2021)<br>Yuan Huang (2017) |
| Philippines | Coverage is lowest in the conflict affected Autonomous Region in Muslim Mindanao (fully immunised 9% in 2017). Polio Outbreak Mindanao (2019) | (DHS, 2017)<br>WHO (2019) |
| Malaysia | Polio Outbreak Sabah Province (Migrants, Indigenous Minorities) | UNICEF (2020) |
| Cambodia | Lower coverage in northeast Provinces of Mondulkiri and Ratanakiri (ethnic minority Provinces)<br>Measles outbreak – reports of reaching children that are less likely to visit health centres and hospitals, such as in Cham Muslim and Vietnamese communities. | DHS (2015)<br>WHO (2020) |
| Indonesia | First case of Polio in 13 years reported in 2019 in remote Papua Province | (Outbreak Observatory 2019) |
| Thailand | Recent measles outbreaks have been linked to the conditions of Myanmar migrant factory workers (2019) as well as to the misinformation and cultural beliefs of populations in Southern Thailand | Wongsanuphat S, (2019) |
| PNG | The polio outbreak in PNG in 2018/2019 was widespread across 9 provinces necessitating a national emergency response | Hall (2019) |
| Samoa | Measles Outbreak in 2018 related to low coverage and concerns of vaccine safety | Champredon (2020) |

*Table 1 Context for Low Coverage and Vaccine Preventable Disease Outbreaks in EAPRO Countries*

The literature indicates that UNICEF has comparative advantages that positions it well to adopt a leadership role on immunization policies and strategic directions. Some of these strategic advantages include promoting equity and coverage, providing supply and supply chain management, building demand for immunization through Communication for Development, supporting efforts to deliver immunization services in humanitarian contexts and for disaster preparedness, and finally in convening partners and promoting a multi-sectoral approach.

UNICEF in partnership with Gavi and national governments is the leading vaccine procurement agency globally with most of the low income and low and middle income countries depending on them for their full needs for the vaccines and immunisation supplies. More recently UNICEF works with a range

of partners on the COVID 19 vaccination effort including with including national authorities and the UN agencies. Other partners include Gavi, WHO, IFRC, national Centres for Diseases Control, NGOs, community-based organisations, and the private sector. Main UNICEF supported activities for the COVID 19 response have included planning, coordination, service delivery, training, monitoring and evaluation, vaccine cold-chain and logistics, communication and community engagement.[6] Collaboration has been identified by UNICEF as the main factor in creating sustainable supply chains with main partners in this effort including "Gavi, the Global Fund, USAID, the World Bank, the United Kingdom's Department for International Development (DFID), the Bill and Melinda Gates Foundation, and private sector companies and many others, to accelerate results for children." [7] UNICEF is a long term member of the Gavi Vaccine Alliance and has collaborated substantially with Gavi in new vaccine introduction, vaccine campaigns, and cold chain support and with health system strengthening.

A major question for the evaluation and engagement framework is the extent to which current partnership models in terms of their structures, processes or guidance are adequate to the task of ensuring efficient, equitable and sustainable service delivery, vaccine, and cold chain support for countries in the coming decade.

***Engagement in Urban Area and In Decentralised Contexts:*** East Asia is one of the most urbanised regions globally and is projected to have 70% of its population living in urban areas by 2030. [8] There are clear opportunities for UNICEF here to engage more with local governments, communities, and other civil partners in urban settings to transition UNICEF immunisation investments towards a more sustainable and system-oriented pathway.

***Engagement in Humanitarian Emergency Contexts:*** The Asia-Pacific region has been described as the most disaster-prone region in the world and is a region that has become even more fragile in the context of COVID-19. Humanitarian reports from EAPRO highlight the extent to which UNICEF is strategically placed to implement multisector approaches for child health and development in humanitarian emergencies.[9]

***Stateless or undocumented populations*** are also a concern for low vaccination status in areas of EAPRO. "Hot spots" for statelessness in EAPRO include in Thailand where there has been a large inflow of refugees from Myanmar as well as migrant workers from neighbouring countries, and in Malaysia where a large inflow of working migrants and their families have migrated for work on plantations in the east of the country. [10] [11] Given globalisation of economies and related international labour migration, and ongoing threats of climate change and conflict, engagement with Stateless and Undocumented populations and their stakeholders is likely to be an emerging public health challenge in the coming decade.

***Gender and Immunisation:*** In relation to gender barriers to immunisation, a range of factors have been identified in the literature including lower community status of women (economics, cultural), gender norms, levels of health literacy, and autonomy of decision making by women as primary care givers. [12] [13] Given that many of these barriers are in fact social determinants of health, engagement cross sector from community to the political level is an essential condition for addressing gender norms and barriers. UNICEF Partnerships with agencies and implementing partners that adopt a gender and social determinants perspective on implementation are therefore central to the UNICEF mission of child health and development.

***UNICEFs communication for development*** **(C4D)** approach aims to improve programming and outcomes for children through addressing social norms, behaviours, and practices. [14] The theory of change of C4D proposes levels of influence from individuals to systems as the main agents of change. Community based organisations, faith-based organisations, local leaders, women & youth groups, the media, and policy makers and decision makers all fall within the category of influencers of change.

UNICEF provides examples of implementation of the approach including helping vulnerable households in Cambodia, disability support for children in Malaysia, and climate change communication in Vietnam. The case from the Philippines illustrates how social accountability with local politicians and communities was promoted to support protection from disease through immunisation. [15]

A review of the C4D program in EAPRO (Cambodia, Laos, Mongolia) in relation to disaster risk reduction found that the approach can facilitate a transition from top-down communication strategies to ones based on local participation, capacity building and dialogue. [16] Main partners in this approach included the education sector, NGOs, local governments, and civil society groups. The review distinguishes between "campaign-based C4D" and C4D that targets "dialogue and participation" and highlights the risk of authority as being a barrier to genuine participation by socially marginalised groups. The review concludes by making several recommendations that are of high relevance to partnership building:

1. The effectiveness of C4D approaches is linked to the capacity of health workers and health systems to support messages and promote health-seeking behaviours.
2. There are important opportunities to harness and support improved partnerships for C4D and dialogue-based approaches with NGOs
3. C4D approaches enable and enhance local capacities as well as the processes that can be used to test assumptions about local-level programming

This more active model of engagement with social disadvantaged communities is also reflected in more ***recent guidance from WHO on engagement***, which focuses more on models of community empowerment, dialogue and capacity building for improved health care access and utilisation. [17]

The impacts and lessons learned from the COVID 19 pandemic are likely to have important consequences with the way that UNICEF engages with stakeholders. A global study of the impacts of the pandemic on routine immunisation found that there was an overall impact of reduced delivery of expected doses (4-6 million) for DPT3 and MCV1 in 2020. This study also noted that in the "super regions" of South East Asia and East Asia that "that monthly doses were delivered at or above expected levels during the second half of 2020." [18] Significant coverage drops in large population countries such as the Philippines, Indonesia, and Myanmar between 2019 and 2020 does however indicate that at country level further assessment is required to assess COVID 19 impacts on routine immunisation.

A common feature of the COVID 19 pandemic literature, including UNICEF sources, is the notion of building back better post pandemic. This notion of building back better, which is also the subject of Regional WHO Resolutions on PHC and COVID 19, stresses the opportunities for countries to adopt learnings from the pandemic.[19] Common themes in these learnings are the unrealised potential of multisector collaborations and community engagement, the urgent need to ensure the availability and safety of a front line workforce, values of integration of health systems for primary health care, [20] and the urgent need to more proactively address health inequalities that have been exacerbated by the pandemic. [21]

In conclusion, the desk review and data analysis has demonstrated both the main challenges for vaccine preventable disease prevention as well as the potential for improved engagement by UNICEF to address some of these challenges. Main theme areas for engagement include working to the strategic advantages of existing UNICEF operations, as well as targeting and tailoring programs towards the unmet needs of the socially disadvantaged. Given that needs are "unmet" in the current context, the evaluation and strategy development provide an opportunity to innovate in engagement strategies for immunisation to bridge the gaps and adapt to a rapidly changing external environment.

For more detail on the review of data and literature on immunisation in EAPRO, please refer to the Desk Review (Annex F).

# 3. Evaluation approach and methodology

## 3.1 Programme's Theory of Change

**The theory of change proposes that better structured and improved strategy of engagement by UNICEF with partners internally and externally will make a contribution to improved health service and immunisation access and utilisation for children [especially the socially disadvantaged and those not accessing the services].**

As outlined in Section 2 of the Inception Report and to the Desk Review Annex, some countries in the region have significant numbers of zero-dose children, which are resulting in outbreaks of vaccine preventable disease such as measles and polio. These disease outbreaks are disproportionally effecting social disadvantaged communities and children in conflict zones, amongst the urban poor and in remote areas and amongst ethnic minorities. This disadvantage is further reflected through inadequate service availability and pandemic related service interruptions.

*The main assumption* is that improved partnership by UNICEF internally with its own health amd mutli sector programs, and externally with governments, partners, sectors (e.g. education, local government) and implementing partners (e.g. NGOs, CBOs, private sector) , will make a contribution towards improved health outcomes for children. This will be via engagement actions that support expanded policy and leadership role of UNICEF nationally and regionally, expanded service access for the socially disadvantaged and for communities in humanitarian emergencies as well as development of more efficient supply chain systems in EAPRO (through close collaborations with vaccine & logistics suppliers, governments and partners).

*Main activities/inputs* include conducting an immunisation engagement assessment, and on the basis of this assessment, development a UNICEF immunisation engagement strategy, as well as partnership building to support improved UNICEF engagement internally (within UNICEF) and externally with stakeholders. Partnership activities will be focused on expanding policy and leadership roles with governments and stakeholders, improving service access for the socially disadvantaged and the efficiency of supply chains, as well as implementation of demand creation strategies.

*The main output* of this partnership building work is that at Regional and National and Sub National Level there are engagement processes, structures and guidance in place that facilitate improved partnerships by UNICEF with governments, development agencies, civil society, health systems, other UNICEF and health programs and with communities.

*At the outcome level,* improved partnership processes, structures and guidance by UNICEF will mean that UNICEF programs are more effective in reducing inequities and improving immunisation coverage, and through undertaking emergency responses, and improving supply chain efficiencies. Given UNICEF capacity and track record in communication, improved engagement with stakeholders and communities will result in increased capacity for demand creation, addressing vaccine hesitancy and refusals, vaccine misinformation, as well as social actions to create favourable social norms around immunization. New or revitalised UNICEF engagement processes, structures and guidance will improve the coherence of UNICEF programming, by promoting synergies internally with other UNICEF programs, as well as externally with governments, systems, sectors and communities. Engagement and partnerships processes, platforms and guidance will also make UNICEF programming more *relevant* to regional, national and community needs and priorities, through the ability to better coordinate, share and exchange existing and new information and resources on best practices for immunisation and PHC. The expanded capacity for engagement will also enable UNICEF to implement

*more equitable programming*, by better advocating, coordinating and targeting resources and programs for the socially disadvantaged and those affected by humanitarian emergencies.

Expected impacts of improved UNICEF engagement include decreased numbers of zero dose children, decreased numbers of vaccine preventable diseases and reductions in immunisation inequities. There are multiple determinants of improved *immunisation impacts* that include political commitment, health system capacity and the quality and reach of the immunisation system. While taking note of this challenge of attribution, it is nonetheless projected that improved partnerships by UNICEF both internally and externally will make a contribution towards health impacts through:

1. Improved service delivery, demand, emergency preparedness and response and supply chain [Effectiveness],
2. Increased UNICEF role in policy and leadership and partnerships [Relevance, Coherence], and
3. More service accessibility for socially disadvantaged and inaccessible populations [Equity].

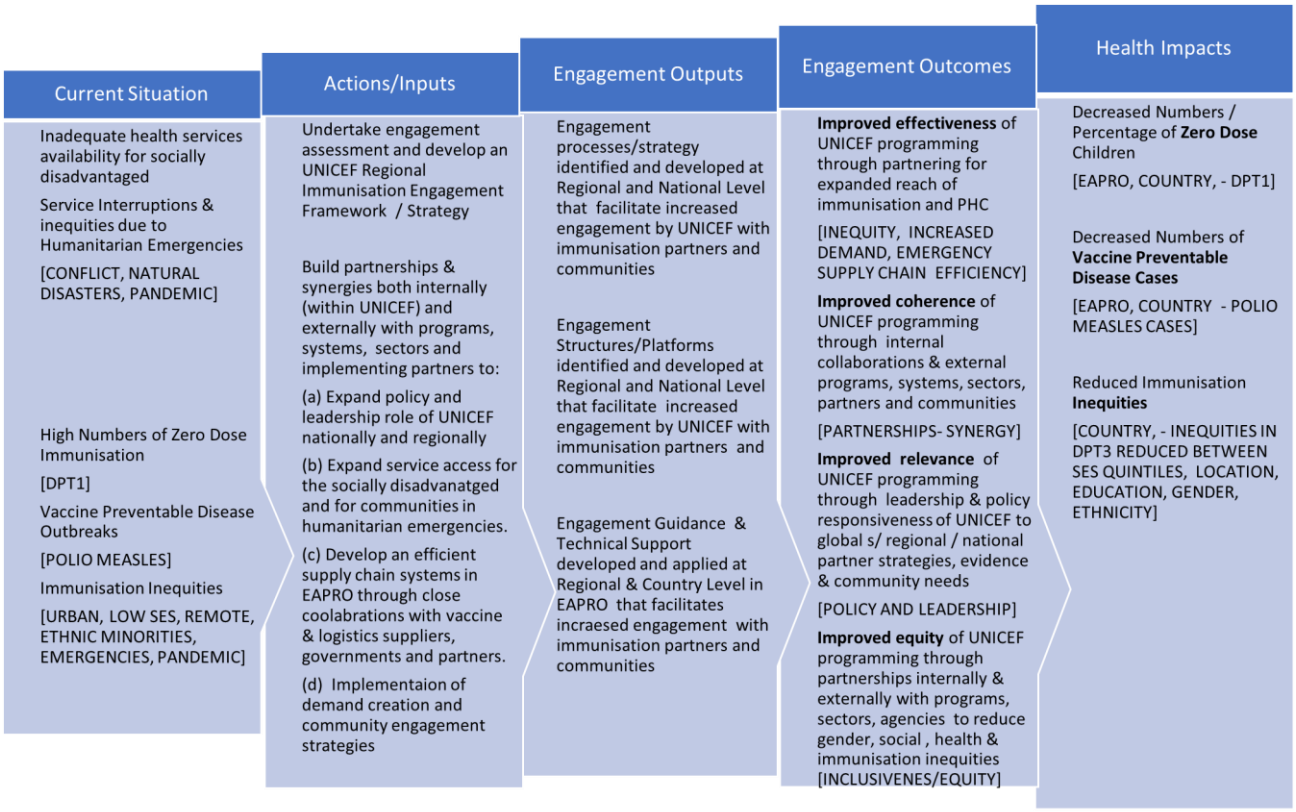



*Figure 1 Theory of Change*

## 3.2 The Evaluation Activities

The objective of the evaluation is to inform the strategy for EAPRO's engagement for immunization for during current decade, and in contribution to the Immunization Agenda (IA) 2030 and UNICEF Immunization Roadmap 2018-2030, and optimizing UNICEF's comparative advantage as an organization for immunization.

The specific purpose of this exercise is to evaluate the areas of engagement of UNICEF EAP Regional Office (RO) and UNICEF Country Offices (COs) in the region vis-à-vis the UNICEF 2018-2030 Roadmap as aligned with IA2030, and achievements made till date. This is intended to inform and provide inputs into the development of strategy of engagement for immunization going forward in future 3-5 years. The exercise takes into account the experience and resources from COVID-19, and leveraging

comparative advantage of UNICEF as an organization. The strategy development involves formative evaluation in providing a robust assessment of alignment in the areas of work UNICEF COs are involved with, alignment and gaps in supporting the country needs, and incorporating these into the operating business at the country office and regional office levels. The exercise takes advantage of the evaluation opportunity to solicit informed opinions of the key stakeholders with respect to the future directions.

The primary audience for this work is the UNICEF East Asia Pacific RO and the UNICEF COs in the region. The secondary audience includes government and partners in the countries and key allies such as GAVI, WHO, UNICEF headquarters (Programmes, Supply) for immunization functions.

Defining Engagement strategy - Engagement is described as an arrangement, formal or informal, on working together with key stakeholders, both internal (UNICEF) and external, to achieve common goals described in Immunization Roadmap. The strategy describes what and how of this arrangement which also aligns with the IA 2030. Moving forward, this definition determines the scope of the evaluation – any methods or tools or data going beyond this definition will be excluded.

As mentioned before, the scope of the evaluation has been expanded to explore the directions for the future engagement strategy. This will take into account the relative strengths of country and regional offices vis-à-vis other immunization partners, as well as the potential for synergies across different programmes of UNICEF. In summary there ae two elements of the current exercise – backward looking (evaluation) and forward looking (defining future strategy).

## 3.3 Sampling of the countries

The sampling approach and selection of the countries is detailed in Annex A. The following is the summary table of the countries and respective methods to be employed (described later in the following section):

| Country | Survey | KII | FGD |
|---|---|---|---|
| Cambodia | ♣ | ♣ | ♣ |
| China | ♣ | | |
| DPR Korea | ♣ | | |
| Indonesia | ♣ | ♣ | ♣ |
| Lao PDR | ♣ | | |
| Malaysia | ♣ | | |
| Mongolia | ♣ | | |
| Myanmar (case study, tentative) | ♣ | ♣ | |
| Pacific Island Countries | ♣ | | |
| Papua New Guinea (case study, tentative) | ♣ | ♣ | |
| Philippines | ♣ | ♣ | ♣ |
| Thailand | ♣ | ♣ | |
| Timor Leste | ♣ | | |
| Vietnam | ♣ | | |
| **Total** | **14** | **6** | **3** |

*Table 2 Summary Table of Survey methods for Each Country*

## 3.4 Data collection methods for the evaluation activities

The nature of this work requires 'compilation and analysis' of the relevant experience, converting the experience into 'identification of the gaps and options', apply the SWOT lens for these options

and develop a strategy. The programme of immunization is endowed with large amount of quantitative data from the countries which is constantly analyzed for programme performance, impact in form of disease reduction or elimination, identifying operational challenges like with supply chain management, community acceptance/refusals. This is a good barometer to assess the impact of engagement dynamics on these parameters. The quantitative data is also a good basis for country categorization to determine which countries would be most suited to assess in-depth, and within countries for identifying which populations are most effected by zero-dose status and disease outbreaks.

The purpose of the evaluation is around engagement which cannot be easily quantified. This means that qualitative methods should be employed for data collection for this evaluation. After looking at the Immunization strategic priorities and within that what should be analyzed to understand the relevance, degree and impact of engagement, the following methods will be deployed for this evaluation:

1) Desk review of policy documents, global and regional – IA2020, UNICEF Roadmap, Gavi 5.0 Strategy, Regional plan/strategy for SEARO and WPRO and related peer reviewed literature and published reports
2) A Survey across all the countries of the region with an open ended questionnaire (country selection explained in annex A). For specific countries/country groups, an adapted format would be followed – for example the countries with limited UNICEF presence and programmes (China, Malaysia, Thailand) the evaluation part of the questions will be excluded

3) Key informant interviews
    a. with in-country UNICEF officials responsible for EPI in six countries, selected as a sub-sample to represent different characteristics of the region – using an uniform structured questionnaire with open ended answers
    b. with Health specialist and EPI official in the Regional UNICEF (EAPRO) to get information on (a) Perspective of the countries in the region, applying comparisons where useful, and (b) internal dynamics of engagement among different programmes at RO
    c. with each Team Leader for Immunization on WHO regional offices (WPRO and SEARO) as most significant Immunization partners to explore the degree of engagement for key issues perceived as global or joint responsibilities.

4) Focus group discussions
    a. country level (for three countries – Cambodia, Indonesia and Philippines) with a team from different partners (WHO, Government, UNICEF) that would validate/challenge information from the survey, as well as collect more information of the subject of engagement
    b. regional level with participants from different programmes in RO
    c. HQ (Programmes division) and Vaccine center of Supply division to collect information on consistencies as well as misalignment among three levels of UNICEF's operations

    The list of questions in the Evaluation matrix will be the pool to work on specific questionnaires for different categories of interviews and FGDs. The first questionnaire to be developed will be for the survey across all the countries.

5) Supplementary information gathered from references, reports, internal communications mentioned during the course of KII and FGDs as important sources. Wherever relevant, this data will be retro-fed into the desk review or factor into the analysis.

The following table summarizes use of different methods for different target respondents:

| Tool/Target | All countries | Six sampled countries (2 case studies and 4 others) | Regional UNICEF office | Regional Partners | UNICEF HQ (Programmes, Supply) |
|---|---|---|---|---|---|
| *Survey* | ♣ | | | | |
| *KII* | | ♣ | ♣ (2) | ♣ (2) | |
| *FGD* | | ♣ (3 only) | ♣ | | ♣ |

*Table 3 Methods According to Target Respondents*

So the grand total is 14 Survey responses, 10 KIIs and 5 FGDs.

