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Terms of Reference – SSA Individual Contract

Review and Documentation of Lessons-Learned arising from GAVI Support to HHS in 8 Selected States in Nigeria

1. IDENTIFICATION

Title of TOR	**Review and documentation of lessons learned arising from GAVI support to HHS in 8 Selected States in Nigeria**
Anticipated start date	**20 January 2025**
Anticipated end date	**31 March 2025**
Contract Supervisors	**Chief of Health, Evaluation Specialist**
WBS	**3210/A0/07/880/008/003**
Grant	SC210684
Estimated Budget (USD)	**USD**

2. BACKGROUND

GAVI's Health Systems and Immunization Strengthening (HSIS) support is a key instrument for achieving GAVI's strategic goal of increasing the effectiveness and efficiency of immunization delivery as an integrated part of strengthened health systems. The current project (2022-2025) in Nigeria represents a significant investment in health system strengthening across eight selected states, focusing on multiple intervention areas including governance, service delivery, community engagement, and health information management.

The project aligns with GAVI's broader approach to HSS support, which aims to demonstrate results in three key areas: increasing immunization coverage and equity, strengthening health systems to deliver integrated primary health care, and improving the sustainability of national immunization programs.

3. CONTEXT OF IMMUNIZATION AND HSS IN NIGERIA

Nigeria has the highest number of unimmunized children in the world, estimated at 4.3 million children in 2018. In recent years, the coverage of DPT3/Penta 3, a key indicator of a country's performance of Routine Immunisation, has fallen from 52 per cent in 2014 to 33 per cent in 2016. Fluctuations have also been observed in the coverage of other antigens given in the country. Evidence form 2016 MICS/NICS surveys indicated that wide variations exist in RI performance across the Country's zones with the South East and South West zones showing high RI performance, while the North East and North West show low performance. The disparity is driven by several factors which include socio-economic status, and personal beliefs of the care givers. The decline in DPT3/Penta 3 in Nigeria from 52% in 2016 to 33% in 2018 has left more than 3.2 million children under the age of 12 months under immunized in 2018, adding to the already existing huge pool of susceptible under-fives which has led to outbreaks of vaccine-preventable disease across the country. Implementable and sustainable strategies to vaccinate very eligible child are critical if we are to save the lives of every Nigerian child. Bottlenecks to the low immunisation coverage include poor community sensitization on available routine services with prioritization of immunization campaigns rather than

on health system strengthening and provision of commodities for routine services; frequent and prolonged public sector health worker strikes in some states; prolonged periods of non-payment of salaries; inadequate funding and fund disbursement delays; insecurity in the north-eastern states affecting the most marginalized communities; inadequate integration of routine immunization services with broader PHC services; poor community linkage, trust and community engagement, which slows the Reach Every Ward immunization approach; weak demand at community level due to low awareness of benefits of immunization; poor quality of immunization data at LGA and health facility levels; and poor maintenance of cold chain equipment.

In alignment with the Nigeria Strategy for Immunisation and PHC Systems Strengthening (NSIPSS) and IA2030 and GAVI's 5.0 strategy for 2021-2025, which are all premised on strengthening national and subnational capacities to improve and sustain immunization coverage and maintain PHC service delivery, UNICEF, GAVI and participating State Primary Health Care Development Agencies/Boards of Bayelsa, Katsina, Jigawa, Kebbi, Zamfara, Niger, Gombe, and Taraba are implementing a three year integrated routine immunization and PHC memorandum of Understanding (MoU) that aims to strengthen Routine Immunization (RI) and PHC systems to significantly contribute to the reduction of mortality by preventing vaccine-preventable deaths by attaining at least 80% equitable, sustainable coverage.

The Government of Nigeria, in partnership with GAVI, implemented a Health System Strengthening (HSS) project to improve immunization and primary healthcare (PHC) services in 8 states: Bayelsa, Katsina, Jigawa, Kebbi, Zamfara, Niger, Gombe and Taraba. Six results areas are attached to the project:

1. Leadership, governance, and coordination of integrated RI and PHC services
2. Service delivery with a focus on PHC and community including outreach to hard-to-reach settlements / Zero Dose communities
3. Demand generation and community engagement to drive utilisation of integrated RI and PHC services
4. Data management and surveillance – data collection, analysis,and use for programming
5. HRH – actions taken to build capacities of critical HRH, recruitment of HRH
6. Supply chain including procurements done through the grant, excluding support under CCOP.

