

Case for the Theory of Change, for a request for GAVI Equity Accelerator (AWF) funding. Annexes with additional documents are also uploaded to Guinea's application file, including a PowerPoint presentation on factual data.

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INTRODUCTION

This document is developed to support Guinea's request for GAVI support for Equity Accelerator Funding (EAF/EAF) for \$US 7,997,101 for the period (2022-2025). This equity accelerator (AWF) funding will help Guinea develop a strategy for the identification and attainment of zero-dose children (EZD), under-immunized children (ESI) and missed communities (CM), in the next 3 years (2023-2025).

To access funding, it is required to develop a Theory of Change (TDC). The TDC focused on both the process and the final product. The Zero Dose Technical Unit (CTZD) team set up by the EPI Programme, worked regularly and closely with the participation of the various stakeholders, despite the many competing activities.

1. SITUATIONAL ANALYSIS

1.1. Current situation of the immunization system

Despite Guinea's efforts to achieve the Sustainable Development Goals (SDGs), indicators are still worrying, with a maternal mortality rate of 550 per 100,000 live births (NV), neonatal mortality at 32 per 1000 NV, the infant and infant mortality rate at 44 and 88 per 1000 NV respectively.

The National Health Policy (PNS) and its National Health Development Plan (PNDS 2015-2024) are consistent with the country's National Socio-Health Development Plan (PNDES 2016-2020¹). The PNDS is based on primary health care (PHC) and health system strengthening that aim for universal access to essential health services and care. The Health District is the operational implementation framework for the PNDS.

The Expanded Programme on Immunization (EPI) is a priority programme of the Ministry of Health and Public Hygiene (MSHP). Since the 80s, it has been the locomotive of the health system (PEV/SSP/ME) according to the strategy of the Bamako Initiative (IB).² It was Guinea's pride. Indeed, many countries have come to draw inspiration from it, including Niger, Senegal, Côte d'Ivoire, Niger, Madagascar, Rwanda, and Vietnam.

Unfortunately, Guinea is currently one of the countries in the West African subregion, where immunization coverage among children under one year of age has steadily declined since 2010. It is still stagnant and below 50%.³

¹ PNDS (2016-2020), MSHP Guinea

² The Bamako Initiative: what benefits for African populations? <https://books.openedition.org/iheid/2521?lang=en#:~:text=L'Initiative%20de%20Bamako%20a,le%20bilan%20de%20cette%20initiative.>

³ DHS Guinea 2018

As part of the relaunch of the EPI and on the recommendation of the meeting of the Inter-Agency Coordination Committee (IACC) on 20 May 2022, the EPI National Coordination with the support of its partners (UNICEF, WHO, GAVI, BMGF, Dalberg, FOSAD) has undertaken a series of reflections on EPI priority interventions in order to accelerate the improvement of vaccination coverage rates. This takes into account the current programmatic context and major challenges, including: i) the political change that has occurred since 05 September 2021 (military coup), ii) the recurrent occurrence of many epidemics (Ebola, Marburg, Lassa, Measles, Yellow Fever), not to mention the Covid-19 pandemic, all of which have a heavy impact on the country's health and vaccination system, iii) the weak institutional positioning of the EPI and the fragmentation as a priority programme ENP/SSP/ME and the lack of human resources dedicated to programme management and immunization in the field, iv) the weakness in the equitable provision of immunization services, with the persistence of low vaccination coverage in the country, including a Penta-3 rate of 47% since 2015 (according to WHO-UNICEF/WUENIC estimates); v) insufficient State funding for the purchase of traditional and co-financed vaccines and frequent vaccine shortages, vi) insufficient accountability and involvement of local authorities and communities, lack of control of target populations with an impact on demand generation and low use of vaccination services and vii) low involvement of civil society organizations from faith-based and private structures in the provision of vaccination.

All these situations weaken the health system, vaccination and consequently the achievement of EZD, ESI and CM. Corrective actions have recently been set out in a roadmap for different horizons (immediate, medium and long term).

Four (4) major operational determinants necessary for optimal vaccination of target populations also conditioned the reflections and analyses. These are the "**4 Vs**": i) the **Vaccine**, ii) the **Vaccinator**, iii) the **Vaccinated**, and iv) the Vaccination system. (See *Appendix, optimal vaccination hypotheses*).

1.2. Root cause analysis to achieve EZD, ESI, CM

The Zero Dose Analysis Map (see *Appendix*)

The IRMMA framework⁴ and the GAVI EZD Analysis Map were closely followed. They were used throughout the working sessions of the members of the Zero Dose Technical Committee (CTZD). They were also used during the 6-day participatory workshop to develop the EZD strategy. This workshop brought together all stakeholders including the 5 Health Districts (SD) with a high concentration of EZD, ESI, CM. The participation of these SDs has made it possible to produce strategies with local specificities, which will allow the development of adapted micro-plans later during the implementation phase. (See *PowerPoint argument*).

⁴ IRMMA
TDC Pitch – Guinea VF 12-01 -2023

The technical workshop was able to develop the main documents required for the submission of the EAF. These documents were then adopted at a strategic workshop that followed by all participants including technical and financial partners (TFPs).

1.3. Number of zero-dose children and their locations (Who and where they are?)

Given the variations and validity of immunization data in Guinea, triangulation of immunization coverage data was carried out according to administrative data, data from demographic health surveys (DHS), WHO-UNICEF data (Wuenic, JRF), global data (IHME) and finally some data from vaccination coverage sample (LCE). Despite the discrepancies and variance of the figures, the data all seem to tend in the same direction. Finally, the Technical Unit (CTZD) decided to work from an adjustment methodology according to the data of the DHS 2018 on a stratified vaccination coverage survey at the regional level. Since accurate vaccination coverage (CV) did not exist at the SD level and administrative CVs were too exaggerated (95-100%), it was necessary to extrapolate and weight the regional CVs to each respective SD. In addition to applying the annual population growth rate of around 1.27% for the period concerned (2019-2022). (See *adjustment methodology Annex 1*).

From the literature review and triangulations of the different data, it appeared that, in the absence of recent survey data, the adjustment methodology was consistent and comparable to other data, particularly those generated at the global level by IHME.

The database generated (2021 estimate) served as a reference for the calculations, vision assumptions and prioritization of the national immunization strategy as well as the AWF vision in Guinea. Since there were no significant major changes in interventions/actions in 2022, the CTZD estimated, keep the baseline of 2022 and start the reduction assumptions in 2023.

When comparing the different lines of evidence, we have the following results:

Year	Spring	Population source	Target population	% Zero Dose	# Zero Dose	% Zero Dose and ESI	# Underimmunized
2021	WUENIC	UN WPP	442 783	38%	168 258	15%	66 417
2020	WONDER	World Pop (unadjusted)	414 846	41%	170 156	14%	59 338
2021	Country estimates	Admin 2021	463 947	41%	192 088	19%	89 435

The difference between the percentage (%) of zero-dose children compared to the target population is relatively small between the different methodologies:

- WUENIC gap and our estimates: 3 percentage points
- Difference between IHME and our estimates: 0.4 percentage point.

In general, zero-dose (EZD), under-immunized (ESI) children and their missed communities (CMS) are target children (surviving children and beyond) in the different localities who missed and missed their first dose of containing vaccine (DTP or Penta 1), as well as those who did not have the chance to have the 3rd dose of the vaccine (DTP3 or Penta 3) or to complete the dose complete their schedule, during routine immunization, for many reasons.

According to the methodology described above, it is estimated according to the different hypotheses in 2021:

- The total number of zero-dose children (EZD, who did not receive Penta 1) in all Health Districts (SDs) in the country to **192,088**;
- The total number of EZD & ESI children underimmunized or vaccinated (who did not receive Penta 3) in the country at **281,646**.

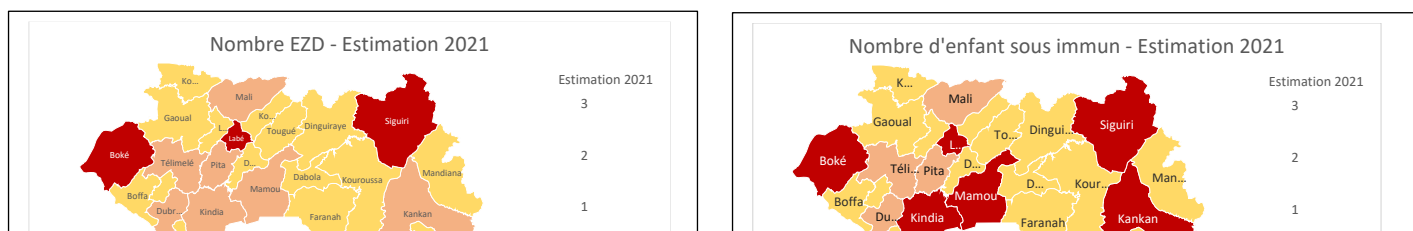
EZD, ESV and CMS do not seem to be concentrated in specific regions. However, there are 05 health districts with a high density of EZD greater than or equal to 9,000 EZD (Siguiiri, Boké, Labé, Ratoma, Matoto) and are unevenly distributed and dispersed. The SDs of low concentration are (Dixinn, Kaloum, Dabola, Yomou), which have among others low populations. (See *Health Districts Prioritization Table & maps below*).