Draft questionnaires and guidelines for KIIs and FGDs are included in Annex B. Notes on the methods employed:

1) WHO-UNICEF data on Immunization performance and Disease incidence is integrated with the Desk review
2) Survey with a Questionnaire will be completed by Health/Immunization officer in UNICEF CO in 14 countries of the universe employed except China, Malaysia and Thailand where the Deputy Representative (Programmes) will be the respondent
3) Key informant interviews
   - Health/Immunization Officer in six selected countries
   - Regional Health Chief
   - Regional Immunization specialist
   - WHO (WPRO) – identified participant
   - WHO (SEARO) – identified participant
4) Focus Group discussions
   - EPI officers in UNICEF, WHO and Government in three countries
   - UNICEF (EAPRO) – Focal points for Nutrition, WASH, Education, PHC (and other programmes as advised)
   - HQ – Programmes division (1-2 participant/s) and Supply division from Vaccine centre (1-2 participant/s)

a) Same questionnaire will be used for survey for 14 countries except for China, Malaysia and Thailand (only forward looking strategy questions)
b) Uniform questionnaire/guide will be used in four selected countries for KIIs and FGDs; and an adapted questionnaire for Myanmar and PNG
c) Questionnaire to be adapted for interviews and FGDs with RO, HQ and WHO
d) The Question guideline for the KIIs and FGDs will be sent in advance to the participants to inform them about the contents of the discussion
e) The questionnaires will collect three types of information – a) facts, b) linkages in the results chain: activity – output – attributable result/outcome, and c) informed opinions

The KIIs and FGDs will be recorded for reference and confirmation, subject to agreement by the participants. The data collection will be entirely remote through virtual mode. The data collection will follow a two-stage process for the countries:

1) Survey, followed by interim read through

2) Key informant interviews and Focus Group Discussions with the countries
3) In-depth interviews and FGDs with UNICEF (EAPRO), UNICEF SD+UNICEF HQ (Immunization unit) and WHO (WPRO and SEARO) will constitute the remaining sample (refer to Table 1 for survey method for each country).

The total number of information sources will be 14 survey responses and 15 audio/video recordings of 10 KIIs and 5 FGDs.

## 3.4 Data collection instruments

Only questionnaires and interview guides will be used for the data collection, embedding the guidance with respective question, if required. These will be appropriately tailored for some countries as well as the interviewees or FGD participants. The questionnaires will dwell upon the final Evaluation matrix and will be finalized after the approval of the inception report.

Nature of the Questionnaires:

- Open ended responses
- Sequencing with most important themes coming upfront. As the discussion proceeds the attention span of the respondents decline incrementally.
- Clubbing of the questions on same or similar theme/s irrespective whichever evaluation criteria the questions belong to
- Also clubbing of questions according to assessment related questions and questions related more to development of the future strategy on engagement.
- Interviewees would spend between 45 to 90 minutes only with concentration.

Pilot testing of the questionnaire/s and uniformity in their administration

- The survey questionnaire and one KII/FGD guide will be run among the members of the evaluation team as a trial
- For uniformity, as far as possible, both John and Raj will lead the interviews and FGDs. Even where only one interviewer is present, the core structure will be followed without too much of a deviation. They would mutually discuss specific issues where the understanding is different. It is expected that after first couple of these conversations, the process will proceed smoothly.

The five survey types/data collection tools are included in Annex B.

## 3.5 The Evaluation criteria

The selection of the evaluation criteria dwelled around the seven strategic priorities of the IA2030 as well as the focus areas of Immunization Roadmap, always asking what and how these have been impacted from engagement perspectives. An initial question was whether this exercise relates to engagement among the key stakeholders or UNICEF's RO and COs' engagement with other partners for achievement of the IA2030 goals. It is the latter which directs this evaluation and its approach, as well as assisting to explore future directions for the engagement strategy.

From the standard six evaluation criteria categories, the following three were decided for this task:

1) Effectiveness – The extent to which the intervention achieved, or is expected to achieve, its objectives, and its results, including any differential results across groups.

2) Relevance - The extent to which the intervention objectives and design respond to beneficiaries , global, country, and partner/institution needs, policies, and priorities, and continue to do so if circumstances change.
3) Coherence - The compatibility of the intervention with other interventions in a country, sector or institution.


*Figure 2 Evaluation Criteria*

Three remaining categories, Efficiency, Impact and Sustainability, are excluded. This is mainly because of the theme of engagement in mind as opposed to an overall Immunization programme evaluation. Further, for more than a decade Equity across geographies and wealth quintiles have received specific attention to improve coverage beyond a certain plateau. Inclusiveness of socially advantaged populations has been an important determinant of immunization coverage. To ensure right attention on these issues another evaluation criteria for Inclusiveness and Equity was added for this exercise with the following understanding:

Inclusiveness, Equity – absence of systemic, avoidable or remediable disparities, discriminations or favoritism between population groups with different social characteristics - wealth, gender, geographical location, ethnicity, religion, age, health status, residential status, sexual orientation.

More specifically for Immunization, these criteria would translate as wealth (access by poor population), gender (presence or absence of female health workers who are more acceptable by the communities), geographic location (rural remote, urban slums), ethnicity and religion (social exclusion).

As outlined in the theory of change and M & Framework, impact is also a consideration of this evaluation. Impact is measured in terms of the contribution of engagement to reductions in zero dose, vaccine preventable diseases, immunisation inequities as well as improvement in coverage of target vaccines. This assessment acknowledges the limitations in measurement of impact, given that improved engagement may be one of several factors that contribute to improved impacts.

### 3.6 Data analysis approach and framework

The data library will consist of:

1) Desk review findings from engagement perspectives
2) Survey responses from 14 countries
3) Video/Audio recordings of 10 KIIs
4) Video/Audio recordings of 5 FGDs

The results from the above material will be grouped with respect to four dimensions in following steps:

1) Responses with respect to evaluation (backward looking, lessons learnt, best practices, case studies and forward looking for strategy formulation
2) Evaluation criteria – further segmentation according to the four evaluation criteria
3) Strategic priorities/thematic areas – separating into different sub-groups
4) Preparing a matrix of which country groups or CO the sub-groups would apply to

To begin the process a master sheet (excel format) with all key results will be prepared and populated as the process proceeds – first with survey responses followed by KIIs and FGDs. After this master sheet is prepared, all the data sources would be archived.

To the extent possible, SWOT parameters will be applied to the summarized results. Development of the recommendations will be an iterative process among the evaluation team and RO leads.

The case studies will follow additional processes – joint identification of the country and the experience which qualify as a case study. It is important to note that not necessarily the best practices would qualify as a case study. It could a failure documentation of which might have better value addition in future.

### 3.7 The Evaluation matrix

## Effectiveness

| QUESTIONS | SUB-QUESTIONS | INTERPRETATION, INDICATORS, SUCCESS-FAILURE CRITERIA | METHODS FOR DATA COLLECTION* and MAIN SOURCES OF DATA/ INFORMATION |
|---|---|---|---|
| How effective has UNICEF engagement been, both internally with other programmes and externally with Immunization stakeholders? | What are the types of engagement (internal and external) where UNICEF has been most successful in the region, countries? | Evidence of good practices which could be emulated | Survey with 14 COs<br>KIIs with RO, CO<br>FGD with RO, WHO |
| | To what extent has UNICEF shown leadership for Immunization policies in the region? | Centrality of driving the agenda and direction as perceived by the countries | Survey with 14 COs<br>KIIs with RO, COs<br>FGDs with RO, HQ, Country partners |
| | To what extent has UNICEF been able to influence its partners' practices and priorities? Can you provide an example? | Centrality of driving the agenda and direction as perceived by the countries | Survey with 14 COs |
| | In which interventions has UNICEF shown leadership in restoration of RI services impacted by Covid-19? | Evidence that UNICEF plays leadership role in crisis | Survey with 14 COs<br>KIIs with RO, COs, WHO<br>FGDs with Country partners |
| | Of the countries in the region that have demonstrated high immunization coverage even during Covid-19 pandemic, what has been UNICEF's role as in comparison with other partners? | Degree of value addition of UNICEF in a multi-partner operating environment | Survey with 14 COs<br>KIIs with COs, WHO<br>FGDs with Country partners |
| | How far has UNICEF succeeded in strengthening Government | Degree to which a sustainable impact is being created | Survey with 14 countries<br>KIIs with COs<br>FGDs with Country partners |

| QUESTIONS | SUB-QUESTIONS | INTERPRETATION, INDICATORS, SUCCESS-FAILURE CRITERIA | METHODS FOR DATA COLLECTION* and MAIN SOURCES OF DATA/ INFORMATION |
|---|---|---|---|
| | capacities for Immunization supply management in the countries? | Validation if the current model for such countries is correct | |
| | Are there examples in supply chain system that have been adopted as a routine by the countries e.g. tools like EVM, Stock management? | Validation of the scalability of new tools | Survey with 14 countries<br>KIIs with COs<br>FGDs with Country partners |
| | How do partnership arrangements need to change or reform in order to improve UNICEF's role in supply chain management? | Future direction in the area of UNICEF's strength | KIIs with RO, COs, WHO |
| | How can UNICEF be more effective in extreme situations like vaccine suspension or large proportion of vaccine refusals? | Measuring the impact of critical issues which cannot be measured through cost benefit or cost effectiveness tools | KIIs with RO, COs |
| | Are C4D interventions for immunisation adequately evidence based? | Level of adequacy of research to inform communication on immunisation | Desk Review<br>Survey<br>KII<br>FGD |
| | Are C4D interventions for immunisation adequately resourced? | Level of Adequacy of resourcing of C4D for immunisation | Desk Review<br>Survey<br>KII<br>FGD |
| | Are C4D interventions for immunisation adequately coordinated? | Level of adequacy of coordination of EPI communication with other programs | Desk Review<br>Survey<br>KII<br>FGD |

| QUESTIONS | SUB-QUESTIONS | INTERPRETATION, INDICATORS, SUCCESS-FAILURE CRITERIA | METHODS FOR DATA COLLECTION* and MAIN SOURCES OF DATA/ INFORMATION |
|---|---|---|---|
| | Are C4D interventions enabling improved access or utilisation of EPI | Impact of C4D on reductions in inequities | Survey |

## Relevance

| QUESTIONS | SUB-QUESTIONS | INTERPRETATION, INDICATORS, SUCCESS-FAILURE CRITERIA | METHODS FOR DATA COLLECTION* and MAIN SOURCES OF DATA/ INFORMATION |
|---|---|---|---|
| How far has UNICEF's engagement in the region addressed the seven strategic priorities identified in Immunization agenda 2030? | To what extent does UNICEF's prioritisation of engagement match the regional gaps & challenges? | Future directions for the interventions | KIIs with RO, COs |
| | What about supply management systems? Do the priorities match the regional gaps & challenges? | Future directions for the interventions where UNICEF is perceived as a leader | KIIs with RO, COs |
| | Does the priority UNICEF gives to data quality match current or future needs in the region? | Progress with using experience to find solutions to critical problems | KIIs with RO, COs |
| | Besides supply management and data quality issues, which other strategic priorities UNICEF should address in future? | Future directions on selection of strategic priorities | KIIs with RO, COs |
| | | | |

| | | | |
|---|---|---|---|
| | IA agenda 2030 identifies Life course and Integration as a strategic priority. What should UNICEF do to move in that direction? | Identify opportunities to implement organizational mandate beyond health sector | KIIs with RO<br>FGDs with RO/HQ |

## Coherence

| QUESTIONS | SUB-QUESTIONS | INTERPRETATION, INDICATORS, SUCCESS-FAILURE CRITERIA | METHODS FOR DATA COLLECTION* and MAIN SOURCES OF DATA/ INFORMATION |
|---|---|---|---|
| To what extent has UNICEF's engagement on immunisation been consistent with interventions in other areas (such as Child Protection, Education, WASH) and international norms to which UNICEF adheres (internal Coherence) | Internally within UNICEF, which programmes have operational linkages with Immunization? Which are the ones with potential in future e.g. School health? | Identification of programme opportunities beyond immunization<br><br>Options for future engagement and synergy | KIIs with RO<br>FGDs with RO |
| | What would prevent working together in future, identified as a principle in IA 2030 – within immunization interventions, PHC/UHC implementation, management directions, earmarked donor funding, others? | Identification of potential negative factors for realistic expectations and risk management | KIIs with RO/HQ<br>FGDs with RO/HQ |
| | What would facilitate working together in future, identified as a principle in IA 2030 – within immunization interventions, PHC/UHC implementation, | Degree of alignment and synergies for achievement of common goals | KIIs with RO/HQ<br>FGDs with RO/HQ |

| | | | |
|---|---|---|---|
| | management directions, earmarked donor funding, others? | | |
| | How far the UNICEF COs demonstrate integration within Immunization interventions like RI, SIAs, and Polio NIDs? | Identify efficiency gains and system wastages – to assist structural and financial planning | Survey with 14 countries<br>KIIs with RO, COs<br>FGDs RO, Country partners |
| | Examples of best practice cases of partnerships of UNICEF immunization in humanitarian situations [internal and external] and how these partnerships assisted to improve immunization and other service access for affected communities? | Evidence of UNICEF contribution | Survey with 14 countries<br>KIIs with RO, COs |
| To what extent has UNICEF's engagement on immunisation been consistent with interventions supported by other agencies (external Coherence) | Which are the most important development partners (region, countries)? How similar (or different) are their interventions to those of UNICEF? | Degree of alignment | KIIs with RO, WHO, COs<br>FGDs with Country partners |
| | To what extent has UNICEF engaged with WHO and Gavi and other development partners [USAID, JICA or AUSAID, China CDC or US CDC, ADB or WB, ASEAN or ASEAN+3] in the region and what are the plus and minus points of UNICEF engagement? | Extent of engagement among most important stakeholders | Desk review<br>Survey with 10 countries<br>KIIs with RO, COs, WHO<br>FGDs with WHO, COs |
| | Which external partnerships are strong and working? Any other potential partnerships UNICEF should work for – regional, country? | Degree of synergy with key partners | Survey with 14 countries<br>FGDs with RO, Country partners |

| | | | |
|---|---|---|---|
| | What are the key drivers for engagement? Which partners are best for UNICEF to engage with? | Learn on UNICEF's strengths for future engagement strategy | Survey with 14 COs<br>KIIs with RO/HQ, COs<br>FGDs with RO/HQ |
| | What are examples from the region (or within countries) that demonstrate the role of UNICEF in engaging effectively with partners and other sectors in humanitarian situations? | Learn on UNICEF's strengthsEvidence of UNICEF contribution and partner segmentation – which partners for specific situations | KIIs with RO/HQ, COs<br>FGDs RO/HQ<br>KIIs with RO, COs<br>FGDs with Country partners |
| | What are the examples, if any, from the region (or within countries) that demonstrate the role of UNICEF in engaging effectively with partners and other sectors in socially disadvantaged communities? | Evidence of value of engagement<br><br>Planning for future engagement strategy | Survey with 14 countries<br>KIIs with RO, COs<br>FGDs with Country partners |
| | What are the examples of countries that implement Immunization as an integrated public health programme? What are the drivers (and mechanisms) for that? | Evidence that integration works (or not) to guide future engagement | Survey with 14 countries<br>KIIs with RO, COs |
| | To what extent UNICEF engagement approaches developing, changing or reforming to better meet the needs of socially disadvantaged and those in humanitarian situations? | Future directions – whether current approaches are sufficient or should be changed | KIIs with COs |

## Equity and Inclusiveness

| QUESTIONS | SUB-QUESTIONS | INTERPRETATION, INDICATORS, SUCCESS-FAILURE CRITERIA | METHODS FOR DATA COLLECTION* and MAIN SOURCES OF DATA/ INFORMATION |
|---|---|---|---|
| How far does the engagement sufficiently address the equity and inclusiveness dimensions for vulnerable, socially disadvantaged, geographically inaccessible and poor populations, and those in humanitarian situations | To what extent has UNICEF engaged in the region to improve access for disadvantaged populations? | Pass – Fail (Sufficient as expected or not) | Desk review<br>FGDs with RO, COs |
| | What are the examples (or case studies) of UNICEF's engagement in the region to improve access for disadvantaged populations? What could other interventions you think in the coming decade? | Identify scalable interventions<br>Avoiding too much piloting for time efficiencies | Survey with 14 countries<br>KIIs with RO, COs<br>FGDs with COs |
| | What are the equity dimensions UNICEF is best placed to address in future? | Degree to which UNICEF could impact equity related interventions | Survey with 14 countries<br>KIIs with RO, COs<br>FGDs with COs |
| | Main humanitarian challenges in the coming decade, and how can UNICEF immunization engage more effectively to anticipate and improve responses (Region, Country). | Extent to which UNICEF can be positioned as a humanitarian agency vis-à-vis other organizations | Survey with 14 countries<br>KIIs with RO, COs |
| | Examples of UNICEF routinely compiling segregated data and tailor-designed strategy/ies for specific groups. | Case studies, number of projects/geographies and pool of resources | Survey with 14 countries<br>KIIs with COs of 2 countries for in-depth studies |
| | How can UNICEF COs advance in the agenda for accessing zero dose children in future? | Extent of understanding and implementing an intervention related to inequity and inclusiveness | Survey with 14 countries<br>KIIs with RO, COs<br>FGDs with COs |

# 4 Ethics and Ethical Clearance

## 4.1 Adhering to the UNEG and UNICEF standards/guidance

Ethical issues and considerations are guided by the United Nations Evaluation Group (UNEG) for evaluation. The evaluators have the obligations as prescribed in the UNEG standards – independence, impartiality, credibility, accountability with no conflicts of interest.

The evaluation does not involve interviews or direct contact with the children or any population groups including vulnerable minorities and socially disadvantaged. The terms of refrence requires data collection through desk review of the documents, reports and other sources in public domain; and, interviews with the officials working in UNICEF, other agencies and Government only. As such a formal clearance by an Ethics committee may not be required.

# 5 Evaluation management

## 5.1 Evaluation team

Two technical units from UNICEF RO are leading this evaluation – Health and M&E. Three consultants are working for the evaluation, to be completed by end June 2022. The evaluation group consists of the following:

Koorosh Raffi – Regional Evaluation Specialist – oversight for achievement of the objectives and clearances (EMG/ERG)

K. Devi Aung – Regional Health Specialist – technical oversight

Scott Bamber – Consultant – quality of evaluation for design, implementation and analysis

John Joseph Grundy – Consultant – technical expertise for Immunization

Raj Kumar – Consultant – technical expertise for evaluation with knowledge of country and regional contexts

Nattha Tritasavit – Administrative support – organizing meetings, recording conversations, sharing notes

a) The three consultants will work together as 'Evaluation team' contributing the inputs for their respective expertise. For synergy, they may agree to divide the work during design, data collection, analysis and report preparation. The team is expected to deliver five products as per the ToRs:

- Inception report
- Evaluation report, including a narrative summary, up to 10 pages, of the assessment, best practices and key lessons
- A brief strategy, up to 4 pages, for engagement for UNICEF Regional Office (EAPRO) and each of Country groups
- Case studies, up to 2 pages of two countries from engagement perspectives
- Summary power point presentation and summarized graphics for the strategy of engagement

The differences with the original ToRs for the deliverables are – length of narrative summary, addition of a self-explanatory brief on engagement strategy, and length of the case studies.

b) For monitoring progress, a weekly or fortnightly meeting to be led by the RO leads to review the progress, agree on the priority work (or deliverable) for the next period, trouble shooting

c) EMG/ERG clearances, as required to be managed by RO leads – ethical clearance (if necessary), inception report, draft evaluation report, draft engagement strategy, final deliverables

d) Final presentation by the Evaluation team with a power point; and submission of final report, strategy and graphics. For the presentation, RO leads will determine participation

## 5.2 Evaluation work plan

The work plan has been prepared in line with the TORs. There are no significant deviations from the original work schedule, to be flagged.

| Dates | Activities and outputs | Notes |
|---|---|---|
| By 22 February | Submission and clearance of the Inception report, including desk review, evaluation methods and tools, and Evaluation questions | The approved IR will supersede the initial TORs |
| 22 February to 5 March | Finalization of the questionnaires for the survey and different groups of target respondents, finalization of the interviewees and FGD participants by names<br><br>Appointments for interviews and FGDs | If possible, the KIIs/FGDs with the RO, Regional WHO and HO will be positioned upfront |
| 5 March to 30 April | Sending and receiving the Survey questionnaires to COs soon after ERG clearance(with a deadline for the responses)<br><br>Conduct of all the interviews and FGDs as per appointments<br><br>Finalizing the Analytical framework for evaluation | Concurrent read through of the survey responses to determine if the KII or FGD guides need modifications |
| 1 May to 31 May | Analysis of the data gathered through surveys, KIIs, FGDs and supplementary review of reports, documents and internal resources (as per analytical framework)<br><br>Draft the narrative summary of the findings and conclusions (10 pages)<br><br>Outline and brief description for future engagement strategy (4 pages)<br><br>EMG/ERG presentation, using Power point | |
| 1 June to 30 June | Final evaluation report, including an executive summary and graphics, for advocacy use<br><br>Strategy for Engagement, either as separate document or as part of the Evaluation report<br><br>Power-Point presentation on the assessment findings, and strategy for engagement for RO and for the COs | Draft report will be shared with ERG/EMG for feedback<br><br>The report will be compliant with GEROS provisions |

| | | |
|---|---|---|
| | Two case studies (1 or 2 pages each) – if possible, one positive and one negative | and UNEG norms and standards |

*Table 4 Evaluation Work Plan*

## 5.3. Risks, Limitations and Mitigation to the Evaluation

**Risks**

a) Historically, Immunization programme alludes to numbers, coverage, data etc. In most situations it is managed as a vertical programme. Consequently the literature on softer aspects like engagement, for example case studies or best practices, is limited.

b) This evaluation is largely of a qualitative nature, heavily dependent on personal inter actions which is best captured through a face to face mode. The travel restrictions with Covid-19 pandemic makes this option impossible. There will be limitations in collecting this type of information through virtual mode. This is particularly important for seeking informed opinions (specifically future directions) from target interviewees/participants. This is not available through published reports, documents or even internal resources. It is nearly impossible to source this it through grey literature such as leadership interviews or internal UNICEF meetings. It is important to underscore that the virtual platforms have been working efficiently as proven during the pandemic times.

b) Wide diversity among the countries in the region with different characteristics (described elsewhere). No single size would suit this type of variance, even for engagement. A good example of UNICEF's structural response for tailored engagement is by way of creating a separate sub-office for PICs with good degree of autonomy and, which represents a region of its own within EAPRO.

c) The interpretations and recommendations will be meant for the region as a whole and specific country groups without any specific messages for the individual countries. There is a possibility that the chosen sample countries may not apply similar dynamics, some errors are also possible. That's why the starting point has been kept as a survey across all the countries.