The agreement between GAVI, the Government of Nigeria, and UNICEF covered three years for a total amount of USD 51,203,303, including a sum of USS48,306,668.00 (forty-eight million, three-hundred six thousand, six-hundred sixty-eight United States Dollars) representing the funds to be managed by UNICEF, and a further amount of USS2,896,635 (two million, eight hundred ninety-six thousand, six-hundred thirty-five United States Dollars) for Financial Management Institutional Capacity Strengthening – PHC Strengthening Fund.-

All participating Primary Healthcare Development Agencies from Bayelsa, Gombe, Niger, Katsina Jigawa, Zamfara, Kebbi, and Taraba states are considered high or significant risk per UNICEF's financial capacity assessments. Noting the foregoing, and in the spirit of holistic and sustainable systems strengthening including capacity transfer to government counterparts, UNICEF Nigeria proposed to equip and support the institutions involved in the PHC Strengthening Fund program with additional dedicated capacity and resources over and above typical minimum UNICEF assurance activities and capacity development interventions. These additional financial assurance measures proposed include:

a) Establishment of a dedicated and seasoned roving team for financial assurance at UNICEF that will enforce supportive supervision with the IPs for on-site/remote reviews, training, and capacity development. Terms of reference for the team will be developed and communicated to Gavi;
b) Embedding a dedicated consultant within each IP acting as the first line of reference on financial management. The consultant will also conduct frequent verifications and local round-table capacity development sessions at the State, LGAs, and Ward levels;
c) Enhanced financial management training and assurance reviews both on-site and remotely;
d) Roll-out of a cloud-based accounting system that will enhance accountability and records management. Currently, partners use manual hardcopy cashbooks to register transactions;
e) Purchase of equipment to allow electronic transaction recording and processing (laptops, scanners, cabinets for each of the eight Implementing Partners.

The monitoring mechanisms included project performance monitoring by UNICEF and period reports to the donor (GAVI). As the project is nearing its end (March 2025), it was agreed to conduct a review and document lessons learned from this experience of GAVI sub-national investment in Health System Strengthening for the improvement of immunization coverage and equity. The current ToR is aimed at supporting an in-depth review of the program, documentation of lessons learned, actionable recommendations for future programming, and strategic decision-making in line with GAVI's 5.0 strategy for 2021-2025.

4. PURPOSE OF THE REVIEW AND LLE

The main purpose of this assignment is mostly on learning and less on accountability. While some aspects of the review look at the merit and comparative advantages of strategic interventions in the GAVI's HSS at the sub-national level in Nigeria, the findings from this assignment are expected to inform the Government of Nigeria (Federal and States), the GAVI Board and UNICEF about current and future investments in HSS, refine strategies and capitalize on lessons learned. It will also serve two major uses: (a) objective assessment of achievements, implementation context, and risks; and (b) inform future stakeholders' engagement. Therefore, the overall purpose of this review and lessons learned harvesting exercise is to facilitate the understanding of what worked/didn't work, why it worked/didn't work, and how interventions adapted to local contexts including innovations at the local level.

5. OBJECTIVES

The main objective is to conduct an in-depth review of the GAVI HSS project implementation in Nigeria, assessing its contribution to health systems strengthening and immunization program improvement. In other terms, this review will examine how the project has influenced health system effectiveness, immunization coverage and equity, and program sustainability while generating evidence-based insights for future design, and implementation of HSS/HSIS interventions. Specific objectives of this review and documentation of lessons learned are to:

1. Conduct an **in-depth program review** to evaluate the program's relevance, coherence, effectiveness, efficiency, and sustainability;
2. **Review Program Implementation, context, and stakeholder's roles and engagement;**
3. **Assess progress, and achievements, and identify systemic barriers, enabling factors, and unintended consequences** for each result area;

4. **Document and analyze lessons learned** using structured reflective frameworks guided by Double-Loop Learning (DLL) to reflect on systemic assumptions and explore deeper insights on each result area.
5. Provide **actionable recommendations** for future programming and strategic decision-making in line with GAVI's 5.0 strategy for 2021-2025.