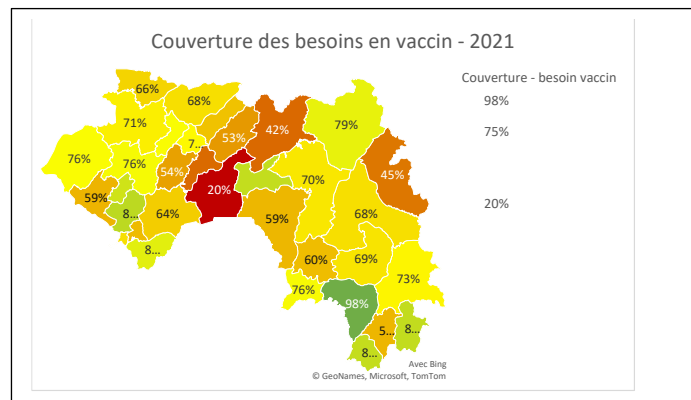
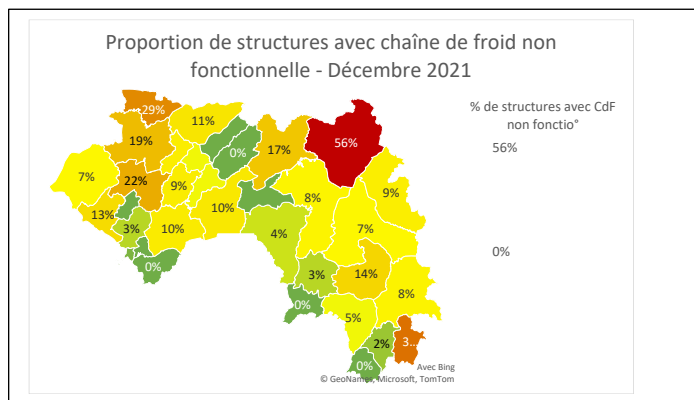
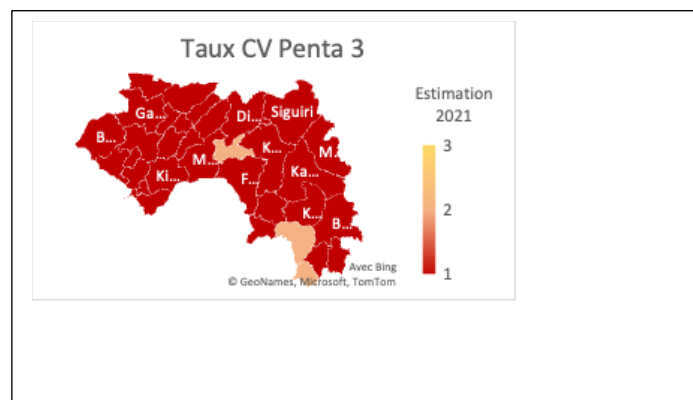
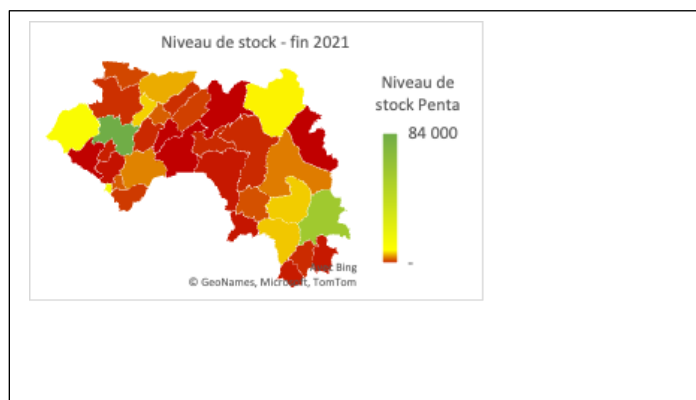
It appeared that areas with a high density of EZD correspond to fairly populated agglomerations with low vaccination coverage. However, disparities exist such as the DS of Dabola whose target population is 7,293 which has only 944 EZD. This would be explained by the high vaccination coverage of 87% which would be due, among other things, to a strong leadership of the Director of the DS (good management of the team, commitment and accountability of the staff and the availability of inputs...).

In the DS of Siguiiri, for example, they are children of difficult access residing behind the mountains (kouroukanboukaria, Soumarayah), from remote areas without telephone network, without radio, with river obstacles (Niger River, Noukounkan River, Mia River, Bafing River), with a high illiteracy rate. The Kintinian and Doko Health Centres are recognized as high-traffic areas with respectively 18% and 11% of the demographic weight taking into account artisanal and industrial mining activities.

It was observed in this analysis that there is a high concentration of EZD in the Siguiiri and Boké DS which correspond to mining areas. In Siguiiri the artisanal gold panning system is a common practice draining mobile populations from almost all of West Africa (Mali, Burkina, Ivory Coast, Senegal, Sierra Leone etc.).

Figure 1: Maps of EZD, ESI, by main determinants (Vaccination coverage, Cold chain Vaccine availability & inputs).





1.4. Why are EZD, ESI, CM not reached?

The zero analysis map was used to understand why these EZD, ESI, CM children were not reached by vaccination. *What were the obstacles, why were these children not reached by immunization and primary health care in general?*

The analysis took into account already existing data, both qualitative and quantitative. Additional data on communities was requested from Health Districts through a form sent by courier. Vaccinators of the 5 SDs with high concentrations of EZD were invited to the EZD workshop. This allowed them to develop micro-plans for immunization equity in their locality. Given the short time between the submission of the EAF application (less than 2 months), the CTZD Unit did not consider it useful to conduct new quantitative and qualitative surveys at the SD level. It considered that the data collected were sufficient to undertake a consistent and documented analysis. It also concluded that there is a need to consider in-depth surveys at a later stage (during the implementation of the EAF) to better assess the number and understand the location and barriers that cause EZD, ESI, CM not to be reached, not benefiting from and not using the service offer.

The analysis map focused on quantitative immunization data from immunization coverage surveys in urban and rural clusters, according to new WHO recommendations. Data from socio-anthropological surveys⁵ were also taken into account, including: (i) the socio-anthropological survey of the GLC University of Sonfonia with the support of UNICEF, as well as (ii) the IPSOS/Targeting study with⁶ funding from the BMGF Foundation.

The barriers identified are associated with supply-side considerations (accessibility and usability of services, supply chain, and human resources for health) and demand (behavioural and social determinants of immunization uptake, gender-related barriers, and socio-economic barriers) as well as weak immunization and primary health care systems.

1.5. Generic factors of non-attainment of EZD, ESI, MC

The main results of the causal analysis are summarized as follows:

1.5.1. Supply Barriers

These barriers include, inter alia, factors limiting access to immunization services, including poor reception, geographical accessibility, road conditions during the rainy season, the state of the cold chain and availability of vaccines and inputs, the availability of human resources, the timing of service delivery that is not in line with that of mothers, the increase in competing activities due to poor planning, poor integration of activities such as vitamin A supplementation, antenatal consultation (CPN), interoperability between health services and civil registration.

⁵ Socio-anthropological survey – LASAG, Faculty of Social Sciences, GLC University of Sonfonia – PEV /UNICEF- 2021

⁶ IPSOS/Targeting study with funding from the BMGF Foundation
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Based on five determinants, the analysis of vaccine equity conducted in 12 SDs in 2019 with the support of partners, including UNICEF, highlighted areas where bottlenecks persist. In terms of equity, a major bottleneck is in terms of accessibility, which results in a limited number of vaccination sites and insufficient health personnel involved in vaccination (which requires creating new sites or expanding partnership with private and faith-based structures). See *Appendix for details of the supply-side causal analysis*.