**Limitations and mitigation**

Five risks are identified for this evaluation:

| Risk | Probability | Mitigation |
|---|---|---|
| Appointments for virtual interviews and FGDs changed at last minute, overlap of the appointments or even cancellation | High | John and Raj will hold parallel interviews for overlapping events. The preference will be for both of them to conduct the KII/FGD to the extent possible<br><br>Response of 80% of the events (KIIs and FGDs) will be considered as Pass response rate (14 out of planned 17)<br><br>Analysis will be carried out with the data already gathered |
| Non-response or delays with return of survey questionnaires | Medium | Up to two reminders, if required<br><br>There will be a deadline of 30 April for survey responses |

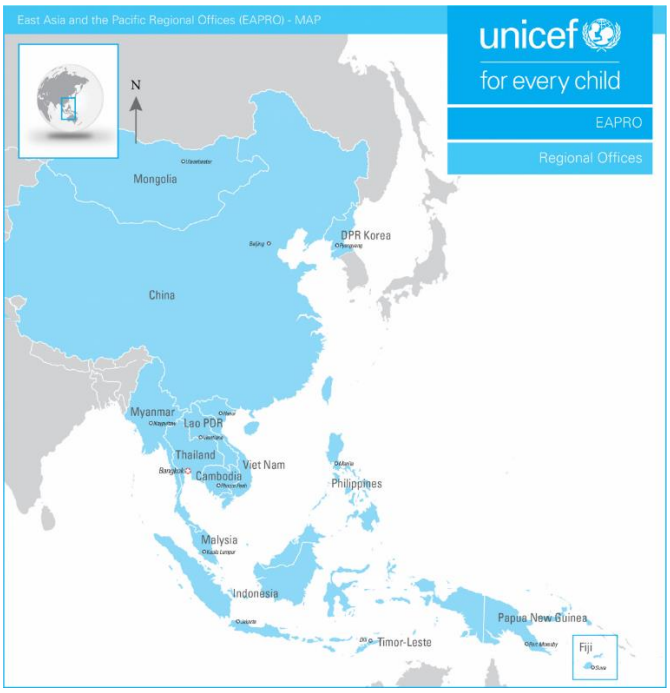
| | | |
|---|---|---|
| | | 80% response for the survey questionnaires will be considered adequate – 11 responses out of 14 planned considered as Pass criteria |
| Interim reading of the survey questionnaires show signification deviations from planned questions | Low | Revise and resolve in discussion with RO Leads |
| Connectivity issues with some participants | Low | Recording for all the events will provide a back up |

*Table 5 Risk Management Matrix*

Overall, the anticipated risks are not significant enough to impact the rigor of the information gathered through the planned events.

## Annex A Sampling methodology and Country selection

The East Asia and Pacific Region consists of 27 countries with active UNICEF operation. These are Cambodia, China, Indonesia, DPR Korea, Lao PDR, Malaysia, Mongolia, Myanmar, Pacific Islands (Cook Islands, Fiji, Kiribati, Marshall Islands, Micronesia, Niue, Nauru, Palau, Samoa, Solomon Islands, Tokelau, Tonga, Tuvalu and Vanuatu), Papua New Guinea, Philippines, Thailand, Timor-Leste and Vietnam. The Region is home to world's largest population country China on one hand, and several island countries with very low populations. UNICEF has no programmatic presence in the high income countries, not listed here.




Besides the size of the population and area, there are other distinctive differences, first of which is 14 island countries, clubbed together in above list, are referred to as a single unit of Pacific island countries (PICs). Three countries, namely China, Malaysia and Thailand have limited UNICEF immunization support and operation[2]. Among the remaining ten, nine countries (Cambodia, DPR Korea, Indonesia, Lao PDR, Mongolia, Myanmar, Papua New Guinea, Timor-Leste and Vietnam) have been recipients of Gavi funding though reduced significantly for graduated countries like Mongolia and Vietnam. Philippines is other remaining country. That constitutes the universe of the countries for this evaluation. China also received Gavi support in early 2000's but that is out of scope; with respect to this evaluation.

Yet another important dimension in the region is governance and decentralization. A number of countries have centralized governance with single party or military rule. This impacts public health implementation without much public opposition or resistance. On the other hand, decentralized governance in some other countries (for example, Indonesia, Thailand, Papua New Guinea) is the way the Government operates, meaning in-country advocacy with sub-national entities becomes an important element of any immunization programme to be delivered to the population.

The countries of EAPRO are spread across two regions of the WHO, the most important Immunization partner for UNICEF – Western Pacific (WPRO) and South East Asia (SEARO). Eight of

[2] These countries have extensive UNICEF Private Fundraising and Partnership (PFP) operations.

the 13 non PICs are part of WPRO and five are SEARO countries. With this type of diversity across the region, it is important to group the countries into logical combinations for data collection. Given the limitations of this evaluation, neither is it feasible to cover all the countries in limited time-framework that the rapid methodology requires; nor is there value addition in that. The following six groups are proposed for the countries of EAPRO for selection of a sample for in-depth exploration and enquiry. The ones in blue colour are SEARO countries.

| **Countries** | **Reasons for same group** | **Recommended country & Data Gathering Tools** |
|---|---|---|
| Group 1<br>China, Malaysia, Thailand | Upper end of economy (GDP PPP); Limited presence and influence UNICEF and international organizations | Thailand (Survey & KII) |
| Group 2<br>Cambodia, Lao People's Democratic Republic, Mongolia | Centralized governance; Lower end of economic development | Cambodia (Survey, KII, FGD) |
| Democratic People's Republic of Korea, Myanmar | Authoritarian; Humanitarian situation with no in-country presence of UNICEF for the time being | Myanmar (Case study) – Survey and KII |
| Group 3<br>Indonesia, Philippines, Vietnam, Timor Leste | Different levels of decentralization (except Vietnam); Large populations except Timor Leste; Relatively strong primary health care systems; Higher end of economic development; No (Philippines) or relatively little Gavi support | Indonesia (Survey, KII, FGD)<br>Philippines (Survey, KII, FGD) |
| Group 5<br>Papua New Guinea | A basket case by itself; Largest receiver of Australian aid | Papua New Guinea (Case study) – Survey, KII only |
| Group 6<br>Pacific Island countries | Small island countries; Large influence of Australia & NZ; Little impact on Regional/Global goals due to small populations | None since UNICEF already has a hub in Fiji for specific situation of the PICs |

*Table 6 Country Classifications*

In conclusion, deep dive interviews and focus group discussions with a sample of six countries – Cambodia, Indonesia, Philippines and Thailand will represent sufficiently the variable country dynamics of the region plus Papua New Guinea and Myanmar as country case studies, both tentative.

From a programmatic angle, the criteria for country selection should be (a) country classification – GNP per capita, Gavi eligibility by group - eligible, transitioning, graduated, never eligible (b) Numbers of unvaccinated/zero dose children and disease outbreaks (Measles, Polio, Diphtheria, Pertussis), (c) Demographic or social context - Urban Poor, Humanitarian Emergency, Ethnic Minority, Remote Area. Since the universe is 14 countries only, not all the criteria can fit into selecting the country. The suggested list of four countries represent the characteristics mentioned. PNG is a unique in a sense that no other country in the region shares similar characteristics, as also Myanmar where the situation has changed dramatically following the military coup a year back – both included as case studies.

Finally, it should be noted that there is an element of subjectivity for country selection, which has been finalized by reaching consensus among the members of the evaluation team (three consultants and two EAPRO specialists).

## Annex B Data Collection Tools

### A. Survey Questionnaire for 14 Countries

This survey is being conducted for the purpose of making a regional assessment of current approaches by UNICEF to engagement on immunisation as well as to inform the development of an EAPRO Regional Strategy on Engagement for immunisation 2022 – 2030. We are requesting your input on how well UNICEF is engaging with stakeholders on immunisation from the national to the community level, and how this engagement can work better in the future.

The survey form should be completed by the Chief of Health and/or Immunisation Officer at UNICEF. We anticipate a time investment between 60 to 75 minutes for completion.

Your responses will be kept confidential and no identifying information will be included in the report. The questionnaires will be achieved after analysis. The draft analysis will be shared with you for checking the errors. The final report will be available to all participants in the survey, key informant interviews and focus group discussions. If you require further background on the purpose of this questionnaire, please contact * at this email * and telephone number/s * Your contribution to this Evaluation and Engagement Strategy will be greatly appreciated.

==========

Country: Date: Designated Role at UNICEF:

<table>
<tr><td>1. List the main immunization partners at your Country Office. For each partner, on a scale of 1 (not at all) to 5 (very much), are these partnerships achieving results in your Country?</td><td>Partner<br>1<br>2<br>3<br>4<br>5<br>Other</td><td>Place X over number<br>1 2 3 4 5<br>1 2 3 4 5<br>1 2 3 4 5<br>1 2 3 4 5<br>1 2 3 4 5</td></tr>
<tr><td>2. Please briefly describe the main results from these partnerships.<br><br>[Please provide links to reports if available]</td><td>Partner<br>1<br><br>2<br><br>3<br><br>4<br><br>5<br><br>Other</td><td>Main Result<br>1<br><br>2<br><br>3<br><br>4<br><br>5<br><br>Other</td></tr>
<tr><td>3. What are UNICEF's comparative advantages/added value in addressing immunization programmes?</td><td colspan="2">1<br><br>2<br><br>3<br><br>4<br><br>5<br><br>Other</td></tr>
</table>

| | | |
|---|---|---|
| 4. Can you provide 1-3 examples where UNICEF has been most successful with engagement or partnerships in immunisation in the country?<br><br>[Please provide links to any published reports if available] | 1.<br><br>2.<br><br>3. | |
| 5. Describe what have been the main roles of UNICEF in maintaining or restoring immunisation services during the COVID pandemic. | 1.<br><br>2.<br><br>3. | |
| 6. **On a scale of 1 (not at all) to 5 (very much),** to what extent do engagement strategies or partnerships need to improve in the coming decade so that UNICEF can have a more effective immunisation program? | Leadership and Policy<br>Supply Chain<br>Coverage Improvement<br>Data Quality<br>Community Engagement<br>Other [Name……..] | MARK WITH X<br><br>1 2 3 4 5 NA<br>1 2 3 4 5 NA<br>1 2 3 4 5 NA<br>1 2 3 4 5 NA<br>1 2 3 4 5 NA<br>1 2 3 4 5 NA<br><br>NA (not Applicable) |
| 7. **On a scale of 1 (not well) to 5 (extremely well)**, how well does current UNICEF immunisation programming align with national immunisation needs, gaps and challenges? | Leadership and Policy<br>Supply Chain<br>Coverage Improvement<br>Data Quality<br>Community Engagement<br>Other [Name……..] | <br>1 2 3 4 5 NA<br>1 2 3 4 5 NA<br>1 2 3 4 5 NA<br>1 2 3 4 5 NA<br>1 2 3 4 5 NA<br>1 2 3 4 5 NA<br><br>NA (not Applicable) |
| 8. What are the three main bottlenecks to improved engagement on immunisation for disadvantaged populations? | 1<br><br>2<br><br>3 | |
| 9. Life course and Integration of Immunisation with health systems/PHC are major global immunisation strategic directions [Immunisation 2030 and UNICEF Immunisation Roadmap]. Can you describe three main priority actions for UNICEF at country level to move in this direction? | 1<br><br>2<br><br>3 | |
| 10. **On a scale of 1 (not well) to 5 (extremely well),** how well does UNICEF immunisation programming operationally link with other UNICEF programs for improving child health and development?<br>11. | Education<br>Health<br>WASH<br>Child Protection<br>Other [NAME……..] | <br>1 2 3 4 5 NA<br>1 2 3 4 5 NA<br>1 2 3 4 5 NA<br>1 2 3 4 5 NA<br>1 2 3 4 5 NA |

| | | |
|---|---|---|
| [Can you give examples of operational links with other program sections?] | | |
| 12. **On a scale of 1 (not well) to 5 (extremely well) ,** how well does UNICEF immunisation programmes link externally with other partners and agencies and sectors?<br><br>[Can you give an example of operational links with other program sections?] | Political Leaders<br>Gavi<br>WHO<br>Ministry of Health<br>National EPI Program<br>Other Sectors<br>Private Sector<br>NGOs/Civil Society<br>Local Government<br>Community Leaders<br>Other [NAME ] | 1 2 3 4 5 NA<br>1 2 3 4 5 NA<br>1 2 3 4 5 NA<br>1 2 3 4 5 NA<br>1 2 3 4 5 NA<br>1 2 3 4 5 NA<br>1 2 3 4 5 NA<br>1 2 3 4 5 NA<br>1 2 3 4 5 NA<br>1 2 3 4 5 NA<br>1 2 3 4 5 NA |
| 13. For the more successful partnerships, what do you consider were the three main factors that made the partnerships work well? | 1<br>2.<br>3. | |
| 14. **On a scale of 1 (not well) to 5 (extremely well),** how well has UNICEF engaged in the country to improve access for different categories of socially disadvantaged populations? | Urban Poor<br>Humanitarian Emergency<br>Remote Area Residents<br>Rural Poor<br>Gender Issues<br>Ethnic /Religious Minority<br>Stateless Population<br>Migrants<br>People with disability<br>Other [Name……..] | 1 2 3 4 5 NA<br>1 2 3 4 5 NA<br>1 2 3 4 5 NA<br>1 2 3 4 5 NA<br>1 2 3 4 5 NA<br>1 2 3 4 5 NA<br>1 2 3 4 5 NA<br>1 2 3 4 5 NA<br>1 2 3 4 5 NA<br>1 2 3 4 5 NA |
| 15. What are best practice examples (or case studies) of UNICEF's engagement in the country that have been tailored to improve access for disadvantaged populations? | 1.<br><br>2.<br><br>3.<br>[Provide link to report or publication if available] | |
| 16. **On a scale of 1 (not well ) to 5 (extremely well),** how well does UNICEF conduct the following C4D (communication for development) interventions or support actions?: | Research to inform communication on immunisation<br><br>Resourcing of C4D for immunisation<br><br>Coordination of C4D communication activities with other programs<br><br>Training of UNICEF CO staff in C4D | 1 2 3 4 5 NA<br><br>1 2 3 4 5 NA<br><br>1 2 3 4 5 NA<br><br>1 2 3 4 5 NA |

| | | |
|---|---|---|
| | Addressing Misinformation or hesitancy about Vaccines | 1 2 3 4 5 NA |
| 17. What is a good example of strategic partnership with respect to C4D that led to either increased immunization coverage or access to socially inaccessible population groups? | | |
| 18. What are the three most important barriers or challenges for UNICEF COs to advance the zero-dose agenda? | 1<br><br>2<br><br>3 | |
| 19. In your view, what are the three most important strategies or priorities for UNICEF COs to advance the agenda for accessing zero dose children and communities in the future? | 1.<br><br>2.<br><br>3.<br>[ Provide link to strategy or report if available] | |
| 20. Any final comments on any aspect of UNICEF's 'engagement' on immunisation in the region or the country?<br><br>Do you wish to be contacted for further discussion or to give more information not covered here? | | |

## B. Key Informant Interview Regional

This interview is being conducted for the purpose of making a regional assessment of current approaches by UNICEF to engagement on immunisation as well as to support development of a EAPRO Regional Strategy on Engagement for immunisation 2022 – 2030. We are requesting your input on how well UNICEF is engaging with stakeholders on immunisation from the national to the community level, and how this engagement can work better in the future. This interview should take approximately 45 minutes. Your contribution to this Evaluation and Engagement Strategy will be greatly appreciated. Do you have any questions? May we proceed?

Regional Role: Date:

1. **How effective has UNICEF engagement been, both internally with other programmes and externally with Immunization stakeholders, in achieving better immunisation services or outcomes?**
   Prompts:

   - Engagement Internally with UNICEF programs at Regional level & With Countries [main structures, processes, coordination – strengths & weaknesses]
   - Engagement Externally with partners, Member States of WHO, Gavi and others, [WHO, USAID, JICA or AUSAID, China CDC or US CDC, ADB or WB, ASEAN or ASEAN+3] [main structures, processes, coordination – strengths & weaknesses]
   - Priority setting for engagement: Government, UNICEF CO, level of autonomy of RO and COs
   - Leadership & Policy and Supply Chain or other aspect of immunisation system [Strengths and weaknesses in Engagement, case studies].
   - Communication for development (C4D): [Strengths and weaknesses – Research - Evidence Base, Resource Allocation, Coordination, Capacity Development]
   - Effects of partnerships, and potentially different approaches.
   - FUTURE: Changes in partnership arrangements that are needed to improve UNICEF's role in supply chain management and policy and leadership and C4D

2. **To what extent do you consider that UNICEF immunisation programs adequately address the seven strategic priorities identified in the IA2030 Agenda?**
   Prompts:

   - Seven Strategic priorities: PHC for UHC, Commitment & Demand, Coverage & Equity, Life Course and Integration, Outbreaks and Emergencies, Supply and Sustainability, Research and Innovation
   - Strengths and weaknesses in Engagement on any of these strategic priorities
   - FUTURE: Life Course and Integration: What should UNICEF do at regional level, or how should UNICEF engagement evolve to move in this direction?

3. **To what extent has UNICEF's engagement on immunisation been consistent with interventions in other areas (such as Child Protection, Education, WASH) and international norms to which UNICEF adheres? [Internal Coherence]**
   Prompts:

   - Coherence of *immunisation management internally* at Regional and Country Level (Routine EPI, SIAs-campaigns, Disease control programs polio measles etc, as well as

with *other Programs* – WASH, Education, C4D etc) – Strengths and weaknesses – case Studies
- FUTURE: Actions by UNICEF Country Office in the coming years that will improve internal collaborations – internal engagement structures, processes, guidance/TA. [How change will be facilitated.]

4. **To what extent has UNICEF's engagement on immunisation been consistent with interventions supported by other agencies [External Coherence]**
   Prompts:

   - Engagement of immunisation with PHC/UHC policy, planning at regional level – strengths and weaknesses, case studies
   - Engagement of immunisation Regionally with Development Partners WHO and Gavi – strengths and weaknesses
   - Drivers of successful collaborations/partnerships regionally
   - FUTURE: Changes or Reforms needed by UNICEF to engage more effectively externally with stakeholders regionally and with countries [Engagement Forums, Activities, Guidance or Support, or other]

5. **Does the current engagement approach at Regional and Country Level sufficiently address the equity and inclusiveness dimensions for vulnerable, socially disadvantaged, geographically inaccessible, and poor populations, and those in humanitarian situations?**
   Prompts:

   - Role of UNICEF regionally in improving access for *social disadvantaged groups* – strengths/weaknesses - [Examples/Case Studies]
   - Role of UNICEF regionally in improving access to immunisation for populations in *humanitarian emergencies* – strengths/weaknesses - [Examples/Case Studies]
   - Zero Dose approach: Regional strategy on engagement with partners and countries Strengths/weaknesses - [Examples/Case Studies]
   - FUTURE: Engagement Changes or Reforms needed by UNICEF with other partners to better meet the needs of socially disadvantaged populations [Engagement Forums, Activities, Guidance or Support, or other]

6. **Do you have any final recommendations on priority actions by UNICEF at Regional level over the next 8 years to improve engagement with stakeholders for better immunisation services and outcomes?**
   Prompts:

   - Priority Actions Internally by UNICEF with its own programs
   - Priority Actions Externally by UNICEF with other partners

7. **Do you have any final comments on any aspect of UNICEF's engagement on immunisation in the region?**

## C. Key Informant Interview Country

This interview is being conducted for the purpose of making a regional assessment of current approaches by UNICEF to engagement on immunisation as well as to support development of a EAPRO Regional Strategy on Engagement for immunisation 2022 – 2030. We are requesting your input on how well UNICEF is engaging with stakeholders on immunisation from the national to the community level, and how this engagement can work better in the future. This discussion should take approximately 45-60 minutes. Your contribution to this Evaluation and Engagement Strategy will be greatly appreciated. Do you have any questions before commencing?