This review will employ **Implementation Research (IR)** approaches and Schön's **Double-Loop Learning (DLL)** framework to understand both operational effectiveness and systemic changes achieved across eight states.

6. SCOPE OF WORK:

The thematic, geographic, and chronological scope of this evaluation are described below, in line with the GAVI's support to the implementation of the Nigeria Government Health System Strengthening Program. The geographic scope of the assignment is limited to the states of Bayelsa, Gombe, Niger, Katsina Jigawa, Zamfara, Kebbi, and Taraba. The period covered is from March 2022 to January 2025. However, experiences, insights and reflections from the senior Government Staff at the federal level will be sought to enrich the review. The following thematic areas will be assessed thoroughly in different steps of the assignment:

a) Leadership and governance capacity with institutionalized accountability.
b) Immunization coverage and equity, and PHC service delivery.
c) Demand creation for immunization, and institutionalizing community engagement strategies.
d) Health Information Management Systems (HIMS).
e) Capacity Building, and adequate deployment of human resources in PHC.
f) Financial risk management, and accountability mechanisms at the federal and state levels under the PHC Strengthening Fund.
g) Healthcare Financing
h) Supply chain (availability of vaccines and essential commodities and services).
i) Monitoring health outcomes.-

7. KEY REVIEW QUESTIONS

The GAVI HSS project's review and documentation of the lessons learned exercise seeks to use a structured process to reflect on and review a near-completion project. The goal is to identify successes, challenges, and lessons learned so that stakeholders can improve future programs and decision-making about similar investments. Methodologically, this involves gathering, structuring, and analyzing feedback from the major stakeholders. It also means moving and looking beyond merely identifying what went right and wrong. The most meaningful utility resides in the possibility of generating actionable insights for improving program design, strategy, implementation, and outcomes. Annex 1 provides an interim set of questions based on the conceptual framework, and methodological design proposed hereafter.

As a matter of caution, the suggested results areas and questions in the review design matrix are not definitive. Applicants are highly encouraged to review, enrich, and refine the questions while preserving key aspects of the methodology, and considering time, technical and analytical constraints. An improved version of the review design matrix should be part

of the technical proposal. The finalization and validation of this annex will happen during the inception phase, and will therefore constitute the basis of the qualitative data collection and analysis

8. CONCEPTUAL FRAMEWORK

An integrated conceptual framework will be necessary to provide a robust structure for assessing the achievements of GAVI-supported HSS in 8 selected states in Nigeria, reviewing the implementation, and offering a powerful approach to documenting lessons learned. To this end, it is suggested to consider using four complementary methodological approaches: selected **OECD DAC Evaluation Criteria** (Relevance, Effectiveness, Efficiency, Sustainability) in combination with the **Implementation Research (IR)** perspective, the **Most Significant Change (MSC)** technique, and **Double-Loop Learning (DLL) Shön's reflective cycle.**

OECD DAC Evaluation Criteria provide a systematic framework to assess project relevance, effectiveness, efficiency, and sustainability. Implementation Research offers a structured framework for understanding real-world implementation dynamics; it examines how interventions were adapted to local contexts, identifies implementation barriers and facilitators, and promotes stakeholder engagement through participatory approaches. The Most Significant Change technique captures stakeholder perspectives and evidence of transformation. Schön's model helps move beyond surface-level analysis by questioning underlying assumptions and exploring systemic factors behind operational achievements, successes, or failures. In the context of documenting lessons learned on the HSS project in 8 selected states in Nigeria, the application of Shön's framework involves reviewing what happened, analyzing why it occurred, and considering how it can be done differently next time.

This integrated framework enables comprehensive evaluation at multiple levels. At the operational level, it examines implementation effectiveness and efficiency through single-loop learning. At the strategic level, double-loop learning explores systemic changes and tests underlying assumptions. Throughout, Implementation Research bridges the gap between GAVI's theoretical framework and practical implementation in states with low immunization coverage.