1.5.2. Demand-side barriers

In the report of the LASAG socio-anthropological study on the acceptability of vaccination in Guinean urban areas of Greater Conakry (Conakry, Dubréka and Coyah), we have a broad view on routine vaccination of children aged 12 to 23 months and the factors that influence vaccination status, according to the socio-demographic characteristics of the respondents (mothers or caregivers and head of household).

Among other things, it is noted that:

- The level of education of the head of household influences the vaccination status of children in the household;
- The proportion of children who have not received any vaccine is higher among children whose parents are single or who live in polygamous households;
- The proportion of children who have not received any vaccine is higher among certain religious sects (Wahhabi, Shi'ism and Tidjania);
- The lowest vaccination coverage was recorded in households whose language spoken is Pular and Malinké, in contrast to Guerzé, Kissien and other local languages;
- Immunization coverage increases as the incomes of caregivers grow;
- The level of knowledge, attitude and practice of mothers/caregivers of children aged 12 to 23 months on vaccination varies from one municipality to another and decreases as one moves away from the date of birth of the children;
- The Health Centre is where children are most likely to receive vaccines;
- Acceptance of antenatal visits (PNCs) can motivate women to vaccinate their children;
- Knowledge of the vaccination schedule is low, with the exception of two key periods (the first days after the birth of the child and the ninth month, due to the risk of measles),
 - In urban areas, there is a less strong tendency to favour community influence in family affairs (socio-anthropological study).

The analysis also shows that:

- Despite the official free vaccination, there are payments of the direct and indirect costs of vaccination, by parents of children;
- Insufficient involvement of local authorities and community participation and engagement bodies (almost all Health and Hygiene Committees – COSAH, are non-functional);

- Insufficient interpersonal communication and awareness of immunization (including fear of AEFI), increased knowledge of parents/caregivers and community commitment to immunization;
- A lack of partnership and contractualization with women's groups, the OSC / OBC CCAV (communal committee for support to vaccination). *(See Appendix for details of the causal analysis related to the request)*
- In the context of COVID-19, half of babysitters said they had encouraged a loved one to vaccinate their child. They also said they felt the fear generated by the pandemic and this slowed down the vaccination of their children;
 - Some special communities and their locations (orphans, beggars, seasonal migrants, etc.) are also a source of inequity.
 - Within large households, certain relationships are of particular importance, including between the mother and her husband, who has control over many of the mother's decisions: i) autonomy to decide to travel for social or family activities such as basic child care or vaccination.

1.5.3. Barriers to the Immunization System

- Lack of knowledge of target populations, boundaries of sectors/districts of Neighbourhoods and villages, areas of responsibility by local authorities and vaccinators;
- The lack of close demographic monitoring of target populations in localities;
- Insufficient state EPI funding for the purchase of traditional and co-financed vaccines;
- The insufficiency or absence of funding for EPI activities at local level and SDs through the Annual Investment Plan (PAI) and Local Development Plan (PDL) of urban and rural municipalities. *See Appendix for details of the causal analysis related to the vaccination system.*

1.6. Specific location-related factors

The analysis of EZD, ESI, CM, and micro-planes of DS with high concentration of ESIs revealed specificities, including:

- 1) **Vaccination in urban and peri-urban areas** (variable reception, inadequate schedules of the vaccination offer, payment of fees, despite free of charge, waiting times and loss of time for mothers, inadequacy of vaccination programs according to the mothers' schedule)
- 2) **Remote and isolated rural areas**, insufficient vaccination sites close to communities, postponement of appointments to open vaccine vials, vaccine and input stock-outs,
- 3) **Areas with river obstacles** (crossing, islands / islets) and mountainous terrain, vaccination carried out by volunteers and trainees in the absence of qualified, trained and dedicated personnel for vaccination
- 4) **Areas with strong influence of religious sects** and veiled women (Wahhabi, Shiism and Tidjania), with husbands who demand that mothers benefit from the

services provided by female staff in leir and place men (despite the lack of human resources),

1.7. Specific factors related to social groups:

Which takes into account special communities and their locations

- Beggars, highly mobile people with physical or mental disabilities (City of Solidarity in Conakry),
- Seasonal migrants from fields, islands and islets, (In the 18 islands and islets of Kobayah in Conakry: salt-extracting populations, migrate to the islands during the period from December to April, farmers in agricultural camps between May and December)
- Orphaned children, abandoned children, children with deceased or destitute parents characterized by insufficient follow-up in very precarious orphanages,
- Sex workers (Population often absent from home, little follow-up of children)
- Living populations in border areas (populations living between two municipalities and being left behind)
- Populations in specific areas (markets, bus stations, mosques etc.).

It appears that specific vaccination strategies are needed to reach these specific populations in these assembly points (vaccination points, targeted awareness, etc.). These places are opportunities to reach these children in these communities.

For example, the micro-plan of the Sigui DS (DS with the highest concentration of EZD), shows that 63% (16 CS and 48 PS) out of 178 structures integrate vaccination activities, i.e. only 32% coverage. At the SD level, only 233 health workers are dedicated to vaccination (53%) of these, 122 (52%) have been specifically trained in EPI management in the last 3 years.

It thus appears that without a drastic paradigm shift and new strategies effectively involving all stakeholders, including vaccinators, local authorities, the Government and technical and financial partners (TFPs), it will be difficult to improve VC and the achievement of EZD, ESI, CM.

The EAF will then be catalytic funding to drive change with the complementary support of technical and financial partners (TFPs).

The identification and resolution of all these barriers will be taken into account in the national strategy of EZD, ESI, CM and consequently in the GAVI Support Theory of Change.

1.8. Equity and Rights

In terms of equity, it is necessary to take into account the different obstacles, as well as the solutions to remove them:

- **Accessibility:** both geographic and affordability, developing in microplans and analysis of vaccine equity. Consideration should be given to the creation, rehabilitation or revitalization of new health and immunization centres to reduce

the distances between them and households. In addition to this situation, there are specific realities that must also be taken into account in the microplans: in particular: i) remote rural areas with difficult access, ii) urban and peri-urban areas, iii) island areas iv) mining areas with a large and very changing demography linked to artisanal activity.

- i) **Socio-cultural barriers** and those related to women's autonomy and decision-making. Indeed, many mothers live in large, low-income, multigenerational households. The targeting study shows that there are specific interpersonal dynamics that are particularly important: i) the mother's relationship with her husband is essential, as he controls much of her decision-making, including the health and vaccination status of their children; ii) influencers from outside the household are also important, as is trust in religious leaders among all groups of mothers.

1.9. Learning

- ii) **Primary Health Care:** the lessons learned in the past with the implementation of the Bamako Initiative, for the involvement and modalities of reaching communities, will be capitalized for the search for zero-dose children, under-immunized children and missed communities (why we did not reach them). NPC interventions, Newborn Care and the Value of Vaccine Monitoring will be leveraged
- iii) **COVID-19 vaccination activities** provide sufficient means and resources. It will look at how to integrate and optimize immunization activities to achieve COVID-19 targets and routine immunization. (e.g. real-time data) in obstacles and in the proposal of activities.

2. NATIONAL VIEW OF THE IMMUNIZATION SYSTEM WITH FAE DEMAND

Zero-dose children (EZD), under-immunized children (ESI) and their missed communities (CMs), are target children (surviving children and beyond) in different localities of the country that have escaped routine immunization, for multiple reasons.

2.1. The main conclusions of the situation analysis

In total, of the 281,646 EZDs and ESIs, 49% are found in 11 SDs with a high concentration of EZDs. This observation will profoundly guide the prioritization of the zero-dose AWF strategy.

The main reasons for non-reaching EZD, ESI, CM, relate mainly to: i) frequent breaks in vaccines, inputs with a cold chain often failing in the field, ii) a lack of dedicated human resources for vaccination, vaccinators are mainly composed of trainees and untrained volunteers, iii) the weakness of community involvement and participation with Health and Hygiene Committees (COSAH) almost non- (iv) socio-behavioural barriers that hamper

demand generation, (iv) a weakness in the vaccination system, as shown by the various analyses.

The situational analysis also shows that whatever the type of SD, they are all fragile, capable of moving from one category to another, if the root causes are not attacked. In addition to this situation, there are a number of other specific realities for which specific responses must be provided. These include: (i) remote and hard-to-reach rural areas, (ii) urban and peri-urban areas, (iii) island areas with hard-to-reach islands and islands, and (iv) mining areas with a large and very changing population linked to artisanal activity, which can be subject to frequent and unpredictable changes.

The objectives and activities of the Theory of Change will be used to develop the remainder of the request for support, including: i) the Work Plan ii) the Monitoring and Learning Plan. Although this EAF funding does not target support for new vaccines, there are plans for some studies to understand why already introduced vaccines such as Men A and the 2nd dose of VAR are not sufficiently used.