1. **How effective has UNICEF engagement been, both internally with other programmes and externally with Immunization stakeholders, in achieving better immunisation services or outcomes?**
   Prompts:

   - Engagement Internally with UNICEF programs at Regional level & With Countries [main structures, processes, coordination – strengths & weaknesses]
   - Engagement Externally with partners, Member States of WHO, Gavi and others [other UN agencies, USAID, JICA, China CDC or US CDC, ADB or WB, NGOs or others]
   - [main structures, processes, coordination – strengths & weaknesses]
   - Priority setting for engagement: Government, UNICEF CO, level of autonomy of CO.
   - Leadership & Policy and Supply Chain or other aspect of immunisation system [Strengths and weaknesses in Engagement, case studies].
   - Effects of partnerships, and potentially different approaches.
   - FUTURE: Changes in partnership arrangements that are needed to improve UNICEF's role in supply chain management and policy and leadership

2. **To what extent do you consider that UNICEF immunisation programs adequately address the seven strategic priorities identified in the IA2030 Agenda?**
   Prompts:

   - Seven Strategic priorities: PHC for UHC, Commitment & Demand, Coverage & Equity, Life Course and Integration, Outbreaks and Emergencies, Supply and Sustainability, Research and Innovation
   - Strengths and weaknesses in Engagement on any of these strategic priorities
   - FUTURE: Life Course and Integration: What should UNICEF do at country level, or how should UNICEF engagement evolve to move in this direction?

3. **To what extent has UNICEF's engagement on immunisation been consistent with interventions in other areas (such as Child Protection, Education, WASH) and international norms to which UNICEF adheres? [Internal Coherence]**
   Prompts:

   - Coherence of *immunisation management internally* at Country Level (Routine EPI, SIAs-campaigns, Disease control programs polio measles etc, as well as with *other Programs* – WASH, Education etc) – Strengths and weaknesses - Case studies
   - FUTURE: Actions by UNICEF at Country Level in the coming years that will improve internal collaborations – internal engagement structures, processes, guidance/TA, C4D. [How change will be facilitated.]

4. **To what extent has UNICEF's engagement on immunisation been consistent with interventions supported by other agencies [External Coherence]**
   Prompts:

   - Engagement of immunisation with PHC/UHC policy, planning at national level – strengths and weaknesses, case studies
   - Engagement of immunisation at country level with Development Partners WHO and Gavi – strengths and weaknesses – case studies
   - Drivers of successful collaborations/partnerships regionally
   - FUTURE: Changes or Reforms needed by UNICEF to engage more effectively externally with stakeholders at the country level [Engagement Forums, Activities, Guidance or Support, other] [Stakeholders – Government, Sectors, NGOs, private sector, community leaders]

5. **Does the current engagement approach at Regional and Country Level sufficiently address the equity and inclusiveness dimensions for vulnerable, socially disadvantaged, geographically inaccessible, and poor populations, and those in humanitarian situations?**
   Prompts:

   - Role of UNICEF at country level in improving access for *social disadvantaged groups* – strengths/weaknesses - [Examples/Case Studies]
   - Role of UNICEF in countries for improving access to immunisation for populations in *humanitarian emergencies* – strengths/weaknesses - [Examples/Case Studies]
   - Zero Dose approach: UNICEF strategy on engagement with stakeholders on zero dose: strengths/weaknesses - [Examples/Case Studies] [Stakeholders – Govt, Sectors, NGOs, private sector, community leaders]
   - FUTURE: Engagement Changes or Reforms needed by UNICEF Country Office with other partners to better meet the needs of socially disadvantaged populations [Engagement Forums, Activities, Guidance or Support, C4D or other]

6. **Do you have any final recommendations on priority actions by UNICEF Country Office over the next 8 years to improve engagement with stakeholders for better immunisation services and outcomes?** [Stakeholders – Govt, Sectors, NGOs, private sector, community leaders]
   Prompts:

   - Priority Actions Internally by UNICEF with its own programs
   - Priority Actions Externally by UNICEF with other partners

7. **Do you have any final comments on any aspect of UNICEF's engagement on immunisation in the region?**

## D.FGD Question Guideline Regional

This discussion is being conducted for the purpose of making a regional assessment of current approaches by UNICEF to engagement on immunisation as well as to support development of a EAPRO Regional Strategy on Engagement for immunisation 2022 – 2030 that is alignment with the Immunisation Agenda 2030. We are requesting your input on how well UNICEF is engaging with stakeholders on immunisation both regionally and at country level, and how this engagement can work better in the future. This discussion should take approximately 45-60 minutes. Your contribution to this Evaluation and Engagement Strategy will be greatly appreciated. Do you have any questions before commencing?

Regional Role: Date:

Participant Introductions

1. **How effective has UNICEF engagement been with Immunization stakeholders in achieving better immunisation services or outcomes?**
   Prompts:
   - Engagement with other development partners [WHO, Gavi,USAID, JICA or AUSAID, China CDC or US CDC, ADB or WB, ASEAN or ASEAN+3, NGOs or others] ]
   - Engagement with stakeholders. Coordination. [Governments, NGOs, Private Sector, other]
   - Priority setting for engagement: Government, UNICEF CO, level of autonomy of RO and COs.
   - Leadership & Policy and Supply Chain or other aspect of immunisation system [Strengths and weaknesses in Engagement, case studies].
   - Effects of partnerships, and potentially different approaches.
   - FUTURE: Changes in partnership arrangements that are needed to improve UNICEF's role in supply chain management and policy and leadership at regional level

2. **To what extent do you consider that UNICEF immunisation programs adequately address the seven strategic priorities identified in the IA2030 Agenda?**
   Prompts:
   - Note: Seven Strategic priorities are: PHC for UHC, Commitment & Demand, Coverage & Equity, Life Course and Integration, Outbreaks and Emergencies, Supply and Sustainability, Research and Innovation
   - Strengths and weaknesses in Engagement on any of these strategic priorities
   - FUTURE: Life Course and Integration: What should UNICEF do at regional level, or how should UNICEF engagement evolve to move in this direction?

3. **To what extent has UNICEF's engagement on immunisation been consistent with interventions supported by other programs, sectors or agencies**
   Prompts:
   - Engagement of immunisation with PHC/UHC policy, planning at regional level – strengths and weaknesses, case studies
   - Engagement of immunisation Regionally with Development Partners WHO and Gavi – strengths and weaknesses

- Engagement by UNICEF internally with its own programs – [Health, Education, WASH, other]
- Drivers of successful collaborations/partnerships regionally
- FUTURE: Changes or Reforms needed by UNICEF to engage more effectively with stakeholders regionally and with countries [Engagement Forums, Activities, Guidance or Support, other]

4. **Does the current engagement approach at Regional and Country Level sufficiently address the equity and inclusiveness dimensions for vulnerable, socially disadvantaged, geographically inaccessible, and poor populations, and those in humanitarian situations?**
   Prompts:

   - Role of UNICEF regionally in improving access for *social disadvantaged groups* – strengths/weaknesses - [Examples/Case Studies]
   - Role of UNICEF regionally in improving access to immunisation for populations in *humanitarian emergencies* – strengths/weaknesses - [Examples/Case Studies]
   - Zero Dose approach: Regional strategy on engagement with partners and countries Strengths/weaknesses - [Examples/Case Studies]
   - FUTURE: Engagement Changes or Reforms needed by UNICEF with other partners to better collaborate with partners to meet the needs of socially disadvantaged populations [Engagement Forums, Activities, Guidance or Support, other]

5. **Do you have any final recommendations on priority actions by UNICEF at Regional level over the next 8 years to improve engagement with stakeholders for better immunisation services and outcomes?**
   Prompts:

   - Priority Actions Internally by UNICEF with its own programs
   - Priority Actions Externally by UNICEF with other partners

**6. Do you have any final comments on any aspect of UNICEF's engagement on immunisation in the region?**

## E.FGD Question Guideline Country

This discussion is being conducted for the purpose of making a regional assessment of current approaches by UNICEF to engagement on immunisation as well as to support development of a EAPRO Regional Strategy on Engagement for immunisation 2022 – 2030 that is in alignment with the Immunisation Agenda 2030 and national immunisation priorities. We are requesting your input on how well UNICEF is engaging with stakeholders on immunisation at country level, and how this engagement can work better in the future. This discussion should take 45-90 minutes. Your contribution to this Evaluation and Engagement Strategy will be greatly appreciated. Do you have any questions before commencing?

Participant Introductions

1. **How effective has UNICEF engagement been with Immunization stakeholders in achieving better immunisation services or outcomes?**
   Prompts:
   - Identify who the most important immunization stakeholders in their country
     - Engagement other development partners [WHO, Gavi, [other UN agencies, USAID, JICA, China CDC or US CDC, ADB or WB, NGOs or others] ]
     - Engagement with stakeholders [Governments, NGOs, Private Sector, other]
     - Effectiveness of Coordination
   - Priority setting for engagement: Government, UNICEF CO, level of autonomy of CO.
   - Leadership & Policy and Supply Chain or other aspect of immunisation system [Strengths and weaknesses in Engagement, case studies].
   - Effects of partnerships, and potentially different approaches.
   - FUTURE: Changes in partnership arrangements that are needed to improve UNICEF's role in supply chain management and policy and leadership at country level

2. **To what extent do you consider that UNICEF immunisation programs adequately address the seven strategic priorities identified in the IA2030 Agenda?**
   Prompts:
   - Note: Seven Strategic priorities: PHC for UHC, Commitment & Demand, Coverage & Equity, Life Course and Integration, Outbreaks and Emergencies, Supply and Sustainability, Research and Innovation
   - Strengths and weaknesses in Engagement on any of these strategic priorities
   - FUTURE: Life Course and Integration: What should UNICEF do at country level, or how should UNICEF engagement evolve to move in this direction?

3. **To what extent has UNICEF's engagement on immunisation been consistent with interventions supported by other programs, sectors or agencies**
   Prompts:
   - Engagement of immunisation with PHC/UHC policy, planning at national or sub national level – strengths and weaknesses, case studies
   - Engagement of immunisation at National or sub national level with Development Partners WHO and Gavi – strengths and weaknesses

- Engagement by UNICEF internally with its own programs – [Health, Education, WASH, other]
- Drivers of successful collaborations/partnerships nationally or subrationally
- FUTURE: Changes or Reforms needed by UNICEF to engage more effectively with stakeholders in countries?

4. **Does the current engagement approach at Regional and Country Level sufficiently address the equity and inclusiveness dimensions for vulnerable, socially disadvantaged, geographically inaccessible, and poor populations, and those in humanitarian situations?**
   Prompts:

   - Role of UNICEF regionally in improving access for *social disadvantaged groups* – strengths/weaknesses - [Examples/Case Studies]
   - Role of UNICEF regionally in improving access to immunisation for populations in *humanitarian emergencies* – strengths/weaknesses - [Examples/Case Studies]
   - Zero Dose approach: Regional strategy on engagement with partners and countries Strengths/weaknesses - [Examples/Case Studies]
   - FUTURE: Engagement Changes or Reforms needed by UNICEF with other partners to better collaborate with partners to meet the needs of socially disadvantaged populations [Engagement Forums, Activities, Guidance or Support, other]

5. **Do you have any final recommendations on priority actions by UNICEF at Country level over the next 8 years to improve engagement with stakeholders for better immunisation services and outcomes?**
   Prompts:

   - Priority Actions by UNICEF Regionally with other partners
   - Priority Actions by UNICEF in countries with other partners

6. **Do you have any final comments on any aspect of UNICEF's engagement on immunisation in the region?**

## Annex C Desk Review

**Purpose and objectives of the Desk review**

The main purpose of this evaluation is to assess East Asia Pacific Region (EAPRO) Regional and Country Office engagement on immunisation for 2018-2021 in support of development of Regional engagement strategy for immunisation for the next 3-5 years (as a contribution towards the IA2030 and UNICEF Immunization Roadmap 2018-2030 goals).[22] This is the first attempt by EAPRO to define this strategy.

Engagement can be visualised from several perspectives. It can be visualised by the way that UNICEF engages internally with its own programs within health and across program sectors including WASH, nutrition and child protection. The engagement perspective can also be shaped by awareness of the comparative advantages of UNICEF in immunisation over other stakeholders in areas such as procurement, distribution and supply of vaccine, cold chain, and supplies, advocating for immunization as a child rights' issue, leadership and policy on immunisation and in addressing demand specific challenges. These engagement perspectives that are internal to UNICEF programming can also be complemented by the external perspective of UNICEF engagement with governments, partners, health sectors and multi sector programs, with implementing partners and with communities.

**Methods**

Literature was purposefully selected through identifying the core policies and strategies on PHC and immunisation from websites [23], from relevant global immunisation data bases, [24]and through consultation with regional offices of UNICEF. The background review is divided into two sections. The first section (program review) examines current policy and strategy landscapes for immunisation and health, with a special focus on models of engagement and the role of UNICEF in these areas. The second section examines sector challenges (and opportunities where relevant) and the implications these have for improved UNICEF engagement on immunisation and PHC in the Region.

**Findings**

**Landscape of Immunisation Policy and Strategy Globally**

*Current global strategies of WHO and UNICEF on Immunisation and PHC. The main policy and strategy directions as outlined in UNICEF Roadmap on Immunisation, the Immunisation Agenda 2030. Strategies and policies are further discussed in terms of engagement/partnership themes.*

***The Operational Framework for Primary Health Care*** is an outcome of the Astana declaration on PHC [25]and the related development of a Vision of Primary Health Care.[26] The operational framework is classified into three main components of multi sector collaboration, integrated services and public health and community empowerment. Operationalising the vision of PHC is framed according to 14 "levers" of which four are strategic and 10 are more operational in nature.[27] Each of these levers is associated with a set of core interventions that are defined for each lever. The four strategic levers of political commitment, resourcing, policy and governance and community engagement have been demonstrated to be essential conditions for successful application of each operational lever.[28]

***The UNICEF Roadmap on Immunisation*** identifies three main principles for programming covering rights to full immunisation and related accountabilities, strengthening delivery systems with a focus on the disadvantaged, and immunisation as a driver of integrated and multi sector interventions to improve child health. [29] The roadmap identifies several shifts in immunisation strategy and operations that include financial sustainability that are summarised in the text box below:

- Ensuring that immunization programmes are financially sustainable and can contribute to stronger
- Health systems that deliver integrated primary health care services and prioritize marginalized and
- underserved communities.
- Strengthening integrated service delivery, supply chain systems and front-line health workforces.
- Building the capacity of UNICEF staff, governments and civil society partners to implement data-driven social and behavioural change interventions.
- Strengthening the emphasis on reaching mothers and adolescents with immunization services.
- Leading efforts to develop and scale up immunization-related innovations and new approaches.
- Committing to and redoubling efforts towards the global eradication of polio, the elimination of maternal and neonatal tetanus, and the attainment of measles and rubella elimination targets.
- Influencing vaccines and immunization supply markets; and
- Strengthening preparedness for humanitarian responses and robust responses, esp. in fragile states

*Figure 3 Shifts in Immunisation Strategy Identified in UNICEF Roadmap Document*

Engagement is conceptualised in several ways and through different sets of stakeholders. *Multi sector engagement* is considered more important. Economic growth is creating new wealth and poverty patterns, which will result in engaging with actors outside health including within the private sector. It will also result in more emphasis on engagement with economists, and finance ministries and specialists. *Engagement with different population age groups* is stressed, as exemplified by provision of TT vaccines for pregnant women and HPV vaccines for adolescents. Community engagement can be improved through *improving skills of front-line health workers* in areas such as interpersonal and community communications. The roadmap indicates the need for a focus on evidence generation and operational research, which will likely entail increased partnerships with stakeholders and the research community on research priority setting, capacity building and implementation. Innovation in *communication technologies* will also open new pathways for community engagement. Engagement is also undertaken through global partnerships
That include Immunization Agenda 2030 [see below], the COVAX initiative , the Global Polio Eradication Initiative, the Measles and Rubella Initiative, and the Maternal and Neonatal Tetanus Elimination Initiative.

***The Immunisation Agenda 2030*** is jointly owned by UNICEF, WHO, and the Vaccine Alliance (Gavi). This global agenda identifies seven strategic priorities all of which are relevant to engagement as illustrated in Table 7.[30] These *strategic priorities* include immunization programmes for primary health care and universal health coverage, commitment and demand, coverage and equity, life-course and integration, outbreaks and emergencies, supply and sustainability and research and innovation. The emphasis on “leaving no-one behind” in the vision statement highlights the focus throughout the document on equity and on tailoring of services for marginalised populations. Impact is measured in terms of reduced morbidity and mortality, equitable access and good health and wellbeing through a PHC approach. The agenda also identified 4 core principles of people centred services, country ownership, and partnership based, and data driven programming. Partnership based actions (of most relevance to this evaluation) are summarised in the table below against the 7 strategic actions of the IA2030 Agenda.

| Strategic priority | Partnership Based Actions |
|---|---|
| PHC for UHC | Public and private partnerships will be formed, including with **partners beyond the health sector, with the private sector and with civil society organizations**, for coordinated strengthening of immunization programmes. |
| Commitment & Demand | New partnerships will be built among **multiple actors** to increase knowledge and raise awareness of the value of immunization, to build community trust and to overcome barriers to equity, including gender-related barriers. |
| Coverage & Equity | Partnerships will be built with **local communities and representatives of marginalized groups** to understand the obstacles to access to vaccination (including **gender barriers** faced by recipients, caregivers and health workers) and to address inequities. |
| Life Course and Integration | Partnerships with other health programmes and with non-health actors (including **education, water, sanitation, hygiene and nutrition**) are built into comprehensive life-course approaches for disease control and elimination, including for pneumococcus pneumonia, diarrhoea and cervical cancer. |
| Outbreaks and Emergencies | Partnerships will be built to prioritize and support **capacity building, planning and leadership of local and national organizations for coordinated Provision of health care**, including vaccination, in such a way as to support existing health systems and surveillance strategies during outbreaks and other acute emergencies and also in settings of humanitarian aid. |
| Supply and Sustainability | Better partnerships will be built to plan for and ensure long-term, **Sustainable financing,** and all partners will have clear roles and responsibilities and be accountable. Enhanced collaboration among stakeholders will support healthy vaccine markets. |
| Research and Innovation | Partners will devise ways to support the development, evaluation, use and sustainability of immunization solutions, drawing on the complementary expertise of national and global stakeholders. |

*Table 7 Partnership Actions Based in Immunisation Agenda 2030 [WHO, UNICEF, GAVI]*

The IA2030 states that there are new directions in this agenda which include tailoring to national needs/contexts, a Life course approach, targeted ways to reduce inequities, application of gender responsive strategies, a stronger focus on system strengthening, measles as a tracer, strengthening partnerships beyond health, innovation, and self-sustainability.

***The Global Vaccine Alliance (Gavi) 5.0 Strategy 2021-2025*** [31] adopts a vison of "leaving no one behind with immunisation" which continues this theme of equity oriented global health programming. The strategy announces a strategic "shift" towards reaching "zero-dose" children and missed communities, tailored, and targeted approaches for countries and more emphasis on programmatic sustainability. Principles include missed communities as a "first priority" , gender focussed, applying immunisation as an enabler for integrated primary health care and promotion of country ownership, all of which have implications for engagement strategy.

In summary, the global literature identifies strategic shifts towards pro equity operations and missed communities, country led and community owned immunisation services, tailored approaches and new approaches to partnership building with communities and beyond the health sector.

**Landscape of Immunisation Policy and Strategy Regionally**

*Current regional strategies of WHO and UNICEF on Immunisation and PHC are discussed here. The discussion identifies the main reform trends set out in Regional PHC/HSS and immunisation strategies and policies (including SEARO/WPRO), as well as results and directions for disease control. Discussion is concentrated on role of engagement in designing and implementing strategies over the past 5 years and into the future.*

Regions and countries are currently undertaking efforts to translate global strategies for PHC and immunisation into regional and national strategies and policies.

WHO has recently developed a ***Regional Strategy on Primary Health Care***, which identifies 12 priority actions for adoption by Member States in the next 8 years to support more of a PHC Orientation of health systems. [32] New directions include promoting multi sector convergence to address the social determinants of health, reorganisation of PHC services especially in terms of urban health and integration with public health, institutionalising a Health in All policies approach, community empowerment and building a culture of wellness and wellbeing, and development of more of a multidisciplinary health team approach. This strategy is complemented by a regional strategy for PHC of the World Bank. [33] This strategy identifies three ***Priorities for Reimagining Primary Health Care*** that include adoption of a multi-disciplinary team-based approach, reform of the health care workforce and improved financing for primary health care systems. Realizing these goals will entail a strategic shift in the design of PHC systems towards quality of care, service integration, fairness and accountability and development of more resilient systems.