The methodology strengthens the review through four distinct advantages. It maintains sensitivity to state-level variations, ensures methodological rigor through combined evaluation approaches, promotes active stakeholder engagement in validation and recommendation development, and generates context-specific insights to inform future programming decisions.

9. METHODOLOGY

The review and documentation of lessons learned from the GAVI-supported Health System Strengthening Project in Nigeria require a structured and evidence-based approach and will employ **mixed methods** (quantitative and qualitative). The mixed-methods approach, combines **qualitative** and **quantitative** methods, to ensure a comprehensive and nuanced understanding of the program's implementation, achievements, and lessons learned. This approach will also enable triangulation of findings from different data sources, enhancing the validity and reliability of the review.

Key Phases of the Review and documentation of lessons learned

The Review Team will: (a) review program implementation by assessing progress, achievements, and identifying barriers, enabling factors, and unintended consequences for each result area against the original project strategy plan/SOW/proposal/work plans; this is important to be able to articulate what was planned vs. what was implemented and why (changes, decisions, barriers, etc); (b) collect and analyze quantitative and qualitative data based on the research framework, engaging stakeholders at national, state, and community levels through interviews, focus group discussions (FGDs), surveys, and document reviews; (c) reflect on systemic assumptions and explore deeper insights, highlighting successful practices, challenges, and actionable lessons for each result area; (d) facilitate validation workshops to refine findings and co-develop recommendations, and finally, (e) prepare a comprehensive report with insights and recommendations for future programming.

Sampling strategy

A purposive sampling strategy will be employed to select KII and FGD participants. Participants purposively selected for the interviews or FGD will derive from the stakeholder mapping exercise to be conducted jointly or refined by the Review Team. They will consider their roles (implementation, oversight, service provider, right holders), capacity, interest, influence, and power over program implementation. The universe will consist of UNICEF Nigeria staff; Government staff from the State Primary Health Care Development Agencies/Boards, Senior Government staff (MoH, PHCDA), representatives of GAVI in Nigeria, CSOs/Implementing Partners, and other key stakeholders at community, LGA, state, and federal levels. Diversity and inclusion criteria, as well as gender lenses, will be employed to ensure the representativity of KIIs and FGD samples.

Data Collection Methods and Tools

Quantitative data collection:
There will be no quantitative primary data collection. All quantitative data will come from secondary sources including but not limited to: analysis of project monitoring data, review of health information systems (HIMS) to analyze state-level trends in immunization coverage, equity, and service delivery, and health system performance metrics, assessment of immunization coverage and equity indicators, and review of budgetary allocations, resource utilization, and performance indicators across participating states.

Qualitative data collection methods and sources:
There will be primary data collection using Semi-structured interviews with key stakeholders, Focus Group Discussions with homogenous target groups of stakeholders. The number and universe of KIIs and FGD will determined in further steps. However, the selection of key informants and the constitution of focus groups should respect variety, and diversity and meet the criteria of inclusion with specific attention to gender considerations. In addition to KIIs and FGD, the review and documentation of lessons learned will be based on thorough document review and analysis, and employ direct observation of PHC facilities and communities to the extent possible. In the

Desk Review:

- Review program design documents, policies, and monitoring data specific to the 8 states.
- Gather and compile state and LGA health indicators, immunization coverage reports, capacity-building records, and project performance data (e.g., immunization coverage, PHC service metrics), Financial and risk assessment reports.

MSC Stories:

- Gather stories from key stakeholders, highlighting changes in governance, service delivery, and community trust at the state level.

***Key Informant Interviews (KIIs)**:*

- Conduct interviews with state health officials, LGA managers, and community leaders.
- Gather stories from key stakeholders, highlighting changes in governance, service delivery, and community trust at the state level (MSC Stories).

***Focus Group Discussions (FGDs)**:*

- Engage with frontline healthcare workers and beneficiaries to explore local perceptions of program impacts

Observations:

- Conduct field visits to selected PHC facilities and communities to observe implementation in diverse sub-national contexts.