2.2. Expanding the partnership

There is a need to expand the partnership beyond the health sector, particularly in the demographic enumeration and monitoring of target populations, mapping with geocodes, capacity building for EPI management, vaccination coverage sample surveys or LQAS, provision of birth certificates, involvement of schools and training centres.

3. BASIS FOR APPLYING FOR EIF SUPPORT - GAVI

Guinea is in a particularly difficult situation with regard to vaccination. A set of prerequisites have not yet been established, including: i) the Comprehensive Multi-Annual Plan (PPAC 2016-2020) which is obsolete and the National Immunization Strategy (NVS) not yet developed, ii) there is no recent external review of the EPI carried out, nor recent vaccination coverage surveys, apart from the Effective Management of Immunization (EFF) process which is ongoing.

During the participatory workshops to develop the theory of change (Coyah 22-27 September 2022), proposals from the zero dose technical unit (CTZD) were made to anticipate the future national vaccination strategy (SNV).

3.1. Investment principles and targeting

The principles relate to:

- Prioritization of SDs with high concentration EZD, ESI, CM and orientations of the majority of AWF investments on the 11 SDs
- Complementarity with domestic investments, other partner funds (RSS2, RSS3, ...)
- Sustainability / sustainability
- Regular learning/monitoring-evaluation
- Innovation: testing and piloting new approaches

3.2. Assumptions guiding the definition of objectives and interventions

Programmatic guidance will be based on the distribution and concentration of zero-dose children. Prioritization and focus will be on the 11 SDs.

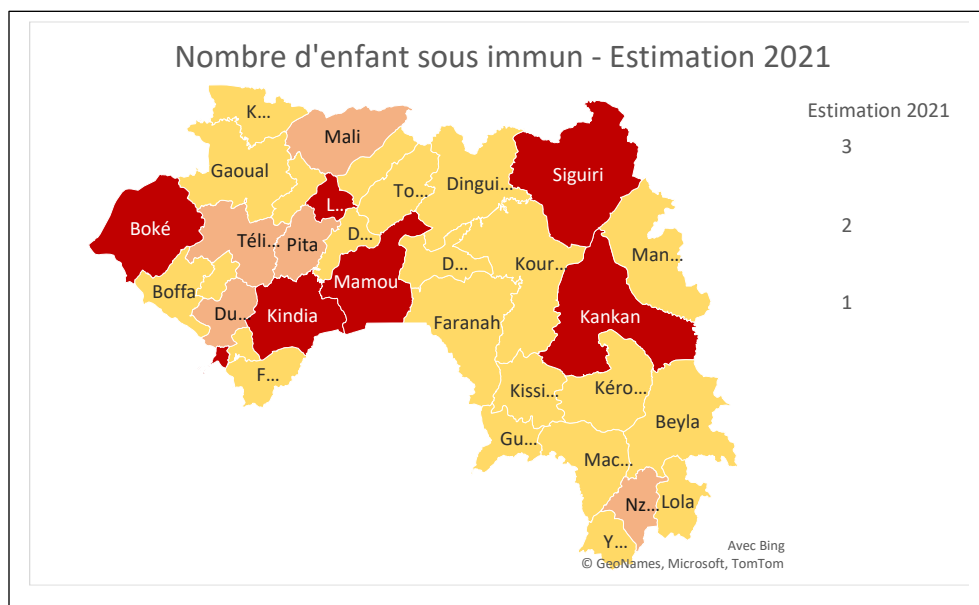
The prioritisation of interventions in the theory of change will be supported by GAVI. The technical and policy workshops on the development of the National Zero Dose Equity Accelerator Funding (EAF) Strategy concluded to proceed with the following priorities in mind:

- Priority 1:** covering SDs with a high concentration (more than 9000) of EZD, ESI and low routine vaccination coverage (SD in red to 11). They are: Siguiri, Kankan, Kindia, Labé, Mali, Mamou, Pita, Nzérékoré, Boké, Ratoma, Matoto. The basic minimum package of activities (PMA) and support activities to quickly increase vaccination coverage towards Penta 3. In addition, specific activities will be added according to microplanes and types of SD.
- Priority 2:** for SD with a medium concentration (between 5000 and 3000) of EZD, ESI and low routine vaccination coverage (SD in yellow). The basic minimum package of activities (PMA) and support activities to raise and maintain vaccination coverage (Penta 3).
- Priority 3:** addressing SDs with a low concentration (less than 3,000) of EZD, ESI, with high systematic coverage (SD in green). The basic minimum package of activities (MAP) and support activities to raise and maintain immunization coverage (Penta 3)

Table 3: Mapping and Prioritization of EZD by Prefecture (Health District) of Guinea (Baseline 2021)

Zero Dose Child (EZD)		Under-immunized child (ESI)					
Prioritization based on EZD number (Without Penta1)		Prioritization based on Penta1 coverage rate		Prioritization based on the number of ISAs		Prioritization based on Penta3 coverage rate	
District	Number of EZDs	District	Penta Cover 1	District	Number of ISAs	District	Penta Cover 3
Siguiri	10 277	Lab	35%	<u>Siguiri</u>	16 502	Lab	15%
Boké	10 059	Koubia	37%	<u>Ratoma</u>	15 353	Koubia	18%
Ratoma	9 667	Tougué	39%	<u>Matoto</u>	15 027	Mamou	18%
Matoto	9 453	Mamou	41%	<u>Boké</u>	14 221	Tougué	19%
Lab	9 174	Mali	41%	Kankan	12 503	Mali	19%
Mamou	8 385	Lélouma	41%	<u>Lab</u>	11 882	Lélouma	20%
Nzérékoré	7 825	Gaoual	47%	Mamou	11 514	Pita	23%
Kindia	7 781	Koundara	47%	Kindia	11 378	Koundara	24%

Mali	7 539	Pita	48%	Mali	10 273	Dalaba	25%
Kankan	6 783	Propose	48%	Pita	9 526	Gaoual	27%
Gueckedou	6 559	Boffa	48%	Nzérékoré	9 124	Propose	27%
Pita	6 431	Gueckedou	49%	Dubrêka	8 291	Boffa	28%
Beyla	6 316	Boké	49%	Télimélé	8 100	Boké	29%
Télimélé	5 815	Dinguiraye	52%	Mandiana	7 856	Forécariah	35%
Dubrêka	5 346	Dalaba	53%	Beyla	7 288	Télimélé	36%
Faranah	4 940	Télimélé	54%	Faranah	7 039	Dinguiraye	36%
Boffa	4 857	Kill	54%	Gueckedou	6 995	Kill	39%
Forécariah	4 620	Nzérékoré	55%	Forécariah	6 955	Kankan	40%
Gaoual	4 573	Beyla	56%	Boffa	6 766	Kindia	41%
Macenta	4 385	Lola	57%	Kouroussa	6 691	Dubrêka	43%
Coyah	4 367	Forécariah	57%	Kissidougou	6 621	Faranah	43%
Kissidougou	4 316	Kindia	60%	Coyah	6 558	Kouroussa	44%
Lélouma	4 239	Faranah	60%	Gaoual	6 283	Coyah	44%
Dinguiraye	4 194	Yomou	62%	Lélouma	5 786	Siguiri	45%
Kouroussa	3 763	Coyah	63%	Macenta	5 663	Kaloum	45%
Tougué	3 329	Dubrêka	63%	Dinguiraye	5 580	Gueckedou	46%
Lola	3 288	Macenta	64%	Kérouané	4 780	Lola	46%
Mandiana	3 061	Kaloum	65%	Tougué	4 467	Ratoma	47%
Koundara	3 017	Kissidougou	66%	Dalaba	4 442	Mandiana	47%
Kill	2 915	Siguiri	66%	Koundara	4 353	Kissidougou	47%
Dalaba	2 786	Ratoma	67%	Lola	4 086	Kérouané	48%
Koubia	2 759	Kankan	67%	Kill	3 865	Nzérékoré	48%
Kérouané	2 522	Matoto	68%	Koubia	3 623	Matoto	49%
Propose	2 226	Kouroussa	68%	Propose	3 127	Beyla	49%
Yomou	1 900	Kérouané	73%	Dabola	2 772	Macenta	54%
Kaloum	961	Mandiana	79%	Dixinn	2 626	Yomou	56%
Dabola	944	Dabola	87%	Yomou	2 222	Dixinn	56%
Dixinn	715	Dixinn	88%	Kaloum	1 511	Dabola	62%



4. INTERVENTION TOWARDS THE ACHIEVEMENT OF EZD, ESI, CM

To achieve the EZD, ESI, CM, a minimum package of activities was agreed during the workshops for the formulation of the zero dose strategy, applicable to the 11 priority SDs with a high concentration of ESD. In addition, support activities were also selected. These measures defined during the workshop with the participation of teams of 5 DS take into account local specificities for the reduction of EZD, ESI, CM.