A ***Regional Strategic Framework for Vaccine Preventable Diseases and Immunization in the Western Pacific*** (2021-2030) aims to expand the scope of immunization, maximising benefits of vaccines and programmes and further accelerating control and elimination activities for vaccine preventable diseases (VPDs) "beyond those originally targeted." [34] The three strategic objectives of this framework include strengthening and expanding immunisation systems and programs, managing health intelligence on VPDs and immunization and ensuring preparedness and response for public health emergencies related to VPDs.[3] Eighteen strategies are proposed to achieve the three strategic objectives. Synergies are identified in the document which have important implications for models of engagement and partnerships. Three categories of synergy are identified by the strategy through health system strengthening and UHC, the prevention of NCDs, including a life-course approach to health; and through health security and emergencies, all of which have important implications for models of engagement and partnership. There are several strategic shifts in this document which align well with global strategies, and which have implications for engagement and partnership approaches. These shifts include transition of programs from vaccination of children to vaccination across the life course, from routine immunisation services to tailored immunisation services, from disease specific surveillance to integrated disease surveillance, from immunisation programming to immunisation programming within the framework of PHC, and from social mobilisation as a method of vaccine uptake to more sophisticated community engagement approaches. The term "engagement"[4] is referred to in context of communities and health workers, trusted public figures, engagement of immunisation programs with relevant related health information and surveillance programs and with the private sector. The strategy identifies "partnerships and collaboration" as one of two main key areas supporting implementation (the other of which is research and innovation). Areas for partnership development include school health, and nutrition and water and sanitation programs.

***A Strategic Framework for the South-East Asia Regional Vaccine Action Plan 2022–2030*** [35] defines three impact goals that include reducing overall mortality and morbidity from vaccine-preventable diseases for all across the life-course, pursuing vaccine-preventable disease elimination and control

[3] Strategic goals for disease prevention and control are also described: (1) sustaining polio-free status; (2) maternal and neonatal tetanus elimination; (3) measles elimination; (4) rubella elimination; (5) accelerated control of hepatitis B; (6) accelerated control of Japanese encephalitis; (7) introduction of new vaccines; and (8) meeting regional vaccination coverage targets.

[4] More clarification on definition of "engagement" required. Engagement for this evaluation refers to inter-partner, inter-programme, inter sector engagement to drive Immunization goals.

goals and regional priorities and achieving measles and rubella elimination, sustaining polio-free status, maintaining MNT elimination, achieving hepatitis B control and leaving no one behind by increasing equitable access and use of new and existing vaccines.

There are similarities between the SEARO and WPRO strategy and plans. The SEARO strategy also aligns closely with the seven strategic priorities of the global IA2030 agenda, and identifies 13 "key areas of focus" that include most of components of the immunisation system, along with political commitment, governance, integration of immunisation into PHC systems and a focus on the disadvantaged. Documentary analysis and surveys conducted in support of the strategy development identified strategy priority 1 (PHC and UHC) and strategic priority 3 (coverage and equity) as priority areas for strategy implementation. A section on partnership in the framework guides countries to make use of existing Regional Working Group and Interagency Coordination Committees (ICCs) in countries and encourages the building of "alliances" with other disease-specific initiatives and health system strengthening, and with civil society organizations (CSOs), the private sector and sub national authorities. Strategic priority 2 on commitment and demand identifies political and financial commitment, sub national support, accountability of providers, public trust, confidence, knowledge and understanding as key areas of focus for implementation. These priorities have wide implications for engagement and partnership with a wide range of stakeholders from health, education, and social and political sectors (including from decentralised authorities). Vaccination across the life course also has implications for multi sector engagement to integrate age-appropriate and catch-up vaccination into public and private health services "to ensure integration of immunization into context-specific programmes such as for education, nutrition, water and sanitation, care of older people and women's empowerment."

Main goals/principles and strategic priorities are contrasted here and some general themes in approach are summarised below. Although strategies are nuanced somewhat to contexts and organisational strengths and priorities, some themes are evident as described below:

1. **Alignment** There is close alignment of all strategies with IA2030.
2. **Integration** is expressed through linkages of immunisation to health system strengthening PHC and UHC, integrated service delivery, and integrated surveillance and information systems and multi sector partnerships.
3. **Immunisation Systems** Strengthening of each component of the immunisation system remains a strong focus, from health workforce to surveillance and supply chains.
4. **Disease Prevention** Pursuing agendas of disease elimination and eradication remain central themes in all strategy documents.
5. **Sustainability** is mainly contextualised in terms of scale up of domestic financing. Programs also need to take account of macro-economic analysis and interventions which are crucial for domestic financing
6. **Complexity** Life course vaccination, decentralisation, pandemics, urbanisation, communication technologies, anti-vaccine movements and humanitarian emergencies in all documents illustrate the very wide and shifting contexts for implementation of immunisation services. The global documents reviewed pre-date Covid-19 pandemic, hence underscore the vulnerability of immunisation programs due to unforeseen circumstances.
7. **Equity** in terms of social marginalisation and gender are expressed frequently across all four strategies with related practice of "tailoring" of services a common theme and social and behavioural change. .
8. **Partnership** There are frequent references to models of partnership collaboration – civil society private sector, DPs, other health programs and interventions, research partners, sub national authorities. There are also strong emphases on governance and accountability.

**The Role of UNICEF in Immunisation and Children's Health and Development**

*Outlines the main role of UNICEF in immunisation, health, and other sectors. UNICEF Annual Reports, Plans and Situation reports outline the existing approaches to engagement*

***Global Roles and Engagement:*** The main area of work for UNICEF is children in need and achieving results for them in terms of their health and development. [36] In a mission statement introducing its latest annual report, UNICEF states that "*we work in some of the world's toughest places to reach the children and young people who are most at risk and most in need. We work to save their lives. To protect their rights. To keep them safe from harm. To give them a childhood in which they're protected, healthy and educated. To give them a fair chance to fulfil their potential.*" [37] This statement reflects the commitment by UNICEF to work with children and communities who are most at risk, as well as reflecting the multi-programmatic character of the UNICEF mission. Both themes have important implications for engagement with regards to the type of populations who are beneficiaries of UNICEF support, as well as types of agencies and partners that UNICEF needs to engage with to fulfill its mission. The most recent annual Report of UNICEF identifies child health and development goals, and cross cutting strategies of humanitarian action and gender as main priorities.[38] In addition to innovation and winning support for children, "partnerships" have been identified in this report as a lead "change strategy." At the global level, public sector partners refer to 146 government partners along with intergovernmental organizations. Private sector partners include corporate organisations, foundations, multi-stakeholder partnerships, philanthropic organisations, and UN partnerships. The UN partnerships include a "WHO-UNICEF Strategic Collaboration" Framework to support collaborations on universal health coverage, mental health, public health emergencies, and maternal and child nutrition and the global response to COVID-19 and the rollout of vaccines. *The UNICEF Health Strategy* aims to increase focus and coherence across health programmes through three main approaches of (1) addressing inequities in health outcomes, (2) strengthening health systems (including for emergency preparedness, response and resilience) and (3) through promoting integrated multisectoral policies and programs.

***Regional and Country Roles and Engagement:*** The East Asia and Pacific website on Health states that "strengthening systems for delivering quality health services to mothers and children without access is a key priority for UNICEF in this region." [39] To achieve maternal and child survival rates, UNICEF states that it works with partners and national and sub-national governments to address key health system bottlenecks. In the immunisation field specifically, UNICEF is active in introducing new vaccines, [5] [Footnote] immunization supply chains and supports immunization campaigns against measles, tetanus and polio. "Special Attention" in EAPRO is preserved for "reaching the most vulnerable and marginalized communities and seeking opportunities to integrate these with other child survival interventions." [40]

UNICEF Supply Division procures most Gavi-funded vaccines and so has a central role in the Global Vaccine Alliance (Gavi). UNICEF also partners with government and WHO utilising Gavi support to assist countries improve immunisation coverage and equity and implement health system strengthening grants in collaboration with ministries of health, local leaders, media and civil society, and communities. [41] De-facto the Gavi support for HSS focusses on the challenges related to immunization delivery with incremental benefits to some aspects of broader health system. The Gavi website also indicate that regional working groups coordinate support for country programmes through partner groups led by WHO and UNICEF.

[5] Pneumococcal conjugate vaccine (PCV), Inactivated Poliovirus (IPV) vaccine, measles, with a focus on reducing immunization inequities and rubella (MR) vaccine, Human Papillomavirus (HPV) vaccine and Japanese Encephalitis (JE),

*The Immunisation Agenda 2030 Implementation framework* sets out a model of collaboration for implementation at Regional and Country Level.[42] Both the regional and country level models of implementation for IA2030 provides information on how partners apply both implementation tools and processes to achieve global immunisation goals. The table of country level actions on advocacy and partnerships outlines "tools and structures" and "processes" under three broad categories for engagement that includes coordinated operational planning, monitoring and evaluation and ownership and accountability.

| |
|---|
| At the country level there are multiple partnerships for immunisation that include health sector steering committees, immunisation coordination committees, program reviews, sub national planning meetings and processes, civil society groupings and National Technical Immunisation Advisory Groups. At the Regional Level these structures can include Regional Immunisation Technical Advisory Groups, Regional committees and working groups, and interagency coordination committees. Partnership processes and guidance at regional and country level can include policy, planning, scientific and safety review, joint reporting on immunisation, coordinated efforts for humanitarian response and attainment of PHC and UHC goals, monitoring regional and country data and progress on disease elimination and eradication goals and making recommendations for improvement and technical support for countries. |

*Figure 4 External Immunisation Engagement Structures, Processes & Guidance at Regional and Country Levels*

Communications and advocacy is the single cross cutting action of the framework, demonstrating that engagement is prioritised at global level as a way the main way to implement the agenda. There are multiple points of engagement outlined in the table below that could be explored further in an evaluation or engagement framework. An important engagement question relates to the extent to which these current structures and processes are contributing to improved coherence in UNICEF programming, as well as to what extent structures internal to UNICEF can also ensure the coherence of overall UNICEF programming for child health and development.

***UNICEFs Comparative Advantages:*** Engagement should also be considered in relation to the *comparative advantages of UNIC*EF in immunisation as identified in external consultations for the roadmap document. [43] The comparative advantages of UNICEF in immunisation programming were identified during consultations leading to the development of the Immunisation Roadmap in 2018:

1. Providing global leadership on immunization policies and strategic directions.
2. Promoting equity and coverage; driving global advocacy efforts.
3. Providing supply and supply chain management.
4. Building demand for immunization through Communication for Development and behaviour change communication efforts.
5. Supporting efforts to deliver immunization services in humanitarian contexts and support disaster preparedness.
6. Convening partners and promoting a multi-sectoral approach.
7. Fostering innovation in response to existing and emerging challenges.

**Trends in Immunization Coverage in EAPRO**

*This section examines and summarises immunisation data (WHO-UNICEF Estimates) on immunisation coverage (DTP3) from 2016-2020.* [44.] *It also examines zero dose vaccination and trends, as well as data for evidence of disease outbreaks over the last 5 years. Observations are provided on trends in coverage and VPDs, and evidence of coverage impacts of COVID 19.* [45] *Where possible, commentary is provided on implications for approach to engagement assessment and future framework.*

Of the 23 countries for which comparisons for DPT3 coverage can be made between 2016 and 2020, nine countries remained stable or increased coverage. Highest coverage increases were in the two Pacific States of Micronesia (+14), Kiribati (+11) and in Timor Leste (+7). 14 of the countries have coverage above 90%. 13 countries experienced coverage decline between 2016 and 2020, with Indonesia (- 8%), the Philippines, PNG and Indonesia (-7%) and Myanmar (-6%) experiencing the largest declines. Overall, coverage in this period is variable but overall declining, particularly in some larger population countries.

It is important to underscore that DPT3 coverage has been a consistent yardstick to assess immunization progress, or even socio-economic development, issues with its robustness and reliability come up at times. For example, some countries with high coverage have reported large outbreaks of Measles, Polio, Diphtheria [see following section]. The absence of a reliable system of data compilation and analysis in several countries results in wide differences between the reported coverage and coverage identified in population surveys.

As demonstrated in Annex C there has been a reduction in immunisation coverage between 2016 and 2020. There were coverage declines in 10 of the countries between 2019 and 2020 which suggests that the COVID 19 pandemic may have had an impact on coverage. A global study of the impacts of the pandemic on routine immunisation found that there was an overall impact of reduced delivery of expected doses (4-6 million) for DPT3 and MCV1 in 2020. This study also noted that in the "super regions" of South East Asia and East Asia that " that monthly doses were delivered at or above expected levels during the second half of 2020." [46] Significant coverage drops in large population countries such as the Philippines, Indonesia and Myanmar between 2019 and 2020 does however indicates that at country level further assessment is required to assess COVID 19 impacts on routine immunisation.

Annex C and Figure 5 provides data on DPT3 coverage between 2016 and 2020 (WUENIC Estimates) according to the country classifications proposed for this evaluation. A series of UNICEF country profiles (2016) on immunisation also provides data on immunisation coverage nationally and sub nationally, supply chain performance and capability, and disparities in coverage by wealth quintiles and by locations. [47]

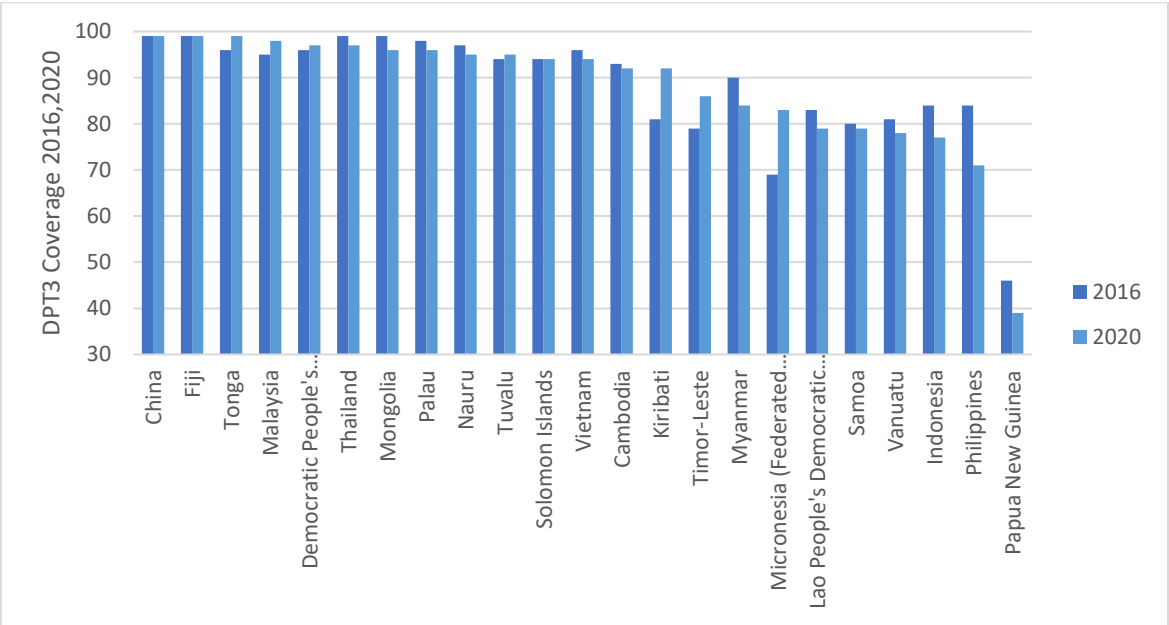



*Figure 5 Diphtheria Pertussis Tetanus Vaccines 3 Coverage 2016, 2020*

| Category 1 | 2016 | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|---|
| China | 99 | 99 | 99 | 99 | 99 |
| Malaysia | 95 | 99 | 99 | 98 | 98 |
| Thailand | 99 | 99 | 97 | 97 | 97 |
| Category 2 | | | | | |
| Cambodia | 93 | 93 | 92 | 92 | 92 |
| Myanmar | 90 | 89 | 91 | 90 | 84 |
| Lao People's Democratic Republic | 83 | 84 | 85 | 80 | 79 |
| Democratic People's Republic of Korea | 96 | 97 | 97 | 97 | 97 |
| Mongolia | 99 | 99 | 99 | 98 | 96 |
| Category 3 | 2016 | 2017 | 2018 | 2019 | 2020 |
| Indonesia | 84 | 85 | 85 | 85 | 77 |
| Philippines | 84 | 82 | 79 | 77 | 71 |
| Vietnam | 96 | 94 | 75 | 89 | 94 |
| Category 4 | 2016 | 2017 | 2018 | 2019 | 2020 |
| Fiji | 93 | 93 | 92 | 92 | 92 |
| Tonga | 96 | 99 | 99 | 99 | 99 |
| Palau | 98 | 97 | 95 | 97 | 96 |
| Nauru | 97 | 87 | 90 | 96 | 95 |
| Tuvalu | 94 | 96 | 89 | 92 | 95 |
| Solomon Islands | 94 | 83 | 85 | 94 | 94 |
| Kiribati | 81 | 90 | 95 | 97 | 92 |
| Timor-Leste | 79 | 83 | 83 | 90 | 86 |
| Papua New Guinea | 46 | 36 | 35 | 35 | 39 |
| Cook Islands | 99 | 99 | 99 | 98 | |
| Marshall Islands | 71 | 80 | 81 | 79 | |
| Niue | 99 | 99 | 99 | 99 | |
| Micronesia (Federated States of) | 69 | 73 | 75 | 78 | 83 |
| Samoa | 80 | 74 | 34 | 58 | 79 |
| Vanuatu | 81 | 85 | 85 | 90 | 78 |
| | | | | | |
| | | | | | |

*Table 8 DPT3 Coverage by Country Draft Classification (WUENIC)*

*Source of Data UNICEF Immunisation* https://data.unicef.org/topic/child-health/immunization/

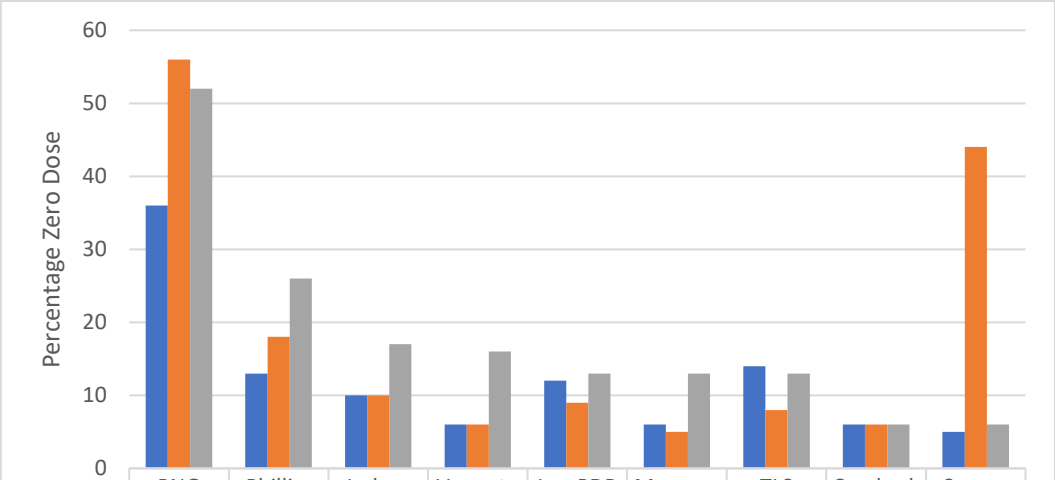
***Impacts of COVID 19:*** Of the 25 countries that can be assessed between 2019 (pre covid) and 2020, 10 countries had a decline in DPT3 coverage. These include larger population countries including Indonesia (- 8%), the Philippines (-6%), and Myanmar (-6%). Five countries improved coverage, including three Pacific countries and PNG (improved from 35% to 39%). Vietnam is the only large population country that improved coverage (5%) between 2019 and 2020 and China maintained a very high coverage rate of 99%. [See section 2.3 for COVID Related Impacts and Responses by UNICEF]. A global study of the impacts of the pandemic on routine immunisation found that there was an overall impact of reduced delivery of expected doses (4-6 million) for DPT3 and MCV1 in 2020. This study also noted that in the "super regions" of South East Asia and East Asia that " that monthly doses were delivered at or above expected levels during the second half of 2020." [48] The

previously mentioned significant coverage drops in large population countries such as the Philippines, Indonesia and Myanmar between 2019 and 2020 does indicates that at country level further assessment is required to assess COVID 19 impacts on routine immunisation.