Data analysis methods and techniques

The Data Analysis Phase involves evaluating the program using the OECD DAC Evaluation Criteria. This includes assessing how state-specific priorities influenced program implementation, analyzing the alignment of project goals with national health priorities and GAVI's objectives (relevance), measuring state-level progress toward immunization and primary health care targets (effectiveness), comparing resource utilization across states to identify areas of improvement (efficiency), and evaluating how well interventions are embedded in state systems (sustainability).

Qualitative data analysis will be performed through thematic analysis and pattern matching; it will be done by using coding software (e.g., NVivo, Atlas, etc.) to identify common themes across states, such as leadership, resource allocation, and health equity. Quantitative analysis will use statistical packages (e.g., SPSS, R, etc.) to evaluate immunization coverage, resource distribution, and disparities among states and local government areas. Quantitative data analysis will include descriptive statistics, trend analysis, equity gap analysis, and performance comparisons. For the credibility of findings and conclusions, mixed-methods approaches supported by triangulation protocols, validation workshops, expert views, and feedback from stakeholders will be used as systematically as possible.

Most Significant Change (MSC) analysis will identify state-specific patterns of success and challenges through MSC stories, and findings will be validated with stakeholders to ensure relevance and accuracy.

DLL reflection will facilitate discussions at federal and state levels to explore systemic assumptions and contextual factors shaping program achievements, implementation successes, or failures, and derive actionable lessons in facilitating the revision of underlying assumptions, policies, and strategies about how the program was supposed to deliver or perform.

Limitations and mitigation measures

A formal evaluation would have been more useful to assess the GAVI HSS project in 8 selected states in Nigeria but the approved project monitoring framework did not request conducting a program evaluation. The current review and documentation of the lessons learned exercise is limited in scope to tell the story of successes or failures, learnings, and accountabilities in managing the

program, or impact/lack of impact of the program to improve immunization coverage and equity, HSS strengthening and integration of health interventions at the PHC level. While the proposed methodology seeks to use four integrated frameworks to understand the implementation facilitators and barriers, review program achievements, challenge existing assumptions, and document lessons learned, the timing of this review (3 months ahead of the project completion date) limits the possibility of a thorough application of analytical frameworks.

The use of OECD DAC criteria to a review (and not evaluation) comes with risks. The scope of this review does not involve an impact assessment; the reference to other criteria such as relevance, coherence, effectiveness, efficiency, and sustainability is localized and limited to the analysis of a few Implementation Research questions. Quantitative data emanating mostly from the program monitoring system, and the impossibility of conducting an impact assessment limit the internal and external validity of the review. The use of a conceptual framework articulating four distinct analytical approaches is an effort to reduce threats to validity. Moreover, in analyzing data and interpreting the findings, efforts will be made to systematically triangulate data sources, and methods and seek perspectives from a mix of stakeholders. While the review and documentation of lessons learned can provide useful insights, it is cautionary to keep in mind that the learnings will be mostly relevant to the context of Nigeria and the intervention states.

Ethical considerations

The review will protect participants from any physical, emotional, or social harm resulting potentially from the assignment. Principles of confidentiality, respect, justice, transparency, benevolence, and protection will be applied during all review phases. Informed consent will be obtained from participants in the KIIs, and FGDs.

10. DELIVERABLES

The following deliverables are expected from

Description	Suggested Content	Timeline
Inception Report	Detailed methodology, work plan, and data collection, list of documents, data sources and people to be contacted (Key Informants) tools	Week 2
Draft Report	Preliminary findings and DLL-driven lessons learned.	Week 7
Final Report	Comprehensive analysis and recommendations	Week 9
Presentation	Key findings shared with stakeholders.	Week 10

11. TIMELINE

Activities	Timeline	Observations
Preliminary work	Week 1	The planning and schedule of activities is based on the best case scenario, and considering the project completion date (March 31, 2025). This timeline is too constrained and would merit consideration. GAVI, UNICEF, and the Review Team should pay attention to meeting agreed deadlines.
Inception Report	Week 2	
Data Collection and Analysis	Weeks 3–6	
Draft Report	Week 7	
Validation Workshop	Week 9	
Final Report	Week 10	

12. MANAGEMENT OVERSIGHT:

The consultant will work under the direct supervision of the Chief of Health and the Evaluation Manager. Designated staff from Abuja and Field Offices will play critical roles. *To facilitate strategic and operational decision-making, a **Review Steering Committee** will be set to play the oversight role. Members of the Steering Committee will include representatives of GAVI, PHCAB, UNICEF, Implementing Partners, and representatives of target populations*. The consultant will report to chief of Health Programme, and work in close collaboration with: the Project implementation team, State-level coordinators, GAVI liaison team, and Ministry of Health representatives, including representatives of State Primary Health Care Development Agencies/Boards and State level Health Insurance Agency???.