4.1. Minimum Package of Activities (PMA) to achieve zero dose in the Districts

- Count of targets by Sector/Neighborhood (Urban Commune), Village/Administrative District (Com Rurale)
- Choice of ReCos by the local administrative authorities (1 ReCo for 650 people according to standards)
- Recruitment of CSAs by local administrative authorities (1 CSA for 10 ReCos)
- Organize vaccination sessions (Fixed Strategy, Advanced Strategy, Mobile/Special Strategy) and Intensified Immunization Activities (AVI)
- Organize radio micro-programs focused on adherence to the vaccination schedule
- Identification and mapping of vaccination sites (Advanced, fixed and mobile/special strategies)
- Establishment of community registers of target populations to enable demographic catch-up and monitoring
- Establishment of mechanisms to strengthen mothers' autonomy and decision-making for vaccination and a vaccine reminder system (SMS and voice)
- Regular supply of vaccines, management tools, vaccination materials to health facilities

- Establish / revitalize Health and Hygiene Committees (COSAH)

4.2. AWF – District EZD Support Activities

- Staff training/upgrading (vaccinators/volunteers/District management team/DRS)
- Formative supervision (DQS, LQA, Community Convenience Survey)
- Organization of monthly data validation meetings
- Monitoring of activities
- Advocacy for the inclusion of EPI priority activities in the Annual Investment Plan (IAP) and Local Development Plan (LDP)
- Pooling strategy seasonal chemoprophylaxis (SPC) Palu with EPI
- ReCos sponsorship system and school group (Child to child)
- Gratification of parents/guardians who have fully vaccinated their child

4.3. Specific measures

There is a need to consider specific and urgent measures to ensure that the objectives and expected results are achieved. The development of SD micro-plans targeting priority activities to address supply, demand, and immunization system barriers and bottlenecks to achieving SEZD, ISE, MC.

The National EPI Coordination should focus on capacity building for the training of vaccination focal points in integration with other activities, to develop guides including: i) on the enumeration of target populations, demographic monitoring and mapping with geocode with community health partners (CHW, RECO, local authorities), training of SD, CS officers on WHO management modules for the intermediate level, including conducting vaccination surveys by sample or LQAS, iii) formative supervision and monitoring and evaluation of targeting EZD, ESI, CM field activities. It will also be useful to update normative, strategic and training documents, and to make resources available for operational activities.

4.4. FAE Microplans – District EZD

Emphasis will be placed on the development and implementation of microplans for SDs, including the 11 priority SDs. These microplans are intended to address barriers including: (i) getting enough vaccines and inputs to the delivery level, (ii) financing premiums for designated vaccinators, (iii) availability of logistics and other necessary equipment and timely availability of funds for operations,

It also appeared that whatever the level of priority of the SDs, that the level of instability and fragility mean that permanent and sustainable measures deserve to be taken to ensure the sustainability of ambitions. This should be taken into account with RSS2 and CDS3 and the support of other partners.

4.5. Innovations,

While strengthening the fundamentals of the EPI (such as monitoring with authorities and communities for accountability and transparency etc.), innovations will be tested, validated and scaled up, including:

- i) Enumeration activities, geolocation of missed households and communities,

- ii) The use of community registries (paper & Excel) to monitor vaccination targets in neighbourhoods and sectors of health areas will be prioritized,
- iii) Strengthening and tracing advanced strategy activities,
- iv) Data interoperability with DHIS2,
- v) Systematic and regular analysis of data for decision-making and action, including reminders of SMS vaccination schedule and dates.
- vi) Volunteering for development (the promotion of human resources on a contractual basis and volunteering for development in search of EZD, ESI, CM, like the US Peace Corps and the National Development Volunteers - VSN) with CSOs/NGOs, professional centers and training and research institutions
- vii) The involvement of CSOs/NGOs and local authorities in the intensive search for EZD, ESI, CM,
- viii) Increased engagement and communication with special areas and missed communities
- ix) Promotion of integrated health and development programmes (PHC, civil registration, emergency obstetric and neonatal care SONU, NPC, FP, surveillance of EPI target diseases) with NGOs with long experience in community work.
- x) Gender factors influence both service use and demand for immunization. As shown in the IPSOS – Targeting study, it appears that the influence of husband, grandmothers, family or friends, community leaders (non-religious) is important. These studies also show barriers related to: i) primary caregivers, known as "caregivers", but also ii) influencers that include grandmothers, women's leaders, political, religious and traditional leaders. There have also been influences that culturally impact mothers' decision-making on vaccination.

5. NATIONAL IMMUNIZATION STRATEGY – (NVS/NIS)

Given the lack of a valid Comprehensive Multi-Year Plan (PPAC) and the absence of recent immunization coverage survey data, it has been difficult to provide factual guidance on the future of EPI. Thus, the EPI seized the opportunity of the exercise of the EAF and the theory of change, to anticipate and make proposals.

5.1. National Immunization Vision of the country:

"A Guinea in which every individual, wherever they are, regardless of age and status, fully benefits from vaccines for their good health and well-being."

5.2. Goal

"SNV plans to protect all target people from vaccine-preventable diseases, while leaving no one behind, in line with the IA2030 agenda and contributing to the strengthening of Primary Health Care (PHC), Universal Health Coverage (UHC) to achieve the Sustainable Development Goals (SDGs) in Guinea."

5.3. Targets of the 2030 National Immunization Strategy

- Reach at least 80% of fully vaccinated children.
- Reduce the number of EZDs and under-immunized at the national level by at least 50%
- Achieve and maintain at least 90% coverage in Penta 3
- Achieve at least 80% of fully vaccinated targets.

5.4. 2025 AWF Funding Targets - Zero Vaccine Equity in Guinea

- Reduce the ⁷ number of ESDs and ISAs by 60% by 2025 in the 11 priority districts, equivalent to a 29% reduction at the national level.
- Have an impact of 18 percentage points on Penta 3* coverage at the national level, from 39% to 57%, targeting 11 priority districts.
- Achieve 52% coverage in VAR1 (with a 5% dropout rate).

* CV Penta 3 = 57% [Impact of the 29% reduction in vaccination coverage in Penta by 2025 from a CV in 2021 estimated at 39%).

- | | |
|--|-----------|
| - Total Unaffected Children = (ESI) + Children Zero Dose (EZD) | = 281,646 |
| - Total EZD | = 192,088 |
| - Remaining ESI | = |
| 89,558 | |

See below Table 5 (2025 reduction targets for EAF Guinea) - 11 SDs

These impacts on EPI performance were estimated taking into account only the additional efforts under the EAF within the 11 districts with a high concentration of EZD and ESI (more than 50% of the total EZD and ESI at the national level), all else being equal. Therefore, if we take into account other ongoing or future initiatives (RSS3, CDS3 ...), the reduction in the number of zero children could be even more important.

5.5. Strategic Outcomes

Four (4) Strategic Outcomes (SO) have been selected from the Excel tool provided by GAVI, based on the EAF. During the workshops at least 3 objectives were chosen per SO and for each Objective, three (3) key activities.

- SO 2: Extend and Reach
- SO 3: Manage, monitor and learn from lessons
- SO 4: Engage and sustain
- SO 1: Introduce and scale

⁷ This 60% reduction is compared to the number of EZDs on the baseline in 2025 (all else being equal). This corresponds to a 55% reduction compared to the number of EZDs in 2021.

(See details in Excel TDC tools provided by GAVI)

The different tabs of the TDC were completed, as well as those of the work plan, the targeted areas and the budget.