***Zero Dose:*** Stagnating routine immunisation coverage and inequities in immunisation coverage based on socio-economic or fragile state characteristics has increased interest from the development community in the concept of "zero dose vaccination." [49]There are several definitions of zero dose vaccination [50] but most of these centre on the identification of individuals who have no vaccination at all, or have not commenced the first in the series of a vaccination in an immunisation schedule (e.g. DPT1)**.**[51] Various observations on zero dose confirm that rates of zero dose cluster in populations affected by conflict, in populations that are otherwise marginalized and excluded, including the urban poor, culturally diverse and remote populations. Zero dose populations may also be associated with gender related barriers to health service access. The Equity Reference Group paper [52] also make important observations on zero dose which demonstrate how this agenda or perspective aligns very well with the UNICEF mission and its related strategic advantages:

1. Zero-dose communities are also likely to lack access not just to immunisation services but also to other health and welfare services and are subject to "multiple deprivations." In this way, the zero-dose focus can provide an entry point for strengthening other services
2. Community engagement is of high importance in developing methods for the identification, measurement and tracking of zero dose children and in addressing the social determinants of health including gender related issues
3. The zero-dose focus aligns with a children's rights approach and can increase the visibility of marginalized and excluded groups and communities

The figure below demonstrates the rates of zero dose (not received DPT1) between 2016 and 2020 in 9 countries that had zero dose rates of 5% or more in 2020. In 6 of the 9 countries, zero dose increased between 2018 and 2020, once again illustrating pandemic impacts. There are significant numbers of zero dose children in some of the larger population countries such as Indonesia, the Philippines and Myanmar.




| | PNG | Phillip. | Indon. | Vanuatu | Lao PDR | Myanma | TLS | Cambod. | Samoa |
|---|---|---|---|---|---|---|---|---|---|
| 2016 | 36 | 13 | 10 | 6 | 12 | 6 | 14 | 6 | 5 |
| 2018 | 56 | 18 | 10 | 6 | 9 | 5 | 8 | 6 | 44 |
| 2020 | 52 | 26 | 17 | 16 | 13 | 13 | 13 | 6 | 6 |

*Figure 6 Percentage Zero Dose 2016-2018-2020 Selected Countries EAPRO*

Literature findings demonstrate some of the determinants of low vaccine coverage and the populations who are most affected. A study of the unimmunised in *Indonesia* has found that "socioeconomic factors were strongly associated with the likelihood of being unimmunised in Indonesia, and the unimmunised children were geographically clustered and lived among the most deprived population." [53] In *Myanmar*, incomplete vaccination coverage was independently associated with low economic status, fewer ante natal care visits, and maternal tetanus vaccination.[54] Lower immunisation coverage is also associated with location, ethnicity, and presence of conflict, with remote ethnic minority states along the border with China more subject to lower rates of immunisation coverage.[55] A multiyear plan for immunisation in Myanmar identified the existence of "hard-to-reach populations in mountainous areas, border areas and peri urban communities in major cities….Mobile and migrant populations in work sites and temporary settlements and socially hard to reach populations."[56] Polio outbreaks have occurred in remote ethnic States of Rakhine State in 2015 [57] and more recently in Kayin State in 2019, a conflict/ethnic minority area where "government access for providing basic health services, including immunization is very limited." [58]The current conflict related humanitarian crisis in Myanmar has meant that millions of children are not accessing basic health services, [59] which suggest likelihood of service interruptions and further outbreaks in the coming year/s. In *China* an analysis of incidence of vaccine preventable disease over the last 7 decades has shown that the highest incidence of disease is in the Western provinces of that country. [60] A recent systematic review in the Lancet also found that after taking account the effects of socioeconomic factors, ethnic minority women in China were far less likely to immunise their children (Odds Ratio 0·57 [0·44–0·74]) compared with majority Han women.[61]

In the *Philippines*, surveys have shown that coverage is lowest in the conflict affected Autonomous Region in Muslim Mindanao (fully immunised 9% in 2017) with immunisation status being also associated with wealth status. [62] This was also the site of polio cases in 2019.[63] In *Malaysia,* there were polio outbreaks in Sabah province in 2019. This province has a high proportion of the population who are migrants or who belong to an indigenous minority and who are exposed to high rates of poverty and lack of civil registration.[64] In Cambodia in recent years, surveys are demonstrating lower coverage in the northeast Provinces of Mondulkiri and Ratanakiri (ethnic minority Provinces).[65] A report on a recent measles outbreak in that country highlighted the challenge of reaching children that are less likely to visit health centres and hospitals, such as in Cham Muslim and Vietnamese communities. [66]The polio outbreak in *PNG* in 2018/2019 was widespread across 9 provinces necessitating a national emergency response that included a nation-wide campaign, risk communication, and enhanced surveillance. [67] The first case of Polio in 13 years in *Indonesia* was reported in 2019 in remote Papua Province, which also reports low immunisation coverage. [68] In *Thailand*, recent measles outbreaks have been linked to the conditions of Myanmar migrant factory workers [69] (2019) as well as to the misinformation and cultural beliefs of populations in Southern Thailand near the border with Malaysia. [70] (2018-19)

Clustering of outbreak cases in urban poor areas in several cities in recent years highlights the challenges of the urban poor, rural to urban migration, the growth of urban slums and the failure of public health services to keep pace with this growth.[71] [6] [Footnote] An additional factor in low immunisation uptake reported in the literature is the impact of adverse events following immunisation which accounts for the very high levels of zero dose in *Samoa* in 2018 (44%) [72]as well

[6] Eastern and South-Eastern Asia has 370 million people living in urban slums – this equivalent to 27.2% of the urban populations in these regions. United Nations SDG Report https://unstats.un.org/sdgs/report/2021/goal-11/

as nationwide impacts on vaccine confidence in the *Philippines* resulting from the adverse events associated with the trial of a dengue vaccine. [73]

These various cases are of high significance in terms of how at regional and country level UNICEF programs engage internally and externally, so as to both engage and coordinate/ target support for marginalised and excluded populations, whether they be the urban poor, ethnic minorities, rural to urban or cross border migrants or communities affected by conflict or anti-vaccine sentiment.

### 3.5 Trends in Vaccine preventable Disease Incidence in EAPRO

Global strategies and World Health and Regional Committee resolutions all commit countries in the region to elimination of measles, eradication of polio, maintenance of tetanus elimination, control of hepatitis B, and prevention or control of other conditions including cervical cancer (HPV vaccination), congenital birth defects (rubella vaccination), and meningitis, pneumonia, diphtheria, and diarrhoea in children (Hib, PCV, rotavirus, DPT vaccines). Although prevention and control of these diseases are good indicators of the effectiveness of immunisation programs, measles and polio outbreaks cases highlight major gaps in immunisation coverage, and potentially, major gaps in the capability of immunisation programs to engage with their stakeholders and populations.

Analysis of trends between 2015 and 2020 for *measles cases* (see Table 9 & 10, see figure 7 )demonstrates that 11 countries have reported significant measles outbreaks between 2015 and 2020. These outbreaks are being reported from reported “high coverage” countries such as Mongolia (30,000 cases in 2016), Vietnam (14,000 cases in 2019) and Thailand (6,000 cases in 2018), as well as from lower coverage countries such as the Philippines (48,000 in 2019), Indonesia (9035 cases in 2017) and Samoa (5687 cases in 2019). The outbreaks from high coverage countries suggest that hidden, mobile, or otherwise underserved populations for immunisation services may not be captured in population estimates or are not accessing health services.

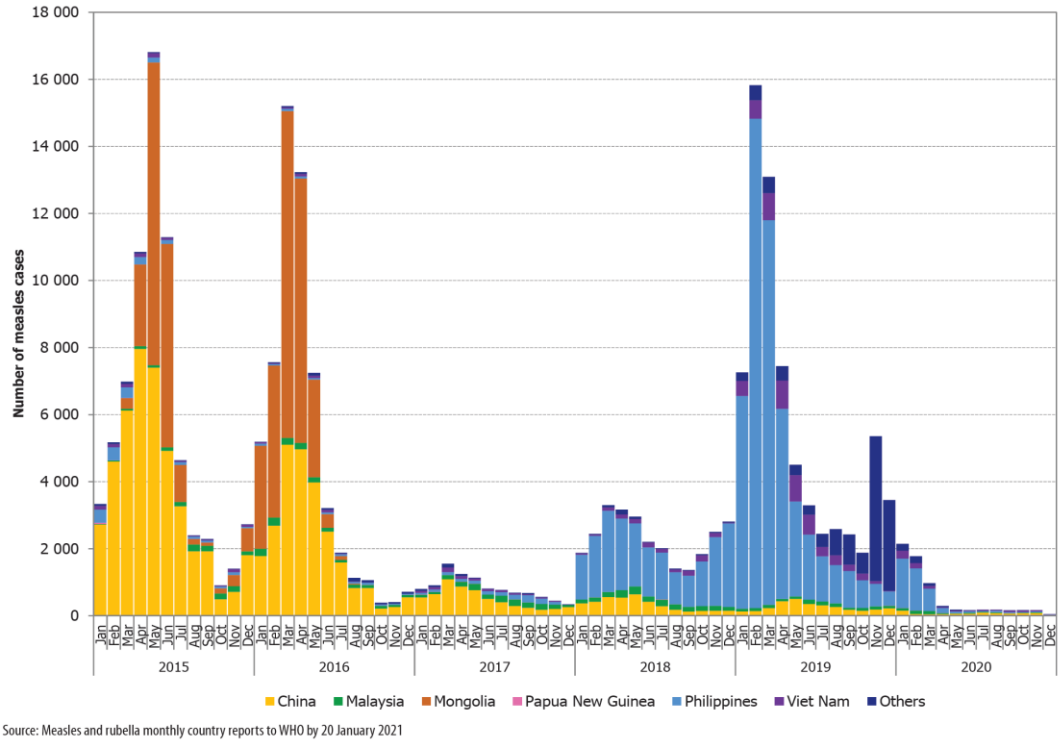



*Figure 7 Measles Cases 2015 – 2020 Western Pacific Region of WHO [74]*

Analysis of trends between 2015 and 2020 for *polio cases* (see Table 10) demonstrates 7 out of 25 countries have reported polio cases in the last 5 years, of which PNG (26 cases) and the Philippines (24 cases) reported the most significant outbreaks. There were no reported Wild Polio cases in this period, with all cases being reported as vaccine derived polio viruses.[75]

Disease eradication and elimination targets in EAPRO are being held back by these outbreak events between 2015 and 2020. From an engagement perspective, questions arise as to the social, demographic and health system characteristics that are associated with the outbreaks, and what engagement or partnership approaches are proposed by UNICEF and others to contribute towards minimising future risk of outbreaks.

*Table 9 Reported Measles Cases EAPRO 2015-2020*

| Country / Region | 2020 | 2019 | 2018 | 2017 | 2016 | 2015 |
|---|---|---|---|---|---|---|
| Cambodia | 379 | 684 | 3 | 10 | 56 | 0 |
| China | 867 | 2,974 | 3,940 | 5,941 | 24,820 | 42,361 |
| Democratic People's Republic of Korea | 0 | | 0 | 0 | 0 | 0 |
| Indonesia | 524 | 1,965 | 5,300 | 9,035 | 6,962 | 15,099 |
| Lao People's Democratic Republic | 138 | 1,119 | 10 | 3 | 8 | 56 |
| Malaysia | 478 | 1,077 | 1,981 | 1,709 | 1,569 | 1,318 |
| Mongolia | 0 | 2 | 1 | 9 | 30,273 | 20,359 |
| Myanmar | 444 | 5,252 | 1,389 | 1,293 | 266 | 6 |
| Papua New Guinea | 4 | 1 | 19 | 7 | 0 | 38 |
| Philippines | 3,832 | 48,525 | 20,827 | 2,428 | 716 | 619 |
| Thailand | | 5,412 | 6,035 | 1,946 | 652 | 154 |
| Timor-Leste | 2 | 22 | 0 | 0 | 2 | 43 |
| Viet Nam | 846 | 14,156 | 2,256 | 227 | 46 | 256 |
| Cook Islands | | 0 | 0 | | | |
| Fiji | | 28 | 0 | 5 | | |
| Kiribati | 0 | 3 | 0 | 0 | | |
| Micronesia (Federated States of) | | 0 | 0 | 0 | 0 | 0 |
| Nauru | | 0 | | | 0 | |
| Niue | | 0 | | | | |
| Samoa | 11 | 5,687 | 0 | 3 | | |
| Solomon Islands | | | 0 | 0 | 0 | 0 |
| Tokelau | | 0 | 0 | 5 | | |
| Tonga | | 659 | 0 | 0 | 0 | |
| Tuvalu | | 0 | | | | |
| Vanuatu | 0 | 0 | 0 | | | 39 |

*Source:* [76]

*Table 10 Confirmed Polio Cases EAPRO 2015-2020*

| Country / Region | 2020 | 2019 | 2018 | 2017 | 2016 | 2015 |
|---|---|---|---|---|---|---|
| Cambodia | 0 | 0 | 0 | 0 | 0 | 0 |
| China | 0 | 1 | 0 | 0 | 0 | 0 |
| Democratic People's Republic of Korea | 0 | 0 | 0 | 0 | 0 | 0 |
| Indonesia | 0 | 0 | 1 | 0 | 0 | 0 |
| Lao People's Democratic Republic | 0 | 0 | 0 | 0 | 3 | 8 |
| Malaysia | 1 | 3 | 0 | 0 | 0 | 0 |
| Mongolia | 0 | 0 | 0 | 0 | 0 | 0 |
| Myanmar | 0 | 6 | 0 | 0 | 0 | 2 |
| Papua New Guinea | 0 | 0 | 26 | 0 | 0 | 0 |
| Philippines | 1 | 14 | 0 | 0 | 0 | 0 |
| Thailand | 0 | 0 | 0 | 0 | 0 | 0 |
| Timor-Leste | 0 | 0 | 0 | 0 | 0 | 0 |
| Viet Nam | 0 | 0 | 0 | 0 | 0 | 0 |
| Pacific Island countries | | | | | | |

*Source:* [77]

Both Hepatitis B Birth Dose and Human Papilloma Virus Vaccination (HPV) are of high relevance to the issue of engagement for several reasons. Hepatitis B birth Dose involves collaborations between maternal and neonatal health and immunisation services, given that this vaccine is most effective when given within 24 hours of birth. [78] HPV vaccination is administered in a "primary" target group of 9-14 aged girls, which means that collaboration is required between school and health authorities, as well as with the health system more generally through community and hospital based services.. Both are high regional priorities, given the high prevalence of hepatitis B at birth, and the high incidence of cervical cancer in Southeast Asia. [79] [80]

For the HPV vaccine coverage rates remain very low. SEAR has extended from zero percent in 2015 to 3% in 2020 for last dose of HPV for the target population. WPR has remained at 5% between 2015 and 2020 for last dose of HPV for the target population. While analyses of this low coverage in LMICs attributes this low coverage to issues of financing, monitoring and evaluation and the capacity to sustain programs beyond demonstration projects, [81] there are also likely to be factors relating to gender barriers to immunisation as well as multi-sector collaborations. [82]

**Implications for Engagement of Immunisation and Disease Trends**

Engagement relevant issues related to this data that could be followed up in the engagement assessment and strategy include the following:

1. What is the contribution of better engagement to the sustaining of high coverage in countries such as China, the Pacific Island States and other countries in the Region?
2. What have been the main factors driving higher coverage improvement in some of the Pacific island States such as Kiribati and Micronesia, and what was the contribution of partnerships/engagement to this improvement?
3. In Samoa and Vietnam, there were sharp improvements to immunisation coverage after impacts of measles vaccine adverse reaction and disease outbreak in Samoa [83] and interruption to vaccine supplies in Vietnam.[84] What was the contribution of improved partnerships/engagement to this rapid turnaround in coverage?

4. Countries demonstrated the resilience of their programs through rapid turn arounds in coverage related to interruptions to program performance that were COVID related. Were there partnership/engagement factors which contributed to this program resilience ?
5. What are the main engagement factors that are acting as success or challenges to scale up of HPV Coverage?
6. There are significant numbers of zero dose children, especially in some of the larger population countries such as Indonesia, the Philippines and Myanmar. Who and where are these populations, what are their socio-economic and cultural characteristics, and how can better partnerships/engagement (with government, civil and development partners, affected populations) enable improved service access and availability? Are there success stories of engagement with such excluded or marginalised groups that could be expanded upon?

**Current Challenges and Opportunities of UNICEF and Immunisation Engagement**

*Summarised here are the main points from literature regarding UNICEF strategic and operational advantages and opportunities for engagement at regional and national level with regards to vaccines and supply chain, engagement with the socially disadvantaged and on gender related issues, and with communities more generally.*

**Engagement on Vaccines and Supply Chain**

As outlined earlier, UNICEF is the leading vaccine procurement agency globally. In fact, UNICEF supplies vaccines to reach 45 per cent of the world children under the age of five.[85]

UNICEF has been a leader in improving vaccine supply during the COVID 19 pandemic. COVAX is a global vaccine equity mechanism led by Gavi, the Vaccine Alliance, WHO and CEPI UNICEF. Action areas for ensuring that these vaccine are accessible includes "country acceptance and capacity, import approvals, and indemnification and liability agreements ……purchase orders and transport arrangements." In addition to vaccines, UNICEF is also involved with the shipping of syringes and safety boxes as well as extending cold chain capacity. [86] Vaccine forecasting and financing have also been core support functions of UNICEF for countries globally and in EAPRO.

UNICEF works with a range of partners on the COVID 19 vaccination effort including with including national authorities, UN and partners, including WHO, IFRC, national Centres for Diseases Control, NGOs, community-based organisations, and the private sector with main activities including planning, coordination, service delivery, training, monitoring and evaluation, vaccine cold-chain and logistics, communication and community engagement.[87] Collaboration has been identified by UNICEF as the main factor in creating sustainable supply chains with main partners in this effort including "Gavi, the Global Fund, USAID, the World Bank, the United Kingdom's Department for International Development (DFID), the Bill and Melinda Gates Foundation, and private sector companies and many others, to accelerate results for children." [88] UNICEF is a long term member of the Gavi Vaccine Alliance and has collaborated substantially with Gavi in new vaccine introduction, vaccine campaigns, and cold chain support and with health system strengthening.

A major question for the evaluation and engagement framework is the extent to which current partnership models in terms of their structures, processes or guidance are adequate to the task of ensuring efficient, equitable and sustainable vaccine and cold chain support for countries in the coming decade.

**Engagement with Socially Disadvantaged Populations**

***Engagement in Urban Area and In Decentralised Contexts:*** East Asia is one of the most urbanised regions globally and is projected to have 70% of its population living in urban areas by 2030. UNICEF consultations with mayors across the region in 2028 found that the main issues for children were addressing spatial barriers to services, equitable access to services, and public spaces in rapidly urbanizing cities, as well as governance and financing for children's services. [89] A review of urban immunisation in the EAPRO Region found that despite urban coverage being generally higher than in rural areas, there were pockets of social disadvantaged and low immunisation coverage which were resulting in significant vaccine preventable disease outbreak. These outcomes were a resulted from the limited capability of local governments to keep pace with the rapid growth of urban populations in such cities as Yangon, Phnom Penh and Ulaanbaatar. Other factors associated with low coverage were lack of development of urban PHC models, poor governance and finance from municipal authorities, and lack of civil registration status of urban migrants.

Some of the evaluations in this report indicated how difficult it is to transition donor and UNICEF support from project support funding to sustainable system support. Recommendations consider clarifications of governance and partnership arrangements for urban immunisation with local authorities, especially in relation to birth and civil registration, accurate population estimates and improved health funding. Other areas of partnership recommended include linking health programmes to social safety nets (health financing schemes for the poor and conditional cash transfers) and closer engagement of health programmes with education services. [90] Due to the multi-sector mission of UNICEF for child health and development, these cross-sector linkages work very well to UNICEFs strategic advantages as an organisation. There are clear opportunities for UNICEF here to engage more with local governments, communities, and other civil partners in urban settings to transition UNICEF immunisation investments towards a more sustainable and system-oriented pathway.

***Engagement in Humanitarian Emergency Contexts:*** The Asia-Pacific region has been described as the most disaster-prone region in the world that have become even more fragile in the context of COVID-19. Humanitarian reports from EAPRO highlight the extent to which UNICEF is strategically placed to implement multisector approaches for child health and development in humanitarian emergencies.[91] The humanitarian situation report for September 2021 details the impacts of COVID 19 on countries across the region, our describes how various programs within the UNICEF structure complement each other in facilitating the humanitarian response. In addition to the vaccine roll out supported by UNICEF, programs have also reduced development impacts on children through nutrition, safe school, early learning, and communication messaging. Internal UNICEF programs involved with these efforts include health, nutrition, WASH, child protection, education and social protection. Partnerships in implementation of the humanitarian response for COVID 19 include "national authorities, UN and partners, including WHO, IFRC, national Centres for Diseases Control, NGOs, community-based organisations and the private sector." The EAPRO Regional Office assisted countries to assess the socio-economic impacts of COVID-19 and coordinated with multiple agencies at the regional and national level to develop a regional response plan aligned with the WHO and UN response plans. In addition to the COVID impacts and vaccine preventable disease outbreaks, recent conflicts in Myanmar [92]and natural disasters in DPR Korea[93] and more recently in the Pacific,[94] in addition to ongoing climate impacts, demonstrate the ongoing risks associated with emergencies and the range of stakeholders that UNICEF will be required to engage with in the coming decade to effectively respond. UNICEFs record of collaborative work in humanitarian contexts clearly demonstrate how strategically positioned UNICEF is to coordinate with partners and develop multi-sector responses that are inclusive of the immunisation response.

***Stateless or undocumented populations*** are also a concern for low vaccination status in areas of EAPRO. "Hot spots" for statelessness in EAPRO include in Thailand where there has been a large

inflow of refugees from Myanmar as well as migrant workers from neighbouring countries, and in Malaysia where a large inflow of working migrants and their families have migrated for work on plantations in the east of the country. [95] [96] A global UNHCR report on statelessness and vaccination found there were significant barriers to vaccination that included lack of civil and health registration and lack of connection and communication with local health authorities. [97] Recommendations by UNHCR to address this issue of statelessness and vaccination included devising national vaccination plans based on both public health considerations and human rights standards, identifying barriers of stateless populations in accessing vaccination, establish plans and tailoring programs for equitable inclusion of all people in vaccination programmes, ensuring messaging on vaccines in multiple languages, creating a "firewall" between vaccination and immigration services, establishing systems for undocumented persons to register and receive vaccinations, and reducing mistrust through including grassroots organizations and stateless persons in various aspects of services management or delivery. These recommendations all entail a high level of engagement with government, local authorities, civil society, and the communities themselves.