13. QUALIFICATIONS AND EXPERIENCE REQUIRED

This assignment will be conducted by a pool of individual consultants under the general oversight of the Review Team Leader. Considering the technical requirements and methodological complexity of the assignment (different conceptual and analytical frameworks) and the limited time scope (three months, or less), UNICEF suggests a pool of three to four individual consultants: one international principal consultant and team leader, two national senior consultants, and a national junior consultant as necessary.

Under the supervision of the Team Leader, the National Senior Consultants are expected to perform two different but complementary roles in supporting the application of the Implementation Research and Structured Reflection Framework. **The international principal consultant/team leader will identify and propose a pool of qualified national consultants from which UNICEF will select the most suitable candidates. Contract modalities for national consultants will be arranged and included in the financial offer prepared and submitted by the International Principal Consultants.** Any approach that does not align with the latter will be duly mentioned, discussed, and agreed between parties.

Qualification requirements for the International Principal Consultant/Team Leader. She or he must meet the following criteria:

- Advanced degree in public health, health systems, or related field

- Minimum 10 years experience in health systems strengthening
- Proven expertise in successful health program evaluations in the context of Nigeria
- Proven expertise in implementation research
- Strong understanding of double-loop learning and reflective practice
- Experience with GAVI HSS projects
- Excellent analytical and writing skills
- Experience in Nigeria's health system
- Knowledge of immunization programming
- Expertise in participatory evaluation methods
- High level of professionalism and an ability to work independently and in high-pressure situations under tight deadlines.
- Excellent written and spoken English skills required.
- Experience in participatory approach is a must as well as facilitation skills and ability to manage diversity of views in different cultural contexts.
- Ability to produce well-written reports demonstrating analytical ability and communication skills (consultant may be asked to provide sample work).

14. APPLICATION REQUIREMENTS

Interested consultants should submit a technical proposal including (a) an understanding of the assignment; (b) a proposed methodology; (c) a work plan, (d) Team composition, (e) CVs, (f) a sample of similar work, and references if applicable. **In addition, they must prepare and submit a separate Financial proposal with the total amount and breakdown per cost categories. Cost for national consultants must be included in the proposal.**

15. EVALUATION CRITERIA FOR SUCCESSFUL APPLICATIONS

Proposals will be evaluated based on the following considerations. Only candidates who score at least 70/85 on the technical proposal:

Category	**Percentage**
Technical Proposal	
Technical understanding	30%
Methodology and approach	30%
Relevant experience	25%
Financial proposal	
Financial offer	15%
Total	100%

16. PAYMENT SCHEDULE

Payment installments will be made against completed deliverables as follows:

Description	**Percentage**
Inception Report	25%
Data collection and production of the first Draft Report	40%

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Validation workshops and presentation to stakeholders	20%
Final report and presentation	15%

Annex 1: Guiding Questions

Caution: the following proposed set of questions on 9 result areas and broken into Implementation Research Questions and Double Learning Loops-driven questions are just illustrative. It represents an effort to capture the essence and substance of the proposed methodology. Yet, they are not final and definitive. Applicants are highly encouraged to review, enrich, and refine the questions while preserving key aspects of the methodology, and considering **time, technical and analytical constraints**. An improved version of the review design matrix should be part of the technical proposal. The finalization and validation of this annex will happen during the inception phase, and will therefore constitute the basis of the qualitative data collection and analysis.