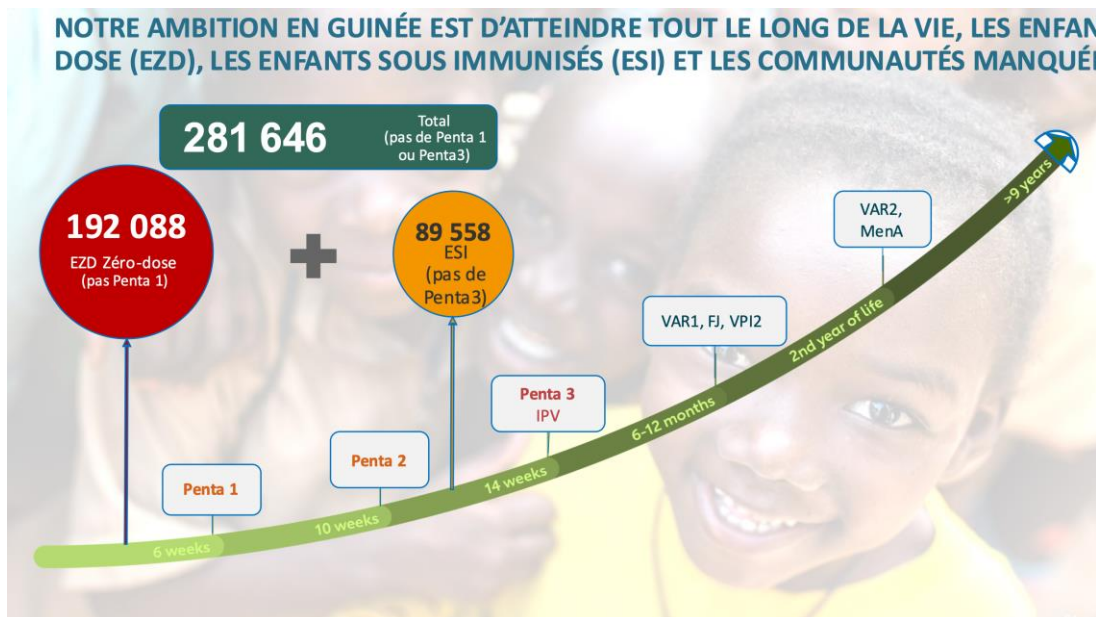
Table 4: Guinea's National Immunization Strategy - 2025 REDUCTION TARGETS

		Taux d'accroissement	1,027447	1,027447	1,027447			
		Trajectoire de l'impact	50%	30%	20%			
Niveau national	Nombre d'enfants 2021	2021 - Poids sur la cible	Données 2022	Données 2023	Données 2024	Données 2025 (objectif)	2025 - Poids sur la cible	Commentaires
Enfants survivants (cible)	463 947	100%	477 419	490 523	503 986	517 819	100%	
Penta 1=0 (EZD) - baseline	192 088	41%	197 666	203 091	208 665	214 392	41%	Dans l'état actuel, il est difficile de faire la part entre enfant Penta 1, 2 et 3.
Penta 1=0 (EZD) - Objectif	192 088	41%	197 666	172 004	158 926	152 219	29%	
Penta3 = 0 [(ESI+EZD) - EZD] - baseline	89 558	19%	92 158	94 688	97 287	99 957	19%	
Penta3 = 0 [(ESI+EZD) - EZD] - Objectif	89 558	19%	92 158	80 194	74 097	70 970	14%	
<Penta3 (ESI + EZD) - baseline	281 646	61%	289 824	297 779	305 952	314 350	61%	
<Penta3 (ESI + EZD) - Objectif	281 646	61%	289 824	252 198	233 023	223 188	43%	
Couverture Penta3		39%	39%	48%	53%	57%		Taux Penta 3 (business as usual = 39%) + impact de la réduction de 29% à horizon 2025
Couverture VAR		34%	34%	43%	48%	52%		Taux Penta 3 (57%) - Taux d'abandon de 5%
Enfant vacc. Penta3		180 939	186 193	236 885	269 484	293 111		
Enfant vacc. VAR		157 742	162 322	212 358	244 284	267 220		

Table 5: 2025 REDUCTION TARGETS EAW GUINEA (11 SD)

		Taux d'accroissement	1,027447	1,027447	1,027447			
		Trajectoire de l'impact	50%	30%	20%			
11 districts prioritaires	Nombre d'enfants 2021	2021 - Poids sur la cible	Données 2022	Données 2023	Données 2024	Données 2025 (objectif)	2025 - Poids sur la cible	Commentaires
Enfants survivants (cible)	219 196	100%	225 210	231 391	237 742	244 268	100%	
Penta 1=0 (EZD) - baseline	93 374	43%	95 936	98 569	101 274	104 054	43%	Dans l'état actuel, il est difficile de faire la part entre enfant Penta 1, 2 et 3.
Penta 1=0 (EZD) - Objectif	93 374	43%	95 936	67 353	51 328	41 622	17%	
Penta3 = 0 [(ESI+EZD) - EZD] - baseline	43 929	20%	45 135	46 374	47 646	48 954	20%	
Penta3 = 0 [(ESI+EZD) - EZD] - Objectif	43 929	20%	45 135	31 687	24 148	19 582	8%	
<Penta3 (ESI + EZD) - baseline	137 303	63%	141 071	144 943	148 921	153 008	63%	
<Penta3 (ESI + EZD) - Objectif	137 303	63%	141 071	99 040	75 477	61 203	25%	
Couverture Penta3		37%	37%	57%	68%	75%		Taux Penta 3 (business as usual = 37%) + impact de la réduction de 60% à horizon 2025
Couverture VAR		32%	32%	52%	63%	70%		Taux Penta 3 (75%) - Taux d'abandon de 5%
Enfant vacc. Penta3	81 892		84 139	132 351	162 266	183 064		
Enfant vacc. VAR	70 933		72 879	120 782	150 378	170 851		

Figure 2: Guinea's collective ambition to reach zero-dose and under-vaccinated children by 2025



The goal of reducing EZD will not stop at Penta 1, but it is aimed to fully vaccinate children with all basic vaccines.

6. TARGETING GAVI SUPPORT

To achieve these significant reduction outcomes, EAF support will target specific geographic areas and subpopulations. We will start for this purpose, with the 11 DS that house the high concentrations of EZD, ESI with a 60% reduction assumption. See *Table 3: Mapping and Prioritization of EZD by Prefecture (Health District) of Guinea (Baseline 2021)*

In this argument, the levels of ambition have been documented by the "IDENTIFY" questions in the minimum required analyses. It specifies in the theory of change, how ambition can be achieved in relation to EAF support.

Based on the above description, Guinea with GAVI AWF support of 7,997,101 \$US plans to reduce EZD and ESI rates by 29% in the next 3 years (2023-2025). The IRMMA analysis made it clear that there was no noticeable change in 2022.

6.1. Key activities

For the EAF period (2023-2025) this will involve:

- i) strengthen the capacities of field operations teams (Vaccinators, RECO, CSOs) through training on immunization coverage surveys according to the new WHO recommendations, EPI management with WHO modules, leadership

management, monitoring, evaluation (RSS), as well as micro-plans mechanisms for strengthening the autonomy and decision-making of mothers, and influencers to remove socio-cultural barriers;

- ii) close coaching at all levels, as well as designating and motivating focal points based on experiences and results in a contractual approach;
- iii) Support the development and implementation of micro-plans equity at the level of the 11 SDs, ensuring that immunization service delivery is made available 7 days a week in fixed centres, that advanced strategies are carried out with regular outings and that demand generation is stimulated with strong involvement of local and customary authorities
- iv) Monitor and measure the implementation of micro-plans involving health care providers, local influencers, local authorities, community representatives, CSOs and the private sector,
- v) Identify new initiatives, advocacy, partnerships and communication channels to identify and reach ESD, ESI and forgotten communities,
- vi) Conduct periodic evaluations to ensure the validity of objectives and activities, as well as the achievement of results,
- vii) Undertake relevant studies to adapt micro-plans and remove obstacles for better strategies,
- viii) Ensure regular formative supervision and monitoring sessions with the involvement of community leaders including COSAH,
- ix) Set up a dashboard in close connection with DHIS2.

7. RISKS TO CONSIDER

Taking into account the Guinean environment and context, a number of risks must be taken into account, including:

- Possible socio-political unrest
- The occurrence of socio-health emergencies (epidemics and disasters)
- Instability / Staff turnover
- The establishment of new mining areas

8. GENDER AND RIGHTS

Gender issues and religious sects must be taken into account. It is the same as children without birth certificates, the beginning of a great inequality with consequences throughout their lives.

The various stakeholders, including CSOs/NGOs, will have to focus on the autonomy and decision-making of mothers and influencers. The table below summarizes some of the barriers and interventions to address them.