There is evidence of some initiatives to improve health and immunisation access for these populations. In Thailand, undocumented stateless students have been enrolled in its national healthcare system through "National Healthcare Fund for Persons with Legal Status Problems." [98] In Malaysia, attempts are being made by UNICEF and partners to facilitate improved vaccination status and access for undocumented populations in Sabah.[99] Given globalisation of economies and related international labour migration, and ongoing threats of climate change and conflict, engagement with Stateless and Undocumented populations and their stakeholders is likely to be an emerging public health challenge in the coming decade.

***Gender and Immunisation**:* Although in most countries gender disaggregated data illustrates that there is parity in immunisation rates between boys and girls, the main gender challenge is that "although mothers and female family members are usually primary caregivers for their children…….their lower status in the household and community limits their capacity to act on their own and their child's behalf." [100] There are four domains that describe how gender inequality on child health at an individual level. These include health, education, protection, and a safe environment. [101] These cross sectoral determinants of gender inequalities therefore works well to UNICEFs strategic advantage as both a health and development agency with a focus on the rights of the child and adolescents. In relation to gender barriers to immunisation, a range of factors have been identified in the literature including lower community status of women (economics, cultural), gender norms, levels of health literacy, and autonomy of decision making by women as primary care givers. [102] [103] Given that many of these barriers are in fact social determinants of health, engagement cross sector from community to the political level is an essential condition for addressing gender norms and barriers.

UNICEF and Gavi facilitats support for three vaccines that support female health. These are tetanus vaccination, and the human papillomavirus (HPV) and rubella vaccines.[104] The gender policy of Gavi recognises the importance of engaging men in caregiving and in addressing the needs of all genders in the health workforce (of whom 70% are women). [105] UNICEF Partnerships with agencies and implementing partners that adopt a gender and social determinants perspective on implementation are therefore central to the UNICEF mission of child health and development.

**Engagement with Communities**

Engagement can refer to how UNICEF Region and Country Offices engage with governments, partners, and civil agencies as well as how UNICEF can engage directly or indirectly through implementing partners with populations and communities, especially with the socially

disadvantaged ones or with communities who are affected by conflict, pandemics, or humanitarian emergency or by gender social norms. Recent developments in global health illustrate how demand generation models are transitioning from models of health education and social mobilisation to models based more on community empowerment and engagement.

***UNICEFs communication for development (*C4D)** program or approach aims to improve programming and outcomes for children through addressing social norms, behaviours, and practices. [106] This approach aims to promote change at all levels including that of individuals, families, communities, institutions, policies, and systems. The theory of change of C4D proposes levels of influence from individuals to systems as the main agents of change. Community based organisations, faith-based organisations, local leaders, women & youth groups, the media, and policy makers and decision makers all fall within the category of influencers of change. The approach is based on the understanding that social and behavioural change can be facilitated by understanding how people make decisions as well as the environmental conditions and social context in which decisions are made. [107]

Partnerships or engagement for change is not only conceptualised in terms of avoidance of harmful behaviours (such as non-uptake of vaccination) but is also conceptualised in terms of empowerment of marginalised groups. The Theory of Change also describes "platforms" for engagement that include community platforms, service platforms and institutional and policy enablers. A central assumption underlying the approach is that all strategies must be applied simultaneously across all levels in society (individual, family, community, institutional and policy system level) to achieve sustainable social and behavioural change.

UNICEF provides examples of implementation of the approach including helping vulnerable households in Cambodia, disability support for children in Malaysia, and climate change communication in Vietnam. The case from the Philippines illustrates how social accountability with local politicians and communities was promoted to support protection from disease through immunisation. [108] A review of the C4D program in EAPRO (Cambodia, Laos, Mongolia) in relation to disaster risk reduction found that the approach can facilitate a transition from top-down communication strategies to ones based on local participation, capacity building and dialogue. [109] Main partners in this approach included the education sector, NGOs, local governments, and civil society groups. The review distinguishes between "campaign-based C4D" and C4D that targets "dialogue and participation" and highlights the risk of authority as being a barrier to genuine participation by socially marginalised groups. The review concludes by making several recommendations that are of high relevance to partnership building:

1. The effectiveness of C4D approaches is linked to the capacity of health workers and health systems to support messages and promote health-seeking behaviours.
2. There are important opportunities to harness and support improved partnerships for C4D and dialogue-based approaches with NGOs
3. C4D approaches enable and enhance local capacities as well as the processes that can be used to test assumptions about local-level programming

This more active model of engagement with social disadvantaged communities is also reflected in more ***recent guidance from WHO on engagement***. [110] A recent publication on social participation for universal health coverage which sets out strategies for more engagement between governments and communities with regards to health policy development. This handbook illustrates with case studies how the concept and practice of identifying "participatory spaces" for dialogue and debate between the population, communities, & civil society and policy makers. As with the previously mentioned engagement "platforms", these participatory spaces have the potential to balance the uneven

power relations between governments, health providers and communities. Various models of community engagement have also been further tested during the COVID 19 pandemic, where guidance from WHO Western Pacific Region recommends actions strengthening community governance structures (including through local government) and building the capacity of community health workers to engage with communities during the pandemic. [111] Most of these guidance documents have models of engagement that incorporate platforms/spaces, partners and enablers or support strategies that facilitate development of more effective engagement.

**COVID 19 pandemic and responses**

The pandemic has had the most severe impact on "children in the poorest countries and communities and those already disadvantaged by discrimination, social exclusion, fragility and conflict." [112] The COVID 19 pandemic has also had an impact on immunisation coverage [113] as outlined in the coverage trends in Annex C. Immunisation coverage declined from March 2020 following the onset of the pandemic. In the Southeast Asia Region of WHO, by April 2020 there were relative differences of 59% in DTP3 compared with the previous year, and thereafter recovered In addition to this rapid recovery, 10 countries in the SEAR Region have introduced COVID-19 vaccination and more than 468 million people have received the first dose of the vaccine.[114] This rapid recovery and subsequent rapid uptake of the COVID 19 vaccine by countries demonstrates the resilience of immunisation programs and in all likelihood the effectiveness of the COVAX initiative and other partnerships in supporting these responses.

UNICEF has been well placed in several ways to respond.[115] Firstly, UNICEFs track record in global immunisation has meant that it has been well positioned to support governments with planning, technical assistance, procurement and supply COVID-19 vaccines and cold-chain equipment through the COVAX mechanism. [116] [117] Secondly, the impact of COVID 19 on existing inequalities, and the impacts on children of school closures, and lack of access to health and protection services, means that UNICEF is well placed to respond through its multi sector and multi programmatic approach to child health and development. Consistent with the UNICEF mission, these approaches have aimed at "restoring children's mental and physical well-being in the areas of health, nutrition, WASH, child protection, education and social protection, focusing on the most vulnerable." [118] Partners in these efforts included national authorities, WHO, IFRC, national programmes, NGOs, CBOs, and the private sector. [7] [Footnote]

A common feature of the COVID 19 pandemic literature, including UNICEF sources, is the notion of building back better post pandemic. This notion of building back better, which is also the subject of Regional WHO Resolutions on PHC and COVID 19, stresses the opportunities for countries to adopt learnings from the pandemic.[119] Common themes in these learnings are the unrealised potential of multisector collaborations and community engagement, the urgent need to ensure the availability and safety of a front line workforce, values of integration of health systems for primary health care, [120] and the urgent need to more proactively address health inequalities. [121]

In conclusion, the desk review and data analysis has demonstrated both the main challenges for vaccine preventable disease prevention as well as the potential for improved engagement by UNICEF to address some of these challenges. Main theme areas for engagement include working to the strategic advantages of existing UNICEF operations, as well as targeting and tailoring programs towards the unmet needs of the socially disadvantaged. Given that needs are "unmet" in the

[7] "With the support of UNICEF's EAP regional office, country offices developed a regional response plan aligned with the WHO COVID-19 Strategic Preparedness and Response Plan, the UN Global Humanitarian Response Plan as well as the UN Framework for the Immediate Socio-economic response to COVID-19." UNICEF Annual Report

current context,  the evaluation and strategy development provide an opportunity to innovate in engagement strategies for immunisation to bridge the gaps and adapt to a rapidly changing external environment.

## Annex D - List of indicators, baselines, and target values from Desk review

| No. | IMPACT | Evaluation Question | Definition | Data Source | Baseline 2018 | 2020 | 2025 | 2030 | Comments |
|---|---|---|---|---|---|---|---|---|---|
| 1 | Number/Percent of eligible child population with zero dose [Not received DPT1] % of zero dose children | Have UNICEF engagement processes made a contribution to improved health outcomes? | Number of children who have not received DPT1 in the first year of Life | Desk Review: WHO UNICEF Joint Report - WUENIC Estimates | SEAR Data<br>WPR Data<br>Country WUENIC data | | | | Data available by WHO Region or by Country |
| 2 | Numbers of reported vaccine preventable diseases [POLIO] in the last 12 months in EAPRO | Have UNICEF engagement processes made a contribution to improved health outcomes? | Number of children reported with a confirmed vaccine preventable disease in the last 12 months (suspected cases/confirmed cases (epi or lab confirmed) | Desk Review: WHO UNICEF Joint Report - WUENIC Estimates | | | | | Data Available by WHO Region or by Country |
| 3 | Numbers of reported vaccine preventable diseases [MEASLES] in the last 12 months in EAPRO | Have UNICEF engagement processes made a contribution to decline in measles cases | Number of children reported with a confirmed vaccine preventable disease in the last 12 months | Desk Review WHO UNICEF Joint Report - WUENIC Estimates | | | | | Data Available by WHO Region or by Country |
| 4 | Percent DPT3 Coverage by SES quintile | Have UNICEF Engagement processes resulted in narrowing of coverage gaps between highest and lowest SES quintiles? | Percent of eligible children who have received DPT3 vaccine the last 12 months | WUENIC Estimates | | | | | Data Available by WHO Region or by Country |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 5 | Percent HPV vaccination for eligible target populations | Have UNICEF Engagement processes with schools and health systems resulted in increased coverage of HPV vaccine for school aged girls? | Percent of eligible girls (aged 9-14 years) (primary target group) who have received HPV vaccine (second dose) in the last year? | | | | | | Data Available by WHO Region or by Country |

| | OUTCOMES | Evaluation Question | Indicator Definition | Data Source | Baseline 2018 | 2020 | 2025 | 2030 | Comments |
|---|---|---|---|---|---|---|---|---|---|
| 6 | Program Effectiveness | How effective UNICEF engagement been, both internally with other programmes and externally with Immunization stakeholders, in leadership and policy for immunisation? | Number/Type of Leadership initiatives and policies that have resulted from UNICEF engagement with partners internally and externally | Desk Review, Evaluation, Case Studies | | | | | COVAX<br>Cold Chain Systems<br>Vaccine Supply<br>New Vaccine Introduction<br>Service Delivery Strategy |
| 7 | Program Relevance | To what extent do UNICEF's engagement processes and structures and technical support addresses the seven strategic priorities identified in Immunization agenda 2030 ? | Extent to which UNICEF engagement approaches address 7 priorities of: IA2030 | Desk Review, Evaluation, Case Studies | | | | | Here we focus on the IA2030. A complementary approach would be to apply the three strategic objectives of the UNICEF immunization Roadmap (or even better latest approach from ROADMAP UPDATE). |
| 8 | Program Coherence | To what extent has UNICEF's engagement on immunisation been consistent with interventions in other areas (such as Child Protection, Education, WASH, RMNCH, and Adolescent Health)? | Number/Type of immunisation initiatives that have successfully engaged with UNICEF programs to expand services access for both immunisation and other health and social services. | Desk Review, Evaluation, Case Studies | | | | | Internal Coherence Measures |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 9 | | To what extent has UNICEF's engagement on immunisation been consistent with interventions supported by other agencies? | Number/Type of immunisation initiatives that have successfully engaged with sectors, programs or agencies that are external to UNICEF that have resulted in expanded access for both immunisation and other health and social services. | Desk Review, Evaluation, Case Studies | | | | | External Coherence Measures |
| 10 | Program Equity | How far the engagement does sufficiently addresses equity and inclusiveness dimensions for vulnerable, socially disadvantaged, geographically inaccessible and poor populations, and those in humanitarian situations? | Number/Type of immunisation or child health partnerships with agencies, communities, implementing partners in socially disadvantaged or humanitarian emergency situations that have resulted in expanded access for immunisation services for vulnerable populations. | Desk Review, Evaluation, Case Studies | | | | | |

| | OUTPUTS | Evaluation Question | Indicator Definition | Data Source | Baseline 2018 | 2020 | 2025 | 2030 | Comments |
|---|---|---|---|---|---|---|---|---|---|
| 11 | Engagement structures | | Number/Type of Engagement structures developed and applied at Regional & Country Level in EAPRO that facilitates increased engagement with immunisation partners* | Desk Review, Evaluation, Case Studies | | | | | Policy Forums (RITAG)<br>Planning Forums<br>Resource Mobilisation Partnerships Arrangements (RWG)<br>Technical Panels (Disease Elimination/Eradication programs/Safety/Cold Chain and Vaccine Supply)<br>Research partnerships structures<br>Gavi Partnership Structures<br>Civil Society and Private sector Partnership Forums<br>Internal UNICEF Policy and Planning forums |
| 12 | Engagement processes | | Number/Type of Engagement processes developed and applied at Regional & Country Level in EAPRO that facilitates increased engagement with immunisation partners ** with focus on:<br><br>Leadership and Policy<br>Cold Chain and Supply Systems<br>Expanding Service Access | Desk Review, Evaluation, Case Studies | | | | | Policy Dialogue on immunisation<br>Planning Processes (Sector, Program)<br>Coordinating Resource Mobilisation and Allocations<br>Surveillance and Monitoring Joint Efforts on Disease Elimination/Eradication)<br>Joint research priority setting or |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | | for socially disadvantaged and populations in Humanitarian Emergencies | | | | | | implementation<br>Joint Monitoring & Evaluation Processes (Joint Appraisals/Reporting<br>Partnering with Civil Society and Private sector for expanded service access, safety and quality<br>Representation of vulnerable / excluded groups in programming by UNICEF or implementing partners<br>Internal UNICEF Policy and Planning processes<br>External UNICEF Policy and Planning activities with other programs, sectors, partners |
| | | Are C4D interventions evidence based? | Level of adequacy of research to inform communication on immunisation | Desk Review<br>Survey<br>KII FGD | | | | | |
| | | Are C4D interventions for immunisation adequately resourced? | Level of Adequacy of resourcing of C4D for immunisation | Desk Review<br>Survey<br>KII FGD | | | | | |
| | | Are C4D interventions for immunisation adequately coordinated and resourced? | Level of adequacy of coordination of immunisation communication with other communication activities (e.g. Nutrition, RMNCH, WASH, Education, Other).[C4D implementers must be coordinated] | Desk Review<br>Survey<br>KII FGD | | | | | |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 13 | Engagement Guidance/Support | Are country office staff adequately trained in C4D? | Number/Type of Engagement Guidance/Tools & Technical Support programs developed and applied at Regional & Country Level in EAPRO that facilitates increased engagement with immunisation partners***<br><br>Level of adequacy of training on C4D for UNICEF Country Office Staff | Desk Review, Evaluation, Case Studies | | | | | Technical Support programs for Improved Engagement Guidelines for Countries in such areas as community engagement, primary health care (integration), program-sector reviews, |

## Annex E Comparison of Global and Regional Immunisation Strategies

| IA2030 | Immunisation Roadmap | WPRO Strategic Framework | SEARO Strategic Framework |
|---|---|---|---|
| **Principles/Strategic Objectives**<br>• People centres services<br>• Country owned programs<br>• Partnership based<br>• Data driven interventions | **Principles/Strategic Objectives**<br>• Advocate for right of every woman and child to full immunization, holding stakeholders accountable;<br>• Strengthen health and community systems to deliver immunization services, focusing on reaching and serving disadvantaged<br>• Position immunization as a driver of equitable delivery of integrated, multi-sectoral interventions | **Principles/Strategic Objectives**<br>• Strengthening and Expanding immunisation systems/ programmes<br>• Maintaining health intelligence on VPDS and immunisation<br>• Ensuring preparedness / response to public health emergencies related to VPDs vaccines and programmes<br>• Synergies with other health programmes and interventions | **Principles/Strategic Objectives**<br>• Ownership, especially at the country level.<br>• Leveraging existing mechanisms.<br>• Promoting continuous quality improvement cycles.<br>• Strengthening stakeholder accountability and technical alignment to address country needs.<br>• Tailoring technical support maturity of each country's immunization programme |
| **Strategic Priorities**<br>• PHC and UHC<br>• Commitment & Demand<br>• Coverage & Equity<br>• Life Course and Integration<br>• Outbreaks and Emergencies<br>• Supply and Sustainability<br>• Research and Innovation | **Strategic priorities (Focus Areas)**<br>• Ensure financial sustainability, integrated PHC services and marginalized communities.<br>• Integrated service delivery, supply chain systems, health workforce.<br>• Capacity of UNICEF staff governments and civil society partners to implement data-driven social and behavioural change<br>• Emphasis on reaching mothers and adolescents with immunization<br>• Immunization-related innovations and new approaches.<br>• Global eradication of polio, MNTE measles and rubella elimination<br>• Influencing vaccines and immunization supply markets.<br>• Strengthening preparedness for humanitarian responses | **Strategic priorities (Strategies)**<br>• Leaving no one behind<br>• Life course vaccination<br>• Tailor made strategies<br>• Vaccine security<br>• Vaccine acceptance, demand<br>• Sustainable domestic financing<br>• Health intelligence on VPDs<br>• Integrated VPD Surveillance and Laboratory Networks<br>• Evidence based decision making<br>• Preparedness for outbreaks and resurgence and other emergencies affecting immunisation programs<br>• Synergies through health system strengthening for UHC, prevention of NCDs and life course approach, health security and immunisation<br>• Research and innovation<br>• Partnership and collaboration | **Strategic priorities (Key Focus Areas)**<br>• Health workforce.<br>• Supply chain and logistics.<br>• VPD surveillance.<br>• Health information systems.<br>• Vaccine safety monitoring.<br>• Immunization integrated into primary health care.<br>• Political commitment and ownership.<br>• Leadership, governance, and management.<br>• Low coverage among disadvantaged populations.<br>• Recognizing and addressing barriers to immunization.<br>• Context-specific interventions.<br>• Subnational support and capacity.<br>• Vaccine forecasting, procurement, and supply. |

## References


[1] UNICEF Roadmap on Immunisation 2018-2030 https://www.unicef.org/sites/default/files/2019-01/UNICEF_Immunization_Roadmap_2018.pdf

[2] WHO & UNICEF Immunisation Agenda 2030 [IA2030] https://www.who.int/teams/immunization-vaccines-and-biologicals/strategies/ia2030

[3] GAVI 5.0 Strategy 2021 - 2025 https://www.gavi.org/our-alliance/strategy/phase-5-2021-2025

[4] The Regional Strategic Framework for Vaccine Preventable Diseases and Immunization in the Western Pacific (2021-2030) WPR / RC71/6

[5] World Health Organization. Regional Office for South-East Asia. (2021). Strategic Framework for the South-East Asia Regional Vaccine Action Plan 2022−2030 as aligned with the global Immunization Agenda 2030. World Health Organization. Regional Office for South-East Asia. https://apps.who.int/iris/handle/10665/343756

[6] UNICEF East Asia and Pacific Region Humanitarian Situation Report No. 1 https://www.unicef.org/media/96401/file/East%20Asia%20and%20Pacific%20Region%20Humanitarian%20Situation%20Report%20No.1,%201%20Jan%20-%2031%20Mar%202021.pdf

[7] UNICEF Creating Sustainable Supply Chains. https://www.unicef.org/supply/creating-sustainable-supply-chains

[8] UNICEF Growing Up Urban in East Asia A conversation with Mayors on Making Cities Safe and Sustainable For Every Child Surabaya, Indonesia 7-8 May 2018 https://www.unicef.org/eap/media/2131/file/Urban.pdf

[9] UNICEF EAPRO East Asia and Pacific Region Humanitarian Situation Report No. 3 Sept 2021 https://www.unicef.org/eap/east-asia-and-pacific-region-humanitarian-situation-report

[10] UNICEF Situation Analysis of Women and children in Malaysia 2020 https://www.unicef.org/malaysia/reports/situation-analysis-women-children-malaysia-2020

[11] Pocock N, Suphanchaimat R, editors. Moving towards culturally competent, migrant-inclusive health systems: a comparative study of Malaysia and Thailand. New Delhi: World Health Organization Regional Office for South-East Asia; 2021. https://apo.who.int/publications/comparative-country-studies

[12] Feletto M, A Sharkey, Rowley E et al A Gender Lens to advance Equity in Immunisation December 2018 Equity Reference Group for Immunisation 2018 https://www.researchgate.net/publication/331593391_A_gender_lens_to_advance_equity_in_immunization{ accessed Sept 10 2020]

[13] Babar T, Hatcher J: Health seeking behaviour and health service utilization in Pakistan: Challenging the policy makers. *Journal of Public Health* 2005, 27:49-54.