Result Area	Main objective	Implementation Research Questions	DLL-Driven Questions
Leadership and Governance Capacity	• Assess how state-level leadership reforms improved decision-making and accountability. • Use DLL to reflect on assumptions about governance readiness and interagency collaboration.	1. How effective were leadership and governance initiatives in improving decision-making and accountability? 2. What mechanisms institutionalized governance reforms, and how effective were they? 3. How did political and systemic factors influence governance outcomes at state and LGA levels? 4. What gaps remain, and how can they be addressed to ensure sustainable governance improvements?	1. What assumptions were made about policymakers' capacity to lead reforms, and how accurate were they? 2. How did systemic factors, such as interagency dynamics or policy misalignment, shape outcomes? 3. Were accountability frameworks adapted to local contexts, and what adjustments are needed? 4. How can governance strategies be redesigned for scalability and sustainability?
Coverage and Equity	• Evaluate disparities in immunization coverage and access across LGAs within states. • Use MSC stories to document successes in reaching underserved populations.	1. How did the project address inequities in immunization and PHC service delivery? 2. What strategies were most effective in improving access for underserved populations? 3. To what extent were disparities reduced across demographic or geographic groups? 4. What factors influenced coverage outcomes, and what gaps remain?	1. What assumptions underpinned equity strategies, and how accurate were they? 2. How did cultural, economic, or geographic barriers impact coverage efforts? 3. What systemic inequities persisted, and why? 4. How can equity strategies be refined for future programming?

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Result Area	Main objective	Implementation Research Questions	DLL-Driven Questions
Demand Creation and Community Engagement	• Explore state-specific cultural and social dynamics influencing demand creation. • Reflect on systemic barriers to sustaining community trust and participation.	1. What strategies were employed to create demand for PHC and immunization services, and how effective were they? 2. How did community engagement contribute to service uptake? 3. What challenges were encountered in institutionalizing community participation? 4. What lessons can inform the sustainability of demand-creation efforts?	1. What assumptions were made about community attitudes toward healthcare, and how valid were they? 2. How did systemic factors, such as cultural norms or trust in health workers, influence engagement outcomes? 3. What barriers, such as misinformation or lack of trust, emerged during implementation? 4. How can engagement strategies be redesigned for long-term impact?
HIMS	• Assess state-level adoption and integration of HIMS into decision-making processes. • Reflect on infrastructure and capacity gaps that limited data utility.	1. How did the project improve the accuracy, timeliness, and use of health data for decision-making? 2. What challenges were encountered in implementing HIMS across states? 3. How did systemic factors, such as infrastructure gaps, influence HIMS adoption? 4. What measures are required to scale and sustain HIMS improvements?	1. What assumptions guided the design and implementation of HIMS, and how accurate were they? 2. How did gaps in infrastructure, training, or policy alignment impact data utility? 3. What systemic barriers, such as resistance to change, limited HIMS success? 4. How can HIMS be redesigned to meet the needs of diverse stakeholders?
Capacity Building	• Analyze the effectiveness of state-level training programs in addressing workforce gaps. • Use DLL to explore assumptions about workforce deployment and retention strategies.	1. How effective were the training programs in improving the capacity of healthcare workers to deliver PHC services? 2. To what extent did the project address gaps in workforce deployment in underserved areas? 3. What challenges were encountered in ensuring adequate retention and utilization of trained personnel? 4. How did capacity building impact the delivery of immunization and PHC services in the targeted states?	1. What assumptions were made about the availability, motivation, and willingness of health workers to participate in capacity-building initiatives? 2. How did systemic factors, such as workforce policies or resource constraints, influence the success of training and deployment efforts? 3. What barriers, such as cultural or institutional resistance, emerged during implementation, and how were they addressed? 4. How can capacity-building strategies be redesigned to ensure alignment with