Table 6: Gender Barriers and Solutions to Address Them

Gender Barriers	Proposed interventions
-----------------	------------------------

<p>Travel autonomy:</p> <ul style="list-style-type: none"> - Women are unable to move to health and vaccination centres for socio-cultural and/or security reasons 	<ul style="list-style-type: none"> - Need for microplanning to address gender barriers. <p>For example, tailoring advanced strategy activities to women's places and agendas.</p>
<p>Decision-making autonomy:</p> <ul style="list-style-type: none"> - The woman does not have the decision-making power for vaccination (fathers and/or grandmothers have it). 	<ul style="list-style-type: none"> - Use moshuées to educate men about the importance of vaccination. - Consider a few influential men as champions of vaccination - Educate grandmothers about the importance of vaccination, while highlighting the reasons for not prioritizing vaccination.
<p>Insufficient time / Opportunity cost:</p> <ul style="list-style-type: none"> - Women do not have time to bring their children to normal working hours 	<ul style="list-style-type: none"> - Extending the opening hours of health and vaccination centres - Include in the Microplans advanced strategies of women's places and time slots (e.g. best places, around water points, etc.) - A basic analysis of missed opportunities for additional interventions (e.g. systematic verification of children during consultations or any other contact
<p>Perception of benefits/risks of vaccination:</p> <ul style="list-style-type: none"> - Measles is recognized as a killer disease (so it is important to vaccinate at 9 months) - Other diseases (such as meningitis, pneumonia or diarrhoea) may have the same consideration. 	<ul style="list-style-type: none"> - A strategic commitment may be included in this component - If there is a reminder system, it can concern several interventions (e.g. SMS reminder, or simply in some cultures, the jar of Pebbles of Grandmothers)

9. PREPAREDNESS FOR A SUCCESS

Given the current weak and fragile situation of the EPI vaccination system, intensified support and accompanying measures are needed at all levels. It will not be a substitute for management and vaccination teams at the various levels both at the central level and in the field.

To achieve the objectives, certain measures must be put in place, including: 1) the timely supply of vaccines and inputs to the districts and 2) the financing of performance bonuses for vaccinators and 3) the logistical and rolling resources necessary to implement fixed and mobile strategies (e.g. vehicles, fuel) and for supervision.

For the EAF period (2023-2025), it will involve: i) strengthening the capacities of field operations teams (Vaccinators, RECO, CSOs) through training on immunization

coverage surveys according to the new WHO recommendations, EPI management with WHO modules, leadership management, monitoring, evaluation (RSS); ii) close coaching at all levels, as well as designating and motivating focal points based on experiences and results in a contractual approach; iii) Monitor and measure the implementation of micro-plans involving health care providers, local influencers, local authorities, community representatives, CSOs and the private sector, identify new initiatives, advocacy, partnerships and communication channels to identify and reach ESD, ESI and forgotten communities, iv) conduct periodic evaluations to ensure the validity of objectives and activities, as well as the achievement of results, but also relevant studies to adapt micro-plans and remove obstacles for better strategies, v) ensure regular training supervision and monitoring sessions with the involvement of community leaders including COSAH, vi) set up a dashboard in close liaison with DHIS2.

The equity accelerator funding will be used to build the capacity of the 11 priority SDs with a high concentration of EZD, ESI, CM. Intensified support will then be considered, for the first year trying to upgrade these SDs by harmonizing the implementation of the Minimum Package of Activities (LDCs) in addition to the supporting activities). Given the fragility and vulnerability of the country's SDs, support for all SDs in the country in proportion to the concentration of the target populations.

Contractual arrangements will be considered as much as possible by involving local implementing partners who have proven their effectiveness. To this end, mapping and selection of local CSOs/NGOs was proposed on a contractual basis.

Without worrying about the local authorities, coaching at all levels will be necessary and specific means will have to be put in place, to allow effective work. Focal points at all levels will be identified and motivated.

New partnerships will be identified and forged, including the Alliance and extended partners, training schools (students, students and trainees), research institutions, rural radios, local implementing and communication partners, CSOs, faith-based organizations, women's groups, and community-based organizations will also be solicited to support the sustainable implementation of the EZD activity, ESI, CM. The SD's micro-plans will be the operational framework for implementation and monitoring for this purpose.

10. MONITORING, MEASUREMENT AND EVALUATION

Without wishing to make vertical this program of EZD, ESI, CM, a close monitoring of the implementation, will be set up with dedicated focal points throughout the implementation. EZD focal points should be designated for monitoring through dashboards, capable of monitoring progress through DHIS2 or other platforms. These resource persons will also

provide answers to the priority learning questions identified and help to better understand how the proposed activities will reach and reduce the number of zero-dose children and contribute to sustainable immunization systems, especially at the community level and in specific contexts (remote rural populations, urban populations, religious sects, socio-cultural barriers, etc.).

These focal points will have to verify whether programmes and interventions reach zero-dose children and forgotten communities, if necessary propose alternatives of solutions and community monitoring system, in close collaboration with local authorities and different stakeholders.

Periodic meetings at different levels will be organized under the leadership of the SDs. The dashboard data and programme indicators including those of EZD, ESI, CM, will be prepared by the focal points and reviewed with all stakeholders.

Even if the introduction of new vaccines will not be a major strategic outcome, it will be useful to organize studies to understand why some new vaccines introduced, such as Men A, do not have satisfactory vaccination coverage.

It will be useful to set up a contractual coaching system, monitoring activities through a dashboard (DHIS2), vaccination institutions at all levels (central, SD, CS) and focal points, by an independent body, in support of vaccination activities with a focus on removing obstacles and bottlenecks of EZD, ESI, CM. This under the leadership of the national authorities.

11. ENSURING POLITICAL WILL

The political and MSHP authorities have clearly shown their willingness to make immunization a national priority. The situational analysis of the revival of the EPI showed the need to open and broaden the partnership to the various sectors of socio-economic development including the Ministries of Territorial Administration and Decentralization (MATD), Economy and Finance (MEF), Technical and Vocational Education (METP), Higher Education and Scientific Research (MESRSI), Communication including civil society and development partners. This will ensure their commitment to prioritize and mobilize local resources to achieve zero-dose and forgotten communities by addressing gender-related and other barriers to immunization.

The Ministry of Health (MSHP) is committed to supporting the contracting approach and to doing everything possible to ensure that the prerequisites and guarantees of accountability and transparency are ensured at all levels.

12. ESTIMATED EAF BUDGET PLANNING – GUINEA (2023-2025)

In order for the EAF to effectively reach the EZD, ESI, CM, in the targeted SDs, substantial funding will be allocated to the work of the SDs through their microplans. Indeed, an

amount of approximately 90% of the EAF will be allocated to SD supporters and at least 10% to CSOs to achieve the targets.

12.1. Orientations of AWF financing in Guinea

GAVI EAF funding for the next 3 years (2023-2025) should focus on ESDs, ISEs, MCs, starting with the 11 SDs of high concentration of ESDs, ISEs, MCs and low vaccination coverage, SDs identified during the situational analysis.

12.2. Evolution of AWF funding (2023-20225)

Table 6: Evolution of AWF Funding (2023-20225)

USD Funding	YEAR 1 (2023)	YEAR 2 (2024)	AN 3 (2025)	TOTAL	%
Central level	140 578	31 799	31 799	204 177	2,61%
Health Districts	2 755 626	2 549 956	1 527 685	6 833 268	87,23%
All levels	173 529	537 881	84 742	796 152	10,16%
TOTAL	3 069 733	3 119 636	1 644 227	7 833 596	100%

12.3. Beneficiaries of the Funds

Table 7: Funding Recipients by Year

Recipient of funds (USD)	2 023	2 024	2 025	TOTAL	%
ENP	1 961 635	2 666 715	1 325 735	5 954 085	74%
MS/UAGCP	569 562	0	0	569 562	7%
Community Health	0	0	0	0	0%
BSD	230 878	230 878	115 439	577 195	7%
UNICEF	0		0	0	0%
WHO	0		0	0	0%
Other DM Branches	0		0	0	0%
OSC	352 251	281 499	262 509	896 259	11%
Total budget	3 114 326	3 179 092	1 703 683	7 997 101	

The main beneficiary will be the EPI (74.5%), CSOs (11.2%) for the research of EZD, ESI, CM at the SD level.

The main sub-recipients will be the 11 priority SDs

The funding will go primarily to support the implementation of micro-equity plans in priority SDs (11 SDs), i.e. USD 7,200,815 (90%) of the funding. This will ensure key activities, including: i) enumeration and mapping of target populations with community registries, allowing regular monitoring and achievement of EZD, ESI, CM, ii) delivery of immunization services in fixed and advanced strategy, iii) demand generation, for the reduction of gender barriers, in particular the adaptation of service schedules in CS to the constraints of mothers, the organization of advanced strategy in places with a strong group of mothers (markets, bus station, etc.). Not to mention support activities (formative supervision, monitoring and evaluation, etc.).