[14] UNICEF Communication for Development (C4D) Advancing positive social and behaviour change https://www.unicef.org/media/73836/file/Global-annual-results-report-2019-communication-for-development-accessible.pdf

[15] UNICEF EAPRO Communication for Development (C4D) Promising Practices https://www.comminit.com/media-development/content/communication-development-c4d-promising-practices

[16] UNICEF Communication for Development Support to Public Health Preparedness and Disaster Risk Reduction in East Asia and the Pacific: A Review https://www.comminit.com/content/unicef-communication-development-support-public-health-preparedness-and-disaster-risk-re

[17] WHO Voice, agency, empowerment - handbook on social participation for universal health coverage. Geneva: World Health Organization; 2021. Licence: CC BY-NC-SA 3.0 IGO https://www.who.int/publications/i/item/9789240027794

[18] Kate Causey, Nancy Fullman, Reed J D Sorensen, et al Estimating global and regional disruptions to routine childhood vaccine coverage during the COVID-19 pandemic in 2020: a modelling study Lancet Open AccessPublished:July 14, 2021DOI: https://doi.org/10.1016/S0140-6736(21)01337-4

[19] WHO Regional Committee for South-East Asia, September 2021. New Delhi: World Health Organization Regional Office for South-East Asia; 2021 https://apps.who.int/iris/handle/10665/345266 .

[20] Editorial The significance of primary health care for building back better: lessons from COVID-19 SEA Journal of Public Health WHO South-East Asia Journal of Public Health | February 2021 | 10(Suppl. 1) S3

[21] WHO SEAR Regional Strategy on Primary Health Care 2022-2030

[22] UNICEF Terms of Reference EAPRO Strategy of Engagement on Immunisation

[23] UNICEF Where we Work https://www.unicef.org/eap/where-we-work [accessed 18 Jan 2022]

[24] UNICEF Immunisation Data https://data.unicef.org/topic/child-health/immunization/

[25] WHO Astana Declaration on PHC https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf
[26] WHO UNICEF Vision on Primary Health Care in the 21st Century https://www.who.int/docs/default-source/primary-health/vision.pdf
[27] WHO UNICEF Operational Framework for Primary Health Care https://www.who.int/publications/i/item/9789240017832
[28] WHO SEARO Regional Strategy for Primary Health Care 2021 https://www.who.int/publications/i/item/9789290229094
[29] UNICEF Roadmap on Immunisation 2018-2030 https://www.unicef.org/sites/default/files/2019-01/UNICEF_Immunization_Roadmap_2018.pdf
[30] WHO & UNICEF Immunisation Agenda 2030 [IA2030] https://www.who.int/teams/immunization-vaccines-and-biologicals/strategies/ia2030
[31] GAVI 5.0 Strategy 2021 - 2025 https://www.gavi.org/our-alliance/strategy/phase-5-2021-2025
[32] WHO SEARO Regional Strategy on Primary Health care 2022-2030 https://www.who.int/publications/i/item/9789290229094#:~:text=This%20South%2DEast%20Asia%20Regional,Sustainable%20Development%20Goals%20(SDGs).
[33] World Bank Priorities for Reimagining Primary Health Care https://www.worldbank.org/en/topic/health/publication/walking-the-walk-reimagining-primary-health-care-after-covid-19-a-health-nutrition-and-population-global-practice-flagsh
[34] The Regional Strategic Framework for Vaccine Preventable Diseases and Immunization in the Western Pacific (2021-2030) WPR / RC71/6
[35] World Health Organization. Regional Office for South-East Asia. (2021). Strategic Framework for the South-East Asia Regional Vaccine Action Plan 2022–2030 as aligned with the global Immunization Agenda 2030. World Health Organization. Regional Office for South-East Asia. https://apps.who.int/iris/handle/10665/343756
[36] UNICEF For Every Child Results https://www.unicef.org/results
[37] UNICEF For every child, results unicef.org/results https://www.unicef.org/results
[38] UNICEF Annual Report 2020 Responding to COVID 19 https://www.unicef.org/media/100946/file/UNICEF%20Annual%20Report%202020.pdf
[39] UNICEF East Asia and Pacific Region Health https://www.unicef.org/eap/what-we-do/health
[40] UNICEF East Asia and Pacific Region Health https://www.unicef.org/eap/what-we-do/health
[41] Gavi The Role of UNICEF https://www.gavi.org/operating-model/gavis-partnership-model/unicef
[42] WHO The Immunisation Agenda 2030 Implementation framework https://www.who.int/publications/m/item/implementing-the-immunization-agenda-2030
[43] UNICEF Roadmap on Immunisation 2018 https://www.unicef.org/sites/default/files/2019-01/UNICEF_Immunization_Roadmap_2018.pdf
[44] UNICEF Immunisation Data https://data.unicef.org/topic/child-health/immunization/
[45] UNICEF Immunisation Data https://data.unicef.org/topic/child-health/immunization/
[46] Kate Causey, Nancy Fullman, Reed J D Sorensen, et al Estimating global and regional disruptions to routine childhood vaccine coverage during the COVID-19 pandemic in 2020: a modelling study Lancet Open AccessPublished:July 14, 2021DOI: https://doi.org/10.1016/S0140-6736(21)01337-4
[47] UNICEF EAPRO Country Profiles in Immunisation https://www.unicef.org/eap/reports/country-profiles-immunization-east-asia-pacific
[48] Kate Causey, Nancy Fullman, Reed J D Sorensen, et al Estimating global and regional disruptions to routine childhood vaccine coverage during the COVID-19 pandemic in 2020: a modelling study Lancet Open AccessPublished:July 14, 2021DOI: https://doi.org/10.1016/S0140-6736(21)01337-4
[49] Zero Dose Community of Practice 2022 https://www.zero-dose.org/
[50] Gavi Reaching Zero Dose Children https://www.gavi.org/our-alliance/strategy/phase-5-2021-2025/equity-goal/zero-dose-children-missed-communities
[51] WHO UNICEF Progress and Challenges with Achieving Universal Immunization Coverage 2019 WHO/UNICEF Estimates of National Immunization Coverage https://www.who.int/immunization/monitoring_surveillance/who-immuniz.pdf
[52] Equity reference Group for Immunisation (ERG): A focus on "zero dose" children: Key issues for consideration February 2020 https://irp.cdn-website.com/44236788/files/uploaded/ERG%20Discussion%20Paper%209%20Zero%20Dose%20FINAL.pdf
[53] Herliana P, Douiri A. Determinants of immunisation coverage of children aged 12–59 months in Indonesia: a cross-sectional study. BMJ Open 2017;7:e015790. doi:10.1136/bmjopen-2016-015790

[54] Nozaki, I., Hachiya, M. & Kitamura, T. Factors influencing basic vaccination coverage in Myanmar: secondary analysis of 2015 Myanmar demographic and health survey data. BMC Public Health 19, 242 (2019). https://doi.org/10.1186/s12889-019-6548-0

[55] WHO SEARO EPI Fact Sheet 2019 https://apps.who.int/iris/bitstream/handle/10665/329987/Myanmar2019_epi-eng.pdf?sequence=1&isAllowed=y

[56] Myanmar Multi Year Plan for Immunisation 2017-2021 https://extranet.who.int/countryplanningcycles/sites/default/files/planning_cycle_repository/myanmar/myanmar_cmyp_2017-2021.pdf

[57] WHO Outbreak News Myanmar 2015 https://apps.who.int/iris/bitstream/handle/10665/329987/Myanmar2019_epi-eng.pdf?sequence=1&isAllowed=y

[58] WHO Myanmar Polio Alert Highlights in 2019 https://www.who.int/myanmar/news/detail/30-09-2019-myanmar-polio-alert-highlights-2019

[59] UNICEF Children in Myanmar A Generation in Peril https://www.unicef.org/myanmar/children-myanmar

[60] Jinhua Pan,1,7 Yesheng Wang,1,7 Lingsheng Cao,3 Ying Wang,4 Qi Zhao,1,2 Shenglan Tang,5 Wenfeng Gong,6 Lei Guo,5 Zhixi Liu,1 Zexuan Wen,1 Bo Zheng,1 and Weibing Wang1,2, Impact of immunization programs on 11 childhood vaccine-preventable diseases in China: 1950–2018 , 2021; Published Online: May 4, 2021; https://doi.org/10.1016/j.xinn.2021.100113

[61] Yuan Huang, David Shallcross et al Ethnicity and maternal and child health outcomes and service coverage in western China: a systematic review and meta-analysis Lancet Global Health 2017 DOI: https://doi.org/10.1016/S2214-109X(17)30445-X

[62] Philippine Statistics Authority Quezon City, Philippines National Demographic and Health Survey The Philippines 2017 https://psa.gov.ph/sites//files/PHILIPPINE%20NATIONAL%20DEMOGRAPHIC%20AND%20HEALTH%20SURVEY%202017_new.pdf

[63] UNICEF WHO Situation Report 12 Polio Outbreak 20 December 2019 https://www.who.int/docs/default-source/wpro---documents/countries/philippines/emergencies/polio/unicef-who-phl-sitrep-12-polio-outbreak-20dec2019.pdf?sfvrsn=dd2a7ab5_2

[64] UNICEF Situation Analysis of Women and children in Malaysia 2020 https://www.unicef.org/malaysia/reports/situation-analysis-women-children-malaysia-2020

[65] DHS Survey Cambodia 2015 https://dhsprogram.com/pubs/pdf/FR312/FR312.pdf

[66] WHO Cambodia Responding to a measles outbreak during the COVID-19 pandemic https://www.who.int/cambodia/news/feature-stories/detail/responding-to-a-measles-outbreak-during-the-covid-19-pandemic

[67] John J Hall, Tabian Ambang, Augustine Asante, Pili Mapira, Adam Craig, Elisabeth Schuele and Maha Pervaz Iqbal Poliomyelitis outbreak in Papua New Guinea: health system and health security implications for PNG and Australia Med J Aust 2019; 211 (4): . || doi: 10.5694/mja2.50283 https://www.mja.com.au/journal/2019/211/4/poliomyelitis-outbreak-papua-new-guinea-health-system-and-health-security

[68] Outbreak Observatory Indonesia Confirms First Polio Case Since 2006 https://www.outbreakobservatory.org/outbreakthursday-1/2/21/2019/indonesia-confirms-first-polio-case-since-2006

[69] Wongsanuphat S, Thitichai P, Jaiyong R, et al. Investigation of Measles Outbreak among Thai and Migrant Workers in Two Factories in Nakhon Pathom, Thailand, 2019. Int J Environ Res Public Health. 2020;17(13):4627. Published 2020 Jun 27. doi:10.3390/ijerph17134627

[70]

[71] UNICEF EAPRO Health and Immunisation Services for the Urban poor in EAPRO https://www.unicef.org/eap/reports/health-and-immunization-services-urban-poor-east-asia

[72] David Champredon Affan Shoukat Burton H Singer Alison P Galvani Seyed M Moghadas Curbing the 2019 Samoa measles outbreak Lancet Published:March, 2020DOI:https://doi.org/10.1016/S1473-3099(20)30044-X

[73] Ma. Sophia Graciela L. Reyes, Edward Christopher Dee, &Beverly Lorraine Ho Vaccination in the Philippines: experiences from history and lessons for the future Pages 1873-1876 | Received 30 Sep 2020, Accepted 19 Oct 2020, Published online: 24 Dec 2020 https://doi.org/10.1080/21645515.2020.1841541

[74] WHO Measles Rubella Bulletin WHO January 2021 https://apps.who.int/iris/handle/10665/339779

[75] Global Polio Eradication Website
[76] WHO Vaccine Reportable Diseases Monitoring Measles Cases https://immunizationdata.who.int/pages/incidence/measles.html?CODE=KHM+CHN+COK+PRK+IDN+KIR+LAO+MYS+FSM+MNG+MMR+NRU+NIU+PNG+PHL+WSM+SLB+THA+TLS+TKL+TON+TUV+VUT+VNM&YEAR=
[77] WHO Vaccine Reportable Diseases Monitoring Polio Cases 2015-2020 Confirmed Poliomyelitis reported total population <15 years.https://immunizationdata.who.int/pages/incidence/polio.html?CODE=CHN&YEAR=
[78] Sandhu HS, Roesel S, Sharifuzzaman M, Chunsuttiwat S, Tohme RA. Progress Toward Hepatitis B Control — South-East Asia Region, 2016–2019. MMWR Morb Mortal Wkly Rep 2020;69:988–992. DOI: http://dx.doi.org/10.15585/mmwr.mm6930a2external icon.
[79] Sandhu HS, Roesel S, Sharifuzzaman M, Chunsuttiwat S, Tohme RA. Progress Toward Hepatitis B Control — South-East Asia Region, 2016–2019. MMWR Morb Mortal Wkly Rep 2020;69:988–992. DOI: http://dx.doi.org/10.15585/mmwr.mm6930a2external icon.
[80] Thinley Dorjia, Tanawin Nopsoponc, Saran Tenzin Tamangd, Krit Pongpirul Human papillomavirus vaccination uptake in low-and middle-income countries: a meta-analysis EClinicalMedicine 34 (2021) 100836
[81] Thinley Dorjia, Tanawin Nopsoponc, Saran Tenzin Tamangd, Krit Pongpirul Human papillomavirus vaccination uptake in low-and middle-income countries: a meta-analysis EClinicalMedicine 34 (2021) 100836
[82] Gavi Gender and Immunisation. https://www.gavi.org/our-alliance/strategy/gender-and-immunisation
[83] Adam T Craig Anita E Heywood Heather Worth Measles epidemic in Samoa and other Pacific islands Lancet Vol 20 VOLUME 20, ISSUE 3, P273-275, MARCH 01, 2020 https://www.thelancet.com/journals/laninf/article/PIIS1473-3099(20)30053-0/fulltext
[84] NIHE Vietnam National EPI Review 2020 [No Link available]
[85] UNICEF Vaccines https://www.unicef.org/supply/vaccines
[86] UNICEF From donation to delivery: how UNICEF gets COVID-19 vaccines where they are needed most https://www.unicef.org/supply/stories/donation-delivery-how-unicef-gets-covid-19-vaccines-where-they-are-needed-most
[87] UNICEF East Asia and Pacific Region Humanitarian Situation Report No. 1 https://www.unicef.org/media/96401/file/East%20Asia%20and%20Pacific%20Region%20Humanitarian%20Situation%20Report%20No.1,%201%20Jan%20-%2031%20Mar%202021.pdf
[88] UNICEF Creating Sustainable Supply Chains. https://www.unicef.org/supply/creating-sustainable-supply-chains
[89] UNICEF Growing Up Urban in East Asia A conversation with Mayors on Making Cities Safe and Sustainable For Every Child Surabaya, Indonesia 7-8 May 2018 https://www.unicef.org/eap/media/2131/file/Urban.pdf
[90] UNICEF EAPRO Health and Immunisation Services for the Urban Poor – Thematic Analysis https://www.unicef.org/eap/sites/unicef.org.eap/files/2018-03/Part_2_of_Health_and_Immunization_for_the_Urban_Poor_in_East_Asia.pdf
[91] UNICEF EAPRO East Asia and Pacific Region Humanitarian Situation Report No. 3 Sept 2021 https://www.unicef.org/eap/east-asia-and-pacific-region-humanitarian-situation-report
[92] UNICEF East Asia and Pacific Region Humanitarian Situation Report No. 1 March 2021 https://www.unicef.org/media/96401/file/East%20Asia%20and%20Pacific%20Region%20Humanitarian%20Situation%20Report%20No.1,%201%20Jan%20-%2031%20Mar%202021.pdf
[93] UNICEF Analysis of The Situation Of Children And Women In The Democratic People's Republic Of Korea 2019 https://www.unicef.org/dprk/media/686/file/Sitan%202019.pdf
[94] UNICEF Tonga https://www.unicef.org/pacificislands/topics/tonga
[95] UNICEF Situation Analysis of Women and children in Malaysia 2020 https://www.unicef.org/malaysia/reports/situation-analysis-women-children-malaysia-2020
[96] Pocock N, Suphanchaimat R, editors. Moving towards culturally competent, migrant-inclusive health systems: a comparative study of Malaysia and Thailand. New Delhi: World Health Organization Regional Office for South-East Asia; 2021. https://apo.who.int/publications/comparative-country-studies
[97] UNHCR THE IMPACT OF COVID-19 ON STATELESS POPULATIONS Policy recommendations and good practices on vaccine access and civil registration JUNE 2021 https://www.refworld.org/docid/60b8d6d84.html
[98] UNHCR THE IMPACT OF COVID-19 ON STATELESS POPULATIONS Policy recommendations and good practices on vaccine access and civil registration JUNE 2021 https://www.refworld.org/docid/60b8d6d84.html
[99] UNICEF Unpublished Report 2022
[100] Equity Reference Group A gender lens to advance equity in immunization https://www.gavi.org/sites/default/files/document/programmatic-policies/ERG_A-gender-lens-to-advance-equity-in-immunization.pdf

[101] United Nations Children's Fund. Gender Counts: A quantitative assessment of gender inequality and its impact on girls and boys in East and Southeast Asia. UNICEF East Asia and the Pacific, Bangkok, 2019. https://www.unicef.org/eap/media/3601/file/EAP%20gender%20count.pdf

[102] Feletto M, A Sharkey, Rowley E et al A Gender Lens to advance Equity in Immunisation December 2018 Equity Reference Group for Immunisation 2018 https://www.researchgate.net/publication/331593391_A_gender_lens_to_advance_equity_in_immunization{ accessed Sept 10 2020]

[103] Babar T, Hatcher J: Health seeking behaviour and health service utilization in Pakistan: Challenging the policy makers. *Journal of Public Health* 2005, 27:49-54.

[104] Gavi Gender and Immunisation https://www.gavi.org/our-alliance/strategy/gender-and-immunisation

[105] Gavi Gender Policy https://www.gavi.org/programmes-impact/programmatic-policies/gender-policy

[106] UNICEF Communication for Development (C4D) Advancing positive social and behaviour change https://www.unicef.org/media/73836/file/Global-annual-results-report-2019-communication-for-development-accessible.pdf

[107] UNICEF Communication for development https://www.unicef.org/esa/communication-for-development

[108] UNICEF EAPRO Communication for Development (C4D) Promising Practices https://www.comminit.com/media-development/content/communication-development-c4d-promising-practices

[109] UNICEF Communication for Development Support to Public Health Preparedness and Disaster Risk Reduction in East Asia and the Pacific: A Review https://www.comminit.com/content/unicef-communication-development-support-public-health-preparedness-and-disaster-risk-re

[110] WHO Voice, agency, empowerment - handbook on social participation for universal health coverage. Geneva: World Health Organization; 2021. Licence: CC BY-NC-SA 3.0 IGO https://www.who.int/publications/i/item/9789240027794

[111] WHO Western Pacific Region Role of community engagement in situations of extensive community transmission of COVID-19 Interim guidance Republished without changes on 11 December 2020 WHO Western Pacific Region https://iris.wpro.who.int/bitstream/handle/10665.1/14521/WPR-DSE-2020-016-eng.pdf

[112] UNICEF Responding to COVID 19 UNICEF Annual Report 2020 https://www.unicef.org/reports/unicef-annual-report-2020

[113] UNICEF Press Statement COVID-19 pandemic leads to major backsliding on childhood vaccinations, new WHO, UNICEF data shows https://www.unicef.org/press-releases/covid-19-pandemic-leads-major-backsliding-childhood-vaccinations-new-who-unicef-data

[114] WHO. Regional Office for South-East Asia. (2021). Strategic Framework for the South-East Asia Regional Vaccine Action Plan 2022–2030 as aligned with the global Immunization Agenda 2030. World Health Organization. Regional Office for South-East Asia. https://apps.who.int/iris/handle/10665/343756

[115] UNICEF Health Results Immunisation 2020 https://www.unicef.org/media/102656/file/Health-Results-2020-Immunization.pdf

[116] UNICEF Humanitarian Situation Report No.1 2021 https://www.unicef.org/media/96401/file/East%20Asia%20and%20Pacific%20Region%20Humanitarian%20Situation%20Report%20No.1,%201%20Jan%20-%2031%20Mar%202021.pdf

[117] EAPRO Situation Report Sept 2021 https://www.unicef.org/media/108746/file/EAPRO-Humanitarian-SitRep-September-2021.pdf

[118] UNICEF Responding to COVID 19 UNICEF Annual Report 2020 https://www.unicef.org/reports/unicef-annual-report-2020

[119] WHO Regional Committee for South-East Asia, September 2021. New Delhi: World Health Organization Regional Office for South-East Asia; 2021 https://apps.who.int/iris/handle/10665/345266 .

[120] Editorial The significance of primary health care for building back better: lessons from COVID-19 SEA Journal of Public Health WHO South-East Asia Journal of Public Health | February 2021 | 10(Suppl. 1) S3

[121] WHO SEAR Regional Strategy on Primary Health Care 2022-2030