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Result Area	Main objective	Implementation Research Questions	DLL-Driven Questions
			systemic realities and long-term sustainability?
Financial Risk Assessment	• Examine how financial accountability mechanisms addressed state-specific challenges. • Reflect on gaps in fund allocation and utilization processes.	1. How effective was the program in identifying and addressing financial risks to immunization and PHC service delivery? 2. What mechanisms were introduced to improve financial accountability and efficiency? 3. To what extent were financial risks mitigated, and what gaps remain? 4. How did financial risk management contribute to the sustainability of program interventions?	• What assumptions were made about the availability and flow of financial resources, and how accurate were they? • How did systemic inefficiencies, such as delays in fund disbursement or misallocation, impact program outcomes? • What alternative approaches to financial risk assessment and mitigation could have been more effective? • How can financial risk management frameworks be institutionalized to ensure long-term accountability and resource optimization?
Health Finacning	1. Strengthening national and subnational political and social commitment to immunisation; 2. Promoting domestic public resources for immunization and primary healthcare (PHC) to improve allocative efficiency; and 3. Preparing and engaging self-financing countries to maintain or increase performance.	1. What specific mechanisms were introduced to increase domestic public resources for PHC and priority interventions at the state level, and how were they implemented? 2. What targeted strategies were used to reduce financial barriers and improve healthcare access among vulnerable populations from ZD ommunities? 3. In what ways did insurance interventions contribute to increased service uptake in ZD communities, and what were the key influencing factors? 4. What lessons from the design and implementation of health financing interventions can inform their sustainability and effectiveness at the state level?	• What assumptions were made about the availability of additional resources for PHC services, and how did they influence implementation? • How did systemic inefficiencies, such as limited financial resources and discrepancies between fund allocation and release, affect program outcomes? • What alternative approaches can improve financial risk protection against health shocks while ensuring the sustainability of healthcare services? • How can health financing strategies support long-term sustainability and continued prioritization by the government?

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Result Area	Main objective	Implementation Research Questions	DLL-Driven Questions
Availability of Vaccines and Commodities	• Assess supply chain efficiency at the state level, focusing on bottlenecks and successes. • Reflect on systemic assumptions about demand forecasting and logistics.	1. What strategies were implemented to ensure consistent availability of vaccines and essential commodities in the targeted states? 2. How did the project address challenges in supply chain management and distribution? 3. What systemic factors influenced the availability and timely delivery of commodities? 4. To what extent did the availability of commodities improve service delivery and health outcomes?	1. What assumptions were made about supply chain efficiency and readiness to handle vaccine and commodity distribution? 2. How did contextual factors, such as funding gaps or infrastructure limitations, affect availability? 3. What systemic barriers, such as forecasting errors or logistical bottlenecks, emerged during implementation? 4. How can supply chain strategies be improved to enhance resilience and ensure consistent availability of vaccines and commodities?
Monitoring Health Outcomes	• Evaluate the robustness of state-level M&E frameworks in tracking health outcomes. • Use DLL to explore systemic gaps in linking monitoring data to program adjustments.	1. How effective were the monitoring and evaluation (M&E) systems in tracking health outcomes and informing decision-making? 2. What challenges were encountered in linking program outputs to measurable health outcomes? 3. How did the project ensure the quality, timeliness, and usability of health data? 4. What lessons can inform the design of more effective M&E frameworks for future programs?	1. What assumptions were made about the capacity and willingness of stakeholders to utilize monitoring data for decision-making? 2. How did systemic issues, such as inadequate infrastructure or staff capacity, limit the effectiveness of M&E systems? 3. What gaps in the monitoring framework, such as missing indicators or lack of real-time data, were identified? 4. How can M&E systems be redesigned to better capture health outcomes and support adaptive programming?
Community Engagement in Immunization	• Document transformative changes in community participation at the state level. • Reflect on systemic assumptions about engagement strategies and their sustainability.	1. What strategies were employed to engage communities in immunization programs, and how effective were they? 2. How did community engagement contribute to increased immunization coverage and service uptake? 3. What challenges were encountered in fostering sustained community participation?	1. What assumptions were made about community attitudes and trust in healthcare services, and how valid were they? 2. How did systemic factors, such as cultural norms or historical mistrust, influence community engagement efforts? 3. What unintended consequences, such as resistance or miscommunication, emerged during implementation?

Review and Documentation of Lessons-Learned arising from GAVI Support to HHS in 8 Selected States in Nigeria

Result Area	Main objective	Implementation Research Questions	DLL-Driven Questions
		4. What lessons can inform the institutionalization of community engagement strategies in health programming?	4. How can community engagement strategies be redesigned to better address systemic barriers and promote long-term involvement?