Immunization financing modalities with the EAF:

Report:

Based on the community health policy in Guinea, the number of RECOs needed in the 11 health districts is 9,631 and the number of CHWs is 967. Taking into account ongoing community health projects in these districts, the unmet need in these districts is: i) RECO: 4,810, ii) CSA: 487

A CSA receives GNF 1,200,000 per month, while RECO receives GNF 500,000. The various stimuli did not make it possible to retain this approach, since the amount required for care for 3 years is exorbitant.

Proposal:

Within 11 SDs, Service Delivery (fixed and advanced strategy)

- For DS & Private Health Structure

2 agents will be taken in each health center and private structure (the PEV agent and the CPN agent) and the head of post. There are 164 health centers, 35 private structures or 199 structures which corresponds to $(199 * 2) = 398$ agents.

- With regard to health posts, in the 11 health districts, there are 869 of which 532 are integrated. By taking the head of health post of each health post, we will have 532 additional agents.

In total for all HR, there will be $(398+532)$ 930 vaccinators.

Vaccinators will receive a monthly premium of GNF 500,000 on a contractual basis. These agents will ensure the availability of the vaccination service every day in their sites and will carry out 2 outings in advanced strategies per week to the vaccination points, i.e. 8 outings per month. For each outing, fuel costs will be covered at the rate of 5 l per outing and 60,000 GNF as a snack fee.

Logistical support will be provided through the maintenance of motorcycles and the provision of management tools.

2.2.2.5.2 Fuel vaccinators for the forward strategy (2 sorties per week per officer and 5 litres per outlet).

Within 11 SDs, for demand generation

In addition, snacks will be paid to the teams of vaccinators during advanced strategies. (See activity 4.6.6.2.1) Support the implementation of awareness-raising activities for the reduction of gender barriers, including the sensitization of people in authority in households (husbands, grandmothers ...) or in religious places (mosques, churches ...), the production and dissemination of spots, interactive programs etc.

4.6.6.5.1 Support the implementation of micro-equity plans in priority SDs (11 SDs) as part of CSO operational support

At the central level

The role of the central level will be mainly dedicated to support, guidance, development of implementation guides/manuals, capacity building of immunization actors, formative supervision and monitoring and evaluation. It will be encouraged to create conditions to foster contracting with CSOs and NGOs, as well as the private sector where possible. As such, a mapping of CSOs will be ensured to retain those that have a good basis to serve as a local implementation partner. It will also be encouraged to complement interventions, particularly with community health, territorial administration and decentralization (MATD) stakeholders for the involvement of local authorities and the inclusion of budgets for the EPI and zero doses in the annual investment plans (PAI) of the Communes and the local development plans (PDL).

The development of a count and mapping guide is already planned in the ATT/GAVI and will be removed from the EAF Guinea budget.

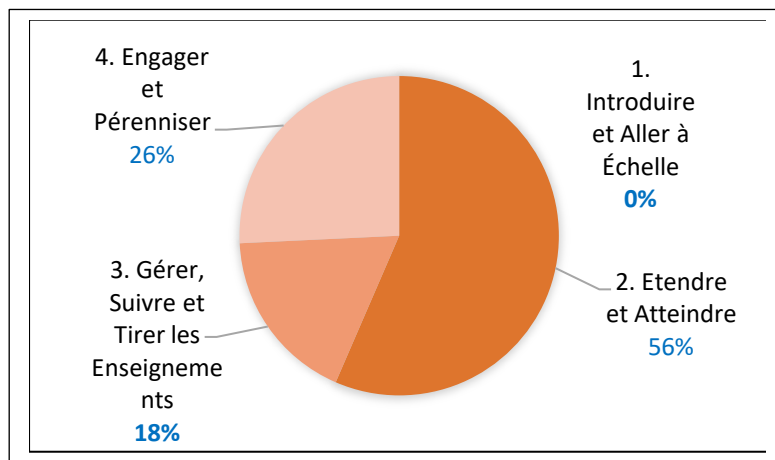
Budget lines with values of "0" have been removed, although they are planned to be financed from other lines of the AWF budget, and other sources such as RSS2 and CDS3. For activity 3.4.4.2.2 (line 30): which is repeated every year according to the budget, which corresponds to a large part of the funding, will be explained by the formation of a critical mass of human resources to organize cluster immunization coverage surveys (LCTs) according to the new WHO guidelines. These cluster LCAs will serve in Year 1 as a baseline for each SD, as well as strengthen community capacity in the conduct of surveys (LQAS/QAS) repeatedly per year. Consideration will also be given to strengthening the capacity of regional and district focal points for the analysis and research of EZD.

Additional funding, in particular the SSR and that of technical and financial partners, will certainly be useful in this process of reducing EZD, ESI, CM for the remaining 27 SDs in the country.

12.4. Distribution of Funding by AWF Strategic Outcomes

Effect	FAE
1. Introduce and Scale	\$0

2. Extend and Reach	\$4,518,829
3. Manage, Monitor and Learn Lessons	\$1,418,877
4. Engage and Sustain	\$2 059 395
Total budget	\$7 997 101



AWF by investment area

Investment area	2023	2024	2025
1. Provision of services	\$1 608 050	\$858 241	\$500 007
2. Human Resources for Health	\$580 924	\$995 870	\$513 835
3. Supply Chain	\$0	\$0	\$0
4. Medical Information System, Monitoring and Learning	\$136 188	\$417 881	\$0
5. Surveillance of vaccine-preventable diseases	\$0	\$0	\$0
6. Demand generation and community engagement	\$575 555	\$579 238	\$481 248
7. Governance, Policy, Strategic Planning and Program Management	\$213 609	\$327 864	\$208 595
8. Health financing	\$0	\$0	\$0
9. Management of Grants and Indirect Costs	\$0	\$0	\$0
10. Results-Based Funding	\$0	\$0	\$0
Total budget	\$3 114 325	\$3 179 093	\$1 703 683

EAF – GAVI by expenditure

Category of expenditure	2023	2024	2025
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1. Human Resources (HR)	\$398 532	\$683 198	\$357 499
2. Transportation and travel expenses	\$424 518	\$727 745	\$363 873
3. External Professional Services (EPS)	\$1 235 745	\$911 669	\$439 539
4. Medical Products, Consumables and Equipment	\$0	\$0	\$0
5. Events (trainings, meetings, workshops, launches)	\$373 445	\$0	\$0
6. Cold chain	\$0	\$0	\$0
7. Infrastructure (INF) and Non-Medical Equipment (ENM)	\$0	\$0	\$0
8. Communication materials and publications	\$454 182	\$528 617	\$334 178
9. Program Administration (PA)	\$227 902	\$327 864	\$208 595
10. Results-Based Funding	\$0	\$0	\$0
Total budget	\$3 114 325	\$3 179 093	\$1 703 683

EAF – GAVI by beneficiary

Recipient of funds	2023	2024	2025
ENP	\$1 961 635	\$2 666 715	\$1 325 735
MS/UAGCP	\$569 562	\$0	\$0
Community Health	\$0	\$0	\$0
BSD	\$230 878	\$230 878	\$115 439
UNICEF	\$0	\$0	\$0
WHO	\$0	\$0	\$0
Other DM Branches	\$0	\$0	\$0
OSC	\$352 251	\$281 499	\$262 509
Total budget	\$3 114 325	\$3 179 093	\$1 703 683

13. CONCLUSION

The stated political will of the Ministry of Health to once again make the EPI the locomotive of the health system based on community health augurs well for a certain commitment. The Equity Accelerator (AWF) funding requested here will be a major catalytic support to contribute to the challenge of reviving the EPI in Guinea, with a particular focus on 11 identified Priority Health Districts. Taking into account the Guinean context and while ensuring a number of prerequisites, it will quickly remove the majority of obstacles and resolve the reasons for non-vaccination in

order to reach zero-dose, under-immunized children, as well as their missed communities. This GAVI support will strengthen child protection and survival to achieve the Sustainable Development Goals in Guinea.

14. ANNEXES

1. Zero dose map & analysis
2. Documents of the FAE Guinea Workshops – August 2022
3. Methodology Adjustment EZD Guinea
4. Experiences Immunization coverage survey Guinea
5. FOSAD Experience Population Enumeration and Monitoring
6. EZD DS Equity Microplans
7. Budget assumptions
8. IHME Report
9. Qualitative analysis reports
10. Dalberg Consulting
11. GAVI AWF submission guide documents